Residential and long-term care facility call

Jan. 8, 2025

All LTCF Facilities

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Agenda

- **Transmission-based precautions and enhanced barrier precautions**
  Marlee Barton, HAI Prevention and Response Infection Preventionist, Nurse Consultant

- **Viral respiratory updates**
  Deborah Aragon, Influenza and RSV Response Unit Manager

- **CDPHE COVID-19 reporting requirements**
  Brynn Berger, COVID-19 Infection Prevention Program Manager

- **Transition of COVID-19 outbreaks to LPHAs**
  Brynn Berger, COVID-19 Infection Prevention Program Manager

Changes to call cadence

- These calls are now moving to a quarterly cadence
    - Next call will be April 9, 12-1pm
- We will continue to send monthly newsletters for now
- Infection prevention and control topic survey
- Contact cdphe_covid_infection_prevention@state.co.us with any questions

Precautions to prevent infections in skilled nursing facilities

Marlee Barton, RN, BSN, MPH, Infection Preventionist

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Objectives

- Understand:
  - Transmission-based precautions (TBP) used in skilled nursing facilities (SNFs)
  - Enhanced-barrier precautions (EBP) used in SNFs
  - Common gaps associated with TBP and EBP
- Answer frequently asked questions (FAQs) regarding EBP

Transmission-based precautions

Transmission-based precautions (TBP)

- Commonly used in all healthcare settings
- Should be used in addition to standard precautions, which are always in place
- Residents who are suspected or confirmed to be **infected** with certain infectious agents
- Needed to prevent transmission

[CDC: Transmission-Based Precautions]

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Types of TBP

- Contact
  - Infections spread through contact.
- Droplet
  - Infections spread by respiratory droplets generated by coughing, sneezing, or talking.
- Airborne
  - Infections spread by airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster).

Type and duration of precautions recommended for selected infections and conditions are available in CDC's Appendix A.

Contact precautions

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Droplet precautions

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Airborne precautions

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Multiple precautions

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TBP are temporary!

- TBP (isolation) restricts residents to their rooms and limits participation in group activities.
    - Can impact quality of life and quality of care

- Ensure the facility follows current evidence-based recommendations for discontinuing TBP.
    - Ensure precautions are maintained during the transmission risk as specified in CDC's Guideline for Isolation Precautions Appendix A.
    - Ensure proper environmental disinfection occurs **prior** to discontinuing.

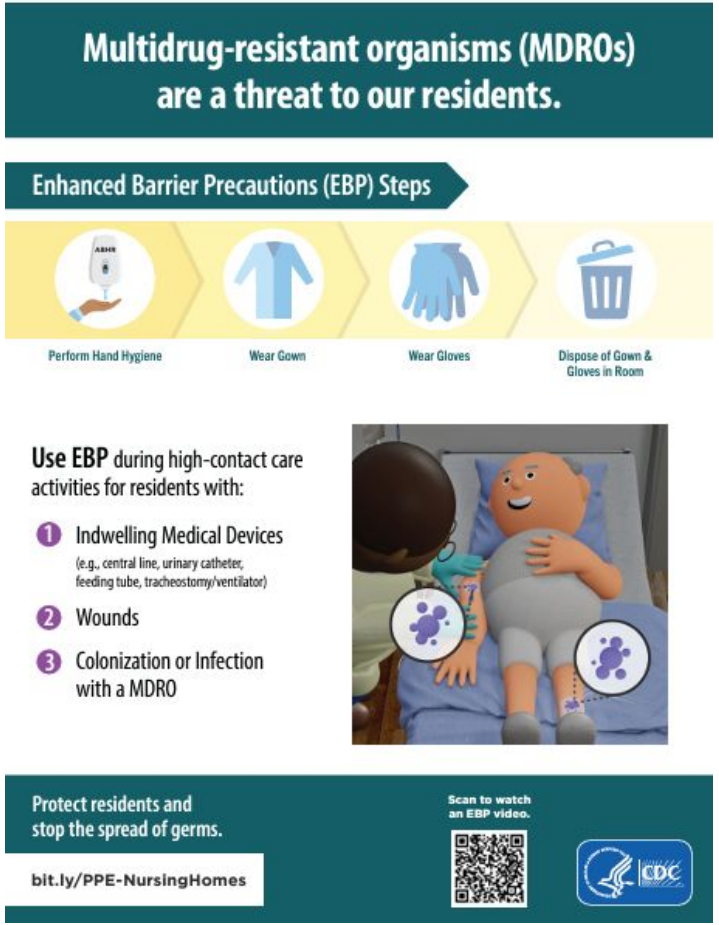
Enhanced-barrier precautions

Enhanced-barrier precautions (EBP)

- Specific to skilled nursing facilities
- Should be used in addition to standard precautions, which are always in place
- Use for residents at risk for **or** with a history of infection/colonization with a multidrug-resistant organism (MDRO)
- Needed to prevent transmission of MDROs

https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html

Using EBP



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High-contact care activities

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Purpose of EBP

- MDRO transmission is common in residential facilities.
  - More than 50% of nursing home residents may be colonized with an MDRO (unknowingly).
- EBP are an infection control intervention designed to reduce transmission while balancing residents' quality of life.
  - Residents are **not** restricted to their rooms or from participation in group activities.
- Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who have no symptoms of illness.
- **EBP does not replace TBP!**
  - It is used when TBP do not otherwise apply!

EBP are indefinite!

