Welcome Nursing Facility Providers!

COVID-19 Updates and Q&A with LTCR and DSHS
July 14, 2021

For more information:
Email: LTCRPolicy@hhs.texas.gov
Phone: 512-438-3161
COVID-19 Q&A

Panelist

Kevin Knippa
Senior Policy Specialist
Policy & Rules
Long-term Care Regulation
Webinar Schedule Change

Starting July 1, the Nursing Facility Provider Webinars has changed to a **monthly schedule**. Webinars will be held the second Wednesday of every month.

The next NF Provider Webinars will be held:

- August 11\(^{th}\)
- September 8\(^{th}\)
- October 13\(^{th}\)

As always, we will send notifications for the webinars through [GovDelivery alerts](#) and post them on the [Nursing Facility Provider Portal](#).
COVID-19 Q&A

Panelist

David Gruber
Associate Commissioner for Regional and Local Health Operations
DSHS
COVID-19 in Texas

- Confirmed cases
- Hospitalizations
- Fatalities
Texas New Cases per Day

Pop: 29.7M; Slope: 73.4; 100k: 0.2; 7 Day Avg: 1,596.7; 7/14 Day Avg Δ: 107.5/57.3

Blue line is 7 Day Moving Average. Δ is the change in the 7 Day Moving Average over a 7 or 14 day period. These preliminary data are current as of 07/13/2021.
Texas New Cases per Day

Pop: 29.7M; Slope: 75.8; 100k: 0.3; 7 Day Avg: 1,596.7; 7/14 Day Avg Δ: 107.5/57.3

Blue line is 7 Day Moving Average. Δ is the change in the 7 Day Moving Average over a 7 or 14 day period.
These preliminary data are current as of 07/13/2021
Texas Hospitalizations Over Time

Pop: 29.7M; Slope: 55; 100k: 0.2; 7 Day Avg: 1,961.4; 7/14 Day Avg Δ: 51.3/37.7

Blue line is 7 Day Moving Average. Δ is the change in the 7 Day Moving Average over a 7 or 14 day period.
These preliminary data are current as of Tue Jul 13 13:10:28 2021
Texas Hospitalizations Over Time

Pop: 29.7M; Slope: 58.1; 100k: 0.2; 7 Day Avg: 1,961.4; 7/14 Day Avg Δ: 51.3/37.7

Blue line is 7 Day Moving Average. Δ is the change in the 7 Day Moving Average over a 7 or 14 day period.
These preliminary data are current as of Tue Jul 13 13:13:32 2021
Texas New Fatalities per Day

Pop: 29.7M; Slope: -0.1; 100k: 0; 7 Day Avg: 22.9; 7/14 Day Avg Δ: 0.3/-0.1

Blue line is 7 Day Moving Average. Δ is the change in the 7 Day Moving Average over a 7 or 14 day period. Preliminary data as of 07/13/2021. Data source are New Fatalities by Date Recorded. Last date of data is 07/13/2021.
Texas New Fatalities per Day

Pop: 29.7M; Slope: -0.1; 100k: 0; 7 Day Avg: 22.9; 7/14 Day Avg Δ: 0.3/-0.1

Blue line is 7 Day Moving Average. Δ is the change in the 7 Day Moving Average over a 7 or 14 day period. Preliminary data as of 07/13/2021. Data source are New Fatalities by Date Recorded. Last date of data is 07/13/2021.
COVID-19 Variant Update

• United States
• Texas
• United Kingdom
CDC- National Data, 3/28/2021 – 6/19/2021

Data*, 5/2/2021 – 6/27/2021

* This data is preliminary and may change prior to being finalized and posted on the CDC website.
Figure 5. Variant prevalence for all England available sequenced cases from 1 February 2021 as of 5 July 2021 (Find accessible data used in this graph in underlying data). Dashed lines indicate period incorporating issue at a sequencing site.
# UK Experience - Risk Assessment of Delta

