Guidance and responses were provided based on information known on 2/23/2022 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

Infection Prevention Updates for Acute Care and Outpatient Settings

February 23, 2022

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DEPT. OF HEALTH AND HUMAN SERVICES

ICAP
Infection Control Assessment and Promotion Program

Questions and Answer Session

Presenters today are:

Gary Anthone, MD	gary.anthone@nebraska.gov
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Josette McConville, RN, CIC	jmcconville@nebraskamed.com
Rebecca Martinez, BA, BSN, RN, CIC	remartinez@nebraskamed.com
Sarah Stream, MPH, CDA, FADAA	sstream@nebraskamed.com

Panelists today are:

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Daniel Taylor, DHHS	daniel.taylor@nebraska.gov

Moderated by Margaret Deacy mdeacy@nebraskamed.com

Please use the Q&A box in the webinar platform to type a question. Questions will be read aloud. If your question is not answered during the webinar, please e-mail it to nebraskaicap@nebraskamed.com or call Monday – Friday 8:00 am – 4:00 pm CST to speak with one of our Infection Preventionists.

Slides and a recording of this presentation will be available on the Nebraska ICAP website https://icap.nebraskamed.com/covid-19-webinars/

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Learning Objectives

During this series, participants should be better able to:

1. Recognize infection prevention and control issues for application of the recommendations to mitigate these issues.
2. Identify resources on infection prevention and control that will be helpful to mitigate infection prevention and control challenges.
3. Describe latest updates on COVID-19 pandemic related to infection prevention and control practices in acute and outpatient settings.

Target Audience

Healthcare professionals working in acute and outpatient settings. To include medical directors, nursing staff, directors of nursing, infection preventionists, quality program leaders, administrators, consultant pharmacists or other staff working in long-term care settings.

ICAP

Mission and Goals

To provide an educational venue that connects infection preventionists and providers from acute and outpatient facilities across Nebraska with the objective of promoting the latest research and best practices in infection prevention and control. These educational webinars are aimed to help promote and strengthen the Nebraska infection prevention and control infrastructure.

The goals for this educational activity include:

1. Increase knowledge of infection control processes for acute and outpatient settings.
2. Increasing awareness of specific infection prevention and control issues that may be confronted in acute and outpatient settings.
3. Provide resources to attendees to help them with infection prevention and control efforts in their own facilities.
4. Provide resources to attendees on the most up to date COVID-19 pandemic related guidance and recommendations.

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In order to obtain either contact hour, you must be present for the entire live webinar and complete the post webinar survey

No conflicts of interest were identified for any member of the planning committee, presenters or panelists of the program content

This CE is hosted by Nebraska Medicine and UNMC along with Nebraska ICAP and Nebraska DHHS

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The accredited provider has mitigated and is disclosing identified relevant financial relationships for the following faculty, planners, and others in control of content prior to assuming their roles:

FACULTY

The faculty have nothing to disclose:

Gary Anthone, MD	Daniel Brailita, MD	
Josette McConville, BSN, RN, CIC	Rebecca Martinez, BSN, BA, RN, CIC	Sarah Stream, MPH, CDA, FADAA

PLANNING COMMITTEE

The planning committee members have nothing to disclose:

Kate Tyner, RN, BSN, CIC	M. Salman Ashraf, MBBS
Margaret Deacy	Jody Scebold, EdD, MSN, RN
Richard Starlin, MD	Daniel Taylor

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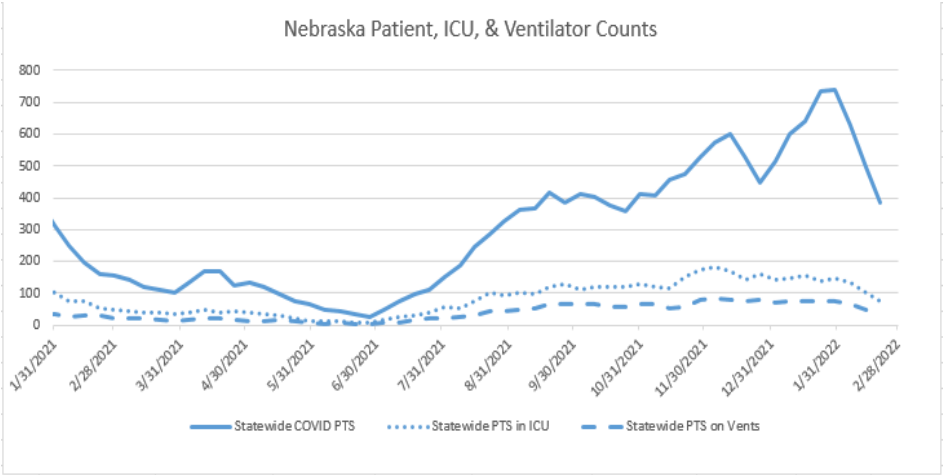
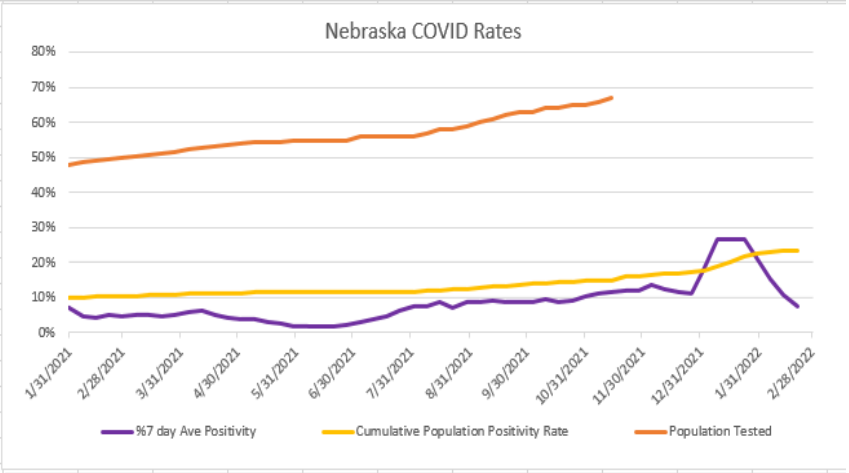
Nebraska DHHS Updates

