

# Residential and long-term care facility call

April 26, 2023

Nursing Facilities and ICFs



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Department of Public  
Health & Environment

The new LTCF call format allows for tailored information to be provided based on facility type.

Upcoming LTCF calls:

- **Assisted Living Residences/Group Homes:** May 10, 2023.
- **Nursing Facilities/ICFs:** May 24, 2023.

The meeting link will remain the same.

Information provided during the call and included in this slide deck is based on currently available information at the time it was drafted. It is subject to change as new guidance is made available.

To ensure you always have the most current information, go to <https://covid19.colorado.gov/lcf>.



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# Agenda

- **Candida *auris* (C. auris)**  
Dr. Chris Czaja, HAI Program Manager and Medical Epidemiologist
- **Chapter 2 updates**  
April Burdorf, COVID-19 Infection Prevention Program Manager
- **Updated vaccination recommendations**  
Christi Schertz, Project Manager
- **Test distribution update**  
Jessica Mechtenberg, Project Manager



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# Candida *auris*

Dr. Chris Czaja, HAI Program Manager and  
Medical Epidemiologist

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# *Candida auris*

April 26, 2023

Christopher Czaja MD DrPH  
HAI/AR Program



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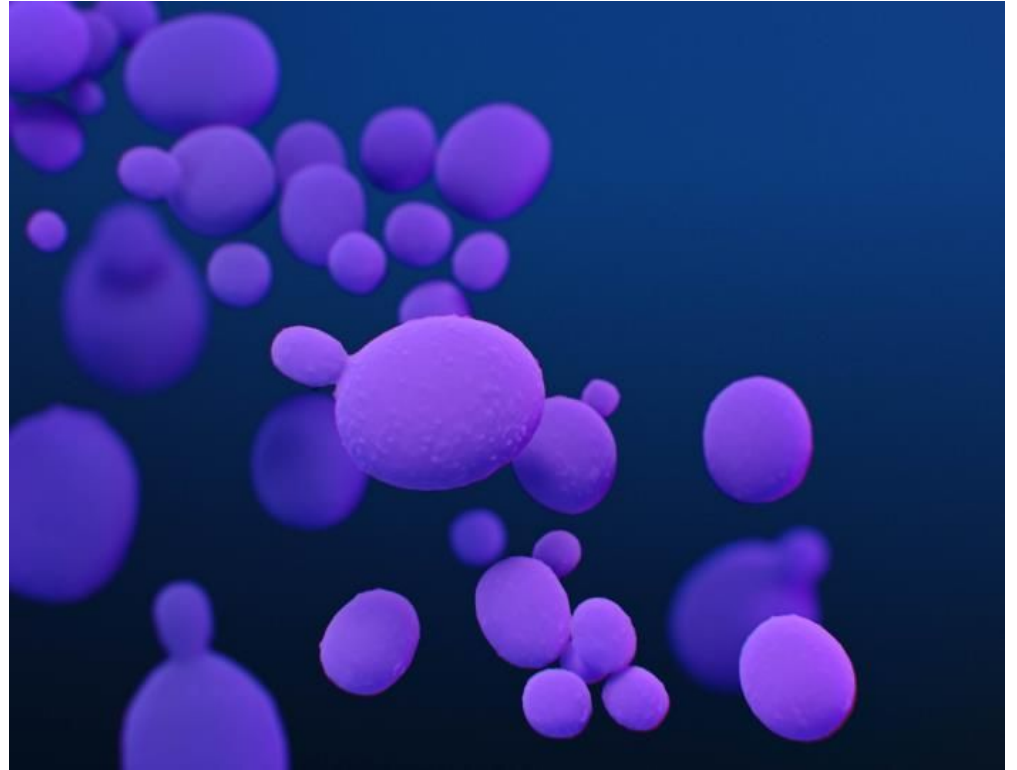
# Epidemiology

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# Background

- Emerging yeast.
- First described in 2009.
- Cause of invasive infections.
- Resistant to antifungals.
- Outbreaks in healthcare settings.



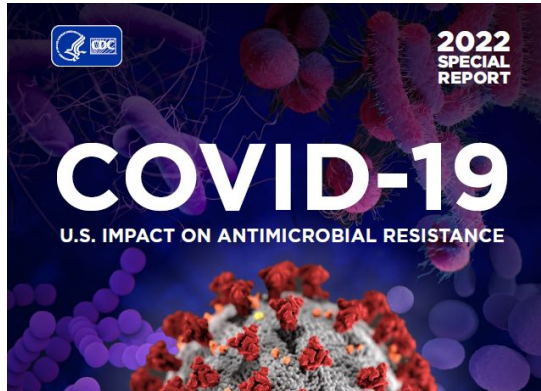
# *C. auris* in the news

Annals of Internal Medicine

ORIGINAL RESEARCH

## Worsening Spread of *Candida auris* in the United States, 2019 to 2021

Meghan Lyman, MD; Kaitlin Forsberg, MPH; D. Joseph Sexton, PhD; Nancy A. Chow, PhD, MS; Shawn R. Lockhart, PhD; Brendan R. Jackson, MD, MPH; and Tom Chiller, MD, MPHTM



Increasing Threat of Spread of Antimicrobial-resistant Fungus in Healthcare Facilities

[Print](#)

Press Release

For Immediate Release: Monday, March 20, 2023

Contact: [Media Relations](#)

(404) 639-3286

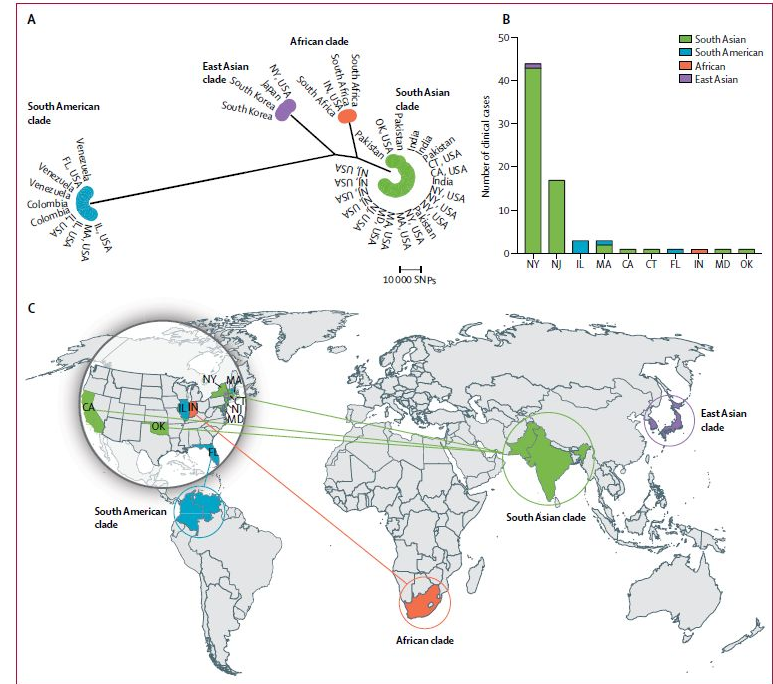


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# Emergence

- First U.S. cases reported in 2016 (earliest case later identified in 2013).
- Simultaneous emergence from four geographic regions (clades I-IV).
- Local spread within regions.