- Residents with a history of a MDRO infection or colonization should remain on EBP indefinitely.
  - MDRO colonization is considered indefinite.
  - Residents remain colonized after the resolution of their infection.
  - Residents infected and colonized with MDROs can transmit to others.

- Residents with indwelling medical devices or wounds can discontinue EBP only if:
  - EBP were only being implemented due to their indwelling medical device and active wounds (i.e., no history of a MDRO).
  - The indwelling device has been removed.
  - Wounds have fully recovered.

TBP vs. EBP

Differences between TBP and EBP

TBP

- All health care facilities
- Active infections (suspect or confirmed)
- Temporary

EBP

- Long-term care facilities providing skilled nursing only
- History of MDRO infection or colonization, or at risk for infection
- Indefinite*

*Residents with no history of MDROs may have EBP discontinued under certain circumstances.

Differences between TBP and EBP

TBP

- Require private rooms (if possible)
- Residents must stay in their room
- PPE required for all activities (every entrance to the room)

EBP

- Do not require private rooms
- Residents can move throughout facility
- PPE required for certain activities

Common gaps

Common infection control gaps associated with TBP and EBP

TBP

- Failing to:
  - Use disposable or dedicated equipment when residents are in isolation.
  - Prioritize cleaning and disinfection of isolation rooms, and not cleaning/disinfecting carts after an isolation room.
- Using inappropriate disinfectants and/or not achieving proper contact time.
- Delays in implementing TBP.

EBP

- Facilities inconsistently using EBP or using them incorrectly.
  - Only using for care of wound, catheter, etc.
  - Ancillary services and contracted workers are not complying with EBP.

Common infection control gaps associated with TBP and EBP

TBP and EBP

- Improper selection and use of PPE
  - Gowns not properly tied, hanging off shoulders
  - Improper donning/doffing order
  - Extending/reusing masks
  - Failing to change gloves during care activities

- Lack of communication between transferring facilities
  - Results in ongoing transmission

FAQs

FAQs

- Can PPE be stored inside the room for EBP?

CDC recommends storing PPE outside of the room whenever possible. However, PPE can be stored inside the room as long as it is adequately protected. This is **not** the case for TBP.

- Is PPE required for ancillary services (PT/OT) for residents on EBP?

PPE is required for close-contact care activities, typically taking place in the resident's room. It is not required in common areas (gyms) when there is not prolonged close contact. Ensure this is clear in your policy and staff are educated.

FAQs

- Are suprapubic catheters considered indwelling medical devices for the purpose of EBP?

While this is not explicit in CDC guidance, it appears that SPC are considered indwelling devices since they enter the body at the insertion point.

- Are ostomies considered indwelling medical devices for the purpose of EBP?

No. Ostomies do not require EBP.

- Are EVS personnel required to wear PPE while cleaning rooms of residents on EBP?

Only if they are changing linens. Linen change is considered a high-contact care activity.

References

- Transmission-Based Precautions | Basics | Infection Control | CDC
- CDC Appendix A for Isolation Precautions
- Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) | HAI | CDC
- Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes

Thank you!

Questions about TBP or EBP?

Email Marlee Barton, MPH, BSN, RN
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cdphe_hai_ar@state.co.us

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Viral respiratory disease updates

Deborah Aragon, MSPH, CIC
Influenza and RSV Response Unit Manager

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Clinical presentation of viral respiratory illness

- Symptoms associated with respiratory illness caused by viruses like influenza, RSV, and SARS-CoV-2 can be similar.
    - Examples: fever, cough, congestion, fatigue, shortness of breath
- Determining which virus is causing illness can be difficult based on symptoms alone.
    - Diagnostic testing is helpful for determining the cause(s) of illness.

Respiratory disease surveillance indicators

- Sentinel lab positivity
- Syndromic surveillance (via emergency department and outpatient visit data)
- Wastewater data
- Sentinel lab specimen submission (e.g., subtyping, variants)
- Cases
- Outbreaks
- Hospitalizations
- Mortality

2024-2025 viral respiratory early season data

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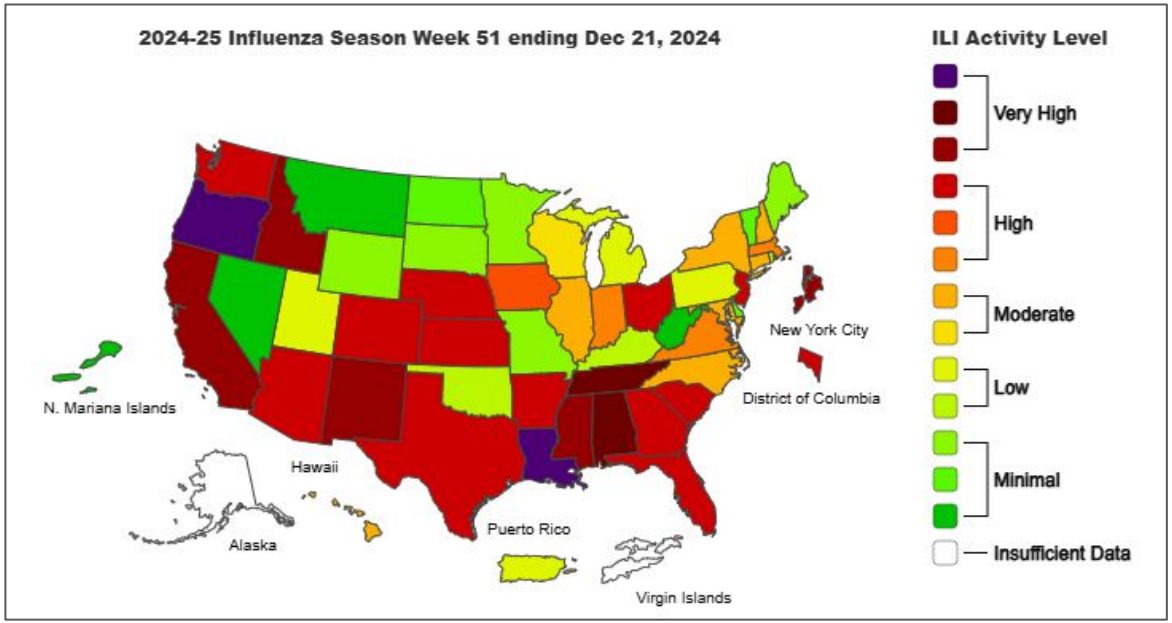
Updates (hint: respiratory season is here!)

