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

January 28th, 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
- Project Firstline
- BinaxNOW Expiration Dates
- COVID-19 Updates
- Therapeutic Options
- Use of Engineering Controls to Improve Air Quality
- LTC Updates
- Questions from last week
- Open Q & A

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
Friday, February 4th	https://illinois.webex.com/illinois/onstage/g.php?MTID=e5d4c87e6706156a65e6e6ca35b3e5a5f
Friday, February 18th	https://illinois.webex.com/illinois/onstage/g.php?MTID=e61a9e21c53f9d2aa91f55a0cdc5a2019
Friday, February 25th	https://illinois.webex.com/illinois/onstage/g.php?MTID=e710feef877cc5d88ec538aa612fcc984

Previously recorded webinars can be viewed on the IDPH Portal

Slides and recordings will be made available after the sessions.

Project Firstline

- 30-minute infection control training
  - Nurses & CNAs

- If interested, please complete this two-minute survey:
  - Availability
  - Topics of interest

Together we have the power to stop infections.

BinaxNOW expiration extension

- BinaxNOW COVID-19 Ag Card Kits now have **15-month** expiry date

- Memo from Abbott has lot numbers and new expiration dates

- https://www.globalpointofcare.abbott/en/product-details/navica-binaxnow-covid-19-us.html
  (Go to Helpful Documents section)

Attachment 1 - BinaxNOW™ COVID-19 Ag Card lots with extended expiry

| Kit Lot Number	Original Expiry	15 Month Expiry
124008	7-Feb-21	7-Nov-21
124073	8-Feb-21	8-Nov-21
124199	10-Feb-21	10-Nov-21
124380	11-Feb-21	11-Nov-21
124410	12-Feb-21	12-Nov-21
124462	14-Feb-21	14-Nov-21
124557	16-Feb-21	16-Nov-21
124569	18-Feb-21	18-Nov-21
124743	21-Feb-21	21-Nov-21
124858	21-Feb-21	21-Nov-21
124865	23-Feb-21	23-Nov-21
125049	24-Feb-21	24-Nov-21
125052	25-Feb-21	25-Nov-21
125406	28-Feb-21	28-Nov-21
125419	28-Feb-21	28-Nov-21
125425	1-Mar-21	1-Dec-21
125523	2-Mar-21	2-Dec-21
125525	2-Mar-21	2-Dec-21
125528	27-Feb-21	27-Nov-21

COVID-19 Update…

Illinois COVID-19 Daily Cases Over Time
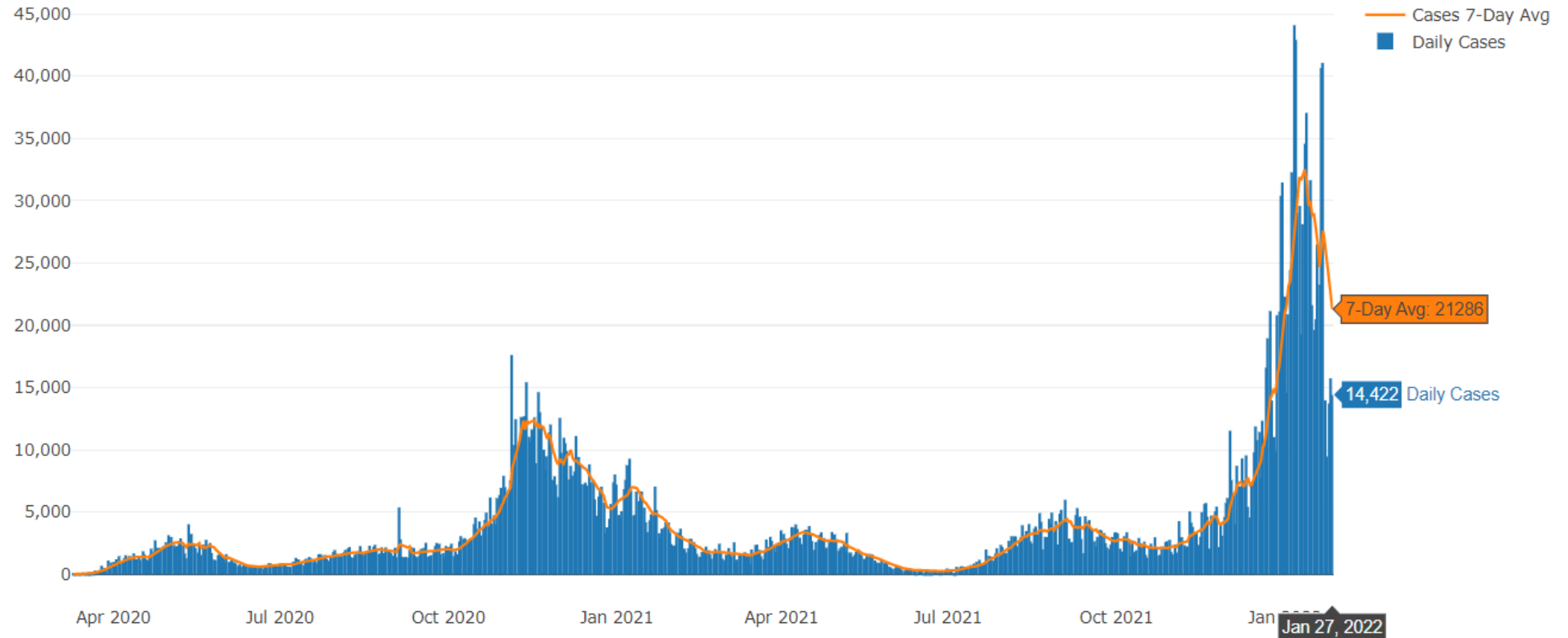
Illinois COVID-19 Daily Deaths Over Time
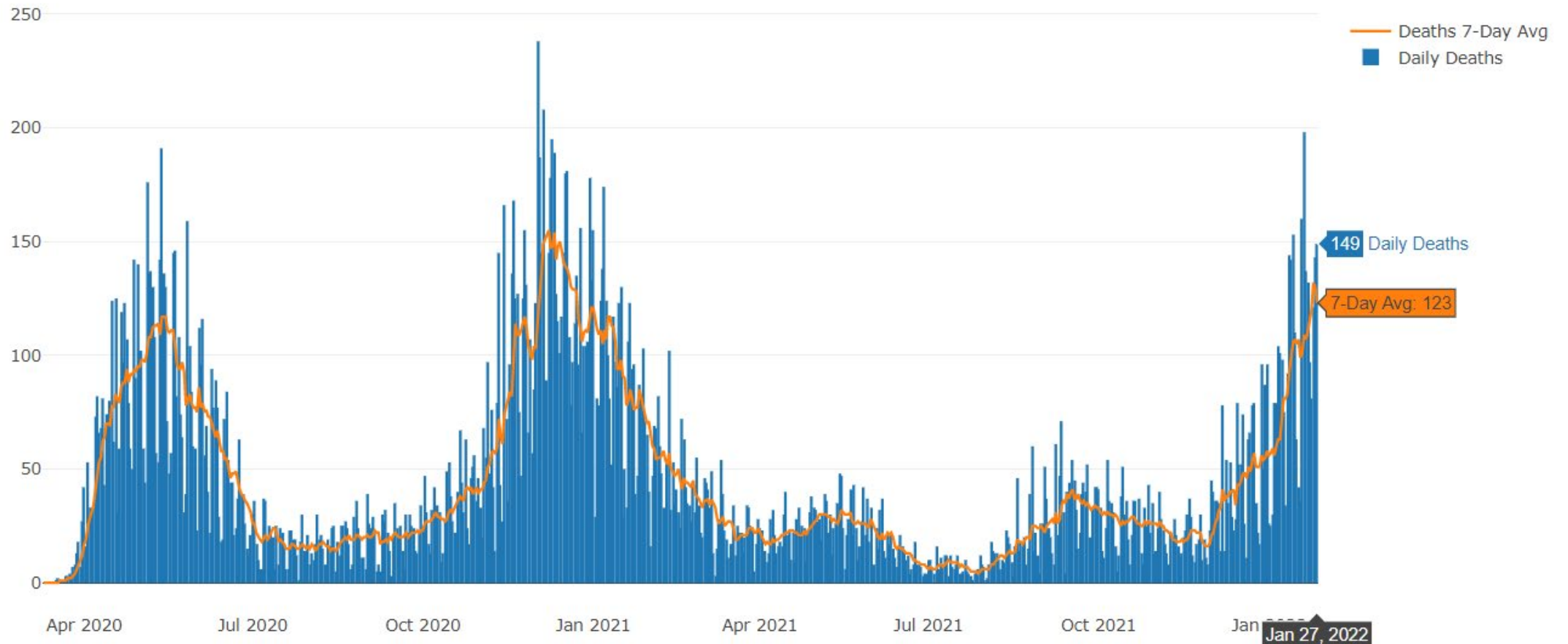
Illinois COVID-19 Deaths By Age

