COVID-19 Question and Answer Session for Long-Term Care and Congregate Residential Settings

January 21st, 2022

Housekeeping

- All attendees in listen-only mode
- Submit questions via Q&A pod to **All Panelists**
- Slides and recording will be made available later

Agenda

- Upcoming Webinars
- SNF Booster Data
- COVID-19 Vaccinations
- LTC Updates
- Open Q & A

Slides and recording will be made available after the session.

IDPH webinars

Upcoming Friday Brief Updates and Open Q&A
1:00 pm - 2:00 pm

Friday, January 28th	https://illinois.webex.com/illinois/onstage/g.php?MTID=e7219111798c190cbec52c8eae6c4836c

Previously recorded webinars can be viewed on the IDPH Portal

Slides and recordings will be made available after the sessions.

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Upcoming Telligen Events

LTC Spotlight: QAA/QAPI Committee, Leading Nursing Homes Back to the Future
January 27, 2022
12pm-1pm MST/1pm-2pm CST
Register here

Root Cause Analysis (RCA) Training
Every Tuesday
9:30am -10:30am MST/10:30am-11:15am CST
Register here

Plan-Do-Study-Act (PDSA) Training
Every other Wednesday
10am-11am MST/11am-12pm CST
Register here

Ask the Pharmacist- Vaccine/Booster Questions
Every Thursday
11am-11:30am CST
Register here

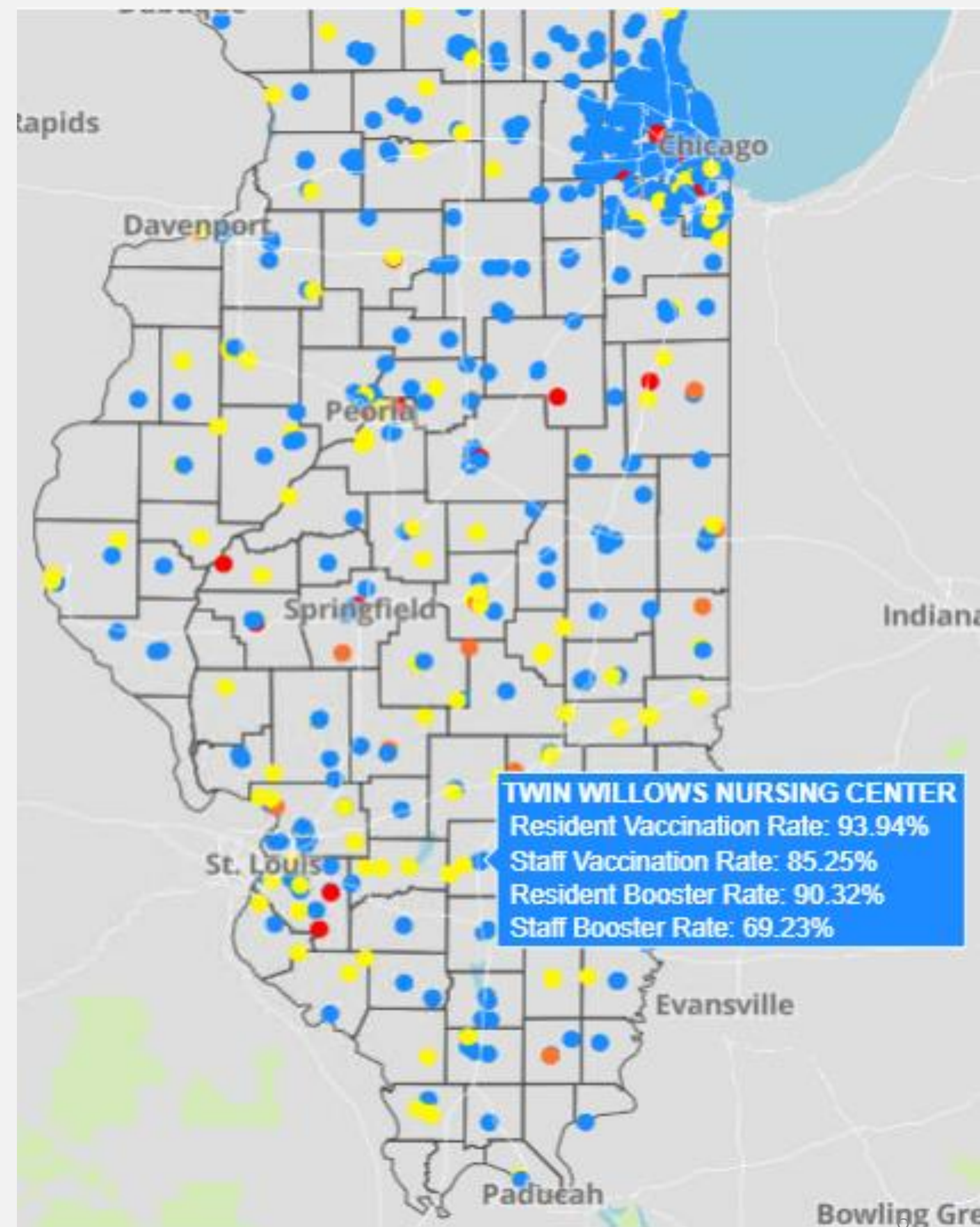
Give Your Nursing Home a Boost-Vaccine/Booster strategies
Every Tuesday 3 PM CT
Every Thursday 10 AM CT
Register here