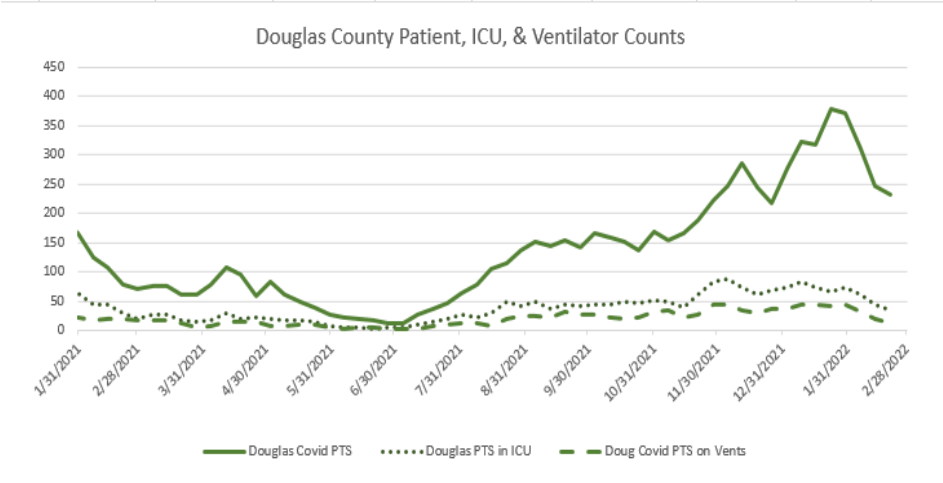
Gary Anthone, MD
Chief Medical Officer, DHHS

ICAP
Infection Control Assessment and Promotion Program

Date	Statewide COVID PTS	%7 day Ave Positivity	Statewide PTS on Vents	Douglas Covid PTS	Doug Covid PTS on Vents	Lanc COVID PTS	Lanc COVID PTS on Vents	Population Tested	Cumulative Population	Fatality Rate	Statewide PTS in ICU	Douglas PTS in ICU	Lancaster PTS in ICU
5/2/2021	135	4.00%	10	82	7	21	1	54%	11.40%	1.02%	40	20	7
5/9/2021	118	4.00%	10	60	8	28	0	54%	11.50%	1.01%	34	18	4
5/16/2021	97	3.20%	15	48	11	21	1	54%	11.50%	1.02%	30	16	4
5/23/2021	73	2.60%	13	38	10	14	3	55%	11.50%	1.00%	22	14	3
5/30/2021	66	1.70%	9	27	6	16	1	55%	11.60%	1.01%	14	8	1
6/6/2021	47	1.70%	4	23	3	11	1	55%	11.60%	1.01%	10	6	1
6/13/2021	45	1.60%	7	20	5	8	2	55%	11.60%	1.01%	12	6	1
6/20/2021	34	1.60%	4	17	4	5	0	55%	11.60%	1.01%	6	2	0
6/27/2021	27	2.20%	2	12	2	8	0	55%	11.60%	1.01%	9	5	2
7/4/2021	46	3.00%	6	13	3	18	2	56%	11.60%	1.01%	15	4	2
7/11/2021	74	3.80%	9	28	2	25	6	56%	11.70%	1.00%	24	9	10
7/18/2021	97	4.80%	18	36	8	28	8	56%	11.70%	1.01%	30	15	10
7/25/2021	110	6.20%	21	46	11	34	6	56%	11.70%	1.00%	40	20	12
8/1/2021	153	7.40%	21	63	12	43	5	56%	11.80%	1.00%	59	26	13
8/8/2021	185	7.70%	27	79	13	49	9	57%	12.00%	1.00%	54	22	11
8/15/2021	246	8.60%	28	104	8	64	11	58%	12.10%	1.00%	75	29	11
8/22/2021	287	7.10%	45	116	19	84	17	58%	12.30%	1.00%	101	48	17
8/29/2021	328	8.60%	44	137	24	91	12	59%	12.60%	0.95%	93	42	20
9/5/2021	361	8.70%	49	152	25	86	15	60%	12.90%	0.94%	100	48	15
9/12/2021	368	9.00%	53	143	23	86	18	61%	13.10%	0.93%	99	37	22
9/19/2021	414	8.80%	68	153	32	87	22	62%	13.40%	0.92%	120	44	30
9/26/2021	385	8.90%	68	141	26	88	22	63%	13.60%	0.91%	127	42	27
10/3/2021	411	8.70%	64	165	27	84	20	63%	13.90%	0.90%	113	44	29
10/10/2021	402	9.50%	67	160	23	77	23	64%	14.10%	0.90%	120	43	30
10/17/2021	375	8.60%	55	152	19	75	15	64%	14.30%	0.90%	120	49	22
10/24/2021	357	9.10%	59	138	21	73	16	65%	14.50%	0.90%	119	46	21
10/31/2021	413	10.20%	65	168	32	72	17	65%	14.80%	0.90%	129	52	16
11/7/2021	407	11.20%	64	155	35	65	13	66%	15.04%	0.87%	122	50	13
11/14/2021	455	11.50%	53	165	22	84	14	67%	15%	0.86%	116	40	19
11/21/2021	476	12.00%	57	189	28	62	14		16.00%	0.86%	153	62	25
11/28/2021	528	12.20%	79	222	43	81	13		16.00%	0.86%	176	83	22
12/5/2021	574	13.60%	84	247	44	85	15		16.30%	0.85%	182	89	24
12/12/2021	601	12.40%	78	286	35	82	16		17%	0.85%	168	74	23
12/19/2021	523	11.70%	74	245	30	105	21		17.00%	0.84%	142	60	28
12/26/2021	446	11.40%	79	217	37	92	23		17.20%	0.83%	162	69	23
1/2/2022	516	18.70%	72	277	37	89	19		17.80%	0.81%	141	74	19
1/9/2022	602	26.50%	75	322	44	97	18		18.80%	0.79%	146	82	20
1/16/2022	639	26.70%	74	318	45	102	13		20.30%	0.75%	156	74	19
1/23/2022	735	26.50%	77	378	42	118	17		21.80%	0.71%	136	67	23
1/30/2022	739	21.10%	74	371	44	128	13		22.70%	0.70%	148	74	22
2/6/2022	627	15.10%	68	310	33	113	12		23.10%	0.70%	135	61	12
2/13/2022	496	10.70%	47	247	20	91	7		23.30%	0.70%	102	43	16
2/20/2022	387	7%	34	233	13	48	4		23.40%	0.71%	73	34	6