**8 July 2021 Risk assessment for SARS-CoV-2 variant: Delta (VOC-21APR-02, B.1.617.2) Public Health England**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>RAG⁴</th>
<th>Confidence</th>
<th>Assessment and rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmissibility between humans</td>
<td>RED</td>
<td>HIGH</td>
<td>Transmissibility appears greater than wild type (first wave) virus. All analyses support increased transmissibility for Delta compared to both wild type virus and Alpha. There is in vitro evidence suggestive of increased replication in biological systems that model human airway, and evidence of optimised furin cleavage. There is epidemiological evidence from secondary attack rates, household transmission studies, and growth rate modelling. The finding of lower CT values in routine testing data, compared to Alpha, may be relevant to the mechanism of increased transmissibility, however there may be multiple contributors.</td>
</tr>
<tr>
<td>Infection severity</td>
<td>LOW</td>
<td></td>
<td>Increased severity (hospitalisation risk) when compared to Alpha. Iterated analysis continues to suggest an increased risk of hospitalisation compared to contemporaneous Alpha cases. Analyses using 2 different sources of hospital data (SARwatch sentinel surveillance and routine hospital episode data) do not yet find any evidence of increased severity once in hospital, in hospital inpatients since Delta became predominant. There is a high level of uncertainty in the estimates for the past 2 months due to data lag and these will be iterated. Data from COCIN (hospitalised patients) are broadly consistent with this, but additional analyses are being undertaken to adjust for age and vaccination status.</td>
</tr>
<tr>
<td>Immunity after natural infection</td>
<td>LOW</td>
<td></td>
<td>Experimental evidence of functional evasion of natural immunity but insufficient epidemiological data. Pseudovirus and live virus neutralisation using convalescent sera from first wave and Alpha infections shows a reduction in neutralisation. National surveillance analyses are underway but there is currently insufficient evidence to assess whether the risk of reinfection differs between Delta and Alpha.</td>
</tr>
<tr>
<td>Vaccines</td>
<td>HIGH</td>
<td></td>
<td>Epidemiological and laboratory evidence of reduced vaccine effectiveness. There are now analyses from England and Scotland supporting a reduction in vaccine effectiveness for Delta compared to Alpha against symptomatic infection. This is more pronounced after one dose. Iterated analysis continues to show vaccine effectiveness against Delta is high after 2 doses. Current evidence suggests that VE against hospitalisation is maintained. Although this is observational data subject to some biases, it holds true across several analytic approaches and the same effect is seen in both English and Scottish data. It is strongly supported by pseudovirus and live virus neutralisation data from multiple laboratories. There are no data on whether vaccine effectiveness to prevent transmission is affected.</td>
</tr>
<tr>
<td>Overall assessment</td>
<td></td>
<td></td>
<td>Delta is predominant in the UK and there is very rapid global spread. All analyses continue to support increased transmissibility and reduced vaccine effectiveness against symptomatic infection. Whilst risk of hospitalisation appears increased, early data on hospitalised patients does not show indicators of increased severity once in hospital and further analyses are required to resolve this. The priority investigations are to improve understanding of asymptomatic transmission in the vaccinated, to monitor for new mutations occurring on Delta, and continued investigation of the viral kinetics and clinical course of disease.</td>
</tr>
</tbody>
</table>

The therapeutics risk assessment is under review for all variants and is not included.

*refer to scale and confidence grading slide

[Risk assessment for SARS-CoV-2 variant: VOC-21APR-02 (B.1.617.2) (publishing.service.gov.uk)](https://publishing.service.gov.uk)
UK Experience - Risk Assessment of Lambda

<table>
<thead>
<tr>
<th>Indicator</th>
<th>RAG*</th>
<th>Confidence</th>
<th>Assessment and rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmissibility between humans</td>
<td>LOW</td>
<td>Insufficient information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lambda (C.37) appears to have transmitted successfully in South America with some wider spread. There is a single study with some evidence of enhanced ACE2 binding. There is insufficient genomic structured genomic surveillance to understand the contribution of Lambda (C.37) to the high levels of transmission that have been seen in some South American countries.</td>
</tr>
<tr>
<td>Infection severity</td>
<td>LOW</td>
<td>Insufficient Information</td>
<td></td>
</tr>
<tr>
<td>Immunity after natural infection</td>
<td>LOW</td>
<td>Experimental evidence of evasion of naturally acquired immunity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There is only one small study available, which finds a reduction in neutralisation with convalescent sera when compared to virus from earlier in the pandemic. The magnitude of the reduction in this single study is moderate (less than B.1.351) but further assessments are required. There are no clinical or epidemiological data on reinfections.</td>
</tr>
<tr>
<td>Vaccines</td>
<td>LOW</td>
<td>Very limited experimental evidence of evasion of vaccine derived immunity</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>There are only 2 pseudovirus studies available (US, Chile). Both find neutralisation by vaccinee sera to be reduced for Lambda compared to viruses from earlier in the pandemic. These are small studies and it is difficult to make any clinical extrapolation from this early data.</td>
</tr>
<tr>
<td>Overall assessment</td>
<td>LOW</td>
<td>Lambda has spread successfully in South America with evidence of some wider global transmission. There is no evidence as yet of a country where it is outcompeting Delta, though careful monitoring of the epidemiology in Chile and Peru is required. There are a small number of cases in the UK which are largely travel associated. Lambda contains a novel combination of mutations and very limited laboratory data are available. The priority studies are pseudovirus and live virus neutralisation with UK vaccinee sera, assessment of growth using in vitro systems and genomic surveillance of those countries where both Lambda (C.37) and Delta are present.</td>
<td></td>
</tr>
</tbody>
</table>

