

December 29, 2022

LTC COVID-19 Update

Presented by:

Lori Davenport, Director of Regulatory & Clinical Affairs

Indiana Department of Health Team



Today's Topics

- Situational Updates, Virus Trends, Infection Control for Outbreak Management, Bivalent Booster data, Update on Therapeutics – Dr. Vuppalanchi
- Expanding Vaccination Accessibility – Lori Davenport

5-Star Work Plans, a 6-week webinar series, purchase by Jan. 18 and save \$\$\$, details [HERE](#)

Mission Possible: SNF Department Head Briefing, a 12-month webinar series, purchase by Jan. 20 and save \$\$\$, details [HERE](#)

LSC Intensive Workshop, a 2-day in-person workshop, details [HERE](#)



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UPDATES AND REMINDERS

SHIREESHA VUPPALANCHI, MD
MEDICAL DIRECTOR

12/29/2022

OUR MISSION:

To promote, protect, and improve the health and safety of all Hoosiers.

OUR VISION:

Every Hoosier reaches optimal health regardless of where they live, learn, work, or play.



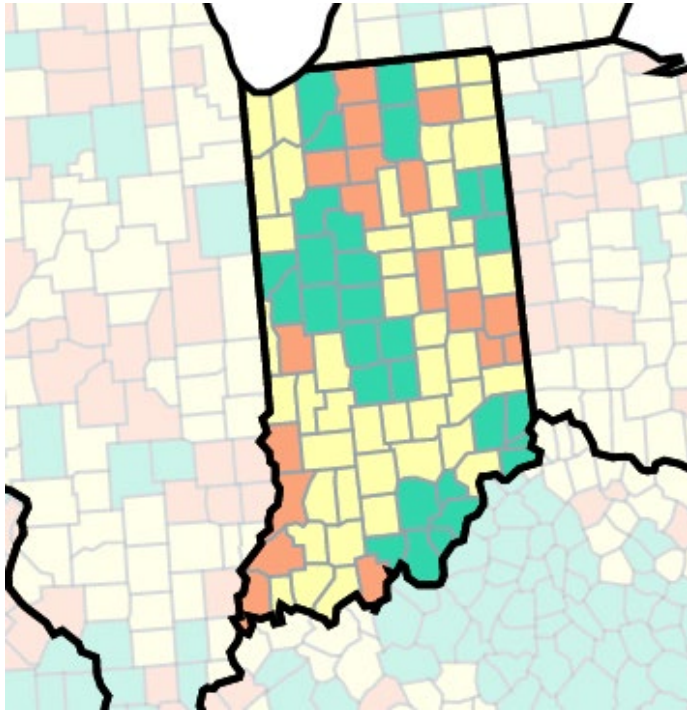


Respiratory pathogens in circulation



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COVID-19 Community levels and transmission

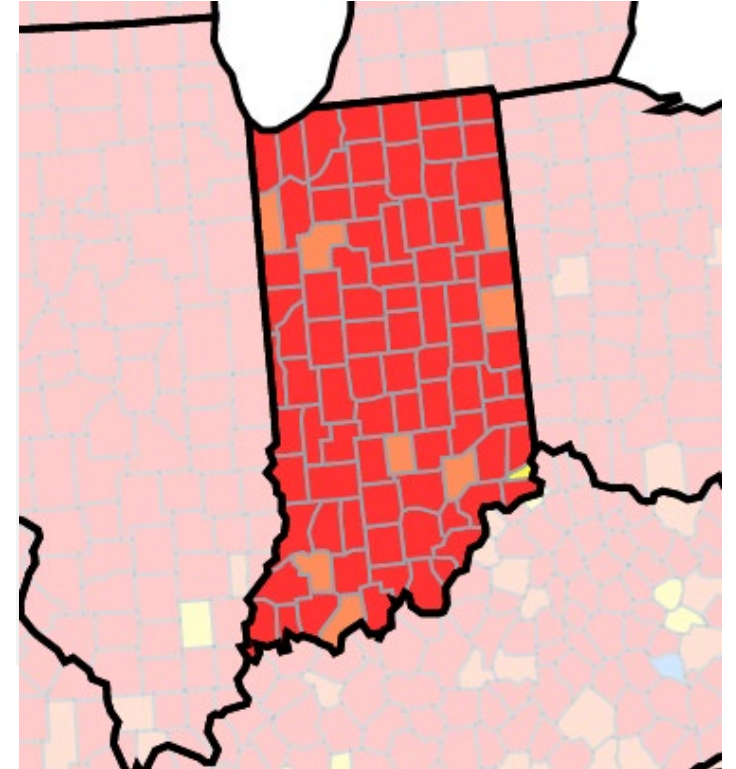


Indiana

[State Health Department](#) 

7-day Metrics

Cases	9,236
% Positivity	N/A %
Deaths	0
% of Population ≥ 5 Years of Age with a Completed a Primary Series	61.3%
New Hospital Admissions (7-Day Moving Avg)	121.14



Hospital census



Indiana COVID-19 Hospital Resource Dashboard

Below results are as of 12/27/2022 11:59 PM. Dashboard updates by 5 p.m. on Wednesdays.

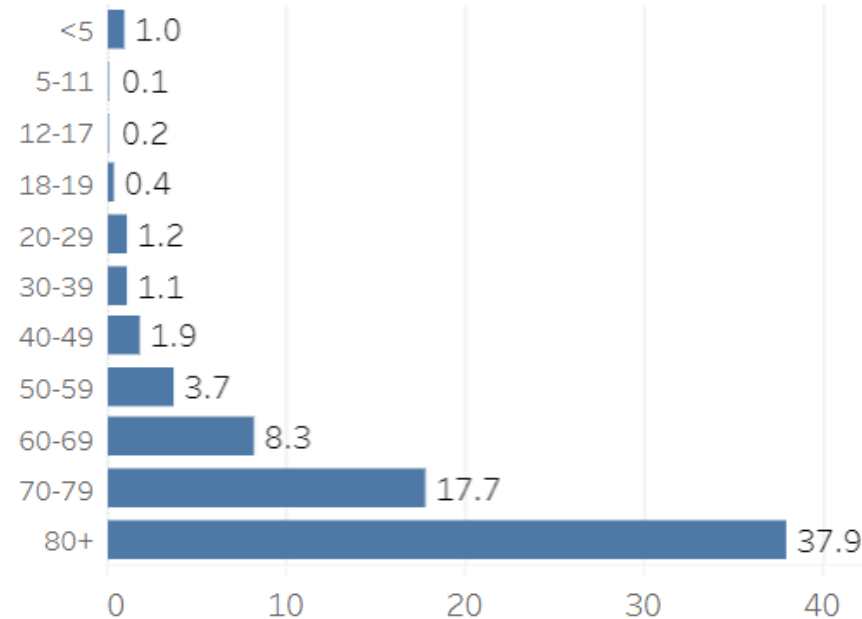
CENSUS	ADMISSIONS				
Total Hospital Census	Total ICU Census	Total Patients on Vents	COVID-19 Census	COVID-19 ICU Census	COVID-19 Patients on Vents
9,257 (↓67)	1,457 (↑2)	425 (↑24)	695 (↑53) <i>7.51% of Total</i>	105 (↑3) <i>7.21% of Total</i>	35 (↓2) <i>8.24% of Total</i>