- National: [Seasonal flu activity continues to increase and is elevated across most of the country].



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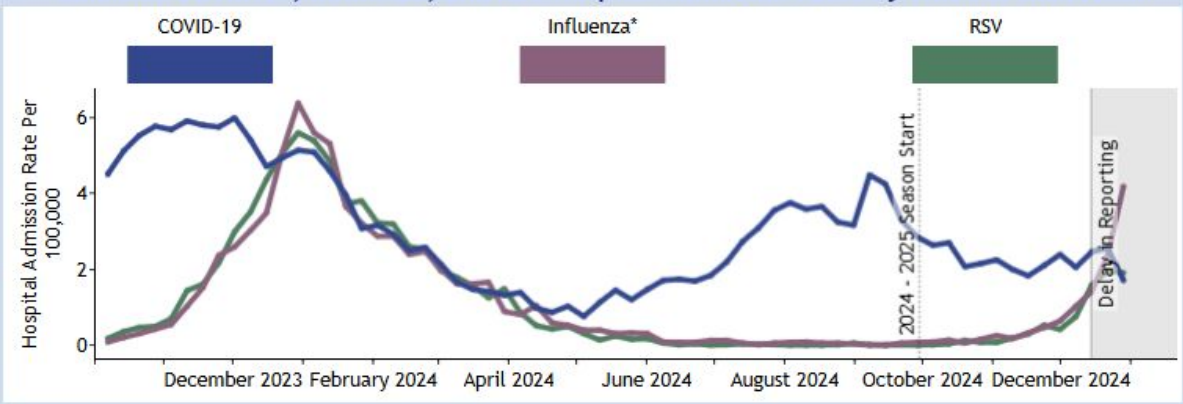
Colorado update

- Colorado: cdphe.colorado.gov/viral-respiratory-diseases-report



Key Metric Changes This Week Compared to Last Week

Pathogen	Weekly Hospital Admission Count	Weekly Diagnosed ED Visit Percent	Weekly Sentinel Percent Positivity
COVID-19	101 (▼50)	1.44% (▲0.38)	7.92% (▲0.45)
Influenza*	246 (▲106)	4.3% (▲1.86)	20.06% (▲7.15)
RSV	113 (▼3)	0.35% (▲0.19)	7.62% (▲1.6)

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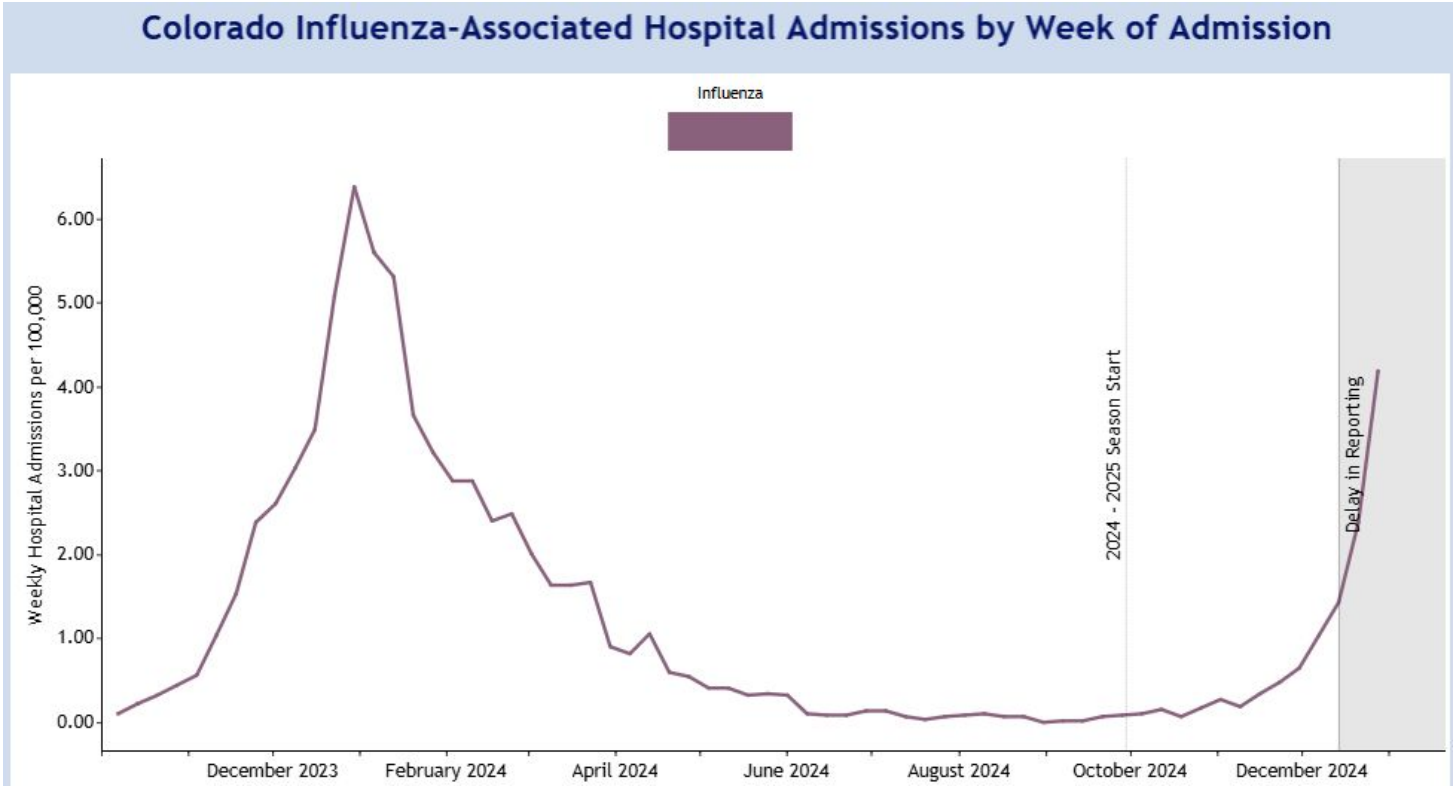
Colorado activity