Total deaths:
30,568

86% Age 60+
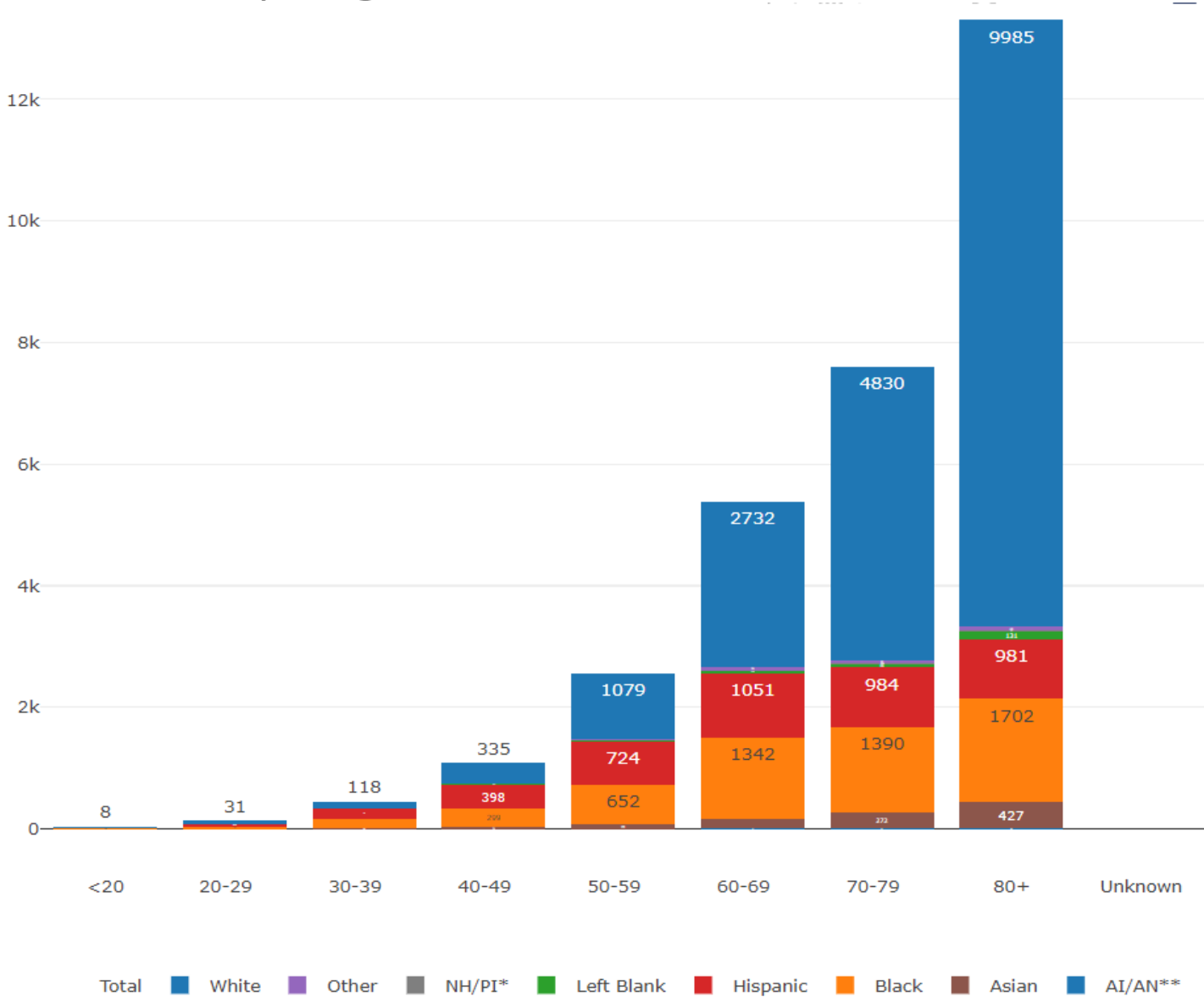
Vaccination is the key to preventing severe illness...

Illinois COVID-19 Vaccinations

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Population:
12,741,080

Highest Rate: 78%
DuPage County

Lowest Rate: 23%
Alexander County
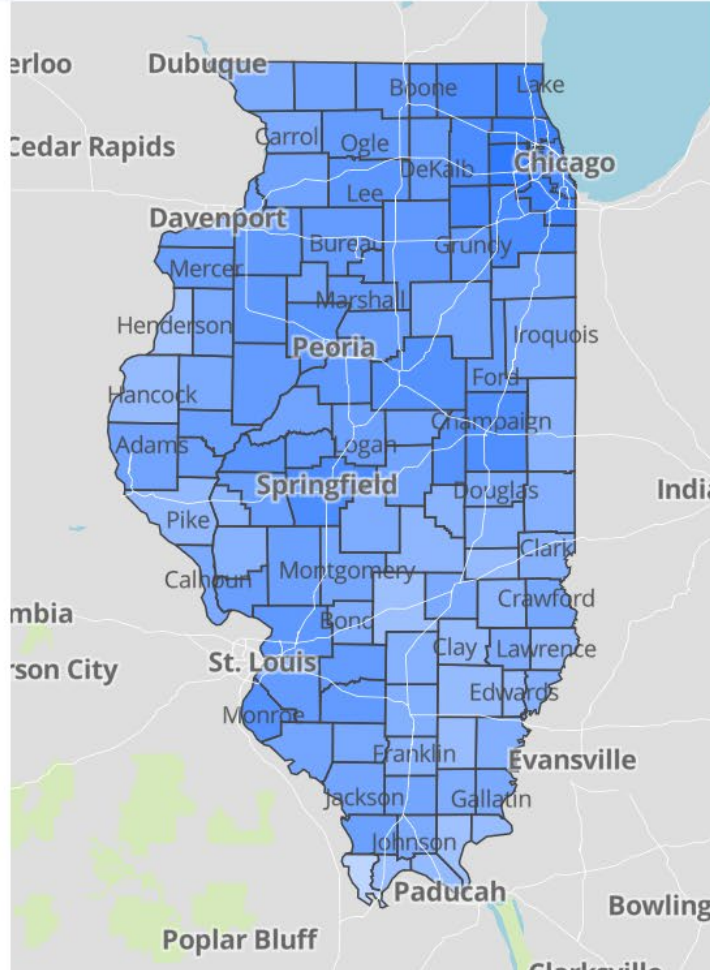
20,110,501

Administered Vaccine Doses

8,746,112 (68.64%)

Population Vaccinated With At Least 1 Dose

7,843,002 (61.56%)

Population Fully Vaccinated

Omicron in LTCs: Even as staff vaccination and booster rates rise, the unvaccinated remain the primary source of staff COVID-19 cases in LTCFs

Unvaccinated staff are responsible for ~90% of COVID-19 cases among staff...

COVID-19 Cases for LTC Staff

Month	Total	Unvaccinated	Vaccinated not boosted	Boosted
Sept	393	89%	11%	0%
Oct	239	89%	10%	1%
Nov	291	89%	10%	1%
Dec	522	88%	11%	2%

Legend: ■ Unvaccinated ■ Vaccinated not boosted ■ Boosted
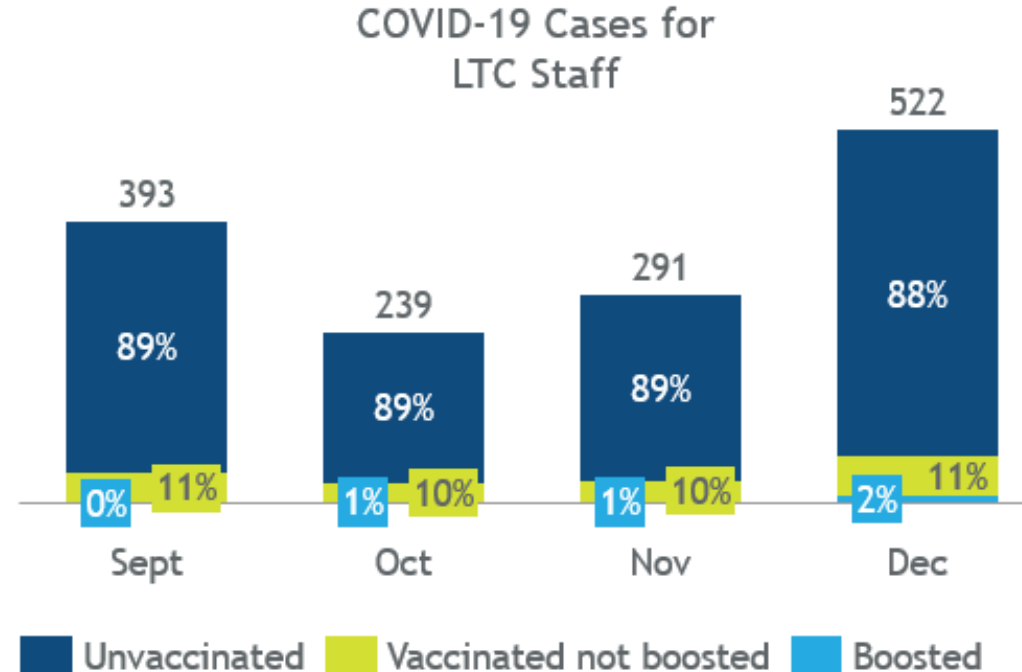
Source: INEDSS

