COVID-19 and HAI Updates and Q&A Webinars for Long-Term Care and Congregate Residential Settings

June 3rd, 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
- For continuing education credit, complete evaluation at https://redcap.dph.illinois.gov/surveys/?s=WJLETP3EDNLNL8X4 by June 10th, 2022
  - Credit only available for the live session
  - Must be registered individually to receive credit

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Agenda

- Upcoming Webinars
- 2022 Illinois Summit on Antimicrobial Stewardship
- Long-term Care Updates
- COVID-19 Boosters
- Facility Assessment and Infection Risk Assessment in Long Term Care
- Open Q & A

Slides and recording will be made available after the session.

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Upcoming COVID-19 and Infection Prevention and Control Updates

1:00 pm - 2:00 pm

Date	Infection Control Topic	Registration Link
Friday, June 24th	Respiratory Protection Program	https://illinois.webex.com/illinois/onstage/g.php?MTID=e9f57a8da8393240cd28b9c61e9d0fecc
Friday, July 8th	Hand Hygiene Education and Performance Measures	https://illinois.webex.com/illinois/onstage/g.php?MTID=ef61d90e0e1f88db1470f0a516f05b916
Friday, July 22nd	Transmission-Based Precautions, PPE, and Resident Placement	https://illinois.webex.com/illinois/onstage/g.php?MTID=ec1926129611cfc5203b18560aa2e60e6

Previously recorded webinars can be viewed on the IDPH Portal

Continued Education will be offered. It will only be for the live presentation. Please ensure when registering that your name and email are correctly spelled. To receive the continued education, you must complete a training survey, which will be provided with the link to the recording.

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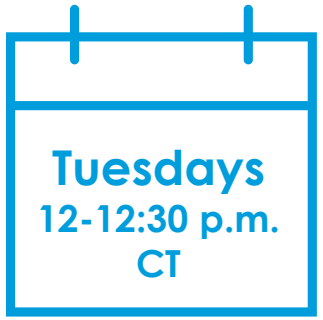
June Telligen Events

For all other events, visit our website: https://www.telligenqiconnect.com/calendar

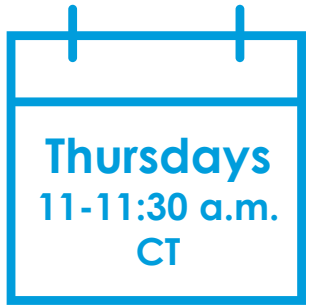
Don't miss out on these upcoming events:



Give Your Nursing Home a Boost!

Join us for a series on Motivational Interviewing from June 7 through July 5 and learn strategies for navigating conversations with residents, families and staff who have low vaccine confidence or vaccine hesitancy.

Register Here



Ask and Expert Series *(NEW)*

This weekly webinar series alternates between case study reviews with Telligen's Infection Preventionist and Q&A discussions with Telligen's Pharmacist

Designed to accommodate your busy schedule, this 30-minute come-and-go-as-you-need series is targeted towards nursing home staff and is an opportunity for open discussion and Q&A.

- **Denton Chancy, PharmD** will cover COVID-19 vaccination topics including educating residents, families and staff who are uncertain about getting vaccinated (June 9 and 23)
- **Jaime Zapata, CIC** will cover topics to strengthen your infection prevention and control program (June 2, 16, 30)

Register Here

Telligen QI Connect™
Partnering to improve health outcomes through relationships and data

NHSN and QAPI Assistance

Contact: nursinghome@telligen.com

This material was prepared by Telligen, a Quality Innovation Network-Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. This material is for informational purposes only and does not constitute medical advice; it is not intended to be a substitute for professional medical advice, diagnosis or treatment. 12SOW-QIN-06/02/2022-4449

2022 Illinois Summit on Antimicrobial Stewardship

- July 12th, 2022
  - Virtual event
- Registration coming soon
  - Questions can be sent to Antibiotic.Stewardship@Hektoen.org
- LTC Poster Session Abstract
  - Submit a brief description of your project/topic (200 words or less), to Antibiotic.Stewardship@Hektoen.org by June 7th, 2022

Long-term Care Updates

- Application of LTC Guidance

Designated COVID Unit using Temporary Barriers

- Waiver that allowed temporary barriers for COVID units expires

- Deadline is Monday, June 6th ----No longer able to use temporary barriers such as plastic Visqueen!! (becomes life safety violation subject to penalties)

CDC Response regarding designated COVID unit:

- **Ideally should separate COVID residents from general population**

  when feasible (e.g., separate floor, unit, wing, hall)

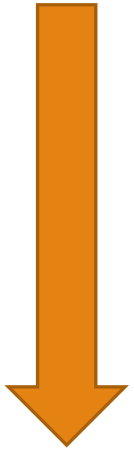
- Residents in isolation or quarantine should have the door closed (if safe to do so), and clear signage on the door to ensure staff wear appropriate PPE

- CDC suggests **facilities focus on ensuring other preventive measures, such as:**
  - **rapid testing/isolation,**
  - **use of source control by everyone in the facility (though we know this is not always possible for some residents), and**
  - **optimizing indoor air quality.**

Designated Covid unit and resident placement

- Using separate hallway, wing, or unit

Ideal



Least preferred

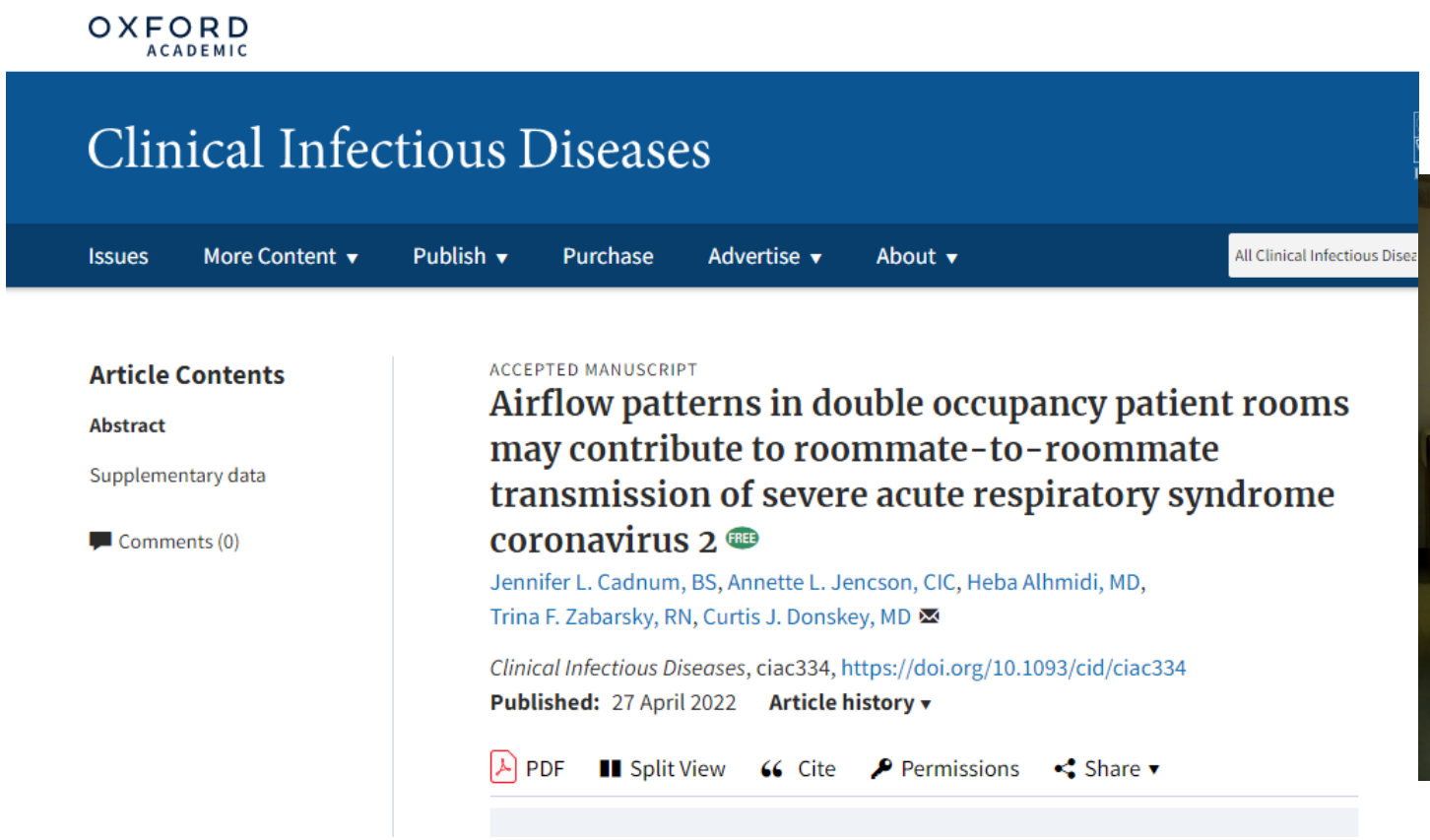
Single room, private bathroom

Single room, shared bathroom (leave exhaust fan running at all times)

Double room, both confirmed cases

Unable to designate covid unit physically separate from other rooms

Ideal	End of hallway, corridor, or unit
	Provide empty room on each side of hallway between COVID rooms and non-COVID rooms
	Single room, private bathroom
	Single room, shared bathroom (leave exhaust fan running at all times)
Least Preferred	Double room, both confirmed cases



Easternstardecorah.com

Conclusions:

Airflow patterns in double occupancy patient rooms may contribute to risk for transmission of SARS-CoV-2 between roommates. **Keeping curtains closed between beds may be beneficial in reducing risk.**

https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciac334/6574835

Other Preventative Measures

Rapid testing/isolation

- This is why we are still screening staff, vendors, visitors, and assessing residents for signs and symptoms of COVID-19---if someone has symptoms then test!
- If identified positive for COVID-19, you are placing them in isolation and if identified as close contact you are placing in quarantine (or excluding from work)

Use of source control by everyone in the facility (though we know this is not always possible for some residents)

- This is why we are still recommending source control (masks or respirators) in healthcare settings

Optimizing indoor air quality

- Emphasis on improving ventilation in long-term care facilities (discussed before but worth reviewing)

Ventilation Considerations

Gasmartbricks.com

Protective ventilation practices and interventions can:

- ***Reduce the airborne concentrations---how do you do that?***
  - ***Increase the introduction of outdoor air***

- ***Reduce the overall viral dose to occupants---how do you do that?***
  - ***Improve central air filtration***

Ventilation in Buildings | CDC

Practical Options to Increase the Introduction of Outdoor Air

Open outdoor air dampers beyond minimum settings to reduce or eliminate HVAC air recirculation.