The theapeutics risk assessment is under review for all variants and is not included.

*refer to scale and confidence grading slide
Summary

• Delta variant is rapidly spreading in Texas
  • Delta is more transmissible and causes greater severity of illness than Alpha (UK variant/B.1.1.7) and other SARS-CoV-2 strains
  • Evidence suggests Delta has become predominant strain in Texas

• **Vaccine effectiveness appears to be impacted by Delta**
  • COVID-19 vaccines available in the US still provide significant protection against disease and hospitalization caused by Delta
  • Vaccination remains the best defense against emergence and spread of variants in Texas

• **DSHS will continue to monitor variants in Texas**
Thank you!

Jennifer A. Shuford, MD, MPH
Jennifer.Shuford@dshhs.texas.gov
COVID-19 Q&A

Panelist

Kevin Knippa
Senior Policy Specialist
Policy & Rules
Long-term Care Regulation
DRTx New Vaccine Hotline

Disability Rights Texas (DRTx) is now providing assistance specific to COVID vaccines through the DRTx Vaccine Hotline. Contact the hotline for help with:

• Signing up for a vaccine through the computer
• Arranging transportation to a vaccine appointment
• Information on the vaccine

For help, call the DRTx Vaccine Hotline for People with Disabilities at 1-800-880-8401 or email us at vaccine@DRTx.org.
The U.S. Food and Drug Administration is warning the public to stop using the Innova SARS-CoV-2 Antigen Rapid Qualitative Test for diagnostic use. The concerns are:

- The performance of the test is not established and presents a health-risk.
- Labeling distributed with certain configurations of the test includes performance claims. These claims did not accurately reflect the performance estimates observed during the clinical studies of the tests.
- The test has not been authorized, cleared, or approved by the FDA for commercial distribution or use in the United States, as required by law. (Cont. on next slide)
FDA: Stop Using Certain Innova COVID-19 Tests

The Innova SARS-CoV-2 Antigen Rapid Qualitative Test is also distributed under the names:

• Innova COVID-19 Self-Test Kit (three tests)
• Innova SARS-CoV-2-Antigen Rapid Qualitative Test (seven tests)
• Innova SARS-CoV-2-Antigen Rapid Qualitative Test (25 tests)

Read the full FDA notice.
2021 Quality in LTC Conference

Join us Aug. 30-31, 2021, to learn about Navigating the New Normal in Texas Long-Term Care.

HHSC and DSHS are hosting an informative two-day, free conference on quality in long-term care. Continuing education credit for multiple disciplines will be provided for this event.

Featured Speakers Include: Alice Bonner, PhD, RN, FAAN; Paige Hector, LMSW; Jeff Jerebker; and Barry Baran.

Email QLTCC@hhs.Texas.giv for more information. (see attached handout)
HHSC is excited to share a new resource for NFs seeking to limit the occurrence of infections: ProtectNursingHomes.org

Built by Yale, UCLA and US Digital Response, the site provides rich detail on staff interconnectivity that has been long desired by NF administrators and health leads, but that has been difficult to attain. Armed with this new information, NFs can take preventive action to reduce risk. It can be a helpful tool in outbreak management for COVID as well as other infections that more routinely challenge nursing homes. (cont. on next slide)
Protect Nursing Homes

As previously featured by the CDC, Leading Age, ASTHO, AARP, NACCHO and others, an overview and demo of the free tool can be found [here](mailto:protectnursinghomes@yale.edu). For questions or comments, please send an email to: protectnursinghomes@yale.edu.
Updated HHSC Vaccine Reporting Emergency Rule

HHSC updated the COVID-19 Vaccine Reporting Emergency Rule.