Omicron in LTCFs: Unvaccinated residents remain most vulnerable to catching and dying from COVID-19 as the Omicron surge drives case numbers higher

Unvaccinated residents continue to make up ~90% of COVID-19 cases among LTC residents ...
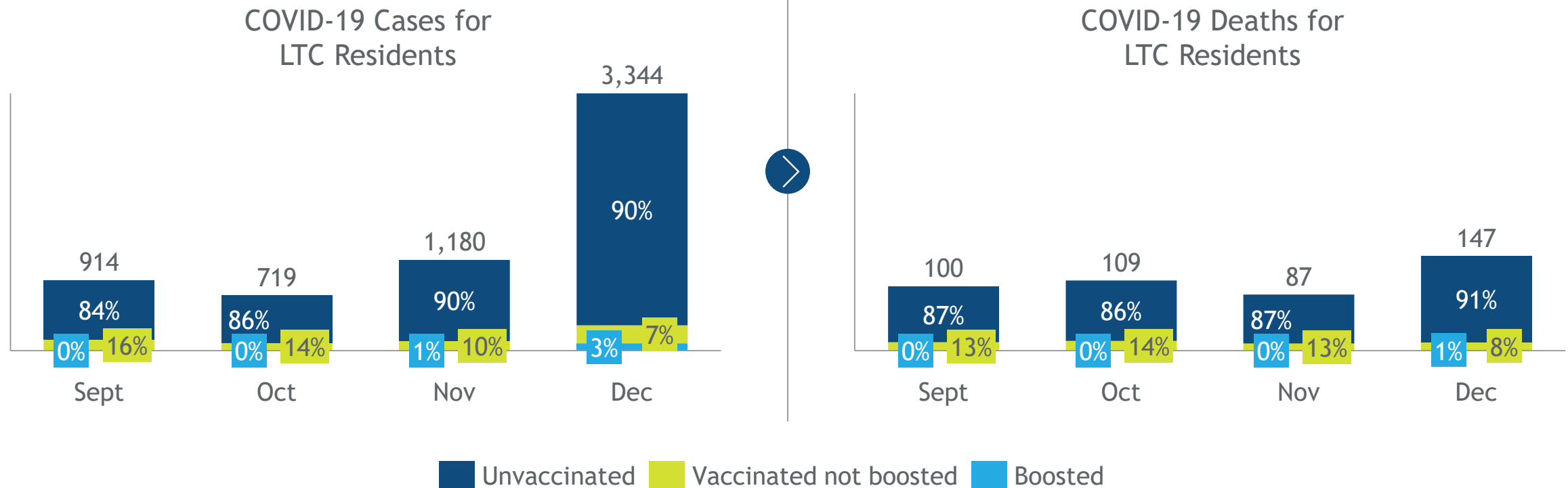
... while booster efforts have proven effective in protecting this vulnerable population

COVID-19 Cases for LTC Residents

	Sept	Oct	Nov	Dec
Total	914	719	1,180	3,344
Unvaccinated	84%	86%	90%	90%
Boosted	0%	0%	1%	3%
Vaccinated not boosted	16%	14%	10%	7%

COVID-19 Deaths for LTC Residents

	Sept	Oct	Nov	Dec
Total	100	109	87	147
Unvaccinated	87%	86%	87%	91%
Boosted	0%	0%	0%	1%
Vaccinated not boosted	13%	14%	13%	8%

Legend: Unvaccinated · Vaccinated not boosted · Boosted

COVID-19 hospitalizations: Hospitalization among unvaccinated remain significantly higher across all age groups in Illinois

COVID-19 admissions per 100K (IL), Nov 28 – Dec 25, 2021

■ Boostered[1]　　■ Fully vaccinated, no booster[2]　　■ Not fully vaccinated[3]

<18 Population
- +8X
- 1.6　12.9

18-39 Population
- +36X
- +2X
- 3.0　4.9　107.0

40-49 Population
- +85X
- +3X
- 3.0　9.4　254.3

50-64 Population
- +71X
- +3X
- 7.0　23.5　499.9

65+ Population
- +93X
- +7X
- 17.0　124.8　1,583.9
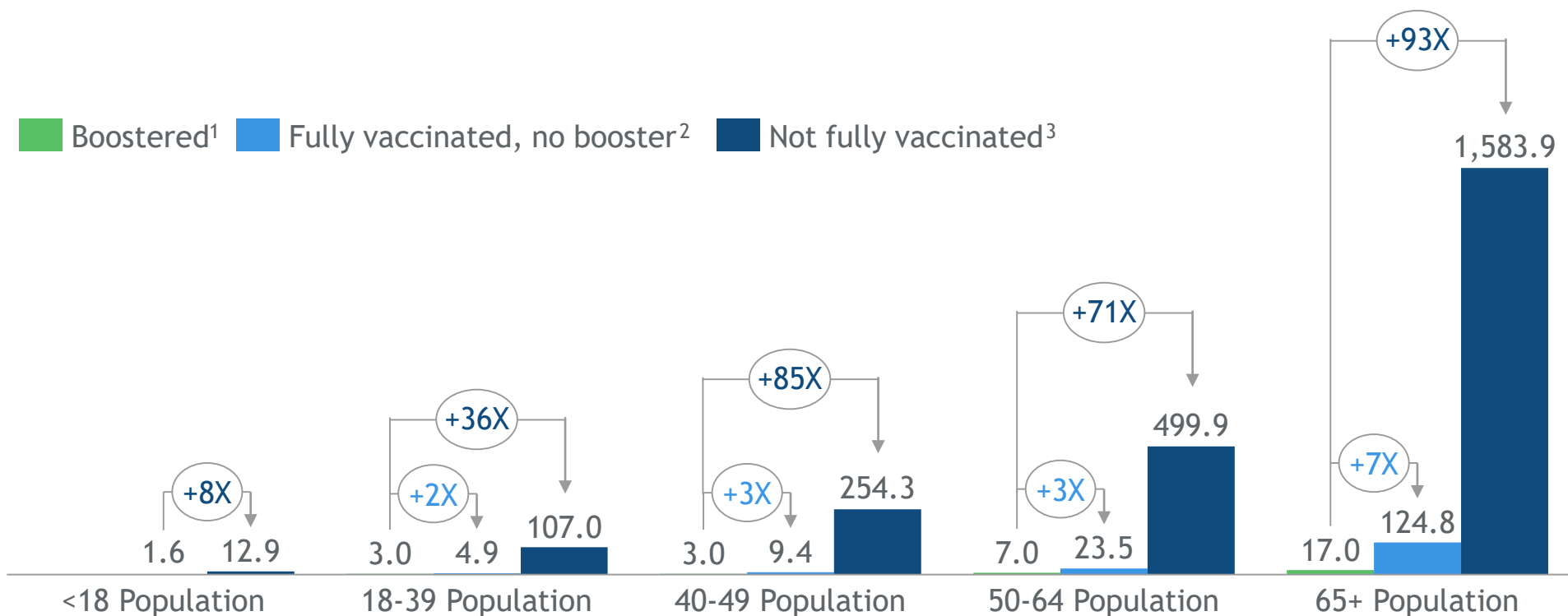
1. Per Illinois Department of Public Health – represents 257 breakthrough admissions between Nov 28 – Dec 25, 2021 for 2.62M boostered individuals in IL (average over time period) 2. Represents 1,244 breakthrough admissions in IL for 5.13M fully vaccinated individuals (average over time period) 3. Represents 10,579 non-breakthrough admissions for 4.97M unvaccinated or partially vaccinated individuals in IL (average over time period)
Source: I-CARE, CDC Hospitalization Trackers, REDCap reports, INEDSS, I-CARE, IDPH data team, Census estimates (2018, 2019 American Community Survey – 1 year estimates)

Access to COVID-19 Therapies Across Illinois: Monoclonal Antibodies and Oral Therapeutics

**Arti Barnes** MD, MPH, Medical Director/Chief Medical Officer

mAB for O!Micron

- Bam/ete not expected to work against Omicron variant [1]

- Regencov 32 -1000 fold reduced susceptibility in vitro- not expected to work[2]

- <mark>**FDA REVOKED BAM/ETE and REGENCOV in Jan 2021**</mark>

- Sotrovimab retains activity in pre-clinical studies [3]

