PDPH/LTCF Conference Call – Friday, 5/19/23

Agenda

- **SARS-CoV-2 Surveillance Update**
- **Guidance Updates and Frequently Asked Questions:**
  - **PA HAN 693: Updated Recommendations Regarding the Monovalent and Bivalent mRNA COVID-19 Vaccines**
  - **PDPH Health Advisory: Updates to COVID-19 Vaccination and Masking Requirements for Healthcare Workers**
  - **CMS QSO 20-39: Nursing Home Visitation -COVID-19 (REVISED)**
  - **CDC Updated IPC Guidance, May 8, 2023**
  - **PA HAN 694: Interim Infection Prevention and Control Recommendations for COVID-19 in Healthcare Settings**
- **SNF NHSN Reporting Update**
- **U-FAST Antibiotic Stewardship Toolkit from Penn/Temple LTC RISE Program and PDPH**
- **Resources and Services**

Department of Public Health
CITY OF PHILADELPHIA

SARS-CoV-2 Surveillance Update

May 11, 2023, marked the end of the COVID-19 public health emergency.

As of May 11, CDC's COVID Data Tracker is no longer reporting:

- Aggregate cases and deaths
- COVID-19 Community Levels
- COVID-19 Community Transmission Levels
- COVID-19 Electronic Laboratory Reporting (CELR) data

Although COVID-19 cases and associated hospitalizations have decreased in recent months, COVID-19 remains an ongoing public health challenge

Updated public health tracking* will keep you informed about COVID-19

Hospital admissions	track →	Spread in communities + severity of illness
Death certificates	track →	Severity of illness
Emergency department visits	track →	Early signs of spread
Genomic sequencing	tracks →	New variants

Check COVID.cdc.gov to know when to take action

*To account for changes in available data after the end of the U.S. Public Health Emergency declaration

bit.ly/mm7219e1

MAY 5, 2023

MMWR

United States COVID-19 Hospitalizations and Deaths

Weekly Update for the United States

Hospitalizations

Hospital Admissions (In Past Week)

9,186

Trend in Hospital Admissions

-4.9% in past week

Apr 19, 2023 May 16, 2023

Deaths

% Due to COVID-19 (In Past Week)

1.5%

Trend in % COVID-19 Deaths

-11.8% in past week

Mar 25, 2023 May 13, 2023

Vaccinations

% with Updated Booster Dose

17.0%

Total Population

Total Hospitalizations

6,152,982

Total Deaths

1,128,903

Total Updated Booster Doses

56,478,510

Guidance Updates

PA HAN 693: April 28, 2023

PDPH Health Advisory: May 10, 2023

CMS QSO 20-39: May 8, 2023

CDC Updated IPC Guidance: May 8, 2023

PA HAN 694: May 11, 2023

COVID-19 Vaccine Updates: PA HAN 693

PENNSYLVANIA DEPARTMENT OF HEALTH
2023 – PAHAN –693 – 04 –28 - ADV

pennsylvania
DEPARTMENT OF HEALTH

Updated Recommendations Regarding the Monovalent and Bivalent mRNA COVID-19 Vaccines

DATE:	4/28/2023
TO:	Health Alert Network
FROM:	Debra L. Bogen, M.D., FAAP, Acting Secretary of Health
SUBJECT:	Updated Recommendations Regarding the Monovalent and Bivalent mRNA COVID-19 Vaccines
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

PA HAN 693

SUMMARY

- The FDA announced on April 18, 2023 that it had rescinded the authorization for the monovalent Pfizer-BioNTech and monovalent Moderna COVID-19 vaccines and that the bivalent Pfizer-BioNTech and bivalent Moderna vaccines are now authorized for all doses for individuals 6 months and older.
- The FDA authorization for the Novavax vaccine is unchanged.
- The definition of up to date for COVID-19 vaccination was simplified and now all individuals 6 years and older who have received a single dose of a bivalent COVID-19 vaccine, regardless of past history of receiving monovalent COVID-19 vaccine, are considered up to date.
- Children 6 months through 4 years of age who are unvaccinated may receive a 2-dose series of the Moderna bivalent or a 3-dose series of the Pfizer-BioNTech bivalent vaccine.
- Children who are 5 years old and are unvaccinated may receive 2 doses of the Moderna bivalent vaccine or 1 dose of the Pfizer-BioNTech bivalent vaccine.
- Children 6 months to 5 years of age who received one, two, or three doses of monovalent COVID-19 vaccine may receive bivalent vaccine but the number of doses that they receive will depend upon the vaccine given and their vaccination history.
- Individuals 65 and older and those with certain immunocompromising conditions may choose to receive an additional dose of the bivalent Pfizer-BioNTech or bivalent Moderna vaccine.
- If you have any questions, please call PA DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