Hospitalizations by Age

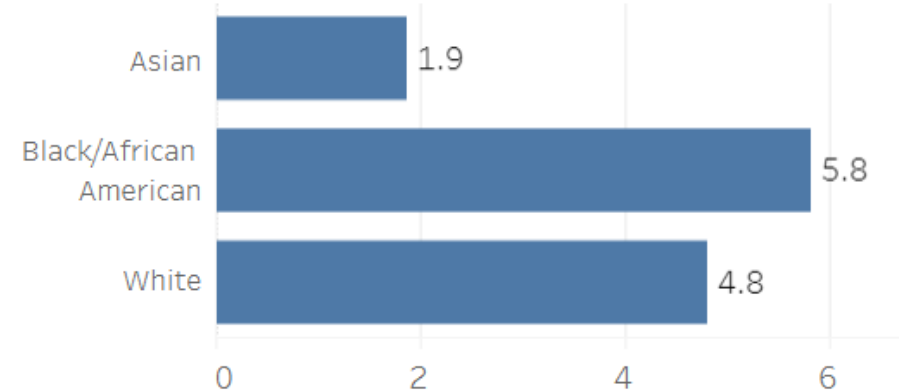
Demographics (Per 10,000 Residents)

Per 10,000 Residents

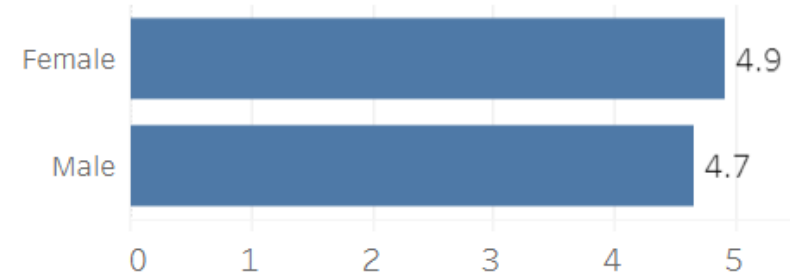
COVID-19 Hospital Admissions by Age



COVID-19 Hospital Admissions by Race



COVID-19 Hospital Admissions by Gender



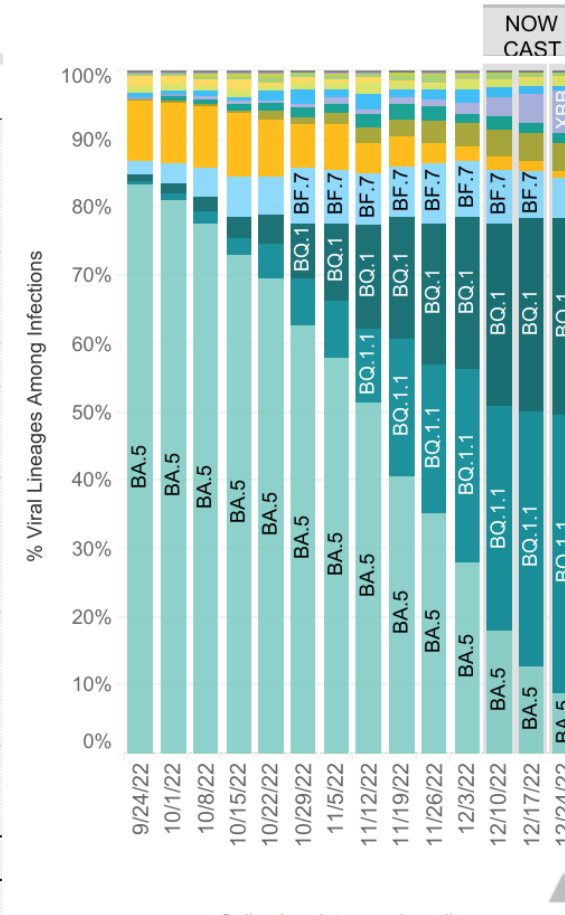
Subvariants: HHS region 5

HHS Region 5: 12/18/2022 – 12/24/2022 NOWCAST

HHS Region 5: 9/18/2022 – 12/24/2022

Region 5 - Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

WHO label	Lineage #	US Class	%Total	95%PI	
Omicron	BQ.1.1	VOC	40.7%	38.2-43.2%	
	BQ.1	VOC	28.9%	26.4-31.6%	
	BA.5	VOC	8.9%	8.0-9.9%	
	XBB	VOC	6.2%	3.5-10.6%	
	BF.7	VOC	5.8%	5.1-6.7%	
	BN.1	VOC	4.2%	3.5-5.0%	
	BA.5.2.6	VOC	1.4%	1.1-1.9%	
	BA.2.75	VOC	1.3%	0.9-1.9%	
	BA.4.6	VOC	0.9%	0.7-1.1%	
	BF.11	VOC	0.9%	0.7-1.1%	
	BA.2	VOC	0.5%	0.3-0.6%	
	BA.2.75.2	VOC	0.2%	0.2-0.3%	
	BA.4	VOC	0.0%	0.0-0.0%	
	BA.1.1	VOC	0.0%	0.0-0.0%	
	B.1.1.529	VOC	0.0%	0.0-0.0%	
	BA.2.12.1	VOC	0.0%	0.0-0.0%	
Delta	B.1.617.2	VBM	0.0%	0.0-0.0%	
Other	Other*		0.1%	0.0-0.1%	



Influenza-like illness

*Indiana Influenza-Like Illness (ILI) Surveillance – Week ending December 17, 2022

The purpose of this dashboard is to describe the spread and prevalence of influenza-like illness (ILI) in Indiana. It is meant to provide local health departments, hospital administrators, health professionals and residents with a general understanding of the burden of ILI. Data from several surveillance programs (such as Syndromic Surveillance, Sentinel Surveillance, Virologic Surveillance) are analyzed to produce this dashboard.

ILI Definition = fever of 100 °F or higher (measured) AND cough and/or sore throat.

