All Member Call
Agenda
May 16, 2023

Welcome

Updates & reminders

- Susan Wallace, swallace@leadingageohio.org
- Randi Hamill, rhamill@leadingageohio.org

Ending of the PHE

- Anne Shelley, ashelley@leadingageohio.org
- Stephanie DeWees, sdewees@leadingageohio.org

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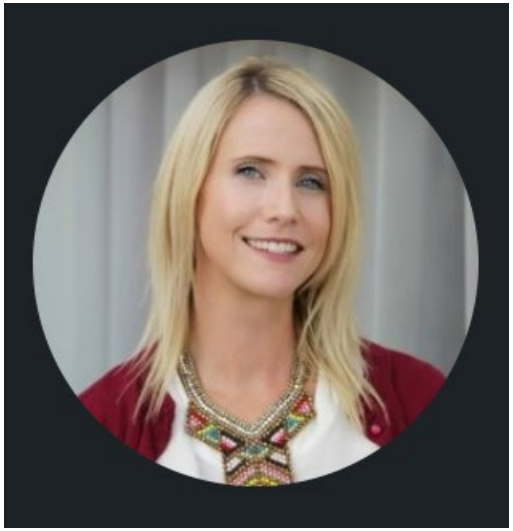
Welcome to LeadingAge Ohio!



Molly Homan
Director of Strategic Communications

Tammie Showalter
Executive Assistant

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Events, updates & reminders

LeadingAge Ohio Awards Nominations: application deadline, 5/31

- Education
  - Leadership Forum, 5/24
  - STAT Webinar: 6/14
  - QIP Collaborative, July – December 2023
  - Hospice Pre-Conference Intensives, 8/28
  - Annual Conference & Trade Show, 8/29 – 8/31
  - Autumn: LSC Virtual Summit, CFO Workshop, Case Mix Series

Events, updates & reminders

- Call for Nominations: LeadingAge Ohio Board of Directors

- Update: HB45 funding
  - Assisted living
  - Hospice
  - HCBS
  - Adult Day Services

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Ending of the PHE

- Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE) QSO-23-13-ALL
  - https://www.cms.gov/files/document/qso-23-13-all.pdf
- HHS Fact Sheet
  - https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html

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CDC & CMS COVID Guidance Changes

CDC updated guidance
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Flong-term-care.html

https://www.cdc.gov/mmwr/volumes/72/wr/mm7219e1.htm?s_cid=mm7219e1_x
https://www.cdc.gov/mmwr/volumes/72/wr/mm7219e2.htm?s_cid=mm7219e2_x

New QSO memos
https://www.cms.gov/files/document/qso-20-38-nh.pdf
https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

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CDC Healthcare Setting

- This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health.
- Updated recommendations for universal source control
  - Added Appendix to assist facilities with how and when to implement broader use of source control, including examples of potential metrics.
- Updated recommendations for admission testing in nursing homes.

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CDC Healthcare Setting

Implications for the Community Transmission Metric with the End of the Public Health Emergency

- With the end of the public health emergency on May 11, 2023, CDC will no longer receive data needed to publish Community Transmission levels for SARS-CoV-2. This metric informed CDC's recommendations for broader use of source control in healthcare facilities to allow for earlier intervention, to avoid strain on a healthcare system, and to better protect individuals seeking care in these settings.
- As described in CDC's Core IPC Practices, source control remains an important intervention during periods of higher respiratory virus transmission. Without the Community Transmission metric, healthcare facilities should identify local metrics that could reflect increasing community respiratory viral activity to determine when broader use of source control in the facility might be warranted (See Appendix).
  - CDC's Core IPC Practices: https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html

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CDC Healthcare Setting

- Source control is recommended for individuals in healthcare settings who:
  - Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
  - Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10days after their exposure

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CDC Healthcare Setting

Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances:

- 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); or
- 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 (See Appendix)
- 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)

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CDC Healthcare Setting

Implement Universal Use of Personal Protective Equipment for HCP

- If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).
- As SARS-CoV-2 transmission in the community increases, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during patient care encounters

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CDC Healthcare Setting

Perform SARS-CoV-2 Viral Testing

- This didn't change for healthcare settings in general.
- Test if symptomatic, close contact
- Nursing Home Testing
  - Admission testing is at the discretion of the facility.
  - Residents who leave the facility for 24 hours or longer should generally be managed as an admission.

