

COVID-19 Chicago Long Term Care Roundtable

7.30.20



- Chicago Epidemiology
- CMS/CDC Updates
- New Employee Screening Tool
- Updated Facility Summary Report Template
- Infection Preventionst (IP) Training/Duties
- Antibiotic Stewardship
- PPE Optimization Strategies
- Q&A

Chicago COVID-19 Update

There are 59,994 cases of COVID-19 and 2,770 deaths among Chicago residents as of July 29, 2020. There are an average of 255 new cases and 3 deaths every day. An estimated 54,286 residents have recovered.¹





COVID Dashboard





COVID Dashboard





COVID Dashboard



× Long-Term Care Case Data

Total number of cases associated with long-term care: 6,129

- # of Residents: 4,482 (73%)
- # of Healthcare workers/employees: 1,647(27%)

Number of deaths among COVID-19 cases in LTC settings: 1,018

- # residents: 1,002
- # healthcare workers: 16

Demographics

Demographic	Resident (n=4,482)	HCW (n=1,647)
Sex		
Male	2,214 (49)	372 (23)
Female	1,986 (44)	1,162 (71)
Unknown	282 (6)	113 (7)
Race/etch		
Black, non-Latinx	1,512 (34)	553 (34)
White, non-Latinx	1,223 (27)	142 (9)
Latinx	590 (13)	331 (20)
Asian, non-Latinx	128 (3)	165 (10)
Other, non-Latinx*	134 (3)	70 (4)
Unknown	895 (20)	386 (23)
Age		
0-17	1 (<1)	1 (<1)
18-29	21 (<1)	315 (19)
30-39	68 (2)	387 (24)
40-49	173 (4)	389 (24)
50-59	528 (12)	333 (20)
60-69	1,128 (25)	193 (12)
70-79	1,129 (25)	24 (1)
80+	1,434 (32)	4(<1)
Unknown	0	1 (<1)



Outcome	Resident (n=4,482)	HCW (n=1,647)
Hospitalized*		
Yes	1,837 (41)	146 (9)
No	2,645 (59)	1500 (91)
Unknown	0	1 (<1)
Died from COVID*		
Yes	1,002 (22)	16 (1)
No	3,480 (78)	1,631 (99)
Unknown	0	0

X Long-Term Care Facility Data

- Number of facilities with at least one <u>resident</u> case: 77
 - Median number of resident cases per facility: 56 (range: 0 to 172)
- Number of facilities with outbreaks: 78
- Number of facilities with known deaths: 71



- Among 71 long-term care facilities with resident deaths,
 - Median number of deaths per facility: **13** (range: 1 to 46)
 - Median % of known resident cases who are deceased: 23.1% (range: 2 to 52%)
 - 16 HCW deaths



COVID-19 Testing Among Individuals Associated with Long-Term Care N=48,114



Data as of 7/21/2020

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CMS Press Release (July 22, 2020)

- \$5 billion in new federal funding for nursing home under the Provider Relief Fund authorized by the CARES Act:
 - This funding can be used for hiring, testing, building infection control programs, purchasing technology for residents to connect with their families, etc.
 - To be eligible for the funding, nursing homes must first complete a 23-module online, self-paced, on demand "Nursing Home COVID-19 Training" which will cover infection control and best practices.

CMS Press Release (July 22, 2020)

- Requirement that all nursing homes within states that have a 5% positivity rate or greater must test all nursing home staff each week.
- Federal Task Force Strike Teams will be deployed to provide onsite technical assistance and education to nursing homes experiencing outbreaks.
 - Federal strike teams have visited facilities within Illinois, but we are not aware of any visits to Chicago facilities thus far.
- CMS will release a list of nursing homes with an increase in cases (based on NHSN data) to states as part of their weekly Governor's report.

Updated CDC Guidance: Discontinuation of Transmission-Based Precautions (TBP)

• CDC no longer recommends a test-based strategy to determine when to discontinue transmission-based precautions for residents with COVID-19. Facilities should instead use the time or symptom-based strategies.

