IHCA INCAL

Regulatory Roundup

Weekly Webinar for Long-Term Care Professionals

IHCA.org/regulatory-roundup

PRESENTERS

Lori Davenport
Indiana Health Care Association

Team Members from
Indiana Department of Health

August 24, 2023

Upcoming Education Offerings

- Sept. 26, Webinar – Meaningful Meetings, details HERE
- Sept. 28-29, In-person – Assisted Living Symposium, details HERE
- Oct. 17, In-person and Virtual option – Indiana Department of Health Conference, details HERE
- Oct. 24, Webinar – Steering Survey Success, details HERE

IHCA
INCAL

Assisted Living Symposium

SEPTEMBER 28-29, 2023

8:30 a.m. - 4:30 p.m.

REGISTER TODAY

www.IHCA.org

SCAN QR CODE TO REGISTER

IHCA INCAL

Today's Agenda

- Getting Ready for October 1, 2023 – Optional State Assessment (OSA) – Deborah Lake, Senior Managing Consultant – FORVIS
- COVID-19 LTC Guidance Refresher – Dr. Vuppalanchi, Medical Director – IDOH
- Q&A

THERE IS NO MEETING ON AUGUST 31

Optional State Assessment (OSA)

Deborah Lake, RN, RAC-CTA / August 24, 2023

forvis.com

FORVIS

Assurance / Tax / Advisory

Optional State Assessment (OSA)

- Agenda
- Need for completion
- Components of the OSA
- Completion requirements
- Effect on delinquent days
- Additional information
- Getting ready

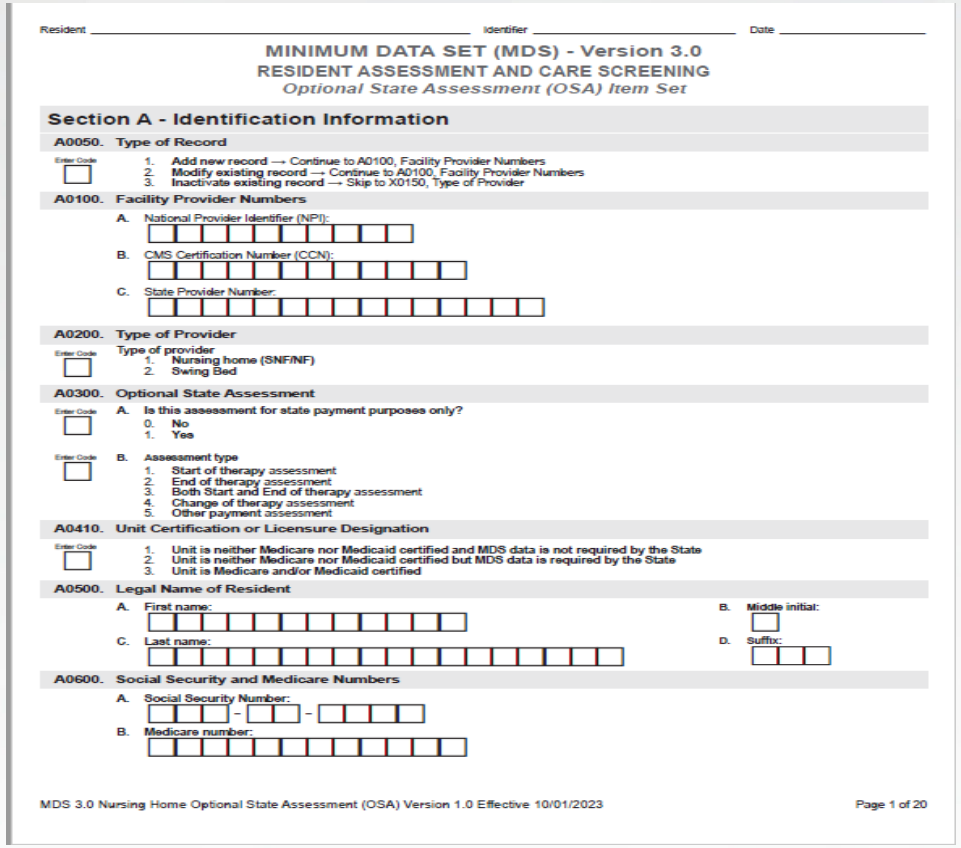
Optional State Assessment (OSA)