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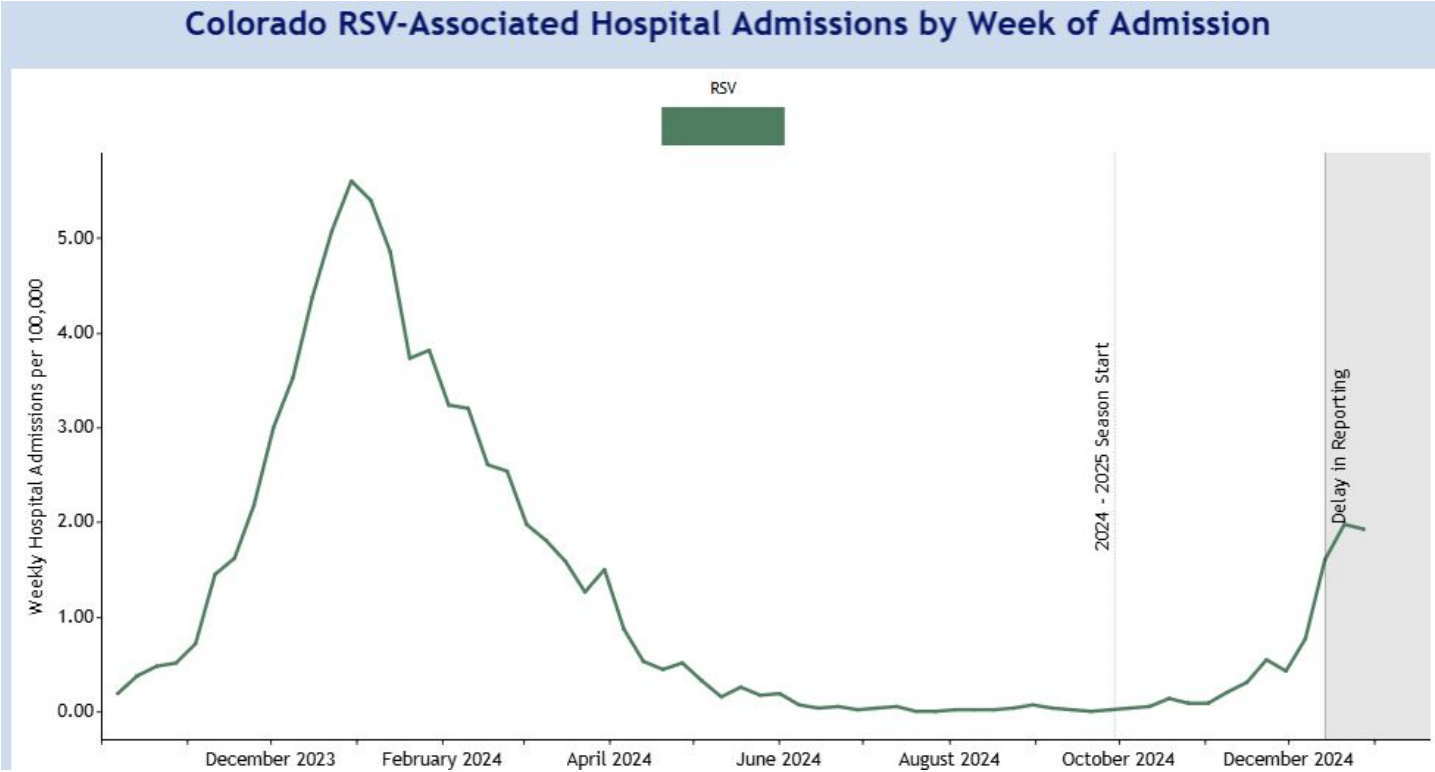