Nebraska Patient, ICU, & Ventilator Counts
800
700
600
500
400
300
200
100
0
1/31/2021
2/28/2021
3/31/2021
4/30/2021
5/31/2021
6/30/2021
7/31/2021
8/31/2021
9/30/2021
10/31/2021
11/30/2021
12/31/2021
1/31/2022
2/28/2022
Statewide COVID PTS
Statewide PTS in ICU
Statewide PTS on Vents


Nebraska COVID Rates
80%
70%
60%
50%
40%
30%
20%
10%
0%
1/31/2021
2/28/2021
3/31/2021
4/30/2021
5/31/2021
6/30/2021
7/31/2021
8/31/2021
9/30/2021
10/31/2021
11/30/2021
12/31/2021
1/31/2022
2/28/2022
%7 day Ave Positivity
Cumulative Population Positivity Rate
Population Tested


Douglas County Patient, ICU, & Ventilator Counts
450
400
350
300
250
200
150
100
50
0
1/31/2021
2/28/2021
3/31/2021
4/30/2021
5/31/2021
6/30/2021
7/31/2021
8/31/2021
9/30/2021
10/31/2021
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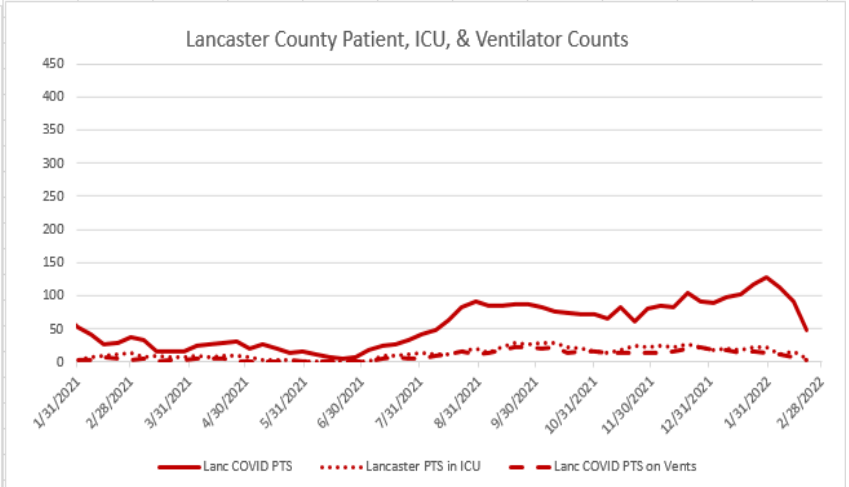
1/31/2022
2/28/2022
Douglas Covid PTS
Douglas PTS in ICU
Doug Covid PTS on Vents


Lancaster County Patient, ICU, & Ventilator Counts
450
400
350
300
250
200
150
100
50
0
1/31/2021
2/28/2021
3/31/2021
4/30/2021
5/31/2021
6/30/2021
7/31/2021
8/31/2021
9/30/2021
10/31/2021
11/30/2021
12/31/2021
1/31/2022
2/28/2022
Lanc COVID PTS
Lancaster PTS in ICU
Lanc COVID PTS on Vents

- Decrease of 109 pts (-131; -112; +4; +96; +37; +86; +70)
- 7 Day rolling average of 9.5% (12.6; 16.5; 17.9; 17.5; 15.7; 13.6)
- 19% of hospitalized COVID pts in ICU (21; 22; 20; 19; 24; 24)
- 47% of COVID ICU pts on Vents (46; 50; 50; 57; 47; 51)
- 15% of statewide ICU pts are COVID pts (20; 27; 29; 27; 29; 26)
- Average of 35 new covid pts admitted per day (57; 66; 82; 88; 68; 62)
- 16 Ped admits last week (16; 32; 31; 25; 29; 17)

BA.2 Variant

Daniel Brailita, MD
Assistant Professor, Division of Infectious Diseases
Associate Medical Director, Nebraska ICAP

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Infection Control Assessment and Promotion Program

Nebraska Case Data

Cases

DAILY NEW CASES	INFECTION RATE	POSITIVE TEST RATE
13.5 PER 100K	0.35	11.9%

Over the last week, Nebraska has averaged 261 new confirmed cases per day (**13.5** for every 100,000 residents). About this data

Share

https://covidactnow.org/us/nebraska-ne/?s=29551816

BA2 Variant info/clinical implications

Cold Spring Harbor Laboratory

bioRxiv

THE PREPRINT SERVER FOR BIOLOGY

bioRxiv posts many COVID19-related papers. A reminder: they have not been formally peer-reviewed and should not guide health-related behavior or be reported in the press as conclusive.