QAPI 101 Mini Collaborative
February 10, 2022 1:30am-12:30 pm CT
Register **HERE**

Check out the Telligen QI Connect™ event page: **https://www.telligenqinqio.com/events**

IDPH website: SNF booster data added

https://dph.illinois.gov/covid19/data/long-term-care-covid-19-facility-level-data.html



Hang in There

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The New York Times — U.S. | Illinois Coronavirus Map and Case Count

	DAILY AVG. ON JAN. 19	14-DAY CHANGE	TOTAL REPORTED
Cases	26,628	+6%	2,713,231
Tests	153,610	+54%	—
Hospitalized	6,835	+9%	—
Deaths	124	+70%	33,052

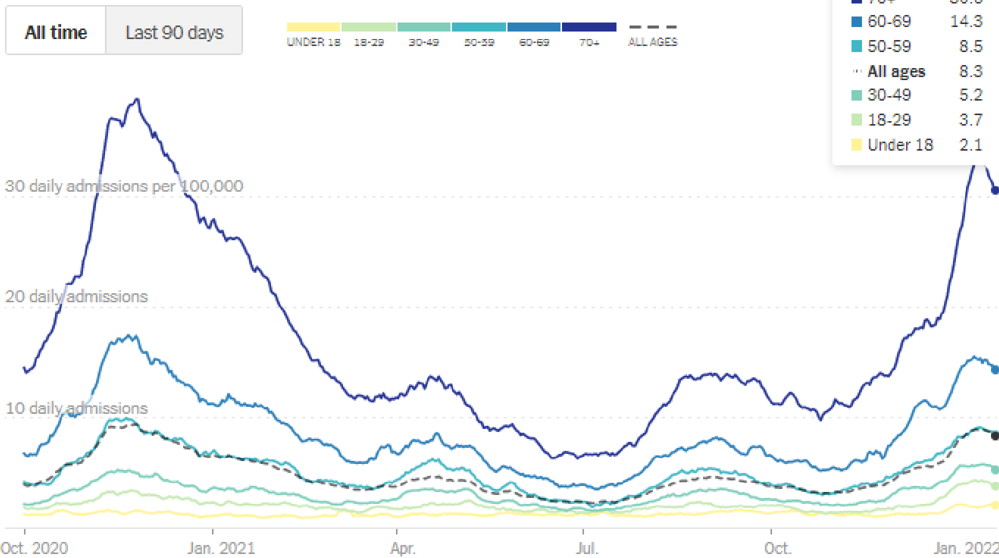
About this data

rejecting such guidance or mandates. Read more here ›

- Masks are mandated indoors by state officials.
- Masks are mandated in schools for all students by state officials.