Philadelphia Mask and Vaccine Mandate Updates

Department of Public Health
CITY OF PHILADELPHIA

Philadelphia Department of Public Health
Division of Disease Control

CHERYL BETTIGOLE, MD, MPH
Health Commissioner

SHARA EPSTEIN, MD
Medical Director, Division of Disease Control

LANDRUS BURRESS, DRPH
Director, Division of Disease Control

Health Advisory

Updates to COVID-19 Vaccination and Masking Requirements for Healthcare Workers
May 10, 2023

SUMMARY POINTS

- Masking is no longer mandated by the Philadelphia Department of Public Health (PDPH) in healthcare facilities.
- PDPH advises that all operators of healthcare facilities should develop and implement masking plans and guidance for staff and visitors based on the risk to certain patient populations and units as well as changes in COVID-19 and other respiratory virus activity in the community.
- No one should be prohibited from wearing a mask at any time in a healthcare facility or while seeing a healthcare provider.
- Healthcare workers are encouraged to mask when in a room with a patient if the patient or family requests that they do so.
- The healthcare worker COVID-19 vaccine mandate remains in effect.

QSO-20-39 Updates

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: QSO-20-39-NH

DATE: **September 17, 2020** ***REVISED 05/08/2023***

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Home Visitation - COVID-19 *(REVISED)*

Memorandum Summary

- CMS is committed to continuing to take critical steps to ensure America's healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation is allowed for all residents at all times.**
- ***Updated guidance to align with the ending of the PHE***

QSO-20-39 Updates

Core Principles of COVID-19 Infection Prevention *and Control (IPC)*

- Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose) in accordance with CDC guidance
- *Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) These alerts should include instructions about current IPC recommendations (e.g., when to use source control).*Cleaning and disinfecting *of frequently* touched surfaces in the facility often, anddesignated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted *following nationally accepted standards, such as CDC recommendations*.

QSO-20-39 Updates

Indoor Visitation during an Outbreak Investigation

An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. To swiftly detect cases, we remind facilities to adhere to CMS regulations *at 42 CFR §483.80 Infection Control following accepted national standards, such as CDC recommendations.* If residents or their representative would like to have a visit during an outbreak investigation, *the visit should ideally occur in the resident's room, the resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit*. While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area

Visitor Testing and Vaccination

While not required, we encourage facilities to offer testing to visitors, if feasible.

CMS strongly encourages all visitors to *stay up to date with their COVID-19 vaccinations* and facilities should educate and also encourage visitors to become vaccinated. Visitor testing and vaccination can help prevent the spread of COVID-19. **Visitors are not required to be tested or vaccinated** (or show proof of such) as a condition of visitation.

CDC Updated IPC Guidance, May 8, 2023: IPC Program

- Assign one or more individuals with training in IPC to provide on-site management of the IPC program
  - This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services.
  - Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the IPC risk assessment.
- Stay connected with the healthcare-associated infection program in your state health department, as well as your local health department, and their notification requirements. Report SARS-CoV-2 infection data to National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module. See Centers for Medicare & Medicaid Services (CMS) COVID-19 reporting requirements.

CDC Updated IPC Guidance, May 8, 2023: Admission Testing

- Managing admissions and residents who leave the facility:
  - Admission testing is at the discretion of the facility. Pros and cons of screening testing are described in Section 1.
  - Residents who leave the facility for 24 hours or longer should generally be managed as an admission.
- Empiric use of Transmission-Based Precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings) and do not meet criteria described in Section 2.

CDC Updated IPC Guidance, May 8, 2023: New Case Approach

- Placement of residents with suspected or confirmed SARS-CoV-2 infection
  - Ideally, residents should be placed in a single-person room as described in Section 2.
  - If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location.
- Responding to a newly identified SARS-CoV-2-infected HCP or resident
  - When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.
  - A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.
  - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.