- Why????
- Effective October 1, 2023 Section G and OSA assessment option will be removed from the MDS 3.0
  - RUGS III or RUGS IV will no longer be supported
- States wishing to maintain their RUGS-based system beyond October 1, 2023 will be required to utilize the OSA with each federally required MDS assessment
- Family and Social Services Administration (FSSA) Memo of April 27, 2023
  - Posted on Myers and Stauffer website under Announcements
  - Indiana Office of Medicaid Policy and Planning (OMPP)
  - Indiana will require the completion of a concurrent OSA with each federal required assessment submitted

FORVIS

Optional State Assessment (OSA)

- Optional State Assessment Item Set and Manual
- Released April 24, 2023
- Final Versions released on August 15, 2023
- 20 pages
- State-required assessment



Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Optional State Assessment (OSA) Item Set

Section A - Identification Information

A0050. Type of Record

Enter Code ☐
1. Add new record → Continue to A0100, Facility Provider Numbers
2. Modify existing record → Continue to A0100, Facility Provider Numbers
3. Inactivate existing record → Skip to X0150, Type of Provider

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐

C. State Provider Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0200. Type of Provider

Enter Code ☐ Type of provider
1. Nursing home (SNF/NF)
2. Swing Bed

A0300. Optional State Assessment

Enter Code ☐ A. Is this assessment for state payment purposes only?
0. No
1. Yes

Enter Code ☐ B. Assessment type
1. Start of therapy assessment
2. End of therapy assessment
3. Both Start and End of therapy assessment
4. Change of therapy assessment
5. Other payment assessment

A0410. Unit Certification or Licensure Designation

Enter Code ☐
1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified

A0500. Legal Name of Resident

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐ B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

A. Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

B. Medicare number: ☐☐☐☐☐☐☐☐☐☐

MDS 3.0 Nursing Home Optional State Assessment (OSA) Version 1.0 Effective 10/01/2023 Page 1 of 20

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

FORVIS

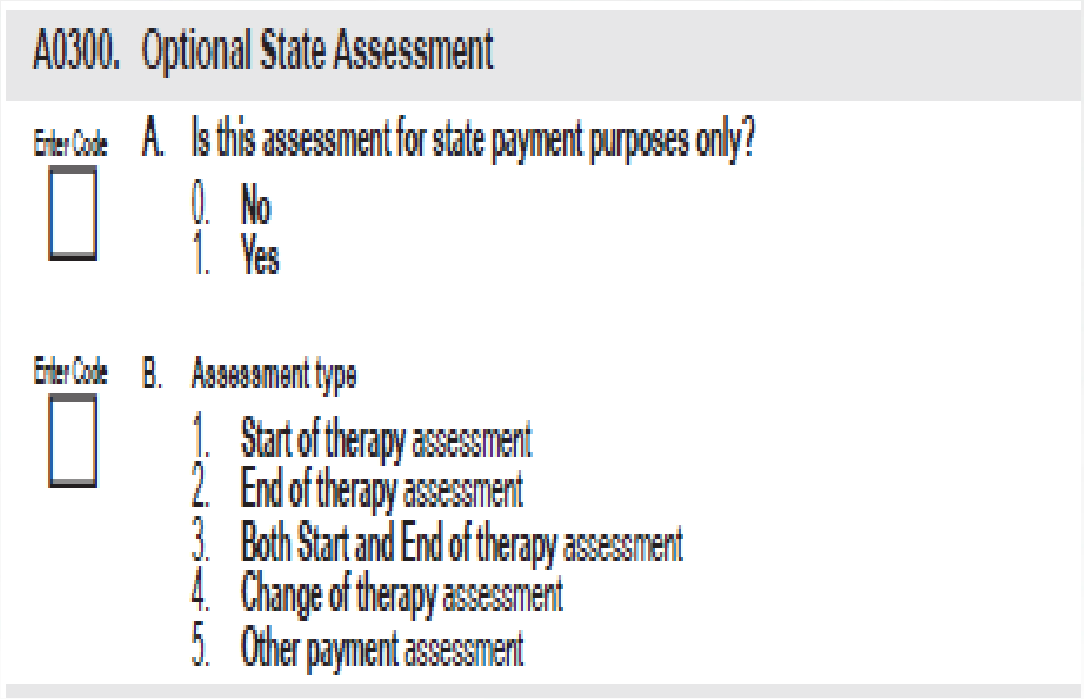
Optional State Assessment

- About the OSA
- Only assessment that will include all MDS data elements required for Resource Utilization Group (RUG) classifications
  - Several items that have been removed/changed for the October 1 items sets remain on the OSA
  - A0300, D0200, D0300, G0110, K0510, O0100, etc.
- Stand-alone assessment
  - Cannot be combined with any other assessment
  - Completed in conjunction (using the same assessment reference date) with federally required assessments