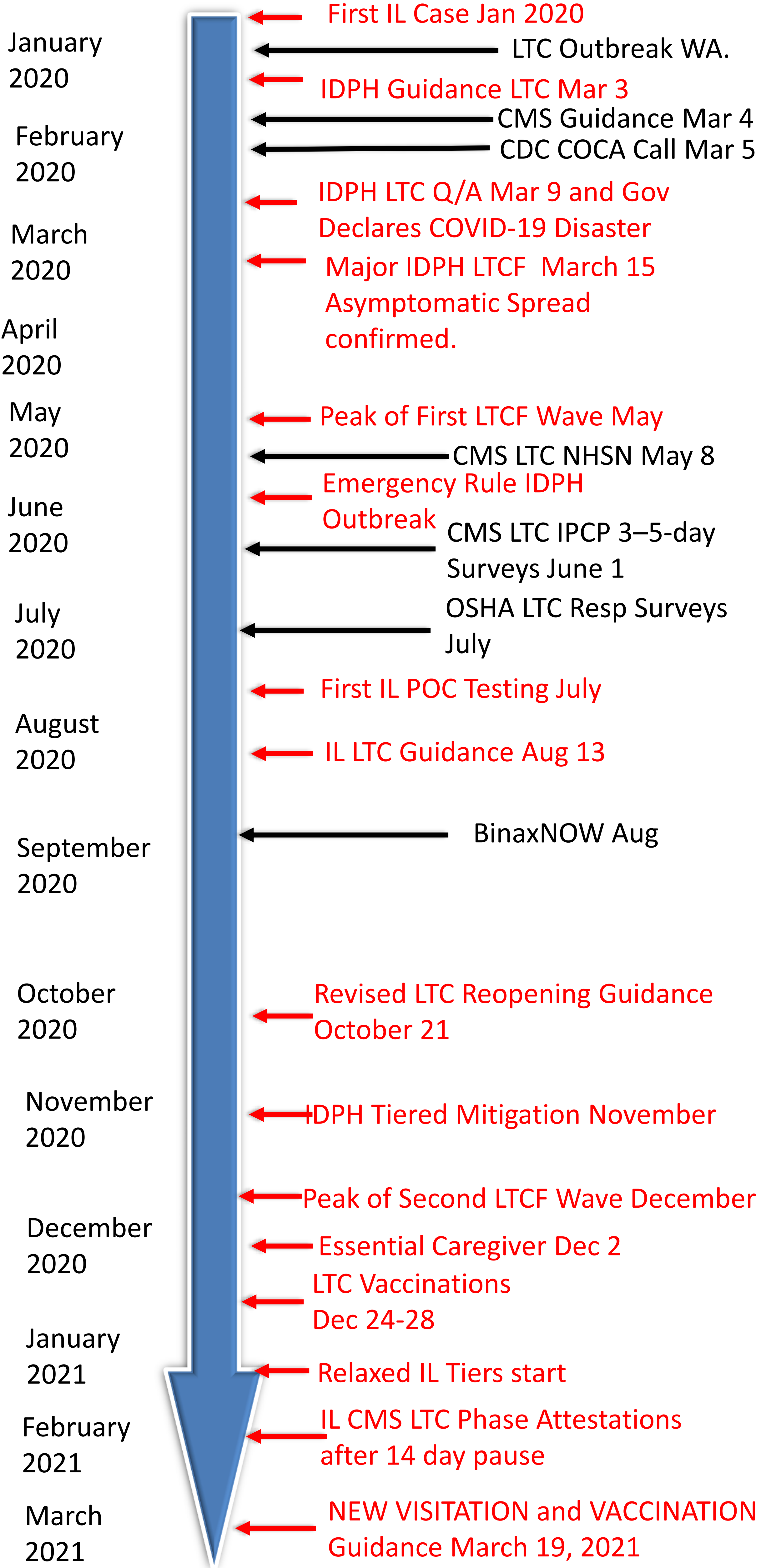
Daily new hospital admissions by age in Illinois

This chart shows for each age group the number of people per 100,000 that were newly admitted to a hospital with Covid-19 each day, according to data from the U.S. Department of Healt[…] Services. Dips and spikes could be due to inconsistent reporting by hospitals.



