December 8, 2022

# LTC COVID-19 Update

Presented by:

**Lori Davenport, Director of Regulatory & Clinical Affairs**

**Indiana Department of Health Team**

Indiana Department of Health

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INDIANA HEALTH CARE ASSOCIATION

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# Today's Topics

- COVID-19 update – Dr. Vuppalanchi
- LTC abuse and incident reporting policy revisions – Brenda Buroker

***Astute Survey Preparedness & Application of Infection Control Regulatory Requirements,*** *a webinar on Dec. 20, details HERE*

***Mission Possible: SNF Department Head Briefing****, a 12-month webinar series, purchase by Jan. 20 and save $$$, details HERE*

***5-Star Work Plans****, a 6-week webinar series, purchase by Jan. 18 and save $$$, details HERE*

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# UPDATE

**SHIREESHA VUPPALANCHI, M.D.**
MEDICAL DIRECTOR

12/08/2022

## 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.

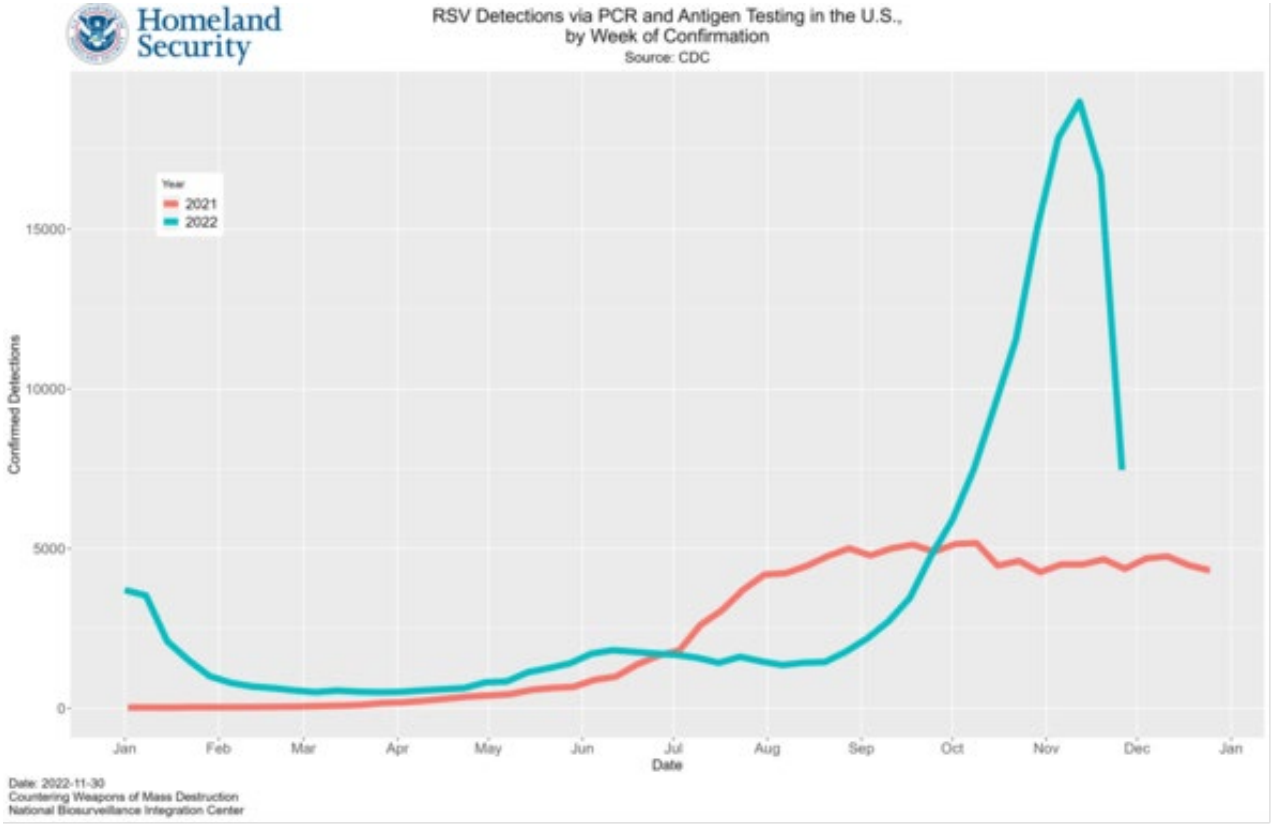
# Increased Respiratory Virus Activity, Especially Among Children, Early in the 2022-2023 Fall and Winter-CDC HAN

- CDC is tracking levels of respiratory syncytial virus (RSV), influenza, and rhinovirus/enterovirus (RV/EV) that are higher than usual for this time of year, especially among children
- RSV activity appears to be plateauing in some places, the timing, intensity, and severity of the current RSV season are uncertain.
- CDC has been tracking early and increasing influenza activity in recent weeks.
- CDC anticipates continued high-level circulation of influenza viruses this fall and winter.
- SARS-CoV-2 also continues to circulate in all U.S. states. CDC expects continued high-level circulation of SARS-CoV-2 this fall and winter.
- **Co-circulation of respiratory syncytial virus (RSV), influenza viruses, SARS-CoV-2, and others could place stress on healthcare systems this fall and winter.**



HAN Archive - 00479 | Health Alert Network (HAN) (cdc.gov)

# RSV




- Preliminary data from October 2022 show that weekly rates of RSV-associated hospitalizations among children younger than 18 years old are higher than rates observed during similar weeks in recent years.
- According to U.S. CDC data, for the week ending 26 November 2022, RSV antigen and PCR detections decreased, as did the overall rate of RSV-associated hospitalizations. The number of hospitalizations is still higher than at this time in previous years.
- CDC reported elevated levels of RSV nationally, but detections are decreasing in the South and Southeast and stabilizing in New England, the Mid-Atlantic, and the Midwest.

# Influenza Surveillance

***Indiana Influenza-Like Illness (ILI) Surveillance – Week ending November 26, 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**

**High**

**Influenza-Associated Deaths**

**7**

for current week

**11 total** for current season

**Syndromic Percent ILI**

**6.67%** ▲2.34%

reported by emergency department and urgent care chief complaints

**Sentinel Percent ILI**

**6.33%** ▲2.10%

reported by sentinel outpatient provider

*The ongoing COVID-19 pandemic may impact Indiana's sentinel and syndromic ILI data due to COVID-19 and influenza having similar symptoms. Reporting of ILI geographic distribution and school-wide outbreaks of influenza have been suspended for duration of the 2021-

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All data will be updated weekly beginning Friday, October 14,2022. Data as of December 2, 2022.
Observed Current Week - November 26, 2022 - November 20, 2022

# Influenza associated deaths by age this season

## Influenza-Associated Deaths

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 dashboard are subject to change as additional cases are back-reported.