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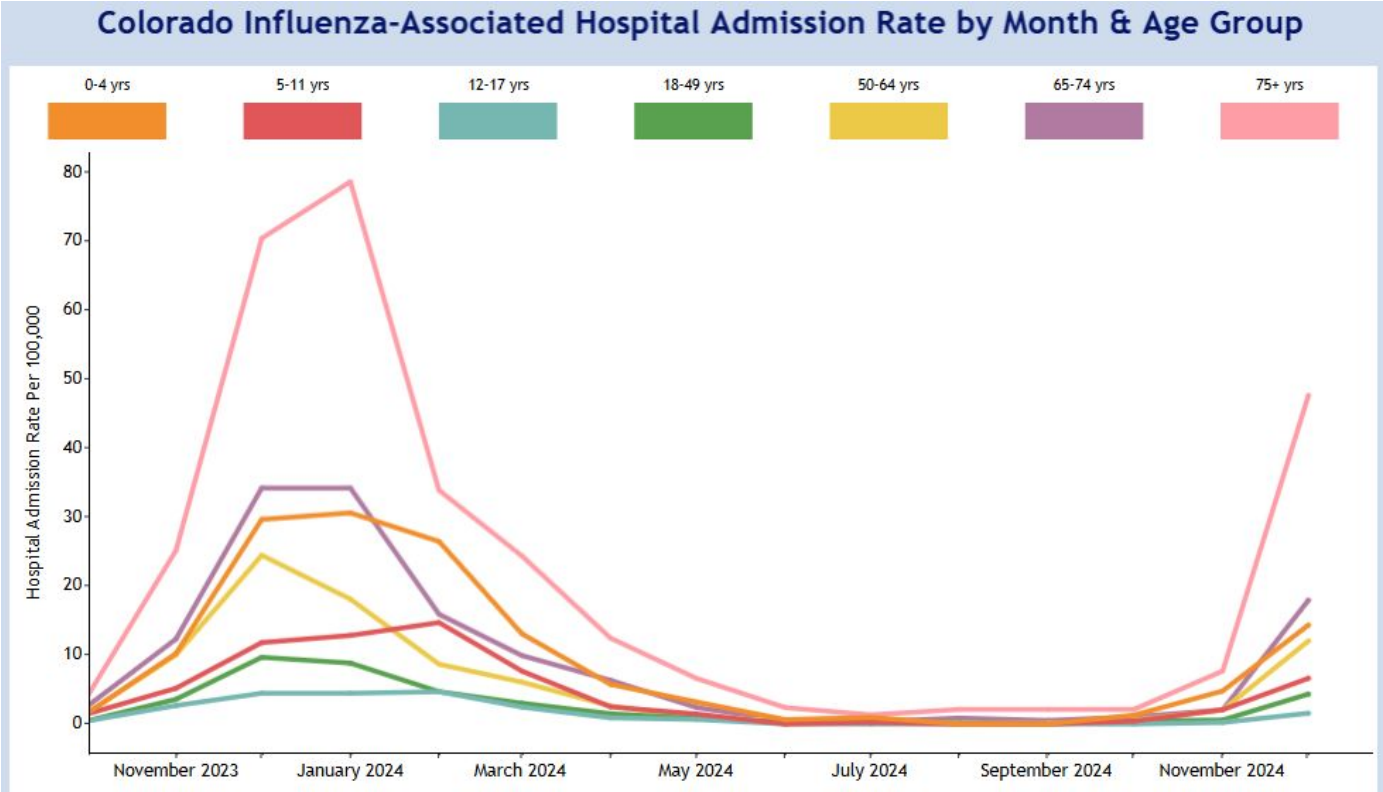
Colorado activity



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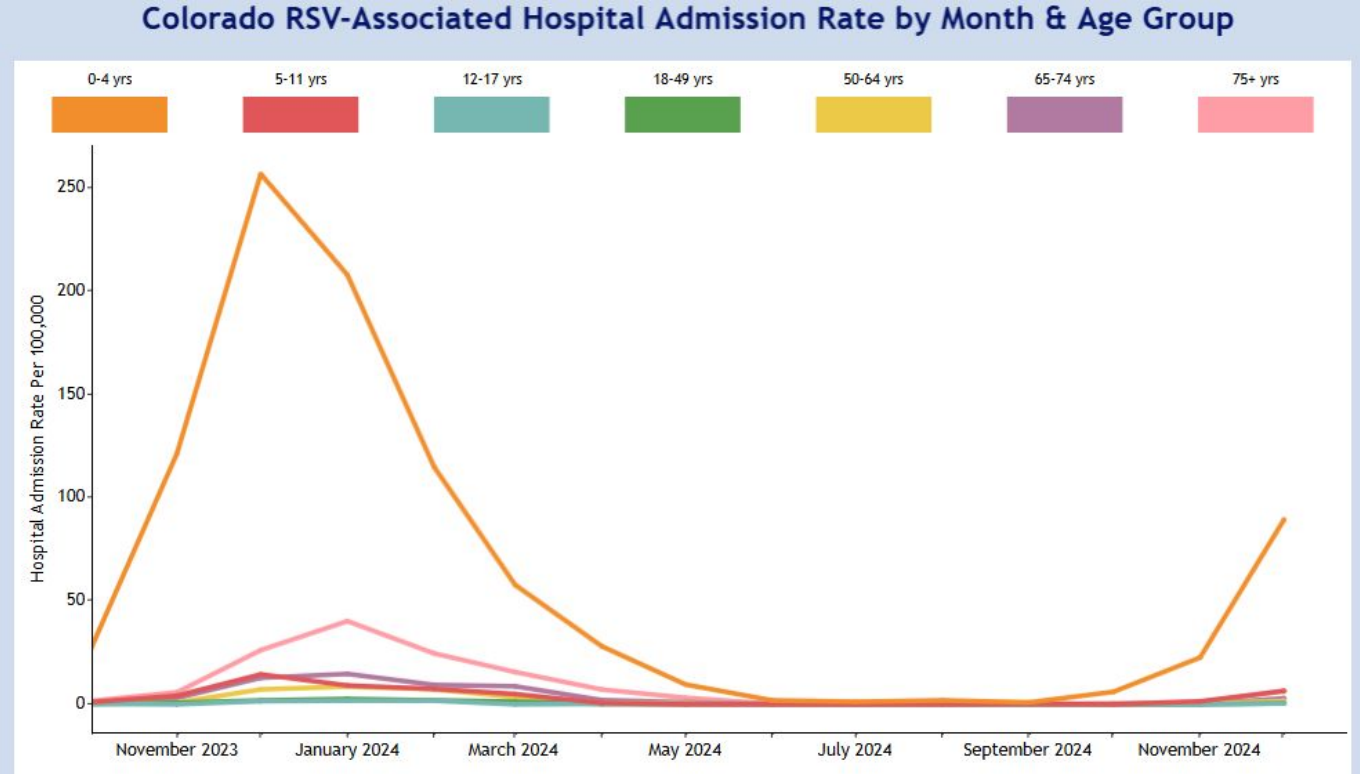
Colorado activity