Open windows and doors, when weather conditions allow, to increase outdoor air flow.

Use fans to increase the effectiveness of open windows by placing fan backwards in the window and exhausting the air in the room to the outside.

Ensure ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space.

Rebalance or adjust HVAC systems to increase total airflow to occupied spaces when possible.

Turn off any demand-controlled ventilation (DCV) controls that reduce air supply based on occupancy or temperature during occupied hours.

In homes and buildings where the HVAC fan operation can be controlled at the thermostat, **set the fan to the "on" position instead of "auto,"** which will operate the fan continuously, even when heating or air-conditioning is not required.

Practical Options to Improve Central Air Filtration

Increase air filtration to as high as possible without significantly reducing design airflow

Make sure air filters are properly sized and within their recommended service life Install properly sized MERV-13 air filters or the highest rated MERV filters that the HVAC system can accommodate.

Inspect filter housing and racks to ensure appropriate filter fit and minimize air that flows around, instead of through, the filter. Close off any gaps around air filters to minimize air moving around them instead of through them.

Ensure restroom exhaust fans are functional and operating at full capacity when the building is occupied.

Inspect and maintain exhaust ventilation systems in areas such as kitchens, cooking areas, etc. Operate these systems any time these spaces are occupied. Operating them even when the specific space is not occupied will increase overall ventilation within the occupied building.

Use portable high-efficiency particulate air (HEPA) fan/filtration systems to enhance air cleaning

Use portable air cleaners to increase air cleaning rates in areas where air flow and central filtration are insufficient:

Generate clean-to-less-clean air movement by evaluating and repositioning as necessary, the supply louvers, exhaust air grilles, and/or damper settings.

Use ultraviolet germicidal irradiation (UVGI) as a supplemental treatment to inactivate SARS-CoV-2 when options for increasing room ventilation and filtration are limited.

In non-residential settings, run the HVAC system at maximum outside airflow for 2 hours before and after the building is occupied.

Approximate Costs of Ventilation Considerations

The following are examples of cost estimates for ventilation interventions:

No cost: opening windows; inspecting and maintaining dedicated exhaust ventilation; disabling DCV controls; repositioning outdoor air dampers

Less than $100: using fans to increase effectiveness of open windows; repositioning supply/exhaust diffusers to create directional airflow

$500 (approximately): adding portable HEPA fan/filter systems

$1500 to $2500 (approximately): adding upper room ultraviolet germicidal irradiation (UVGI)

Update

- Visitor screening tool is now posted (available for use—not mandatory)

https://dph.illinois.gov/content/dam/soi/en/web/idph/covid19/guidance/ltc/Screening-Tool-for-Visitors_03.31.22.pdf

- PPE tables have been updated and are now posted

https://dph.illinois.gov/content/dam/soi/en/web/idph/covid19/guidance/ltc/PPE-Table-COVID19_03.22.2022.pdf

Why Do We Need ongoing COVID-19 Boosters?
Two Main Reasons

SARS-CoV-2 Variants

Waning Immunity

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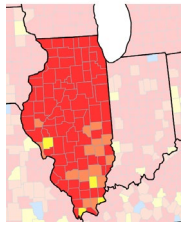
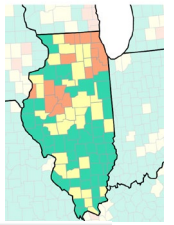
New SARS-CoV-2 Variants



Surveillance Intensity

What happens when most people are testing at home or not testing for “colds” or “allergies”?



medRxiv
THE PREPRINT SERVER FOR HEALTH SCIENCES

CSH Cold Spring Harbor Laboratory BMJ Yale

The prevalence of SARS-CoV-2 infection and uptake of COVID-19 antiviral treatments during the BA.2/BA.2.12.1 surge, New York City, April-May 2022

Saba A Qasmieh, McKaylee M Robertson, Chloe A Teasdale, Sarah G Kulkarni, Margaret McNairy, Luisa N. Borrell, Denis Nash

doi: https://doi.org/10.1101/2022.05.25.22275603

This article is a preprint and has not been peer-reviewed [what does this mean?]. It reports new medical research that has yet to be evaluated and so should *not* be used to guide clinical practice.

0 0 0 0 9 0 820

‘We’re playing with fire’: US Covid cases may be 30 times higher than reported

A person receives a Covid-19 test swab on the street in New York on 26 May 2022. Photograph: Justin L

Severe undercounting undermines our efforts to ‘understand and get ahead of the virus’, researcher says after New York survey

The United States is now in its fourth-biggest Covid surge, according to official case counts - but experts believe the actual current rate is much higher.

Conclusions and Relevance: The true magnitude of NYCs BA.2/BA.2.12.1 surge was vastly underestimated by routine SARS-CoV-2 surveillance. Until there is more certainty that the impact of future pandemic surges on severe population health outcomes will be diminished, representative surveys are needed for timely surge detection, and to estimate the true burden of infection, hybrid protection, and uptake of time-sensitive treatments.

https://www.theguardian.com/world/2022/jun/01/us-covid-surge-cases-rate?utm_term=62989f3b0f85c5251da6792ae306ffe1&utm_campaign=GuardianTodayUS&utm_source=esp&utm_medium=Email&CMP=GTUS_email

https://www.medrxiv.org/content/10.1101/2022.05.25.22275603v1

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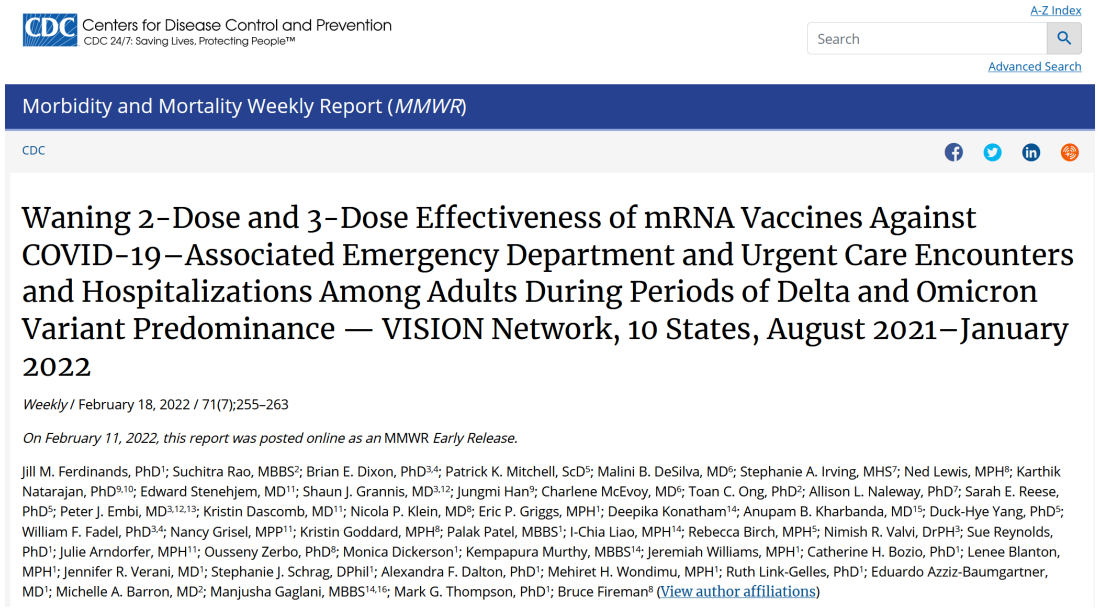
Waning Immunity from COVID-19 vaccine



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

A-Z Index
Search
Advanced Search

Morbidity and Mortality Weekly Report (*MMWR*)

CDC

Waning 2-Dose and 3-Dose Effectiveness of mRNA Vaccines Against COVID-19–Associated Emergency Department and Urgent Care Encounters and Hospitalizations Among Adults During Periods of Delta and Omicron Variant Predominance — VISION Network, 10 States, August 2021–January 2022

Weekly / February 18, 2022 / 71(7);255–263

On February 11, 2022, this report was posted online as an MMWR *Early Release.*

Jill M. Ferdinands, PhD[1]; Suchitra Rao, MBBS[2]; Brian E. Dixon, PhD[3,4]; Patrick K. Mitchell, ScD[5]; Malini B. DeSilva, MD[6]; Stephanie A. Irving, MHS[7]; Ned Lewis, MPH[8]; Karthik Natarajan, PhD[9,10]; Edward Stenehjem, MD[11]; Shaun J. Grannis, MD[3,12]; Jungmi Han[9]; Charlene McEvoy, MD[6]; Toan C. Ong, PhD[2]; Allison L. Naleway, PhD[7]; Sarah E. Reese, PhD[5]; Peter J. Embi, MD[3,12,13]; Kristin Dascomb, MD[11]; Nicola P. Klein, MD[8]; Eric P. Griggs, MPH[1]; Deepika Konatham[14]; Anupam B. Kharbanda, MD[15]; Duck-Hye Yang, PhD[5]; William F. Fadel, PhD[3,4]; Nancy Grisel, MPP[11]; Kristin Goddard, MPH[8]; Palak Patel, MBBS[1]; I-Chia Liao, MPH[14]; Rebecca Birch, MPH[5]; Nimish R. Valvi, DrPH[3]; Sue Reynolds, PhD[1]; Julie Arndorfer, MPH[11]; Ousseny Zerbo, PhD[8]; Monica Dickerson[1]; Kempapura Murthy, MBBS[14]; Jeremiah Williams, MPH[1]; Catherine H. Bozio, PhD[1]; Lenee Blanton, MPH[1]; Jennifer R. Verani, MD[1]; Stephanie J. Schrag, DPhil[1]; Alexandra F. Dalton, PhD[1]; Mehiret H. Wondimu, MPH[1]; Ruth Link-Gelles, PhD[1]; Eduardo Azziz-Baumgartner, MD[1]; Michelle A. Barron, MD[2]; Manjusha Gaglani, MBBS[14,16]; Mark G. Thompson, PhD[1]; Bruce Fireman[8] (View author affiliations)

What is added by this report?

- *During the Omicron-predominant period*
- *Vaccine Effectiveness (VE) against COVID-19–associated Emergency/Urgent Care (ED/UC) visits and hospitalizations*
- *87% and 91%, during the 2 months after a third dose*
- *Decreased to 66% and 78% by the fourth month after a third dose.*
- *Protection against hospitalizations exceeded that against ED/UC visits.*

What are the implications for public health practice?