### Influenza-Associated Deaths for All Ages by Season

2022-2023

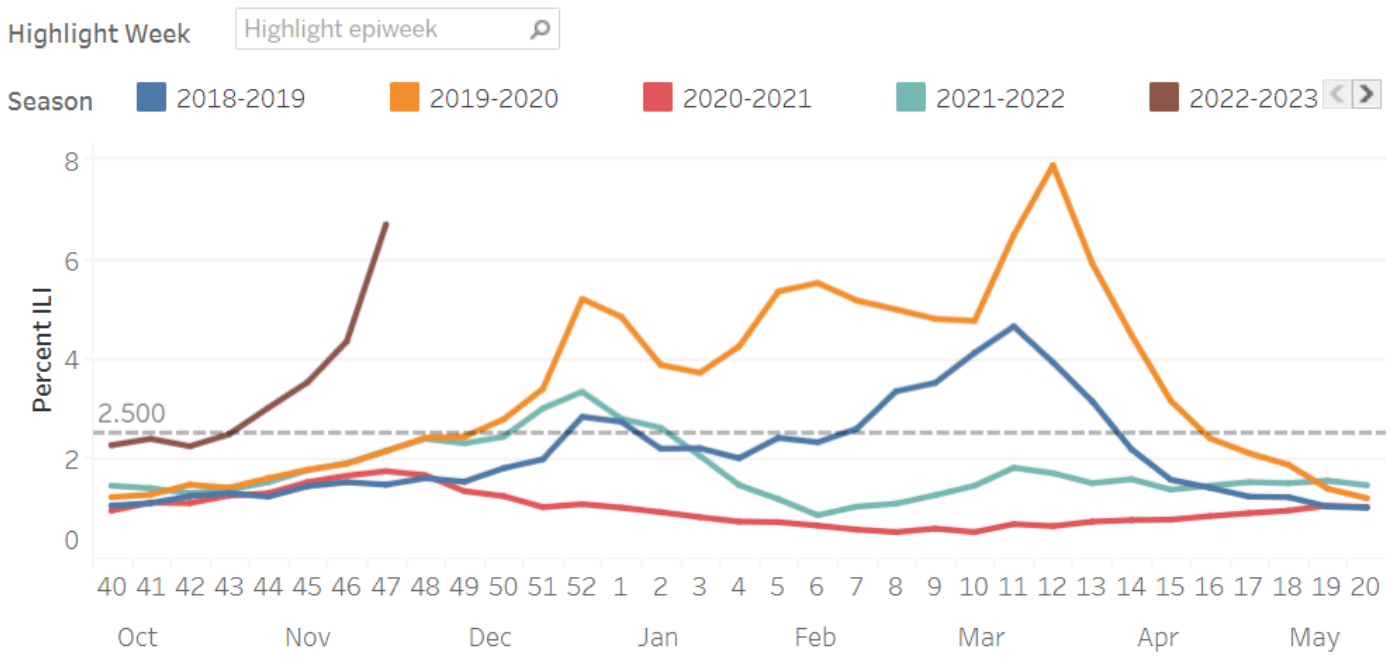
| Season | Age Category | Count |
|---|---|---|
| 2022-2023 | Age 0-4 | 0 |
| | Age 5-24 | 0 |
| | Age 25-49 | 0 |
| | Age 50-64 | 3 |
| | Age 65 and older | 8 |
| Grand Total | | 11 |

# Influenza Dashboard

## Emergency Department and Urgent Care Visits for ILI

The Indiana Department of Health (IDOH) uses a system called ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics) to track and monitor syndromic surveillance for ILI. In ESSENCE, a visit is classified as ILI when a patient presents with a chief complaint of fever (greater than or equal to 100 °F) accompanied by a cough and/or sore throat, or complaining of "influenza". Epidemologists at

### Percent ILI by Season

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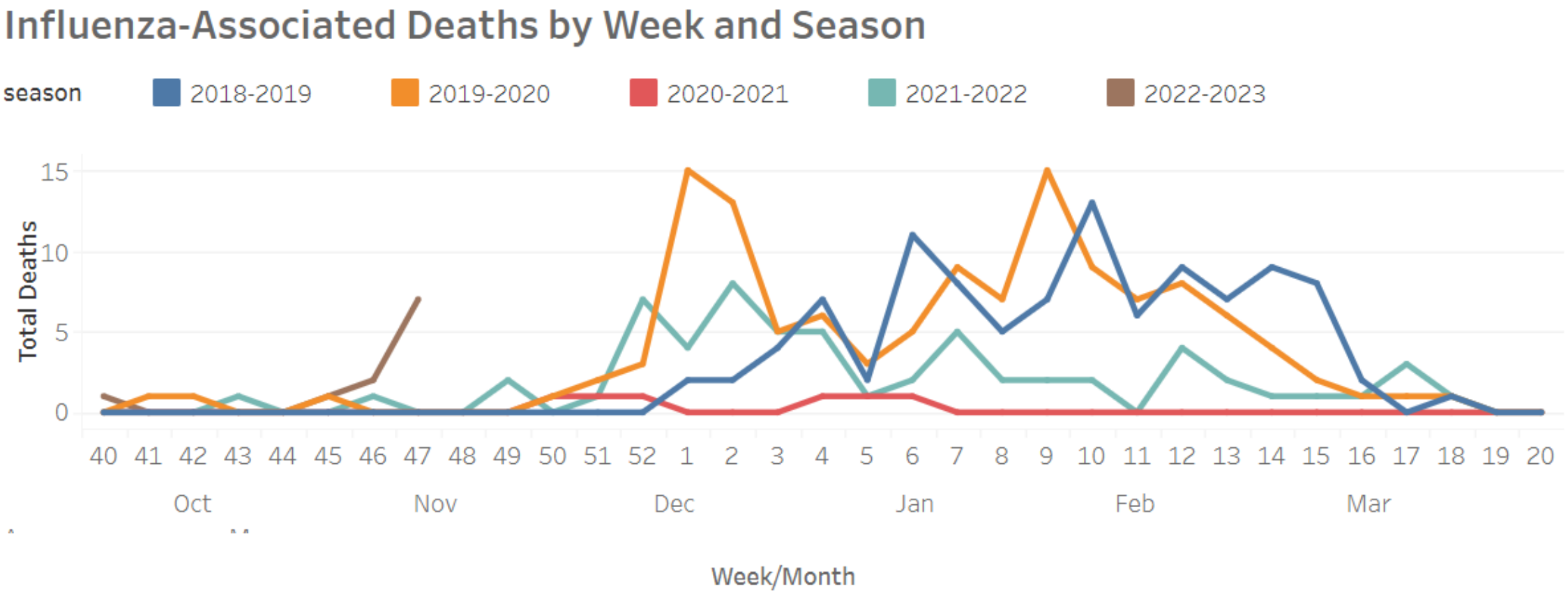
https://www.in.gov/health/erc/infectious-disease-epidemiology/diseases-and-conditions-resource-page/influenza/influenza-dashboard/

# Influenza-associated death by week and season

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[Health: Infectious Disease Epidemiology & Prevention Division: Influenza Dashboard]

# From CDC FluView

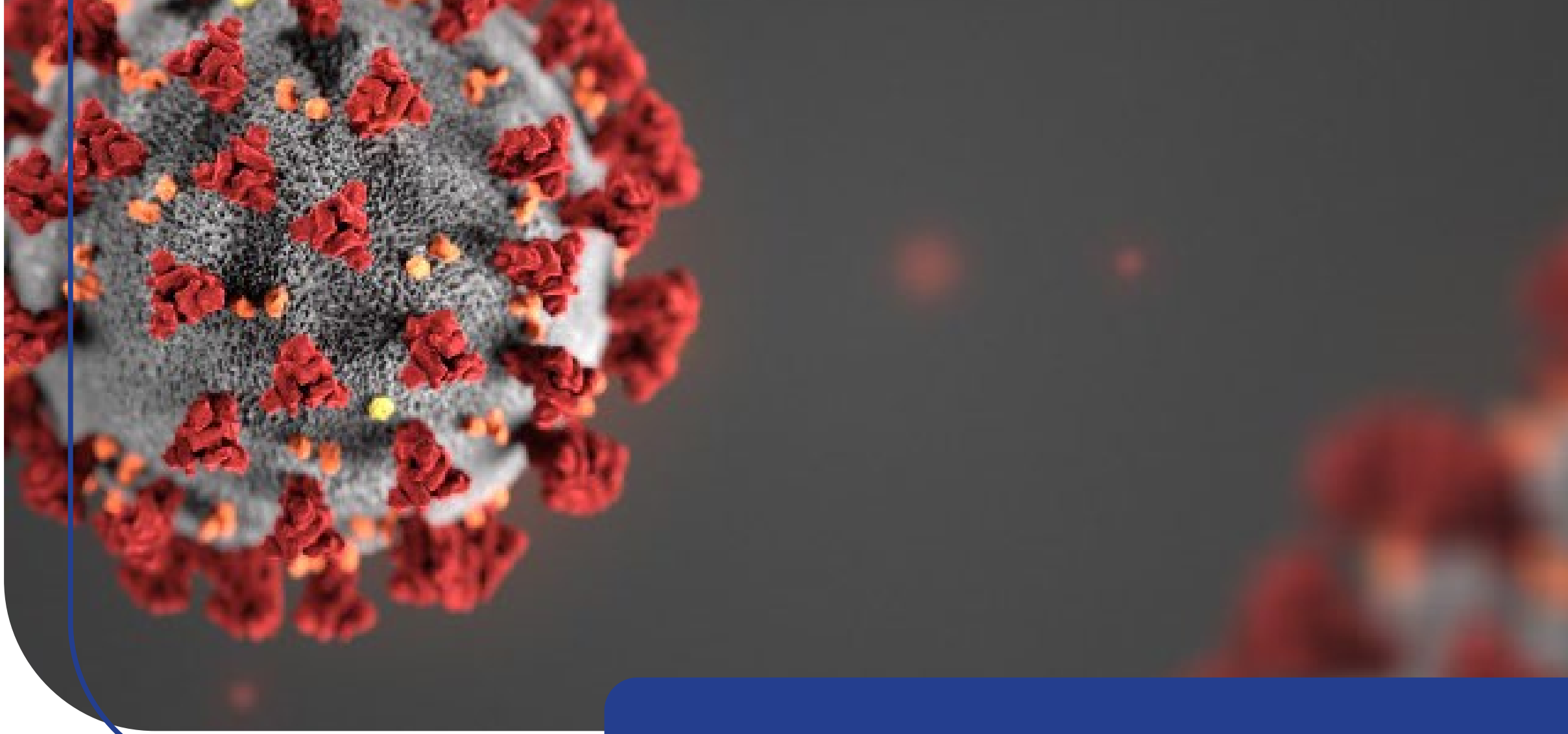
- Nearly 20,000 lab-confirmed flu patients in the U.S. were hospitalized for the week ending Nov. 26, up from 11,269 flu patients admitted the week prior, according to the CDC's latest FluView report.
- Latest report estimates there have been at least 8.7 million flu illnesses, 78,000 hospitalizations and 4,500 flu-related deaths. That's up from the estimated 6.2 million cases, 53,000 hospitalizations and 2,100 deaths estimated the week prior.
- The overall cumulative hospitalization rate is 16.6 per 100,000 — the highest it's been this early in the season since the 2010-11 flu season.