ILI Activity Code

Very High

Influenza-Associated Deaths

15

for current week

65 total for current season

Syndromic Percent ILI

6.56% ▼ 0.91%

reported by emergency department and urgent care chief complaints

Sentinel Percent ILI

6.62% ▼ 0.70%

reported by sentinel outpatient provider

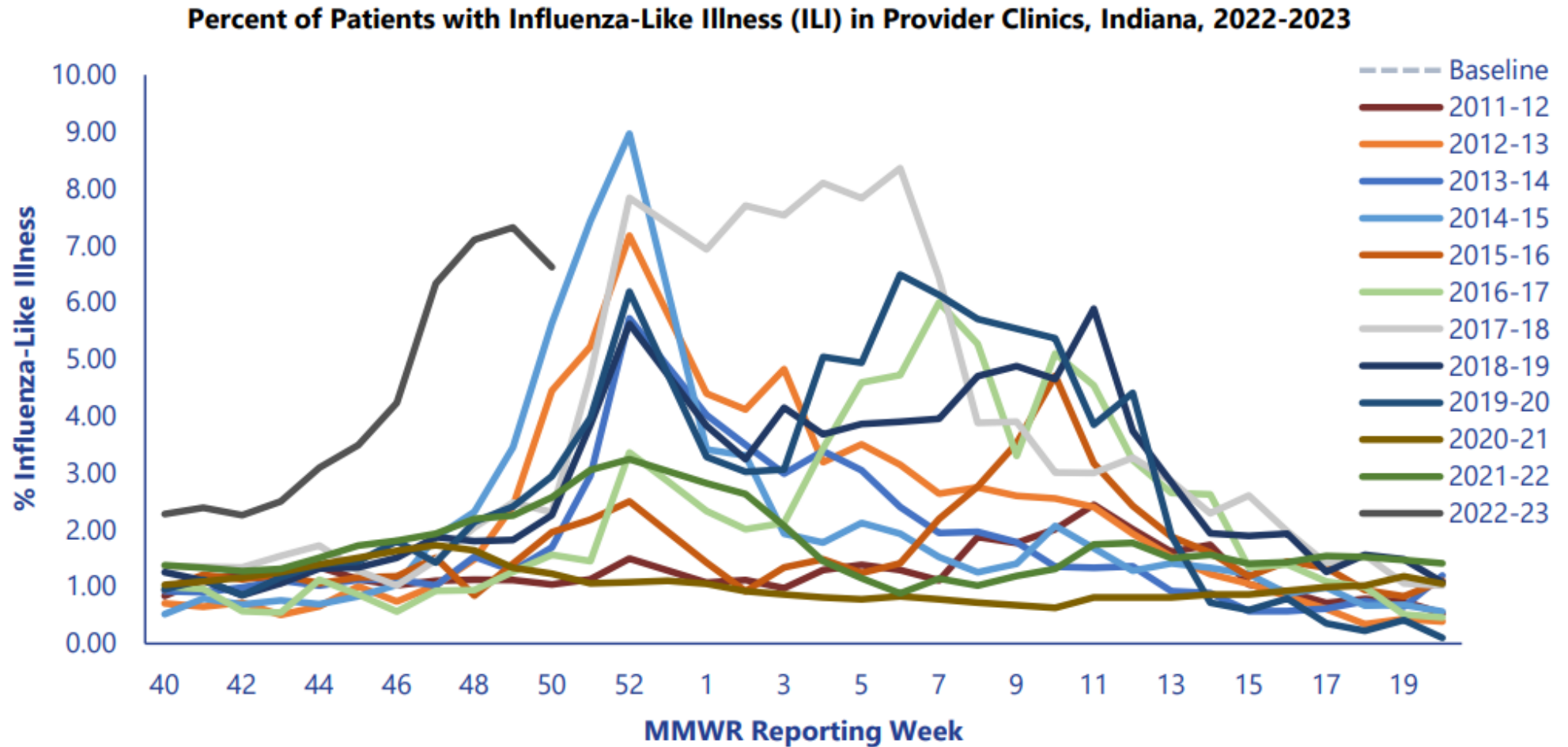
Weekly Influenza Report: Week 50

Report Date: Tuesday, December 27, 2022

*Influenza-like illness – Week ending December 17, 2022	
ILI Activity Code	Very High
Percent of ILI reported by sentinel outpatient providers	6.62%
Percent of ILI reported by emergency department & urgent care chief complaints	6.56%
Percent positivity of influenza specimens tested at IDOH	21%
Number of influenza-associated deaths this season	64
Number of long-term care facility outbreaks this season	17

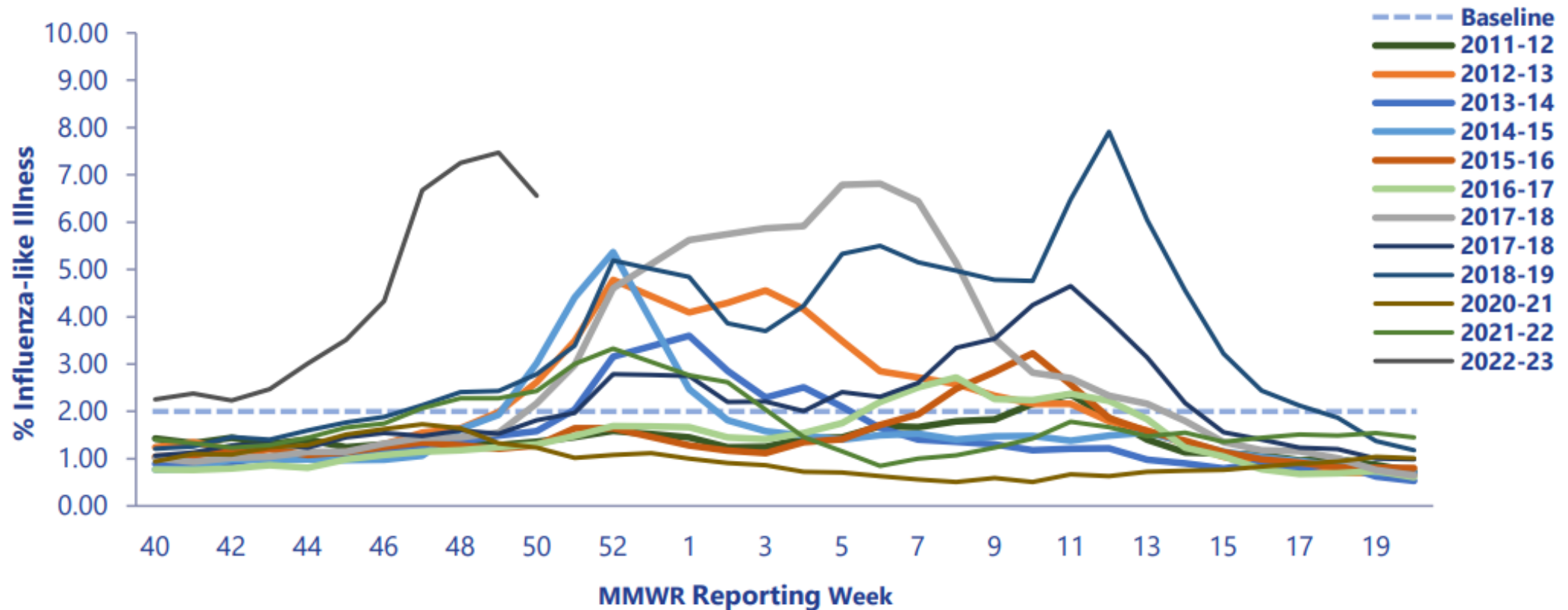
**The ongoing COVID-19 pandemic may impact Indiana's sentinel and syndromic ILI data.*

ILI in Provider Clinics



ILI in ED and Urgent Care

**Percent of Patients with Influenza-Like Illness (ILI) Chief Complaint in Emergency
Departments & Urgent Cares, Indiana, 2022-2023**



Influenza-associated Mortality

Data are obtained from the National Electronic Disease Surveillance System Base System (NBS). Influenza-associated deaths are reportable within 72 hours of knowledge; however, not all cases are reported in a timely manner so data in this report are subject to change as additional cases are back-reported.