- *Remain up to date with recommended COVID-19 vaccinations to best protect against COVID-19–associated hospitalizations and ED/UC visits.*

https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.htm

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Waning Immunity from COVID-19 Disease

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Protection and Waning of Natural and Hybrid Immunity to SARS-CoV-2

Yair Goldberg, Ph.D., Micha Mandel, Ph.D., Yinon M. Bar-On, M.Sc., Omri Bodenheimer, M.Sc., Laurence S. Freedman, Ph.D., Nachman Ash, M.D., Sharon Alroy-Preis, M.D., Amit Huppert, Ph.D., and Ron Milo, Ph.D.

Conclusions

- *"Protection against reinfection for persons previously infected with SARS-CoV-2 (regardless of whether they had received any dose of vaccine decreased as the time increased since the last immunity-conferring event*
- *However, this protection was higher than that conferred after the same time had elapsed since receipt of a second dose of vaccine among previously uninfected persons.*
- *Vaccine after infection reinforced protection against reinfection."*

https://www.nejm.org/doi/full/10.1056/NEJMoa2118946

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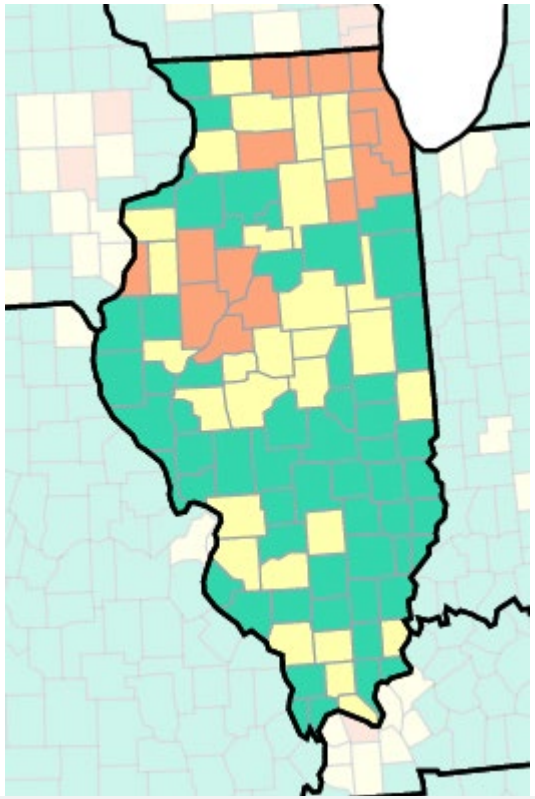
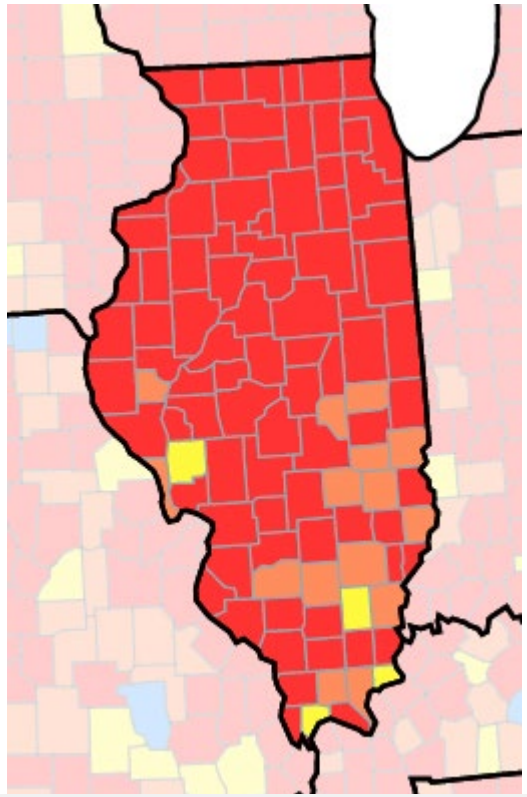
Increased COVID-19 in the Community

Community Levels



Low Medium High No Data

Community Transmission



High Substantial Moderate Low No Data

Data from 6/2/22

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Centers for Disease Control and Prevention Change in Booster Recommendations

The following people **should** receive a second COVID-19 booster dose:

- People 12 years and older who are moderately or severely immunocompromised
- People 50 years and older

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#considerations-covid19-vax-booster

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Up to Date

Photo credit: Deb Burdsall

You are considered up to date if:

- You have completed your primary series but are not yet eligible for a booster
- You have received 1 booster but are not recommended to get a 2nd booster
- You have received 1 booster but are not yet eligible for a 2nd booster
- You are eligible and have received a 2nd booster

Stay up to date by getting recommended boosters when you are eligible!

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html

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Up to Date

Executive Order 2022-05

Executive Order 2021-22 is further amended and revised as follows:

Section 2: Vaccination and Testing Requirements for Health Care Workers.

g. Beginning March 15, 2022, Health Care Workers at skilled nursing and intermediate care facilities licensed under the Nursing Home Care Act, facilities licensed under the ID/DD Community Care Act, and facilities licensed under the MC/DD Act, must be up-to-date on COVID-19 vaccinations in order to be considered fully vaccinated against COVID-19. An individual is considered “up to date” on COVID-19 vaccinations when they have received all CDC-recommended COVID-19 vaccines, including any booster dose(s) when eligible.

https://coronavirus.illinois.gov/resources/executive-orders/display.executive-order-number-05.2022.html

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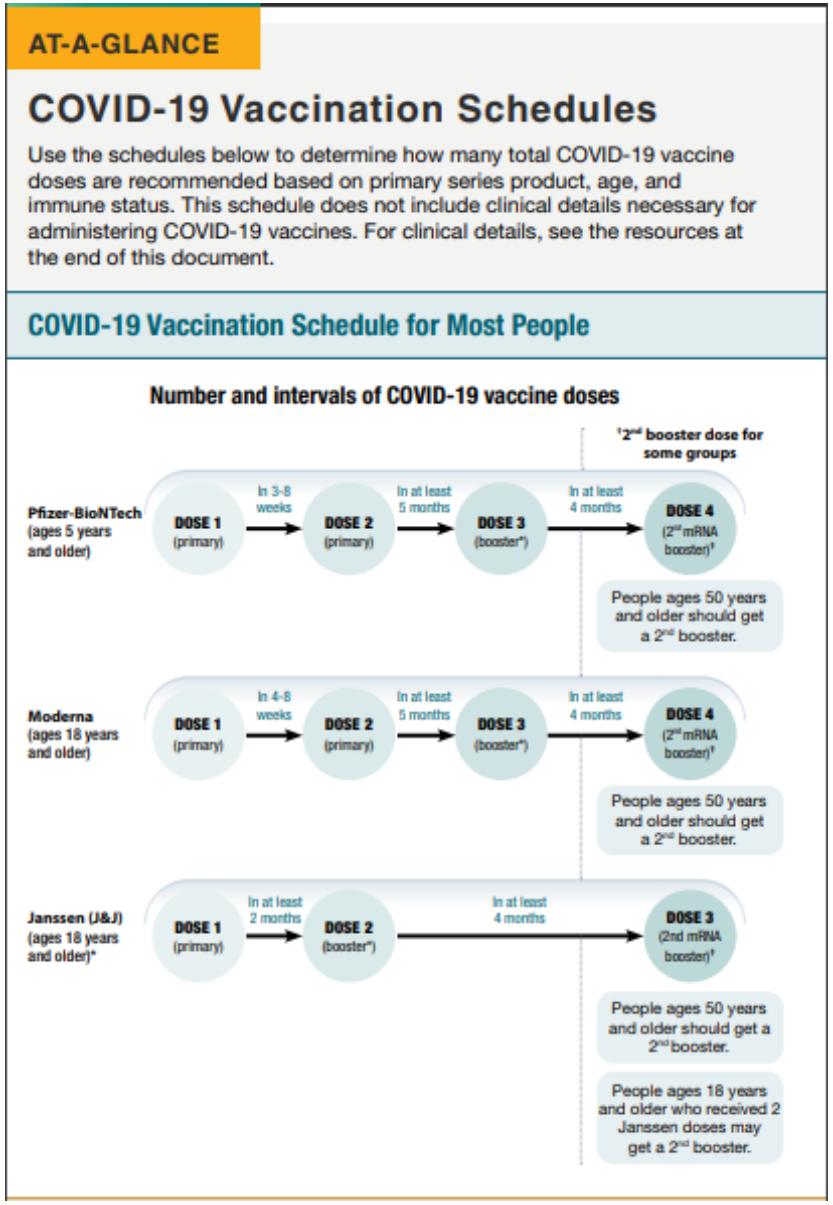
Vaccine Schedules



AT-A-GLANCE

COVID-19 Vaccination Schedules

Use the schedules below to determine how many total COVID-19 vaccine doses are recommended based on primary series product, age, and immune status. This schedule does not include clinical details necessary for administering COVID-19 vaccines. For clinical details, see the resources at the end of this document.

COVID-19 Vaccination Schedule for Most People

Number and intervals of COVID-19 vaccine doses

†2nd booster dose for some groups

Pfizer-BioNTech (ages 5 years and older): DOSE 1 (primary) → In 3-8 weeks → DOSE 2 (primary) → In at least 5 months → DOSE 3 (booster*) → In at least 4 months → DOSE 4 (2nd mRNA booster)†

People ages 50 years and older should get a 2nd booster.

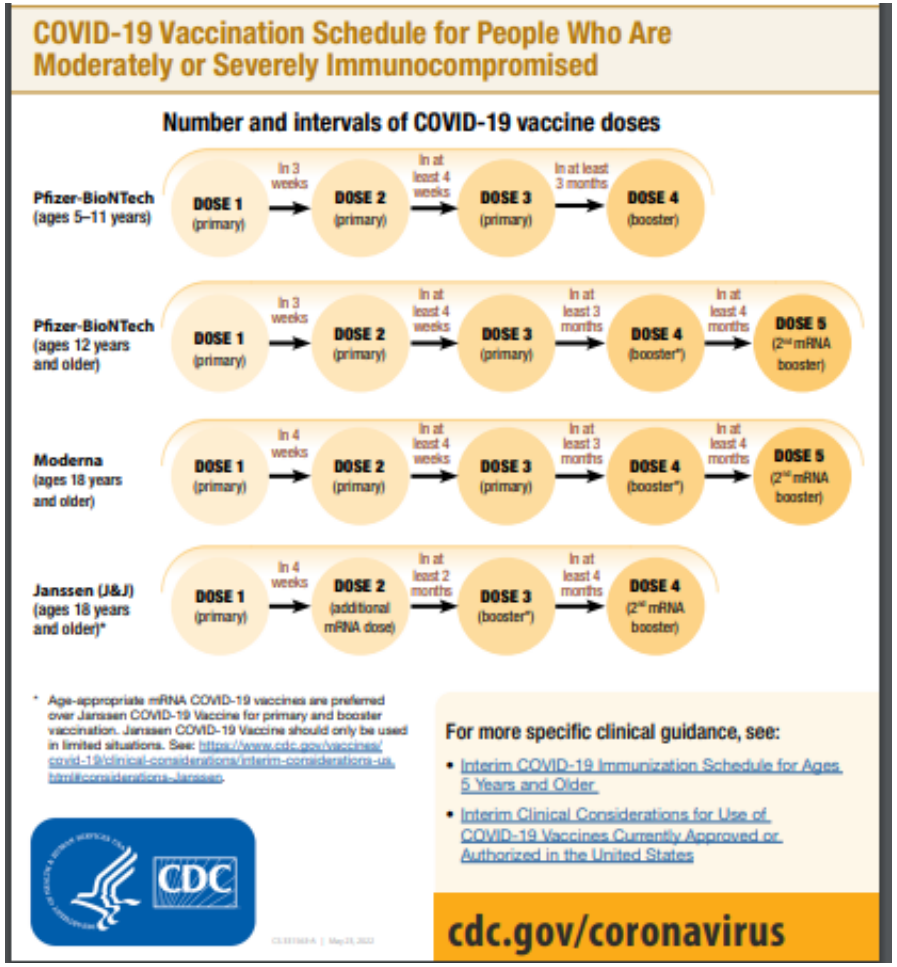
Moderna (ages 18 years and older): DOSE 1 (primary) → In 4-8 weeks → DOSE 2 (primary) → In at least 5 months → DOSE 3 (booster*) → In at least 4 months → DOSE 4 (2nd mRNA booster)†

People ages 50 years and older should get a 2nd booster.