Updates include:

• NFs reporting COVID-19 vaccine data to NHSN (which is required for all Medicaid/Medicare certified NFs) are no longer required to submit vaccine data to HHSC via Survey Monkey

• All NF Administrators and Directors of Nurses must enroll in the emergency communication system – COMING SOON

• HHSC will inform NFs when this communication system is available and provide instructions on how to sign up. (cont. on next slide)
HHSC will soon be implementing an emergency communication system. This system will:

• Allow HHSC to send out targeted alerts to facilities via text and email.

• Alerts will replace current protocol of LTCR Regional offices calling individual facilities for issues such as: following up on NFs report of a staffing/PPE shortage, information needed during a natural disaster, etc.

• Once the HHSC emergency Communication system is established, all NFs will be required to respond to any requests received through the system.
Reminder: CMS Vaccine Requirements

Submitting Weekly Reports

NFs must submit weekly COVID-19 reports to NHSN.

Weekly NHSN reports are required each week, even if no vaccine activity has occurred.

See QSO-21-19 or the May 19th 2021 NF Provider Webinar (recording or slides) for more information.

Please note that licensed-only NFs and NFs not reporting to NHSN are still required to submit COVID-19 vaccine reports to HHSC as described in PL 2021-01.
## Reporting Overview

<table>
<thead>
<tr>
<th>Event</th>
<th>Report to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Case of COVID-19</strong></td>
<td>Local Health Authority</td>
</tr>
<tr>
<td></td>
<td>HHSC – <strong>ONLY</strong> in limited situations (see PL 2021-04)</td>
</tr>
<tr>
<td></td>
<td>Residents and Family (see PL 2020-37)</td>
</tr>
<tr>
<td></td>
<td>NHSN via weekly reports (see PL 2020-37)</td>
</tr>
<tr>
<td></td>
<td>NHSN if positive test was conducted at the NF (see PL 2020-46)</td>
</tr>
<tr>
<td><strong>COVID-19 Vaccine</strong></td>
<td>For Medicare/Medicaid-Certified NFs – Report weekly to NHSN (see QSO-21-19)</td>
</tr>
<tr>
<td></td>
<td>For Licensed-only NFs – Report to HHSC (see PL 2021-01)</td>
</tr>
<tr>
<td><strong>Resident Deaths</strong></td>
<td>HHSC (see PL 2020-37)</td>
</tr>
</tbody>
</table>
Reporting Overview

NFs must submit the following reports on a weekly basis, even if there has been no related activity in the facility:

• NHSN Weekly COVID-19 Reports

• NHSN Weekly COVID-19 Vaccine Reports
COVID-19 Q&A

Panelist

Bijendra Bhandari
Infection Prevention Policy Specialist
Policy & Rules
Long-term Care Regulation

• Cohorting Guidance Review (Determining when to quarantine)
Quarantine Guidance Review

Per the **COVID-19 Response Emergency Rule** NFs are still required to cohort residents by COVID-19 status, which includes:

- COVID-19 negative
- Unknown COVID-19 status (Quarantine)
- COVID-19 Positive (Isolation)

Residents identified as having Unknown COVID-19 status must be quarantined **per CDC guidance**. Per CDC guidance some residents may not need to be quarantined, depending on certain factors.

*(cont. on next slide)*
Quarantine Guidance

Review

Unknown COVID-19 status is defined as a resident who:

• Is newly admitted or readmitted
• Has left the facility overnight
• Has had known exposure or close contact with a person who is COVID-19 positive
• Is exhibiting symptoms of COVID-19 while awaiting test results

Per CDC guidance, depending on certain factors, quarantine might not be recommended. (cont. on next slide)
Quarantine Guidance Review

NFs will have to determine whether the resident is **fully-vaccinated** or recovered from COVID-19 in the past 90 days (**Recovered**).