FORVIS

Optional State Assessment

- A0300 Optional State Assessment
- A0300B will be coded as “5” (Other Payment Assessment)



A0300. Optional State Assessment

Enter Code

A. Is this assessment for state payment purposes only?

0. No
1. Yes

Enter Code

B. Assessment type

1. Start of therapy assessment
2. End of therapy assessment
3. Both Start and End of therapy assessment
4. Change of therapy assessment
5. Other payment assessment

Optional Payment Assessment

- Section B

Section B - Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

0. **No** → Continue to B0700, Makes Self Understood
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression

0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

FORVIS

Optional Payment Assessment

- Section C
- BIMS interview plus 2 questions for staff assessment

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

FORVIS

Optional State Assessment

- Section D
- Mood interviews will be the PHQ-9 and PHQ-9-OV

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐

FORVIS

Optional State Assessment

- Section E
- Presence of behaviors only – no items for effect of behaviors

Section E - Behavior

E0100. Potential Indicators of Psychosis

Check all that apply

- ☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ Z. **None of the above**

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Enter Code ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)

Enter Code ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)

Enter Code ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0800. Rejection of Care - Presence & Frequency

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

Enter Code ☐

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence & Frequency

Has the resident wandered?

Enter Code ☐

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

FORVIS

Optional State Assessment

- Section G

• 4 late-loss ADLs only

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

		1. Self-Performance	2. Support
		↓ Enter Codes in Boxes ↓	
A.	**Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B.	**Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
H.	**Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I.	**Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐

FORVIS

Optional State Assessment

- Section H
- Bowel and/or bladder training programs only

Section H - Bladder and Bowel

H0200. Urinary Toileting Program

Enter Code ☐

C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. No
1. Yes

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

0. No
1. Yes

FORVIS

Optional State Assessment

- Section I
- Includes only diagnoses that calculate into a RUG category

Section I - Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Infections		
☐	I2000.	**Pneumonia**
☐	I2100.	**Septicemia**
Metabolic		
☐	I2900.	**Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
Neurological		
☐	I4300.	**Aphasia**
☐	I4400.	**Cerebral Palsy**
☐	I4900.	**Hemiplegia or Hemiparesis**
☐	I5100.	**Quadriplegia**
☐	I5200.	**Multiple Sclerosis (MS)**
☐	I5300.	**Parkinson's Disease**
Pulmonary		
☐	I6200.	**Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
☐	I6300.	**Respiratory Failure**
None of Above		
☐	I7900.	**None of the above active diagnoses** within the last 7 days

Optional State Assessment

- Section J
- Shortness of breath and Problem Conditions only

Section J - Health Conditions	
Other Health Conditions	
J1100. Shortness of Breath (dyspnea)	
↓	Check all that apply
☐	C. **Shortness of breath** or trouble breathing **when lying flat**
☐	Z. None of the above
J1550. Problem Conditions	
↓	Check all that apply
☐	A. Fever
☐	B. Vomiting
☐	C. Dehydrated
☐	D. Internal bleeding
☐	Z. None of the above

FORVIS

Optional State Assessment

- Section K
- Weight loss and parenteral/IV

Section K - Swallowing/Nutritional Status

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last **7 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐
Z. **None of the above**	☐	☐

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

3. **During Entire 7 Days**
   Performed during the entire ***last 7 days***

	3. During Entire 7 Days
A. **Proportion of total calories the resident received through parenteral or tube feeding** 1. 25% or less 2. 26-50% 3. 51% or more	Enter Code ☐
B. **Average fluid intake per day by IV or tube feeding** 1. 500 cc/day or less 2. 501 cc/day or more	Enter Code ☐

Optional State Assessment

- Section M
- Collection of information on skin conditions and associated treatments
  - Pressure ulcers
  - Venous/arterial ulcers
  - Infection of the foot
  - Diabetic foot ulcers
  - Open lesions of the foot
  - Open lesions other than ulcers, rashes, cuts
  - Surgical wounds
  - Burns

