

Guidance and responses were provided based on information known on 08.10.2023 and may become out of date. Guidance is being updated rapidly; users should look to CDC and NE DHHS guidance for updates.



Infection Control Assessment
and Promotion Program

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

COVID-19 and LTC

August 10th, 2023

Presentation Information:

Panelists are:

Dr. Salman Ashraf, MBBS

Kate Tyner, RN, BSN, CIC

Josette McConville, RN, CIC

Lacey Pavlovsky, RN, MSN, CIC, LTC-CIP

Ishrat Kamal-Ahmed, M.Sc., Ph D.

Sarah Stream, MPH, CDA, FADAA

Jody Scebold, EdD, MSN, RN

Rebecca Martinez, RN, BSN, CIC

Jenna Preusker, PharmD, BCPS

Daniel Taylor, DHHS

Deanna Novak, DHHS

Becky Wisell, DHHS

Cindy Kadavy, NHCA

Kierstin Reed, LeadingAge

Melody Malone, PT, CPHQ, MHA

Debi Majo, BSN, RN

Carla Smith, RN, CDP, IP-BC, AS-BC

Monika Maxwell, RN

Moderated by Marissa Chaney

salman.ashraf@nebraska.gov

lttyner@nebraskamed.com

jmconville@nebraskamed.com

lacey.pavlovsky@nebraska.gov

ishrat.kamal-ahmed@nebraska.gov

sstream@nebraskamed.com

jodscebold@nebraskamed.com

remartinez@nebraskamed.com

jepreusker@nebraskamed.com

daniel.taylor@nebraska.gov

deanna.novak@nebraska.gov

becky.wisell@nebraska.gov

cindyk@nehca.org

kierstin.reed@leadingagene.org

melody.malone@tmf.org

deborah.majo@tmf.org

carla.smith@tmf.org

monika.maxwell@tmf.org

machaney@nebraskamed.com

Slides and a recording of this presentation will be available on the ICAP website:

<https://icap.nebraskamed.com/events/webinar-archive/>

Use the Q&A box in the webinar platform to type a question. Questions will be read aloud by the moderator. If your question is not answered during the webinar, please either e-mail it to NE ICAP or call during our office hours to speak with one of our IPs.



Continuing Education Disclosures

- 1.0 Nursing Contact Hour and 1 NAB Contact Hour is awarded for the LIVE viewing of this webinar
- In order to obtain nursing contact hours, 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 along with Nebraska ICAP and Nebraska DHHS
- 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 (ANCC) Commission on Accreditation

Introduction



Nebraska ICAP is excited to welcome Dr. Juan Teran Palencia to the team! Dr. Teran will be our main medical director moving forward as Dr. Ashraf transitions to his full time role as Ne DHHS HAI/AR Medical Director.

Dr. Teran went to medical school in Ecuador, completed his Internal Medicine Residency at University of Miami/JFK Hospital and completed his Infectious Disease Fellowship at Boston University School of Medicine. He has clinical interests of antimicrobial stewardship and Multi-Drug Resistant gram-negative infections.

You will start to see him on the ICAP webinars and in ICAP announcements. The ICAP team can't wait to work with Dr. Teran and use his clinical expertise to support your facility!

Educational Opportunities



CONSULTANT PHARMACIST TRAINING TO PROMOTE AND SUPPORT ANTIMICROBIAL STEWARDSHIP IN LONG TERM CARE

A UNMC ID Project ECHO Series



- No cost to participants – fees covered by Nebraska ASAP through the CDC ELC Grant
- Year-long educational series held virtually through UNMC ID Project ECHO
- 6 didactic sessions, once a month from August 2023 - January 2024
- 4 office hours sessions will be held once a month from March 2024 - June 2024
- Participants who successfully complete all 6 didactic sessions and at least 2 of 4 office hours sessions (participation confirmed by submission of completed evaluations) will receive a certificate of completion from Nebraska ASAP

[Register Here - First Session: August 18, 2023 at 12:00](#)

Or Visit the Nebraska ASAP website: [Home – ASAP](#)

Nebraska ASAP can share this with your pharmacist:

[LTC Consultant Pharmacist Contact Information](#)



TMF Health Quality Institute CMS Quality Innovation Network- Quality Improvement Organization (QIN-QIO)





Melody Malone, PT, CPHQ, MHA
Quality Improvement Specialist

NHSN QA Alert Related to COVID-19 Vaccination

- NHSN Home**
- Alerts
- Dashboard ▶
- Reporting Plan ▶
- Resident ▶
- Event ▶
- Summary Data ▶
- COVID-19 ▶
- Vaccination Summary
- Import/Export
- Surveys ▶
- Analysis ▶
- Users ▶
- Facility ▶
- Group ▶

COVID-19 Vaccination Summary Data Alerts

COVID-19 DATA	COVID-19 Vaccination Summary Data	Missing Events	Incomplete Events	Missing Summary Data	Incomplete Summary Data
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Week Start Date	Week End Date	Vaccination Form Type		Variable	QA Flag Description	Confirmed
06/26/2023	07/02/2023	Resident		pctAnyVacc	The total (complete + partial) vaccination coverage rate is less or equal than 10%	N
07/03/2023	07/09/2023	Resident		pctAnyVacc	The total (complete + partial) vaccination coverage rate is less or equal than 10%	N
07/10/2023	07/16/2023	Resident		pctAnyVacc	The total (complete + partial) vaccination coverage rate is less or equal than 10%	N
07/17/2023	07/23/2023	Resident		pctAnyVacc	The total (complete + partial) vaccination coverage rate is less or equal than 10%	N

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NHSN QA Alert Related to COVID-19 Vaccination – Memo July 14, 2023

- The QA alert is generating incorrectly for some facilities saying that they have reported a primary vaccination rate of less than 10%.
- Please disregard these QA alerts, as the alerts are not impacting a facility's ability to enter, update, save or analyze data.
- Additionally, please do not edit weekly COVID-19 vaccination module data from within the QA alerts screen.

CMS-Targeted COVID-19 Training

For frontline nursing home staff and management learning

- Available through the [CMS Quality, Safety & Education Portal \(QSEP\)](#)
- Five frontline nursing home staff modules with three hours total training time
- Ten management staff modules with four hours total training time
- [QSEP Group Training Instructions – English](#) (PDF)
- [QSEP Group Training Instructions – Spanish](#) (PDF)

CMS QSO-23-16-Hospitals Memo

- [Requirements for Hospital Discharges to Post-Acute Care Providers](#)
- Reminding state agencies, accrediting organizations and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers
- Highlighting the risks to patient health and safety that can occur due to an unsafe discharge
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patient health and safety

Advance Care Planning

- [Toolkit for Health Care Advance Planning](#)
- [Caring Conversations Workbook and Materials](#)
- [Advance Care Planning for African Americans](#)
- [Five Wishes](#)
- [Loving Conversations Video Series](#)

TMF COVID-19 Bivalent Vaccine Toolkit

[TMF COVID-19 Bivalent Vaccine Toolkit](#)

- Resources for nursing home residents and families
 - › [Letter template to families regarding bivalent vaccine](#)
- COVID-19 therapeutics resources
- Resources for nursing home staff and leadership
- Motivational interviewing four-part webinar series (videos)
- Additional resources

Long COVID-19



Long COVID, or Post-COVID Conditions (PCC), is broadly defined as signs, symptoms and conditions that continue or develop after the initial COVID-19 infection.

Also known as: Post-COVID Conditions, long-haul COVID, post-acute COVID-19, long-term effects of COVID, post-acute sequelae of SARS-CoV-2 (PASC) and chronic COVID.

SYMPTOMS OF LONG COVID:

General Symptoms *(Not a Comprehensive List)*

- Tiredness or fatigue that interferes with daily life
- Symptoms that get worse after physical or mental effort (also known as "post-exertional malaise")

Neurological Symptoms

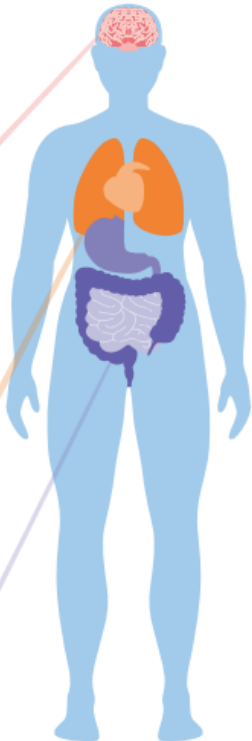
- Difficulty thinking or concentrating (sometimes referred to as "brain fog")
- Headache
- Sleep problems
- Dizziness when you stand up (lightheadedness)
- Pins-and-needles feelings
- Change in smell or taste
- Depression or anxiety

Respiratory and Heart Symptoms

- Difficulty breathing or shortness of breath
- Cough
- Chest pain
- Fast-beating or pounding heart (also known as heart palpitations)

Digestive Symptoms

- Diarrhea
- Stomach pain



Other Symptoms

- Joint or muscle pain
- Rash
- Changes in menstrual cycle

Who is at risk: Some people may be more at risk for developing Long COVID

- People who have experienced severe COVID-19 illness, especially those who were hospitalized or needed intensive care
- People who have underlying health conditions, such as diabetes, asthma, autoimmune diseases or obesity
- People who are unvaccinated
- People who experience multisystem inflammatory syndrome (MIS) during or after COVID-19 illness

Other factors that may be important include the following:

- Female
- Older age
- Immune response to initial infection
- The SARS-CoV-2 variant that caused the initial infection

Source: [Nearly 1 in 5 American Adults Who Have Had COVID-19 Still Have "Long COVID."](#) Centers for Disease Control and Prevention (CDC)



Hypotheses for Long COVID (From: [Long COVID > Fact Sheets > Yale Medicine](#))

- **Residual organ damage:** Caused by the body's own immune response to SARS-CoV-2 infection.
- **Remaining virus:** After the immune system eliminates the virus, some remnants of it survive in one or more organs, and it continues to stimulate an immune response.
- **Exaggerated immune response:** In some people, COVID-19 sparks an exaggerated immune response; the immune system then remains in an overexcited state, resulting in various symptoms.



Preventing Long COVID:

- Prevent one from getting infected by practicing good infection prevention and control protocols.
- Stay [up to date](#) with COVID-19 vaccine recommendations.
- Get tested and timely therapeutics when needed.