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Vaccinated or Recovered</th>
<th>Unvaccinated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly Admitted/Readmitted</td>
<td><strong>No Quarantine</strong></td>
<td>Quarantine</td>
</tr>
<tr>
<td>Left Overnight</td>
<td><strong>No Quarantine</strong></td>
<td>Quarantine</td>
</tr>
<tr>
<td>Known Exposure or close contact</td>
<td>Quarantine</td>
<td>Quarantine</td>
</tr>
<tr>
<td>Symptomatic while Awaiting Test Results</td>
<td>Quarantine</td>
<td>Quarantine</td>
</tr>
</tbody>
</table>
Quarantine Guidance Review

Per CDC guidance, NFs cannot use COVID-19 testing as a basis for quarantine decisions.

Residents who meet the criteria for being quarantined must be quarantined even if the resident has a recent COVID-19 negative test result.

NFs also cannot quarantine residents who do not need to be quarantined per CDC guidance. Doing so could be considered unnecessary isolation of a resident.
Quarantine Guidance Review

For residents who require quarantine:

The CDC still endorses the 14-day quarantine period, but has also provided alternate options:

• 10-day quarantine, without testing
• 7-day quarantine, with a negative COVID-19 test result on or after day 5

See CDC guidance: Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing
COVID-19 Q&A

Panelist

Christine Riley
Clinical Policy Specialist
Policy & Rules
Long-term Care Regulation

- Updates to COVID-19 Related Products
- Cohorting Guidance Review (Cohorting areas and staffing)
Non-NIOSH-Approved Respirators

FDA has revoked the use of non-NIOSH approved filtering facepiece respirators.

- Effective July 6, 2021, the FDA no longer authorizes for emergency use non-NIOSH-approved respirators for healthcare personnel.
- The FDA recommends that providers and facilities consider redistributing non-NIOSH approved respirators they may still have in inventory to non-healthcare settings for non-medical use and other countries in need.

(Cont. on next slide)
Non-NIOSH-Approved Respirators

- While it is possible that non-NIOSH approved respirators may be reconditioned for use as source control, the FDA does not recommend reconditioning of non-NIOSH-approved respirators because there is currently sufficient supply of source control medical devices, including NIOSH-approved respirators.

- See [Revoked EUAs for Non-NIOSH-Approved Disposable Filtering Facepiece Respirators](#) and [FAQs on the EUAs for Non-NIOSH Approved Respirators During the COVID-19 Pandemic](#) for more information.
How can I tell if my N95 Respirator is NIOSH approved?

The NIOSH approval number and approval label are key to identifying NIOSH-approved respirators. The NIOSH approval label can be found on or within the packaging of the respirator or sometimes on the respirator itself. The required labeling of NIOSH-Approved N95 filtering facepiece respirators includes the NIOSH name, the approval number, filter designations, lot number, and model number to be printed on the respirator. (cont. on next slide)
Non-NIOSH-Approved Respirators

How can I tell if my N95 Respirator is NIOSH approved? (cont.)

You can verify that your respirator approvals are valid by checking the NIOSH Certified Equipment List (CEL).
Non-NIOSH-Approved Respirators

**Appendix A** provides a table with all KN95 non-NIOSH approved respirators that were previously authorized under the [FDA’s Umbrella EUA](#) for non-NIOSH approved respirators from China.

**Exhibit 1** provides another table with other respirator models that were previously authorized under a different [FDA Umbrella EUA](#). This table lists respirator models from countries other than China.

Since both of the EUA’s linked have been revoked, **all of the models listed in Appendix A and Exhibit 1 are no longer authorized for use by the FDA.**
Pause on Use of Bamlanivimab

There has been a pause on the distribution of bamlanivimab / etesevimab. This combination monoclonal antibody therapy is not as effective against the Gamma or Beta COVID-19 variants.

- US government stopped distributing this combination treatment due to situations where the variant is not known.
- Providers should not dispose of this monoclonal antibody product, but should continue to store according to the manufacturer's guidelines.
The Johnson & Johnson vaccine is temporarily unavailable.

DSHS has not received any more information from the CDC as to when Johnson & Johnson vaccine will be available again.

Providers will be updated as soon as new information is received.
Cohorting Guidance

The COVID-19 Response Emergency Rule requires NFs to have:

• cohorting plans that include designated space for COVID-19 negative residents, COVID-19 positive residents, and residents with unknown COVID-19 status; and

• spaces for staff to don and doff PPE that minimize the movement of staff through other areas of the facility

NFs are still required to cohort residents based on COVID-19 status.
Creating separate spaces for unknown COVID-19 or COVID-19 positive residents can vary depending on the number of applicable residents and the layout of the facility.