New Results

Follow this preprint

Virological characteristics of SARS-CoV-2 BA.2 variant

Daichi Yamasoba, Izumi Kimura, Hesham Nasser, Yuhei Morioka, Naganori Nao, Jumpei Ito, Keiya Uriu, Masumi Tsuda, Jiri Zahradnik, Kotaro Shirakawa, Rigel Suzuki, Mai Kishimoto, Yusuke Kosugi, Kouji Kobiyama, Teppei Hara, Mako Toyoda, Yuri L Tanaka, Erika P Butlertanaka, Ryo Shimizu, Hayato Ito, Lei Wang, Yoshitaka Oda, Yasuko Orba, Michihito Sasaki, Kayoko Nagata, Kumiko Yoshimatsu, Hiroyuki Asakura, Mami Nagashima, Kenji Sadamasu, Kazuhisa Yoshimura, Jin Kuramochi, Motoaki Seki, Ryoji Fujiki, Atsushi Kaneda, Tadanaga Shimada, Taka-aki Nakada, Seiichiro Sakao, Takuji Suzuki, Takamasa Ueno, Akifumi Takaori-Kondo, Ken J Ishii, Gideon Schreiber,
The Genotype to Phenotype Japan (G2P-Japan) Consortium, Hirofumi Sawa, Akatsuki Saito, Takashi Irie, Shinya Tanaka, Keita Matsuno, Takasuke Fukuhara, Terumasa Ikeda, Kei Sato

doi: https://doi.org/10.1101/2022.02.14.480335

This article is a preprint and has not been certified by peer review [**what does this mean?**].

0 | 0 | 0 | 0 | 120 | 0 | 8594

Abstract Full Text Info/History Metrics Preview PDF

Abstract

Soon after the emergence and global spread of a new severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) Omicron lineage, BA.1 (ref[1, 2]), another Omicron lineage, BA.2, has initiated outcompeting BA.1. Statistical analysis shows that the effective reproduction number of BA.2 is 1.4-fold higher than that of BA.1. Neutralisation experiments show that the vaccine-induced humoral immunity fails to function against BA.2 like BA.1, and notably, the antigenicity of BA.2 is different from BA.1. Cell culture experiments show that BA.2 is more replicative in human nasal epithelial cells and more fusogenic than BA.1. Furthermore, infection experiments using hamsters show that BA.2 is more pathogenic than BA.1. Our multiscale investigations suggest that the risk of BA.2 for global health is potentially higher than that of BA.1.

As BA.2 subvariant of Omicron rises, lab studies point to signs of severity

By Brenda Goodman, CNN

Updated 1:06 PM ET, Sat February 19, 2022

ICAP

BA2 Variant info/clinical implications

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Clinical severity of Omicron sub-lineage BA.2 compared to BA.1 in South Africa

Nicole Wolter, Waasila Jassat, DATCOV-Gen author group, Anne von Gottberg, Cheryl Cohen

doi: https://doi.org/10.1101/2022.02.17.22271030

This article is a preprint and has not been certified by peer review [what does this mean?]. It reports new medical research that has yet to be evaluated and so should *not* be used to guide clinical practice.

Abstract | Full Text | Info/History | Metrics | Preview PDF

ABSTRACT

Early data indicated that infection with Omicron BA.1 sub-lineage was associated with a lower risk of hospitalisation and severe illness, compared to Delta infection. Recently, the BA.2 sub-lineage has increased in many areas globally. We aimed to assess the severity of BA.2 infections compared to BA.1 in South Africa. We performed data linkages for (i) national COVID-19 case data, (ii) SARS-CoV-2 laboratory test data, and (iii) COVID-19 hospitalisations data, nationally. For cases identified using TaqPath COVID-19 PCR, infections were designated as S-gene target failure (SGTF, proxy for BA.1) or S-gene positive (proxy for BA.2). Disease severity was assessed using multivariable logistic regression models comparing individuals with S-gene positive infection to SGTF-infected individuals diagnosed between 1 December 2021 to 20 January 2022. From week 49 (starting 5 December 2021) through week 4 (ending 29 January 2022), the proportion of S-gene positive infections increased from 3% (931/31,271) to 80% (2,425/3,031). The odds of being admitted to hospital did not differ between individuals with S-gene positive (BA.2 proxy) infection compared to SGTF (BA.1 proxy) infection (adjusted odds ratio (aOR) 0.96, 95% confidence interval (CI) 0.85-1.09). Among hospitalised individuals, after controlling for factors associated with severe disease, the odds of severe disease did not differ for individuals with S-gene positive infection compared to SGTF infection (aOR 0.91, 95%CI 0.68-1.22). These data suggest that while BA.2 may have a competitive advantage over BA.1 in some settings, the clinical profile of illness remains similar.

Previous | Next

Posted February 19, 2022.

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COVID-19 SARS-CoV-2 preprints from medRxiv and bioRxiv

Subject Area

Infectious Diseases (except HIV/AIDS)

Subject Areas

All Articles

- Addiction Medicine
- Allergy and Immunology
- Anesthesia
- Cardiovascular Medicine
- Dentistry and Oral Medicine
- Dermatology
- Emergency Medicine
- Endocrinology (including Diabetes Mellitus and Metabolic Disease)
- Epidemiology
- Forensic Medicine
- Gastroenterology

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How to Appraise

Study 1

- Lab data
- BA.2 outcompeting BA.1 in all respects
- BA.2 shows potential to evade our therapies including monoclonal
- BA.2 has significantly higher growth
- BA.2 kills more infected hamsters than BA.1 does
- BA.2 is not even closely related to Omicron as we thought
- BA.2 should kill more people- headline news

Study 2

- Clinical- in the context of a specific population (South Africa)
- BA.2 quickly outcompeting BA.1
- BA.2 appears inherently more transmissible than BA.1
- In the specific population (a population with high levels of prior infection), BA.2 DID NOT cause more severe disease than BA.1
- More data needed to apply this reassurance to a global scale