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Viral respiratory disease outbreaks

Reportable outbreaks

- All communicable disease outbreaks are reportable to CDPHE.
- We track:
  - Flu in LTCFs/residential care, correctional facilities
  - RSV in LTCFs/residential care and school/child care facilities
  - Other non-COVID-19 viral respiratory outbreaks that involve a large number of cases, or cases with severe outcomes (hospitalizations and/or deaths)

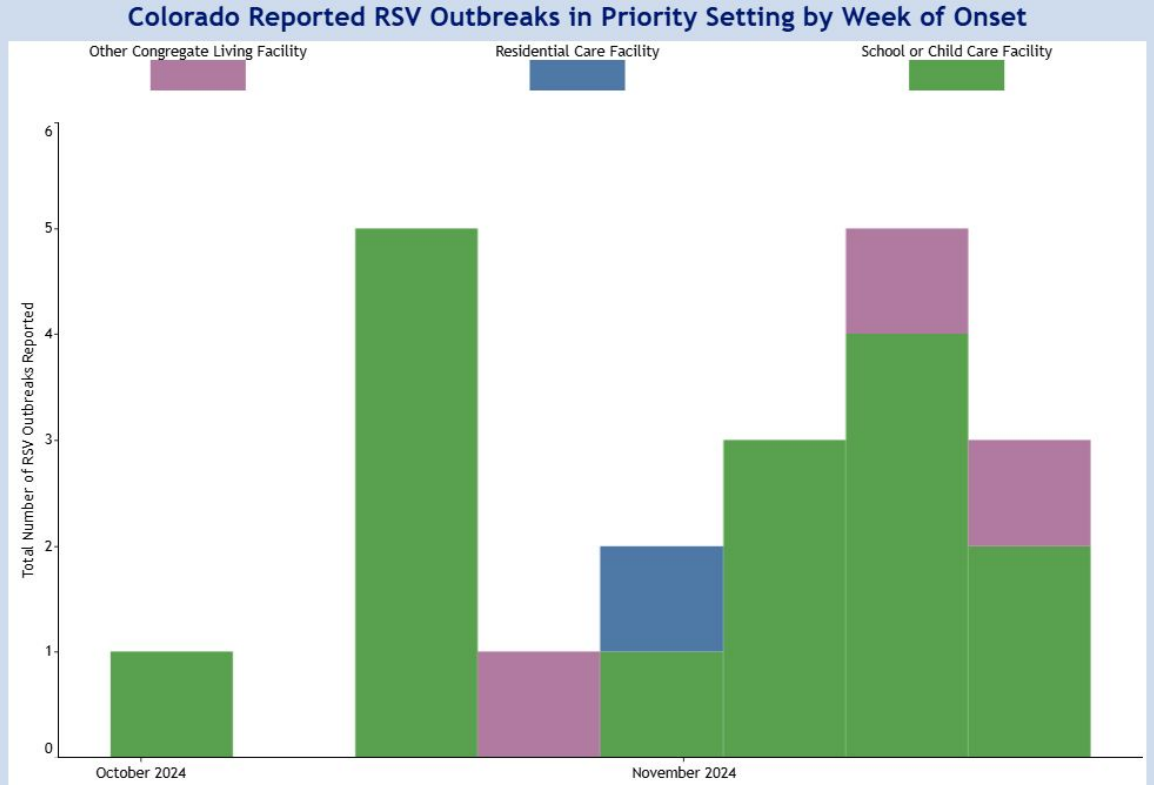
When are other viral respiratory illness outbreaks assigned an outbreak number?