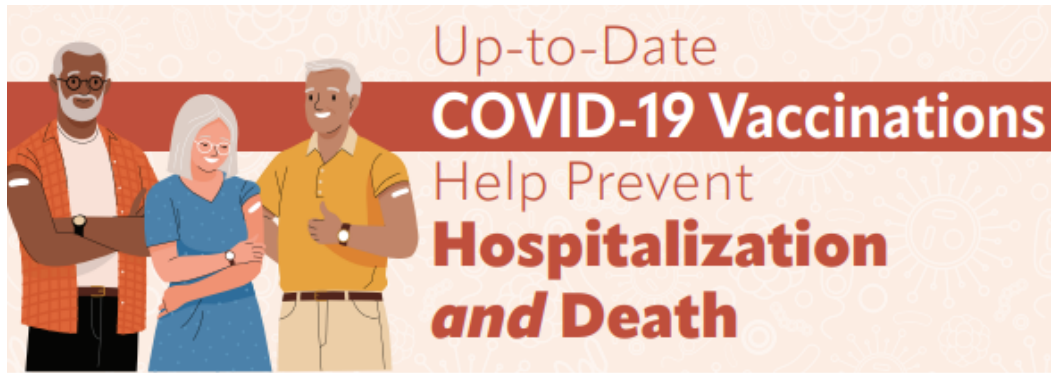


Treatment:

Patient-centered approach: Holistic approach is beneficial. There is no test for Long COVID. Together with your health care provider, you can create a personal care plan to manage your symptoms and improve your quality of life.



WWW.TMFNETWORKS.ORG



Up-to-Date COVID-19 Vaccinations Help Prevent **Hospitalization and Death**

Your vaccination status determines your risk of hospitalization and death.

HOSPITALIZATION *Incidence per 100,000 population*



1 person
Up to Date
with COVID-19
vaccinations is
hospitalized



2.6 people *vaccinated*
but not *Up to Date* are
hospitalized



16 people *unvaccinated*
are hospitalized

DEATH *Incidence per 100,000 population*



1 person
Up to Date
with COVID-19
vaccinations
dies



2.4 people *vaccinated*
but not *Up to Date* die



9.8 people
unvaccinated die

GET BOOSTED NOW

**COVID vaccines lose power
like batteries.**



Recharge your protection.

***Ask a nurse about getting your latest
COVID-19 vaccine today!***

Implementing CLAS to Improve Health Equity Education Series

- Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care National Standards
- [Implementing CLAS to Improve Health Equity: Using patient-centered data to meet CLAS standards video](#)
 - › [Handout: Implementing CLAS to Improve Health Equity: Using patient-centered data to meet CLAS standards \(PDF\)](#)
- [Register: Implementing CLAS to Improve Health Equity](#)
Two Sessions: **Aug. 30, 2023**, and **Oct. 18, 2023**, from 11:30 a.m. to 12:30 p.m. CT

Upcoming TMF QIN-QIO Training

LTC Connect

Fall Reduction and ADLs – Helping to Prevent ED Visits

Thursday, Aug. 17, 2023
1:30 – 2 p.m. CT

Immunizations

Thursday, Sept. 21, 2023
1:30 – 2 p.m. CT

An open Q&A session will follow the 30-minute LTC Connect presentation.

Nursing Home Office Hours

Health Equity and Vaccine Hesitancy

Tuesday, August 22, 2023
1:30 – 2:30 p.m. CT

Register [once](#) for multiple TMF QIN-QIO events.
Check out our [Nursing Home Recorded Events](#).

TMF QIN-QIO Resources

Website: tmfnetworks.org

- [How to Create an Account on the TMF Network](#)
- [Calendar of Events](#)
- [Nursing Home Resources](#)
- [Quality Measures Video Series and Resources](#)
- [Quality Assurance Performance Improvement Video Series](#)

Need Assistance?

Connect With Us!



Email

nhnetwork@tmf.org

Submit requests for help with NHSN and/or quality improvement assistance.



Follow Us on Facebook

[TMF QIN Nursing Home Quality Improvement Facebook](#)

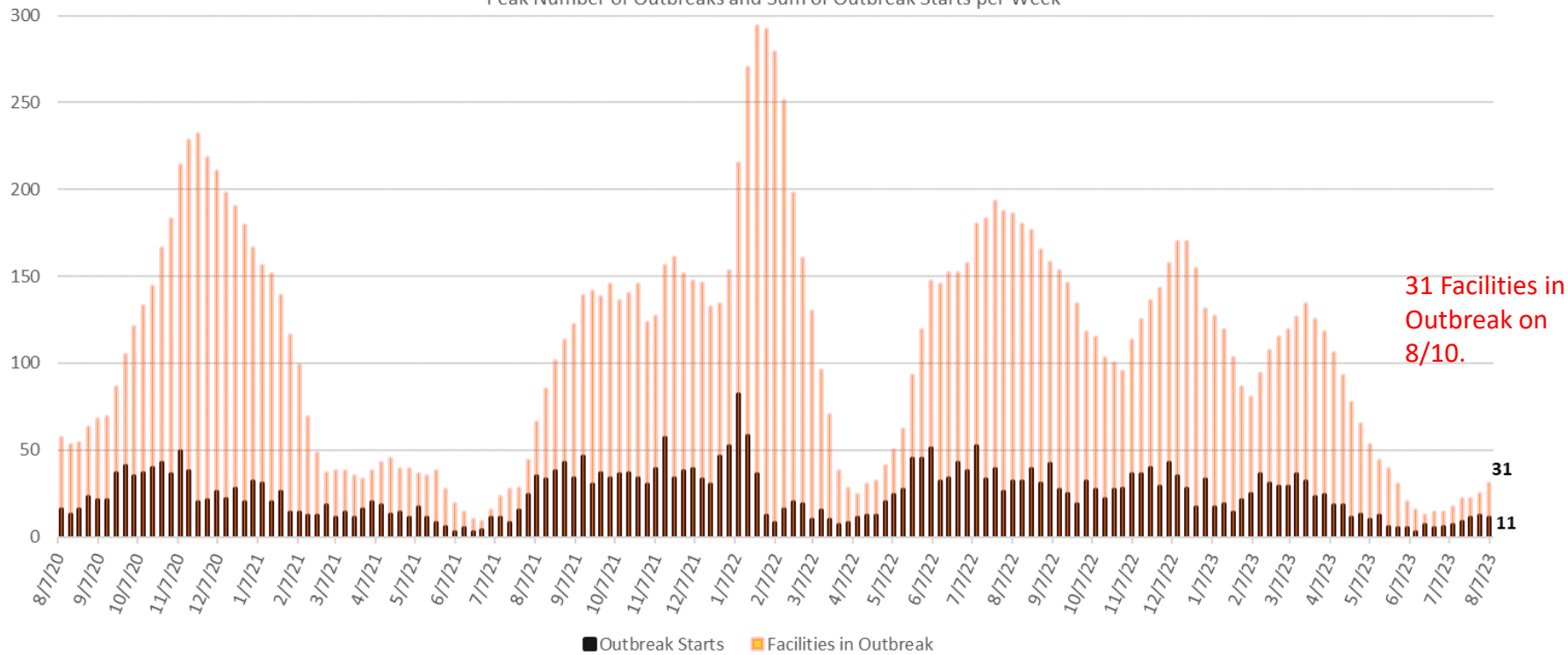
Nebraska Statistics



Nebraska LTC Facility COVID-19 Outbreaks

Nebraska LTC Facilities in COVID Outbreak by Week

Peak Number of Outbreaks and Sum of Outbreak Starts per Week



**Updated: 8/7/2023

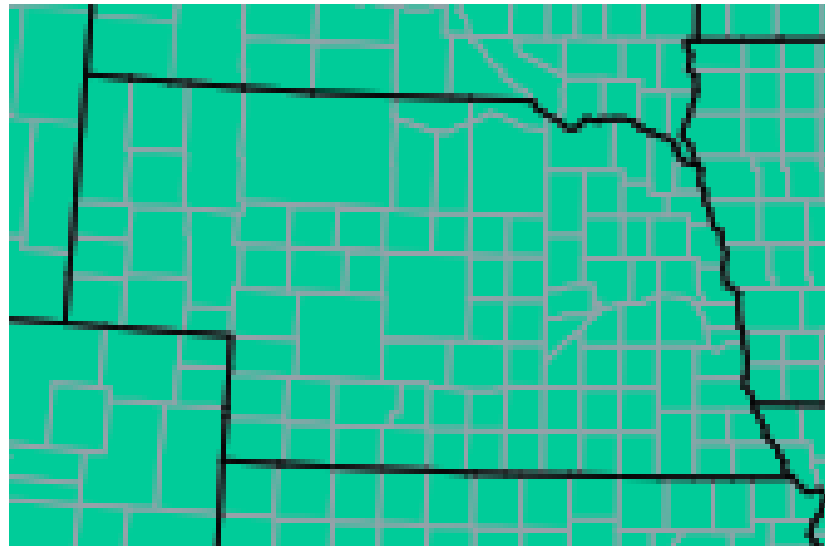
Source: Unofficial Counts Compiled by Nebraska ICAP based on data reported by facilities and DHHS; Actual numbers may vary slightly. Numbers reflect the peak during the week.