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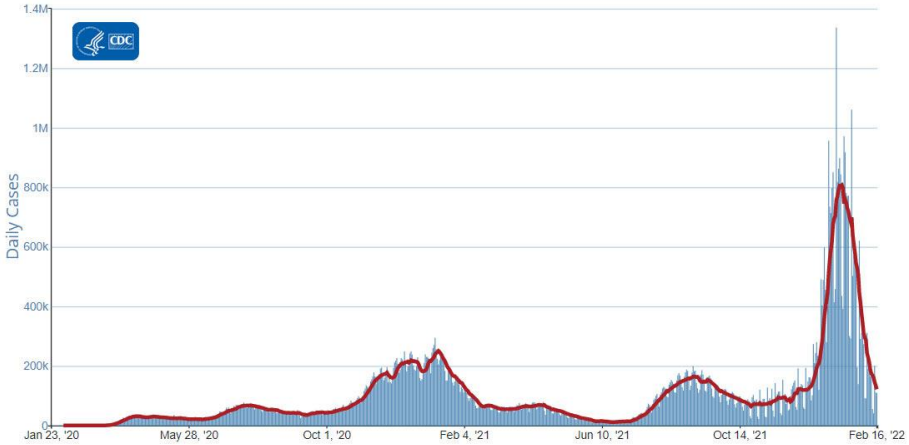
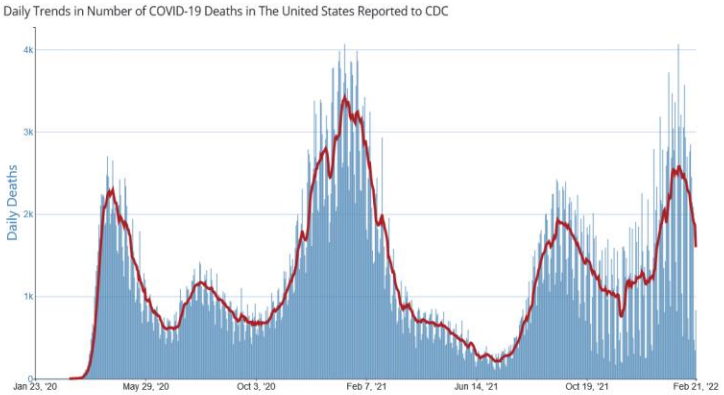
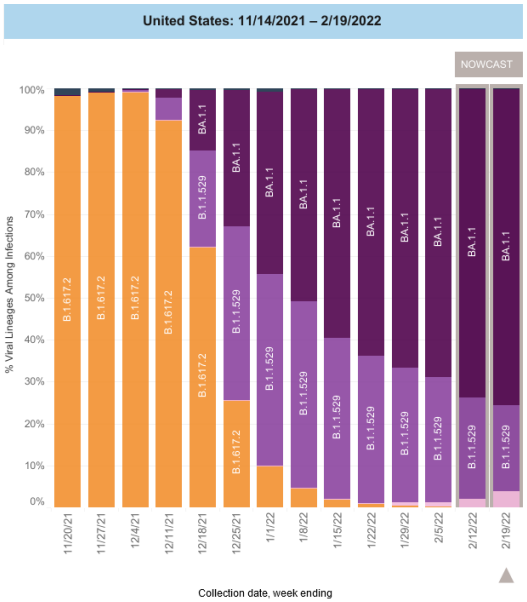
WHO 's Technical Advisory Group on SARS-CoV-2 Virus Evolution Statement - 2/22/22

- Although BA.2 sequences are increasing in proportion relative to other Omicron sublineages (BA.1 and BA.1.1), there is still a reported decline in overall cases globally.
- BA.2 sublineage should continue to be considered a VOC and that it should remain classified as Omicron
- Preliminary laboratory data from Japan generated using animal models without any immunity to SARS-CoV-2 highlighted that BA.2 may cause more severe disease in hamsters compared to BA.1.
- Real-world data on clinical severity from South Africa, the United Kingdom, and Denmark, where immunity from vaccination or natural infection is high: in this data, there was no reported difference in severity between BA.2 and BA.1.
- Need to continue to monitor clinical outcomes and breakthrough

US- Case Loads, Deaths and Omicron Proportions (CDC)







United States: 2/13/2022 – 2/19/2022 NOWCAST

USA

WHO label	Lineage #	US Class	%Total	95%PI
Omicron	BA.1.1	VOC	75.6%	71.1-79.7%
	B.1.1.529	VOC	20.6%	16.7-25.1%
	BA.2	VOC	3.8%	3.0-4.8%
Delta	B.1.617.2	VOC	0.0%	0.0-0.0%
Other	Other*		0.0%	0.0-0.0%

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.
** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates
\# AY.1-AY.133 and their sublineages are aggregated with B.1.617.2. BA.1 and BA.3 are aggregated with B.1.1.529. For regional data, BA.1.1 is also aggregated with B.1.1.529, as it currently cannot be reliably called in each region.

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Questions and Answer Session #1

Please use the QA box in the webinar platform to type a question

Attendees also have the option to upvote other attendee's questions

Questions will be read aloud by the moderator

A recording of the discussion will be made available on the Nebraska ICAP website

<u>Panelists:</u>

Gary Anthone, MD

Daniel Brailita, MD

Daniel Taylor

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+	Acute Care and Outpatient Settings Webinar Slides

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CMS QSO-21-08-NLTC Revised 2/4/2022

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ICAP
Infection Control Assessment and Promotion Program

CMS QSO-21-08-NLTC

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-21-08-NLTC
REVISED 02/04/2022

DATE: **December 30, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: COVID-19 Focused Infection Control Survey Tool for Acute and Continuing Care *Providers and Suppliers* **(REVISED)**

CMS QSO-21-08-NLTC Revised

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Key Summary

- **COVID-19 Focused Infection Control Survey Tool:**
  - CMS developed the focused infection control (FIC) survey and tool at the beginning of the PHE to help surveyors and facilities absorb the critical infection prevention and control practices for combating COVID-19. Based on stakeholder feedback and survey activity, we believe acute and continuing care (ACC) facilities have incorporated COVID-19 management strategies into their infrastructure and operations, and **there is no longer a need to continue the required use of the special FIC survey and tool on a national basis.** Surveyors will continue to evaluate infection prevention and control elements related to COVID-19 through the existing survey process, while incorporating lessons learned about infection control oversight during the PHE. State Survey Agencies (SAs) & Accrediting Organizations (AOs) may continue to use the targeted FIC survey, on a case by case basis, if warranted.