• Time-based strategy (for asymptomatic residents)

• 10 days (or 20 days if resident is severely immunocompromised) have passed since the specimen collection date for the initial positive test.

• Symptom-based strategy (for symptomatic residents)

- At least 10 days (or 20 days if resident is severely immunocompromised and/or experienced severe/critical illness) have passed since symptom onset; **AND**
- At least 24 hours have passed since last fever (without the use of fever-reducing medication); AND
- Symptoms (e.g., cough, shortness of breath) have improved

Updated CDC Guidance: Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection

 CDC no longer recommends a test-based strategy to determine the duration of work exclusion for staff with COVID-19. Facilities should instead use the time or symptom-based strategies.

• Time-based strategy (for asymptomatic staff)

• 10 days (or 20 days if staff member is severely immunocompromised) have passed since the specimen collection date for the initial positive test.

• Symptom-based strategy (for symptomatic staff)

- At least 10 days (or 20 days if staff member is severely immunocompromised and/or experienced severe/critical illness) have passed since symptom onset; AND
- At least 24 hours have passed since last fever (without the use of fever-reducing medication); **AND**
- Symptoms (e.g., cough, shortness of breath) have improved

CDC Definitions: Severe & Critical Illness

- Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- **Critical Illness**: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

CDC Definition: Severely Immunocompromised

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions [or lengthening the duration of HCP work restrictions].
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

***** *New* Employee Screening Tool

- Currently finalizing an employee screening tool.
- Facilities are welcome to adopt this tool or to incorporate the components of the tool into their existing screening mechanisms.
- Final version will be posted to the CDPH LTCF website shortly.



If an employee returned from taket within the last 14 days from a country under a Lever 5 started later of a state covered by Chicago's Emergency Travel Order (see https://www.chicago.gov/citiy/en/sites/covid-19/home/emergency-travel/notices/warning/coronavirusglobal and https://www.chicago.gov/citiy/en/sites/covid-19/home/emergency-travel-order.html), exclude from work until 14 days have passed since their return.

Exceptions:

- Employees who live in a different state and commute to Chicago for work do not need to be excluded.
 Healthcare workers who are tested between day 5-7 after their return can return to work as early as day 8
- if they receive a negative result and have no symptoms. These HCP should continue to abide by quarantine outside of work (e.g., not going to restaurants, staying home when possible) to complete 14 days.

New Employee Screening Tool: Symptom & Travel Screen

Long-term Care Facility COVID-19 Employee Screening Tool

Date: _____ Time: ____ AM/PM Employee Name: _____

Are you experiencing any of the following symptoms?

Fever (>100 °F)	Yes 📃 N	o 🔲 Comments:
Chills	Yes 📃 N	o 🔲 Comments:
Cough	Yes 🔲 N	o 🔲 Comments:
Shortness of breath/difficulty breathing	Yes 🔲 N	o 🔲 Comments:
Fatigue (new or unusual onset)	Yes 📃 N	o 🔲 Comments:
Muscle or body aches	Yes 🔲 N	o 🔲 Comments:
Headache (new or unusual onset)	Yes 🔲 N	o 🔲 Comments:
New loss of taste or smell	Yes 📃 N	o 🔲 Comments:
Sore throat	Yes 🔲 N	o 🔲 Comments:
Congestion or runny nose	Yes 📃 N	o 🔲 Comments:
Nausea or vomiting	Yes 🛄 N	o 🔲 Comments:
Diarrhea	Yes 🔲 N	o 🔲 Comments:
Other symptoms (please list):		

Have you traveled outside of Illinois in the past 14 days? Yes Please list all states/countries that you visited

Please list all states/countries that you visited within the last 14 days, including the dates of travel in each location:



Please return this form to the screener.

New Employee Screening Tool: Temperature Check & Exceptions

Screener name:

Employee temperature: °F/°C

If employee answered yes to any of the symptom questions, please immediately restrict from work until all of the following criteria are met:

- At least 10 days have passed from symptom onset;
- At least 24 hours have passed since last fever without the use of fever-reducing medications;
- Improvement in symptoms (e.g., cough, shortness of breath)

Exception: If a clinical decision is made by the evaluating healthcare provider that COVID-19 is not suspected and testing is not indicated, then return to work decisions should be based on the other suspected or confirmed diagnoses.