Janssen (J&J) (ages 18 years and older)*: DOSE 1 (primary) → In at least 2 months → DOSE 2 (booster*) → In at least 4 months → DOSE 3 (2nd mRNA booster)†

People ages 50 years and older should get a 2nd booster.

People ages 18 years and older who received 2 Janssen doses may get a 2nd booster.



COVID-19 Vaccination Schedule for People Who Are Moderately or Severely Immunocompromised

Number and intervals of COVID-19 vaccine doses

Pfizer-BioNTech (ages 5–11 years): DOSE 1 (primary) → In 3 weeks → DOSE 2 (primary) → In at least 4 weeks → DOSE 3 (primary) → In at least 3 months → DOSE 4 (booster)

Pfizer-BioNTech (ages 12 years and older): DOSE 1 (primary) → In 3 weeks → DOSE 2 (primary) → In at least 4 weeks → DOSE 3 (primary) → In at least 3 months → DOSE 4 (booster*) → In at least 4 months → DOSE 5 (2nd mRNA booster)

Moderna (ages 18 years and older): DOSE 1 (primary) → In 4 weeks → DOSE 2 (primary) → In at least 4 weeks → DOSE 3 (primary) → In at least 3 months → DOSE 4 (booster*) → In at least 4 months → DOSE 5 (2nd mRNA booster)

Janssen (J&J) (ages 18 years and older)*: DOSE 1 (primary) → In 4 weeks → DOSE 2 (additional mRNA dose) → In at least 2 months → DOSE 3 (booster*) → In at least 4 months → DOSE 4 (2nd mRNA booster)

* Age-appropriate mRNA COVID-19 vaccines are preferred over Janssen COVID-19 Vaccine for primary and booster vaccination. Janssen COVID-19 Vaccine should only be used in limited situations. See: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#considerations-Janssen.

For more specific clinical guidance, see:

- Interim COVID-19 Immunization Schedule for Ages 5 Years and Older
- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States

cdc.gov/coronavirus

https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-vacc-schedule-at-a-glance-508.pdf

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How Does This Impact Congregate Settings?

- Universal personal protective equipment use (page 7)
- Routine testing of staff in facilities licensed under Ill. Adm. Codes 300, 350, and 390 (page 9)
- Management of visitors (pages 11, 19)
- Contact tracing (pages 13, 14)
- Resident as close contact (pages 20, 21)
- Management of new admissions/readmissions (pages 22, 23)
- Dining (page 26)
- Work Exclusions & Restrictions for Asymptomatic HCP with Exposures (page 32)

https://dph.illinois.gov/covid19/community-guidance/long-term-care.html

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Practical Implementation

- Modify vaccine tracking logs to include the second booster
- Work with your Human Resources team to identify those 50 years and older
- Provide updated information to team members about the change
  - Stress eligibility for those under 50 who are:
    - Under treatment for a solid tumor or hematologic malignancy
    - Taking immunosuppressive threat for a solid organ transplant
    - Within 2 years of CAR-T-cell therapy or hematopoietic cell transplant
    - Diagnosed with a moderate or severe primary immunodeficiency
    - In advanced or untreated HIV infection
    - Undergoing active treatment with high-dose corticosteroids

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromised

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Hang in There: Why Congregate Care Needs to Continue Infection Prevention Core Measures

- Lots of COVID-19 out there
- Consider encouraging mask use in the community both away from work as well as within the care communities
- The basic core infection prevention steps help keep COVID-19 out of your buildings to protect residents and staff
- Stay Up to Date with vaccinations: Definition has changed and will continue to change as more boosters are recommended. Build boosters into expectation and workflow
- Think treatment if persons are positive for COVID-19: https://dph.illinois.gov/covid19/community-guidance/covid19-treatment/matchmaker.html

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Facility Assessment and Infection Risk Assessment in Long Term Care

Deb Burdsall

Hektoen Institute of Medicine/IDPH

Disclosure Statement

- Deb Burdsall has no relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Learning Objectives

Review	Select	Formulate
• assessment tools that provide the basis for long term care infection prevention and control programs within your facility	• appropriate infection prevention and control resources and tools	• a plan to develop and maintain an effective infection prevention and control program utilizing evidence-based strategies and resources

CMS Infection Prevention and Control Program (IPCP) Reform of Requirements

Phase I

November 28, 2016

Basis and Scope

Definitions

Facility Assessment

Basic Infection Prevention and Control Program (IPCP)

Phase II

November 28, 2017

IPCP linked to Facility Assessment

Antibiotic Stewardship

Present Quality Assurance/ Performance Improvement (QAPI) plan to State Survey Agency

Number and Competency of Nursing Services Staff

Phase III

November 28, 2019

Trained Infection Preventionist (IP)

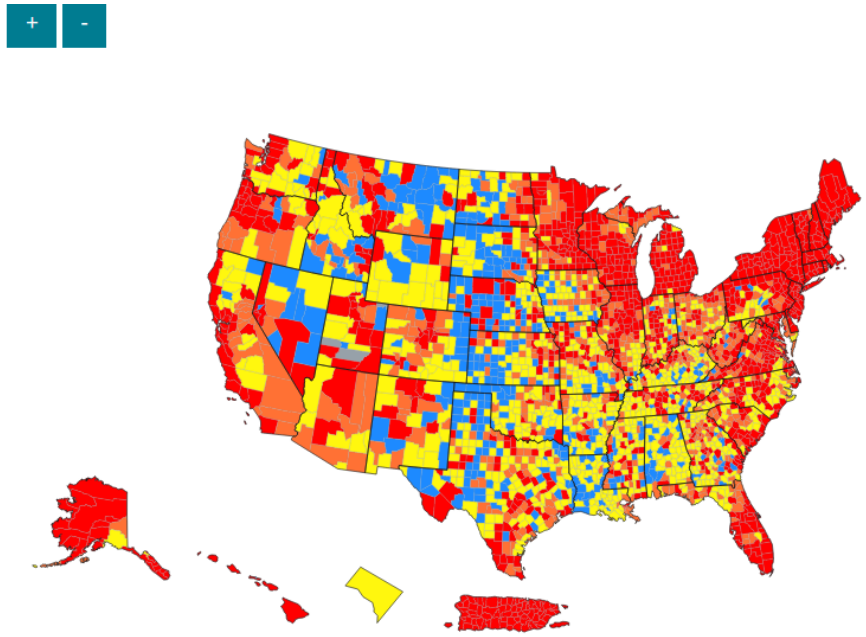
IP participation on Quality Assessment and Assurance (QAA) committee (for QAPI input)

Compare and contrast the necessary assessment tools that provide the basis for long term care infection prevention and control programs.

- What type of tools are you already using that have infection prevention and control considerations?
- Resident Assessment Inventory (RAI) Minimum Data Set (MDS) CMS Certified Facilities
- Facility Assessment: CMS Certified Facilities
- Infection Control Risk Assessment
- Infection Control Risk Assessment for Construction (ICRA)
- Tuberculosis Risk Assessments
- Centers for Disease Control and Prevention (CDC) Infection Control Assessment and Response (ICAR)
- Various resident level assessments (e.g. skin risk assessment)

Congregate Care is Already Adjusting to Looking at Risk Levels

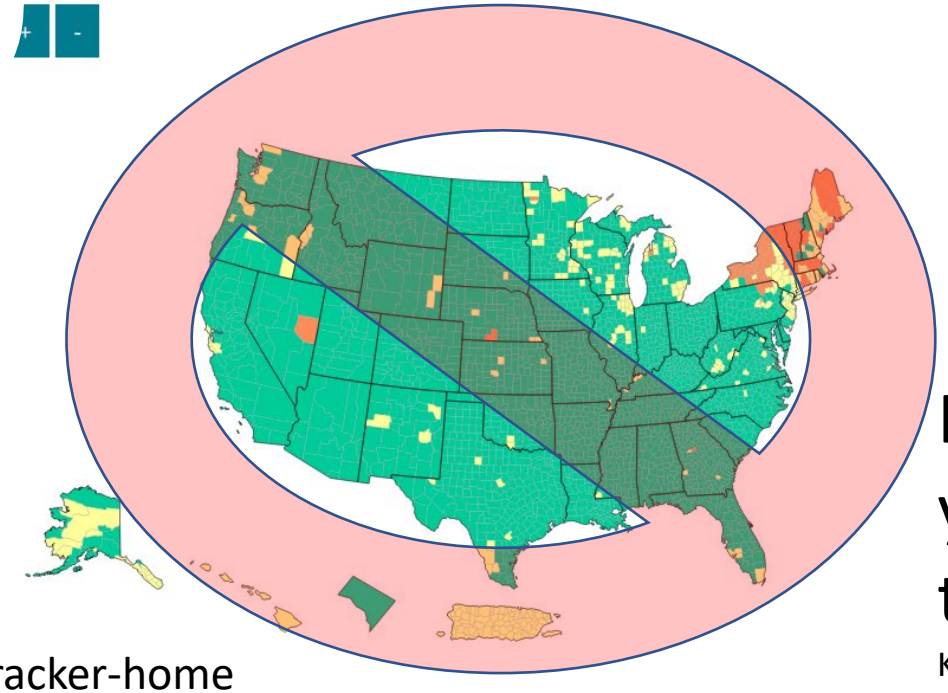
- **Use Community <u>Transmission</u> Levels= Healthcare**
- Determined by the higher level
  - New cases per 100,000 persons in the past 7 days*
  - Percentage of positive NAATs tests during the past 7 days**
- Community Levels=General Community
- Determined by the higher
  - New admissions
  - Inpatient beds metrics, based on the current level of new cases per 100,000 population in the past 7 days.