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CDC Healthcare Setting

Appendix: Considerations for Implementing Broader Use of Masking in Healthcare Settings

- Use of well-**fi**tting masks in healthcare settings are an important strategy to prevent the spread of respiratory viruses. Well-fitting masks can help block virus particles from reaching the nose and mouth of the wearer (wearer protection) and, if someone is ill, help block virus particles coming out of their nose and mouth from reaching others (source control). Masking by healthcare personnel as part of Standard and Transmission-Based Precautions and by ill individuals as part of respiratory hygiene and cough etiquette (i.e., for people with symptoms) are already well-described. This appendix describes considerations for implementing broader use of masking in healthcare settings. However, even when masking is not required by the facility, individuals should continue using a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

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When to Implement Broader Use of Masking

- The overall benefit of broader masking is likely to be the greatest for patients at higher risk for severe outcomes from respiratory virus infection and during periods of high respiratory virus transmission in the community.
- Facilities should consider several factors when determining how and when to implement broader mask use:
- The types of patients cared for in their facility. Facilities might tier their interventions based on the population they serve. For example, facilities might consider a lower threshold for action in areas of the facility primarily caring for patients at highest risk for severe outcomes(e.g., cancer clinics, transplant units) or in areas more likely to provide care for patients with a respiratory infection(e.g., urgent care, emergency department). Except when experiencing an outbreak within the facility, facilities with residents or patients that generally do not leave the facility might consider implementing masking only for staff and visitors
- Input from stakeholders. Reviewing plans with stakeholders including patient and family groups and healthcare personnel can help a facility determine practices that will be more broadly supported.
- Plans from other facilities in the jurisdiction with whom the facility shares patients. Some jurisdictions might consider a coordinated approach for all facilities in the jurisdiction.
- What data are available to make decisions. Facilities and jurisdictions might have access to more granular data for their jurisdiction to help guide efforts locally

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Metrics for Community Respiratory Virus Transmission

- CDC is in the early stages of developing metrics that could be used to guide when to implement select infection prevention and control practices for multiple respiratory viruses. However, at this time there are some general metrics that could be used to help facilities make decisions about community respiratory virus incidence. Data on the exact metric thresholds that correspond with a higher risk for transmission are lacking. In addition, data from these systems are generally not available for all jurisdictions.
- Some facilities might consider recommending masking during the typical respiratory virus season (approximately October-April).
- Facilities could also follow national data on trends of several respiratory viruses.

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SARS-CoV-2 Specific Metrics

- During the COVID-19 pandemic one of the strongest indicators of increasing cases in nursing homes was increasing community incidence. If a jurisdiction still has access to SARS-CoV-2- community incidence, using these data to guide local recommendations at the levels previously described (community incidence > or = to 100/100,000) could be considered.
  - ODH COVID-19 Dashboard https://coronavirus.ohio.gov/dashboards/overview
- CDC will also continue to collect and report SARS-CoV-2 hospital admissions data on the CDC COVID Data Tracker. These data continue to be available at the county level and are used by CDC to help the public decide when masking in the community should be considered. Based on CDC analyses from data from late 2022 and early 2023, these levels might be less useful to inform masking recommendations in healthcare facilities.
  - https://covid.cdc.gov/covid-data-tracker/#datatracker-home
- Using the current cut off for masking in the community (>20 new COVID-19 admissions per 100,000 population over the last 7 days), the ability of these levels to indicate ongoing SARS-CoV-2 transmission at nursing homes (at 1 new infection per 100 resident-weeks, or higher) was low (sensitivity < 20%), although the specificity was high. Using a lower cut off of10 new COVID-19 admissions per 100,000 population (7-day total) increased sensitivity to about 40% but reduces specificity. CDC continues to recommend that healthcare facilities institute facility-wide masking when masks are recommended in the community.