If an employee returned from travel within the last 14 days from a country under a Level 3 travel alert or a state covered by Chicago's Emergency Travel Order (see https://wwwnc.cdc.gov/travel/notices/warning/coronavirusglobal and https://www.chicago.gov/city/en/sites/covid-19/home/emergency-travel-order.html), exclude from work until 14 days have passed since their return.

Exceptions:

- Employees who live in a different state and commute to Chicago for work do not need to be excluded.
- Healthcare workers who are tested between day 5-7 after their return can return to work as early as day 8 if they receive a negative result and have no symptoms. These HCP should continue to abide by quarantine outside of work (e.g., not going to restaurants, staying home when possible) to complete 14 days.

X States Currently Covered by the Emergency Travel Order

- Florida
- Louisiana
- Mississippi
- Arizona
- Alabama
- Georgia
- Tennessee
- Nevada
- South Carolina
- Oklahoma
- Texas

- Idaho
- Arkansas
- California
- North Carolina
- Utah
- lowa
- Kansas
- Missouri (as of 7/31)
- Wisconsin (as of 7/31)
- Nebraska (as of 7/31)
- North Dakota (as of 7/31)

Reporting Obligations when using Commercial Laboratories

- As required by IDPH, all facility testing plans must identify "a dedicated laboratory contracted or otherwise engaged to provide COVID-19 clinical testing services..."
- IDPH has a list of commercial lab options on their <u>LTC testing website</u>.
- Facilities using commercial laboratories <u>must</u> report positive cases to CDPH using the <u>COVID-19</u> <u>Online Case Report Form</u>.



COVID-19 Case and Cluster Report Form

Both individual lab-confirmed cases and clusters of COVID-19 are reportable conditions to the Chicago Department of Public Health.

For Healthcare Facilities and Laboratories: individual lab-confirmed cases:

Healthcare providers must report individual lab-confirmed cases of COVID-19 into <u>I-NEDSS</u>. This form should only be used if you are an outpatient facility and do not have access to I-NEDSS or you are a lab who does not report electronically to I-NEDSS.

For community single cases or clusters:

Single cases or clusters of two or more cases (at least one of which is lab-confirmed) in a community congregate setting (such as a child care setting, long-term care facility, camps/athletic facilities, faith community, correctional facility, homeless shelter etc.) should be reported using this form.

If you have been notified that a person who attends, lives, or works in their your facility tested positive for COVID-19, please report here.

Vpdated CDPH Facility Summary Report Template

- Added some new fields and data validation to the template.
- New fields include:
 - Test type (e.g., PCR, rapid antigen, serology)
 - Date of *first* admission to facility
 - Date of **most recent** admission to facility
- You will received a revised template pre-filled with the data you have submitted to date.
- Until you receive the updated template, please continue use the existing template.
- Reminder that reports are due by 12 p.m. on Thursdays via the <u>CDPH Facility</u> <u>Summary Report Upload Site</u>.

	1					CDPH I	acility	Summa	ry Repo	ort
Date:										
Submitting Facility:										
Name of reporter:										
Instructions:	Tab 1: Fill in all positive and symptomatic resident	Tab 2: Fill in all postive and symptomatic staff								
ab 1: Resi or the below ubmit to CDF	i dent Repo rows, please do PH by 12 pm (no	o rt ocument all C oon) every The	O¥ID-19 lab-co ursday	onfirmed positi	ive residents A	ND symptom	atic residents			
Resident's Last Name	Resident's First Name	Resident's DOB	Test result (positive/aega tive/peadiag/a	Test type (PCR/Rapid Astigen/Serol	Specimen Collection Date	Room (On Date of Symptom Onset or Date of	Bed Number (On Date of Symptom	Covid positive on admission (to be	Date of First Admission	Date of Mos Recent Admission
Lusthamo	This thank	(mm/dd/yyyy)	ot tested)	ogy)	(mm/dd/yyyy)	Transfer) (must be	Onset or Date of	entered by	to Facility	to Facilit

LTCF Infection Prevention & Control (IPC) Program

- <u>CDC Guidance:</u> Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program.
 - This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the <u>facility risk assessment</u>.
 - CDC has an <u>online training course</u> that can be used to orient individuals to this role in nursing homes.
 - Can get CEUS and/or obtain a certificate of completion
 - Note that this is separate from the training program that is required to be completed prior to receiving money from the federal Provider Relief Fund.