Community Transmission in US by County

	Total	Percent	% Change
High	1231	38.21%	7.85%
Substantial	595	18.47%	– 1.09%
Moderate	966	29.98%	– 5%
Low	427	13.25%	– 1.77%

How is community transmission calculated?



COVID-19 Community Levels in US by County

	Total	Percent	% Change
High	79	2.45%	0.71%
Medium	318	9.86%	1.86%
Low	2827	87.69%	– 2.57%

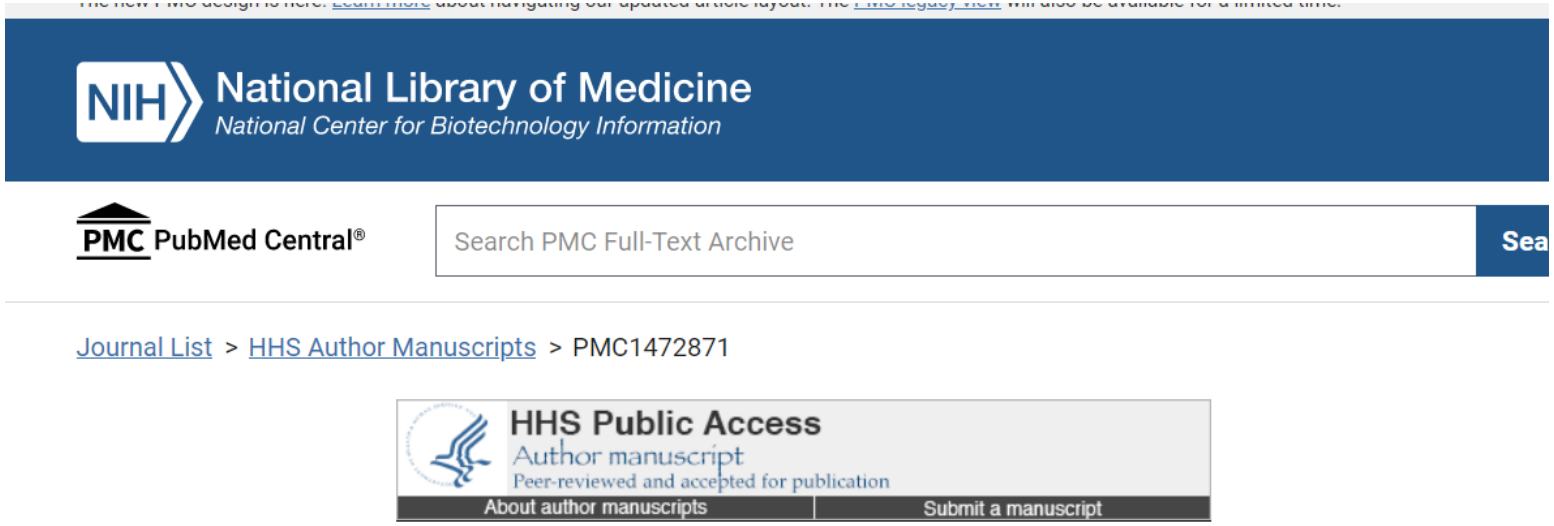
How are COVID-19 Community Levels calculated?

If you see Green you are looking at the wrong map.

https://covid.cdc.gov/covid-data-tracker/#datatracker-home

Karen Trimberger and Mary Alice Lavin

Resident Assessment Inventory (RAI)



1988: *In response to poor nursing home quality (IOM, 1986), the United States (US) Congress mandated the Resident Assessment Inventory (RAI), a multi-dimensional instrument to guide assessment and care planning with a goal of improving quality of care*.

Originally a paper document

West J Nurs Res. Author manuscript; available in PMC 2006 Jun 1.
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doi: 10.1177/0193945905284710
PMCID: PMC1472871
NIHMSID: NIHMS8342
PMID: 16585806

Author Manuscript

MDS Coordinator Relationships and Nursing Home Care Processes

Mary L. Piven, PhD, RN, Post-Doctoral Fellow,[1] Donald Bailey, PhD, RN, Assistant Professor of Nursing,[1] Natalie Ammarell, PhD, Research Associate,[1] Kirsten Corazzini, PhD, Assistant Professor of Nursing,[1] Cathleen S. Colón-Emeric, MD, MHSc, Assistant Professor of Medicine,[2] Deborah Lekan-Rutledge, RN, MSN, Clinical Associate of Nursing,[1] Queen Utley-Smith, EdD, RN, Assistant Professor of Nursing,[1] and Ruth A. Anderson, PhD, RN, FAAN, Associate Professor of Nursing[1]

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472871/

MDS Language: Updates Align More Closely with CDC and Standard Infection Prevention and Control Language

- https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

I: Active Diagnoses in the Last 7 Days (cont.)

- In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility's surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.
- Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility's Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.

WHOA!!!

- FORGET SOMETHING?
- Start with the Facility Assessment
- All of this takes Interdisciplinary Teamwork
- A journey, not a sprint

#APIC2022

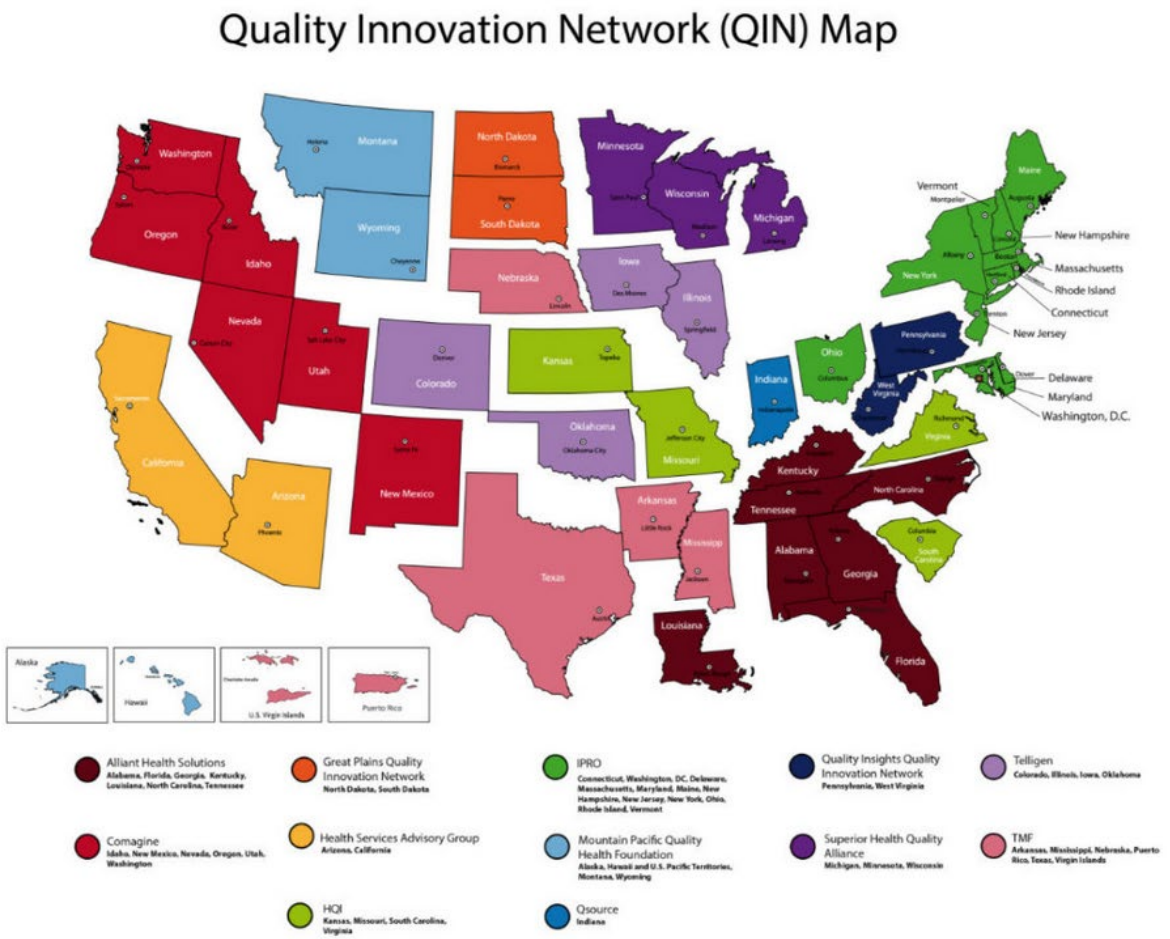
Quality Innovation Network-Quality Improvement Organization (QIN-QIO)

By participating in a local Quality Innovation Network-Quality Improvement Organization (QIN-QIO) initiative, you'll gain access to valuable resources, including evidence-based improvement strategies that are aligned with other major health quality initiatives and that can help you prepare for participation in the Centers for Medicare & Medicaid Services' Quality Payment Program.