1. Gruel et al preprint, open access
2. Wilhelm et al, preprint MedRxIV
3. Cathart et al, preprint, biorxIV

Illinois Department of Public Health

https://opendata.ncats.nih.gov/variant/activity
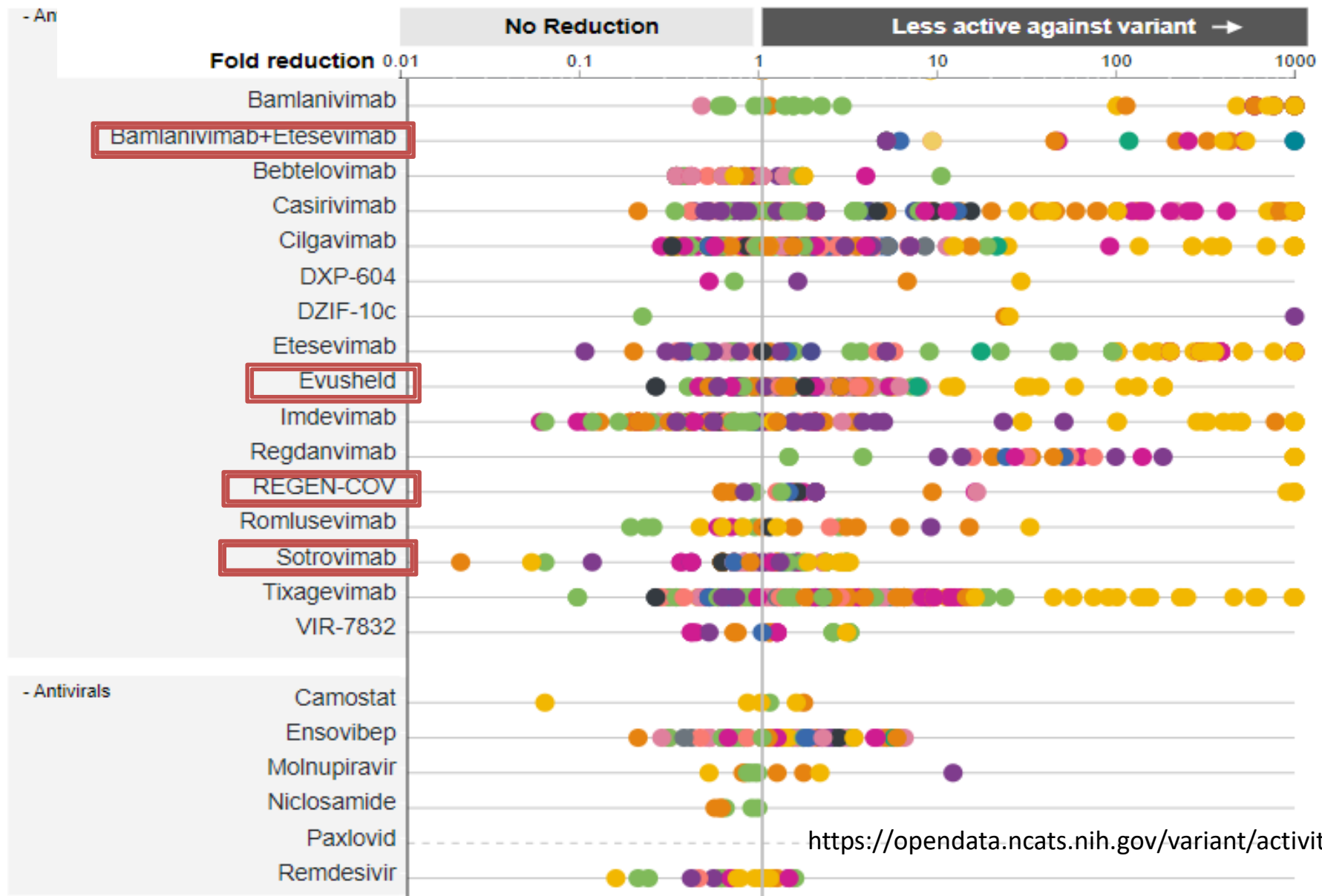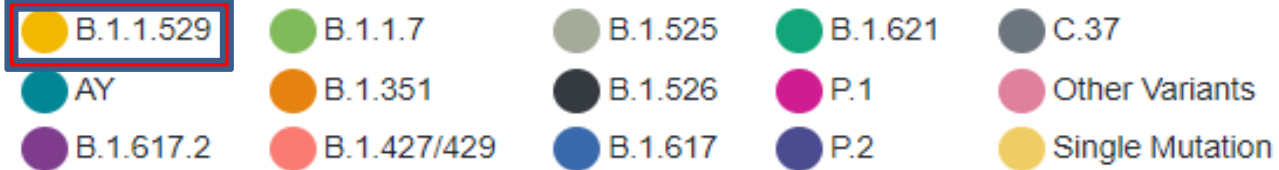
The WHY: Does it work?

- Clinical Trials: mAb treatment clinically proven to reduce relative risk of admission by ~ 70+%[1]

- Sotrovimab early treatment- 85%relative risk reduction of hospitalization or death

- Bamla- for PEP In SNFs– 80% reduction in mod/severe Covid-19 (Delta)

- Bam/ete for early treatment in SNF ~ 3 times higher odds of hospitalization or death in those who did NOT receive bam/ete.

  - 75% relative reduction in deaths in those who received bam/ete

Who? When?

- For **treatment:**
  - Non-hospitalized patients
  - Mild to moderate illness (eg, not requiring supplemental oxygen or, if on chronic supplemental oxygen, without an increased oxygen requirement)
  - Administered as soon as possible AND within 10 days of symptom onset.
    - Use early in the course of disease associated with better efficacy.
    - EUA does not mention asymptomatic state

FDA EUA FACT SHEETS

WHO? WHEN?

- For **post exposure** prophylaxis (casiri/imde subQ or IV OR bamla/ete IV, **NOT sotrovimab**)
  - Close contact OR institutional setting exposure (high risk)
  - Not been fully vaccinated OR who are expected to have inadequate response to vaccination (anyone considered immunosuppressed)
  - Within 7 days of exposure
    - Studies used 96 hours from exposure to measure efficacy

mAB and COVID-19 vaccine/booster

- Limited data on how they may interact with each other

- If vaccine is administered first, no delay in mAB

- If mAB if administered first, CDC suggests a 90 day delay till vaccine administered considering that re-infection in 90 days from receipt of such therapies is rare.

- "*Receipt of passive antibody therapy in the past 90 days is not a contraindication to receipt of COVID-19 vaccine. COVID-19 vaccine doses received within 90 days after receipt of passive antibody therapy do not need to be repeated*."

HHS clinical implementation guide for Monoclonal Antibodies, Dec 2021

What to do in an outbreak

- If you don't already have mAB on hand
  - Determine if there is a local infusion site that patients can be transported to:
    - https://dph.illinois.gov/covid19/covid-19-outpatient-therapy-locator.html
    - Covid 19 Patients can be transported per CDC guidance
  - If administering mAB on site : Use matchmaker function on IDPH monoclonal antibody website to locate doses nearby
    - If no doses available, contact IDPH immediately so as to have mAB re-allocated from another site for immediate use in an outbreak

How to obtain Monoclonal

- **Sign up for doses on our IDPH monoclonal website – weekly allocation at present**

- **HHS determines each state's weekly amount of mAb products based on COVID-19 case burden and mAb utilization.**

- State health departments subsequently identify which sites in their respective jurisdictions receive the product and the amount each site receives.

POCKETBOOK MATH!
REIMBURSEMENT AND COVERAGE

- Monoclonal antibodies are expensive but **are free through the federal government**
  - Sotrovimab: ~$2000 cost per dose (IV only)
- Medicare will pay approximately
  - $450 in most settings (including LTCs)
  - $750 in the beneficiary's home or residence
- **HRSA COVID-19 Uninsured Program will Reimburse Monoclonal Antibody Treatments based on Medicare Rates**

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REPORTING USE!!!

TeleTracking and NHSN

- MUST report quantity of product used in the last week
- MUST report quantity remaining on hand
- Report patient course not number of vials
- Due by Wednesday each week, compliance is tracked by HHS.

Casirivimab (REGN10933) / Imdevimab (REGN10987) (Therapeutic A)

39a. Current inventory on hand (in courses)

10

39b. Courses used in the last week

7

Bamlanivimab (Therapeutic B)

39c. Current inventory on hand (in courses)

15

39d. Courses used in the last week

Unknown

Getting ahead of the curve

- <mark>Pre</mark>-exposure prophylaxis mAB Evusheld approved by the FDA
- Restricted to those who are
  - Immunocompromised and will not mount a good response to the vaccine
  - Have a vaccine contraindication

FDA EUA FACT SHEETS

Monoclonal Antibodies for COVID-19 Preexposure Prophylaxis Can't Come Fast Enough for Some People

Rita Rubin, MA

Retired family physician Brian Koffman, MD, constantly fields questions that begin with the same 6 words: When will I be able to…hug my grandchildren…eat in a restaurant…go to an art gallery?