CDC Nursing Home Infection Preventionist Training Course

Living (Long-term Care Facilities [LTCFs])

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Infection Prevention Training

The Nursing Home Infection Preventionist Training course is designed for individuals responsible for infection prevention and control (IPC) programs in nursing homes.

The course was produced by CDC in collaboration with the Centers for Medicare & Medicaid Services (CMS).

This specialized nursing home training covers:

- Core activities of effective IPC programs,
- Recommended IPC practices to reduce:
 Pathogen transmission
 - Healthcare-associated infections
 - Antibiotic resistance

Available Continuing Education

The course is made up of 23 modules and sub-modules that can be completed in any order and over multiple sessions.

Cost: Free

Available continuing education: CME, CNE or CEUs

To earn continuing education, register for the course

On This Page

Available Continuing Education

Infection Prevention and Control Resources

Advertising Buttons

Start the Training

Nursing Home Infection Preventionist Training Course

CMS Memo: Detailed Description

Specialized Infection Prevention and Control Training

Course

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To access content, you first need to create an account. If you already have an account, please login.

ID 3814

If you wish to earn continuing education (CME, CNE, or CEUs) or obtain an overall certificate of completion, you must first I Nursing Home Infection Preventionist Training Course by selecting the blue Register button at the top right of this page. Se More link below for information about the course, including tips and resources to guide you in completing modules and obt continuing education (CE).

Program Description:

Show More

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lame	Completed Date	Score	Hours
* Module 1 - Infection Prevention & Control Program			0.75h
Module 2- The Infection Preventionist			0.5h
* Module 3 - Integrating Infection Prevention and Control int			0.42h
Module 4 – Infection Surveillance			1h
* Module 5 - Outbreaks			0.75h

Infection Preventionist Job Duties

Your facility's IP can be responsible for a number of activities, including:

- Developing and implementing infection prevention & control policies and procedures
- Conducting facility risk assessments
- Performing infection surveillance
- Investigating and reporting communicable diseases
- Providing competency-based training to staff (e.g., donning and doffing PPE)
- Auditing adherence to recommended IPC practices (e.g., hand hygiene, environmental cleaning and disinfection)
- Establishing an antibiotic stewardship program

Antimicrobial Stewardship Needs in **Nursing Homes**





UP TO **70%** of nursing home residents

received antibiotics during a year²³



UP TO **75%** of antibiotics are prescribed incorrectly*²³



Centers for Disease Control and Prevention National Center for Emerging and Zoonotic Infectious Diseases

Antimicrobial Stewardship Programs in X Nursing Homes are Mandated by CMS

Revised Requirements for Participation: Centers for Medicare and Medicaid Services (CMS) **<u>Required</u>** all long-term care (LTC) facilities to have an antimicrobial stewardship program (ASP) by November 28, 2017.





7 CDC Core Elements for Antimicrobial **X** Stewardship Programs in Nursing Homes



The Core Elements of Antibiotic Stewardship for Nursing Homes CHECKI IST



Summary of Core Elements for Antibiotic Stewardship in Nursing Homes



Leadership commitment Demonstrate support and commitment to safe and appropriate antibiotic use in your facility



Accountability Identify physician, nursing and pharmacy leads responsible for promoting and overseeing







Establish access to consultant pharmacists or other individuals with experience or training in antibiotic stewardship for

Action

vour facility

Implement at least one policy or practice to improve antibiotic use



Tracking

Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use in your facility

Reporting

Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff

Education

Provide resources to clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improving antibiotic use



https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html#anchor 1557415462

Antibiotics aren't Indicated for Viruses

Viruses or Bacteria What's got you sick?