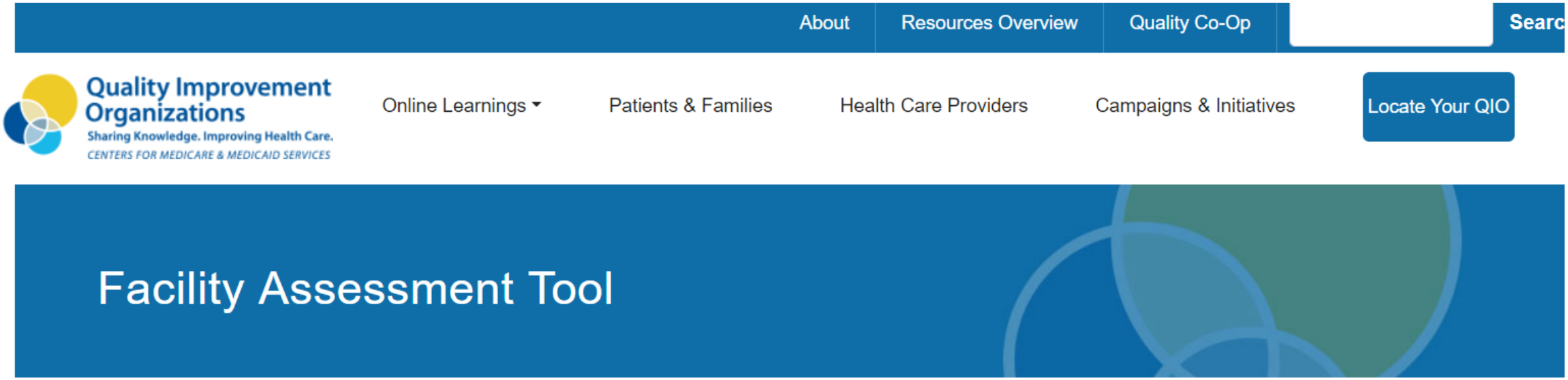
Nell Griffin: ngriffin@telligen.com
Lisa Bridwell: lbridwel@telligen.com

https://www.telligen.com/

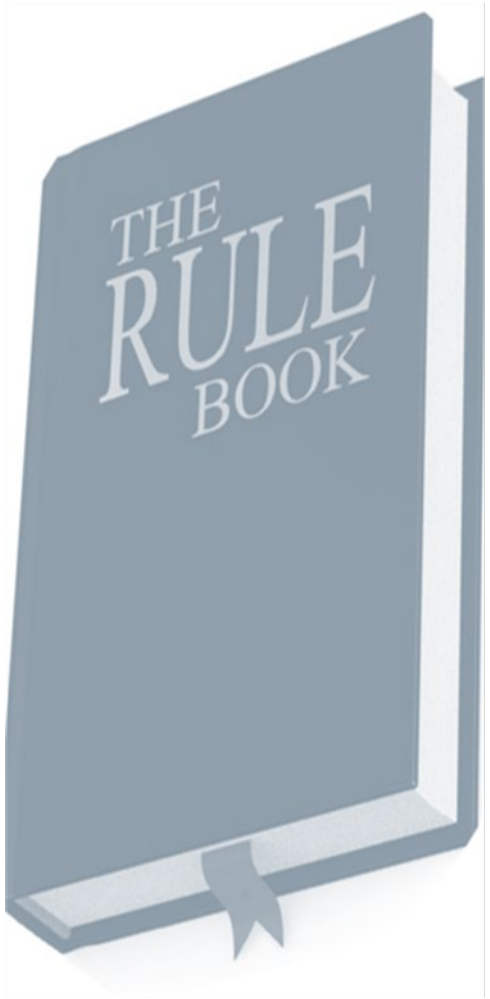
NursingHome@telligen.com
www.telligenqiconnect.com



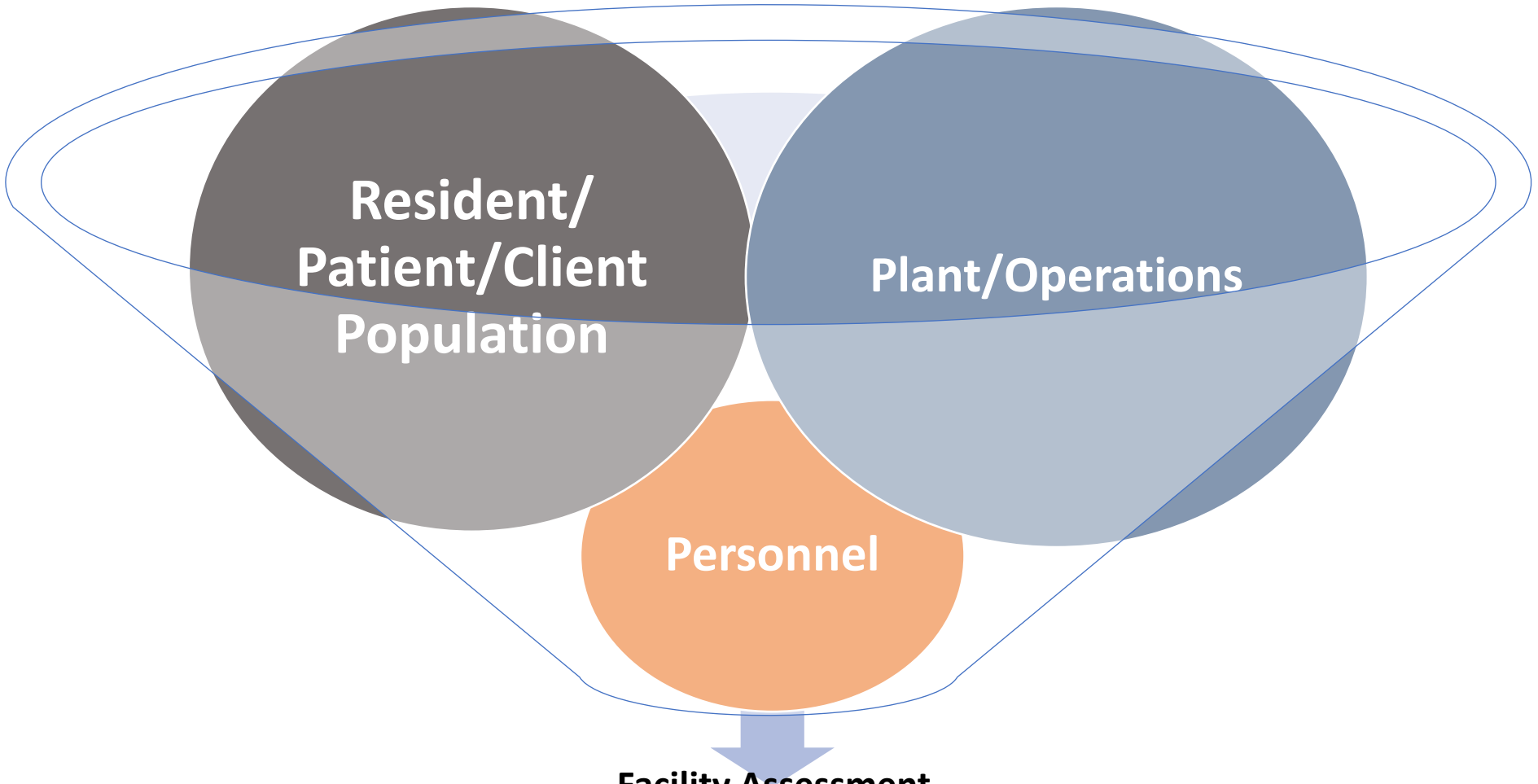
https://qioprogram.org/locate-your-qio



https://qioprogram.org/facility-assessment-tool



Facility Wide Assessment



Facility-wide Assessment

- “Determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies”
- “The facility must review and update that assessment:
  - As necessary
  - At least annually (pending legislative change)
  - Whenever there is, or facility plans for, any change that would require a substantial modification to any part of this assessment”

Federal Register Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities Final Rule: 10/4/16.

Must Address: Residents, Patients, and Clients

- The facility's resident population, including, but not limited to:
  - Number of residents and resident capacity
- The care required by the resident population:
  - Types of diseases, conditions, physical and cognitive disabilities
  - Overall acuity and other pertinent facts that are present within that population
- Any ethnic, cultural or religious factors that may potentially affect the care provided:
  - Activities
  - Food
  - Nutrition

Federal Register Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities Final Rule: 10/4/16.

Must Address: The Facilities

- Physical environment, equipment, services
- Physical plant considerations
- The facility's resources
- All buildings
- Other physical structures and vehicles
- Equipment (medical and non-medical)
- Community-based risk assessment, utilizing an all-hazards approach

Federal Register Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities Final Rule: 10/4/16.

Must Address: Services and Resources

- Therapies and pharmacy
- Contracts, memorandums of understanding
- Third party agreements to provide services or equipment
- Both normal operations and emergencies
- Health information technology resources
- Managing patient records (EHR)
- Electronic sharing of information with other organizations

Federal Register Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities Final Rule: 10/4/16.

Must Address: Personnel

- Necessary staff competencies for level and types of care needed
- Any ethnic, cultural or religious factors that may potentially affect the care
- All personnel, including managers, staff (both employees, volunteers, and those who provide services under contract)

Federal Register Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities Final Rule: 10/4/16.

WHOA!!!

- FORGET SOMETHING?
- Start with the Facility Assessment ⬇
- Then Infection Prevention Risk Assessment

Select appropriate infection prevention and control resources and tools

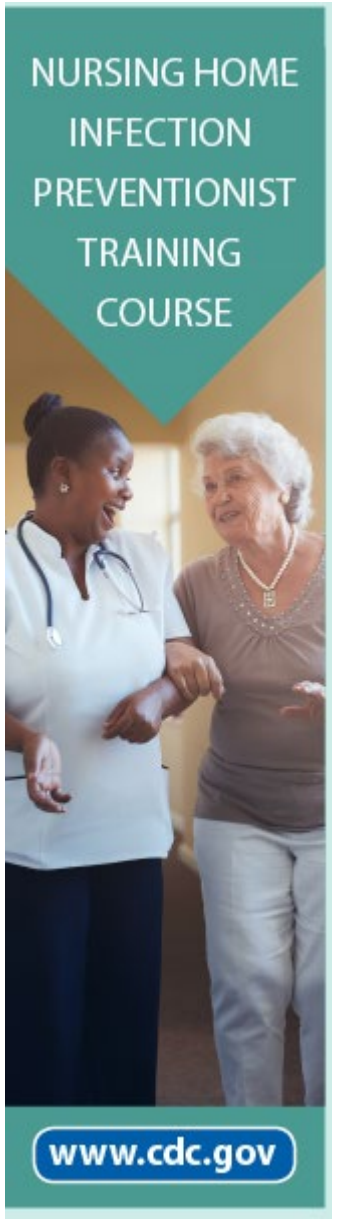
Don’t reinvent the wheel

Tools and resources are available

INFECTION EVENT	PROBABILITY OF OCCURRENCE (How likely is this to occur?)				LEVEL OF HARM FROM EVENT (What would be the most likely?)				IMPACT ON CARE (Will new treatment/care be needed for resi				READINESS TO PREVENT (Are processes/resources in place			RISK LEVEL (Scores ≥ 8 are considered highest priority for improvement efforts.)
Score	High	Med.	Low	None	Serious Harm	Moderate Harm	Temp. Harm	None	High	Med.	Low	None	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
Facility-onset Infections(s)																
Device- or care-related																
Catheter-associated urinary tract infection (CAUTI)																
Central line-associated bloodstream infection (CLABSI)																
Tracheostomy-associated respiratory infection																
Percutaneous-gastrostomy insertion site infection																
Wound infection																
Other (specify):																
Resident-related																
Symptomatic urinary tract infection (SUTI)																
Pneumonia																
Cellulitis/soft tissue																
Clostridioides difficile infection																
Tuberculosis*																
Other (specify):																
Outbreak-related																
Influenza*																
Other viral respiratory pathogens*																
Norovirus gastroenteritis*																
Bacterial gastroenteritis (e.g.,*Salmonella, Shigella*)																
Scabies																
Conjunctivitis																
Group A *Streptococcus**																
MDRO																
Other (specify):																

* Risk assessment should take into account the frequncy of this disease in the community as part of determining probability of occurrence. Data from State/local health department may be informative.