CDC COVID-19 Data Tracker

US Reported COVID-19 New Hospital Admissions Rate per 100,000 in the Past Week, by County

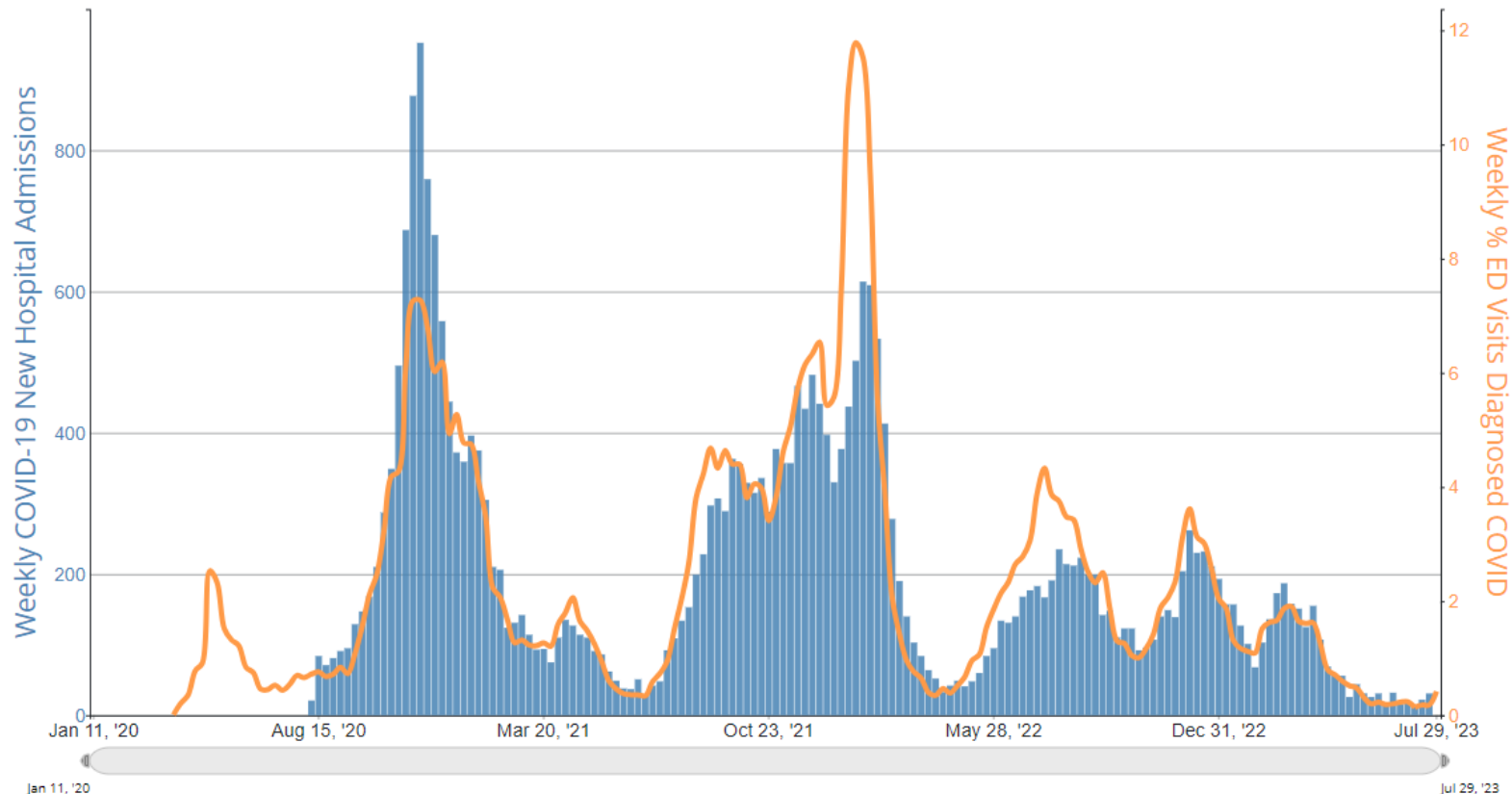
Time Period: New COVID-19 hospital admissions per 100,000 population (7-day total) are calculated using data from the MMWR week (Sun-Sat) ending July 22, 2023.



● Low (<10.0) ● Medium (10.0 to 19.9) ● High (≥ 20.0) ● Insufficient data

CDC COVID-19 Data Tracker

COVID-19 New Hospital Admissions and Percentage of Emergency Department (ED) Visits Diagnosed as COVID-19, by Week, in Nebraska, Reported to CDC



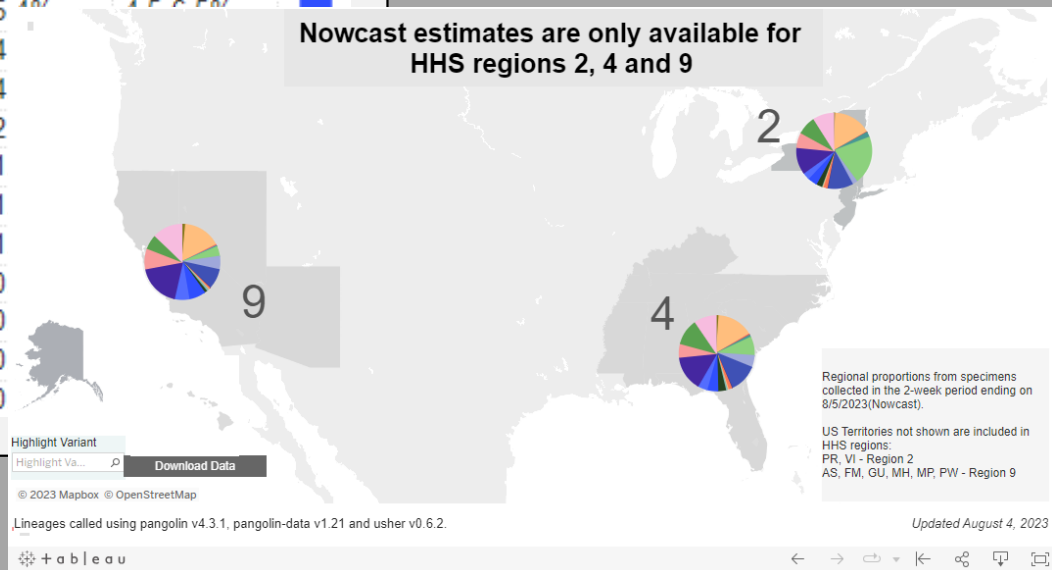


What's happening with variants?

Nowcast Estimates in United States

WHO label	Lineage #	%Total	95%PI
Omicron	EG.5	17.3%	14.1-21.0%
	XBB.1.16	15.6%	12.5-19.2%
	XBB.2.3	11.2%	9.5-13.1%
	XBB.1.5	10.3%	8.6-12.3%
	FL.1.5.1	8.6%	4.2-16.1%
	XBB.1.16.6	7.7%	5.6-10.6%
	XBB.1.16.1	7.2%	6.0-8.7%
	XBB.1.9.1	5.4%	4.5-6.5%
	XBB.1.9.2	4	
	XBB	4	
	XBB.1.5.72	2	
	XBB.1.5.10	1	
	FE.1.1	1	
	CH.1.1	1	
	XBB.1.5.68	0	
	XBB.1.5.59	0	
EU.1.1	0		
XBB.1.5.1	0		

**Weighted and
Nowcast Estimates
for two-week period
7/23/23 – 8/5/23**



Wastewater Surveillance

Time Period: Jul 17, 2023 – Jul 31, 2023

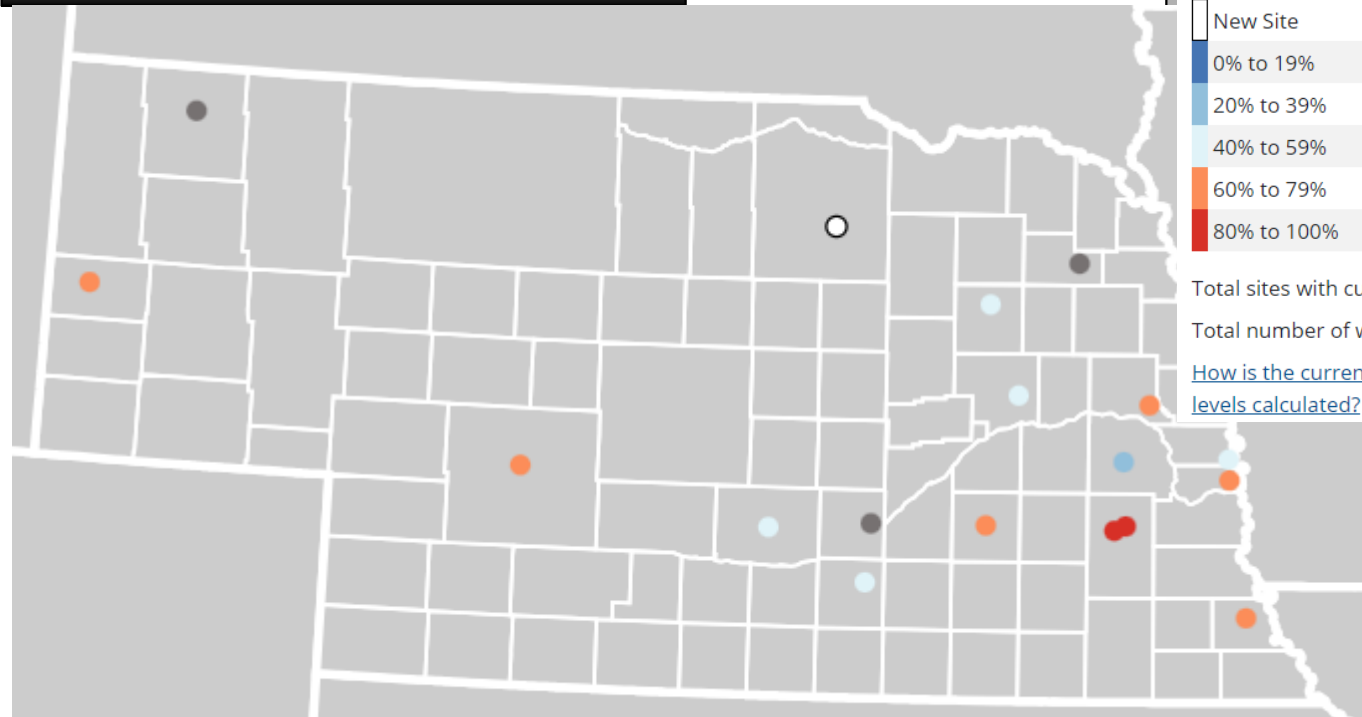
Current SARS-CoV-2 virus levels by site, Nebraska

Current virus levels category	Num. sites	% sites	Category change in last 7 days
New Site	1	7	0%
0% to 19%	0	0	N/A**
20% to 39%	1	7	0%
40% to 59%	5	33	0%
60% to 79%	6	40	- 14%
80% to 100%	2	13	100%

Total sites with current data: 15

Total number of wastewater sampling sites: 18

[How is the current SARS-CoV-2 level compared to past levels calculated?](#)



○ New site ● 0% to 19% ● 20% to 39% ● 40% to 59% ● 60% to 79% ● 80% to 100% ● No recent data

Managing COVID-19 Outbreaks

CDC Recommendations:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
 - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

ICAP Resources:

- [Summary-of-Recommendations-for-COVID-19-in-a-Long-Term-Care-Facility-5.11.23.pdf \(nebraskamed.com\)](#)
- [Zones-PPE-and-Testing-5.24.2023.pdf \(nebraskamed.com\)](#)

EBP Part 2: Nebraska Novel MDRO Update and EBP Implementation



July 13th Webinar

Part 1: Introduction to Enhanced Barrier Precautions (EBP)



Long Term Care Webinars

**07.13.23 LTC Enhanced Barrier Precautions
Part 1**

- [Slide Deck](#)
- [Recording](#)

Enhanced Barrier Precautions (EBP)

Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce the transmission of MDROs.