- Increased severity of symptoms
- High levels of reported school absenteeism
- High transmission levels of illness in the community

Examples of other viral respiratory-related illnesses or conditions that could potentially need to be monitored:

- Croup
- Pneumonia
- Bronchitis
- Other viral respiratory pathogens

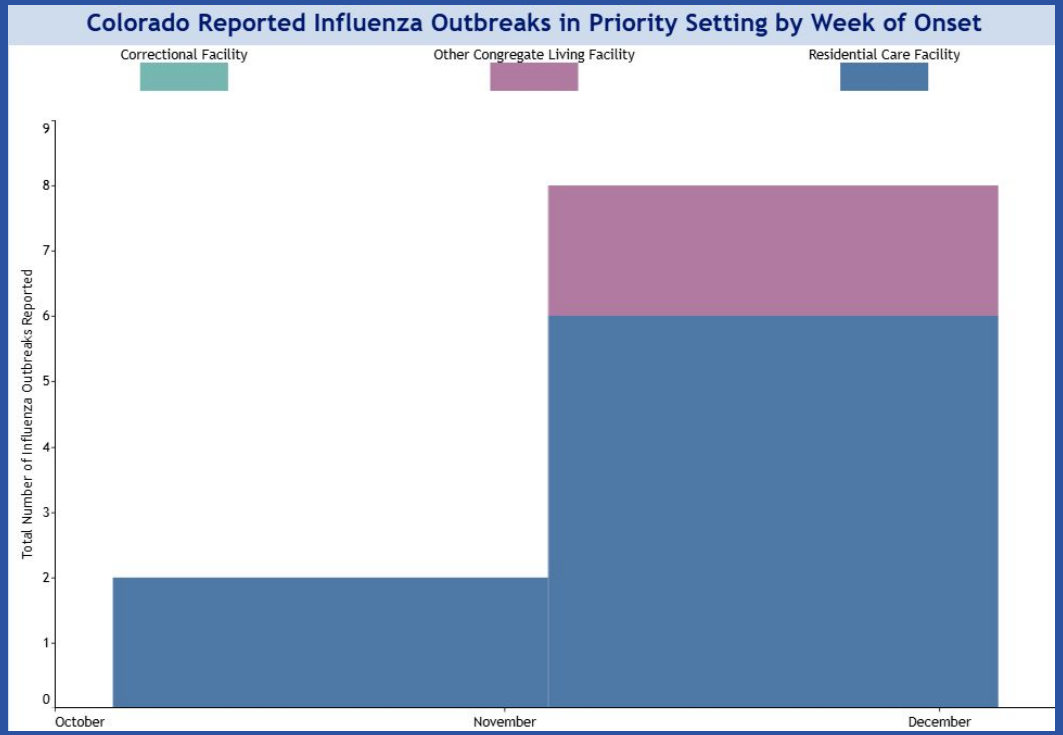
RSV outbreak surveillance



RSV outbreaks reported by setting type by season:

Season (Oct-May)	School/ child care settings	RLTCFs
2021-2022	100	12
2022-2023	460	25
2023-2024	140	41
2024-2025	16	1

Influenza outbreak surveillance



Influenza outbreaks reported by setting type by season:

Season (Oct-May)	RLTCFs	Correctional facilities
2021-2022	32	4
2022-2023	44	3
2023-2024	50	7
2024-2025	8	0

Influenza and RSV resources

Viral respiratory disease surveillance data

- Colorado Viral Respiratory Diseases Report

Guidance documents (2024-2025 guidance docs in final stages approval)

- Guidance for influenza outbreaks in LTCF settings
- Guidance for influenza outbreaks in correctional facilities
- Guidance for RSV outbreaks in LTCF settings

Additional resource:

- Communicable disease manual pages for influenza and RSV can be found at cdphe.colorado.gov/communicable-disease-manual

Team email: cdphe_flu_rsv@state.co.us

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Highly pathogenic avian influenza (HPAI) update

Background: HPAI in Colorado timeline

January 2022

USDA detects H5N1 in wild birds.*

February 2022

USDA confirmed outbreak of H5N1 in a commercial turkey flock in Indiana.*

Late March 2022

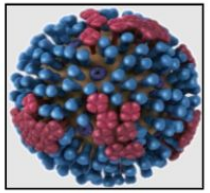
H5N1 detected in wild goose in Colorado.*

Mid April 2022

H5N1 detected in commercial chicken flock in Colorado.*

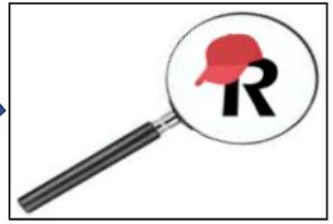
Late April 2022

Colorado resident tests positive for H5N1 using RT-PCR.**



May 2022 - March 2024

Ongoing surveillance of high risk individuals.***



Late March 2024

H5N1 detected in lactating dairy cattle in Texas.*

Late April 2024

Dairy cattle in Colorado confirmed to have H5N1.*

July 2024

Egg layer facilities in Colorado confirmed to have H5N1.

*Image from USDA
**Image from CDC
*** Image from REDCap

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Colorado cases of H5N1: 2024

Human cases:

- 10 confirmed positive

Dairy cattle:

- 64 confirmed positive herds (none positive since August)

Poultry (9+ million birds):

- 30 backyard flocks confirmed positive
- 12 commercial flocks confirmed positive

Colorado cases of H5N1: 2024

Confirmed wild birds	67
Confirmed mammals	25
Confirmed domestic cats	8
Total people assessed for exposure	4,889 (some lost to follow-up)
Total people exposed and intended to be actively monitored	2,446
Total people whose monitoring is complete	2,367
Total people currently being actively monitored	0

Thank you!

Questions about flu/RSV/non-COVID viral respiratory diseases/reporting?