New flu hospitalizations spike nearly 74% in one week: 8 FluView notes (beckershospitalreview.com)

# Prevention

- Offer prompt vaccination against influenza and COVID-19 to all eligible people aged 6 months and older who are not up to date. Vaccination can prevent hospitalization and death associated with influenza and SARS-CoV-2 viruses.
  - Influenza vaccines have been updated for the current season. The data suggest influenza vaccination this season should offer protection against the predominant A(H3N2) viruses to date.
  - Currently approved SARS-CoV-2 bivalent mRNA booster doses for use in patients 5 years of age and older offer protection against both the ancestral SARS-CoV-2 virus and the currently predominant Omicron BA.4 and BA.5 subvariants that cause COVID-19.
  - Emerging evidence suggests that COVID-19 vaccination provides some protection against multisystem inflammatory syndrome in children (MIS-C) and against post-COVID-19 conditions, and that vaccination among persons with post–COVID-19 conditions might help reduce their symptoms.



# COVID-19

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# Hospitalizations as of 11/29


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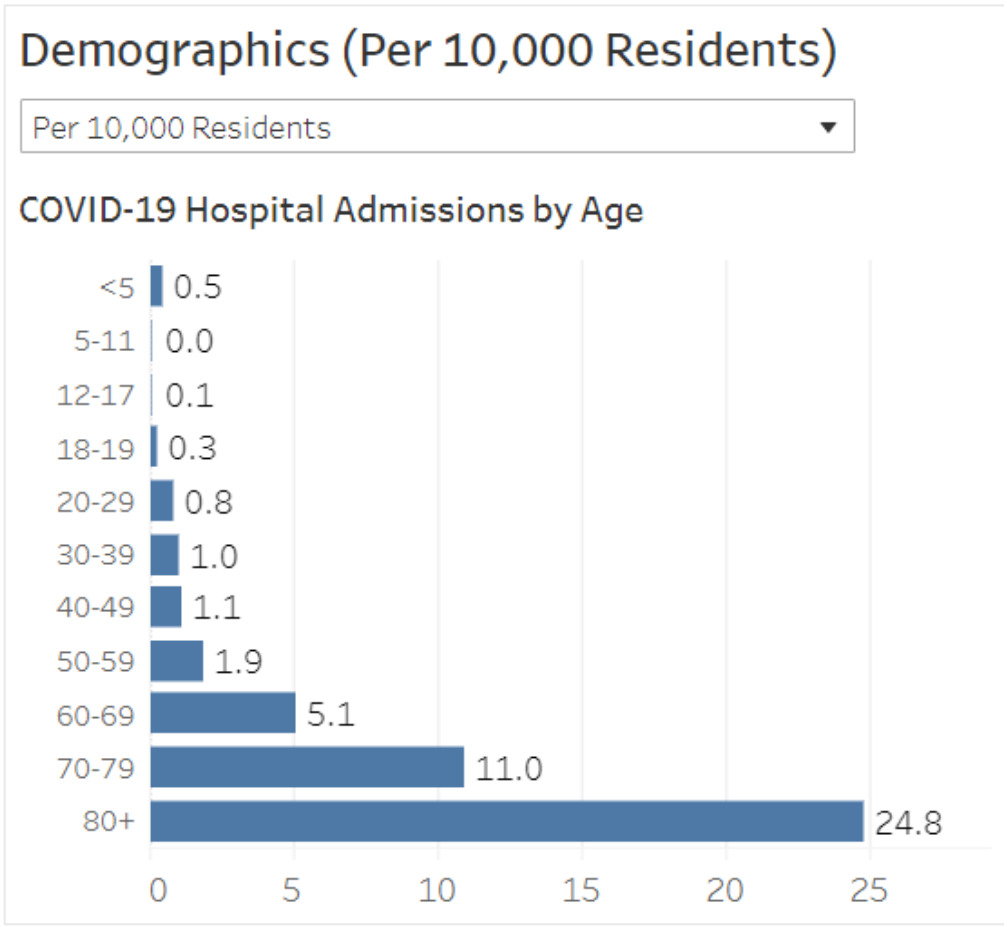
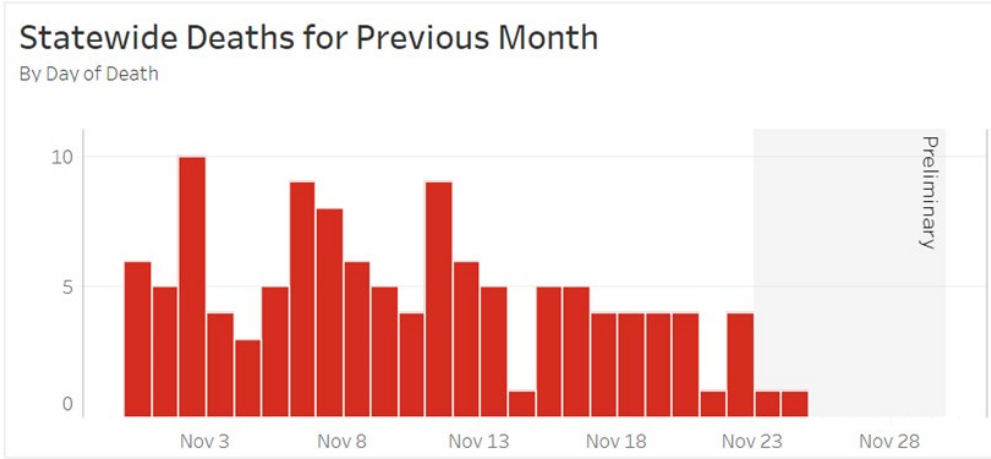
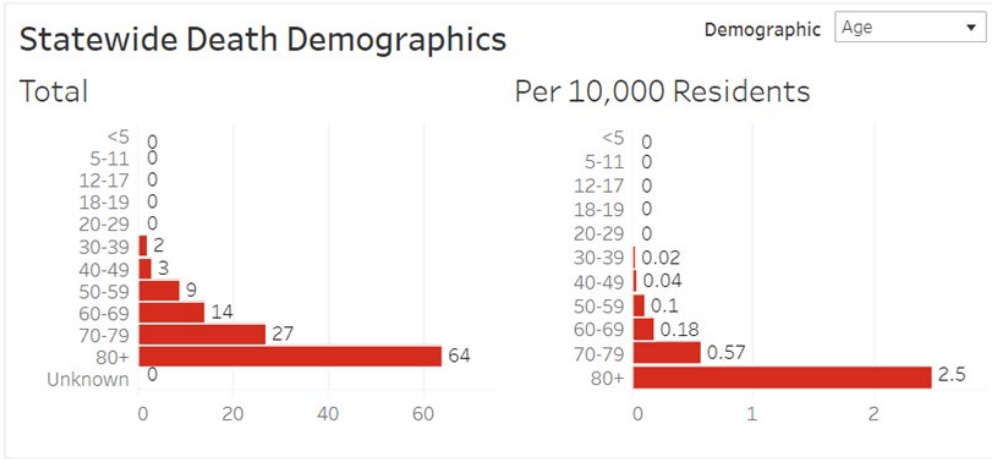
[Novel Coronavirus (COVID-19): Hospital Dashboard (in.gov)]