About this data

Omicron Wave



First IL Case Jan 2020
LTC Outbreak WA.
IDPH Guidance LTC Mar 3
CMS Guidance Mar 4
CDC COCA Call Mar 5
IDPH LTC Q/A Mar 9 and Gov Declares COVID-19 Disaster
Major IDPH LTCF March 15 Asymptomatic Spread confirmed.
Peak of First LTCF Wave May
CMS LTC NHSN May 8
Emergency Rule IDPH Outbreak
CMS LTC IPCP 3–5-day Surveys June 1
OSHA LTC Resp Surveys July
First IL POC Testing July
IL LTC Guidance Aug 13
BinaxNOW Aug
Revised LTC Reopening Guidance October 21
IDPH Tiered Mitigation November
Peak of Second LTCF Wave December
Essential Caregiver Dec 2
LTC Vaccinations Dec 24-28
Relaxed IL Tiers start
IL CMS LTC Phase Attestations after 14 day pause
NEW VISITATION and VACCINATION Guidance March 19, 2021
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020
July 2020
August 2020
September 2020
October 2020
November 2020
December 2020
January 2021
February 2021
March 2021
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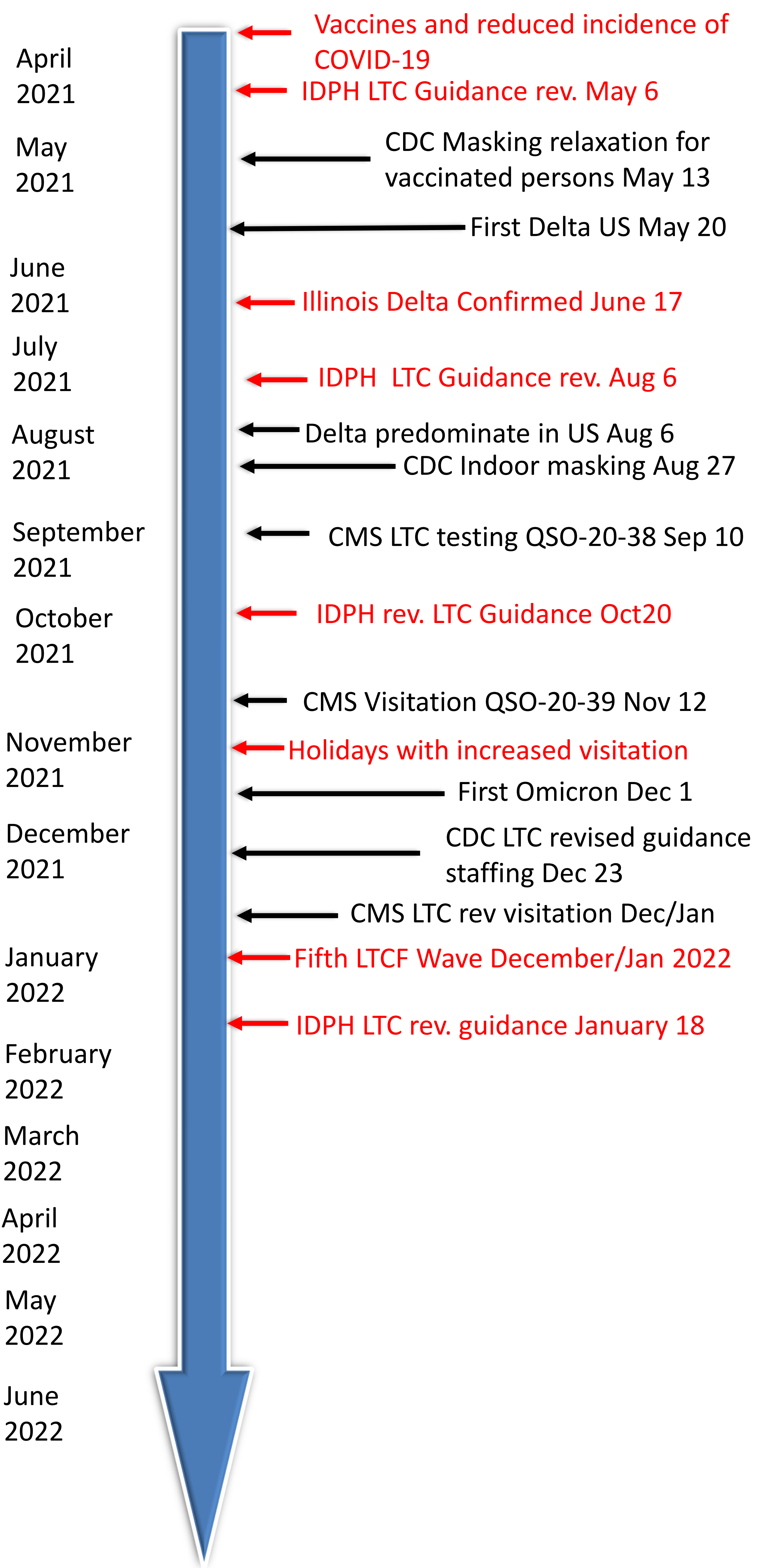

Vaccines and reduced incidence of COVID-19
IDPH LTC Guidance rev. May 6
CDC Masking relaxation for vaccinated persons May 13
First Delta US May 20
Illinois Delta Confirmed June 17
IDPH LTC Guidance rev. Aug 6
Delta predominate in US Aug 6
CDC Indoor masking Aug 27
CMS LTC testing QSO-20-38 Sep 10
IDPH rev. LTC Guidance Oct20
CMS Visitation QSO-20-39 Nov 12
Holidays with increased visitation
First Omicron Dec 1
CDC LTC revised guidance staffing Dec 23
CMS LTC rev visitation Dec/Jan
Fifth LTCF Wave December/Jan 2022
IDPH LTC rev. guidance January 18
April 2021
May 2021
June 2021
July 2021
August 2021
September 2021
October 2021
November 2021
December 2021
January 2022
February 2022
March 2022
April 2022
May 2022
June 2022
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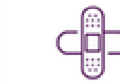
CDC 24/7: Saving Lives, Protecting People

COVID-19

We have the tools to
Fight Omicron


Vaccines & Booster

Masks

Testing

Your Health | Vaccines | Cases & Data | Work & School | Healthcare Workers | Health Depts | Science | More

Vaccines
- Your Vaccination +
- Types of Vaccines Available +
- Possible Side Effects
- **Stay Up to Date with Vaccines** –
  - Possibility of COVID-19 Illness after Vaccination
- Safety & Monitoring +
- COVID-19 Vaccines are Effective +
- Myths & Facts +
- Frequently Asked Questions +

Stay Up to Date with Your Vaccines

Updated Jan. 16, 2022 Languages Print

Get Vaccinated and Stay Up to Date

Up to date means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.

Fully vaccinated means a person has received their primary series of COVID-19 vaccines.

COVID-19 Vaccines

COVID-19 vaccines available in the United States are effective at protecting people from getting seriously ill, getting hospitalized, and even dying. As with vaccines for other diseases, people who are up to date are optimally protected. CDC recommends that everyone 5 years and older get their primary series of COVID-19 vaccines, and receive a booster dose when eligible.

When Are You Up to Date?