# Epidemiology

*C. auris* clinical cases have steadily increased since 2015 and significantly increased in 2020. The increase in 2020 could be a result of staffing and supply shortages, an increased number of sicker patients, and changes in infection prevention and control practices (e.g., re-use or extended use of gowns and gloves).



# Spread of *C. auris* in the United States

- Exponential increase in case counts.
- Increased detection through screening.
- Increasing geographic spread.
- Endemic in some states.

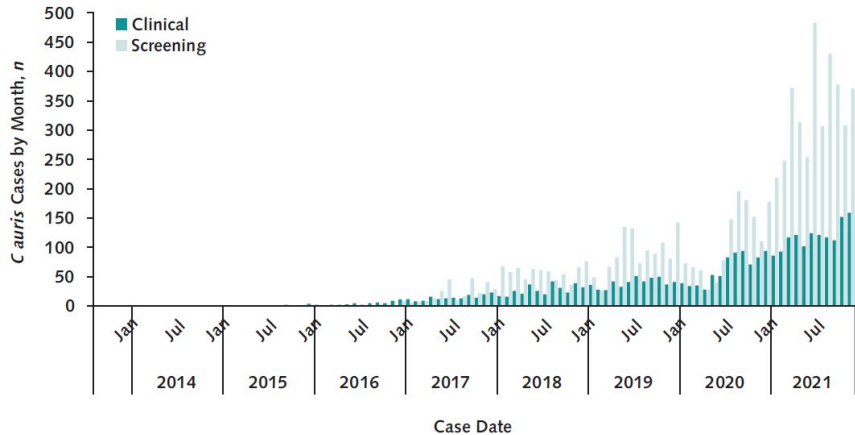
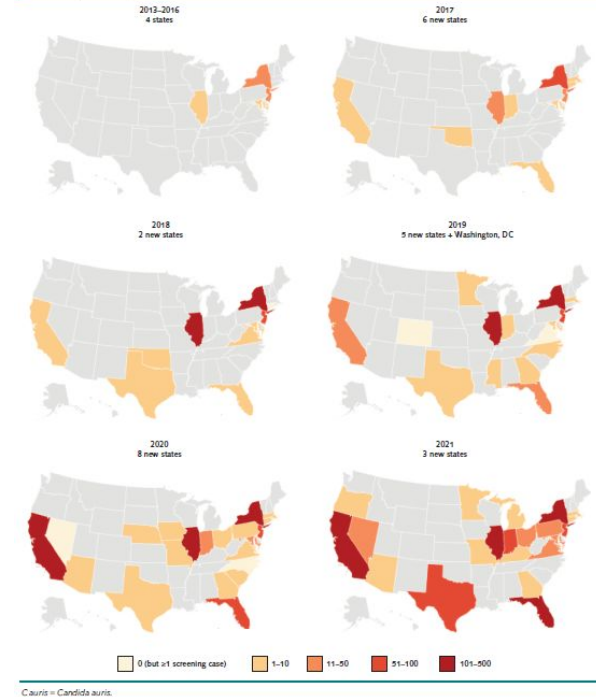


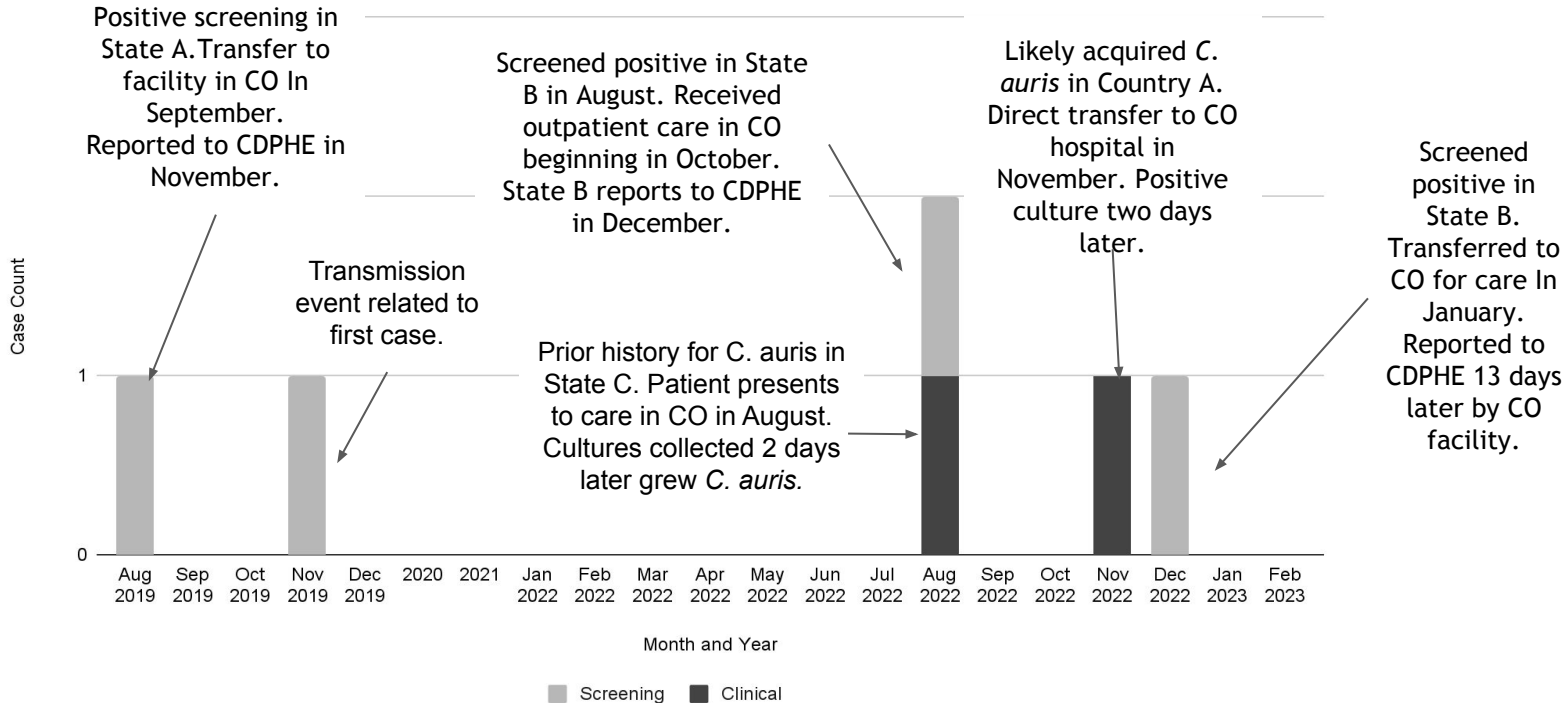
Figure 3. Geographic distribution of clinical *C. auris* cases in the United States reported to the Centers for Disease Control and Prevention by state during 2013 to 2021.