# COVID-19 hospitalizations and deaths within the previous month (as of 11/29)

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[Novel Coronavirus (COVID-19): Hospital Dashboard (in.gov)]

# Bivalent boosters

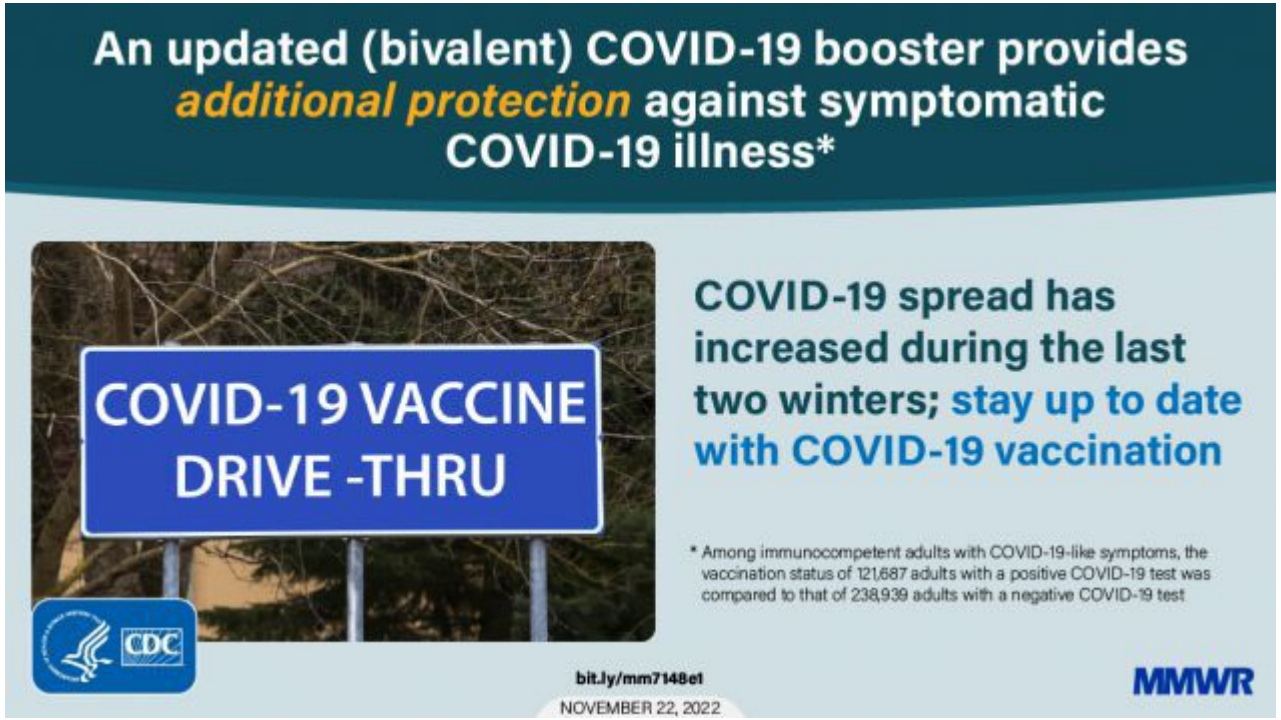
- Waning vaccine effectiveness with time since monovalent vaccine receipt has been observed during the Omicron-predominant period, with more rapid waning during the period when Omicron BA.4/BA.5 lineages predominated.
- Results from this study show that bivalent boosters provide protection against symptomatic SARS-CoV-2 infection during circulation of BA.4/BA.5 and their sublineages and restore protection observed to wane after monovalent vaccine receipt, as demonstrated by increased rVE with longer time since most recent monovalent dose.
- 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.
- In this study, relative benefits of a bivalent booster compared with monovalent vaccine doses alone increased with time since receipt of last monovalent dose.



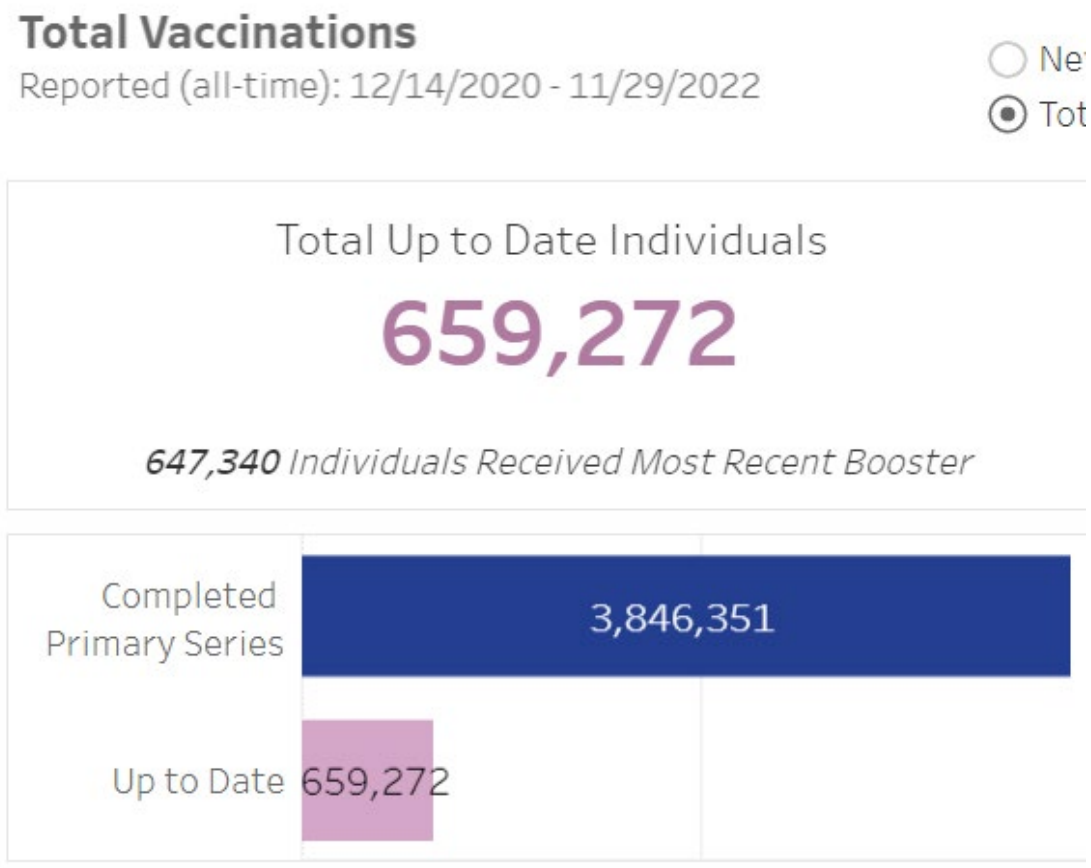
Effectiveness of Bivalent mRNA Vaccines in Preventing Symptomatic SARS-CoV-2 Infection — Increasing Community Access to Testing Program, United States, September–November 2022 | MMWR (cdc.gov)

# Covid Vaccine Rates

- Many people eligible for bivalent booster haven't received it
- Vaccine is available to order — no barrier for clinicians to order whatever you need as long as you order the minimum quantities