No change in PPE recommendations for caring for (+) residents

No change in isolation for (+) residents

CDC Updated IPC Guidance, May 8, 2023: When and How to Test

- Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
  - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
  - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

CDC Updated IPC Guidance, May 8, 2023: When to Expand Approach

- Empiric use of Transmission-Based Precautions for residents and work restriction for HCP are not generally necessary unless residents meet the criteria described in Section 2 or HCP meet criteria in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. However, source control should be worn by all individuals being tested.
- 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. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. 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.

CDC Updated IPC Guidance, May 8, 2023: 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.
- 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.
- 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.

When to mask

Symptomatic

Positive test

Close contact or higher risk exposure (HCP)- Mask for 10 days

Working on unit with an outbreak of any respiratory infection

During periods of higher levels of COVID-19 in community

If recommended by public health

CDC Updated IPC Guidance, May 8, 2023: SARS-CoV-2 Metrics

- 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.
- Using the current cutoff 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 cutoff of 10 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.

CDC Updated IPC Guidance, May 8, 2023: Other Respiratory Viral Metrics

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.

CDC Updated IPC Guidance, May 8, 2023: Other Respiratory Viral Metrics

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.

PADOH IPC Guidance: PA HAN 694

PENNSYLVANIA DEPARTMENT OF HEALTH
2023 – PAHAN – 694 – 05-11-UPD
UPDATE: Interim Infection Prevention and Control Recommendations for COVID-19 in Healthcare Settings

pennsylvania
DEPARTMENT OF HEALTH

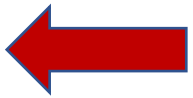
DATE:	05/11/2023
TO:	Health Alert Network
FROM:	Debra L. Bogen, M.D., FAAP, Acting Secretary of Health
SUBJECT:	**UPDATE: Interim Infection Prevention and Control Recommendations for COVID-19 in Healthcare Settings**
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

PADOH IPC Updated Guidance: PA HAN 694

This HAN update provides comprehensive information regarding infection prevention and control for COVID-19 in healthcare settings based on changes made by the Centers for Disease Control and Prevention (CDC) on May 08, 2023. Major additions and edits in this version include:

- A description of implications for the CDC community transmission metric with the end of the public health emergency;
- Updated recommendations for universal source control and admission testing in skilled nursing facilities;
- An appendix was added to assist facilities to implement broader use of source control based on levels of respiratory virus transmission (and not only COVID-19) in the community.

This update replaces PA-HAN-663. New content is written in red. If you have additional questions about this guidance, please contact DOH at 1-877-PA- HEALTH (1-877-724-3258) or your local health department.



PA HAN 694

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

With the end of the PHE 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 the 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 viral activity to determine when broader use of source control in the facility might be warranted (See Appendix).

PA HAN 694

Even when a facility does not require masking for source control, it should allow individuals to use 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. For example, if an individual or someone in their household is at increased risk for severe disease, they should consider wearing masks or respirators that provide more protection because of better filtration and fit to reduce exposure and infection risk, even if source control is not otherwise required by the facility. HCP and healthcare facilities might also consider using or recommending source control when caring for patients who are moderately to severely immunocompromised.

PA HAN 694

- **Source control is recommended in healthcare settings for individuals 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 10 days after their exposure.

- **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).

PA HAN 694

- Managing admissions and residents who leave the facility:
  - o Admission testing is at the discretion of the facility. Additional information on screening testing is described in Section 1.
  - o Residents who leave the facility for 24 hours or longer should generally be managed as a new admission.

PA HAN 694: Appendix

CONSIDERATIONS FOR IMPLEMENTING BROADER USE OF MASKING IN HEALTHCARE SETTING

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 the 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.

PA HAN 694: Appendix

Facilities could also follow national data on trends of several respiratory viruses.

- **SARS-CoV-2 specific metrics**

  During the COVID-19 pandemic one of the strongest indicators of increasing cases in skilled nursing facilities 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.

  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 provided by CDC to help the public decide when masking in the community should be considered. Based on CDC analyses of data from late 2022 and early 2023, these levels might be less useful to inform masking recommendations in healthcare facilities. Using the current cutoff 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 cutoff of 10 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.