	Co	Are		
Common Condition	Bacteria	Bacteria or Virus	Virus	Needed?
Strep throat	 			Yes
Whooping cough	~			Yes
Urinary tract infection	× .			Yes
Sinus infection		×		Maybe
Middle ear infection		×		Maybe
Bronchitis/chest cold (in otherwise healthy children and adults)*		~		No*
Common cold/runny nose			× .	No
Sore throat (except strep)			~	No
Flu or COIVD-19			× -	No

Studies show that in otherwise healthy children and adults, antibiotics for bronchitis won't help you feel better.

Upper Respiratory Tract Infection Prescribing of Antibiotics in Nursing Homes

	Appropriate	Inappropriate	Unjustified	
Acute bronchitis	35 (34%)	0	66 (65%)	
Pneumonia	168 (87%)	18 (9%)	7 (4%)	
Common cold	335 (86%)	0	54 (14%)	
Influenza-like illness	13 (76%)	0	4 (24%)	
Pharyngitis	35 (85%)	0	6 (15%)	
Sinusitis	6 (55%)	0	5 (45%)	
Total	592 (79%)	18 (2%)	142 (19%)	•



Bacterial Co-infection in COVID-19 Not Common

Acute Bacterial Co-Infection in COVID-19

A Rapid Living Review and Meta-analysis



*****Antibiotics are NOT needed for COVID-19 patients



Harmful effects of overusing antibiotics:

- Drug toxicity
- Antibiotic associated C. difficile infections
- Antibiotic Resistance

AHRQ Minimum Criteria for Antibiotics Tool

Topics Programs Research Data Tools Funding & Grants News About	Yes
Home > Nursing Home Antimicrobial Stewardship Guide > Toolkits >	No
Determine Whether It Is Necessary To Treat a Potential Infection With Antibiotics	
Minimum Criteria for Antibiotics Tool This decision support tool can help prescribers determine appropriate treatment for nursing home residents suspected of having one of three common infection urinary tract, skin and soft tissue, and lower respiratory. It uses criteria from the SBAR forms included in the Minimum Criteria for Common Infections Toolkit. No	Is the resident over the age of 65?
To use the tool, first select the type of suspected infection. Then answer the questions that appear on screen. When the tool has enough data to make a determination, it will tell you if the minimum criteria for antibiotics are met and identify other actions to consider. Green check mark: minimum criteria for antibiotics are met. Red X: minimum criteria for antibiotics are not met.	Minimum criteria for initiating antibiotics are NOT MET Consider initiating the following:
CHOOSE POTENTIAL INFECTION (CHOOSE ONE): Urinary Tract Infection Skin and Soft Tissue Infection Lower Respiratory Tract Infection	 Notify physician/nurse practitioner/physician assistant if symptoms worsen or if unresolved (suggest duration). For cough, consider using a cough suppressant.
Does the resident have:	For discomfort, consider using acetaminophen or other pain reliever.
No Fever Fever of 100°F (37.9°C) but less than 102°F (38.9°C) Fever of >102°F (38.9°C)	 Consider using a heating pad or hot water bottle on the chest at bedtime for (suggest duration in minutes), although or Raise upper body (use multiple pillows) to sleep/rest. Encourage fluid by mouth or gastrostomy tube (G-tube) until urine is light yellow in color (suggest frequency and duration)
imum critoria not mot will aivo a	 Encourage saltwater gargles. Record fluid intake (suggest duration). Initiate intravenous fluid hydration and/or initiate hypodermoclysis.

monitoring and/or additional testing.

https://www.ahrq.gov/nhguide/toolkits/determine-whether-to-treat/antibiotic-tool.html



LOEB Minimum Criteria for Starting Antibiotics

Lower respiratory tract infection with temp >38.9 °C (102 °F)	At least one of the following criteria: Productive cough Respiratory rate >25 breaths / minute 		
with temp >37.9 °C (100 °F) or 1.5ºC (2.4 ºF) above baseline	 Both of the following criteria Cough, AND At least one of the following crite Pulse >100 beats / minutes Rigors 	eria □ Delirium □ Respiratory rate >25 bpm	
afebrile with COPD and >65 years old	 Both of the following criteria New or increased cough Purulent sputum production 		
afebrile without COPD	 All of the following criteria New cough Purulent sputum production At least one of the following criteria Delirium		
with new infiltrate on chest X-ray consistent with pneumonia	 At least one of the following criteria □ Productive cough □ Temp >37.9 °C (100 °F) or 1.5 °C (2.4 °F) above baseline □ Respiratory rate >25 breaths / minute 		

Note: Consider ordering chest X-ray and CBC with differential for febrile residents with cough and any of these criteria (HR >100, worsening mental status, or rigors).