FORVIS

Optional State Assessment

- Section N
- Collection of number of injections and insulin injections/orders

Section N - Medications

N0300. Injections

Enter Days ☐ **Record the number of days that injections of any type** were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to O0100, Special Treatments, Procedures, and Programs

N0350. Insulin

Enter Days ☐ A. **Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days

Enter Days ☐ B. **Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days

FORVIS

Optional State Assessment

- Section O
- Collection of special treatments, therapy and restorative services

Section O - Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident.**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. **Chemotherapy**	☐	☐
B. **Radiation**	☐	☐
Respiratory Treatments		
C. **Oxygen therapy**	☐	☐
D. **Suctioning**	☐	☐
E. **Tracheostomy care**	☐	☐
F. **Invasive Mechanical Ventilator** (ventilator or respirator)	☐	☐
Other		
H. **IV medications**	☐	☐
I. **Transfusions**	☐	☐
J. **Dialysis**	☐	☐
M. **Isolation or quarantine for active infectious disease** (does not include standard body/fluid precautions)	[redacted]	☐
None of the above		
Z. **None of the above**	☐	☐

Optional State Assessment

- When to complete:
- With any federally required assessment with an assessment date (ARD) of 10-1-23 and beyond until further notice
- Concurrently with each federally required OBRA (regardless of payer source) and PPS Assessment
  - 5-day
  - Admission
  - Annual
  - Significant Change in Status
  - Quarterly
  - Significant Corrections

FORVIS

Optional State Assessment

- Not required with:
- Interim Payment Assessment (IPA)
- Stand-alone Part A PPS Discharge
- OBRA Discharge assessment
  - Unless combined with another OBRA or PPS assessment
- Assessments completed for insurance/managed care

FORVIS

Optional State Assessment

- Determination of delinquent assessments effective October 1, 2023
- Any assessment record with an ARD (A2300) greater than 113 calendar days from the previous ARD will be deemed delinquent
- A federally required MDS record without a concurrent OSA will be deemed delinquent for all days assigned to the record (beginning on the ARD, Entry date, Quarter start date, etc.)
- Delinquent assessments with a Medicare or Other payer source determination will be assigned a CMI value equal to the highest case mix index
  - (ES3 = 3.00)

FORVIS

Optional State Assessment

- Determination of Delinquent Assessments:

- Delinquent assessments with a Medicaid payer source determination will be assigned a RUG code and the associated case mix index of BC2 or BC2 low needs as occurs today
  - BC2 = 0.43

- OSA record submissions with an ARD that does not match a federally required assessment will be excluded from MDS processing and case-mix calculation, which may result in delinquent determinations

FORVIS

Optional State Assessment

- Additional Information:
- Myers and Stauffer audits will only be done on OSA assessments submitted by providers
  - Updated Time-Weighted User's Guide and Supportive Documentation Requirements expected to be released for October 1, 2023
- OSA assessments are to be submitted thru the iQIES system
- Quality measures will not be obtained from MDS items on the OSA

Optional State Assessment

- Looking ahead to October 1
- MDS staffing
  - Time commitment
  - Scheduling
- Documentation
  - 4 late loss ADLs
  - Section GG items
- Software
  - OSA compatibility
  - Possible streamlining of data input

FORVIS

Thank you!

Deborah.lake@forvis.com

forvis.com

FORVIS

Assurance / Tax / Advisory

Indiana Department of Health

COVID-19 LTC GUIDANCE REFRESHER

SHIREESHA VUPPALANCHI, M.D.
MEDICAL DIRECTOR

08/24/2023

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.

COVID-19 Definitions

- Close contact is generally defined as being within 6 feet for at least 15 minutes (cumulative over a 24-hour period)
  - However, it depends on the exposure level and setting; for example, in the setting of an aerosol-generating procedure (AGP) in healthcare settings without proper personal protective equipment (PPE), this may be defined as any duration
- High Risk Exposure: Health care personnel (HCP) who had prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and:
  - HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)
  - HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
  - HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

Guidance

- This guidance applies to all U.S. settings where healthcare is delivered (including nursing homes, licensed residential facilities and home health)
- Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses
- Ensure everyone is aware of recommended infection control practices in the facility
- Testing at admission/ empiric TBP for admissions is at the discretion of the facility
- Avoid testing if someone was confirmed COVID-19 positive within the last 30 days as it can be difficult to interpret the result
- Recommend to use an antigen test for those with COVID-19 in the last 31-90 days instead of PCR