Use EBP when performing high-contact resident care activities for residents who meet the criteria for the use of EBP

- Includes the use of gown and gloves
- Resident does not need a private room
- Resident may participate in communal activities and dining and is not restricted to their room
- Intended to be used for the resident's entire length of stay in the facility, or until wound is healed or invasive device is removed



Which Residents Meet the Criteria for EBP?

Residents with any of the following:

- Infection or colonization with an MDRO when Contact Precautions do not apply
 - For the purposes of this guidance, the MDROs for which the use of EBP applies are based on local epidemiology.
- At a minimum, they should include resistant organisms targeted by CDC, but can also include other epidemiologically important MDROs.

Examples of MDROs Targeted by CDC include:

- Pan-resistant organisms,
- Carbapenemase-producing carbapenem-resistant Enterobacterales,
- Carbapenemase-producing carbapenem-resistant *Pseudomonas* spp.,
- Carbapenemase-producing carbapenem-resistant *Acinetobacter baumannii*, and
- *Candida auris*

Additional epidemiologically important MDROs may include, but are not limited to:

- Methicillin-resistant *Staphylococcus aureus* (MRSA),
- ESBL-producing Enterobacterales,
- Vancomycin-resistant *Enterococci* (VRE),
- Multidrug-resistant *Pseudomonas aeruginosa*,
- Drug-resistant *Streptococcus pneumoniae*

Novel MDRO Update

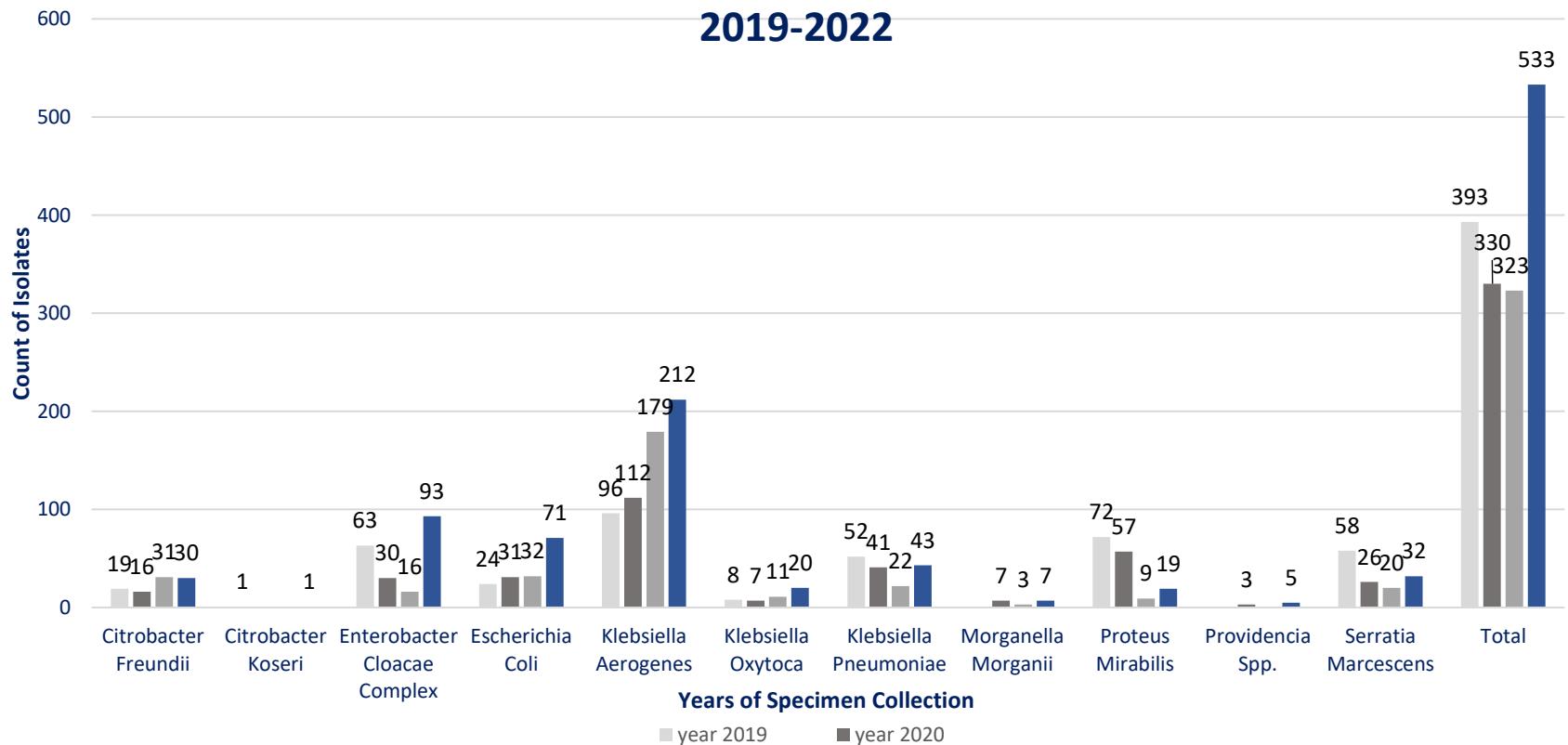
Ishrat Kamal-Ahmed, M.Sc., Ph.D.
**Nebraska DHHS HAI -Antimicrobial Resistance
Epidemiologist**

Lacey Pavlovsky, MSN, RN, CIC, LTC –CIP,
**Nebraska DHHS HAI –Antimicrobial Resistance
Infection Preventionist and NHSN Coordination Lead**

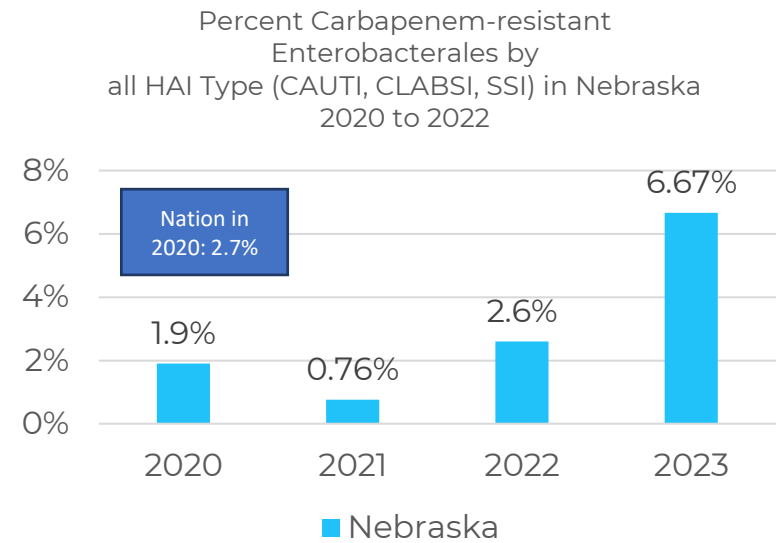
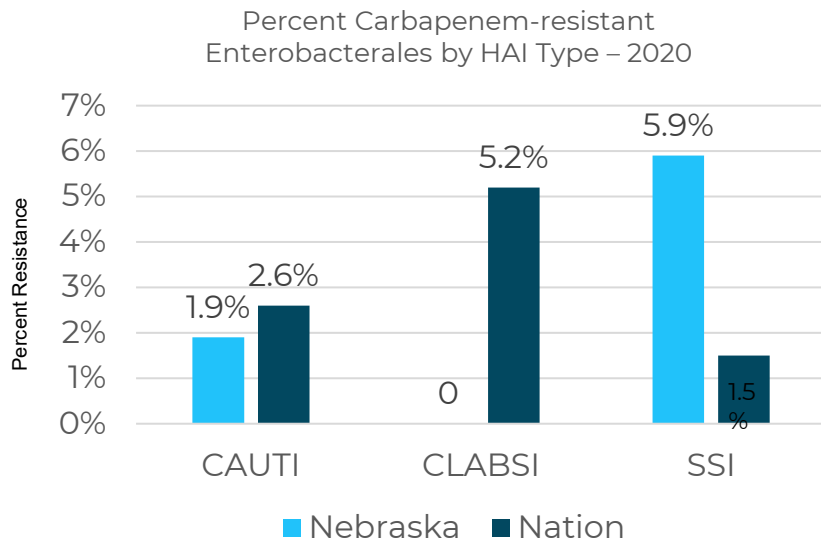


Carbapenem-Resistant Enterobacteriales in Nebraska

Carbapenem-resistant Enterobacteriales (CRE) Isolates in Nebraska, 2019-2022



CRE Trends Related to HAIs



Source: NHSN Data

<https://arpsp.cdc.gov/profile/antibiotic-resistance/carbapenem-resistant-enterobacteriales>
<https://arpsp.cdc.gov/profile/geography/nebraska>