*C. auris* = *Candida auris*.

# C. auris - Colorado

Colorado C. auris cases by collection date (August 2019 - February 2023)





# Reasons for increased spread in the United States

- Stressed healthcare and public health systems during the pandemic.
- Staff and equipment shortages.
- Increased patient burden and disease severity.
- Increased antimicrobial use.
- Changes in patient movement patterns.
- Gaps in non-COVID-19 IPC measures.

# Surveillance

- **Candida auris case, screening:** Person with confirmatory laboratory evidence from a swab collected for the purpose of screening for *C. auris* colonization regardless of site swabbed.
- **Candida auris case, clinical:** Person with confirmatory laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care.
- **Colorado:** Screening and clinical cases of *C. auris* are immediately reportable to CDPHE by lab or providers.

# Clinical diagnosis

- Routine clinical culture.
- Can be misidentified as a number of different organisms (mostly other *Candida spp.*) when using traditional phenotypic methods for yeast identification.
- Diagnostic devices based on matrix-assisted laser desorption/ionization time-of-flight (MALDI-TOF) can differentiate *C. auris* from other *Candida* species.
- Can be missed if *Candida spp.* are not further speciated (e.g., *Candida* in urine considered a contaminant).



# Clinical presentation

- Blood > urine, respiratory, wound, tissue.
- Older age (60+ years).
- Comorbidities: Respiratory failure, renal failure, diabetes, COVID-19.
- Medical devices: Mechanical ventilation/tracheostomy, gastrointestinal tube, foley, central line.
- Prior surgeries.
- Prolonged hospital stay.
- Co-colonization with a carbapenemase producing organism (53%).
- Prior *C. auris* colonization (23%).
- Prior residence in post-acute care facility with an outbreak.
- Discharge to skilled nursing or long-term acute care.
- Mortality 20-60%.



# Antifungal resistance

- **Regional differences associated with clade.**
- **Most isolates are azole resistant: >95% Mid-Atlantic, Mountain, Northeast, Southeast, West; ~10% Midwest.**
- **Amphotericin B resistance is common: ~85% Mid-Atlantic, ~45% Northeast, ≤5% Midwest, Mountain, Southeast, West.**
- **Echinocandin resistance is uncommon but increasing: 2018 (0.2%) -> 2019 (1.4%) -> 2020 (1.2%). In 2021, 19 patients with echinocandin-R isolates and seven with pan-R isolates, including two outbreaks.**
- **\*Echinocandins are first line treatment.**

# Treatment of infection

- Consultation with an infectious disease specialist is recommended when caring for patients with *C. auris* infection.
- Infectious Diseases Society of America has guidelines for treatment of candidiasis:  
<https://www.idsociety.org/practice-guideline/candidiasis/>.
- CDC has treatment guidance for *Candida auris*:  
<https://www.cdc.gov/fungal/candida-auris/c-auris-treatment.html>.
- There are no vaccines for *C. auris* or CPOs.



# Transmission

- Person-to-person via direct or indirect contact.
- Contamination and persistence in the healthcare environment, including patient care areas and shared equipment.
- Prolonged asymptomatic colonization can go unrecognized.
- Facilitated by patient movement between multiple healthcare facilities and interstate and international travel.
- Facilitated by common gaps in infection control.
- Most U.S. transmission in long-term acute care hospitals and ventilator-capable skilled nursing facilities.

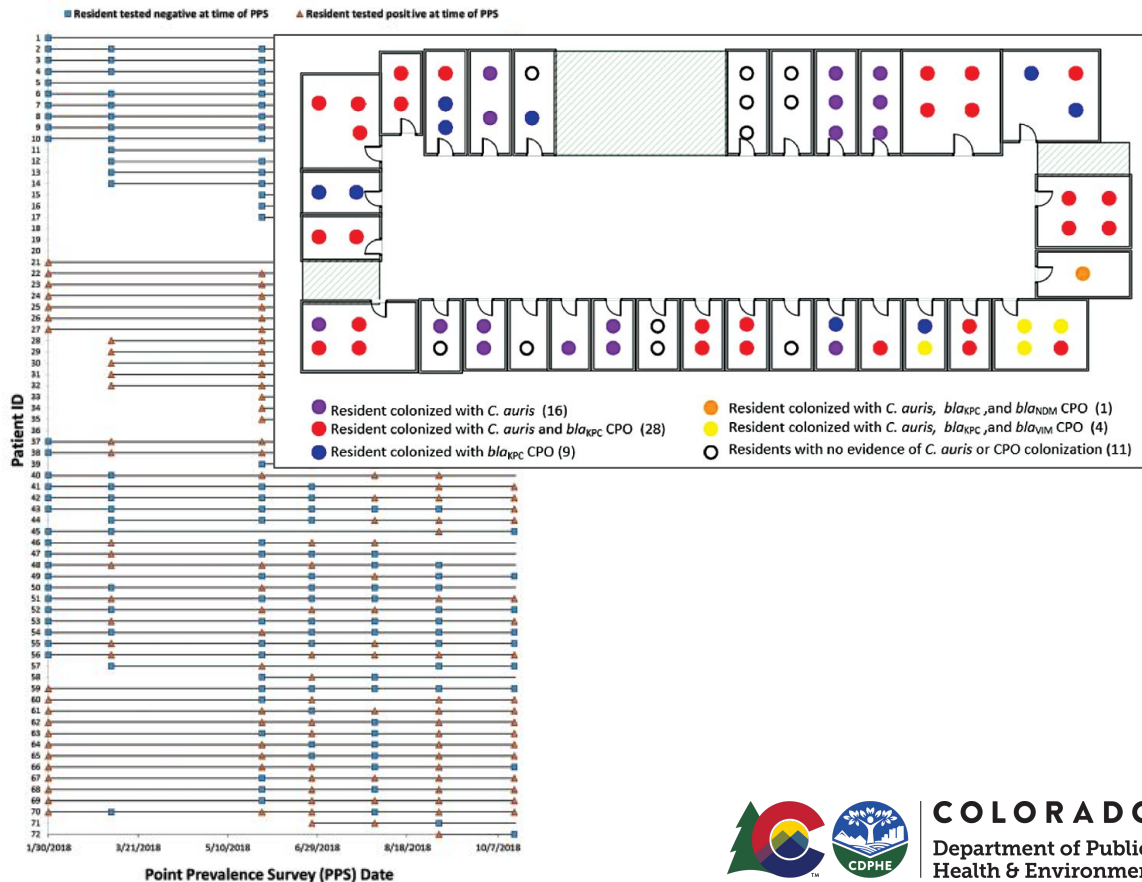
# Long-term acute care hospitals and ventilator-capable skilled nursing facilities

- At-risk patients with medical comorbidities and devices.
- Long healthcare facility stays.
- Frequent healthcare worker contact.
- Prolonged, broad-spectrum antibiotic exposure.
- Share patients with multiple healthcare facility types.
- Efforts to prevent and respond to antimicrobial resistance threats in these facilities can influence the prevalence of antimicrobial resistance threats in a region or healthcare network.