Up To Date with COVID-19 Vaccinations

- Different for different age groups and immune conditions
- **Up To Date:** A person is considered "boosted" and **up to date** right after getting their booster dose(s).
- **Up to Date** is flexible term that may be modified if further doses are necessary
- **Fully Vaccinated:** 2 weeks after final dose in primary series
- **Booster Dose:** Normal immune function, additional booster after 2 mRNA or 1 viral vector vaccine
- **Additional Primary Dose(s)**: Moderately or Severely Immunocompromised, considered part of the primary series

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COVID-19 Vaccination Mandates

- State of Illinois
  - Effective September 5, 2021
  - executive-order-2021-20.pdf (illinois.gov)

- Centers for Medicare & Medicaid Services (CMS)
  - Upheld by the Supreme Court
  - Condition of Participation
  - https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/guidance-interim-final-rule-medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-0

- Occupational Safety and Health Administration (OSHA)
  - Struck down by Supreme Court

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CMS COVID-19 Vaccination Mandate

Within 30 days (1/27/22)

- Policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19
- Facilities with a staff vaccination rate above 80% at survey with a specific plan to achieve a 100% rate within 60 days would not be subject to additional enforcement action

Within 60 days (2/28/22)

- 100% of staff have received the necessary doses to complete the vaccine series
- At the 60-day mark, a facility above 90% with a plan to achieve a 100% staff vaccination rate within an additional 30 days would not be subject to additional enforcement action.

Within 90 days (3/30/22) and thereafter

- Facilities failing to maintain compliance with the 100% standard may be subject to enforcement action

https://www.cms.gov/files/document/qso-22-07-all.pdf

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Long-term Care Updates

- Application of LTC Guidance

Visitors

Visitors must follow the quarantine and isolation guidance for LTC residents; the shortened CDC time periods for the general public do not apply. This means that a visitor must be in isolation for 10 full days after a positive test, or 14 days of quarantine if a close contact of a COVID-19 positive individual, regardless of vaccination status.

*Statement added to ensure everyone recognizes the difference between general public and LTC visitor isolation and quarantine times—not meant for facilities to enforce visitor isolation and quarantine!!

Facilities will need to inform families that the shortened quarantine and isolation periods do not apply to them if they want to visit their loved ones and could consider posting signage at entrances, sending letters to families of residents, informing them during the screening process, etc.

Visitation and visitor masks

- Visit outdoors
- Create dedicated visitation space indoors
- Permit in room visits when the resident's roommate is not present
- Resident and visitor should wear a well-fitting mask ***(preferably those with better protection, such as surgical masks or KN95)***
- Offering visitors surgical masks or KN95 masks.
- Restricting the visitor's movement in the facility to only the location of the visit.
- Not conducting visits in common areas (except those areas dedicated for visitation).
- Increasing air-flow and ventilation.
- Cleaning and sanitizing the visitation area after each visit.
- Providing reminders in common areas (e.g., signage) to maintain physical distancing, perform hand-hygiene, and wear well-fitting

https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

Visitation during an Outbreak

There may be times when the scope and severity of an outbreak warrants the health department to recommend a pause or limitations on visitation as ***a temporary, short-term intervention (e.g. 14 days).*** We expect these situations to be ***extremely rare*** and only occur after the facility has been working with the local health department to manage and prevent escalation of the outbreak. We also expect that if the outbreak is severe enough to warrant pausing visitation, it would also ***warrant a pause on accepting new admissions*** (as long as there is adequate alternative access to care for hospital discharges).

Facilities must document the outbreak control measures taken, including consultations with the local health department, that preceded the decision to limit visitation.

Quarantine for HCP

- Quarantine for HCP has changed
- Quarantine work exclusion has been reduced **from 14 days to 10 days** for **<u>HCP ONLY</u>**
- This update does not apply to residents!
- No change in HCP Isolation timeframe

  unless in contingency or crisis staffing

Return to work
On Day 11

Staffing Mitigation Strategies

- Contingency staffing options (IDPH LTC Guidance, pages 14-16)
- Crisis staffing options (IDPH LTC Guidance, pages 14-16)
- Must be implemented sequentially
- Document efforts
- Work with local health departments

https://dph.illinois.gov/content/dam/soi/en/web/idph/covid19/guidance/ltc/IDPH%20LTC%20COVID-19%20Guidance%2001.18.21.pdf

Defining Contingency & Crisis Staffing

Contingency staffing

Staffing shortages are imminent, and if action is not taken will interrupt care functions. Contingency strategies are used to mitigate staffing shortages.

Crisis staffing

Staffing shortages already exist, and crisis strategies are used in order to continue to provide resident care.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Why are HCP allowed to return to work early (before 10 days has passed)?

- Not ideal (best practice is to be off for 10 days)
- A measure to continue to provide safe care to residents
- Contingency and crisis staffing strategies are to be used when staffing shortages are anticipated (contingency) and as a measure to continue to provide resident care (crisis)

Definition Change related to Testing

Conduct facility-wide testing of all residents and HCP immediately ***(but not earlier than 24 hours after exposure),*** regardless of vaccination status.