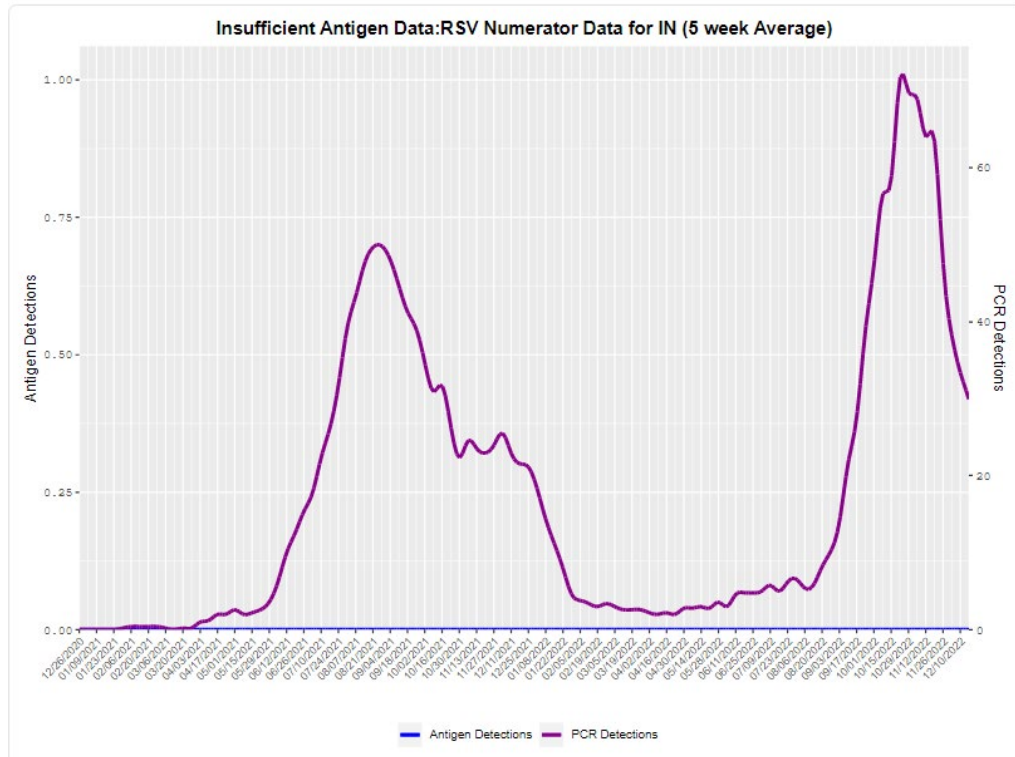
Number of Influenza-associated Deaths for all Ages*, Indiana, 2022-2023 Season	
Age Category, years	Season total
0-4	-
5-24	1
25-49	5
50-64	14
65+	44
Total	64

Breakout of Ages* for Pediatric-associated Influenza Deaths, 2022-2023 Season	
Pediatric Age Category	Season total
0-5 months	-
6-23 months	-
2-4 years	-
5-11 years	1
12-17 years	-
Total	1

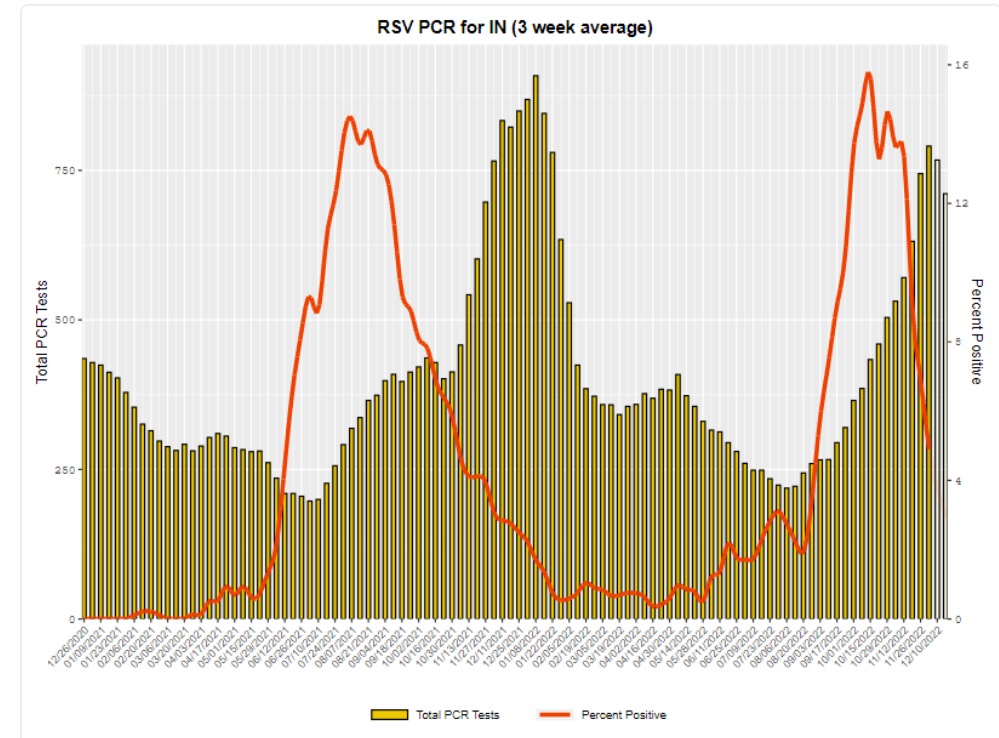
*Due to changes in the reporting rule as of 12/2015, influenza-associated deaths are reportable if either laboratory confirmed or listed as cause of death on death certificate. Therefore, case counts are not directly comparable to previous seasons in which influenza-associated deaths were only reportable by laboratory confirmation.

RSV trends

Detections



Total PCR Tests





**Strategies to prevent/
contain outbreaks**



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Practice Core Principles of Infection Prevention

- Remember to practice infection prevention principles such as hand hygiene
- Avoid overcrowding in an indoor space
- Ensure adequate ventilation when holding gatherings
- Test for pathogens promptly based on symptoms
- Practice transmission-based precautions based on symptoms and/or diagnosis

Reminders

- Screen for symptoms at entry and have signs posted in strategic locations throughout the facility. Change the signs frequently to catch people's attention.
- Educate on the benefits of vaccination and infection control principles
- Encourage vaccination
- Protect the most vulnerable individuals with additional measures
- Isolate if symptomatic or confirmed
- Test: if symptomatic, exposed, contact traced, or part of outbreak testing, unable to contain the spread
- Vaccinate
- Treat the eligible individuals
- Revisit or revise facility policies based on your situation: passive, active screening, masks, extra testing

An illustration of a hand holding a megaphone, set against a teal background. The megaphone is white with red accents. A large white speech bubble extends from the megaphone towards the right side of the image.