Antibiotics should not be used for up to 24 h after large-volume aspiration in those without COPD but with temp \leq 38.9°C (102 °F) and non-productive cough.

Criteria Comparison for LRTIs

As least 1 of the constitutional criteria

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Suspected Lower Respiratory Intection
Loeb Criteria
Fever > 102° F AND at least one of the following: • Respiratory rate > 25 • Productive cough Fever 2.4° F increase above baseline temperature, AND cough AND at least one of the following: • Pulse > 100 • Rigors • Delirium • Respiratory rate > 25 Afebrile resident with COPD and >65 years AND new or increased cough with purulent sputum production Afebrile resident without COPD and new cough with purulent sputum production AND at least one of the following: • Respiratory rate > 25 • Delirium New infiltrate on chest X-ray thought to represent pneumonia AND at least one of the following: • Fever 2.4° F increase above baseline temperature • Respiratory rate > 25 • Productive cough Chest X-ray and complete cell count with differential is reasonable for residents with fever, cough, AND at least one of the following: • Pulse > 100 • Worsening mental status • Rigors



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SBAR Form: Antibiotic Stewardship Tool

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S	Situation:	I am calling to follow-up on [resident's name:]	who was started on antibiotic(s) recently.				
B	Background: This patient was started on:							
-		Antibiotic #1:		Start date:				
		Antibiotic #2:		Start date:				
	For:	UTI Pneumonia Bronchitis	□Skin infection □GI inf	ection				
		□Fever of unknown source	Other, specify:					
	Vitals at init	ial presentation were as follows: BP/	HR Resp. rate	Temp 02 Sats				
	Symptoms a	and positive exam findings at that time were:						
•	The diagnos Assessmer	is fits: □McGeer criteria □Loeb criteria n t:	□Neither □Asses	sment tool not used				
Α	Current vita	l signs: BP / HR Resp. rate	Temp O ₂ Sats					
	Since startin	ng antibiotic(s), the resident:						
		now has <u>no</u> signs or symptoms of infection	□has re	emained the same				
		\Box has improved but continues to have signs and	symptoms of:					
		□ has <u>new or worsening</u> signs/symptoms of:						
	Microbiolo	gy culture result (fax microbiology report if availat	ole):					
		□ has not returned yet	□has <u>no</u> growth	□was not obtained				
		\Box has positive Gram stain/growth of [specify Gra	am stain/microorganism:]				
		Is susceptible to the antibiotic(s) prescribed:	□Yes □No □Not tested by lab	□Don't know □Not yet performed by lab				
		Other antibiotics the organism is sensitive to						
R	Recommen	ndation:						
	Patient is	not improving and needs further evaluation.						
	Patient h	as improved and needs final antibiotic therapy pla	in.					
	Nurse's Sigr	nature:		Date/Time:				
	□ Faxed or	Called to: By:		Date/Time:				

Personal Protective Equipment (PPE) Optimization Strategies

- **Conventional capacity:** Strategies that should already be in place as part of general infection prevention and control plans in healthcare settings.
- Contingency capacity: Strategies that can be used during periods of anticipated PPE shortages.
- Crisis capacity: Strategies that can be used when supplies cannot meet the facility's current or anticipated PPE utilization rate. These strategies are not commensurate with U.S. standards of care.
- <u>Note</u>: CMS reopening guidance states that, prior to relaxing restrictions for a facility, staff should have access to adequate PPE:
 - Crisis capacity strategies do <u>not</u> constitute access to adequate PPE