CMS QSO-21-08-NLTC Revised

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Key Summary

- **Visitation Restrictions:**
  - We recognize that requirements for entering healthcare facilities such as visitation restrictions were used to mitigate the introduction of COVID-19 into facilities. **At this time, continued federal guidance regarding visitation restrictions for ACC facilities are no longer necessary.** Facilities should continue to adhere to basic COVID-19 infection prevention principles consistent with national standards of practice.

CMS QSO-21-08-NLTC Revised

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Product Recall

FDA Warns Consumers Not to Use Certain Powdered Infant Formula Produced in Abbott Nutrition's Facility in Sturgis, Michigan

The FDA is advising consumers not to use Similac, Alimentum, or EleCare powdered infant formulas if:

- the first two digits of the code are 22 through 37; and
- the code on the container contains K8, SH or Z2; and
- the expiration date is 4-1-2022 (APR 2022) or later.

FDA Warns Consumers Not to Use Certain Powdered Infant Formula Produced in Abbott Nutrition's Facility in Sturgis, Michigan | FDA

Home (similacrecall.com)

CDC Guidance – 2/11/22 Updates and Reminders

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Infection Control Assessment and Promotion Program

Vaccination Schedule for General Public

Pfizer-BioNTech [1]	Moderna [1]	Johnson & Johnson's Janssen [1,2]
Ages Recommended 5+ years old	**Ages Recommended** 18+ years old	**Ages Recommended** 18+ years
Primary Series 2 doses Given 3 weeks (21 days) apart [3]	**Primary Series** 2 doses Given 4 weeks (28 days) apart [3]	**Primary Series** 1 dose
Booster Dose Everyone ages 18 years and older should get a booster dose of either Pfizer-BioNTech or Moderna (COVID-19 vaccines) 5 months after the last dose in their primary series. Teens 12-17 years old should get a Pfizer-BioNTech COVID-19 Vaccine booster 5 months after the last dose in their primary series.	**Booster Dose** Everyone ages 18 years and older should get a booster dose of either Pfizer-BioNTech or Moderna (COVID-19 vaccines) 5 months after the last dose in their primary series.	**Booster Dose** Everyone ages 18 years and older should get a booster dose of either Pfizer-BioNTech or Moderna (mRNA COVID-19 vaccines) at least 2 months after the first dose of J&J/Janssen COVID-19 vaccine. You may get J&J/Janssen in some situations.
When Fully Vaccinated[4] 2 weeks after 2nd dose	**When Fully Vaccinated**[4] 2 weeks after 2nd dose	**When Fully Vaccinated**[4] 2 weeks after 1st dose

CDC - Different COVID-19 Vaccines
CDC - Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States

Summary of COVID Vaccine Schedule Updates 2/11/2022

- Updated guidance for moderately or severely immunocompromised people
  - Clarification of existing recommendation to receive a 3-dose mRNA vaccine primary series followed by a booster dose for a total of 4 doses
  - New guidance to shorten the interval between completion of the mRNA vaccine primary series and the booster dose to at least 3 months (instead of 5 months)
  - New guidance for those who received the Janssen COVID-19 Vaccine primary series to receive an additional dose and a booster dose, for a total of 3 doses to be up to date
- Updated guidance that it is no longer necessary to delay COVID-19 vaccination following receipt of monoclonal antibodies or convalescent plasma

CDC - Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States

CDC - Summary Document for Interim Clinical Considerations

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Revised Guidance for Moderately or Severely Immunocompromised

Prior Guidance

People who are moderately or severely immunocompromised should receive a booster dose **at least 5 months** after the last (third) dose of an mRNA COVID-19 vaccine.

Current Guidance

People who are moderately or severely immunocompromised should receive a booster dose **at least 3 months** after the last (third) dose of an mRNA COVID-19 vaccine.

CDC - ACIP Meeting - February 4, 2022

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Revised COVID-19 Vaccination Schedule for Moderately or Severely Immunocompromised

Vaccine	Vaccination Schedule				
Pfizer-BioNTech (ages 5 years and older)	1st dose	2nd dose (21 days after 1st dose)	3rd dose (at least 28 days after 2nd dose)		Booster dose* (at least 3 months after 3rd dose)
Moderna (ages 18 years and older)	1st dose	2nd dose (28 days after 1st dose)	3rd dose (at least 28 days after 2nd dose)		Booster dose* (at least 3 months after 3rd dose)
Janssen (ages 18 years and older)	1st dose	Additional dose† (at least 28 days after 1st dose)		Booster dose* (at least 2 months after additional dose)	

People ages 5 – 11 years should not receive a booster

***Any COVID-19 vaccine can be used for the booster dose in people ages 18 years and older, though mRNA vaccines are preferred. For people ages 12–17 years, only Pfizer-BioNTech can be used.**

People ages 5–11 years should not receive a booster dose.

†Only Pfizer-BioNTech or Moderna COVID-19 Vaccine should be used

CDC - ACIP Meeting - February 4, 2022

NE ICAP added emphasis of footnotes

Description of moderate and severe immunocompromising conditions and treatment

Moderate and severe immunocompromising conditions and treatments include but are not limited to:

- Active treatment for solid tumor and hematologic malignancies
- Receipt of solid-organ transplant and taking immunosuppressive therapy
- Receipt of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppression therapy)
- Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection (people with HIV and CD4 cell counts <200/mm^3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV)
- Active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

Factors to consider in assessing the general level of immune competence in a patient include disease severity, duration, clinical stability, complications, comorbidities, and any potentially immune-suppressing treatment. Age or place of residence alone (e.g., residence in a long-term care setting), independent of a patient's medical condition, should not be used to determine the level of immune competence, as the balance of benefits and risks of a third primary dose for people who are not moderately or severely immunocompromised is currently unknown.

CDC - Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States

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Revised Guidance for Passive Antibody Products (i.e. monoclonal antibodies or convalescent plasma) and Vaccination

Prior Guidance

Defer COVID-19 vaccination for:

- 30 days if product used for post exposure prophylaxis
- 90 days if product used for treatment
- No guidance for pre-exposure prophylaxis

Current Guidance

- No recommended deferral period
- However, tixagevimab/cilgavimab (EVUSHELD™) should be deferred for at least two weeks after vaccination

CDC - ACIP Meeting - February 4, 2022

ICAP

IP ENIGMAS

New on this webinar!