Guiding principles

- Isolation, testing, infection control recommendations are irrespective of vaccination status
- Individuals with COVID-19 can transmit the virus starting two days prior to positive test (if asymptomatic), or onset of symptoms (if symptomatic) and during the period of isolation
- How to count duration of isolation: Day of positive test if asymptomatic or onset of symptoms is day zero. Day 1 is the next day after this.
    - Close contacts include those with exposure 48 hours before the positive test/onset of symptoms apart from while in isolation

Infection control principles

- Must use source control if a person is symptomatic, has been a close contact, or has suspected/ confirmed COVID-19 infection
  - Allow the option to use a mask if someone wants to exercise extra caution, based on their perceived level of risk for infection due to their recent activities/ their potential for developing severe disease if exposed or according to additional criteria set by the facility (examples: outbreak, lot of cases in your area, based on the risk for the people you serve)
- Optimize the use of engineering controls and indoor air quality
- Hand hygiene, proper PPE based on symptoms, diagnosis
- Proper environmental cleaning

Broader use of source control may be considered

- By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days)
- Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission
- Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high)

Consideration for use of N95 masks

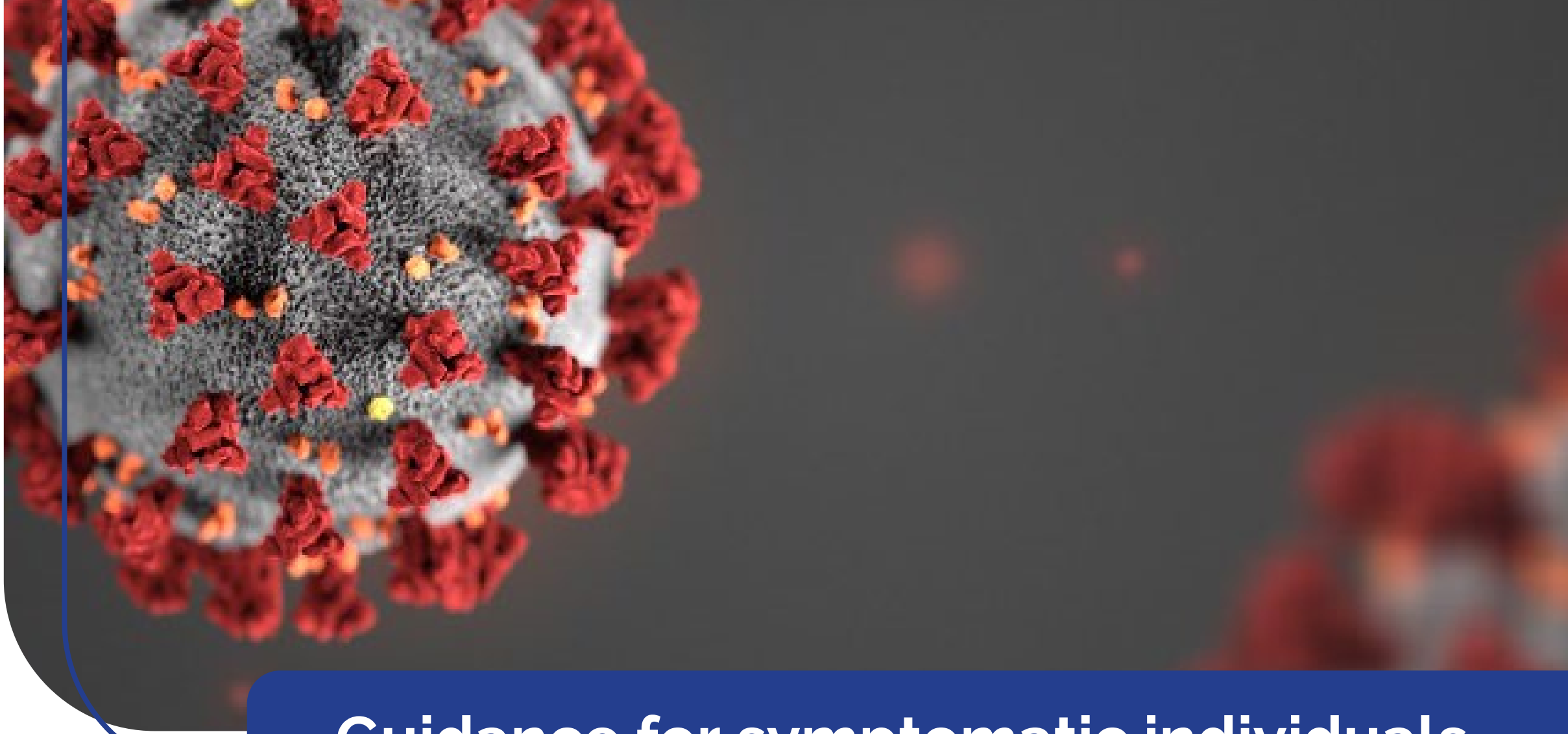
- If increasing case trends, consider N95 use by HCP for all aerosol generating procedures (AGP) as the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases
- If increasing case trends, N 95 masks can also be used by HCP when the patient is unable to use source control and the area is poorly ventilated.
- They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place.
- To simplify implementation, facilities in counties with higher levels of SARS-CoV-2 transmission may consider implementing universal use of NIOSH Approved particulate respirators with N95 filters or higher for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.