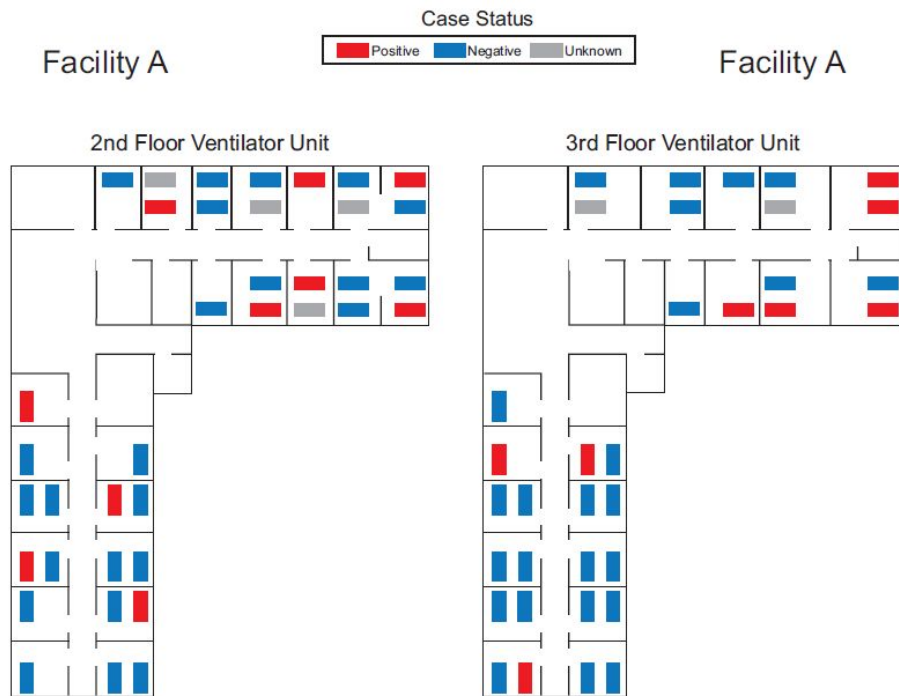


# Colonization - ventilator-capable skilled nursing facility, Chicago, 2018

- Prolonged, intermittent colonization.
- Prevalence can be high (40-70%).
- Co-colonization with carbapenemase-producing organisms.
- 5-10% develop invasive infection.



# Risk factors for colonization: New York



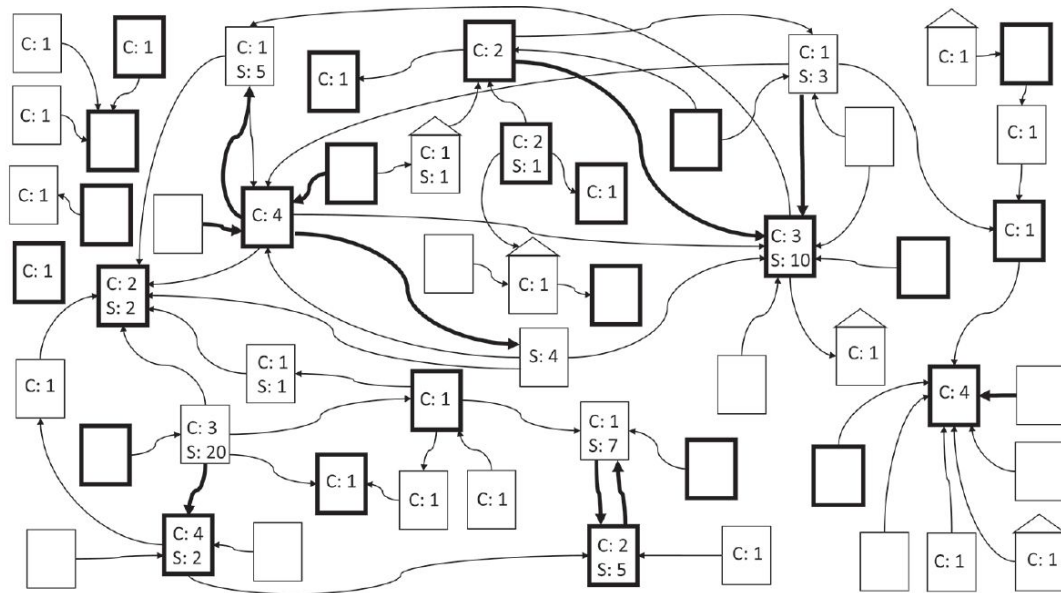
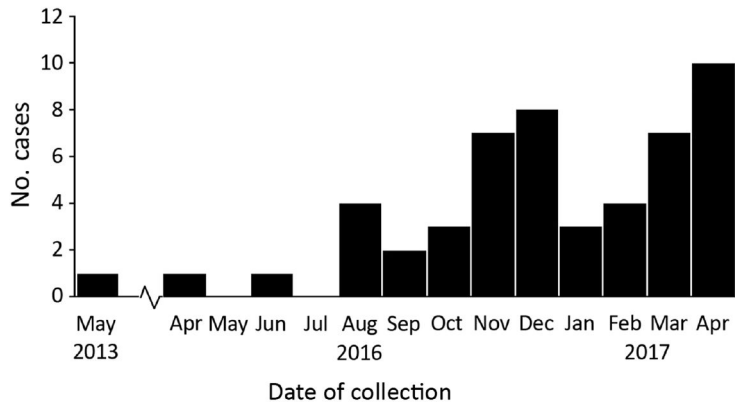
## Risk factors

- Mechanical ventilation.
- Acute care hospital visit.
- Carbapenem use.
- Fluconazole use.

**Figure 1.** Facility maps depicting the *Candida auris* colonization status and location of patients at the time of a single point prevalence survey in the ventilator unit of a skilled nursing facility, New York, 2016–2018.

