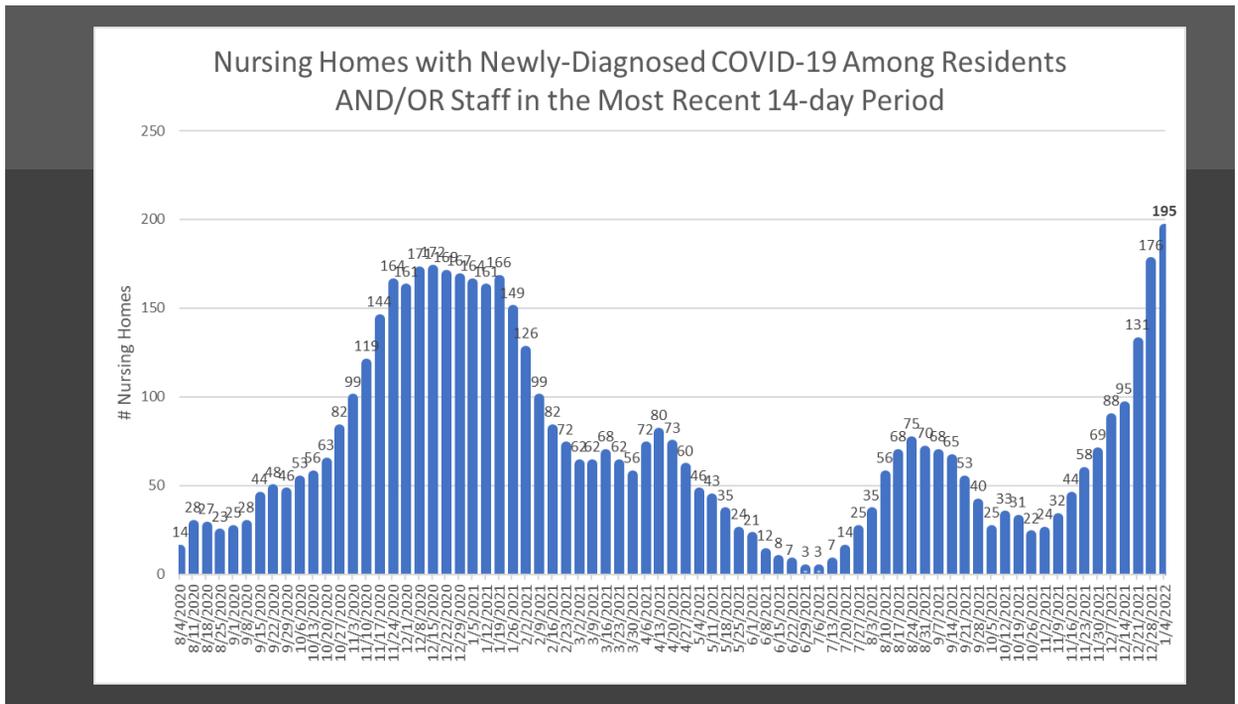# Agenda 1/12/22   **weekly meetings during month of January**

- Opening remarks from Commissioner Juthani

- Nursing Home Data

- Tip of the Week: N95s and Eye Protection

- Making Visitation Safer

- Hospital discharge guidance (not mandate)

- Updated: Booster Recommendations

- Booster mandate: EO 14G

- Upcoming Events

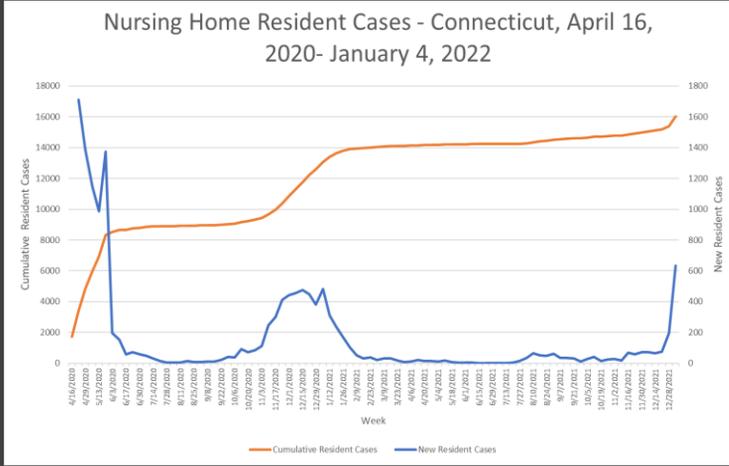- Appendix: Testing slides from last week