GET YOUR FLU SHOT

Vaccination



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COVID-19 Vaccination Dashboard

Total Vaccinations

Reported (all-time): 12/14/2020 - 12/27/2022

☐ New
☒ Total

Total Up to Date Individuals

770,702

757,275 Total Individuals Received Most Recent Booster

Total Individuals Vaccinated

Completed
Primary Series

3,851,298

Up to Date

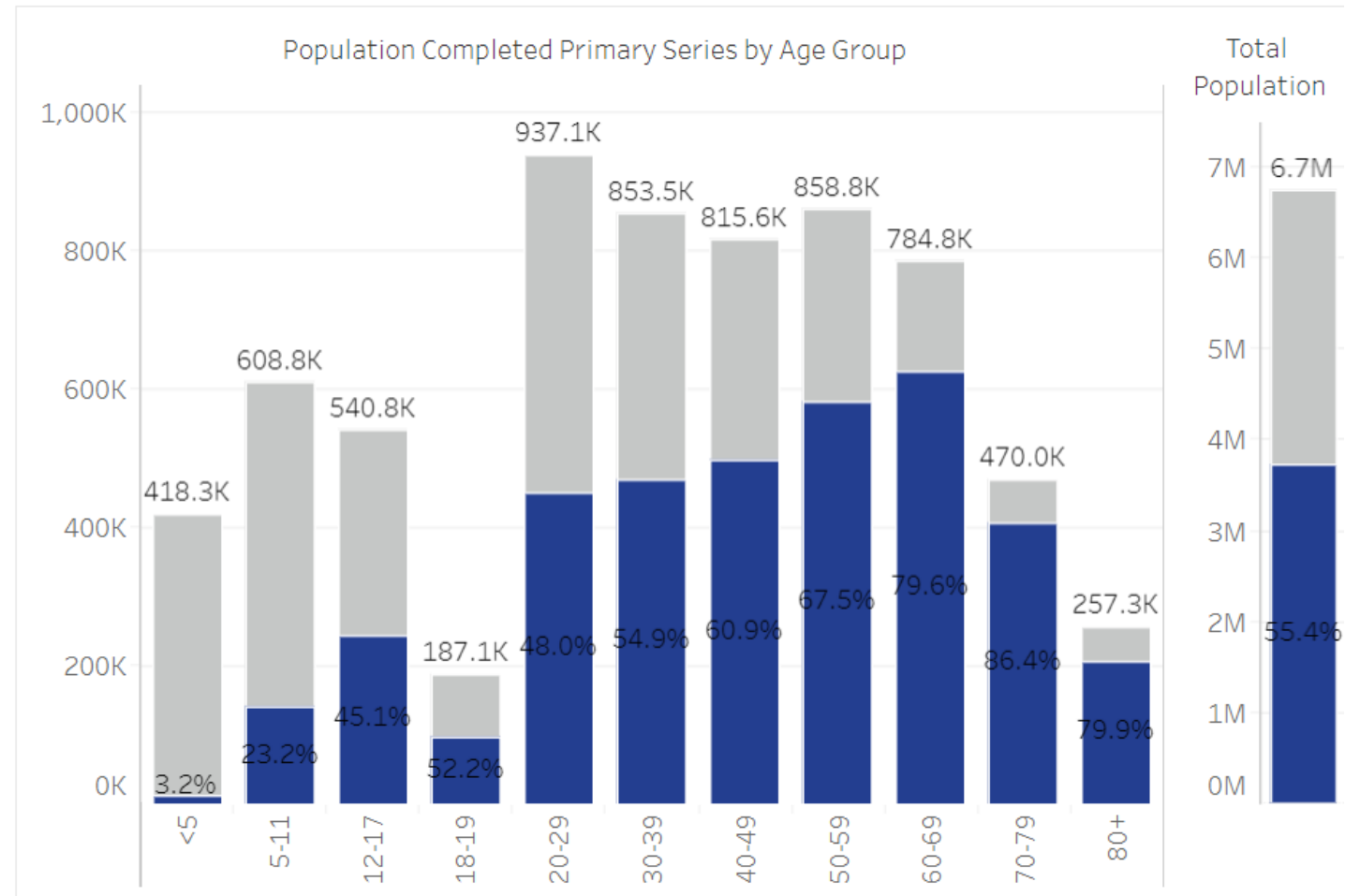
770,702



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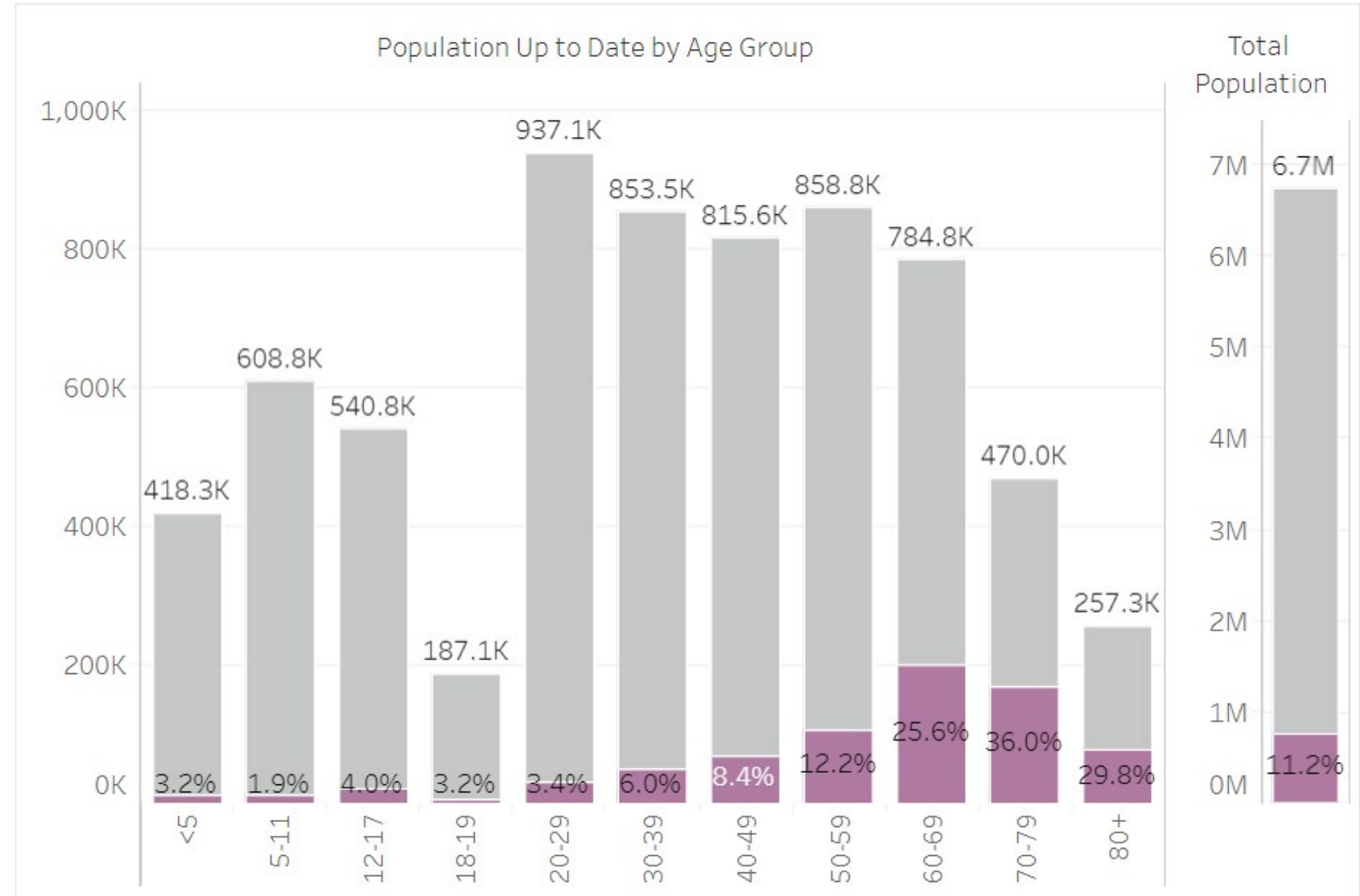
Completed primary series - by age group