# COVID-19 Vaccination status

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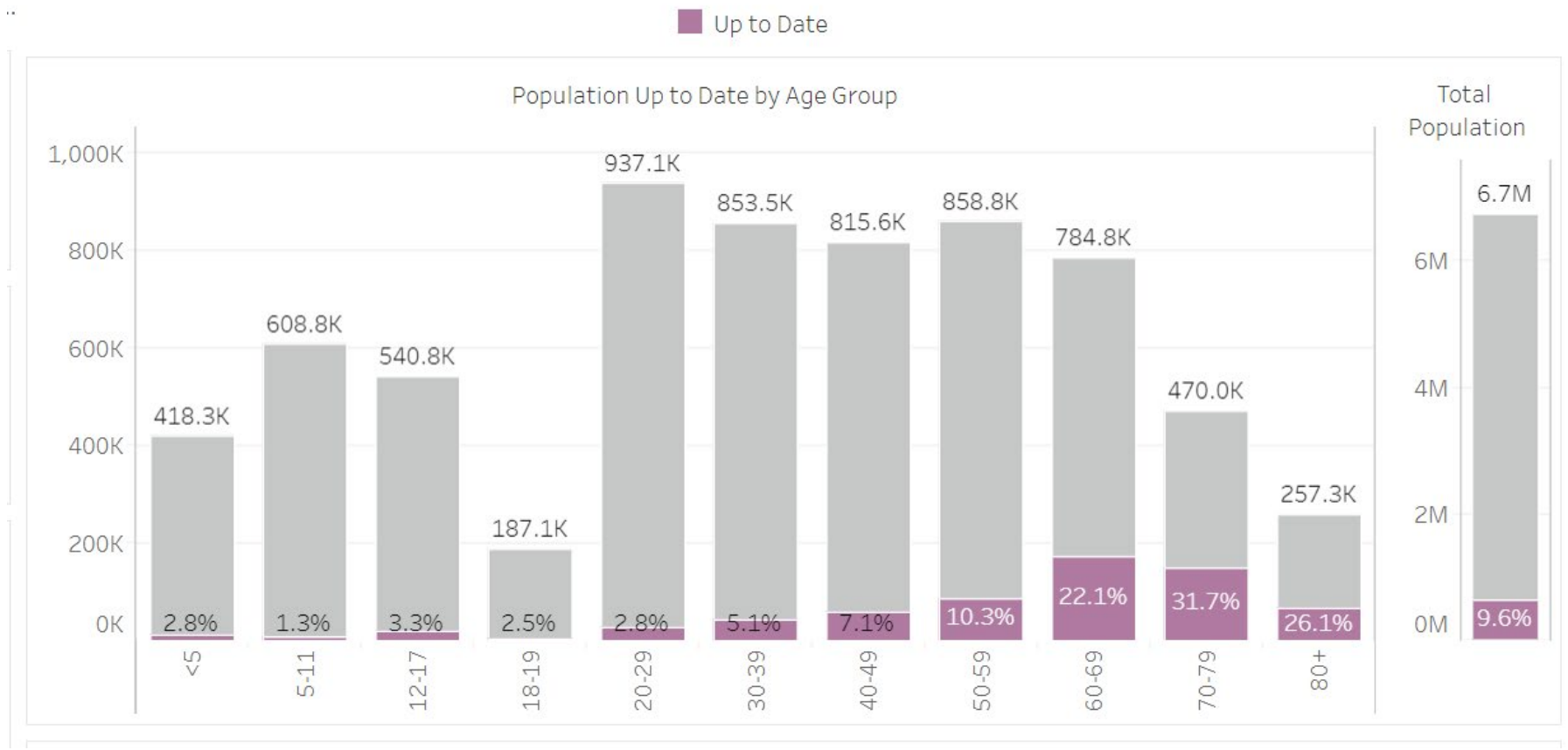
Novel Coronavirus (COVID-19): Vaccine Dashboard

# COVID-19 Vaccination status by age

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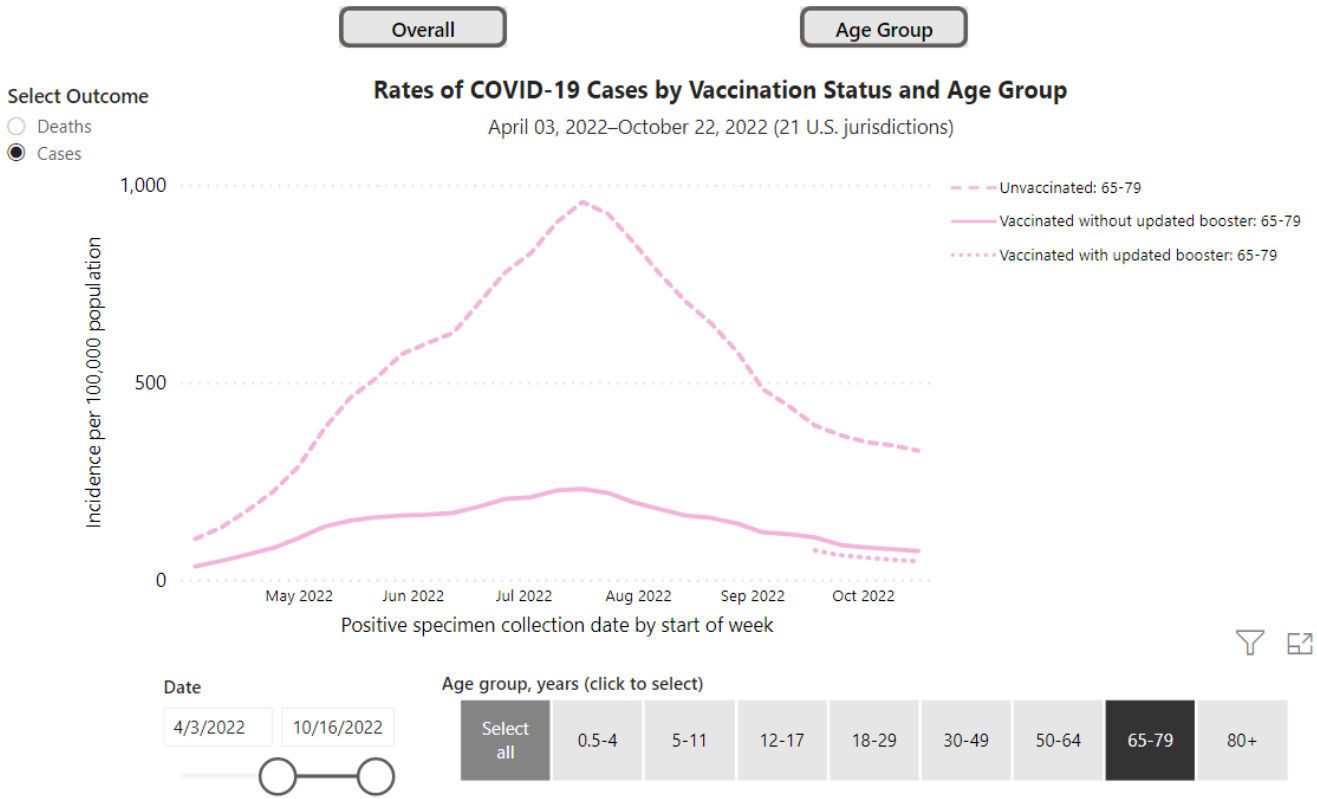
# Cases Ages 65-79 by vaccination status