1

2

Nursing Home Resident Incidence, statewide
April 16, 2020 – January 4, 2022

Resident Census: 18,927

Date Reported	New Resident Cases (diagnosed that week)
5-Oct	29
12-Oct	42
19-Oct	15
26-Oct	24
2-Nov	29
9-Nov	18
16-Nov	70
23-Nov	58
30-Nov	71
7-Dec	73
14-Dec	66
21-Dec	84
28-Dec	197
4-Jan	632

Facility Metrics	#Nursing Homes
New res. cases, last 2 weeks	137 (+70)
No new res. cases, >2 weeks	68

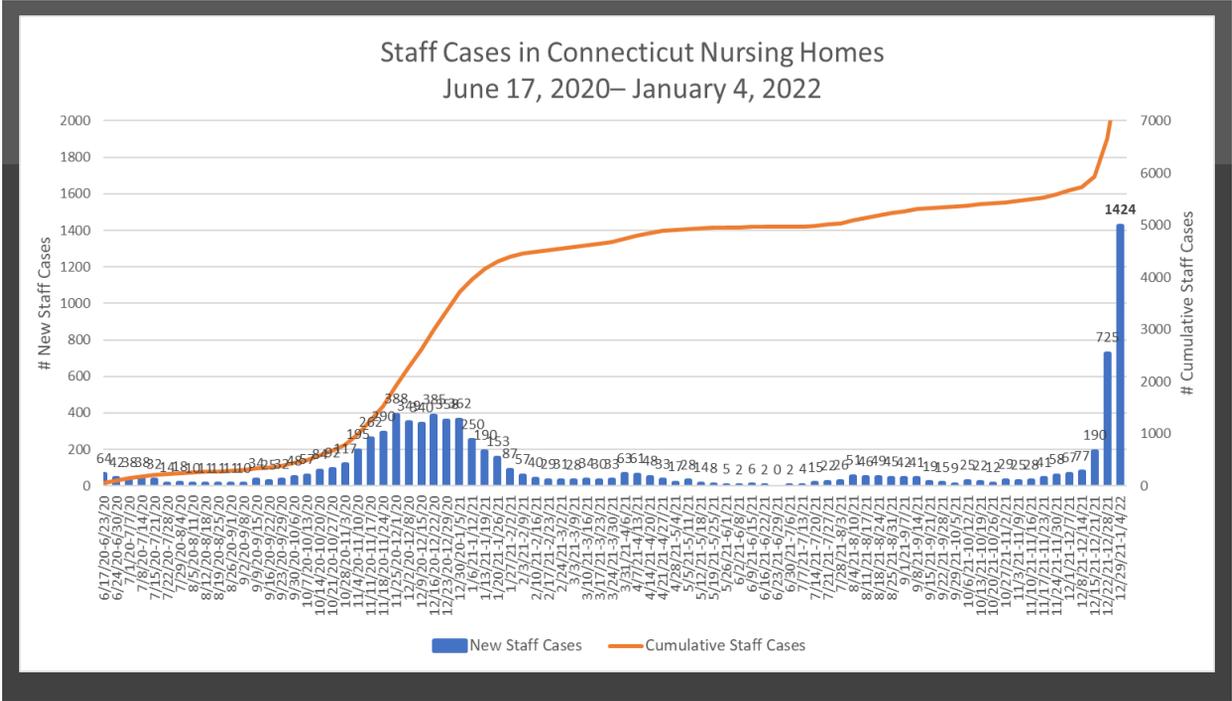Nursing Home Resident Cases - Connecticut, April 16, 2020- January 4, 2022