Infection events | IPC practice failures



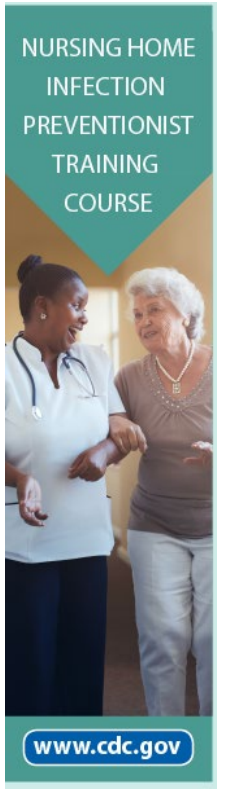
Risk Based Approach from University of North Carolina SPICE and CDC

https://www.cdc.gov/longtermcare/training.html#anchor_1557254909

INFECTION EVENT	PROBABILITY OF OCCURRENCE				LEVEL OF HARM FROM EVENT				IMPACT ON CARE				READINESS TO PREVENT			RISK LEVEL
	(How likely is this to occur?)				(What would be the most likely?)				(Will new treatment/care be needed for resid				(Are processes/resources in plac			(Scores ≥ 8 are considered high
Score	High	Med.	Low	None	Serious Harm	Moderate Harm	Temp. Harm	None	High	Med.	Low	None	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	3	2	1	0	3	2	1	
Facility-onset Infections(s)																
Device- or care-related																
Catheter-associated urinary tract infection (CAUTI)	3						1		3					2		9
Central line-associated bloodstream infection (CLABSI)				0				0				0				0
Tracheostomy-associated respiratory infection				0				0				0				0
Percutaneous-gastrostomy insertion site infection		2					1		3						1	7
Wound infection	3					2			3					2		10

Infection Event

- How likely is this to occur?
- What would be the most likely level of harm?
- Will new treatment be need for the resident?
- Are processes/resources in place to identify and address the issue
- Risk score of 8 or higher prioritizes prevention of the Infection event



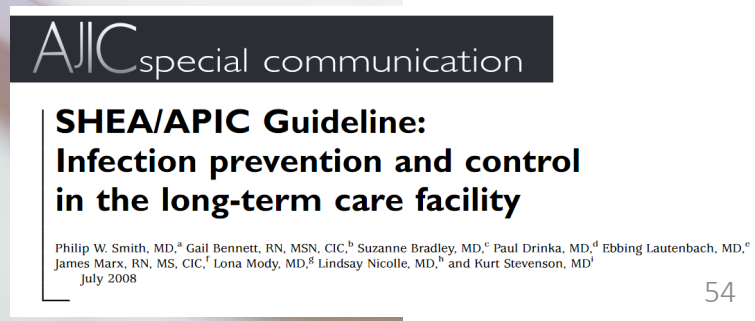
https://www.cdc.gov/longtermcare/training.html#anchor_1557254909

CDC Infection Control Assessment and Response (ICAR)

Under Revision

- Infection Control Program and Infrastructure
- Healthcare Personnel and Resident Safety
- Surveillance and Disease Reporting
- Hand Hygiene
- Personal Protective Equipment (PPE)
- Respiratory / Cough Etiquette
- Antibiotic Stewardship
- Injection Safety and Point of Care Testing
- Environment of Care
- (Consider adding Dietary!!)

CDC 24/7



https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

Tools to Collect Data to Base Risk

Tools- Free Excel Program from Minnesota
Contact your Electronic Medical Record Company

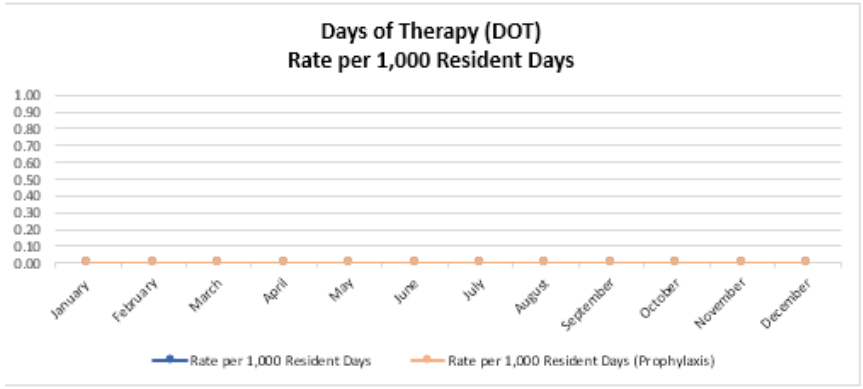
DEPARTMENT OF HEALTH ICAR

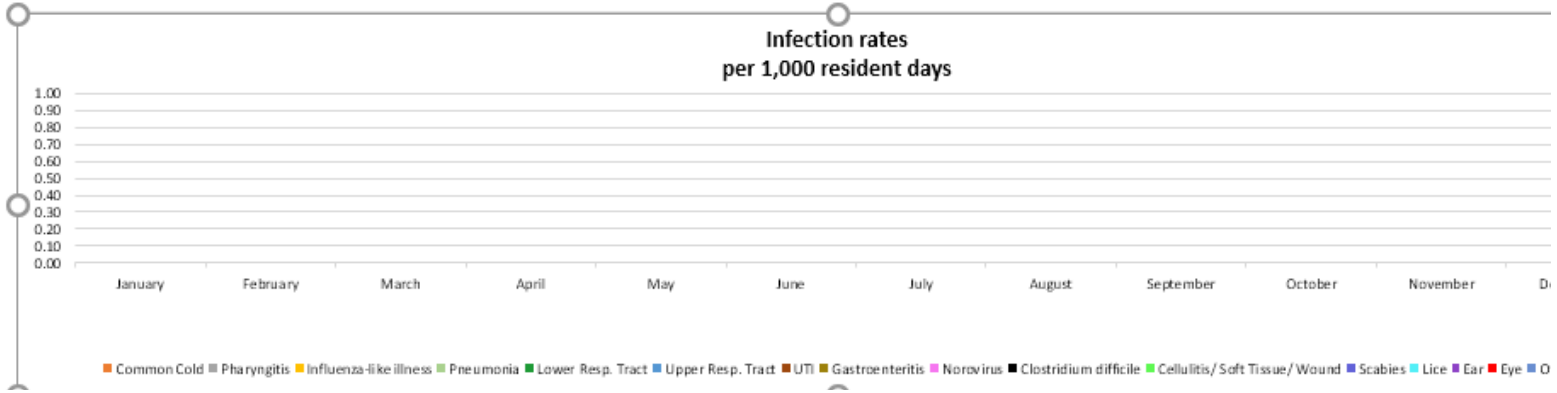
Total Days of Therapy

Month	Total Days of Therapy per Month	Rate per 1,000 Resident Days	Days of Therapy per Month (Prophyla	1,000 Resident Days (Prophyla
January	0	0.00	0.00	0.00
February	0	0.00	0.00	0.00
March	0	0.00	0.00	0.00
April	0	0.00	0.00	0.00
May	0	0.00	0.00	0.00
June	0	0.00	0.00	0.00
July	0	0.00	0.00	0.00
August	0	0.00	0.00	0.00
September	0	0.00	0.00	0.00
October	0	0.00	0.00	0.00
November	0	0.00	0.00	0.00
December	0	0.00	0.00	0.00

Total Infection Rates per 1,000 Resident Days

Month	Total	Common Cold	Pharyngitis	Influenza-like illness	Pneumonia	Lower Resp. Tract	Upper Resp. Tract	UTI	Gastroenteritis	Norovirus	Clostridium difficile	Cellulitis / Soft Tissue/ Wound	Scabies	Lice	Ear	Eye	Other
January																	
February																	
March																	
April																	
May																	
June																	
July																	
August																	
September																	
October																	
November																	
December																	





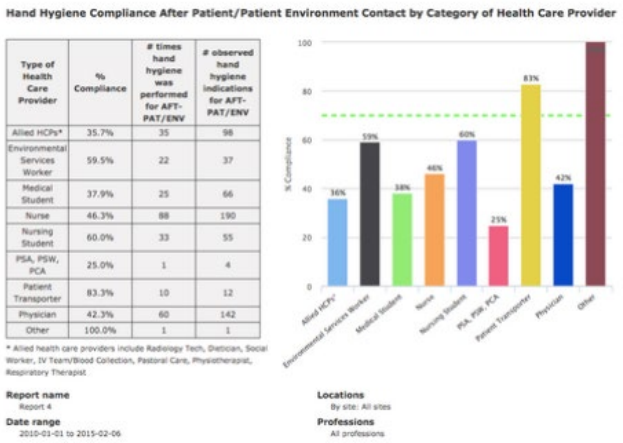
https://www.health.state.mn.us/diseases/antibioticresistance/hcp/asp/ltc/index.html

SpeedyAudit

HOME

iScrub Lite
SwipeSense
2.9 • 11 Ratings
Free

4 Missed Hand Hygiene Opportunities

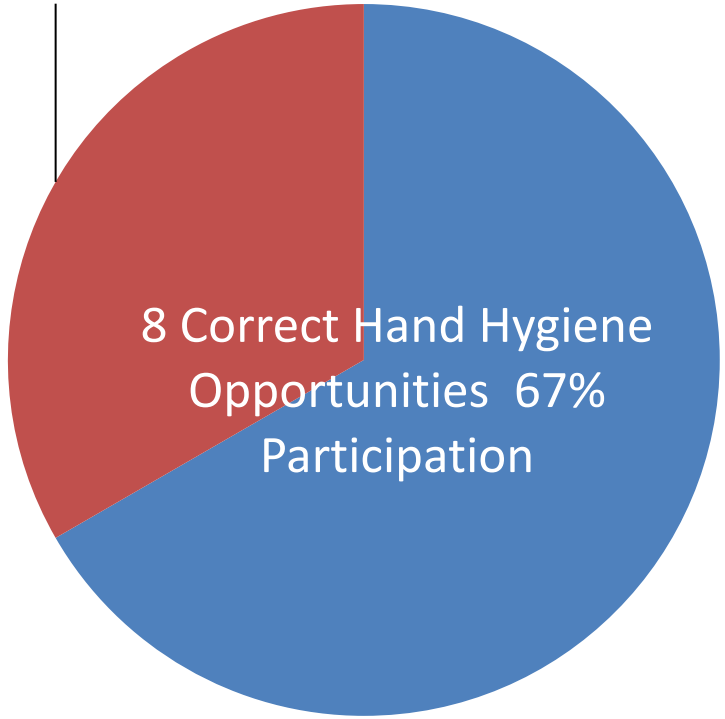

Hand Hygiene Compliance After Patient/Patient Environment Contact by Category of Health Care Provider