Screening

- Place visual alert with infection control principles at each entrance and throughout the facility
- Have a process in place for passive screening by everyone entering the building asking whether they have
  - Confirmed COVID-19 and are under isolation
  - Symptoms of COVID-19
  - Close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP)
- Instruct HCP to report any of the 3 above criteria to occupational health or another point of contact designated by the facility so these HCP can be properly managed

Screening

- Visitors with confirmed SARS-CoV-2 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation: this time period is longer than what is recommended in the community
- For visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact



Guidance for symptomatic individuals, confirmed COVID-19, or close contact

Indiana Department of Health

Symptomatic Individuals

- TBP/ work restriction
- Test even if mild symptoms
- One PCR should suffice. If first one came negative, can consider a second PCR if high suspicion for COVID-19. If using antigen test, if first test is negative, repeat the test 48 hours later.
- Test for other infections if it is not COVID-19
- Follow isolation/ work restriction based on the diagnosis
- Cover cough if not restricted from work based on the above testing

Confirmed COVID-19: Resident

- Place in single room or cohort with another confirmed COVID-19 case if needed
- Avoid AGP if possible
- TBP for:
  - 10 days if asymptomatic, mild or moderate illness and not an immunocompromised individual (and improving symptoms, fever free without fever reducing meds for 24 hours)
  - 10-20 days if severe illness, hospitalized for COVID-19 or immunocompromised
  - Immunocompromised ones may need a test-based strategy to come out of isolation (may need specialist consultation)
- Can go out of room for medical reasons only
- Avoid visitation during the isolation period if possible
  - Provide alternate options to in person visitation (such as tablets)
  - If in person visitation is happening, inform IP principles to the visitor and minimize time spent in the room

Confirmed COVID-19: Staff

Restrict from work

- For 10 days if asymptomatic, or mild to moderate illness. Return at that time if improving symptoms, and fever free without fever reducing meds for 24 hours
    - Mild to moderate cases (if improving and fever free without fever reducing meds), asymptomatic ones may return after 7 days with a negative test within 48 hours prior to return to work. If that test is positive, complete the ten-day period before returning to work.
- For 10-20 days if hospitalized for COVID-19, or severe illness or immunocompromised
- May need test-based strategy to return to work if immunocompromised (consider specialist consultation)

Close contacts or high-risk exposure

- Monitor for symptoms
- Test on days 1, 3 and 5 after a close contact or a high-risk exposure
- Mask when out of the room (residents), when at the facility (staff)
- TBP or work restriction following close contact may be considered if:
  (for 7 days with negative test, or 10 days without a negative test)
  - Resident/staff is unable to be tested or wear source control as recommended for the 10 days following their exposure
  - Resident/staff is moderately to severely immunocompromised
  - Resident is residing (or staff is providing care) on a unit with others who are moderately to severely immunocompromised
  - Resident is residing (or staff is providing care) on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Outbreak

- Any single staff or resident case is considered an outbreak
- Perform testing based on contact tracing: Test on days 1,3 and 5. Watch for symptoms and close contacts should mask when out of the room for 10 days.
  - If additional cases are identified, contact trace again and follow above instructions
  - If continuing to find new cases each time resort to broad based testing. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
    - If antigen testing is used, more frequent testing (every 3 days), should be considered.
- If unable to contact trace, perform broad based testing (unit, wing or entire building): Test on days 1, 3 and 5
- If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated

If continuing transmission

In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of empiric use of transmission-based precautions for residents and work restriction of HCP with higher-risk exposures.