3

Nursing Home Resident Deaths Associated to COVID-19
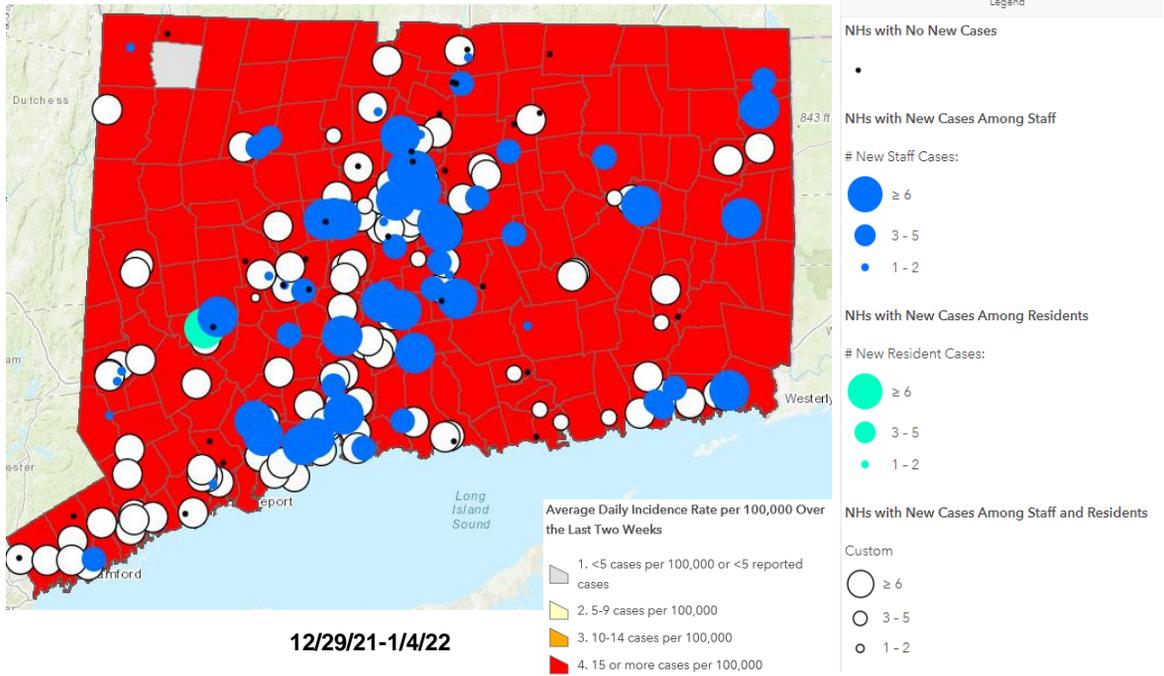4/15/2020-1/4/2022
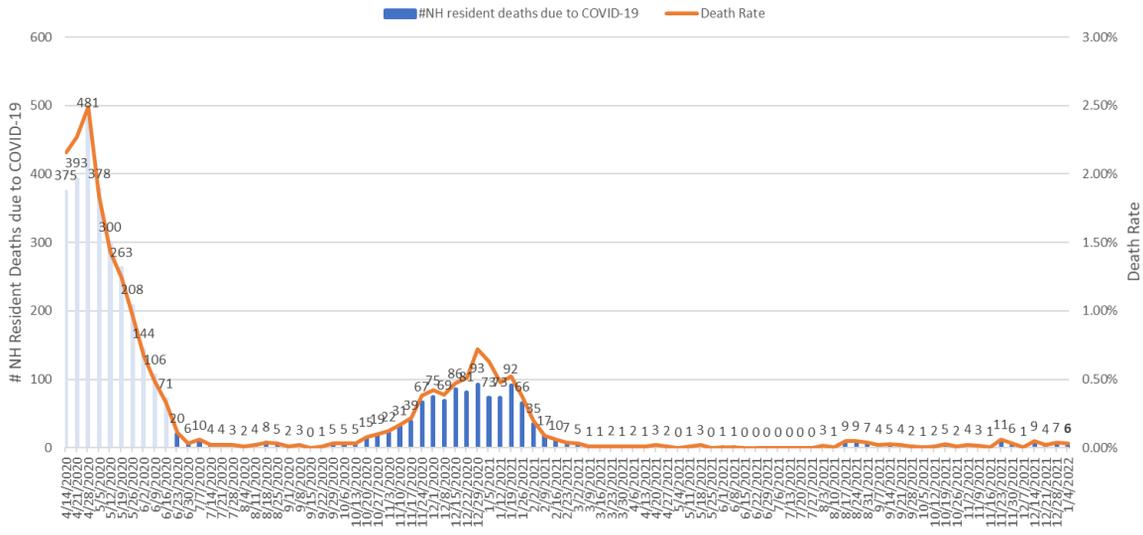
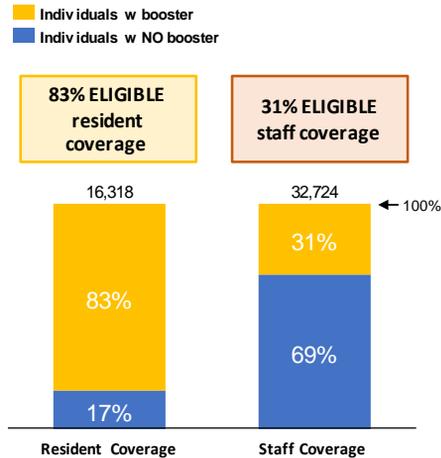Note: Light blue= OCME lab-confirmed and suspected deaths due to COVID-19, Darker blue= NHSN data