PA HAN 694: Appendix

- **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. The National Respiratory and Enteric Virus Surveillance Systems (NREVSS) also provides additional information on the circulation of several respiratory viral pathogens. Lastly, outpatient respiratory illness visits determined by data reported to **ILINet**, are aggregated to provide state level estimates of influenza-like illness. Weekly statewide activity levels are provided which can serve as a guide when determining whether respiratory virus activity is increasing/decreasing. Additional information on influenza in Pennsylvania is also posted weekly when activity is determined to be above background levels.

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Guidance FAQs

Do all staff and consultants need COVID screening on entrance to the facility?

- A screening questionnaire and temperature check on arrival to the facility are not required.
- Per PAHAN-694: 2023-694-5-11-UPD-IPC for Healthcare.pdf (pa.gov)
  - Ensure everyone is aware of recommended IPC practices in the facility.
  - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene).
  - Establish a process to make everyone entering the facility, regardless of their vaccination status, aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
    - A positive viral test for SARS-CoV-2
    - Symptoms of COVID-19
    - Higher-risk exposure for health care personnel

Should we screen visitors to the facility?

- Symptom screening with a questionnaire is not a requirement, but you can still do them.
  - Temperature check not needed
- Per Nursing Home Visitation -COVID-19 (REVISED) (cms.gov):
  - Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19.
  - For visitors with confirmed COVID-19 infection, or symptoms, or have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance.

Can I hire someone who declined the COVID vaccine?

- The Philadelphia healthcare worker COVID-19 vaccine mandate remains in effect.
- To be considered in compliance with the HCW COVID-19 Vaccine mandate, an individual must have received at least one of the following:
  - 2 doses of monovalent vaccine
  - One dose of bivalent vaccine
  - One dose of Janssen vaccine
- An individual may not simply opt out of vaccination.
  - They must submit for approval of a medical or religious exemption to the healthcare Institution where the individual works in accordance with the policies established by the institution.
- https://hip.phila.gov/document/3629/PDPH-HAN_Advisory_6_MaskingRequirements_05.10.2023_orQRaZQ.pdf/

When should my staff wear eye protection?

- Per Standard Precautions for all potential splashes, or sprays of blood, or body fluids to the eyes e.g., wound irrigation, emptying bedpan or emesis basin
- Resident has COVID or suspected COVID
- If COVID transmission in the community increases, consider using eye protection for all resident care encounters

- 2023-694-5-11-UPD-IPC for Healthcare.pdf (pa.gov)

If I have mild symptoms that could be allergies or a cold, am I required to test myself to rule out COVID?

- Yes, you should test yourself for COVID.
  - You could also have a different URI e.g., rhinovirus, RSV, metapneumovirus, influenza.
- Do not come to work if you have a fever or significant signs and symptoms of a respiratory illness.

My roommate tested positive for COVID. How long do I need to wear a mask at work? Do I need to tell my employer that I've had an exposure?

- Wear a mask for 10 days after your last day of exposure.
  - Last day of exposure will depend on your ability to isolate from your roommate
- You will also need a series of 3 COVID tests.
- Notifying your employer of a community exposure is prudent, but not required.

Department of Public Health
CITY OF PHILADELPHIA

SNF NHSN Reporting Updates

NHSN Updates

- Changes to CDC vaccine recommendations do not impact reporting definitions for the current quarter, thus continue to report the same way as currently for Q2 (03/27/23 – 06/25/23)

NHSN Updates

- Updates to LTCF Covid-19 Module Surveillance Pathways will be made for Q3.
  - Register for **training webinars** regarding these changes:
  - **Jun 1, 2023 02:00 PM** https://cdc.zoomgov.com/webinar/register/WN_lQ92SJReSe6gu3RlRbiqaA
  - **Jun 7, 2023 01:00 PM** https://cdc.zoomgov.com/webinar/register/WN_WO7zz66lSwyFGUfEx2bU7g

- Access to **training materials** for facilities:
  - Materials pertaining to Healthcare Personnel COV-19 Vaccination Data Reporting HPS | Weekly HCP COVID-19 Vaccination | NHSN | CDC
  - Operational Guidance: Operational Guidance COVID-19 Vaccination Reporting Rule (cdc.gov)

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U-FAST Antibiotic Stewardship Toolkit

Antibiotic Stewardship: Why and How?