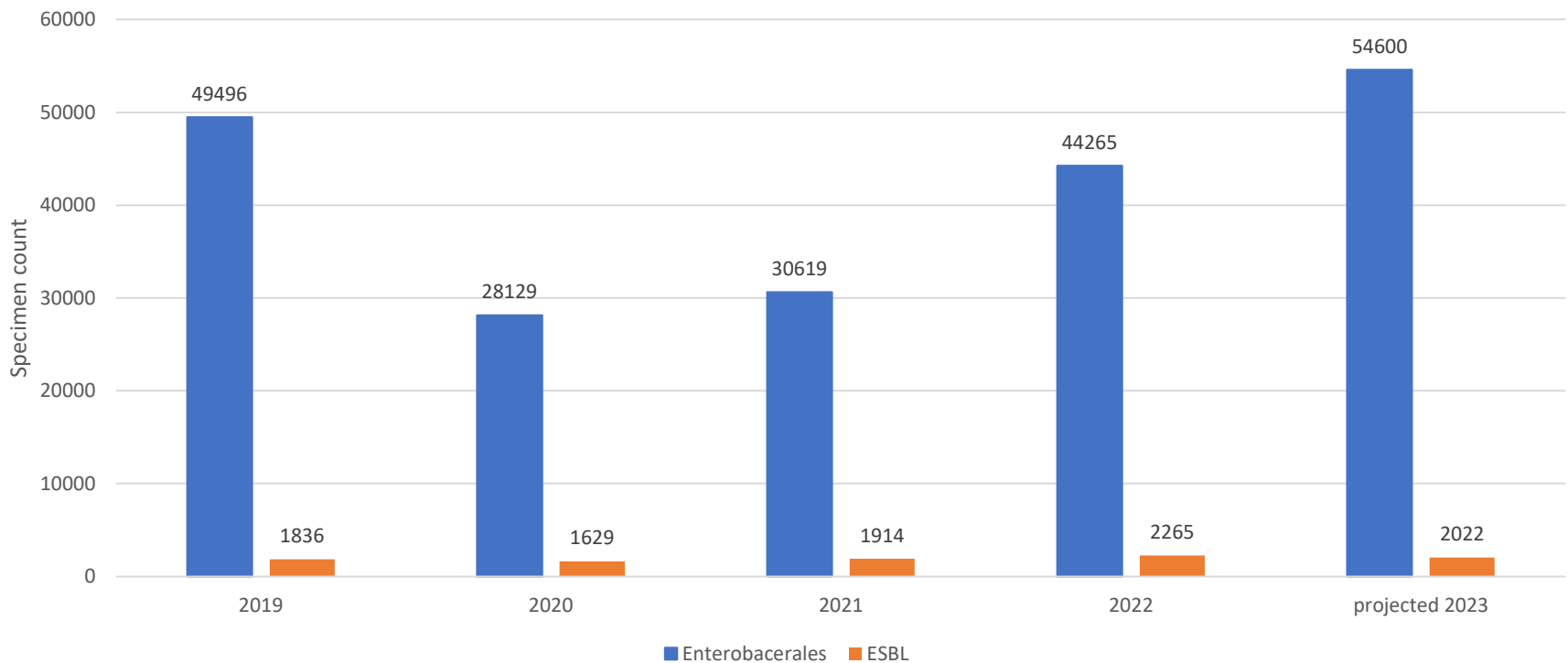
Carbapenemase Genes Identified in Enterobacterales Isolates, Nebraska 2019-2023

Year	KPC	NDM	OXA-48	OXA-181	VIM	Other	Total
2019	18	9	0	3	0		30
2020	8	0	1	0	0		9
2021	3	0	1	0	0		4
2022	8	3	1	0	1		13
2023	3	4	3	0	0	4	14

In 2023, 1 case each of Carbapenemase producing *Pseudomonas aeruginosa* and *Acinetobacter Baumannii* has also been isolated

Ceftriaxone Resistant Enterobacterales

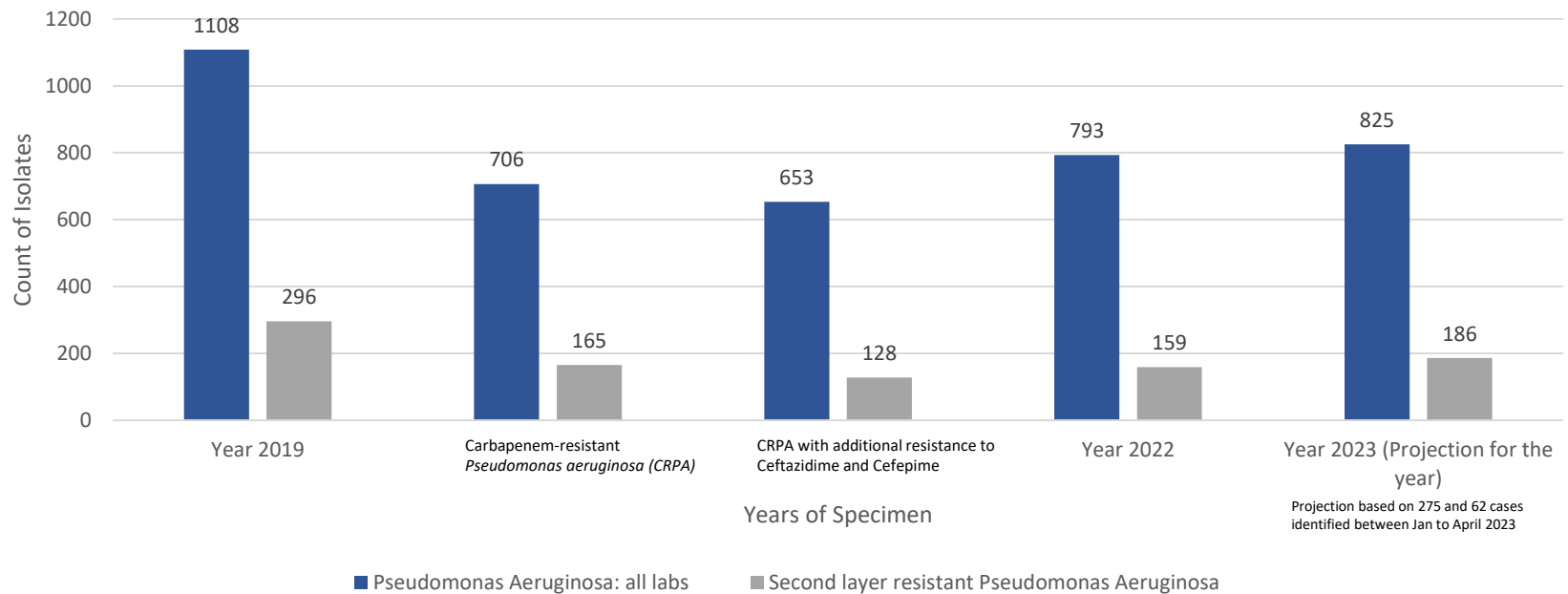
Enterobacterales and Ceftriaxone Resistant Enterobacterales



**Ceftriaxone Resistance Enterobacterales can be suggestive of ESBL organism
2023 data is based on January-June 2023 data

Carbapenem-Resistant Pseudomonas Aeruginosa

Carbapenem-Resistant Pseudomonas Aeruginosa (CRPA) isolates in Nebraska, 2019-2022



Candida auris

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, MPH, MPTM

Background: *Candida auris* is an emerging fungal threat that has been spreading in the United States since it was first reported in 2016.

Objective: To describe recent changes in the U.S. epidemiology of *C. auris* occurring from 2019 to 2021.

Design: Description of national surveillance data.

Setting: United States.

Patients: Persons with any specimen that was positive for *C. auris*.

Measurements: Case counts reported to the Centers for Disease Control and Prevention by health departments, volume of colonization screening, and antifungal susceptibility results were aggregated and compared over time and by geographic region.

Results: A total of 3270 clinical cases and 7413 screening cases of *C. auris* were reported in the United States through 31 December 2021. The percentage increase in clinical cases grew each year, from a 44% increase in 2019 to a 95% increase in 2021. Colonization screening volume and screening cases increased in 2021 by more than 80% and more

than 200%, respectively. From 2019 to 2021, 17 states identified their first *C. auris* case. The number of *C. auris* cases that were resistant to echinocandins in 2021 was about 3 times that in each of the previous 2 years.

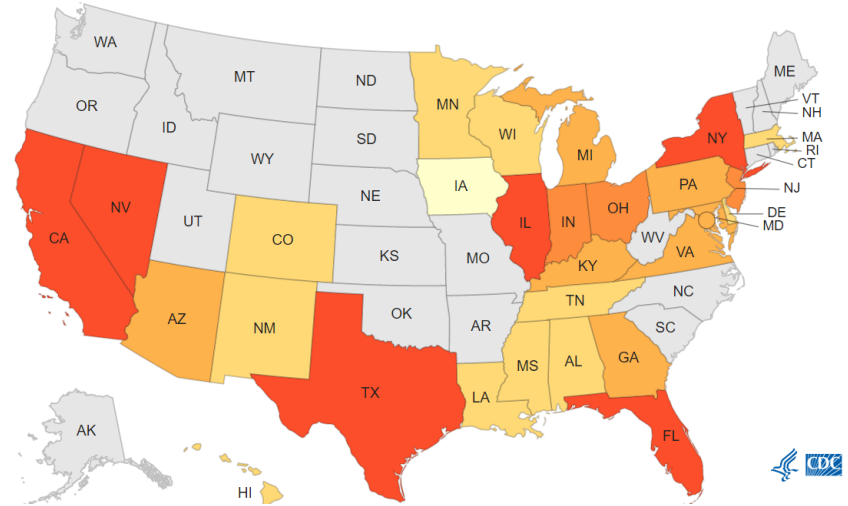
Limitation: Identification of screening cases depends on screening that is done on the basis of need and available resources. Screening is not conducted uniformly across the United States, so the true burden of *C. auris* cases may be underestimated.

Conclusion: *C. auris* cases and transmission have risen in recent years, with a dramatic increase in 2021. The rise in echinocandin-resistant cases and evidence of transmission is particularly concerning because echinocandins are first-line therapy for invasive *Candida* infections, including *C. auris*. These findings highlight the need for improved detection and infection control practices to prevent spread of *C. auris*.

Primary Funding Source: None.

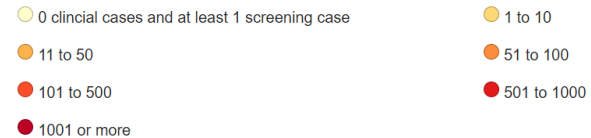
Ann Intern Med. 2023;176:489-495. doi:10.7326/M22-3469 [Annals.org](https://www.annals.org)
For author, article, and disclosure information, see end of text.
This article was published at [Annals.org](https://www.annals.org) on 21 March 2023.