The inquiries come from some of the estimated 200 000 people in the US who, like 70-year-old Koffman of Chula Vista, California, are living with chronic lymphocytic leukemia (CLL).

While their healthy, fully vaccinated peers have resumed enjoying activities that most took for granted before COVID-19, many with CLL or other factors that compromise the immune system such as medication to prevent organ rejection after transplant surgery continue to shelter in place more than a year and a half into the pandemic.

They've played by the rules, as Koffman puts it, completing their recommended course of 3 messenger RNA (mRNA) vaccines. But they can't count on vaccination to protect them against SARS-CoV-2 because

iStock.com/izzetugutmen

exposed to someone with laboratory-confirmed SARS-CoV-2.

monoclonal antibodies while opposing vaccine and mask mandates, they're not a sub-

REMDESIVIR (ANTIVIRAL)

- **Remdesivir 200 mg** IV on Day 1, followed by **100 mg** IV daily on Days 2 and 3
  - initiated as soon as possible
  - within 7 days of symptom onset
  - aged ≥12 years and weighing ≥40 kg
- Off label use for non hospitalized patients
- J0248 CMS code for outpatient remdesivir
- Observe 1 hour post infusion

ORAL AGENTS

Oral pills for outpatient treatments-

- Molnupiravir authorized by the FDA (~30% effective in reducing hospital admissions)
  - 800 mg twice a day for 5 days
  - Given within 5 days of symptom onset
  - Safety concerns- mutagenesis
- Paxlovid also authorized by the FDA (~89% effective in reducing hospital admissions)
  - Twice a day for 5 days
  - Combined with a boosting agent ritonavir (significant drug interactions)

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Paxlovid (Drug Interactions)

- Use another Covid-19 agent if the patient is on
  - Clopidogrel, rivaroxaban
  - Sildenafil or tadalafil (for pulm HTN)
  - Phenytoin
  - Colchicine
  - Amiodarone
  - 12 other agents

- Hold these agents while on Paxlovid
  - Atorvastatin, simvastatin, rosuvastatin
  - Tacrolimus, sirolimus
  - Clonazepam, midazolam
  - Tramadol, hydrocodone, oxycodone
  - Vardenaphil, sildenafil (for ED)

NIH Statement on Paxlovid Drug-Drug interactions

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Molnupiravir

- Pregnancy – AVOID, especially under 10 weeks
- Contraception
  - Natal females should use contraception during and for 4 days after completing last dose
  - Natal males should use contraception for THREE MONTHS after completing last dose
- Breastfeeding
  - Unknown- advised to avoid for up to 4 days after last dose

ORAL AGENTS

- Distributed through state agencies
- Baseline two-week allocations through HHS
  - \>12000 doses for molnupiravir
  - \>3000 doses for Paxlovid
  - ~3000 doses for Evusheld (PREP)- allocated to regional hospitals, pharmacy partners
- Allocations based on population distribution and case rates
  - LTCs assigned protected allocation
  - Some FQHCs qualified for separate allocation
- **DAILY UTILIZATION REPORTING THROUGH HPoP!!**

COVID-19 Outpatient Therapy Locator

Use this map to locate locations for therapies provided free from HHS to prevent COVID-19 infection (Evusheld and Sotrovimab) and severe illness or hospitalization for COVID-19 (Sotrovimab, Paxlovid and Molnupiravir). These allocations are EXTREMELY limited and so we encourage providers and patients to consider all other **options for treatment as suggested in the NIH treatment guidelines** including products like remdesivir, that are not available through the state, as treatment options. Please also note that Molnupiravir is only an alternative when other therapies are NOT available. Prescribers must discuss risks, benefits and safety profiles of these agents with the patients and provide them the EUA Patient Fact sheets.

Please note that these medications are in very limited supply and are allocated to the State of Illinois in weekly to two-weekly periods, depending on the product. **More information can be found on our website.**
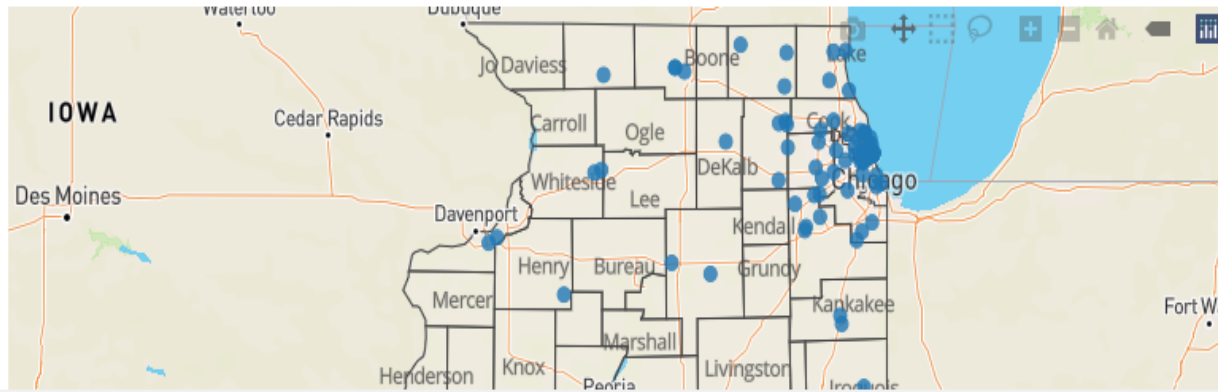
Outpatient Therapy Location Details:
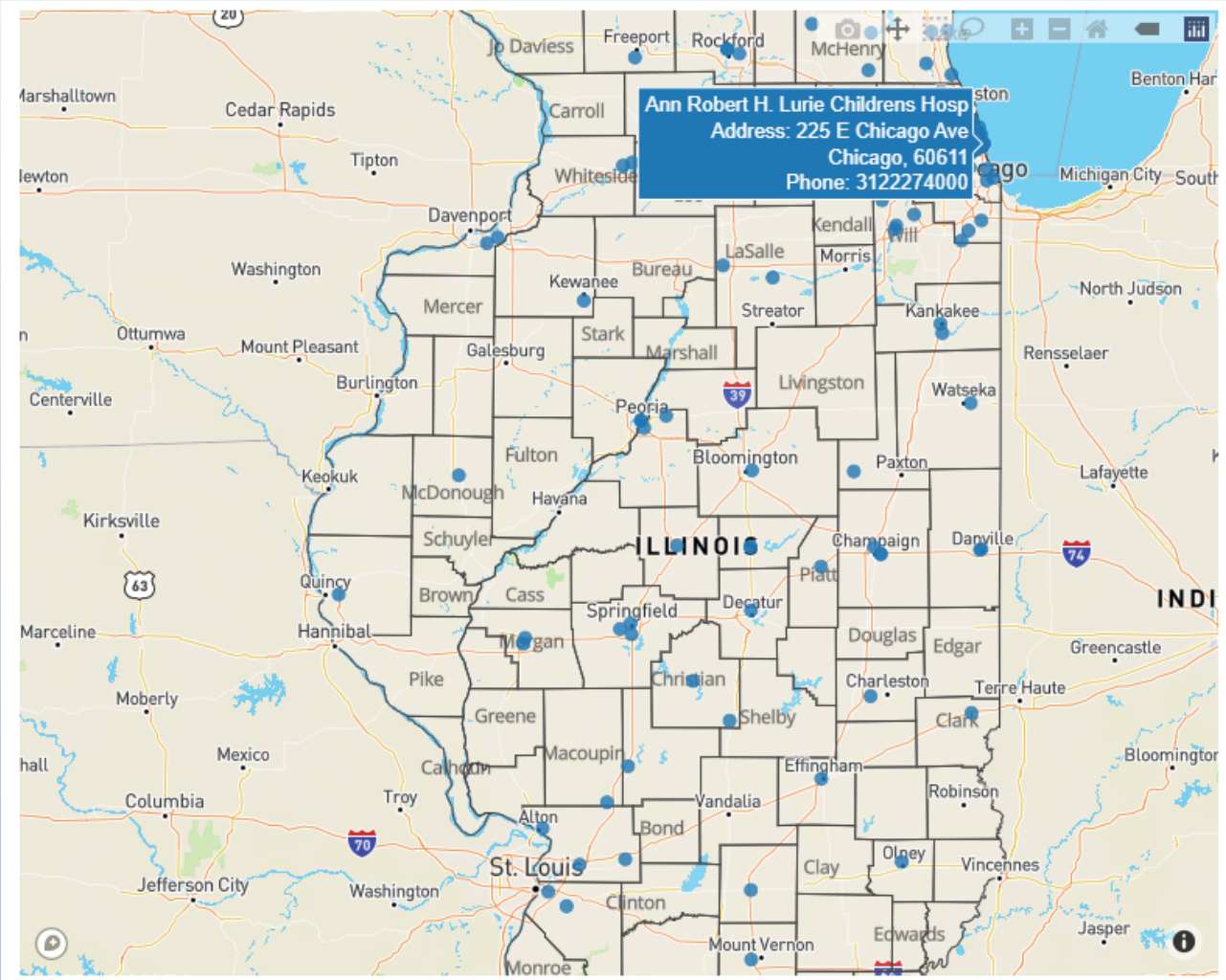
Outpatient Therapy Location Details:

Amita Health St. Mary'S Hospital

500 W Court St.

Kankakee, IL 60901

Phone: +1 (815) 937-2175

Molnupiravir: Yes
Paxlovid: Yes
Evusheld: Yes
Sotrovimab: No

NIH Tier	Risk Group
1	•Immunocompromised individuals not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying conditions, regardless of vaccine status (see Immunocompromising Conditions below); *or* •Unvaccinated individuals at the highest risk of severe disease (anyone aged ≥75 years or anyone aged ≥65 years with additional risk factors)
2	•Unvaccinated individuals at risk of severe disease not included in Tier 1 (anyone aged ≥65 years or anyone aged <65 years with clinical risk factors)
3	•Vaccinated individuals at high risk of severe disease (anyone aged ≥75 years or anyone aged ≥65 years with clinical risk factors) **Note:** Vaccinated individuals who have not received a COVID-19 vaccine booster dose are likely at higher risk for severe disease; patients in this situation within this tier should be prioritized for treatment.
4	•Vaccinated individuals at risk of severe disease (anyone aged ≥65 years or anyone aged <65 with clinical risk factors) **Note:** Vaccinated individuals who have not received a COVID-19 vaccine booster dose are likely at higher risk for severe disease; patients in this situation within this tier should be prioritized for treatment.

NIH Clinical Decision Tree

Adult or pediatric (age 12 and older and weight 40kg or greater) with mild to moderate COVID-19 & high risk for progression to severe disease

+

Consider one of the following therapeutics, if available[1,2]:

Paxlovid within **5 days of symptom onset**
eGFR 60 mL/min or greater: 300mg nirmatrelvir taken with 100mg ritonavir twice daily for 5 days
eGFR >30-<60: 150mg nirmatrelvir taken together with 100mg ritonavir twice daily for 5 days; evaluate concomitant use of CYP3A inducers and medications with high dependency on CYP3A for clearance as these may be contraindicated per Paxlovid EUA

OR

sotrovimab 500 mg IV within **ASAP 10 days of symptom onset** (sotrovimab EUA)

OR

Remdesivir 200mg IV x 1 dose on day 1, 100mg IV x1 on days 2-3 begun ASAP and within **7 days of symptom onset**[1]

Is Patient:
- Hospitalized for COVID-19 **OR**
- Requiring O$_2$ **OR** an increase in baseline home O$_2$ due to COVID-19

No →

No

Symptom onset within the past 5-7 days?

Yes → **Does patient have severe renal impairment (eGFR <30mL/min) OR severed hepatic impairment (child-pugh class C)**

No

Symptom onset within the past 10 days?

Yes → **Consider the following (symptoms within 10 days)[1]: sotrovimab 500 mg IV** (sotrovimab EUA)

Yes

No

Yes

Treatment of symptoms, Management per NIH & CDC Guidelines

If none of the above therapeutics are available for patient treatment within 5 days of symptom onset and patient is age 18 or greater

No → **Possibility of pregnancy, if applicable, is ruled out?**

Yes

Consider molnupiravir
- Authorized only in patients ages 18 and older
- Within 5 days of symptom onset
- Molnupiravir 800mg by mouth every 12h for 5 days
- Prescribers must review and comply with the mandatory requirements outlined in the molnupiravir EUA

Limited use of bamlanivimab/etesevimab and REGEN-COV as they are not expected to be active against the Omicron variant[1]

December 30, 2021

[1]Refer to the NIH COVID-19 Treatment Guidelines Panel's Statement on the Use of Anti-SARS-CoV-2 Monoclonal Antibodies or Remdesivir for the Treatment of Covid-19 in Nonhospitalized patients when Omicron is the Predominant Circulating Variant; Remdesivir is only approved for hospitalized individuals with COVID-19. Outpatient treatment is based on information from the literature (Dec 22, 2021 Early Remdesivir to Prevent Progression to Severe Covid-19 in Outpatients; DOI: 10.1056/NEJMoa2116846)
[2] COVID-19 convalescent plasma with high titers of anti-SARS-CoV-2 antibodies is authorized for the treatment of COVID-19 in patients with immunosuppressive disease in either the outpatient or inpatient setting (COVID-19 Convalescent Plasma EUA)

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LTC allocation of therapeutics

- We allocate 20% of sotrovimab to LTC pharmacies: 300-400 doses

- We allocate >15% of oral therapeutics to LTC pharmacies- > 400 courses of paxlovid > 1000 courses of molnupiravir

Over Time

Treatment From Facility by Therapeutic Type

Type	4-Jan	11-Jan	18-Jan	25-Jan
BAMETES	1	9	2	0
CASIMDEV	29	19	23	11
EVUS	0	0	9	0
MOLNUP	0	0	0	5
PAXL	0	0	3	13
SOTRO	0	1	17	25
Total	**30**	**29**	**54**	**54**

Treatment From Other by Therapeutic Type

Type	4-Jan	11-Jan	18-Jan	25-Jan
BAMETES	13	3	2	1
CASIMDEV	48	61	25	12
EVUS	0	0	0	1
MOLNUP	0	0	0	8
PAXL	0	0	1	1
SOTRO	0	0	36	28
Total	**61**	**64**	**64**	**51**

Will vaccines work against Omicron?

- Yes, if you are boosted or recently vaccinated
  - 70% protective (effective) for avoiding hospital admissions (Pfizer vaccine)
  - 88% protective after 3 doses

Table 6: Vaccine effectiveness against hospitalisation for Omicron (all vaccine brands combined). OR = odds ratio, HR = hazard ratio, VE = vaccine effectiveness (CI=Confidence interval)

Dose	Interval after dose	OR against symptomatic disease (95% CI)	HR against hospitalisation (95% CI)	VE against hospitalisation (95% CI)
1	4+ weeks	0.74 (0.70-0.77)	0.65 (0.30-1.42)	52% (-5-78)
2	2-24 weeks	0.82 (0.80-0.84)	0.33 (0.21-0.55)	72% (55-83)
2	25+ weeks	0.98 (0.95-1.00)	0.49 (0.30-0.81)	52% (21-71)
3	2+ weeks	0.37 (0.36-0.38)	0.32 (0.18-0.58)	88% (78-93)

Collie et al, NEJM Dec 2021
UK health Security Agency- Technical Briefing Dec 2021

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In Summary

- Therapeutics can prevent hospitalizations and deaths with Covid
- Therapeutics are FREE from the federal government and re-imburseable through CMS
- Ordering of most products is currently through IDPH in weekly-biweekly allotments, reporting through Teletracking and HPOP
- VACCINES ARE JUST AS EFFECTIVE IN PREVENTING HOSPITALIZATIONS