4
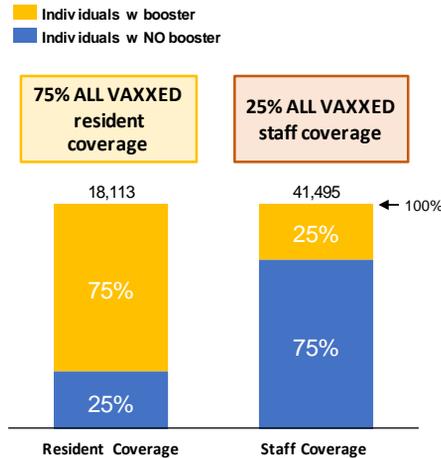
Staff Cases in Connecticut Nursing Homes June 17, 2020– January 4, 2022

5

Nursing Homes with Positive Staff or Residents June 17, 2020-January 4, 2021

6

12/29/21-1/4/22

Legend

NHs with No New Cases

NHs with New Cases Among Staff

New Staff Cases:
- ≥ 6
- 3 – 5
- 1 – 2

NHs with New Cases Among Residents

New Resident Cases:
- ≥ 6
- 3 – 5
- 1 – 2

NHs with New Cases Among Staff and Residents

Custom
- ≥ 6
- 3 – 5
- 1 – 2

Average Daily Incidence Rate per 100,000 Over the Last Two Weeks
1. <5 cases per 100,000 or <5 reported cases
2. 5-9 cases per 100,000
3. 10-14 cases per 100,000
4. 15 or more cases per 100,000

7

Nursing Home Booster Coverage
Reported via NHSN | As of January 2, 2022

Booster Coverage – *Of ELIGIBLE Individuals*

- Individuals w booster
- Individuals w NO booster

83% ELIGIBLE resident coverage

31% ELIGIBLE staff coverage

16,318

32,724

← 100%

31%

83%

17%

Resident Coverage

Staff Coverage

69%

Booster Coverage – *Of ALL VAXXED Individuals*

- Individuals w booster
- Individuals w NO booster

75% ALL VAXXED resident coverage

25% ALL VAXXED staff coverage

18,113

41,495

← 100%

25%

75%

25%

Resident Coverage

Staff Coverage

75%

For homes that have >0% ELIGIBLE individual coverage:
- Median ELIGIBLE res. coverage: 88%
- Median ELIGIBLE staff coverage: 32%

For homes that have >0% ALL VAXXED individual coverage:
- Median ALL VAX res. coverage: 82%
- Median ALL VAX staff coverage: 26%

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4

Tip of the Week: N95s and Eye Protection

HCPs working in facilities with current COVID-19 outbreaks and/or located in counties with substantial or high transmission should consider implementing universal use of the PPE listed below to reduce the risk of work exposure for staff:

* N95 or equivalent respirator
* Eye Protection

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Recommended Work Restrictions for HCP Based on Vaccination Status and Type of Exposure

Exposure	Personal Protective Equipment (PPE) used	Work Restriction for HCP who have received all COVID-19 vaccine and booster doses as recommended by CDC
Higher-risk: HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection[3]	• HCP not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)[4] • HCP not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask • HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure[1]	• In general, no work restrictions.[5] • Perform SARS-CoV-2 testing immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure.[6] • Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing

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Making Visitation Safer

- Regulatory framework (Revised 11/12/21): QSO-20-39-NH Revised (cms.gov)
- Updated FAQs (1/6/22) Nursing Home Visitation FAQs (cms.gov)
- CDC Infection Control Guidance: Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC

Risk of COVID-19 introduction during visitation increases with:
- Higher community transmission rates
- Unvaccinated/unboostered visitors
- Lapses in core principles of infection control
- Masks coming off