Most Recent 12 Months



Number of *C. auris* clinical cases through December 31, 2022

In the most recent 12 months, there were 2,377 clinical cases and 5,754 screening cases (January 2022 - December 2022).



Lyman M et al. *Ann Intern Med.* 2023 Apr;176(4):489-495.
<https://www.cdc.gov/fungal/candida-auris/tracking-c-auris.html>

Candida auris Surveillance Efforts in Nebraska

- Education has been done by NPHL to make labs aware of CDC recommendation regarding all yeast isolates from normal sterile site need to be identified to the species level along with potential of misidentification
- NPHL has the ability to assist other labs with *C. auris* identification and has communicated to send potential isolates when they are unable to perform identification or are suspecting misidentification
- Labs are also advised to report any *C. auris* case and send the isolate to NPHL
- Nebraska DHHS team and NPHL are also exploring launching wastewater surveillance for *C. auris* and some other MDROs.

Identification Method	Database/Software, if applicable	<i>C. auris</i> is confirmed if initial identification is <i>C. auris</i> .	<i>C. auris</i> is possible if the following initial identifications are given. Further work-up is needed to determine if the isolate is <i>C. auris</i> .
Bruker Biotyper MALDI-TOF	RUO libraries (Versions 2014 [5627] and more recent)	<i>C. auris</i>	n/a
	CA System library (Version Claim 4)	<i>C. auris</i>	n/a
bioMérieux VITEK MS MALDI-TOF	RUO library (with Saramis Version 4.14 database and Saccharomycetaceae update)	<i>C. auris</i>	n/a
	IVD library (v3.2)	<i>C. auris</i>	n/a
	Older IVD libraries	n/a	<i>C. haemulonii</i> <i>C. lusitaniae</i> No identification
VITEK 2 YST	Software version 8.01*	<i>C. auris</i>	<i>C. haemulonii</i> <i>C. duobushaemulonii</i> <i>Candida</i> spp. not identified
	Older versions	n/a	<i>C. haemulonii</i> <i>C. duobushaemulonii</i> <i>Candida</i> spp. not identified
API 20C		n/a	<i>Rhodotorula glutinis</i> (without characteristic red color) <i>C. sake</i> <i>Candida</i> spp. not identified
API ID 32C		n/a	<i>C. intermedia</i> <i>C. sake</i> <i>Saccharomyces kluyveri</i>
BD Phoenix		n/a	<i>C. catenulata</i> <i>C. haemulonii</i> <i>Candida</i> spp. not identified
MicroScan		n/a	<i>C. lusitaniae</i> ** <i>C. guilliermondii</i> ** <i>C. parapsilosis</i> ** <i>C. famata</i> <i>Candida</i> spp. not identified
RapID Yeast Plus		n/a	<i>C. parapsilosis</i> ** <i>Candida</i> spp. not identified
GenMark ePlex BCID-FP Panel		<i>C. auris</i>	n/a

* There have been reports of *C. auris* being misidentified as *C. lusitaniae* and *C. famata* on VITEK 2. A confirmatory test such as cornmeal agar may be warranted for these species.
 ** *C. guilliermondii*, *C. lusitaniae*, and *C. parapsilosis* generally make hyphae or pseudohyphae on cornmeal agar. If hyphae or pseudohyphae are not present on cornmeal agar, the isolate should raise suspicions of being *C. auris* as *C. auris* typically does not make hyphae or pseudohyphae. However, some *C. auris* isolates have formed hyphae or pseudohyphae. Therefore, it would be prudent to consider any *C. guilliermondii*, *C. lusitaniae*, and *C. parapsilosis* isolates identified on MicroScan and any *C. parapsilosis* isolates identified on RapID Yeast Plus as possible *C. auris* isolates and further work-up should be considered.

If *C. auris* is confirmed: Place patient in transmission-based precautions, report to CDC (candidaauris@cdc.gov), and notify state and local health departments.
 If *C. auris* is possible: Further work-up is needed to determine if actually *C. auris*. Send isolates to a reference lab, a state public health lab, a regional lab, or CDC for further identification. Place patient in transmission-based precautions and notify state and local health departments and CDC (candidaauris@cdc.gov).

<https://www.cdc.gov/fungal/candida-auris/identification.html>

https://www.cdc.gov/fungal/candida-auris/pdf/Testing-algorithm_by-Method_508.pdf

Updated Guidance for Prevention and Response to MDROs

Strategies for Prevention and Response to Novel & Targeted Multidrug-Resistant Organisms (MDROs)

[Print](#)

Overview

Multidrug-resistant organisms (MDROs) are continuing to develop and spread in healthcare settings throughout the United States. Because of this, efforts to prevent MDRO transmission are still needed. In the past, MDROs were identified after lab confirmation, however, research has found that these organisms can spread long before being detected. A prevention approach that incorporates multiple healthcare facilities can potentially limit spread more effectively than response strategies alone.

CDC has developed two guides and FAQs for healthcare facilities, state, local, and territorial health departments to limit the spread of novel or targeted (e.g., *Candida auris*, carbapenemase-producing CRE) MDROs, FAQs, and a graphic (Figure 1) showing the relationship between prevention and response activities.

On This Page

- Comparison of Strategies
- FAQs
- Lab Resources
- Investigation Guides
- Colonization Screenings
- Inter-facility Transfer Forms
- MRDO Resources



Prevention Strategies

To prevent the spread of novel and targeted MDROs across healthcare



Containment Strategy

To address the initial response to novel and targeted MDROs

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

Updated December 2022

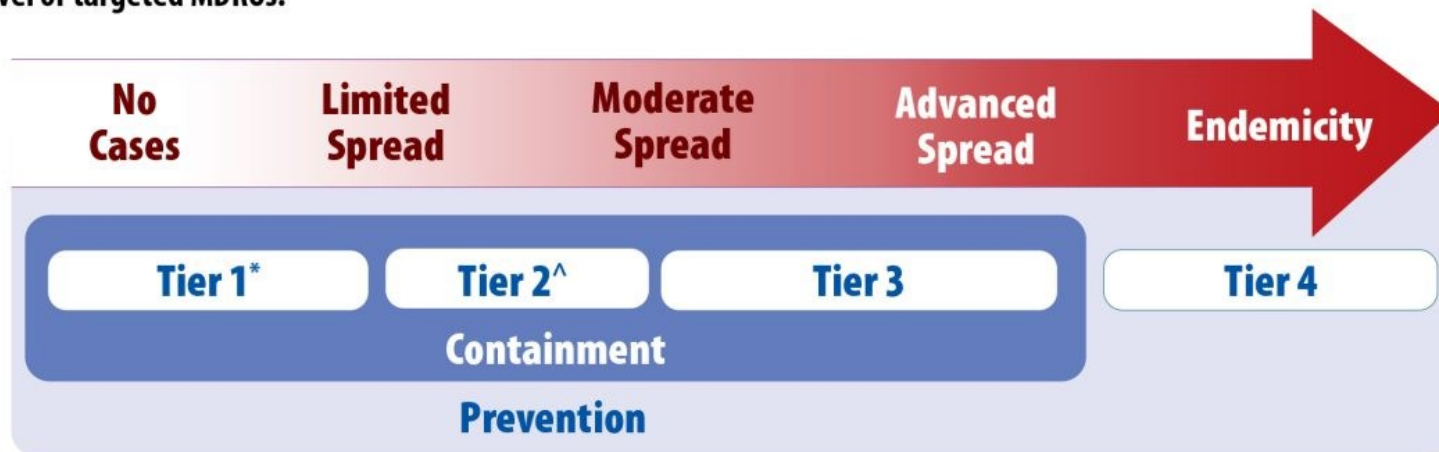
CDC
Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases

Tier Definitions and Examples

Tier	Definition of Included Organisms and Mechanisms	Examples (not all inclusive) of organisms/mechanisms for Nebraska
Tier 1	Never (or very rarely) been identified in the United States and for which experience is extremely limited	Novel Carbapenamases
Tier 2	<ol style="list-style-type: none"> 1. Primarily associated with healthcare settings and are not commonly identified in the region (i.e., not been previously identified in the region or have been limited to sporadic cases or small outbreaks), corresponding to “not detected” or “limited to moderate spread” epidemiologic stages. 2. No current treatment options exist (pan-not susceptible) and potential to spread more widely 	<i>C. auris</i> Carbapenamases (e.g. KPC, NDM, OXA-48, VIM, IMP) <ul style="list-style-type: none"> • Enterobacterales • Pseudomonas aeruginosa • Acinetobacter baumannii
Tier 3	Include MDROs targeted by the facility or region for epidemiologic importance that have been identified frequently across a region, indicating advanced spread, but are not considered endemic	To be determined. Potential considerations are ESBL, non-carbapenamase producing carbapenem resistant organisms (CRW, CRPA, CRAB)
Tier 4	Endemic in a region and have been targeted by public health for their clinical significance and potential to spread rapidly	MRSA, VRE

Tier Definitions, Epidemic Stages, Response and Prevention

Figure 1. Relationship between epidemic stages, response tiers, containment response, and prevention activities for novel or targeted MDROs.



Organism or resistant mechanism that have

*Never (or very rarely) been identified **in the United States** and for which experience is extremely limited are Tier 1.

^Never (or very rarely) been identified **in a public health jurisdiction but are more common in other parts of the U.S.** are Tier 2.