THANK YOU

Ashley Thoele, ashley.thoele@illinois.gov
Kristin Rzeczkowski, kristin.rzeczkowski@illinois.gov
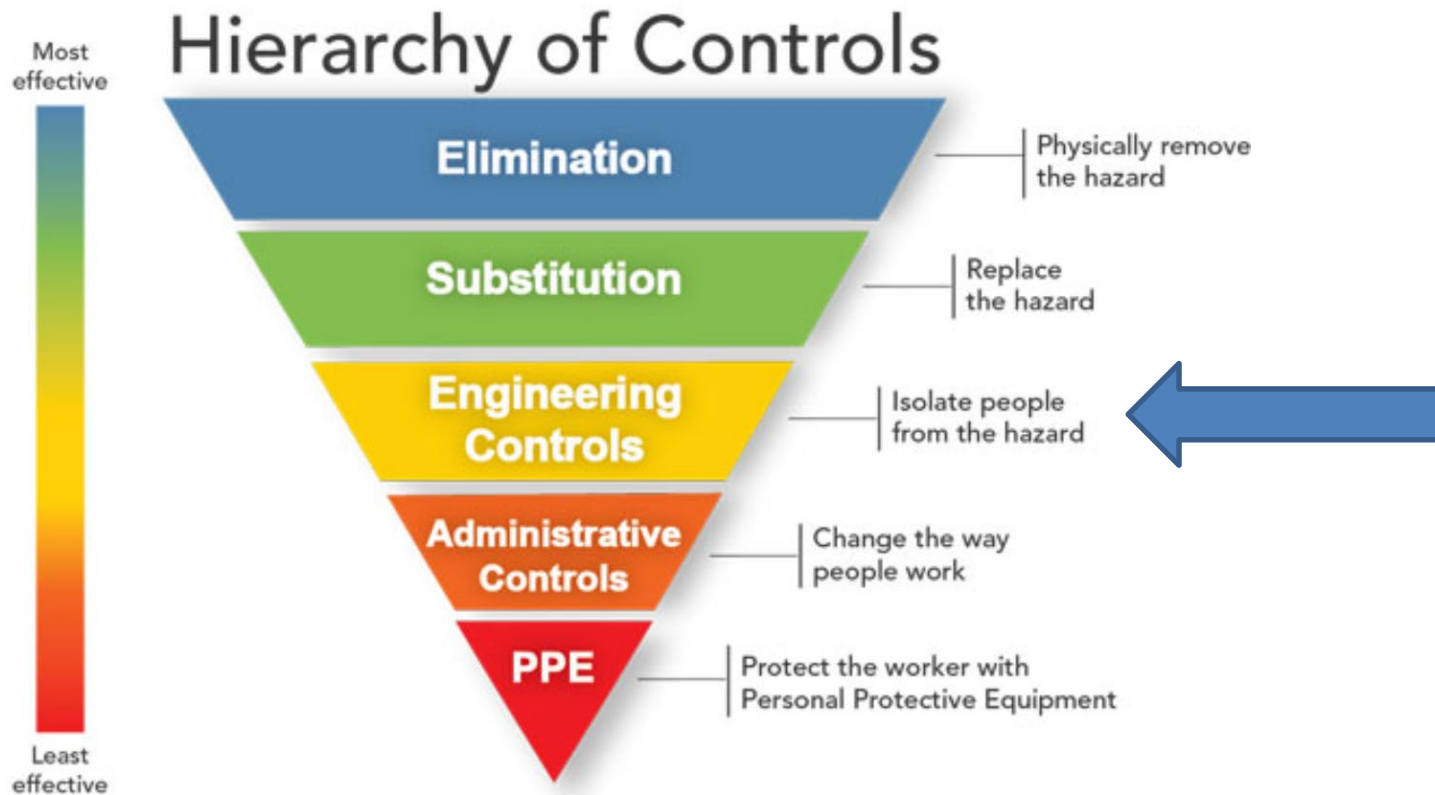Aaron Eisfelder: DPH.mabtherapy@illinois.gov
IEM team, OPR team

Use of Engineering Controls to Improve Air Quality

Improving Ventilation

Hierarchy of Controls

Most effective

- **Elimination** — Physically remove the hazard
- **Substitution** — Replace the hazard
- **Engineering Controls** — Isolate people from the hazard
- **Administrative Controls** — Change the way people work
- **PPE** — Protect the worker with Personal Protective Equipment

Least effective

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/

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Public Health Guidance

- Follow all current regulatory and statutory requirements and recommendations, including;

  - Vaccination, Masking, PPE, Social Distancing

  - Administrative measures, circulation of occupants, hand hygiene, disinfection of high touch surface areas

Slide Source: Joanne Senoga, MD, Ph.D., MPH

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Improving Indoor Air Quality

Goal

- To introduce as much fresh air as possible

- To filter the air that is recirculating in the building

- To reduce and remove potential airborne contaminants

Ventilation Basics

- Air Changes per Hour (ACH)
    - A calculation that utilizes the air flow in cubic feet per hour divided by the room volume in cubic feet.
    - Represents the number times per hour that the air in the room changes.
        - More frequent air changes reduces potential contaminants.
    - While air changes per hour are part of the overall heating and cooling or central ventilation system, it is not something that can be modified by a thermostat.
    - Adjusting the air changes per hour requires a heating ventilation and air conditioning (HVAC) engineer or specialist.

Ventilation Basics

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.TABLE B PRESSURE RELATIONSHIPS AND VENTILATION RATES OF
CERTAIN AREAS FOR NEW INTERMEDIATE CARE FACILITIES AND SKILLED
NURSING FACILITIES**

Section 300.TABLE B   Pressure Relationships and Ventilation Rates of Certain Areas for New Intermediate Care Facilities and Skilled Nursing Facilities

Area Designation	Pressure Relationship to Adjacent Areas	Minimum Air Changes Per Hour Supplied To Room	All Air Exhausted Directly Outdoors	Recirculated within Room Units
Resident Rm	0	2	Optional	Optional

https://www.ilga.gov/commission/jcar/admincode/077/07700300ZZ9998bR.html

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Improving the Air Changes per Hour

- Portable air cleaners, air purifiers, air sanitizers, air scrubbers
    - Devices that draw in, filter, and exhaust the room air within in the room
        - Filter with a Minimum Efficiency Reporting Value (MERV) of 13

    - They must be sized for the room.

    - Location in the room is important to the optimal function.
        - The goal is to pull air from the room into the cleaner.
        - Placement should not be directly in front of the room supply vent.
        - Exhaust from the cleaner should not be close to the return supply.

Improving the Air Changes per Hour

- Ensure the air cleaner is certified by the Association of Home Appliance Manufacturer's (AHAM).
  - AHAM lists all devices they have certified.
  - A Clean Air Delivery Rate (CADR) is assigned to the air cleaner.
  - The CADR will be noted on the device and/or shipping container and can also be found on the AHAM website.

Room Size: 370 ft^2
Tobacco Smoke CADR: 240
Dust CADR: 240
Pollen CADR: 240
Volts / Frequency: 120V / 60Hz
Show Certificate

https://www.ahamdir.com/room-air-cleaners/

Improving the Air Changes per Hour

- Ensure the air cleaner is certified by the Association of Home Appliance Manufacturer's (AHAM).
  - The higher the CADR, the better the filtration.
  - The CADR is based on use with the highest fan speed.
  - The CADR for smoke applies best for COVID-19.
  - A noise rating may be shown on the device. Lower is better.

Room Size: 370 ft^2
Tobacco Smoke CADR: 240
Dust CADR: 240
Pollen CADR: 240
Volts / Frequency: 120V / 60Hz
Show Certificate

https://www.ahamdir.com/room-air-cleaners/

Improving the Air Changes per Hour

- Consider use of an air cleaner in the following areas
  - Dialysis
  - Therapy gyms
  - Dining rooms
  - Family lounges
  - Resident rooms

- Limitations
  - Door to the room should be closed for the air cleaner to be beneficial.
  - Room size may dictate more than one air cleaner.
  - Facility electrical demand may be challenged.

Central Ventilation Air Basics

- The central ventilation system conditions the air supplied throughout the facility.
  - It is basically a big fan that pushes either hot or cold air through the ventilation ductwork.

  - Outside air is brought in through louvers/dampers, filtered, conditioned, and sent throughout the building.

  - Air is then returned through ductwork, filtered, and the process continues.

Improving Filtration of Central Ventilation Air

- Filters used in ventilation systems are assigned a Minimum Efficiency Reporting Value (MERV).
  - A MERV of 1 has the lowest filter efficiency and a MERV of 16 has the highest.
  - When possible, a MERV 13 filter is recommended for COVID-19 control
    - Some central ventilation systems have pre-filters and final filters. Installing a MERV 13 in the pre and final filter may improve the efficiency to greater than a MERV 13 rating.
    - Using a filter with a lower MERV rating in both the pre and final filter may also improve the efficiency to a MERV 13 rating or greater.

https://www.ashrae.org/technical-resources/filtration-disinfection#mechanical

Improving Filtration of Central Ventilation Air

- Limitations and Cautions
  - The fan and filter slot should be used to guide the filter choice.

  - Not all filter racks can accommodate a MERV 13 or greater filter.
    - The filter should fit snuggly without bending or crushing.
    - Air should not leak around the filter.

  - Fans in central ventilation systems may not be strong enough to push the air through higher MERV filters.
    - The filtration capacity of the filters may create more demand on the fan resulting in a decrease in the air supplied.

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Improving Filtration of Central Ventilation Air

- Limitations and Cautions
  - Consult with a Heating, Ventilation, and Air Conditioning (HVAC) engineer or service person before making any modifications.
    - Make changes one at a time and monitor the change before another change is made.

  - Follow manufacturers instructions for use (IFU) to guide filter changes.
    - Higher efficiency filters may not require as frequent changes as lower efficiency filters.

  - PPE should be worn for any maintenance to the central ventilation system, including filter changes.
    - Filters should be bagged at the point of removal and can be managed as regular waste.

To Do List

- Meet with the facility engineer/maintenance director.
- Confirm that the ventilation system is constantly running.
- Confirm that toilet and shower exhausts are fully functional and always left on.
- Determine what the rating is for the filter on the central air handler or furnace.
- Increase the efficiency of the filter to a MERV 13 if possible.

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 quarantine for 14 days if a close contact of a COVID-19 positive individual, regardless of vaccination status.

Waiting on clarification from CDC!!

New Admissions and Quarantine

Create a Plan for Managing New Admissions and Readmissions

- Residents with confirmed SARS-CoV-2 infection who have not met criteria to discontinue Transmission-Based Precautions should be placed in the designated COVID-19 care unit, regardless of vaccination status.