# Epidemiologic links between healthcare facilities affected by *Candida auris*, New York, USA, 2013-2017

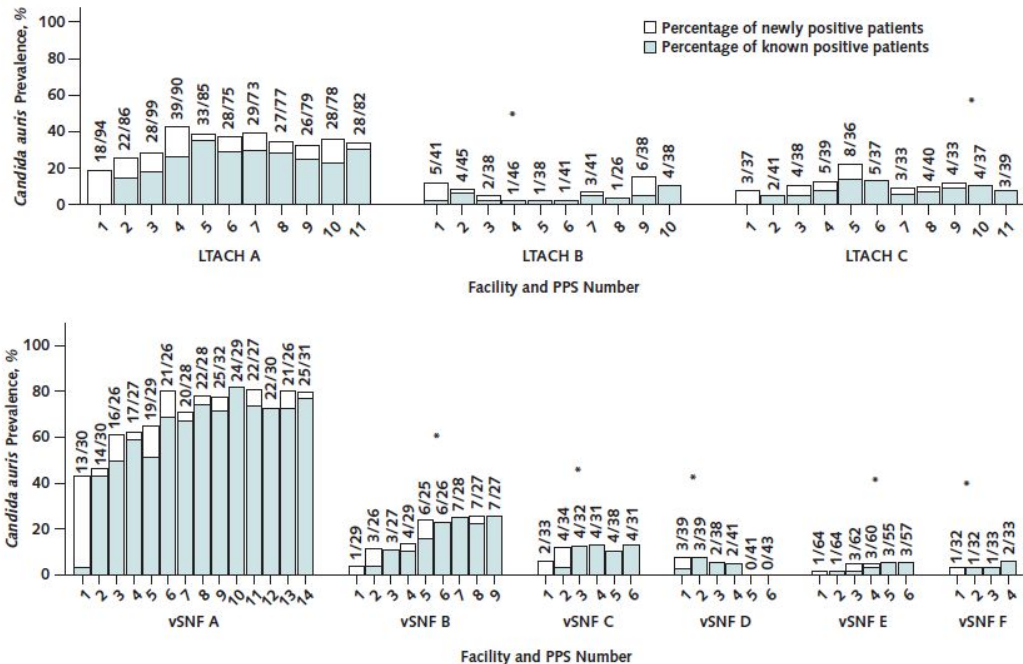
- Large interconnected web of acute care hospitals and long-term care facilities (60% ventilator-capable skilled nursing facilities).



Bold box = hospital; non-bold box = long-term care; C = clinical case; S = screening case.

# Containment: Orange County, 2018

Figure 1. Prevalence of *Candida auris* and the total number of screening cases (new and known) among total facility census, identified on serial PPSs within all OC LTACHs and 6 vSNFs (A to F), by PPS number—OC, California, March to October 2019.



## Lessons learned

- Single regional introduction with undetected transmission.
- Containment efforts can control transmission if initiated early.

LTACH = long-term acute care hospital; OC = Orange County; PPS = point prevalence survey; vSNF = ventilator-capable skilled-nursing facility.

\* First facility instances of 2 consecutive PPSs with no new positive detections.



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# Response

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# Public health response

For accessible version go to <https://www.cdc.gov/hai/containment/guidelines.html>

## Interim Guidance for a Public Health Response to **Contain** Novel or Targeted Multidrug-resistant Organisms (MDROs)



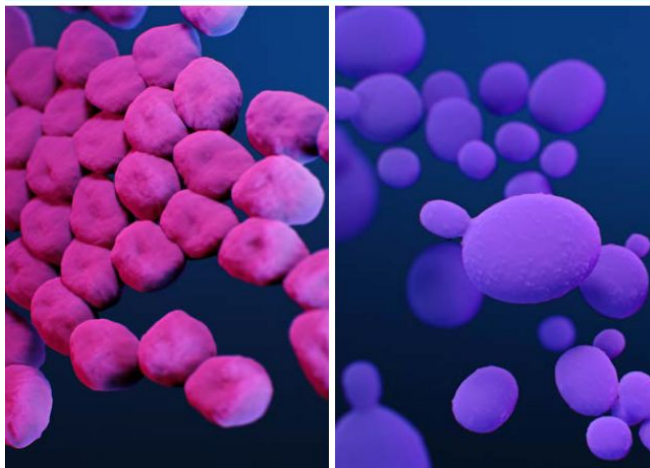
Updated December 2022



Centers for Disease  
Control and Prevention  
National Center for Emerging and  
Zoonotic Infectious Diseases

## Public Health Strategies to **Prevent** the Spread of Novel and Targeted Multidrug-resistant Organisms (MDROs)

Accessible Link: <https://www.cdc.gov/hai/mdro-guides/prevention-strategy.html>



Centers for Disease  
Control and Prevention  
National Center for Emerging and  
Zoonotic Infectious Diseases

CE33643-A



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# Early detection: Admissions screening, Colorado

- Health care providers should conduct admission screening tests for *C. auris* and carbapenemase-producing organisms (KPC-, NDM-, VIM-, IMP-, OXA-48-producing carbapenem-resistant *Enterobacterales*, *Acinetobacter* spp., and *Pseudomonas aeruginosa*) in patients with the following exposures:
  - Overnight stay or invasive medical or surgical procedure in a healthcare facility outside the U.S. in the previous year.
  - Overnight stay in a long-term acute care hospital or ventilator-capable skilled nursing facility anywhere in the U.S. in the previous year.
- Repeat admissions screening is unnecessary if a patient is known to have previously tested positive or has a documented negative test within 30 days prior to admission in the absence of a recent exposure.



# Sample collection

- Contact CDPHE for detailed instructions on how to collect and submit specimens for colonization screening tests to the AR Lab in Utah.
- CDPHE can coordinate the delivery of sample collection kits and timing of specimen submission via FedEx.
- Specimens include:
  - Rectal or stool swab screening carbapenemases.
  - Skin swab screening of the bilateral axilla and groin for *C. auris*.



# Infection prevention

- **Hand hygiene with alcohol based hand rub.**
- **Single patient room.**
- **Contact Precautions or Enhanced Barrier Precautions (skilled nursing) for confirmed cases, patients who meet screening criteria, and contacts of cases.**
- **Clean and disinfect the environment, including daily and terminal room cleaning, shared, and reusable equipment. Use EPA-registered hospital disinfectants from List P.**
- **Notify the receiving facility or unit at patient transfer.**
- **Base level of care on clinical criteria.**



# Containment goals

1. Identify infected and colonized patients.
2. Implement appropriate infection control measures.
3. Identify ongoing transmission.
4. Prevent further spread.

<https://www.cdc.gov/hai/mdro-guides/containment-strategy.html>



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# Containment activities

1. Initial infection prevention measures.
2. Conduct a health care investigation.
3. Conduct a contact investigation (colonization screening).
4. Prospective and retrospective laboratory surveillance.
5. Environmental cultures (special situations only).
6. Ensure adherence to infection control measures (assessment, recommendations, education, and notification).



# Colorado guidance: Contact investigation

- Once a case of *C. auris* or CPO is identified, work with CDPHE to conduct contact tracing and an investigation according to updated CDC guidance.
- This will include broader screening of patients who are health care contacts within facilities to which the patient was admitted in the 30 days prior to identification, *even if transmission-based precautions were in place.*
- Screening should begin within one week of initiation of the public health response.