Completed Primary Series



Up to date - By age group

Up to Date



Please encourage your patients to stay up to date with vaccination

A recent [CDC report](#) showed that adults ages 65 years and older continue to have the highest COVID-19-related mortality rates. Adults ages 85 years and older remain at particularly high risk of dying of COVID-19. The proportion of COVID-19-related deaths accounted for by adults in this age group increased during April–September 2022 from 28% to around 40% of COVID-19-related deaths.

The COVID-19-related death rate among unvaccinated people who are 65 years and older has consistently been higher than the rate among vaccinated people. [CDC data](#) on nursing homes showed that COVID-19 case rates are higher in nursing home residents who have not received all recommended doses than among those who are up to date.

COVID-19 vaccination rates as of Dec. 11 show that 43% of nursing home residents in the United States are up to date with COVID-19 vaccination and only 10% of nursing home staff in the United States are up to date with COVID-19 vaccination.

Barriers to Vaccination

- Skepticism: Continue to educate and encourage vaccination to stay up to date, especially the at-risk population such as the elderly
- Operational challenges: Please email svuppalanchi@health.in.gov and David McCormick (DMcCormick@health.in.gov). Please specify the challenges you are facing.

Bivalent vaccine effectiveness against symptomatic SARS-CoV-2 in immunocompetent persons

Data from the Increasing Community Access to Testing (ICATT) national SARS-CoV-2 testing program:

- Study of vaccine effectiveness of the U.S.-authorized bivalent mRNA booster formulations found that:
 - Bivalent boosters provided significant additional protection against symptomatic SARS-CoV-2 infection in persons who had previously received 2, 3, or 4 monovalent vaccine doses.
 - Due to waning immunity of monovalent doses, the benefit of the bivalent booster increased with time since receipt of the most recent monovalent vaccine dose.
- Total of 360,626 nucleic acid amplification tests (NAATs) performed at 9,995 retail pharmacies for adults aged ≥ 18 years, who reported symptoms consistent with COVID-19 at the time of testing and no immunocompromising conditions, were included in the analysis from Sept. 14–Nov. 11, 2022
- Relative vaccine effectiveness (rVE) of a bivalent booster dose compared with that of ≥ 2 monovalent vaccine doses among persons for whom 2–3 months and ≥ 8 months had elapsed since last monovalent dose was 30% and 56% among persons aged 18–49 years, 31% and 48% among persons aged 50–64 years, and 28% and 43% among persons aged ≥ 65 years, respectively.
- Bivalent mRNA booster doses provide additional protection against symptomatic SARS-CoV-2 in immunocompetent persons who previously received monovalent vaccine only, with relative benefits increasing with time since receipt of the most recent monovalent vaccine dose

MMWR Dec. 16, 2022-Bivalent booster VE hospitalization in immunocompetent >65 years- IVY network

- Between Sept. 8–Nov. 30, adults aged ≥ 65 years admitted for COVID-19-like illness to any of 22 hospitals in 18 states participating in the IVY Network were eligible for inclusion in this test-negative design, case-control analysis.
- Among patients hospitalized with COVID-19–like illness who received testing for SARS-CoV-2 by nucleic acid amplification test or antigen test, those who received a positive test result ≤ 10 days after illness onset and ≤ 3 days after hospital admission were classified as case-patients, and those who received a negative test result during the same interval were classified as control patients.
- Among immunocompetent adults aged ≥ 65 years hospitalized in the multistate IVY Network, a bivalent booster dose provided 73% additional protection against COVID-19 hospitalization compared with past monovalent mRNA vaccination only.

MMWR Dec. 16, 2022- Bivalent booster VE in ED/ urgent care visit/ hospitalization in immunocompetent- VISION network

- From Sept. 13–Nov. 18, the VISION Network evaluated vaccine effectiveness (VE) of a bivalent mRNA booster dose (after 2, 3, or 4 monovalent doses) compared with 1) no previous vaccination and 2) previous receipt of 2, 3, or 4 monovalent-only mRNA vaccine doses, among immunocompetent adults aged ≥ 18 years with an emergency department/urgent care (ED/UC) encounter or hospitalization for a COVID-19–like illness.
- VE of a bivalent booster dose (after 2, 3, or 4 monovalent doses) against COVID-19–associated ED/UC encounters was 56% compared with no vaccination, 31% compared with monovalent vaccination only with last dose 2–4 months earlier, and 50% compared with monovalent vaccination only with last dose ≥ 11 months earlier.
- VE of a bivalent booster dose (after 2, 3, or 4 monovalent doses) against COVID-19–associated hospitalizations was 57% compared with no vaccination, 38% compared with monovalent vaccination only with last dose 5–7 months earlier, and 45% compared with monovalent vaccination only with last dose ≥ 11 months earlier.
- Bivalent vaccines administered after 2, 3, or 4 monovalent doses were effective in preventing medically attended COVID-19 compared with no vaccination and provided additional protection compared with past monovalent vaccination only, with **relative protection increasing with time since receipt of the last monovalent dose.**

Influenza Vaccination

We don't have data yet on vaccine effectiveness for the current flu vaccine, but so far, most of the circulating viruses are closely related to current vaccine strains.



Therapeutics



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Important Updates on COVID-19 Therapeutics for Treatment and Prevention

Dec. 20

- The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Update to supplement the CDC HAN Health Advisories issued on April 25, and May 24, to emphasize to healthcare providers, public health departments, and the public that the majority of Omicron sublineages circulating in the United States have reduced susceptibility to the monoclonal antibody bebtelovimab and the monoclonal antibody combination cilgavimab and tixagevimab (Evusheld™).
- Antiviral therapeutics for the treatment of COVID-19, ritonavir-boosted nirmatrelvir (Paxlovid™), remdesivir (Veklury®), and molnupiravir (Lagevrio™), retain activity against currently circulating Omicron sublineages. These medications can prevent severe disease, hospitalization, and death and are widely available but have been underused.