NOTE: This is a change----the previous guidance had instructed facilities to test **"but not earlier than two days"**

The new IDPH LTC Guidance (January 18, 2022) reflects new statement "not earlier than 24 hours"

Other Important changes

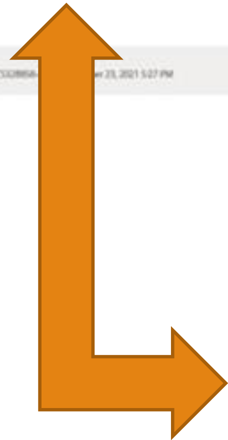
- There is no need to test individuals who have had COVID-19 in the prior 90 days if they remain asymptomatic

- Broad-based Approach
  - This approach is broad from the start or onset and requires testing of all residents and HCP regardless of vaccination status when a single case of COVID-19 is identified in the facility. ***If using the broad-based approach and not completing contact tracing, the facility must quarantine all unvaccinated residents.***

Work Restrictions for Asymptomatic HCP with Exposures

Vaccination Status	Conv
Boosted	No wo negati and 5-
Vaccinated or Unvaccinated, even if within 90 days of prior infection	10 day negati

†Negative test result within 48 hours before returning to work
‡For calculating ... for those with infection consider



Removed "even if within 90 days of prior infection" statement

APPENDIX A: SUMMARY TABLES

Table 5: Work Exclusions & Restrictions for Asymptomatic HCP with Exposures - New

Vaccination Status	Conventional		Contingency		Crisis (Must notify LHD and OHCR)	
	Work Exclusion	**Required Testing**	**Work Exclusion**	**Required Testing**	**Work Exclusion**	**Required Testing**
Boosted HCP have received all COVID-19 vaccine doses, including booster dose(s) **Screen for symptoms twice per shift**	Allowed to work with testing **Must be asymptomatic**	Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection. Note: HCP with ***prolonged, continued exposure in the home,*** must additionally test weekly for two weeks after the last exposure date.	Allowed to work **Must be asymptomatic**	No additional testing required to work **but include HCP in outbreak testing completed every 3-7 days,** unless within 90 days of COVID-19 infection	Allowed to work **Must be asymptomatic**	No additional testing required to work **but include HCP in outbreak testing completed every 3-7 days**, unless within 90 days of COVID-19 infection.
Vaccinated or Unvaccinated **Vaccinated HCP** have received all primary COVID-19 vaccine doses but not the booster. **Unvaccinated HCP** have NOT received all primary COVID-19 vaccine doses. **Screen for symptoms twice per shift**	10 days off (ideal) **OR** 7 days off **Must be asymptomatic**	If excluded from work for 10 days, no testing is required to return to work. Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection, must additionally test weekly for two weeks after the last exposure date. May return after 7 days with **one negative test*** Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work following testing cadence noted above under 10 days off.	Allowed to work **with negative testing*** **Must be asymptomatic**	Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection. Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection., must additionally test weekly for **two weeks after the last exposure date.** .	Allowed to work **with negative testing*** **Must be asymptomatic**	Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection. Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 **for two weeks after the last exposure date.**

NOTE: Asymptomatic Exposed HCP must complete required testing listed above and should be included in the facility's routine testing for unvaccinated HCP and outbreak testing every 3-7 days until there are no more positive results for 14 days.

*** Negative test result must be within 48 hours of returning to work. Either an antigen test or NAAT can be used, as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection.**

* For calculating day of test:
1) for infection consider day of symptomatic onset or first positive test if asymptomatic, as day 0
2) for exposure consider day of exposure as day 0

Screening Exposed Staff Returning to Work

APPENDIX A: SUMMARY TABLES

If staff are returning to work after an exposure, they need to be screened TWICE A SHIFT for 14 days after the exposure.

Must remain asymptomatic to work.

Table 5: Work Exclusions & Restrictions for Asymptomatic HCP with Exposures - New

Vaccination Status	Conventional		Contingency		Crisis (Must notify LHD and OHCR)	
	Work Exclusion	**Required Testing**	**Work Exclusion**	**Required Testing**	**Work Exclusion**	**Required Testing**
Boosted HCP have received all COVID-19 vaccine doses, including booster dose(s) **Screen for symptoms twice per shift**	Allowed to work with testing **Must be asymptomatic**	Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection. Note: HCP with ***prolonged, continued exposure in the home,*** must additionally test weekly for two weeks after the last exposure date.	Allowed to work **Must be asymptomatic**	No additional testing required to work **but include HCP in outbreak testing completed every 3-7 days,** unless within 90 days of COVID-19 infection	Allowed to work **Must be asymptomatic**	No additional testing required to work **but include HCP in outbreak testing completed every 3-7 days**, unless within 90 days of COVID-19 infection.
Vaccinated or Unvaccinated **Vaccinated HCP** have received all primary COVID-19 vaccine doses but not the booster. **Unvaccinated HCP** have NOT received all primary COVID-19 vaccine doses. **Screen for symptoms twice per shift**	10 days off (ideal) **OR**	If excluded from work for 10 days, no testing is required to return to work. Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection, must additionally test weekly for two weeks after the last exposure date.	Allowed to work with **negative testing*** **Must be asymptomatic**	Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection. Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection., must additionally test weekly for **two weeks after the last exposure date.** .	Allowed to work **with negative testing*** **Must be asymptomatic**	Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection. Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 **for two weeks after the last exposure date.**
	7 days off **Must be asymptomatic**	May return after 7 days with **one negative test*** Note: HCP with ***prolonged, continued exposure in the home,*** are allowed to work following testing cadence noted above under 10 days off.				