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Metrics Encompassing Other Respiratory Viruses

- The RESP-NET interactive dashboard or data from the National Emergency Department Visits for COVID-19, Influenza, and Respiratory Syncytial Virus can be used to inform when respiratory virus season is beginning or ending, as described above.
- For more granular information, outpatient respiratory illness visits determined by data reported to ILINet, are aggregated to provide state level estimates. Cutoffs for action are not well-defined and data are reported as 13 activity levels which correspond to the number of standard deviations below, at, or above the mean for the current week compared with the mean during non-influenza weeks. Choosing a lower level will likely increase sensitivity for true increases in ILI.

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Examples Using Metrics

Ohio Dashboard of Cases - Threshold 100/100,000

Cases per 100,000 Residents Over 2 Weeks

Statewide Average: 40.0

5/11/23

#	County	Cases Per 100K	Case Count	Population
1	Ashland	129.0	69	53,484
2	Morgan	103.4	15	14,508
3	Carroll	100.3	27	26,914
4	Ashtabula	80.2	78	97,241

Cases per capita values pulled on 05/11/23 for case onset dates of 04/27/23 through 05/10/23.

5/4/23

#	County	Cases Per 100K	Case Count	Population
1	Morgan	261.9	38	14,508
2	Jackson	169.7	55	32,413
3	Ashtabula	122.4	119	97,241
4	Carroll	115.2	31	26,914
5	Ashland	87.9	47	53,484

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Examples Using Metrics

CDC COVID Tracker

Ashtabula County	6.3
Cuyahoga County	6.3
Geauga County	6.3
Lake County	6.3
Darke County	5
Greene County	5
Montgomery County	5
Preble County	5

Decide Threshold

- Community ≥ 20
- NH possibly ≥ 10

New COVID-19 hospital admissions per 100000 population past week (total)

COVID-19 hospital admissions levels in US by county

Based on new COVID-19 hospital admissions per 100,000 population

	Total	Percent	% Change
≥ 20.0	10	0.31%	0.16%
10.0 - 19.9	16	0.5%	-0.43%
<10.0	3195	99.25%	0.25%

Time Period: New COVID-19 hospital admissions per 100,000 population (7-day total) are calculated using data from the MMWR week (Sat-Sun) ending May 6, 2023.

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Examples Using Metrics

Cases – ODH Dashboard

#	County	Cases Per 100K	Case Count	Population
1	Ashland	129.0	69	53,484
2	Morgan	103.4	15	14,508
3	Carroll	100.3	27	26,914
4	Ashtabula	80.2	78	97,241

Threshold 100/100,000

Hospitalizations – CDC COVID Tracker

Ashtabula County	6.3
Carroll County	2.8
Morgan County	2.2
Ashland County	0.6

- Community ≥ 20
- NH possibly ≥ 10

Cases would have put facilities back into universal source control while hospitalizations would not

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Surveyor Resources Updated

Effective Date	Document/File Name	Description of Change
05/12/2023	Survey Resources	Updates due to the end of the PHE and memo QSO-23-13-ALL: 1. COVID-19 FIC Survey folder 2. LTC Survey Pathways folder (CMS 20054- Infection Prevention Control and Immunization, CMS-20140 Arbitration) 3. Entrance Conference Worksheet 4. List of Revised Ftags 5. LTCSP Mapping Document-Streamlined 6. LTCSP Procedure Guide 7. LTCSP_UG_12.4.0_FINAL

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes

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More to Come

- In the future, CDC will move toward integrating COVID-19 monitoring within a sustainable respiratory viruses surveillance strategy. CDC displays data for diagnosed or laboratory-confirmed COVID-19, flu, and respiratory syncytial virus (RSV) on the National Syndromic Surveillance Program dashboard (for ED visits) and the RESP-NET dashboard (hospitalizations).
- Removal of the vaccine mandate
- Stay Informed
  - The Source (Thursday)
  - YAWA

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