# Implementation of containment

- **Long-term acute care and long-term care settings, hospital intensive care units, and hospital units with longer lengths of stay and patients at higher risk of acquisition and infection:**  
Point prevalence survey on affected units and targeted testing of overlapping patients transferred to other units or discharged to long-term care.



# Implementation of containment

- **Other settings:** Targeted colonization screening of overlapping patients and patients with a risk factor for acquisition who are still admitted may be appropriate unless it will take several days to identify higher risk contacts or if most higher risk contacts have been discharged from the facility.
- Additional point prevalence surveys are indicated if there is evidence or suspicion for ongoing transmission.



# Colonization screening

- CDPHE can coordinate colonization screening testing at the Regional Antimicrobial Resistance Laboratory for free.
- Facilities can also test at a clinical laboratory with appropriate testing options.
- Laboratory methods include culture, PCR, and whole genome sequencing to detect organisms and carbapenemases.
- Call the CDPHE Healthcare-Associated Infections and Antimicrobial Resistance Program at 303-692-2700 during business hours or email [cdphe\\_hai\\_ar@state.co.us](mailto:cdphe_hai_ar@state.co.us).



# Disease reporting

- Screening and clinical cases of *C. auris* are immediately reportable to CDPHE by lab or providers.
- Carbapenem-resistant *Enterobacterales*, *Acinetobacter baumannii* complex spp., and *Pseudomonas aeruginosa* are four-day laboratory-reportable conditions (303-692-2700; 303-370-9395 after hours).
- Isolate or clinical material must be submitted to the CDPHE laboratory.



# Thank you!

[christopher.czaja@state.co.us](mailto:christopher.czaja@state.co.us)



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# Chapter 2 updates

April Burdorf, COVID-19 Infection Prevention Program  
Manager

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# Chapter 2: General licensing standards

On April 19, 2023, the Board of Health adopted rules which were incorporated into facility licensing Chapter 2 General Licensing Standards.

The final adopted rulemaking included requirements for all licensed facilities to develop and maintain communicable disease infection prevention plans that include provisions for testing, vaccination, and treatment in accordance with applicable state laws, rules, and executive orders for all types of licensed health facilities.



# Chapter 2 updates

- Under Chapter 2, the final adopted rulemaking included requirements for all licensed facilities to develop and maintain communicable disease infection prevention plans that include provisions for testing, vaccination, and treatment in accordance with applicable state laws, rules, and executive orders for all types of licensed health facilities.



# Chapter 2 updates

For more information on the newly adopted permanent rules, refer to the April 19th rulemaking hearing documents:

<https://cdphe.colorado.gov/board-health-meetings>



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# Infectious disease mitigation, vaccine, and treatment plans

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# Mitigation, vaccine, and treatment plans

## Infectious disease mitigation, vaccine, and treatment plans

- A. All facilities licensed under this chapter shall **establish, maintain, and implement an infectious disease mitigation, vaccine, and treatment plan.** The plan must demonstrate prevention of and responsiveness to communicable diseases that are or may become present in the individual facility setting. The plan may include testing, vaccination, and treatment.



# Designated staff: Vaccines

**This plan shall address, at a minimum, the following:**

- (1) Identification of designated staff who shall coordinate vaccine information, administration, and tracking and reporting of the vaccination status of staff and, if applicable, residents on an ongoing basis;**



# Vaccination plans

(2) The name and location of the infectious disease vaccine and treatment provider(s) that will be used by the facility to facilitate administration of vaccines and treatment;

(3) How the facility will assess and address the vaccination of new staff and, if applicable, residents.





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# Infection Control Officer

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# Infection Control Officer

1.

**(B) Each facility shall assign at least one (1) staff member responsible for the site management of the facility's infection prevention and control program and training.**

**This individual shall be responsible for the following:**

- (1) Completing an infection prevention and control training from a nationally recognized provider or the department's training program within two (2) weeks of appointment/designation that meets the following requirements based on facility type;**



# Infection Control Officer

- (A) Infection Control Officers at Nursing Care Facilities and Intermediate Care Facilities for persons with intellectual and developmental disabilities shall complete at least **nineteen (19) hours of initial training.**



# Infection Control Officer

- The infection control officer should complete CDC's online training modules or complete/have documentation of other comparable infection prevention training education.
- Acceptable programs and certifications include:
  - CDC's Nursing Home Infection Preventionist Training Course.
  - American Health Care Association's Infection Preventionist Specialized Training.
  - APIC's Long-Term Care Infection Preventionist Essentials Training.
  - CIC, LTC-CIP, or a-IPC certification.



# Infection Control training

**(2) Completing a minimum of 1.5 hours of continuing education in infection prevention and control on an annual basis from a nationally recognized provider or the Department's training program sufficient to stay current on changing guidance and requirements in the field;**



# Prevention, response, reporting

**(3) Providing on-site management of infectious disease prevention and response activities and general infection prevention duties;**

**(4) Ensuring the facility complies with department reporting requirements related to infectious diseases;**



# Infection Control Officer

Remain informed of changing guidance and requirements.

## The on-site IC must:

- Stay up to date with infection prevention related threats impacting your community.
- Attend CDPHE technical assistance webinars.
- Subscribe to and review the RCF infection prevention newsletter.
- Review the [Colorado Health Facilities Interactive \(COHFI\) messages](#) from the department.
- Sign up to receive [HAN notifications from CDPHE](#).





# How do I sign up for the bi-weekly call?

## Need assistance?

- CDPHE hosts a bi-weekly virtual technical support meeting. [Register for the support meeting at this link.](#)
- If you would like to sign up to receive occasional infection prevention updates, including our bi-weekly newsletter and slides following the technical support meeting, [sign up to receive email notifications.](#)
- CDPHE's call center is available to answer calls from facilities from 8:30 a.m. to 5 p.m. Mondays through Fridays. Call 303-692-2700 or email [cdphe\\_covid\\_infection\\_prevention@state.co.us](mailto:cdphe_covid_infection_prevention@state.co.us). After hours, call 303-370-9395.
- [Find your local public health agency.](#)

## Contacts

- Infection Prevention Program - [cdphe\\_covid\\_infection\\_prevention@state.co.us](mailto:cdphe_covid_infection_prevention@state.co.us)
  - Email questions about:
    - Disease control and guidance.
    - Isolation.
    - Quarantine.
    - PPE use.
    - Infection prevention.
    - Outbreak line lists.
    - Reporting an outbreak.
    - COVID-19 vaccination, testing, and treatment.
    - Newsletters and calls.
- CDPHE Project Firstline - [cdphe\\_project\\_firstline@state.co.us](mailto:cdphe_project_firstline@state.co.us)
  - Access to free infection prevention training resources.
  - Infection prevention training support at your facility.
  - Support for a CO.TRAIN account setup to complete the RCF Infection Prevention Program Training Plan.