- Widespread antibiotic use has led to **resistant germs**, ***C. difficile*** infections, and **adverse drug side effects**
- **Antibiotics are unique drugs**: they impact not just the person receiving them, but also the environment and community around them
- Goal: The **right antibiotic**, at the **right dose**, for the **right duration**, at the **right time** for every resident

Residents in nursing homes with higher antibiotic use have a

24% increased risk

of antibiotic-related harm.[2]

In nursing homes with higher antibiotic use,

even residents who do not receive antibiotics are at increased risk

of indirect antibiotic-related harms due to the spread of resistant bacteria or *C. difficile* germs from other patients.[2]

- **Urinary tract infections**: most common reason for antibiotic use & greatest stewardship opportunity in SNFs
- **U-FAST:** Resource package with 9 tools specifically designed to address all aspects of UTI care

	Resource	How to use	Link
1	**Asymptomatic bacteriuria** • One-page guide to managing residents with positive urine cultures and NO symptoms of UTI	Use this guide to provide stewardship education to bedside nursing staff and prescribers* in your facility. Consider posting the guide around areas where staff may be working	AHRQ
2	**Approaching a suspected UTI** • Guide to appropriate workup for residents with signs and symptoms of UTIs • 4x6 pocket cards, and 8x11 poster included	Distribute the pocket cards for prescribers to carry during rounds for easy access. Consider posting the 8x11 version around touchdown spaces or other areas where prescribers may be working	AHRQ – 8x11 AHRQ – 4x6
3	**Nursing SBAR for suspected UTI** • Communication tool to structure UTI discussion when nursing is contacting prescribers	Review the form with bedside nurses as part of training or annual education. Request that the form be filled out and kept in medical record during all resident encounters for suspected UTI.	AHRQ
4	**Collecting urine cultures** • One-page guide to proper technique for urine culture collection in residents with & without catheters	Distribute this guide to bedside nursing staff who are involved in the collection of urine cultures. Consider including it with nursing training or annual education, and/or posting it around nursing stations	AHRQ
5	**Diagnosis and treatment of UTIs** • Specific UTI diagnosis & treatment recommendations, including choice of antibiotic and duration	Distribute this guide to prescribers in your facility. Consider posting the around touchdown spaces or other areas where prescribers may be working	AHRQ
6	**Antibiotic timeout tool** • Protocol to reassess antibiotics after 48-72hrs based on the additional culture and clinical data available	Use this form routinely after all new antibiotic orders. Contact your electronic medical record provider (e.g., Point-Click-Care) to ask if it can be inserted as a user-defined alert. Consider tracking and reporting antibiotic timeout results at QAPI meetings.	RISE
7	**Talking to residents & family members about UTIs** • Talking points to respond to common questions from residents & family members about UTIs	Use this guide to provide stewardship education to bedside nursing staff and prescribers in your facility. Consider posting around areas where staff may be working.	AHRQ
8	**Resident/family educational pamphlet** • Trifold brochure for residents & families with answers to general FAQs around antibiotics	Keep copies of this pamphlet on the unit and provide as a resource to any resident or family member who has questions about antibiotics.	CDC
9	**Antibiotic commitment poster** • A public display of your community's commitment to antibiotic stewardship and accountability	Contact PDPH (HAI.PDPH@phila.gov) or your RISE team member to have poster customized for your facility, including company logo, electronic signatures, and/or pictures of facility leadership.	PDPH

Electronic version of U-FAST emailed to all Philadelphia SNFs on Wednesday, 5/17/23

Printed U-FAST binder will be mailed to all communities within 2 weeks

RISE team member will contact you to confirm binder was received and answer any initial questions

Please reach out with any questions to your RISE team member or PDPH!

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Department of
Public Health
CITY OF PHILADELPHIA

Resources and Services

Reminder: HAI/AR Services

- Infection Control Assessment and Response (ICAR) visit
- Onsite education
- N95 qualitative fit test training
- Quarterly newsletter

- Sign-Up Form for HAI/AR Services

APIC Membership for SNF Infection Preventionists

Connecting LTCF IPs to a professional organization offers:

- Online educational resources
- Online peer community and support
- Local chapter networking opportunities and LTC Focus Group support

PDPH Organizational Membership (annual):

- One membership per facility
- Can be transferred to a new IP
- Link to sign up:
  https://app.smartsheet.com/b/form/3e8cffae22f84c2692ee614321f816f0

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Thank you!

Our next call will be on **Wednesday, June 21, 2023 @ 11:00 AM**