NOTE: Asymptomatic Exposed HCP must complete required testing listed above and should be included in the facility's routine testing for unvaccinated HCP and outbreak testing every 3-7 days until there are no more positive results for 14 days.

*** Negative test result must be within 48 hours of returning to work. Either an antigen test or NAAT can be used, as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection.**

* For calculating day of test:
1) for infection consider day of symptomatic onset or first positive test if asymptomatic, as day 0
2) for exposure consider day of exposure as day 0

Contingency Strategy HCP with COVID

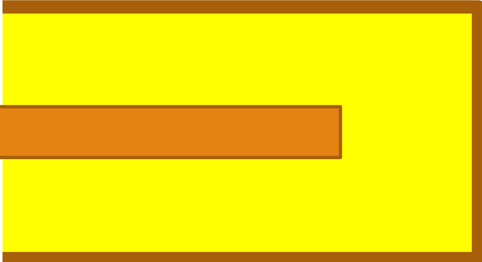
Work Restrictions for HCP With SARS-CoV-2 Infection

Webi

Table 4: Work Exclusions & Restrictions for HCP with COVID-19 Infection - New

Vaccination Status	Conventional		Contingency		Crisis (Must notify LHD and OHCR)[2]	
	Work Exclusion	**Required Testing**	**Work Exclusion**	**Required Testing**	**Work Exclusion**	**Required Testing**
Boosted, Vaccinated and Unvaccinated	10 days off (ideal) **OR**	No testing required to return to work	5 days off	May return after 5 days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. **Must have one negative test[1]** completed within 48 hours before work shift begins or rapid antigen test prior to shift.	Allowed to work exce[illegible] ha[illegible] prioritized	No additional [illegible]
	7 days off	May return to work after 7 days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. **Must have one negative test[1]** completed within 48 hours before work shift begins or rapid antigen test prior to shift				

[1]Either an antigen test or NAAT can be used as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection.
[2]LHD – Local Health Department, OHCR = IDPH Office of Health Care Regulation



NEW

Define Mild & Moderate Illness

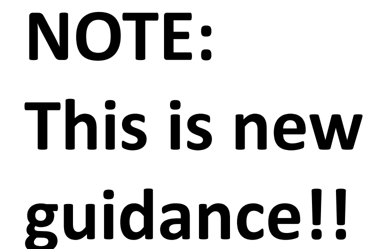
Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

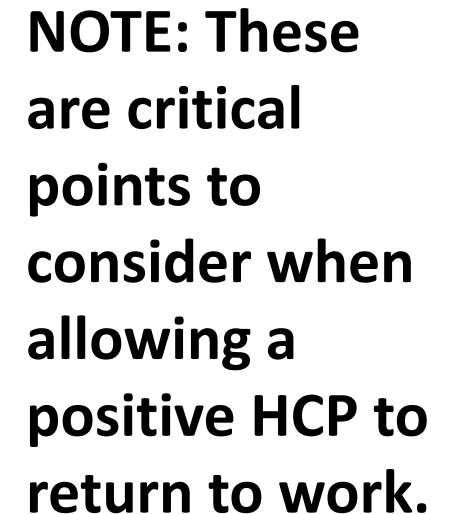
Reminder: If HCP return sooner than expected do the following:

- If HCP are permitted to return to work before meeting all conventional Return to Work Criteria, they should still adhere to the recommendations described below.
  - Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.
  - HCP should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
    - A respirator or well-fitting facemask should be worn continuously even when they are in non-patient care areas such as breakrooms.
    - They should practice physical distancing from coworkers at all times.
    - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
    - They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.



Who can positive HCP care for??