Crisis	Contingency	Conventional
 Extended use of isolation gowns Reuse of cloth isolation gowns Prioritize gowns for certain activities: Activities where splashes or sprays are expected During high-contact patient care activities (e.g., dressing, bathing, transferring) Aerosol-generating procedures For other transmission-based precaution indications (e.g., C. diff) 	 Shift toward cloth isolation gowns, but not extended use Use coveralls 	• Use isolation gown alternatives that offer equivalent or higher protection.
• When <u>no</u> gowns are available, consider using alternatives that have not been evaluated as effective (e.g., lab coats)		



Crisis	Contingency	Conventional
 Use eye protection devices beyond the manufacturer-designated shelf life Prioritize eye protection for activities where splashes and sprays are anticipated or prolonged face-to-face or close contact is unavoidable Consider using safety glasses that cover the sides of eyes 	 Shift eye protection supplies from disposable to re- usable devices (i.e., goggles or reusable face shields) Implement extended use of eye protection 	• Use eye protection according to product labeling and local, state, and federal requirements



Crisis	Contingency	Conventional
 Use facemasks beyond the manufacturer-designated shelf life Implement limited reuse of facemasks Prioritize facemasks for selected activities such as activities where splashes and sprays are anticipated, prolonged face-to-face contact with an infectious patient, and aerosol- generating procedures, if respirators are no longer available 	• Implement extended use of facemasks	• Use facemasks according to product labeling and local, state, and federal requirements
• When <u>no</u> facemasks are available, use a face shield that covers the entire front (that extends to the chin or below) and sides of the face with a cloth mask		

N95 Respirators

Crisis	Contingency	Conventional
 Use of respirators past their manufacturer-designated shelf life Use of respirators approved under standards used in other countries that are similar to NIOSH-approved respirators (e.g., KN95s) Limited reuse of respirators (no more than 5 uses, unless otherwise directed by manufacturer guidance) Prioritize the use of N95 respirators by activity (e.g., aerosol-generating procedures) 	 Temporarily suspend annual fit testing Extended the use of N95 respirators by wearing the same N95 for repeated close contact encounters with several different patients 	 Implement just-in-time fit testing Limit respirators during training Implement qualitative fit testing Use NIOSH-approved alternatives to N95 respirators such as other filtering facepiece respirators (FFRs), elastomeric respirators, and powered air purifying respirators (PAPRs)



Crisis	Contingency	Conventional
 Use gloves past their manufacturer-designated shelf life for healthcare delivery Prioritize the use of non-sterile disposable gloves Consider non-healthcare glove alternatives (e.g., food service gloves) Extend the use of disposable medical gloves within a patient cohort (must be sanitized between patients) 	 Use gloves past their manufacturer- designated shelf life for training activities Use gloves conforming to other U.S. and international standards 	 Continue providing patient care as in usual infection control practice

CDPH LTCF COVID-19 HAN Webpage

• New to the HAN:

- Slides/video from IDPH COVID-19 LTCF Q&A webinars (7/17 & 7/22)
- CDC Decision Memo on Duration of Isolation and Precautions for Adults with COVID-19
- IDPH PPE Guidance for COVID-19 in Long Term Care Settings
- CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease
- National CMS/CDC Nursing Home COVID-19 Training Series
- Coming soon:
 - Slides from today's webinar
 - New employee screening tool



Long-term care facilities (LTCFs), including nursing homes, skilled nursing facilities, and assisted living facilities, provide care to some of the most vulnerable populations, including elderly people and those with chronic medical conditions. Resources below aim to provide interim guidance for the prevention and control of COVID-19 in LTCFs. Given the high risk of spread once COVID-19 enters a LTCF, facilities must act immediately to protect residents, families, and staff from serious illness, complications, and death.

1. Keep COVID-19 from entering your facility

- Visitor restrictions
- Emergency travel order
- Universal masking
- Staff work restrictions
- Reopening guidelines
- 2. Identify infections early
 - Reporting cases to CDPH
 - Resident monitoring
 - Testing and specimen collection
 - Notification and communication

3. Prevent spread of COVID-19

• Transmission Based Precautions



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