Aerosol Generating Proced

Indiana Department of Health

Aerosol Generating Procedures

- Some procedures performed on patients are more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking or breathing
- These aerosol generating procedures (AGPs) potentially put healthcare personnel and others at an increased risk for pathogen exposure and infection
- There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for healthcare settings

Aerosol Generating Procedures

Commonly performed medical procedures that are often considered AGPs, or that might create uncontrolled respiratory secretions, include:

- open suctioning of airways
- sputum induction
- cardiopulmonary resuscitation
- endotracheal intubation and extubation
- non-invasive ventilation (e.g., BiPAP, CPAP)
- bronchoscopy
- manual ventilation

It is uncertain whether aerosols generated from some procedures may be infectious, such as:

- nebulizer administration*
- high flow O2 delivery

*Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.

AGP guidance (including for nebulized treatments)

- If not symptomatic, not a close contact, and not a suspected/ confirmed COVID-19, perform AGP with standard precautions.
- If suspected/ confirmed COVID-19, avoid AGP if possible. If performed, ensure TBP are in place, and minimize the number of people in the room.
- If symptomatic, avoid AGP if possible. TBP if performed and minimize the number of people in the room.
- If a close contact and needs AGP, perform with TBP. Allow one hour time for air exchange. If anyone going into the room within that one hour, wear TBP.

Reporting

Indiana Department of Health

Division of Long Term Care

COVID-19 Long-term Care Reporting Summary

Event	Where and when to report		
	Certified SNF/NF	RCF (Licensed AL)	Assisted Living (Unlicensed)
NEW **Positive COVID-19 — test either by PCR or POC: Resident cases only**	Long-term Care Gateway Application/ Within 24 hours of the result if the number of cases meets the outbreak reporting threshold*	Long-term Care Gateway Application/ Within 24 hours of the result if the number of cases meets the outbreak reporting threshold*	N/A
Positive COVID-19 Point-of-Care test **– Staff or Resident**	NHSN Covid Module / Weekly per CMS instructions	N/A	N/A
Positive COVID-19 Lab Result (PCR Not Point-of-Care) – **Staff or Resident**	NHSN Covid Module / Weekly per CMS instructions	N/A	N/A
COVID-19 Related Death – Staff or Resident	Complete a Confidential Report of Communicable Disease Form. Enter "COVID-19" for the Disease section, fax to 317-234-2812.	Complete a Confidential Report of Communicable Disease Form. Enter "COVID-19" for the Disease section, fax to 317-234-2812	Complete a Confidential Report of Communicable Disease Form. Enter "COVID-19" for the Disease section, fax to 317-234-2812.

***Outbreak Reporting Threshold:* three cases of COVID-19 occur in residents in one defined area (such as hall, unit, neighborhood, street, pod, secured unit, vent unit) in a 48-hour period; or 10% or more of the current building census has COVID-19.**

***Effective April 4, 2022, reporting of negative results, either individual test results or in aggregate, is optional, but can be reported to NHSN*

**** Effective July 12, 2023, reporting COVID-19 POC results into the IDOH REDCap is no longer required*

Long-Term Care Gateway Application: https://gateway.isdh.in.gov/

COVID-19 Death: Complete Confidential Report of Communicable Disease Form (https://forms.in.gov/Download.aspx?id=5082) **and fax to: 317-234-2812**

Indiana Department of Health

Last updated: 7.12.23

Vaccines

Indiana Department of Health

Current boosters (bivalent formulation)

Recommendation is that everyone over age 6 should get one bivalent vaccine. Certain groups may get another dose as follows.

- People aged 65 years and older may get 1 additional dose of COVID-19 vaccine 4 or more months after the 1st updated COVID-19 vaccine
- People who are moderately or severely immunocompromised may get 1 additional dose of updated COVID-19 vaccine 2 or more months after the last updated COVID-19 vaccine. Talk to your healthcare provider about additional updated doses.