WE WANT TO HEAR FROM YOU!

- Are you new to infection control?
- Are you looking for practical problem solutions?
- This recurring segment will bring you answers!
- Submit your questions today to nebraskaicap@nebraskamed.com

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IP ENIGMAS

Your facility recently transferred a patient and just received a call from the receiving hospital that the patient has meningitis.

IP ENIGMAS

Audience Poll: Put the steps in the proper order

[A] Work with Employee Health provider to plan prophylaxis strategy

[B] Call the receiving facility for additional information, including the microbiology report and diagnosis

[C] Talk to the ER lead/manager about the patient presentation: including signs and symptoms, PPE used, and contact tracing processes [identify who was in the room, duration, tasks performed]

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IP ENIGMAS

Image courtesy of CDC

- Don't jump to conclusions
  ...and don't let the patient care team jump to conclusions.

- Only specific meningitis infections are transmitted by the droplet route *and* require prophylactic treatment of exposed healthcare workers
  - *Neisseria meningitidis* (on a gram stain appears as gram negative diplococci)
  - *Haemophilus influenzae* (on a gram stain appears as gram-negative bacilli or coccobacilli with random arrangements)

- Ensure that messaging to the patient care team is clear, directive, and compassionate - even if prophylaxis is not indicated

CDC - Meningococcal Disease
CDC - Haemophilus influenzae Disease (Including Hib)

Nebraska Free COVID-19 Testing

- Free rapid testing resources for the public through Nebraska DHHS
- Visit the Nebraska DHHS website and find the COVID-19 Testing Page
- https://dhhs.ne.gov/Pages/COVID-19-Testing.aspx

Free rapid at-home test kits are available at locations throughout the state such as Local Health Departments (LHDs), public libraries, and other community partners.

Getting a kit and taking an at-home test is as easy as **1 – 2 – 3.**

1. Find a location with at-home test kits.
2. Go to that location and pick up your test kit.
3. Take the test at home. See instructions for using your at-home test kit in both English & Spanish.

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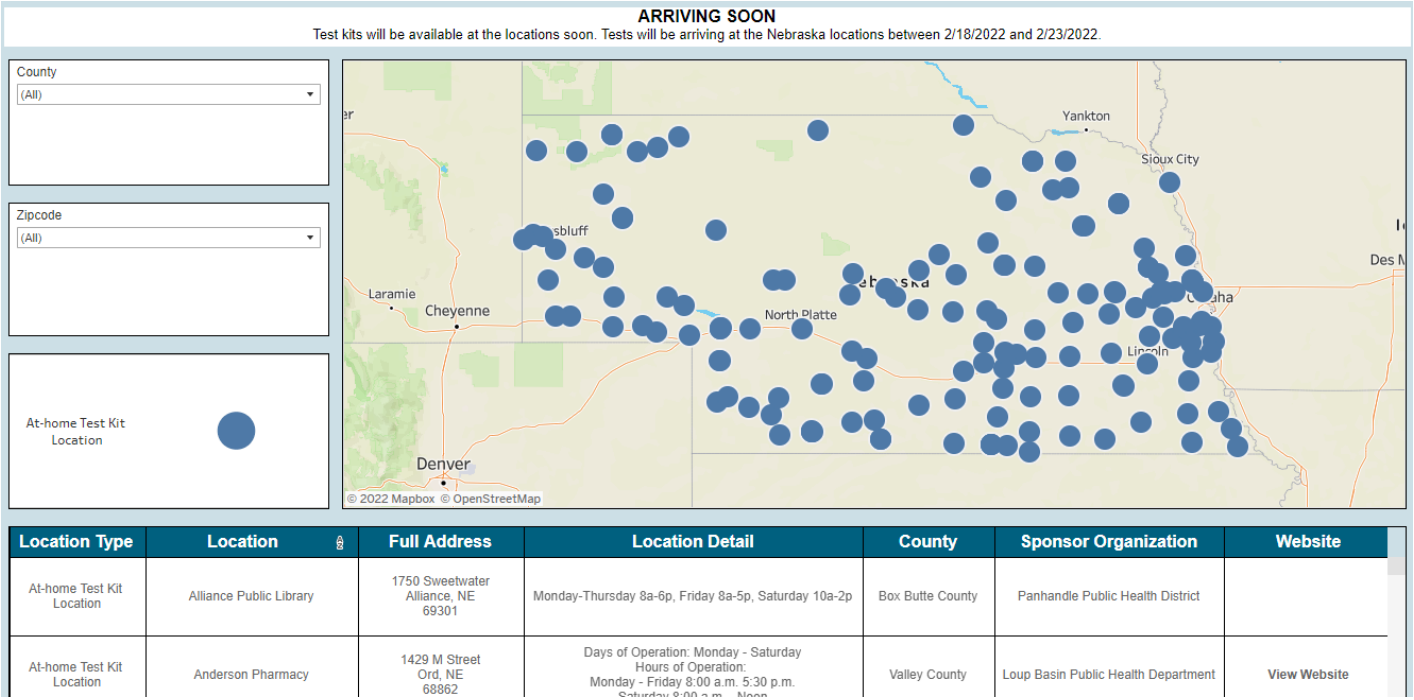
Nebraska Free COVID-19 Testing



Location Type	Location	Full Address	Location Detail	County	Sponsor Organization	Website
At-home Test Kit Location	Alliance Public Library	1750 Sweetwater Alliance, NE 69301	Monday-Thursday 8a-6p, Friday 8a-5p, Saturday 10a-2p	Box Butte County	Panhandle Public Health District	
At-home Test Kit Location	Anderson Pharmacy	1429 M Street Ord, NE 68862	Days of Operation: Monday - Saturday Hours of Operation: Monday - Friday 8:00 a.m. 5:30 p.m.	Valley County	Loup Basin Public Health Department	View Website