Tamiflu Shortages

- Here is a note from [FDA](#) on 12/5/22 with compounding instructions for pharmacists.
- Although there currently is not a nationwide oseltamivir phosphate oral suspension shortage, we are aware there may be localized shortages where demand is especially high.
- If one pharmacy does not have it in stock, please check if another local pharmacy has it in stock.
- Please email me at svuppalanchi@health.in.gov if you are experiencing shortages and provide specifics.

Interim Guidance for Clinicians to Prioritize Antiviral Treatment of Influenza in the Setting of Reduced Availability of Oseltamivir

CDC released a HAN on Dec. 14:

- Prioritize oseltamivir treatment as soon as possible for hospitalized patients with suspected or laboratory-confirmed influenza.
- Among outpatients, prioritize antiviral treatment for patients who test positive for influenza as follows:
 - Patients at increased risk of influenza complications and who test positive for influenza within 2 days of illness onset.
 - Patients who have progressive or severe influenza not requiring hospitalization, even if they test positive for influenza more than 2 days from illness onset.
 - Patients who are pregnant, less than 2 weeks postpartum, or immunocompromised
 - Children younger than 5 years of age

Guidance to Prioritize Antiviral Treatment of Influenza in the Setting of Reduced Availability of Oseltamivir

Institutional Settings

- When an influenza outbreak is not occurring, prioritize oseltamivir for early treatment of influenza in residents of congregate settings, such as long-term care facilities (LTCFs), who test positive for influenza.
- In the setting of laboratory-confirmed influenza outbreaks in LTCFs:
 - Early empiric antiviral treatment of suspected influenza in residents is recommended. Once an influenza diagnosis is confirmed through testing, post-exposure antiviral chemoprophylaxis of exposed residents is recommended.
 - Because institutional outbreaks can be prolonged, consider using a limited duration treatment dosage (twice daily for 5 days) for post-exposure oseltamivir instead of extended use of oseltamivir chemoprophylaxis (once daily), with ongoing active daily monitoring and influenza testing for all residents with new illness signs and symptoms.
 - If oseltamivir is not available, baloxavir, zanamivir, or peramivir may be used for treatment of influenza.
 - Although baloxavir may be used for treatment, there are no available data on using baloxavir in LTCFs for treatment or post-exposure chemoprophylaxis.

Guidance to Prioritize Antiviral Treatment of Influenza in the Setting of Reduced Availability of Oseltamivir

Other Considerations

- In hospitalized patients, oseltamivir can be administered orally or enterically via oro- or nasogastric tube. For hospitalized patients who cannot absorb enterically-administered oseltamivir (e.g., due to gastric stasis, malabsorption, or gastrointestinal bleeding), or when oseltamivir is not available, intravenous peramivir is an option.
- For children who are not able to swallow prescribed oseltamivir capsules, the prescribed capsules may be opened and mixed with a thick sweetened liquid, such as chocolate syrup, prior to administration.
- When local generic oseltamivir availability issues are resolved, CDC recommends reverting back to original antiviral recommendations that include clinical diagnosis and empiric antiviral treatment of influenza in outpatients.
- Healthcare providers should use clinical judgment and all available data when making decisions about prescribing antibiotics to patients presenting with acute respiratory illness

Questions?

CONTACT:

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CDC Expands COVID-19 Provider Vaccine Agreements to LTC Facilities

- CDC is taking steps to make it easier for LTC to administer the COVID-19 vaccine to staff and residents.
- LTC pharmacies can transfer COVID-19 vaccine boosters in a single dose vials.
- Waiving some of the reporting requirements



What you need to know

- You can become a sub-providers in the CDC COVID-19 Vaccination Program.
- Must be enrolled in CHIRP – Indiana



Agreement – Important notes

- This **does NOT** eliminate the required weekly aggregate reporting of vaccine information through NHSN.
- If you have a federal vaccine provider agreement in place, this is not necessary.
- You will need to talk to your LTC pharmacy about reporting requirements in your state.
- To receive single dose files from the LTC pharmacy, you will need to sign the CDC [COVID-19 Sub-Provider Vaccine Agreement for LTCF](#) located on the [CDC website](#). Most of the requirements outlined in this agreement are steps you already follow for other vaccines such as influenza.



State Laws and Regulations

Reporting to the STATE CHIRP system – Indiana

- Children & Hoosiers Immunization Registry Program



Why nursing home providers need access to CHIRP related to COVID-19 vaccinations:

Enables a registered and approved vaccine provider to record all newly administered vaccinations

Provides immediate access to immunizations records of new patients.

Decreases staff time spent retrieving immunization records

Reduces costs: staff time paperwork, and vaccine use

Flag's opportunities to give needed vaccinations.

Provides reminder cards and letters resulting in fewer missed appointments

Maintains immunization data in a confidential and secure system.



Direct Enrollment – CHIRP

- Allows long-term care facilities to receive COVID-19 vaccinations by enrolling directly at ISDH's enrollment site (different than working with a LTC Pharmacy where the pharmacy handles the vaccination and coordinates with the facility to administer).
- Under the Direct Enrollment option, the LTC facility is solely responsible for vaccine ordering, storage, handling, and administration, and reporting supply and administration information to the state.



Registering for CHIRP

- Complete enrollment form -

https://chirp.in.gov/chirp_files/docs/PROVIDER_SITE%20ENROLLMENT_AGREEMENT_revision_7-13_form_fill.pdf

- Individual CHIRP users are required to complete a user agreement form -

https://chirp.in.gov/chirp_files/docs/IUA-2016-edit.pdf



Recommendations for Consideration

- Enroll in CHIRP to help with care coordination regarding COVID-19 vaccinations.
- Designate individual user or users at your facility.
- Maintain the signed individual user agreement in the employee personnel record.
- Ensure your HR department is aware of the Remove User form that must be completed within 1 week of a designated user's last day of employment and faxed to CHIRP program at 317-233-8827.



The Winter Playbook – handout

- Help residents and staff access updated COVID-19 vaccines
- Ensure that residents and staff are testing if they are symptomatic and know how to access COVID-19 treatment options.
- Improve indoor air quality across facilities



Request to be informed

Operational Challenges

- Lori Davenport – ldavenport@ihca.org
- Dr. Vuppalanchi -- svuppalanchi@health.in.gov





THANK YOU!

Contact Information

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- Dave McCormick – Immunization Division, IDH
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THANK YOU!



Winter Playbook for Nursing Homes and Other Long-term Care Facilities to Manage COVID-19 and Protect Residents, Staff, and Visitors

While COVID-19 is no longer the disruptive force it once was, real challenges persist, particularly for older Americans, who suffer from serious illness or deaths from COVID-19 at higher rates than the rest of the population.

Seniors continue to have the highest risk of being hospitalized and dying because of COVID-19. In fact, over the past two months, nearly 90 percent of COVID-19 deaths nationwide have occurred among individuals age 65 and older, with 70 percent occurring among those age 75 and older. Each week, around 2,000 seniors are dying from COVID-19. We know that people living in congregate care settings are also at high risk, as 1 in 5 recent COVID-19 deaths were in nursing homes and other long-term care facilities, such as assisted-living facilities.