Fall COVID-19 boosters

- Moderna, Pfizer and Novavax, are expected to offer the revised shots for this fall, for which virtually all children and adults will be eligible.
- The new shots are designed to target the XBB variants — strains of the virus descended from the original Omicron variant — which are now the most common form in circulation
- New formulation boosters are expected to be available by late September or early October

Additional bivalent dose vs. wait for the fall booster?

Whether to take additional bivalent dose (for those eligible) vs. wait for the new formulation should be determined by discussion between the clinician and the individual, based on the risk factors and history

Timing of the vaccination to illness or administration of other vaccines

- May administer vaccine once the individual is fully recovered from an infection or illness
- May administer vaccine once the individual with COVID-19 has met the criteria to end isolation
- Spacing with other vaccines per the table below:

TABLE 3-4. Guidelines for spacing of live and non-live antigens

Antigen combination	Recommended minimum interval between doses
Two or more non-live[a],[b],[c]	May be administered simultaneously or at any interval between doses
Non-live and live[d]	May be administered simultaneously or at any interval between doses
Two or more live injectable[d]	28 days minimum interval, if not administered simultaneously

Indiana Department of Health

Variants

Indiana Department of Health

EG.5 subvariant

- Accounts for 20.6% of the cases in the country per the last update on CDC data tracker
- On 8/9/23 WHO designated EG.5 and its sub-lineages as a variant of interest (VOI)
  - EG.5 is a descendent lineage of XBB.1.9.2, which has the same spike amino acid profile as XBB.1.5. EG.5 was first reported on 17 February 2023, and designated as a variant under monitoring (VUM) on 19 July 2023.
- As of 7 August 2023, 7,354 sequences of Omicron EG.5 have been submitted to GISAID from 51 countries
- While EG.5 has shown increased prevalence, growth advantage, and immune escape properties, there have been no reported changes in disease severity to date.

COVID Variant: BA.2.86

- 9 known detections globally
- Highly divergent (37 amino acid mutations) from previous variants
- Predict some degree of immune escape but population has 98% pre-existing immunity so unclear if this will cause more severe disease (too early to tell)
- No anticipated effects on therapeutics
- Minimal to no effects on current diagnostics
- Low risk of this new strain rendering new vaccine ineffective to severe disease is low per CDC

Indiana Department of Health

https://www.cdc.gov/respiratory-viruses/whats-new/covid-19-variant.html

Treatment

Indiana Department of Health

Treatment options for COVID-19

Start treatment early in the course of illness

Treatment	Who	When	How
Nirmatrelvir with Ritonavir (Paxlovid) *Antiviral*	Adults; children ages 12 years and older	Start as soon as possible; must begin within 5 days of when symptoms start	Taken at home by mouth (orally)
Remdesivir (Veklury) *Antiviral*	Adults and children	Start as soon as possible; must begin within 7 days of when symptoms start	Intravenous (IV) infusions at a healthcare facility for 3 consecutive days
Molnupiravir (Lagevrio) *Antiviral*	Adults	Start as soon as possible; must begin within 5 days of when symptoms start	Taken at home by mouth (orally)

Some treatments might have side effects or interact with other medications you are taking. Ask a healthcare provider if medications to treat COVID-19 are right for you. If you don't have a healthcare provider, visit a Test to Treat location or contact your local community health center or health department.

If you are hospitalized, your healthcare provider might use other types of treatments, depending on how sick you are. These could include medications to treat the virus, reduce an overactive immune response, or treat COVID-19 complications.

Guidance links

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- in.gov/health/ltc/files/Revised-Reporting-Chart-Revised-LTC-COVID-19-Reporting-Guidance-Chart-7-12-23.pdf
- https://www.cdc.gov/coronavirus/2019-ncov/your-health/treatments-for-severe-illness.html
- https://www.fda.gov/vaccines-blood-biologics/updated-covid-19-vaccines-use-united-states-beginning-fall-2023
- CDC COVID Data Tracker: Variant Proportions
- https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html#t-04
- Occupationally-Acquired Infections in Healthcare Settings | Infection Control | CDC

Questions?

CONTACT:

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

Q&A

Reminder

THERE IS NO MEETING ON AUGUST 31

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

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

Paul Krievins
- pkrievins@isdh.in.gov

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

Tammy Alley – Vaccine Questions, IDH
- talley@isdh.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

IHCA INCAL