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

Containment Response Elements Upon Identification of Targeted MDROs

Response Elements

Elements	Tier 1	Tier 2	Tier 3	Tier 4
Healthcare Investigation¹				
Review the patient's healthcare exposures prior to and after the positive culture¹	ALWAYS Typical review period: 30 days prior to culture collection to present	ALWAYS Typical review period: 30 days prior to culture collection to present	ALWAYS Typical review period: Current admission and sometimes immediately prior admission	Prioritize prevention; containment principles generally do not apply.
Contact Investigation¹				
Screening of healthcare contacts (i.e., residents and patients)²	ALWAYS	ALWAYS	USUALLY	Prioritize prevention; containment principles generally do not apply.
Household contact screening	USUALLY	RARELY	RARELY	
Healthcare personnel screening	USUALLY	RARELY	RARELY	
Additional Actions if Transmission Identified in Healthcare				
Recurring response-driven point prevalence surveys³	ALWAYS	ALWAYS	RARELY	Prioritize prevention; containment principles generally do not apply.
Evaluate potential spread to healthcare facilities that regularly share patients with the index healthcare facility⁴	USUALLY	USUALLY	RARELY	

Elements	Tier 1	Tier 2	Tier 3	Tier 4
Clinical Laboratory Surveillance				
Retrospective lab surveillance⁵	ALWAYS	ALWAYS	RARELY	Prioritize prevention; containment principles generally do not apply.
Prospective lab surveillance⁵	ALWAYS	ALWAYS	ALWAYS	
Environmental Cultures				
Environmental sampling	SOMETIMES	RARELY	RARELY	Prioritize prevention; containment principles generally do not apply.
Infection Control Measures				
Notify healthcare providers; promptly implement appropriate transmission-based precautions	ALWAYS	ALWAYS	ALWAYS	Prioritize prevention; containment principles generally do not apply.
Infection control assessment with observations of practice	ALWAYS	ALWAYS	SOMETIMES	
Clear communication of patient status with transferring facilities	ALWAYS	ALWAYS	ALWAYS	

Notification to Facilities for Targeted MDROs

Initial Notification

Upon Identification of targeted MDRO (such as any CPO), HAI/AR team notify all facilities that patient have previously visited so the chart can be flagged.

Adding an Alert

HAI/AR team adds an infectious diseases alert into the CyncHealth, which also generate notification for HAI/AR team when the patient gets admitted to hospital, visit ED or get discharged

Prospective Monitoring

Upon receiving new admission/visit alert, HAI/AR team reaches out to the IP at the facility to make sure they have received the notification and proper precautions are being taken

What We Want to Do Next

- Set up a process which allows for an automatic notification to the IP (or other designated staff) upon admission to a facility
- Add a flag to the Clinical Portal of CyncHealth for anyone taking care of the patient to be able to review it
- Explore possibility of adding the information to PDMP so information is available to outpatient clinicians too.

Containment Response Strategies, Tier 1 to Tier 3

1. Initial response measures
2. Conduct a healthcare investigation
3. Conduct a contact investigation
4. Clinical Laboratory Prospective and Retrospective Surveillance*
5. Environmental Cultures**
6. Implement a system to ensure adherence to infection control measures

* For Tier 3, only prospective surveillance recommended for most responses
** Environmental cultures not routinely performed for Tier 2 and Tier 3 organisms/mechanisms

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

Goals of initial containment response include:

- ❑ Identify affected patients.
- ❑ Ensure appropriate control measures are promptly implemented to limit further spread.
- ❑ Determine if transmission within a healthcare facility and dissemination to other facilities are occurring (Tiers 1-2).
- ❑ Characterize novel organisms or mechanisms to guide further response actions, patient management, and future responses.
- ❑ Coordinate response with ongoing prevention activities (e.g., MDRO education, infection prevention and control improvement initiatives, routine colonization screening, and improved interfacility communication) in the region.
- ❑ In addition to this general guidance, further pathogen-specific guidance for some MDROs can be found here:
 - [Vancomycin-resistant *Staphylococcus aureus* \[PDF – 20 pages\]](#)
 - [Carbapenem-resistant Enterobacterales](#)
 - [Candida auris](#)

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

Implement a System to Ensure Adherence to Infection Control Measures



[This Photo](#) by Unknown Author is licensed under [CC BY-SA-NC](#)

These steps outline assessment and ongoing support of measures to promote high levels of adherence to recommended infection control practices at facilities where the index patient received care, including the facility where the patient or resident is currently receiving care.

Infection control steps typically occur concurrently with or even precede the contact investigation.

Communication on MDRO Status

- ❑ Healthcare facilities and health departments should ensure the index patient's MDRO status and required infection control precautions are communicated at transfer to higher or lower levels of care.
 - ❑ A decision to discharge a patient from one level of care to another (e.g., moving a patient from an intensive care unit to a medical ward) or to another healthcare facility should be based on clinical criteria and not colonization status.
- ❑ Healthcare facilities should:
 - ❑ Educate and inform the HCP and visitors for the index patient about the organism and precautions indicated to prevent transmission.
 - ❑ Flag affected patients' medical records to initiate appropriate infection control precautions upon readmission.
 - ❑ Make plans for how receiving facilities will be notified of affected patients' MDRO status, if the patient is transferred, including whether to notify the health department prior to transfer.



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

Contact Precautions

- ❑ Contact Precautions are used when caring for residents who are **actively infected** with an MDRO (like C. auris or CP-CRE) – meaning they have symptoms or might even be on antibiotics for an infection.
 - require the use of a gown and gloves whenever entering the room
 - placing the resident in a single person room,
 - restricting them from all group activities.



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

Enhanced Barrier Precautions (EBP)

- Used in the Long-term care setting
- EBP are indicated for nursing home residents with any of the following:
 - Infection or colonization with an MDRO when Contact Precautions do not otherwise apply
 - Wounds and/or indwelling medical devices
- EBP is not limited to outbreaks or specific MDROs
- Use of gown and gloves during high-contact resident care activities
- No private room required
- Residents can participate in group activities
- Intended to be used for resident's entire length of stay



Reassessment of Colonization

- ❑ In general, screening individuals with a history of colonization or infection with a targeted MDRO with the aim of discontinuing transmission-based precautions is not recommended.
 - ❑ Long-term follow-up of colonized patients in healthcare facilities, especially those patients who continue to require complex medical care, such as ventilator support, suggests colonization persists for a prolonged period of time.
 - ❑ Repeat colonization swabs may alternate between detecting and not detecting.

Onsite Infection Prevention and Control Assessments

- ❑ Health departments or other experts (ICAP) should conduct on-site IPC assessments at all healthcare facilities identified in the healthcare investigation and any outpatient facilities where patients or HCP may have had extensive contact with the index patient, such as wound care clinics.
- ❑ If multiple healthcare facilities are identified as part of the healthcare investigation, prioritize assessments for the facility currently caring for the index patient, for any facilities with evidence of transmission, and for high-acuity post-acute care facilities (e.g., LTACHs and vSNFs).
- ❑ Conduct IPC assessments on-site whenever possible:
 - ❑ If an on-site assessment cannot be conducted promptly, consider a remote video assessment in the interim, prior to the on-site assessment.
 - ❑ If many facilities are identified as part of the healthcare investigation, consider using remote video assessment to rapidly initiate identification and mitigation of IPC gaps and determine which facilities to prioritize for on-site assessments first.
 - ❑ If a facility has recently participated in a recent infection control assessment (e.g., in the last three months), a repeat assessment may not be needed, but health departments should assess the facility's progress in mitigating previously identified infection control gaps

Summary

- Initiate Enhanced Barrier Precautions (EBP) if Tier 1, Tier 2, and Tier 3 organisms are identified in your facility.
- Consider EBP for Tier 4 organisms based on facility risk assessment (e.g., MRSA outbreak).
- Notify state HAI/AR team when a Tier 1 or Tier 2 organism is identified, to facilitate colonization screening.
- Contact precaution are recommended if the resident has acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained, or for a limited period of time during a suspected or confirmed MDRO outbreak investigation.
- Always follow basic infection prevention and control guidance, including standard precautions, in addition to EBP.

Implementation Resources



Pre-Implementation Tool

Pre-Implementation Tool—Enhanced Barrier Precautions (EBP) (For use in Skilled Nursing Facilities/Nursing Homes only)

This NEW tool is designed to be used prior to implementation of EBP in your facility (either a unit, wing, or entire facility) as a guide for developing a successful plan for the implementation of EBP during high-contact resident care activities. It is intended for use in skilled nursing facilities/nursing homes.

This tool can be customized to meet facility-specific needs. EBP can be implemented in a manner that works best for your facility. While implementation of EBP for all residents who meet criteria is the goal, this may not initially be feasible for your facility. If, during the development of your implementation plan, challenges arise for facility-wide implementation, you may choose to implement EBP on a unit or wing first, preferably one where most residents would meet criteria for the use of EBP (e.g., residents with indwelling medical devices, wounds, or known MDRO infection or colonization).

HCP can reduce personal protective equipment (PPE) consumption by bundling multiple high-contact resident care activities (e.g., changing briefs, assisting with toileting, bathing/showering and providing hygiene could be bundled with changing linens).

Facility Name: _____

Date of Assessment: _____

1. Does your facility currently have a developed timeline for implementation of EBP?

- Yes
 No
 Unknown

If yes, when do you expect to begin implementation?

- In 3–4 weeks
 In 1–2 months
 In >2 months

2. If question 1 is answered “Yes”, have you developed a policy and procedure document for the use of EBP?

- Yes
 No
 Unknown

If no, what challenges are you having with the development of a policy and procedure document?

- Staffing shortages
 Leadership input
 Other, please specify: _____

3. Does your facility currently have an interdisciplinary team (IDT) that manages facility infection prevention and control practices?

- Yes
 No
 Unknown

If yes, who currently serves on the facility's IDT? (Select all that apply)

- Medical director
 Director of Nursing
 Nurse (RN, LPN, LVN)
 Environmental services
 Certified nursing assistant
 Other, please specify: _____

Staff Training Resources

A message from:

Dear Valued Staff:

You will soon see an increase in the circumstances when we are asking you to wear a gown and gloves while caring for residents. This is based on new recommendations from the Centers for Disease Control and Prevention to protect our residents and staff from multidrug-resistant organisms (MDROs), which can cause serious infections and are hard to treat. These new recommendations are called Enhanced Barrier Precautions, or EBP.

WHY are we implementing Enhanced Barrier Precautions at this facility?

Studies have shown that more than 50% of nursing home residents have MDROs on or in their body, especially in wounds or medical devices like urinary catheters. Most of the time people never know they are carrying these germs, but under certain conditions they can cause serious infections.

These germs can be transferred from one resident to another on staff hands, if they aren't cleaned between caring for residents, and on staff clothing during activities involving a lot of physical contact with the resident. A gown and gloves can keep these germs from getting on staff clothing and, in combination with cleaning hands with alcohol-based hand sanitizer, can prevent transfer to other residents.

This approach focuses our efforts on the residents and activities that pose highest risk for spread of MDROs.

WHAT are Enhanced Barrier Precautions?

Enhanced Barrier Precautions require staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading an MDRO.