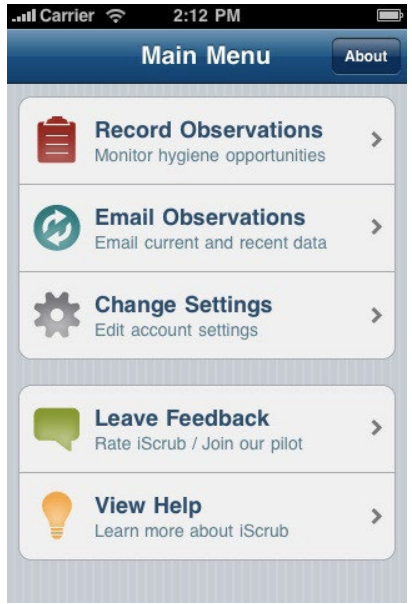
Type of Health Care Provider	% Compliance	# times hand hygiene was performed for AFT-PAT/ENV	# observed hand hygiene indications for AFT-PAT/ENV
Allied HCPs*	35.7%	35	98
Environmental Services Worker	59.5%	22	37
Medical Student	37.9%	25	66
Nurse	46.3%	88	190
Nursing Student	60.0%	33	55
PSA, PSW, PCA	25.0%	1	4
Patient Transporter	83.3%	10	12
Physician	42.3%	60	142
Other	100.0%	1	1

* Allied health care providers include Radiology Tech, Dietician, Social Worker, IV Team/Blood Collection, Pastoral Care, Physiotherapist, Respiratory Therapist

Report name
Report 4
Date range
2010-01-01 to 2015-02-06

Locations
By site: All sites
Professions
All professions



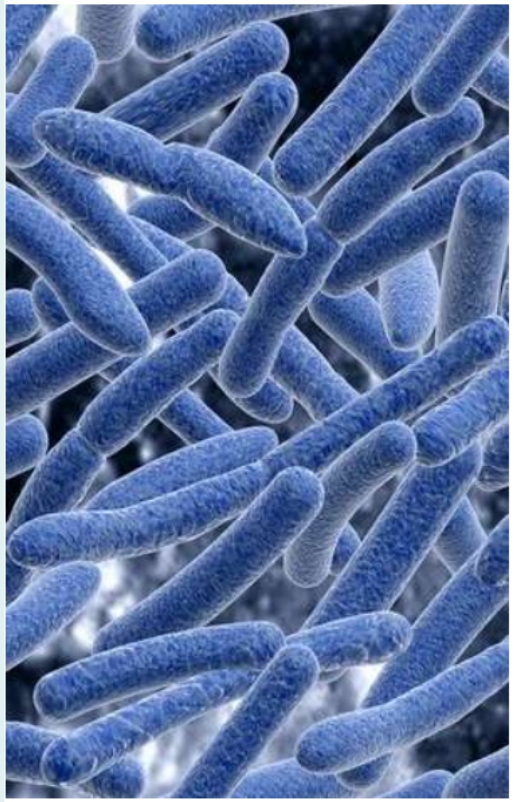


https://www.speedyaudit.com/

https://apps.apple.com/us/app/iscrub-lite/id329764570

XDRO registry

Extensively drug resistant organism registry | Citations | Help | Login



The XDRO registry is a product of collaboration between IDPH, Medical Research Analytics and Informatics

To report CRE, please log-in through IDPH portal and access the XDRO registry under 'product application'

New users (who do not have access to the IDPH web portal): You must register for access to the IDPH web portal. Fill out the form to create a new username, and select the box to access the application "INEDSS (Disease Surveillance) System/XDRO registry (extensively drug resistant organism)." This may take several weeks to process.

Users who have access to the IDPH web portal, but not the INEDSS/XDRO application: If you already have a username and access to the IDPH web portal, **do not fill out a new registration form.** Please have your facility Portal Registration Authority (PRA)* send an email to DPH.Security@illinois.gov requesting for you to have access to the additional application "INEDSS (Disease Surveillance) System/XDRO registry (extensively drug resistant organism)." Make sure your PRA includes your full name and User ID.

Existing INEDSS users: Your existing IDPH log-in will automatically give you access to the XDRO registry. For log-in issues, please call the Central Management Services customer service center at 217-524-3648 or 312-814-3648.

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* If you do not know the PRA for your facility, please Click here to find your PRA. If you still cannot find your PRA after scrolling through the list, please email DPH.Security@illinois.gov to

Illinois XDRO Registry

https://portalhome.dph.illinois.gov/

Tuberculosis Risk Assessment

BOX. Indicators of risk* for tuberculosis (TB) at baseline health care personnel assessment†

Health care personnel should be considered to be at increased risk for TB if they answer "yes" to any of the following statements.

1. Temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)

Or

2. Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication

Or

3. Close contact with someone who has had infectious TB disease since the last TB test

Abbreviation: TNF = tumor necrosis factor.

* Individual risk assessment information can be useful in interpreting TB test results. (Lewinsohn DM, Leonard MK, LoBue PA, et al. Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention clinical practice guidelines: diagnosis of tuberculosis in adults and children. Clin Infec Dis 2017;64:111–5). https://academic.oup.com/cid/article/64/2/111/2811357

† Adapted from a tuberculosis risk assessment form developed by the California Department of Public Health. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf .

Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR Morb Mortal Wkly Rep 2019;68:439–443. DOI: http://dx.doi.org/10.15585/mmwr.mm6819a3external icon.

Formulate a plan to develop and maintain an effective infection prevention and control program utilizing evidence-based strategies and resources.

WHOA!!!

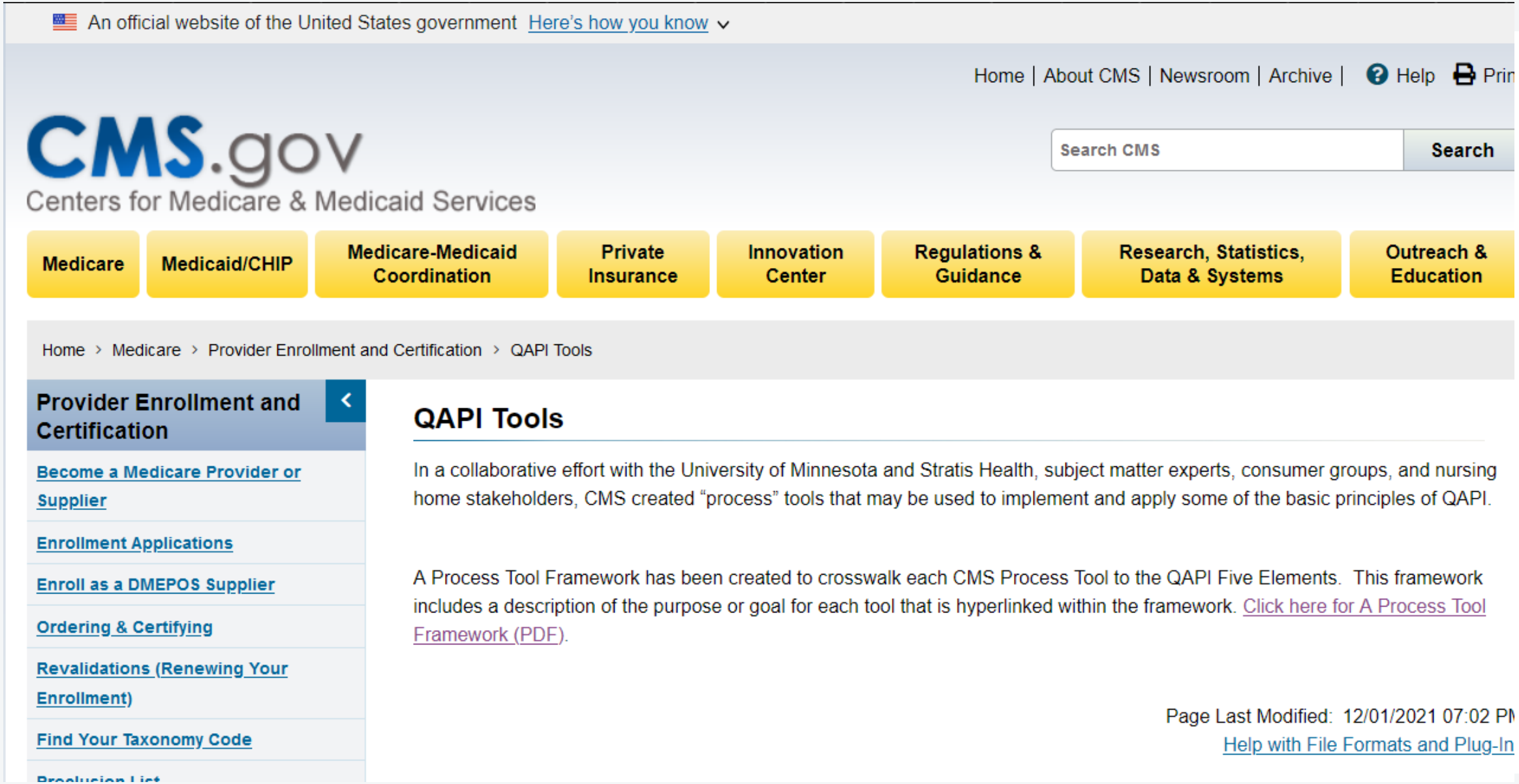
- FORGET SOMETHING?
- Start with the Facility Assessment
- Then Infection Prevention Risk Assessment
- Then TB, construction risk assessments
- These assessments build the framework for the interdisciplinary Infection Prevention and Control Program led by the Infection Preventionist

Ideal QAPI Performance Improvement Projects

Performance Improvement Projects: Interdisciplinary Teamwork

1. *Focus on topics that are meaningful and address the needs of residents and staff*
2. *Charter PIP teams*
3. *Support staff in being effective PIP team members.*
4. *Use tools that support effective teamwork.*
5. *Plan, implement, measure, monitor, and document changes, using a structured PI approach*

https://www.cms.gov/sites/default/files/repo-new/62/Process%20Tool%20framework.pdf



https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools

Summary

- Assessment = Ready
- Plan = Aim
- Implement= Fire!
- Review= Did you get it?
- Reliance on IP personnel vastly expanded role in guidance
- Lessons learned moving forward should focus on continuing to strengthen congregate care infection prevention and control infrastructure in the next 1-5 years
- Continue to support and encourage communication and interdisciplinary collaboration

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.

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Reminders

- For continuing education credit, please fill out the following evaluation by June 10th, 2022:
  - https://redcap.dph.illinois.gov/surveys/?s=WJLETP3EDNLNL8X4

- 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**