- In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.

- Fully vaccinated residents and residents within 90 days of a SARS-CoV-2 infection do not need to be placed in quarantine.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Previous CDC table for Strategies to Mitigate Staffing Shortages (old terminology)

Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

HCP are considered "boosted" if they have received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC. HCP are considered "vaccinated" or "unvaccinated" if they have NOT received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC.

For more details, including recommendations for healthcare personnel who are immunocompromised, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).

Work Restrictions for HCP With SARS-CoV-2 Infection

Vaccination Status	Conventional	Contingency	Crisis
Boosted, Vaccinated, or Unvaccinated	10 days OR 7 days with negative test† if asymptomatic or mildly symptomatic (with improving symptoms)	5 days with/without negative test, if asymptomatic or mildly symptomatic (with improving symptoms)	No work restriction, with prioritization considerations (e.g., asymptomatic or mildly symptomatic)

Previous CDC table

Work Restrictions for Asymptomatic HCP with Exposures

Vaccination Status	Conventional	Contingency	Crisis
Boosted	No work restrictions, with negative test on days 2‡ and 5–7	No work restrictions	No work restrictions
Vaccinated or Unvaccinated, even if within 90 days of prior infection	10 days OR 7 days with negative test	No work restriction with negative tests on days 1‡, 2, 3, & 5–7	No work restrictions (test if possible)

†Negative test result within 48 hours before returning to work

‡ ... consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0

CDC

CS328856-A | December 23, 2021 5:27 PM

cdc.gov/coronavirus

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Updated Jan. 21, 2022

Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

"Up to Date" with all recommend...

For more details, including recom...
90 days of prior infection, refer to...
(conventional standards) and Stra...

Work Restrictions for H...

Vaccination Status
Up to Date and Not Up to Date

Work Restrictions for A...

Vaccination Status
Up to Date
Not Up to Date

†Negative test result within 48 hours before...
‡For calculating day of test: 1) for those with...

CDC

CS328856-A | 01/07/2022

cdc.gov/coronavirus

Removed "boosted, vaccinated, unvaccinated" and added new terminology—"Up to Date and Not Up to Date"

Removed statement "even within 90 days"

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

IDPH Guidance

January 18th IDPH LTC guidance reflects updated CDC guidance pertaining to "within 90 days of prior infection"

IDPH tables from Jan. 18, 2022 do not reflect "Up to date" terminology

APPENDIX A: SUMMARY TABLES

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

Defining Vaccination Status:
IDPH LTC Guidance (January 18, 2022 release)

Vaccination status

○ **Boosted:** Have received all COVID-19 vaccine doses, including a booster dose.

○ **Up to date**: An individual has received the primary series of COVID-19 vaccine (either two doses or one dose, depending on the vaccine), and has received all additional and booster doses for which they are eligible as recommended by the CDC. ([CDC up to date recommendations for COVID-19 vaccines](#))

○ **Not Up to date**: An individual has not received all COVID-19 vaccinations for which they are eligible, as outlined under "up to date".

○ **Fully Vaccinated ("Vaccinated"):** Two weeks have passed since an individual received the second dose of a two-dose primary series, or one dose of a single dose vaccine. These individuals have NOT received a booster dose.

○ **Unvaccinated:** have NOT received all primary COVID-19 vaccine doses.

Boosted & Up to Date mean the same thing RIGHT NOW

"90-Day Window"

Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-CoV-2 infection:

All HCP who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested immediately as described in the testing section.

Restriction from work, quarantine, and testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic.
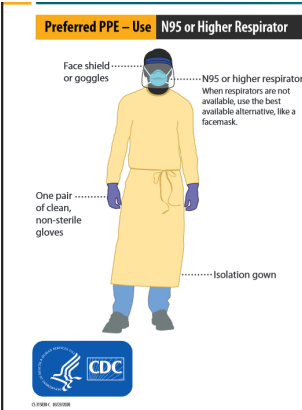
September 10, 2021 CDC Recommendations

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Stay Up to Date

General Vaccine Administration

Source Control / PPE

Preferred PPE – Use N95 or Higher Respirator

Know How to Wear Your Fac... Know how to wear your face mask correctly.

cdc.gov/COVID19

Detection, Isolation/Quarantine

Screening and Surveillance

Hand Hygiene

Surface Cleaning / Disinfecting

The National Personal Protective Technology Laboratory (NPPTL)

NIOSH-Approved Particulate Filtering Facepiece Respirators
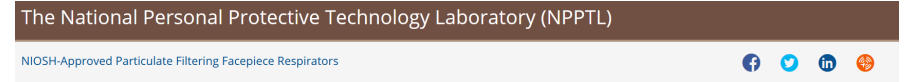
NIOSH-approved N95 Particulate Filtering Facepiece Respirators

Updated July 22, 2021
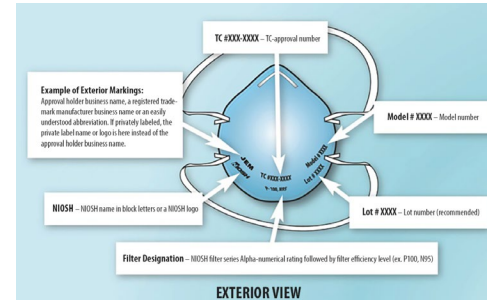
Image: Harper College

Respiratory Protection / Ventilation

Core Infection Prevention Practices

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Vaccine requirement applies to the following Medicare and Medicaid-certified provider and supplier types

- Q: To which provider and supplier types does this apply?
  - A: The staff vaccination requirement applies to the following Medicare and Medicaid-certified provider and supplier types:
  - Ambulatory Surgery Centers
  - Community Mental Health Centers
  - Comprehensive Outpatient Rehabilitation Facilities
  - Critical Access Hospitals
  - End-Stage Renal Disease Facilities
  - Home Health Agencies
  - Home Infusion Therapy Suppliers
  - Hospices
  - Hospitals
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities
  - Clinics
  - Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
  - Psychiatric Residential Treatment Facilities (PRTFs)
  - Programs for All-Inclusive Care for the Elderly (PACE) Organizations
  - Rural Health Clinics/ Federally Qualified Health Centers (Medicare only)
  - Long Term Care facilities.

https://www.cms.gov/files/document/cms-omnibus-covid-19-health-care-staff-vaccination-requirements-2021.pdf

Private Duty/Private Caregiver and CMS Vaccine Condition of Working in Medicare and Medicaid-certified provider and supplier types

- Q: If a resident has a private caregiver (not employed by the facility but by the resident) would this apply to the CMS Mandate ?

  "Q: Which staff are covered under this requirement?

  A. This vaccination requirement applies to eligible staff working at almost all CMS-certified facilities that participate in the Medicare and Medicaid programs, regardless of clinical responsibility or patient contact. The requirement includes all current staff as well as any new staff who provide any care, treatment, or other services for the facility and/or its patients. This

  includes facility employees, licensed practitioners, students, trainees, and volunteers.

  *Additionally, **this also includes individuals who provide care, treatment, or other services for the facility and/or its patients under contract or other arrangements.**"*

- Would they need to provide us with an exemption in not vaccinated ?
  – Yes

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How Often Should We Taking Resident Vitals?

Moderate or high community rates of COVID-19 or other respiratory illness

- Actively monitor all residents **upon admission** and **at least daily** for
  - Fever
  - Symptoms of respiratory illness and/or COVID-19
  - Oxygen saturation (O2) via pulse oximetry
  - Suggest BP as required by order or medication
- Residents with close contacts
  - Suggest actively monitoring for Fever, symptoms, O2 via pulse oximetry **per shift**
- If residents have fever or symptoms consistent with COVID-19 or are positive
  - Suggest **2x per shift or with any condition change** (add BP)

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Long-Term Care (LTC) Respiratory Surveillance Line List

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Line List

The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness.

Each row represents an individual resident or staff member who may have been affected by the outbreak illness (i.e., case). The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes. While this template was developed to help with data collection for common respiratory illness outbreaks the data fields can be modified to reflect the needs of the individual facility during other outbreaks.

Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf

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COVID-19 Vaccination after COVID-19 Infection

- *Data from multiple studies indicate that the currently approved or authorized COVID-19 vaccines can be given safely to people with evidence of a prior COVID-19 infection.*
- *People with known current COVID-19 infection should wait until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met.*
- *Unvaccinated people who were close contacts of a person with COVID-19 infection*
- *Generally wait to seek vaccination until quarantine has ended*
- *However, **to avoid missed opportunities for vaccination, vaccination during quarantine could be considered***
  - *Likely to have repeated COVID-19 exposures*
  - *Because they are unable to effectively quarantine (e.g., residing in a congregate or crowded setting or during outbreaks in their community)*
  - *Will have limited access to vaccination after their quarantine period has ended*
  - *Are unlikely to otherwise seek vaccination after their quarantine period has ended*

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**