- Visit the map to find pick up locations for the free rapid tests
- https://datanexus-dhhs.ne.gov/views/CovidTestingLocations/CovidTestingLocations?:isGuestRedirectFromVizportal=y&:embed=y

Nebraska Free COVID-19 Testing

- They can go here for a proctored test with a provider that will supply them an official lab report of their result
- https://dhhs.ne.gov/Pages/COVID-19-Testing.aspx

Virtually-Guided Option

- This option starts a guided telehealth session with a professional test guide who will walk you through the process for taking the test and viewing the results.
- You will be provided a *documented result that can be used for official purposes like travel, return to school/work, etc. and will be shared with the State of Nebraska through standard reporting processes.*

Non-Guided Option

- You can choose to take the test yourself without the guided telehealth session.
- Using this option provides you with test results that are **only** for personal use, *and **do not** produce a result that can be used for travel, return to school/work, etc.*
- iPhone and Android users can also download a smartphone app which allows you to store, access and display test results.
  - iPhone App
  - Android App

Find FREE Rapid At-home Test Kits in Nebraska

START a Virtually-Guided Home Test Session

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Questions and Answer Session #2

Please use the QA box in the webinar platform to type a question

Attendees also have the option to upvote other attendee's questions

Questions will be read aloud by the moderator

A recording of the discussion will be made available on the Nebraska ICAP website

<u>Panelists:</u>

Daniel Brailita, MD
Josette McConville, BSN, RN, CIC
Rebecca Martinez, BA, BSN, RN, CIC
Sarah Stream, MPH, CDA, FADAA
Kate Tyner, RN, BSN, CIC
Jody Scebold, EdD, MSN, RN
Chris Cashatt, RN, BSN, CIC

COVID-19 RESOURCES – VACCINATION

COVID-19 RESOURCES – HEALTHCARE FACILITIES

COVID-19 RESOURCES – PPE

COVID-19 RESOURCES – SCHOOLS & BEHAVIORAL HEALTH

COVID-19 RESOURCES – EXPERT INFORMATION

COVID-19 WEBINARS

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ICARs for Acute & Outpatient Settings

- Infection Control Assessment and Response (ICAR) tools are used to systematically assess a healthcare facility's infection prevention and control practices and guide quality improvement activities (e.g., by addressing identified gaps)
  - ICAP is offering on-site and tele (virtual) assessments to both acute and outpatient settings

- Call NE ICAP at 402.552.2881 to be connected with an Infection Preventionist
  - Or scan the QR code

- Ask to be added to the ICAP email distribution list
  - https://nebraskamed.formstack.com/forms/add_me_to_email_distribution_list

Requests?

Join us for our next webinar on March 9, 2022!
We will highlight the HEROS Program and Educational Offerings

Image by rawpixel.com

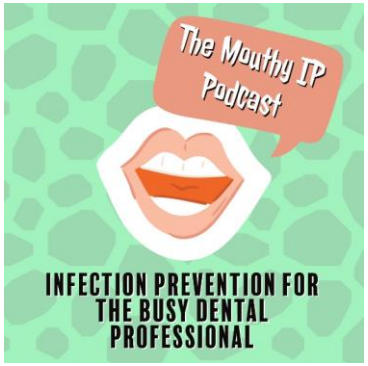
If you have suggestion(s) for future webinar topics or an IP ENIGMA to discuss include them in the continuing education (CE) survey or contact us with your requests!

Call us at 402.552.2881

Email us at nebraskaICAP@nebraskamed.com

You can also be added to our setting specific mailing lists, receive webinar and training invites and be connected to an Infection Preventionist that specializes in your area by filling out the contact form at: https://nebraskamed.formstack.com/forms/icap_question

Listen to New ICAP Podcasts!



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Spotify: https://open.sp otify.com/show/2evXIrvZFiZFP2VZBq9cVK?si=DVhPEewJSL2xXIrDi0Y2Bg&dl_branch=1
Amazon Music: https://music.amazon.com/podcasts/2bc794ab-59af-4bbe-a8df-6a72309fa024/THE-MOUTHY-IP
Podchaser: https://www.podchaser.com/podcasts/the-mouthy-ip-1955086

Twitter: @dirty_drinks
Amazon Music: https://music.amazon.com/podcasts/769c29a8-1e71-46a5-9ab3-94020d7af1f7/DIRTY-DRINKS
Apple Podcasts: https://podcasts.apple.com/us/podcast/dirty-drinks/id1574937193
Podchaser: https://www.podchaser.com/podcasts/dirty-drinks-1963455
Spotify: https://open.spotify.com/show/3Y8w2YVedZYnX8ZS897mU9?si=lyBNetUTTSGtlg3PmBH3Tg&dl_branch=1

ICAP Contact Info

Call 402-552-2881

Office Hours are Monday – Friday
8:00 AM - 4:00 PM Central Time
Weekends and Holidays 8:00-4:00

On-call hours are available for emergencies only

Scan the QR Code to be taken to our website contact form. You can request a call back from an IP, Sign up for newsletters and reminders and request an ICAR Review for your facility.

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Webinar CE Process

1 Nursing Contact Hour is awarded by NE Medicine *

* Nebraska Medicine is approved as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

***1 AMA PRA Category 1 Credit™* for Physicians offered by UNMC**

CNE Nursing Contact Hours:

- Completion of survey is required.
  - The survey must be specific to the individual obtaining credit. (i.e.: 2 people cannot be listed on the same survey)
- One certificate is issued monthly for all webinars attended
- Certificate comes directly from ICAP via email
- Certificate is mailed by/on the 15th of the next month
- Survey functionality is lost on mobile devices

AMA PRA Category 1 Credit™

Completion of survey is required.

- The survey must be specific to the individual obtaining credit. (i.e.: 2 people cannot be listed on the same survey)
- One certificate is issued monthly for all webinars attended
- Certificate can be downloaded from the UNMC CCE system directly, they will email you access
- Survey functionality is lost on mobile devices

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