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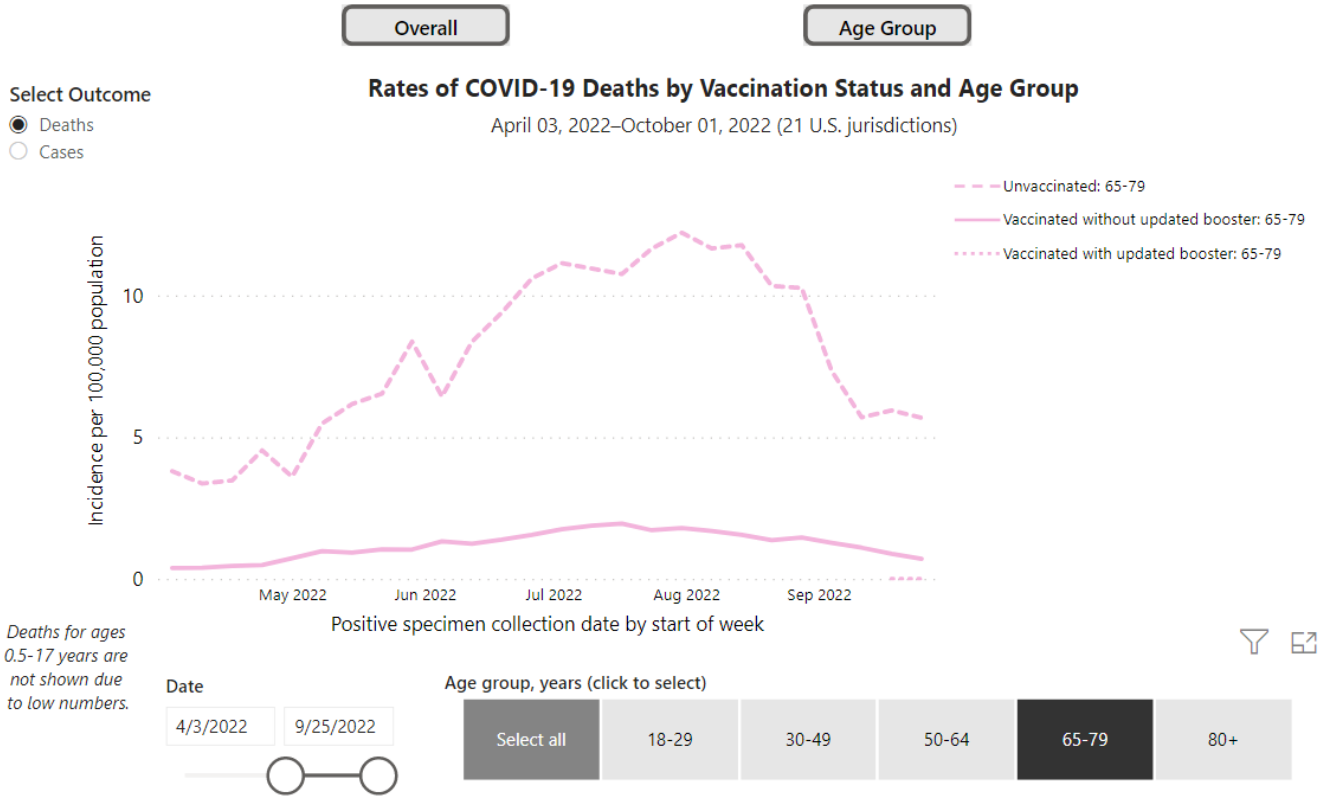
[CDC COVID Data Tracker: Rates of COVID-19 Cases and Deaths by Vaccination Status]

# Deaths Ages 65-79 by vaccination status

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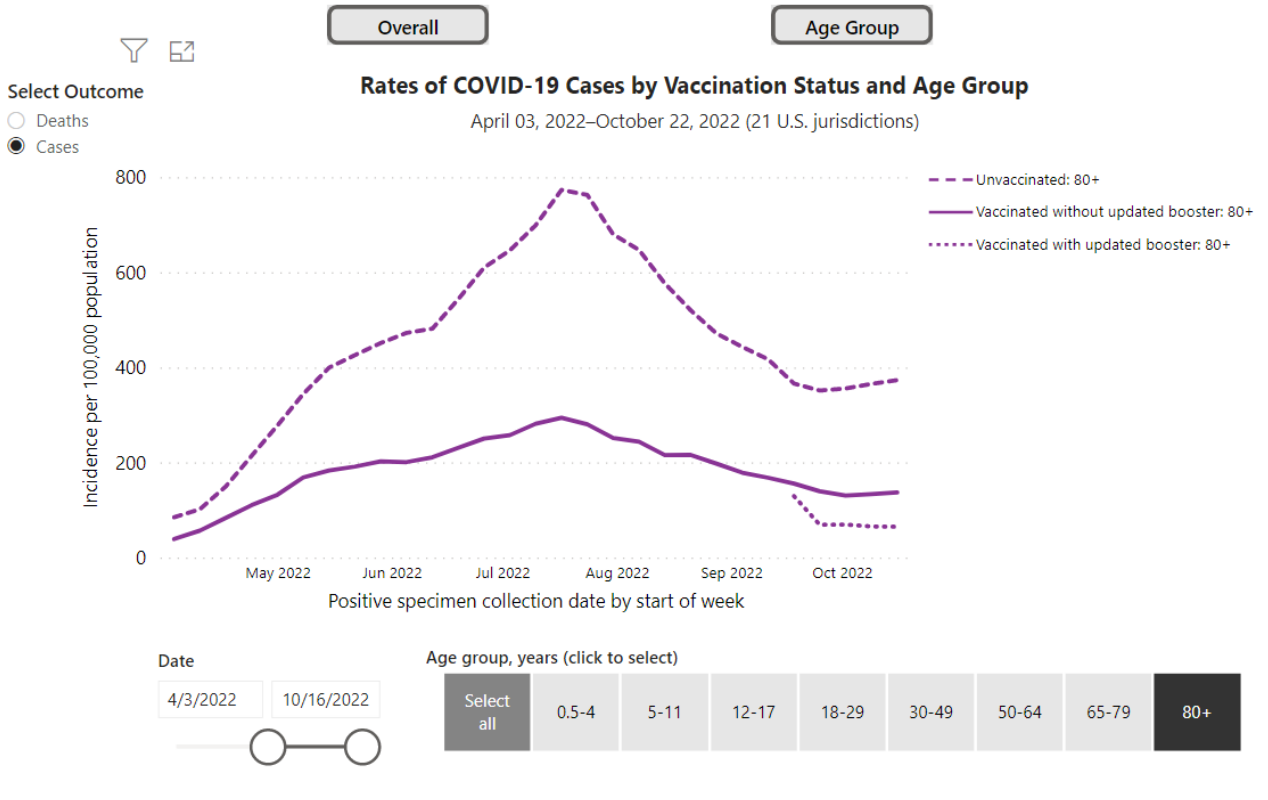
[CDC COVID Data Tracker: Rates of COVID-19 Cases and Deaths by Vaccination Status]

# Cases Ages 80+ by vaccination status

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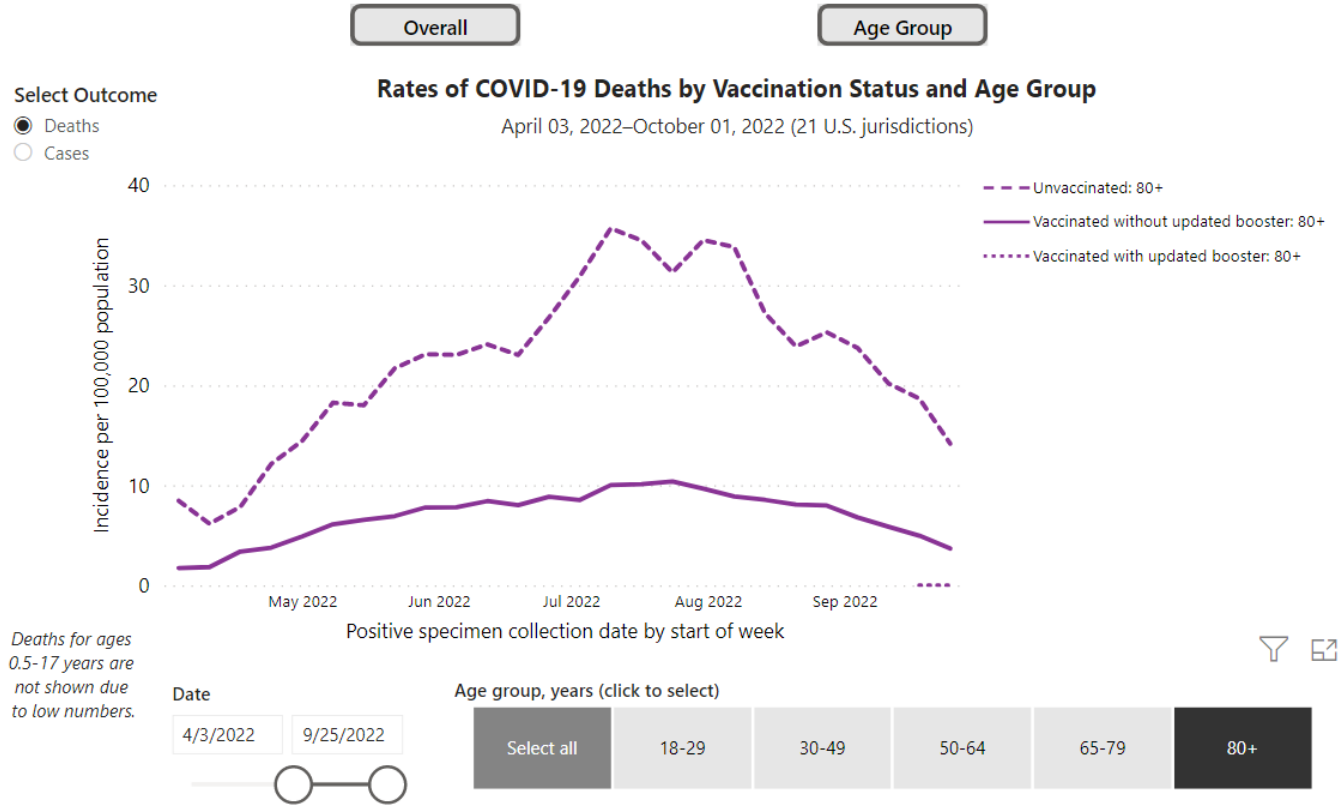
[CDC COVID Data Tracker: Rates of COVID-19 Cases and Deaths by Vaccination Status]