# Can I get a copy of the slides?

Can I get a copy of the slides following the bi-weekly call?

*Yes, copies of the slides are sent through our Residential Care and Long-Term Care Facility Newsletter and through CDPHE's COHFI (Colorado Health Facility Interactive) messages.*

## Need assistance?

- CDPHE hosts a bi-weekly virtual technical support meeting. [Register for the support meeting at this link.](#)
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# Infection Control Officer

## Reporting to public health

The IC must be aware of [conditions reportable to public health](#) and ensure outbreaks and individual cases of reportable conditions are reported to public health.

## Report a disease

Communicable Diseases	
Animal-related diseases	>
Communicable Disease Manual	
Diseases A to Z	>
Emerging Infections Program (EIP)	
Foodborne illness	>
Healthcare-associated infections (HAIs)	

This page is for laboratories, health care providers, or public health staff who need to report a case of illness to the department.

### [Diseases and conditions that must be reported](#)

Additional lab submission requirements:

- [Specimen submission requirements for clinical microbiology laboratories.](#)
- [Colorado Lab Guidance for Selected Reportable Antimicrobial Resistant Organisms](#)

### [How to report COVID-19/SARS-CoV-2 results and outbreaks](#)

For information on how to report COVID-19/SARS-CoV-2 cases and outbreaks to CDPHE.



# Reportable conditions list

Complete Board of Health rules can be found at: [cdphe.colorado.gov/all-regulations/regulations-adopted-by-the-board-of-health](http://cdphe.colorado.gov/all-regulations/regulations-adopted-by-the-board-of-health)

Immediate reporting by phone is required of any illness that may be caused by biological, chemical or radiologic terrorism.

As indicated below, reporting by labs (diagnostic results and those highly correlated with disease) and providers (including suspected conditions) is required in accordance with Regulation 6 CCR 1009-1. In addition to reporting positive laboratory results to public health, clinical laboratories are required to submit isolates and/or clinical material to the CDPHE laboratory for select pathogens. For all other pathogens, isolate/clinical material submission may be requested.

Time	Rep		Time	Rep	
4d	L	<i>Acinetobacter baumannii</i> , carbapenem-resistant (CRAB)*	4d	P	Influenza-associated death if <18 years
4d	P	Acute flaccid myelitis	4d	L&P	Influenza-associated hospitalization
24h	P	Animal bites (by dogs, cats, rabies reservoir species & other wild carnivores)	4d	L&P	Legionellosis
4d	P	Animal bites (by any other mammals)	4d	P	Leprosy (Hansen's Disease)
Imm	L&P	<b>Anthrax*</b>	4d	L&P	Listeriosis*
4d	L	Arboviral Diseases (Eastern equine encephalitis, LaCrosse encephalitis virus, Japanese encephalitis virus, California encephalitis serogroup, St. Louis encephalitis virus, Western equine encephalitis virus, Powassan virus and others)	4d	L&P	Lyme disease
Imm	L&P	<b>Botulism</b>	4d	L&P	Lymphogranuloma venereum (LGV) <sup>U</sup>
4d	L&P	Brucellosis*	4d	L&P	Malaria
4d	L&P	Campylobacteriosis	Imm	L&P	<b>Measles (rubeola)</b>
Imm	L&P	<i>Candida auris</i> (identified or suspected, including <i>Candida haemulonii</i> )*	Imm	L&P	<b>Meningococcal Disease (<i>N. meningitidis</i> or gm-neg diplococci)*<sup>T</sup></b>
30d	L	Candidemia <sup>S-county</sup>	4d	P	Multisystem Inflammatory Syndrome in Children (MIS-C) if <21 years
4d	L&P	Chancroid <sup>o</sup>	4d	L&P	Mumps
4d	L	Chikungunya	30d	L	<i>Mycobacterium</i> , nontuberculous (NTM) <sup>S-county</sup>
4d	L&P	Chlamydia <sup>o</sup>	Imm	L&P	<b>Outbreaks (all types, including foodborne, water, person-to-person, healthcare settings)</b>
Imm	L&P	<b>Cholera*</b>	1wd	L&P	Pertussis (whooping cough)
4d	P	CJD & other transmissible spongiform encephalopathies (TSEs)	Imm	L&P	<b>Plague*</b>
30d	L	<i>Clostridioides difficile</i> <sup>S-county</sup>	Imm	L&P	<b>Poliomyelitis</b>
4d	L	Colorado tick fever	4d	L	<i>Pseudomonas aeruginosa</i> , carbapenem-resistant
1wd	L&P	COVID-19 (SARS-COV-2 positive result on any test type and COVID-19 lineage or sequencing)	4d	L&P	Psittacosis
1wd	L&P	COVID-19 (SARS-COV-2 negative or inconclusive result on any test type)	4d	L&P	Q fever ( <i>Coxiella burnetii</i> )
Imm	L&P	Coronavirus, severe or novel (MERS-CoV or SARS-CoV)	Imm	L&P	<b>Rabies, human (suspected)</b>
4d	L&P	Cryptosporidiosis	4d	L&P	Respiratory Syncytial Virus (RSV)-associated hospitalization <sup>S-county</sup>
			4d	L&P	Rickettsiosis (including RMSF and typhus)
			1wd	L&P	Rubella, acute infection
			4d	L&P	Rubella, congenital

Pay attention to COVID-19 cases and outbreaks (all types) in healthcare settings.

Outbreaks are immediately reportable by both laboratories and providers.



The IPC should ensure timely and accurate reporting in EMResource.

- Reporting should occur once during each bi-monthly reporting period: Period one and period two. Multiple reports within the same reporting period will overwrite previous reporting and does not meet requirements for future reporting periods.
  - Reporting period one is defined as days 1-14 of each month.
  - Reporting period two is defined as days 15-31 of each month.



# Provide necessary supplies

**(5) Providing facility access to, and ensuring proper supply, use, handling, and implementation of personal protective equipment (ppe) and disinfectants, used per manufacturer's guidelines;**



# Provide necessary supplies

Ensure that facility personnel have access to all the necessary supplies required to adhere to recommended infection prevention and control practices, including but not limited to:

- Hand hygiene supplies.
- Supply of surface disinfectant.
- Personal protective equipment.



# Respiratory protection program

**(6) Maintaining a facility respiratory protection program compliant with occupational safety and health administration (OSHA) respiratory protection standard (29 CFR 1910.134);**





# Respiratory Protection Program

The onsite person responsible for infection prevention and control must implement a respiratory protection program that is compliant with the Occupational Safety and Health Administration (OSHA) respiratory protection standard (29 CFR 1910.134) for employees, if not already in place.

The program should include medical evaluations, training, and fit testing.



# Respiratory Protection Program Training

CDPHE is offering training to help facilities get started with the development of Respiratory Protection Plans (RPP). Join us virtually on one of the dates and times listed below for an introductory overview of the RPP. **Registration is required** and each session is limited to 30 attendees. Select only one session, all content will be the same in each occurrence.