Email: deborah.aragon@state.co.us or cdphe_flu_rsv@state.co.us

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CDPHE COVID-19 reporting requirements

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COVID-19 Infection Prevention Program Manager

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CDPHE COVID-19 reporting requirements

- In Nov. 2024, the Board of Health approved some updates to COVID-19 reporting requirements.
  - Any changes will take effect on Jan. 14, 2025.
- The following slides cover CDPHE's COVID-19 reporting requirements that apply to residential and long-term care facilities.
- CDPHE COVID-19 (SARS-CoV-2) Reporting Requirements webpage

6 CCR 1009-1

COVID-19 (SARS-CoV-2) test results: current

- **Current requirement through Jan. 13, 2025:**
  - Report all positive test results for rapid point-of-care COVID-19 tests (both antigen and molecular) to public health within four working days.
    - Most RLTCFs report these results via SimpleReport.
    - Results should be investigated and included on outbreak line lists.
  - Positive antigen tests performed without oversight (unproctored at-home tests) should also be investigated and reported on outbreak line lists.

[CDPHE COVID-19 (SARS-CoV-2) Reporting Requirements webpage]

COVID-19 (SARS-CoV-2) test results: updated

- **Updated requirement effective Jan. 14, 2025:**
  - Positive test results by laboratories capable of electronic laboratory reporting (ELR) are required to be reported to public health. Individual health care providers, **long-term care facilities**, K-12 schools, and other non-laboratory reporters **no longer need to report individual laboratory results**.
- Facilities should still investigate and respond to all positive test results among residents and staff. During an outbreak, positive test results should be included on outbreak line lists.

[CDPHE COVID-19 (SARS-CoV-2) Reporting Requirements webpage]

COVID-19-associated hospitalizations

- **Continuing requirement:** Report COVID-19-associated hospitalizations within four working days of detection.
  - Definition: Patients who are hospitalized and had a **positive COVID-19 test** during their hospitalization or **within the 14 days prior to hospital admission**. This includes patients who were tested at their primary care provider's office, an urgent care facility, **a residential or long-term care facility**, or an emergency room before being hospitalized.
  - Report via the CDPHE Reportal.
    - Reportal user site and user guides and resources

CDPHE COVID-19 (SARS-CoV-2) Reporting Requirements webpage

Deaths due to COVID-19

- **Updated requirement:** Report deaths due to COVID-19 within four working days of detection.
  - Definition: Deaths where COVID-19 is an underlying cause of death or named as a significant contributing condition on the death certificate.
  - Reporting is primarily fulfilled via death certificate review by CDPHE. However, individual health care providers and coroners must respond to inquiries from public health when clarification or additional information is required as specified in 6 CCR 1009-1 regulations 1, 2, and 5.

CDPHE COVID-19 (SARS-CoV-2) Reporting Requirements webpage

COVID-19 outbreaks

- **Continuing requirement:** Report known or suspected outbreaks immediately (within four hours of detection).
  - Report to the local public health agency or to CDPHE by completing the online outbreak report form (preferred), emailing cdphe_covid_infection_prevention@state.co.us, or calling 303-692-2700.
  - Outbreak definitions are in CDPHE's COVID-19 mitigation and outbreak guidance documents:
    - COVID-19 guidance for nursing facilities and intermediate care facilities
    - COVID-19 guidance for assisted living residences and group homes

Importance of outbreak reporting and line lists

- By reporting outbreaks as required, you provide valuable information about COVID-19 to public health!
- Maintain an up-to-date line list to monitor the progression of the outbreak and to help inform your mitigation efforts.
  - Document hospitalizations and deaths on the line list, even if they are not directly caused by COVID-19.
  - Public health may request line lists during an outbreak investigation.
  - CDPHE line list template for COVID-19, influenza, and/or RSV

Transition of COVID-19 outbreak investigations to LPHAs

Brynn Berger, MPH, CIC
COVID-19 Infection Prevention Program Manager

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Transition of COVID-19 outbreaks to LPHAs

- CDPHE is transitioning COVID-19 outbreak investigations in residential and long-term care facilities to local public health agencies.
- These investigations (except those in state-run facilities) will transition to LPHAs **by the end of May 2025.**
    - Some LPHAs have chosen to complete this transition early.

LPHAs that have completed the transition

- Eight LPHAs now lead new COVID-19 outbreaks in their jurisdictions:
  - Adams County Health Department
  - Arapahoe County Public Health
  - Boulder County Public Health
  - Denver Department of Public Health and Environment
  - Douglas County Health Department
  - Jefferson County Public Health
  - Northeast Colorado Health Department (Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma counties)
  - Pueblo Department of Public Health and Environment

Find your local public health agency

Should my facility contact the LPHA or CDPHE?

- If your facility is in one of those eight LPHA jurisdictions, the LPHA is now your main point of contact for COVID-19 mitigation and outbreak response.
    - CDPHE will complete any existing outbreak investigations.
- For all other facilities, CDPHE will be the main point of contact for COVID-19 mitigation and outbreak response until your LPHA begins to manage these outbreaks.

Next steps

- CDPHE will transition COVID-19 outbreaks to LPHAs upon request.
- We will notify facilities when their LPHA completes the transition.
- Regardless of the public health agency managing the outbreak:
  - Continue to follow the CDPHE COVID-19 guidance that is appropriate for your facility type.
  - Report known or suspected outbreaks immediately (within four hours of detection) to the local public health agency or CDPHE.

Thank you!

Additional questions?

Email cdphe_covid_infection_prevention@state.co.us

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