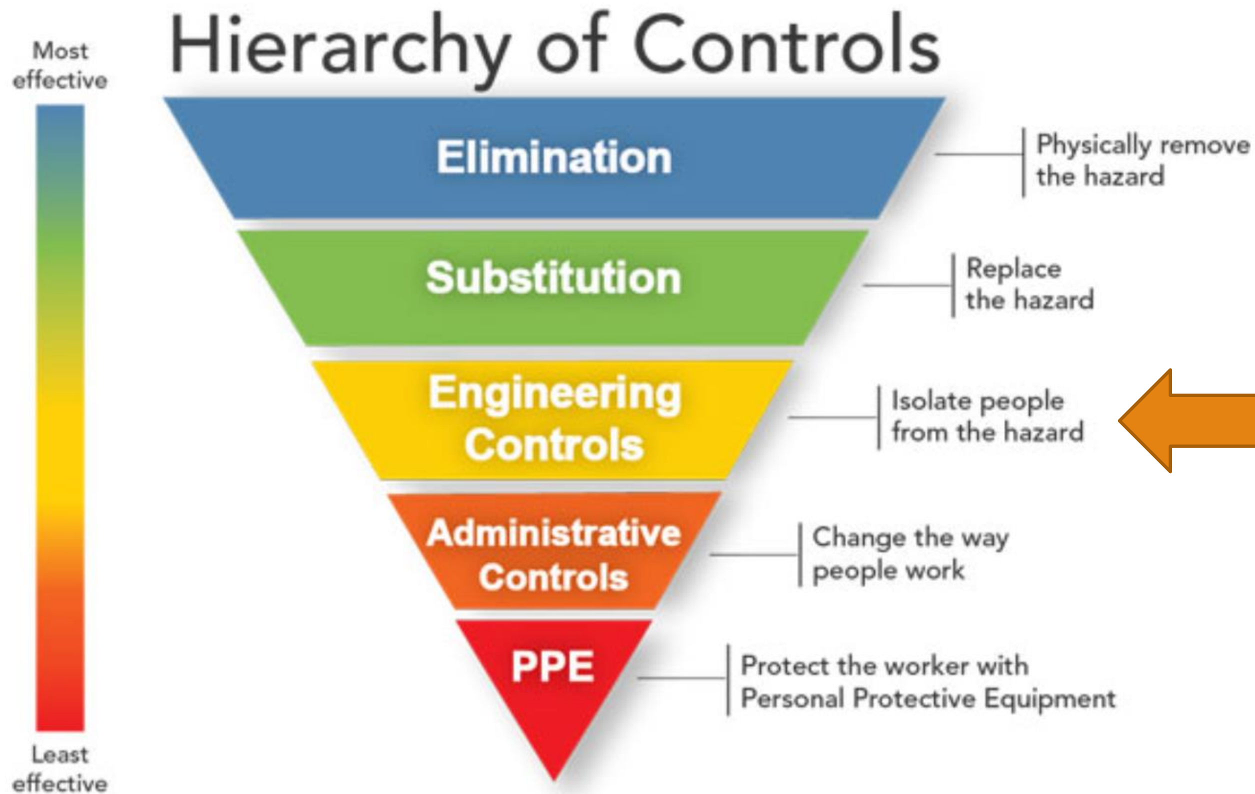
- If HCP are requested to work before meeting all criteria, they should be restricted from contact with moderately to severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:
  - If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with suspected SARS-CoV-2 infection.
  - As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients *without* suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies that do not involve care of uninfected patients by potentially infectious HCP. Strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential.



Allowing HCP who are positive for COVID-19 to work

- A last resort option
- HCP is willing to work
- HCP well enough to work
- HCP should only provide care to confirmed or suspected COVID-19 residents (unless in dire circumstances and only then with notification to local health department)
- Facilities should discuss changes in staffing with local health departments--- from Conventional to Contingency and especially before implementing Crisis staffing options

Improving Ventilation



Ventilation is considered an Engineering Control and is more effective than PPE in reducing the risk of airborne concentrations.

The idea behind this hierarchy is that the control methods at the top of graphic are potentially more effective and protective than those at the bottom. Following this hierarchy normally leads to the implementation of inherently safer systems, where the risk of illness or injury has been substantially reduced.

https://www.cdc.gov/niosh/topics/hierarchy/

Improving ventilation practices and interventions can reduce the airborne concentrations and reduce the risk that residents, visitors, and HCP come in contact with viral particles.

Approaches include:

- Increasing the introduction of outdoor air.
- Ensuring ventilation systems are operating properly as defined by ASHRAE Standard 62.1
- Optimizing the use of engineering controls to reduce or to eliminate exposures.
- Exploring options to improve ventilation delivery and indoor air quality in all shared spaces. The higher number of air exchanges per hour will result in better results with respect to purging airborne contaminants. Refer to the CDC suggested options for Air Changes per Hour (ACH).
- Using portable High-Efficiency Particulate Air (HEPA) fan/filtration systems to enhance air cleaning.

https://dph.illinois.gov/content/dam/soi/en/web/idph/covid19/guidance/ltc/IDPH%20LTC%20COVID-19%20Guidance%2001.18.21.pdf

Open Q&A

Submit questions via Q&A pod to **All Panelists**

Please do not resubmit a single question multiple times

Slides and recording will be made available after the session.

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Reminders

- SIREN Registration
  - To receive situational awareness from IDPH, please use this link to guide you to the correct registration instructions for your public health related classification: http://www.dph.illinois.gov/siren

- NHSN Assistance:
  - Contact Telligen: **nursinghome@telligen.com**