- [Register for Wednesday, April 26, 2023 at 3 - 3:45 p.m.](#)
- [Register for Tuesday, May 2, 2023 at 10 - 10:45 a.m.](#)
- [Register for Wednesday, May 3, 2023 at Noon - 12:45 p.m.](#)



# Educating staff, residents and family

**(7) Advising and educating residents, staff, and visitors on current precautions being taken in the facility for infectious diseases and the prevention of their spread; and**

**(8) Notifying residents, designated representatives, and staff of updated centers for disease control (CDC) vaccination recommendations, and ensuring recommended vaccines for infectious diseases are available to staff and residents inside their facility on an annual basis.**



# Project Firstline IPC materials and job aids

- Fact sheets.
- Posters.
- Social media images.
- Videos.

Free to use and download from CDC's website!  
Great materials to post around your facility to remind staff about IPC practices.

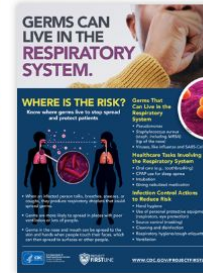
## Fact Sheets



## Infographics



[Skin Profile](#)  
[PDF - 1 Page]



[Respiratory System Profile](#)  
[PDF - 1 Page]



[Blood Profile](#)  
[PDF - 1 Page]



[Gut Profile PDF](#)  
[PDF - 1 Page]

## Posters



[Thousands of Germs Poster 1](#)  
[PDF - 1 Page]



[Thousands of Germs Poster 2](#)  
[PDF - 1 Page]



[What would you see? Poster](#)  
[PDF - 1 Page]



[Dirt and Dust Profile](#)  
[PDF - 1 Page]



[Devices Profile PDF](#)  
[PDF - 1 Page]



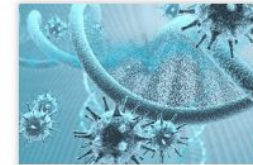
# Topics

## Infection Control and COVID-19

- The Concept of Infection Control
- The Basic Science of Viruses
- How Respiratory Droplets Spread COVID-19
- How Viruses Spread from Surfaces to People
- Multi-Dose Vials
- PPE: Eye Protection, Gloves & Gowns, Respirators
- Hand Hygiene
- Environmental Cleaning and Disinfection
- Source Control
- Asymptomatic Spread of COVID-19
- Ventilation



The Concept of Infection Control



The Basic Science of Viruses



How Respiratory Droplets Spread COVID-19



How Viruses Spread from Surfaces to People  
Topic Four: How Viruses Spread



How COVID-19 Spreads: A Review  
Topic Five: How COVID-19



Multi-Dose Vials  
[Topic Six: Multi-Dose Vials](#)  
(Section Plan) PDF - 44 Pages



PPE Part 1 – Eye Protection  
Topic Seven: PPE Part 1 – Eye



PPE Part 2: Gloves & Gowns



Hand Hygiene  
Topic Nine: Hand Hygiene PDF



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# Updated vaccination recommendations

Christi Schertz, Project Manager

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# COVID-19 vaccine recommendations

On April 19, 2023 [Centers for Disease Control and Prevention \(CDC\) updated COVID-19 vaccine recommendations](#) to allow more flexibility for people at higher risk who want the option of added protection from additional COVID-19 vaccine doses.

These changes include:

- An additional updated (bivalent) mRNA vaccine dose is now allowed for adults aged 65 years and older (at least 4 months after the first bivalent mRNA vaccine dose) and people who are immunocompromised (at the discretion of their health care provider). This allows more flexibility for healthcare providers to administer additional doses to immunocompromised patients as needed.
- Monovalent (original) mRNA COVID-19 vaccines are no longer authorized for use in the United States.



# COVID-19 vaccine recommendations

- People aged 6 years and older who are not immunocompromised should receive one updated mRNA COVID-19 vaccine, regardless of whether or not they completed their monovalent primary series.
- People aged 6 years and older who have already received an updated mRNA vaccine do not need to take any action unless they are 65 years or older or immunocompromised.
- For children aged 6 months through 5 years, multiple doses continue to be recommended. The number of doses will vary by age, vaccine, and which vaccines were previously received.





# COVID-19 vaccine recommendations

- Alternatives to mRNA COVID-19 vaccines remain available for people who cannot or will not receive an mRNA vaccine.
- CDC's recommendations for use of (monovalent) Novavax or Johnson & Johnson's Janssen COVID-19 vaccines were not affected by the changes made.



# COVID-19 vaccine recommendations

- Before providers can give additional bivalent vaccines, CDC needs to finish updating their [interim clinical guidance](#) and standing orders.
- CDPHE expects CDC to update their standing orders this week.
- Pfizer and Moderna primary series doses are on hold until CDC completes these updates.
- Providers may continue to administer **first bivalent boosters** to those eligible during this interim period.



# COVID-19 vaccine recommendations

CDC will continue to monitor COVID-19 disease levels and vaccine effectiveness in the months ahead and potential COVID-19 vaccine updates this fall.

## Resources:

- [CDC Statement](#)
- [Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC](#)
- [Stay Up to Date with COVID-19 Vaccines | CDC](#) (website updates pending)
- [Long-term and residential care facilities | Colorado COVID-19 Updates](#)
- [Ongoing COVID-19 Long-Term Care Vaccination Plan | CDPHE](#)
- [COVID-19 vaccine dose calculator | CDPHE](#)



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# Point of care test distribution

Jessica Mechtenberg, Project Manager

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# POC Test Distribution Reminders

- All nursing facilities and intermediate care facilities should receive their final shipment of rapid point-of-care tests by the end of day Friday, April 28.
- If you do not receive your tests by Saturday, email [jessica.mechtenberg@state.co.us](mailto:jessica.mechtenberg@state.co.us).
- Check the lot number with [Abbott's list of expiry date extensions](#) to determine the true expiration date of tests.
- CDPHE recommends writing the true expiration dates on the test kits prior to placing them in storage.



# Rapid test auto shipments from HHS

- Some facilities with active CLIA waivers may still be receiving free automated biweekly shipments of Binax point-of-care testing supplies from HHS.
- If your facility no longer needs these tests, email [Binax.team@hhs.gov](mailto:Binax.team@hhs.gov) to stop or pause these shipments.
- If you think your facility is eligible to receive supplies, but is not currently receiving shipments, email [Binax.team@hhs.gov](mailto:Binax.team@hhs.gov).



# PCR Testing End Date

- Facilities will be able to use PCR lab partners (ATCG and Mako) through May 8.
- After May 8, facilities will need to work with their lab partner to return leftover testing supplies.



# Thank you!

Additional questions?

Email [cdphe\\_covid\\_infection\\_prevention@state.co.us](mailto:cdphe_covid_infection_prevention@state.co.us)



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