# Deaths Ages 80+ by vaccination status

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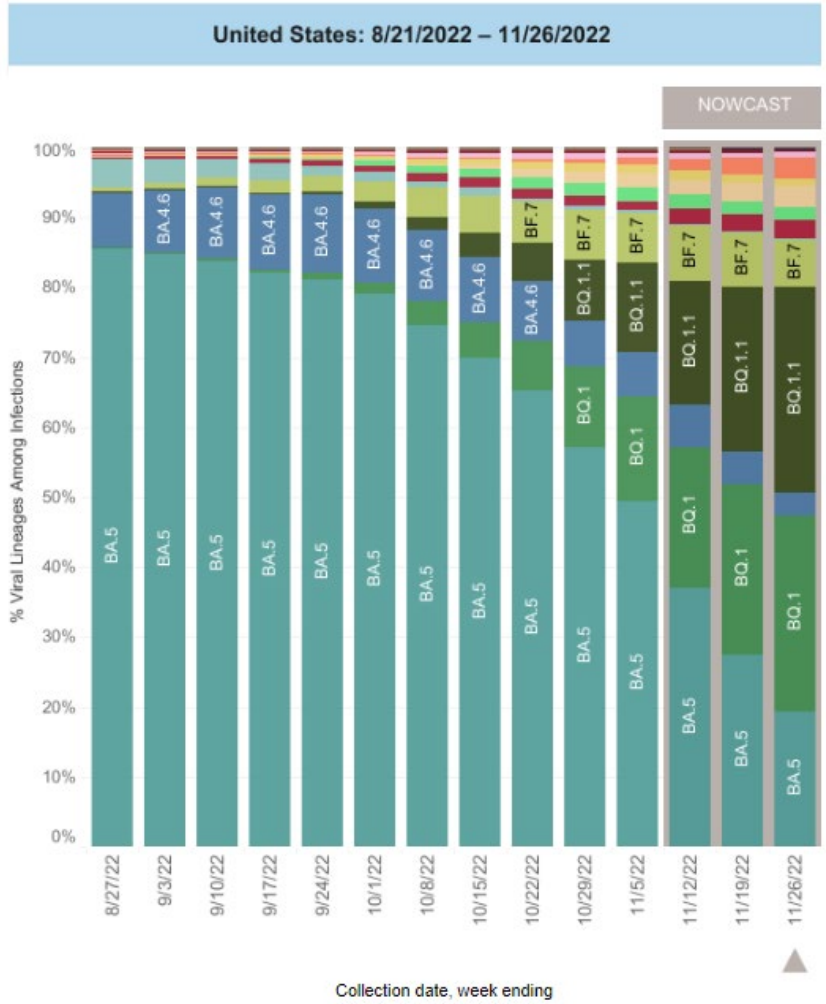
[CDC COVID Data Tracker: Rates of COVID-19 Cases and Deaths by Vaccination Status]

# Testing

- Use diagnostic testing to guide treatment and clinical management
- Molecular assays are recommended when testing for RSV, influenza, SARS-CoV-2, and other respiratory viruses in hospitalized patients with suspected respiratory virus infections, and multiplex respiratory testing should be considered since multiple respiratory viruses may cause severe illness.

# COVID-19 Variant Update

- Nowcast data from the Centers for Disease Control and Prevention published last week estimates that the combined proportion of COVID-19 cases caused by the Omicron BQ.1 and BQ.1.1 subvariants to be above 57% nationally, and already above 50% in all individual regions but one,
- Data show a sustained trend of increasing prevalence across all regions




**United States: 11/20/2022 – 11/26/2022 NOWCAST**

**USA**

| WHO label | Lineage # | US Class | %Total | 95%PI |
|---|---|---|---|---|
| Omicron | BQ.1.1 | VOC | 29.4% | 27.0-31.9% |
| | BQ.1 | VOC | 27.9% | 25.5-30.5% |
| | BA.5 | VOC | 19.4% | 17.1-21.9% |
| | BF.7 | VOC | 7.0% | 6.2-8.0% |
| | BA.4.6 | VOC | 3.3% | 2.9-3.8% |
| | XBB | VOC | 3.1% | 1.5-6.0% |
| | BN.1 | VOC | 2.9% | 2.3-3.8% |
| | BA.2.75 | VOC | 2.6% | 2.0-3.5% |
| | BA.5.2.6 | VOC | 1.8% | 1.5-2.2% |
| | BF.11 | VOC | 1.1% | 0.8-1.4% |
| | BA.2 | VOC | 0.8% | 0.5-1.1% |
| | BA.2.75.2 | VOC | 0.6% | 0.4-0.7% |
| | BA.4 | VOC | 0.0% | 0.0-0.1% |
| | 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% |

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.
** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates
# BA.1, BA.3 and their sublineages (except BA.1.1 and its sublineages) are aggregated with B.1.1.529. Except BA.2.12.1, BA.2.75, BA.2.75.2, BN.1,XBB and their sublineages, BA.2 sublineages are aggregated with BA.2. Except BA.4.6, sublineages of BA.4 are aggregated to BA.4. Except BF.7, BF.11, BA.5.2.6, BQ.1 and BQ.1.1, sublineages of BA.5 are aggregated to BA.5. For all the lineages listed in the above table, their sublineages are aggregated to the listed parental lineages respectively. Previously, XBB was aggregated with other. Lineages BA.2.75.2, XBB, BN.1, BA.4.6, BF.7, BF.11, BA.5.2.6 and BQ.1.1 contain the spike substitution R346T.

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https://covid.cdc.gov/covid-data-tracker/#variant-proportions

# Preventive and Therapeutic Options against Subvariants

- Paxlovid and Remdesivir are the preferred treatment in the eligible groups and are expected to be active against these subvariants. Molnupiravir also is expected to be active against these subvariants and can be considered if unable to use the former two.
- **The U.S. Food and Drug Administration announced this week that bebtelovimab is not currently authorized for emergency use because it is not expected to neutralize Omicron subvariants BQ.1 and BQ.1.1**., according to data included in the Health Care Provider Fact Sheet. Eli Lilly and its authorized distributors have paused commercial distribution of bebtelovimab.
- The subvariants BA.4.6, BA.2.75.2, BF.7, BQ.1, and BQ.1.1 are likely to be resistant to tixagevimab plus cilgavimab (Evusheld). The anticipated loss of susceptibility is based on knowledge about amino acid mutations that confer antibody resistance and on available data from *in vitro* neutralization studies.



Statement on Omicron Subvariants | COVID-19 Treatment Guidelines (nih.gov)

# Your health matters and depends on your actions

- Influenza is on the rise, and COVID-19 and RSV are still in circulation
- Not one measure alone will be enough
- Take the whole picture into consideration
- Host factors, hand hygiene, ventilation, size of the crowds, infection control practices that each person in the crowd is following, vaccinations, masking, distancing, and treatments all matter
- Dynamic state, so our actions should correspond


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# Questions?

## CONTACT:

**Shireesha Vuppalanchi, MD**
Medical Director
Indiana Department of Health
svuppalanchi@isdh.in.gov

Indiana Department of Health

# LONG TERM CARE ABUSE AND INCIDENT REPORTING POLICY REVISIONS

**BRENDA BUROKER, RN**
DIVISION DIRECTOR, LONG-TERM CARE

12/08/2022

## 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.

# Long-Term Care Abuse and Incident Reporting Policy

IDOH incident reporting policy was revised to reflect updated federal regulations and state rules in 2022.