Inform visitors (before visit): importance of vaccination + booster, masking + physical distancing

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Making Visitation Safer:
Check for Layers of Protection Upon Entry

- **DO NOT VISIT if:**
  - Active COVID-19 infection
  - Symptoms of COVID-19
  - Meet criteria for quarantine (after exposure)
- **Assess mask wearing**
  - Offer a medical/surgical mask if using cloth mask
  - Ask to adjust mask if poorly-fitting/worn
- **Ask about vaccination and testing prior to visitation**
  - If visitor declines to disclose vaccination status, they should wear source control AT ALL TIMES (even in resident's room)
  - CMS encourages visitor testing if feasible in counties with substantial to high community transmission
  - Encourage testing 2-3 days prior to visitation
- **Reminders**
  - Hand hygiene
  - **Substantial to high community transmission:** mask should ALWAYS stay on (even in resident's room)
  - **During outbreak (facility-onset resident case or staff case in past 14 days):** mask should ALWAYS stay on (even in resident's room)

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Hospital Discharge Guidance (not mandate)

- Puts hospitals and homes on same page: standard for testing that can be requested (no more than 1 test within 48 hours of transfer)

- If homes don't have the staff or space to safely take a patient, they can decline admission.
- Nursing Homes should not admit individuals that they are not able to care for.

- SNFs have the resources and know-how to isolate patients with COVID-19
- High vaccination coverage, booster rates, masking, distancing, and other infection measures also limit the impact of COVID-19

12

Am I following the most up-to-date guidance?

- **Follow the latest guidance on CDC's website and the latest CMS regulations.**

- CT DPH generally follows CDC guidance
  - As needed, additional guidance from CT DPH will be posted here: https://portal.ct.gov/DPH/HAI/COVID-19-Healthcare-Guidance
  - Outdated guidance documents are removed from the main page and archived (link at bottom of page)

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Updated: Booster Recommendations

Vaccination/booster after infection
"People w ith know n current SARS-CoV-2 infection should **defer vaccination at least until recovery from the acute illness (if symptoms were present)** has been achieved and criteria to discontinue isolation have been met."

Vaccination/booster can be given after isolation ends.

Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC

- **Do I qualify for a COVID-19 vaccine booster and which one? |FDA**
- **https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html**

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EO 14B – Vaccine Booster Mandate for LTC

➢ Signed on January 6, 2022

➢ Revises EO 13F by requiring fully vaccinated "covered LTC workers" to receive booster doses by February 11, 2022

➢ DPH is revising the EO 13F Implementation Guidance to reflect the booster requirement – guidance should be available by January 14, 2022

  * Will largely be the same guidance

  * You will not be required to have existing covered LTC workers resubmit medical or spiritual/religious exemptions

  * Compliance reporting likely will be due to DPH by Monday, February 14, 2022, through the FLIS portal; working on the portal, won't be available until after February 1st

  * All facilities will be required to report

  * Additional instructions regarding "combination reporting"

  * Additional and revised FAQs to address boosters, combination reporting, mix and match vaccine, forms, etc.

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Upcoming Events

  *Information Gathering survey

    *Goal: Establish real time data related to census and resource gaps

  *Essential Support Person Guidance

    *Collaborative workgroup, multi state agency with significant consumer engagement

    *Draft document currently in review

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Testing slides from 1/5/22

1. BinaxNOW from HHS
2. Other testing resources
3. When/how to send to state lab
4. Outbreak testing
5. Self-testing

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BinaxNOW

- State has none in stock and does not plan on purchasing
- HHS (Federal gov't) are distributing to LTCFs based on **CLIA designation** and county positivity rate ($\geq$5%)

FACILITY TYPE	DESIGNATION CRITERIA
Assisted Living Facility	CLIA application under 04- Assisted Living Facility Confirm "Facility Type" Designation here
Nursing Homes	Medicare-certified Skilled Nursing Facility (SNF) and/or Medicaid-certified Nursing Facility (NF) Confirm Designation here

- **Verify you have the correct CLIA Certificate of Waiver designation in place. If you believe the designation on your CLIA Certificate of Waiver is incorrect, please reach out to dph.flislab@ct.gov**
- **Report antigen test use accurately on NHSN!!**
- Purchase commercially from Abbott: https://www.globalpointofcare.abbott/en/product-details/navica-binaxnow-covid-19-us.html