This toll is heartbreaking and unacceptable, particularly as we now have updated COVID-19 vaccines and treatments that can – along with other strategies such as improving indoor air quality – can help prevent COVID-19 deaths.

Nursing home and other long-term care facility leaders have a responsibility – and in some cases, an obligation – to step up and take action to protect their residents from COVID-19 – a responsibility that is even more acute ahead of further potential increases in cases and hospitalizations this winter.

As expected, COVID-19 infections and hospitalizations are rising in many parts of the U.S. following the Thanksgiving holiday, including in nursing homes and other congregate settings. In some parts of the country, hospitalization rates for people 70 years and older are at their highest levels since the Omicron BA.1 surge last winter. This increased circulation of the virus is likely to continue during the winter, a time when Americans gather together indoors with loved ones and respiratory viruses like COVID-19 and the flu spread more quickly.

Through widely available vaccines, treatments, and tests, as well as layered prevention strategies like improved indoor air quality and making masks available to visitors, long-term care facilities can reduce serious illness, prevent hospitalizations and deaths, and minimize disruptions for their communities.

Failure to take action will mean more Americans will needlessly suffer the immeasurable loss of a loved one this holiday season. Some long-term care facilities and their staff are already leading the charge on implementing these tools to protect residents, with high rates of residents up-to-date on COVID-19 vaccination, timely use of treatments, and thoughtful prevention measures like improving indoor air quality. That work is saving lives.

To that end, the Administration is calling on all long-term care facility leaders to step up this winter:

1. Help residents and staff access updated COVID-19 vaccines.

We have updated COVID-19 vaccines that target the versions of COVID-19 we are facing now. As of December 4, just 42 percent of nursing home residents and 10 percent of nursing home staff have gotten an updated COVID-19 vaccine – putting tens of thousands of Americans at higher risk of serious illness or worse from COVID-19. Offering COVID-19 vaccinations to residents and staff and educating about their benefits is a requirement by the Centers for Medicare & Medicaid Services (CMS) for nursing homes, and other long-term care facility settings can act to help their communities get the updated vaccine.

- ✓ Offer vaccinations for residents and staff throughout the winter. Partner with a vaccine provider to host on-site vaccination clinics for your facilities, including vaccination clinics that offer both the annual flu shot and updated COVID-19 vaccine. Consider options to reach staff who work overnight and weekend hours.
- ✓ For skilled nursing facilities, leverage new flexibilities to have staff administer COVID-19 vaccines this winter. Take advantage of newly available single-dose vials with these new temporary flexibilities available to skilled nursing facilities to have vaccine doses available on site so residents can get a COVID-19 vaccination when they want one.
- ✓ Disseminate clear information to your residents and staff regularly throughout the winter on the importance of getting the updated COVID-19 vaccine, as well as the annual flu shot. Follow up with residents who have not yet received an updated vaccine—as well as their family members, reminding them that immunity wanes over time and the updated shot will give them added protection.
- ✓ Host in-person or virtual events and activities to help answer resident and staff questions on COVID-19 vaccination. You can work in partnership with Quality Improvement Organizations as a resource.
- ✓ Offer paid time off for staff vaccinations, such as what the federal government has done for its employees and their families.

2. Ensure that residents and staff are testing if they are symptomatic, and know how to access COVID-19 treatment options (such as oral antiviral pills) if they test positive.

There are widely available and easily accessible COVID-19 treatments, including oral antiviral medications like Paxlovid (nirmatrelvir/ritonavir) and Lagevrio (molnupiravir), that have been shown to reduce hospitalizations and serious illness. Timely prescribing of COVID-19 antivirals is now part of high-quality care in long-term and post-acute care settings – and can save lives. Recent data encouragingly suggests the highest utilization rates of COVID-19 treatments are in long-term care facilities, but there are still many eligible residents not receiving these potentially life-saving treatments. Every facility can act to ensure its community of residents is aware of COVID-19 treatments and their effectiveness and to promote easy access to these lifesaving treatments.

- ✓ Ensure your residents and staff get tested if they have COVID-19 symptoms and your facilities are able to assess if residents are eligible for treatment options. Testing leads to treatment, and timely treatment prevents serious illness and saves lives.

- ✓ Ensure that your facility has test kits on-hand and available for residents and staff.
- ✓ Increase awareness of valuable resources, such as the millions of tests per week available for long-term care facilities to order for free from the federal government, free at-home tests that are available to residents through their health insurance, and telehealth and virtual care options for COVID-19 evaluation and treatment.
- ✓ Working with pharmacy partners, ensure your facilities have adequate supply of oral antivirals stocked to minimize treatment delays and ensure patients initiate treatment within 5 days of symptoms.
- ✓ Initiate test-to-treat programs within your nursing homes. This can include prescribing by both clinicians as well as consulting pharmacists to ensure that residents have timely access to care for COVID-19. This can also include incorporating telehealth options to ensure timely access to treatment.
- ✓ Educate your prescribing clinicians so that they feel comfortable providing treatment and reviewing [guidance](#) that provides information on how many drug-drug interactions with Paxlovid can be readily managed.

3. Improve indoor air quality across facilities

Taking steps to improve air quality inside nursing homes and other congregate settings can reduce the spread of COVID-19, the flu, and other respiratory illnesses, in addition to offering other health benefits. More passive measures that require less individual behavior change, like improving indoor air quality, will help reduce the risk and spread of COVID-19 and other airborne viruses.

Actions that improve indoor air quality in facilities that have mechanical ventilation/Heating, Ventilation, and Air Conditioning (HVAC) systems:

- ✓ Schedule an inspection to ensure the system is operating properly and address issues found in the assessment.
- ✓ Replace air filters in mechanical ventilation systems to the highest filtration level they can accommodate, including MERV-13 filters when possible.
- ✓ Switch HVAC systems to the “on” position instead of “auto” at all occupied hours, with increased run-time and enhanced settings when COVID-19 Community Levels are higher.

In all facilities:

- ✓ Use portable air cleaners in areas where residents, staff, and visitors congregate, such as dining rooms, recreation rooms, and resident rooms, to supplement clean air flow. Prioritize rooms of residents who have respiratory infections or those who are immunocompromised.

- Nursing homes can purchase portable air cleaners with high-efficiency particulate air filters through the [Centers for Medicare & Medicaid Services' civil money penalty reinvestment program](#).
- Additional funding is available through state and local government allocations of the American Rescue Plan State and Local Fiscal Relief Program, as well as CDC's Nursing Home and Long-Term Care Facility Strike Team and Infrastructure Program and their Strengthening Healthcare Associated Infections and Antimicrobial Resistance (AR (HAI/AR) Program).
- ✓ Turn on ceiling fans to mix the air, turn on restroom and kitchen vents to move contaminated air outdoors, and use window and exhaust fans to direct the airflow out of the room when safety measures and thermal comfort allow.
- ✓ Where possible, repair or address condition of windows or doors to increase air flow as conditions permit.
- ✓ For a tailored approach, partner with an occupational and environmental health and safety professional, HVAC expert, or other indoor air quality expert to recommend additional strategies to reduce the spread of airborne illnesses and improve indoor air quality to meet individual facility needs.