These include the following residents:

- Residents known to be infected or colonized with an MDRO;
- Residents with an indwelling medical device including central venous catheter, urinary catheter, feeding tube (PEG tube, G-tube), tracheostomy/ventilator regardless of their MDRO status;
- Residents with a wound, regardless of their MDRO status

High-contact resident care activities where a gown and gloves should be used, which are often bundled together as part of morning or evening care, include:

- Bathing/showering,
- Transferring residents from one position to another (for example, from the bed to wheelchair),
- Providing hygiene,
- Changing bed linens,
- Changing briefs or assisting with toileting,
- Caring for or using an indwelling medical device (for example, central venous catheter, urinary catheter, feeding tube care, tracheostomy/ventilator care),
- Performing wound care (for example, any skin opening requiring a dressing)

Unlike the residents who are on Contact Precautions, such as for acute diarrhea, residents on Enhanced Barrier Precautions do not require placement in a private room, they can continue to participate in group activities, and they will remain on Enhanced Barrier Precautions for the duration of their stay in the facility.

Please NOTE: *The gown and gloves used for each resident during high-contact resident care activities should be removed and discarded after each resident care encounter. Hand hygiene should be performed and new gown and gloves should be donned before caring for a different resident.*

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



Implementation of Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms

[CDC - Implementation of EBP Slide Set](#)

[CDC - Implementation of EBP Recording](#)

[CDC - Implementation of EBP -
Communication to Staff](#)



Communication to Residents and Families

Keeping Residents Safe – Use of Enhanced Barrier Precautions

A message from: [REDACTED]

Dear Residents, Families, Friends, and Volunteers:

You may have noticed new signs on some doors that say "Enhanced Barrier Precautions" and staff wearing gowns and gloves more often. We're doing this based on new recommendations from the Centers for Disease Control and Prevention to protect our residents and staff from germs that can cause serious infections and are hard to treat. You may have heard these germs called multidrug-resistant organisms or MDROs in the news.

Studies have shown that more than 50% of nursing home residents have these germs on or in their body, especially in places where the skin is broken, such as wounds or insertion sites of medical devices like feeding tubes. Most of the time people never know they are carrying these germs but under certain conditions they can enter the body and cause serious infections.

Fortunately, there are many things we can do to keep these germs from spreading, but we need your help! Two important practices are:

- 1. Cleaning our hands.** Alcohol-based hand sanitizer can kill these germs and keep us from spreading them with our hands. This is why we remind you and your visitors to frequently clean your hands.
- 2. Using gowns and gloves.** Since we can't wash our clothes between caring for residents, gowns and gloves help keep these germs from getting on our clothes and spreading to others when we are having close contact with residents. This is why you might see us wearing a gown and gloves when we are performing transfers or other activities involving a lot of contact with a resident. Just because we are wearing a gown and gloves doesn't mean that a resident is carrying one of these germs. We also wear them to protect residents who might be more vulnerable to developing a serious infection if exposed to these germs. We will also wear them if we expect a care activity to be messy, like if we are changing a dressing on a wound.

To support these practices, you will see more alcohol-based hand sanitizer dispensers, carts to hold clean gowns and gloves, and trash cans so we can change gowns and gloves between residents. You will also see more signs to help remind staff when they should be wearing gowns and gloves.

We are always happy to answer any questions you might have about actions we are taking to protect our residents and staff and appreciate your support!

Please contact us with additional questions at: [REDACTED]

Sincerely,
[REDACTED]

To learn more about Enhanced Barrier Precautions, please visit **Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs)** at <https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html>.

C312499-8

[Keeping Residents Safe – Use of Enhanced Barrier Precautions \(cdc.gov\)](https://www.cdc.gov)




Sample Signage

STOP


ENHANCED BARRIER PRECAUTIONS

STOP


EVERYONE MUST:


 Clean their hands, including before entering and when leaving the room.

PROVIDERS AND STAFF MUST ALSO:

 Wear gloves and a gown for the following High-Contact Resident Care Activities.

- Dressing
- Bathing/Showering
- Transferring
- Changing Linens
- Providing Hygiene
- Changing briefs or assisting with toileting
- Device care or use:
 - central line, urinary catheter, feeding tube, tracheostomy
- Wound Care: any skin opening requiring a dressing

 Do not wear the same gown and gloves for the care of more than one person.

 U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

[CDC Enhanced Barrier Precautions - Example Sign](#)

[CDC Contact Precautions - Example Sign](#)

[CDC Droplet Precautions - Example Sign](#)

[CDC Airborne Precautions - Example Sign](#)

EBP – CDC Resources

- CDC Implementation [Implementation of Personal Protective Equipment \(PPE\) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms \(MDROs\) | HAI | CDC](#)
- CDC FAQs Enhanced Barrier Precautions [Frequently Asked Questions \(FAQs\) about Enhanced Barrier Precautions in Nursing Homes | HAI | CDC](#)
- Pre-Implementation Tool EPB [Pre-Implementation Tool—Enhanced Barrier Precautions \(EBP\) \(cdc.gov\)](#)
- Sample Sign [enhanced barrier precautions final rev3 \(cdc.gov\)](#)
- Sample Letter to Residents and Families [Keeping Residents Safe – Use of Enhanced Barrier Precautions \(cdc.gov\)](#)
- Sample Letter to Staff [Help Keep Our Residents Safe - Enhanced Barrier Precautions in Nursing Homes \(cdc.gov\)](#)
- Staff Training Slides <https://www.cdc.gov/hai/pdfs/containment/EBP-Presentation-July2022.pptx>
 - Recording of these slides [Introduction to Enhanced Barrier Precautions in Nursing Homes – YouTube](#)
- IP Training Slides [PowerPoint Presentation \(cdc.gov\)](#)
 - Recording of these slides [Implementation and Use of Enhanced Barrier Precautions in Nursing Homes - YouTube](#)

ICAP Updates and Information



Next Webinar Information

When is it? Thursday, September 14 at noon, CST



What is the topic? Part 3 of The Enhanced Barrier Precaution series, plus a review of fall vaccines.



APIC NEBRASKA

2023 Fall Conference

SPEAKERS

David Cates Ph. D. (Behavioral Health, NMC)

- Resilience Building in Healthcare Settings

Lacey Pavlovsky/Dr. Ashraf (NE DHHS State HAI/AR Program)

- State of the State HAI Report

Kait Chapman (State Extension Office)

- Bed Bugs

Angela Ritchey (Steris)

- Is It Clean? Identifying cleaning tests and establishing quality program for cleaning verification of medical devices

Adam Moench (Phigenics)/Storm Keffer (NE DHHS)

- Water Management Programs

Jodee Sun/Kristi Felix (SJDC LTC), Lacey Pavlovsky (DHHS)

- Panel Discussion: CBIC Long Term Care Infection Control Certification

Nancy Dach (3M)

- Reducing the Risk of Surgical Site Infections: What are we missing?

[REGISTER HERE](#)

DATE: Friday, September 15, 2023
8 a.m.-3:30 p.m. (registration opens at 7 am)

LOCATION: CHI Health St. Elizabeth, Lincoln, NE

COST: \$65 per attendee-lunch included

CEUs: 6 hours applied for through IWCCW

Registration is open to everyone

Webinar CE Process

1 Nursing Contact Hour and 1 NAB Contact Hour is offered for attending this LIVE webinar.

Individual surveys must be completed for each attendee.

Questions? Contact Marissa at:

Machaney@nebraskamed.com 402-552-2881

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 quarterly for all webinars attended
- Certificate comes directly from ICAP via email
- Certificate is electronically mailed the next month

NAB:

- 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)
- **You must have a NAB membership**
- Credit is retrieved by you
- Any issues or questions regarding your credit must be directed to NAB customer service.
 - ICAP can verify survey completion and check the roster list
- Due to NAB changes, attendance will be submitted quarterly. ICAP will send an email stating when credits are ready for retrieval.



Infection Prevention and Control Hotline Number:

Call 402-552-2881

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

On-call hours are available for emergencies only

Weekends and Holidays from 8:00 AM- 4:00 PM

****Please call the main hotline number only during on-call hours****



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Instagram

Follow **NebraskaICAP** for the latest news and IPC tips!



Questions and Answer Session

Use the QA box in the webinar platform to type a question. Questions will be read aloud by the moderator.

Panelists:

- Dr. Salman Ashraf, MBBS
- Kate Tyner, RN, BSN, CIC
- Josette McConville, RN, BSN, CIC
- Lacey Pavlovsky, RN, MSN, CIC
- Rebecca Martinez, BA, BSN, RN, CIC
- Jody Scebold, EdD, MSN, RN
- Sarah Stream, MPH, CDA, FADAA
- Daniel Taylor, DHHS
- Deanna Novak, DHHS
- Becky Wisell, DHHS
- Cindy Kadavy, NHCA
- Kierstin Reed, LeadingAge
- Melody Malone, PT, CPHQ, MHA
- Debi Majo, BSN, RN
- Carla Smith, RN, CDP, IP-BC, AS-BC
- Monika Maxwell, RN

Moderated by Marissa Chaney
Supported by Margaret Deacy

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Long Term Care Facility Webinars



Long Term Care Webinars

07.28.22 LTCF – CMS Survey Updates and FAQs

[Slide deck](#)



Long Term Care Webinars

07.14.22 LTCF – CMS Survey Updates, Enhanced Barrier Precautions and Antibiotic Timeout

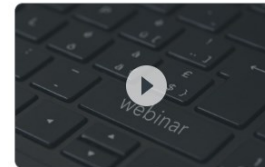
[Slide deck](#)



Long Term Care Webinars

07.07.22 LTCF – Prevention of Urinary Tract Infection

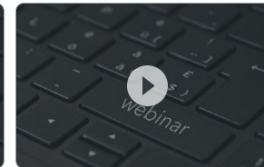
[Slide deck](#)



Long Term Care Webinars

06.30.22 LTCF – COVID Resources and Updates

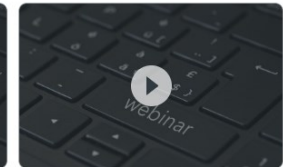
[Slide deck](#)



Long Term Care Webinars

06.23.22 LTCF – Antibiotic Stewardship

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Long Term Care Webinars

06.16.22 LTCF – Environmental Cleaning and Disinfection

[Slide deck](#)

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