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Other Testing Resources

1. **Laboratory with molecular SARS-CoV-2 testing**
   a. AL toolkit: Document.aspx (mutualaidplan.org)
   b. State-contracted labs: CTsource Contract Board (search "testing", LTCFs must establish their own contracts with testing vendors)
2. **Another Point-Of-Care Antigen Test**
   a. Many available: In Vitro Diagnostics EUAs - Antigen Diagnostic Tests for SARS-CoV-2 | FDA
   b. Update dph.flislab@ct.gov: State of CT FDA Emergency Use of Authorization EUA Attestation Form
   c. Ensure staff are adequately trained in new processes
3. **Self tests (for staff) – must be administered by "self"**
   a. Available at some retailers
   b. Town distributions
4. **Community testing sites (for staff)**
   a. 211ct.org
   b. State-Supported COVID Testing Sites (ct.gov)

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Confirmatory PCR Testing at SPHL

1. If symptomatic residents testing negative for COVID-19, **test for other respiratory viruses** (e.g., flu). **Don't** order full respiratory viral panel at State Lab unless non-COVID virus suspected.
2. **State Public Health Lab (SPHL) cannot provide for mass routine screening or outbreak testing.**
   * SPHL will conduct **diagnostic testing for certain long-term care cases** (PCR confirmation after antigen test).
   * Due to current testing demands, please limit **5 confirmatory specimens per facility.**
   * When COVID-19 is circulating at high levels, treat asymptomatic antigen positives as infectious
3. **If you need respiratory specimen collection kits (not antigen test kits):** check with your local health dept before calling SPHL.
4. **SPHL does not have a routine courier for specimens from LTCFs.** Couriers are for cases and outbreaks of epidemiologic importance (must be pre-approved by DPH HAI-AR Program)

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Outbreak Testing

A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident should trigger **an outbreak investigation**.

* An outbreak investigation involves rapid identification and isolation of new cases critical for stopping further viral transmission.

* Testing should begin *immediately (no sooner than 24hrs if discrete exposure) u*pon identification of a single new case of COVID-19 infection in any staff or residents.

Facilities have the *option to perform outbreak testing through two approaches:* <u>contact tracing </u>or <u>broad-based</u> (e.g. facility-wide, unit level or floor level) testing.

For more information, please see <u>Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes</u>

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Testing Trigger	Staff	Residents
Symptomatic Individual identified	Staff with signs or symptoms must be tested.	Residents with signs or symptoms must be tested.
*Outbreak: Newly identified COVID-19 positive staff or resident in a facility that can identify **close contacts**	Test **all staff** that had a <u>higher-risk exposure</u> with a COVID-19 positive individual.	Test **all residents** that had close contact with a COVID-19 positive individual.
*Outbreak: Newly identified COVID19 positive staff or resident in a facility that is **unable to identify close contacts**	Test **all staff** facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility).	Test **all residents** facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility).

*During outbreak testing ALL individuals should be tested regardless of vaccination status
*Testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic, including if they have had close contact or a higher-risk exposure

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Close Contact Testing during a COVID-19 Outbreak Investigation

* Exposed HCP and residents, regardless of vaccination status, should have a series of **two viral tests** for SARS-CoV-2 infection.
    * Testing is recommended <u>immediately</u> (but not earlier than 24 hrs after the exposure) and, if negative, again <u>5-7</u> days after the exposure.

* **If testing of close contacts reveals additional positives**, contact tracing should be continued to identify exposed resident and HCPs to the newly identified positive individual(s).
    * A facility-wide or group-level (e.g., unit, floor) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.

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Broad Based Testing during a COVID-19 Outbreak Investigation

* If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor).
* Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, **immediately** and, if negative, **again 5-7 days later**.
    * If **no additional cases are identified**, unvaccinated residents should still be quarantined for 14 days, and no further testing is indicated.
* If **additional cases are identified**, 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.

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Self-testing: evaluating your risk of spreading infection

- **What?** Antigen tests, not under CLIA
- **Who?** Anyone, regardless of vaccination or symptom status
  - Antigen testing preferred for those needing to test (e.g., for symptoms) if previously positive in past 90 days
- **When?** Symptoms, after exposure, before indoor gatherings
- **Reporting to public health?** NO

Positive self-test result	Negative self-test result
Isolate and notify close contacts (who should quarantine)	Infection not detected but *does not entirely rule out infection*. Repeat test after >24h

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