Title: Indiana Department of Health Long-Term Care Abuse and Incident Reporting Policy

- Replaces: Long-Term Care Incident Reporting Policy, revised 06/07/2022
- Can be accessed via IDOH Incident Reporting by Long Term Care Facilities website: https://www.in.gov/health/long-term-carenursing-homes/incident-reporting-by-long-term-care-facilities/

# Definitions

Definitions apply to comprehensive care facilities and/or licensed residential facilities.

**"Abuse**: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse means any physical or mental injury or sexual assault inflicted on a resident in the facility, other than by accidental means."

- This would include any incident described in the above definition and described within:

| 483.12 | Freedom from Abuse, Neglect, and Exploitation |
|---|---|
| F600 | *Free from Abuse and Neglect |
| F602 | *Free from Misappropriation/Exploitation |
| F603 | *Free from Involuntary Seclusion |
| F604 | *Right to be Free from Physical Restraints |
| F605 | *Right to be Free from Chemical Restraints |

# Definitions

**“Alleged violation**: Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or other health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. “

- The allegation does not have to be proven
- The investigation does not need to be complete
- Reporting is indicated if the facility becomes aware of an allegation

# Definitions

"**Elopement**: Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so OR a resident with decision making capacity leaves the premises or a safe area, without facility knowledge, and **does not return as per the resident plan of care or service plan, related to leaving the facility**."

- If the resident with decision making capacity leaves the facility, per the plan of care or service plan, it is NOT considered an elopement.

# Definitions

**Injuries of unknown source**: An injury should be classified as an "injury of unknown source" when **all** the following criteria are met:

a. The source of the injury was not observed by any person
b. The source of the injury could not be explained by the resident or clinical condition
c. The injury is suspicious because of:
   i. The extent of the injury, or
   ii. The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or
   iii. The number of injuries observed at one particular point in time, or
   iv. The incidence of injuries over time

# Instructions for Submitting an Incident Report

Incident reports are to be submitted online via the IDOH Gateway: https://gateway.isdh.in.gov/Gateway/SignIn.aspx

- Incident Reporting Forms may be submitted via email or telephone **ONLY** when the IDOH Gateway online system is nonoperational.

# Instructions for Submitting an Incident Report

Initial report should include:

- Facility name and contact information
- Name and job title of staff completing the report
- Actual or identified date and time of the incident
- Name(s) of resident(s) involved
- Name and title of staff involved
- Brief description of event
- Type of injury(s) sustained
- Immediate action taken to respond to the event and protect the resident
- Preventive measures taken while the investigation is in process

# Instructions for Submitting an Incident Report

- Follow-up report should include:
  - Results of the investigation
  - Interventions implemented or corrective action taken
  - Method in which facility will continue to monitor efficacy of plan/interventions
  - Other persons or agencies to which the incident was reported
- Follow-up reports should be submitted within 5 days
- Initial and follow-up report can be submitted together if **all necessary information** has been obtained within the timeframe for initial reporting

# Incidents Excluded from Reporting Requirement

Not required to report includes, but is not limited to:

- Non-targeted outbursts
- Residents with certain conditions (e.g., Huntington's/Tourette's) who exhibit verbalizations
- Physical contact as a result of accidental or spontaneous body movement
- Arguments or disagreements, which do not include any bullying, aggressive, threatening, humiliating, etc. behavior or communication
- Consensual sexual contact between residents who have the capacity to consent to sexual activity

# Incidents Excluded from Reporting Requirement

Not required to report includes, but is not limited to (continued):

- Affectionate contact such as hand holding or hugging or kissing a resident who indicates that he/she consents to the action through verbal or non-verbal cues
- Sexual activity between residents in a relationship, married couples or partners, unless one of the residents indicates that the activity is unwanted through verbal or non-verbal cues.
- Bruising in an area where the resident has had recent medical tests/lab draws and there is no indication of abuse or neglect
- Injuries where the resident was able to explain or describe how he/she received the injury as long as there is no other indication of abuse or neglect
- Injuries that were witnessed by staff, where there is no indication of abuse or neglect

# Comprehensive Care Facilities – SNF/NF

Federal regulation at §483.12(c):

"In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.",

# Comprehensive Care Facilities – SNF/NF

State Rules

410 AIC 16.2-3.1-13 Administration and management:

"…Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:

(A) epidemic outbreaks;
(B) poisonings;
(C) fires; or
(D) major accidents …"

410 IAC 16.2-3.1-28 Staff treatment of residents:

"… (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. (e) The results of all investigations must be reported to the administrator or the administrator's designated representative and to other officials in accordance with state law (including to the department) within five (5) working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken."

# Licensed Residential Facilities

State Rules

410 IAC 16.2-5-1.3 Administration and management:

…(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:

(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:

(A) epidemic outbreaks;
(B) poisonings;
(C) fires; or
(D) major accidents.

If the division cannot be reached, a call shall be made to the emergency telephone number published by the division."

# Summary

- Definitions apply to all licensed comprehensive care facilities and/or licensed residential facilities
- Incidents for all licensed providers must be reported through the IDOH Gateway
- Reporting time frames
  - Comprehensive Care Facilities:
    - Incidents involving abuse, neglect, exploitation, mistreatment, or serious bodily injury = immediately, but not later than two hours after the allegation is made
    - Incidents not involving abuse or result in serious bodily injury = not later than 24 hours after the allegation is made
    - Follow-up report submitted within 5 days of the incident
  - Licensed Residential Facilities
    - An incident that directly threatens the welfare, safety, or health of a resident = within twenty-four (24) hours of becoming aware of an occurrence
    - Follow-up report submitted within 5 days of the incident

# Questions?

**Christina Samuels, RN BSN PHNS RAC-CT, LTC**
**Rules and Regulation: csamuels@health.in.gov**

**Tammy Alley, RN Deputy Director Survey**
**Management: talley@health.in.gov**

**Brenda Buroker, RN, Division of Long-Term Care**
**Director: bburoker@health.in.gov**

# Contact Information

Lori Davenport – IHCA/INCAL Clinical/Regulatory
- ldavenport@ihca.org
- 765-516-0148

Amy Kent – Assistant Commissioner, IDH
- amkent1@isdh.in.gov
- 317-233-7289

Brenda Buroker– Dir. Of LTC, IDH
- bburoker@health.IN.gov
- 317-234-7340

Paul Krievins
- pkrievins@isdh.in.gov

Kelly White – Reporting, IDH
- kewhite@isdh.in.gov

Tammy Alley – Vaccine Questions, Surveys IDH
- talley@health.in.gov
- 317-223-7441

Randy Synder – Vaccine Questions, IDH
- rsnyder1@isdh.in.gov

Russell Evans
- russ@probarisystems.com
- outreach@probarisystems.com
- 317-804-4102

Paul Peaper – IHCA/INCAL President
- ppeaper@ihca.org

Dr. Shireesha Vuppalanchi – Clinical, IDH
- svuppalanchi@health.in.gov

Brenda Buroker – Survey, IDH
- bburoker@isdh.in.gov
- 317-234-7340

Jan Kulik
- jkulik@isdh.in.gov
- 317-233-7480

Peter Krombach
- pkrombach2@isdh.in.gov

Michelle Donner
- midonner@isdh.in.gov

Pam Pontones – CDC Guidance, IDH
- ppontones@isdh.IN.gov
- 317-233-8400

Kara Dawson – NHSN
- kdawson@qsource.org
- 317-628-1145 OR contact:
- Angeleta Hendrickson - ahendrickson@qsource.org
- Teresa Hostettler - thostettler@qsource.org

Deeksha Kapoor – IHCA/INCAL Communications/PR
- dkapoor@ihca.org

Rob Jones – IDH Gateway Assistance
- rjones@isdh.in.gov

David McCormick
- DMcCormick@isdh.IN.gov

Dr. Lindsey Weaver
- lweaver@isdh.in.gov

**Langham Customer Service**
- 866-926-3420
- Covidsupport@elangham.com

Deanna Paddack – Infection Prevention, IDH
- dpaddack@isdh.in.gov
- 317-464-7710

Dave McCormick – Immunization Division, IDH
- DMcCormick@isdh.IN.gov

Jennifer Spivey – Infection Control, IDH
JSpivey1@isdh.IN.gov
317-232-0639
317-471-7844 cell

Christina Samuels – Rules & Regs, IDH
csamuels@health.in.gov
317-233-7067

# THANK YOU!

Indiana Department of Health