The key is to try to create **meaningful separation** between residents of each COVID-19 cohort.

There is no “black and white” approach to cohorting. There are many variables to consider. The key is to follow core infection prevention and control measures.
Cohorting Guidance

Meaningful Separation of different COVID-19 cohorts (cohort areas) can include:

• Separate wings/hallways for different COVID-19 cohorts
• Having a hallway with different cohort areas separated by fire doors or empty room(s)
• Having a single resident in quarantine/isolation in a private room on the end of a hallway
• Having residents quarantine in private rooms, with donning/doffing stations outside the residents’ rooms
What about COVID-19 negative residents moving between different COVID-19 cohort areas?

There is nothing in rule that prohibits a resident from traversing through different COVID-19 cohort areas. However, NFs must ensure appropriate infection prevention and control measures are followed.

NFs should prevent the movement of COVID-19 negative residents or residents with unknown COVID-19 status through COVID-19 positive cohort areas as much as possible. (Cont. on next slide)
What about COVID-19 negative residents moving between different COVID-19 cohort areas?

COVID-19 residents who must move through unknown COVID-19 areas should practice appropriate infection prevention and control measures.

NFs should educate residents on wearing facemasks and maintaining physical distancing from residents with unknown COVID-19 status.
Staffing – COVID-19 Positive Cohort

The recent update to the COVID-19 Response Emergency Rule removed the requirement that NFs have separate, dedicated staff for each COVID-19 cohort.

Per federal and state rule, NFs must have infection prevention and control policies and procedures that follow accepted national standards related to standard precautions and transmission-based precautions to prevent the spread of infections.

Updates to CDC guidance over the past few months have simplified recommendations related to staffing during COVID-19.
Staffing – COVID-19 Positive Cohort

Per CDC guidance, NFs should have separate staff dedicated to caring for COVID-19 positive residents.

If possible, the staff should avoid working on both the COVID-19 positive area and other COVID-19 cohort areas during the same shift.

The CDC recommends implementing other staffing mitigation strategies before sharing staff between COVID-19 positive cohorts and other cohorts.
Staffing – Unknown COVID-19 Cohort

NFs may share staff between Unknown COVID-19 cohorts and negative COVID-19 cohorts if necessary.

NFs working with Unknown COVID-19 status cohorts should continue following all appropriate infection prevention and control measures, including wearing full PPE with proper donning and doffing, proper hand hygiene, etc.
Non-Direct Care Staff

Non-direct care staff (i.e. dietary staff, environmental staff) may enter Unknown COVID-19 Status cohort areas.

Non-direct care staff entering the Unknown COVID-19 Status cohort area should wear all appropriate PPE.

CDC recommends non-direct care staff be excluded from COVID-19 positive cohort areas to the extent possible.
TMF Health Quality Institute
CMS Quality Improvement Organization

Melody Malone, PT, CPHQ, MHA
Quality Improvement Specialist
NHSN Release Coming Soon

• Webinar Session held Monday, July 12, 2021 from 1:00 – 2:00 PM EST should be posted, soon.

• For NHSN change details, go to: https://tmfnetworks.org/Resources/Online-Forums/aft/372
NHSN Q&A

Q: What if I missed the email for Level 3 access?

A: 1. Now as soon as someone is submitted as a new User, they will receive the invitation for Level 3. This expires quickly. **There is no longer a Level 1 access!**

2. Therefore, if you experience problems during new user additions and upgrades, please email the NHSN user support **nhsn@cdc.gov** with “Enhancing Data Security” in the subject line.

TIP: See: [Increasing LTCF SAMS Level Access to NHSN](https://example.com/tip)
NEW: Nursing Home COVID-19 Vaccination Data Dashboard

- **Nursing Home COVID-19 Vaccination Data Dashboard**
  - Includes counts of residents and healthcare personnel, or staff, who received any COVID-19 vaccine and data at the national and state level of CMS-certified nursing homes.
  - CDC updates this data dashboard weekly on Thursday at 8:00 am Eastern.
COVID-19 Vaccination Coverage and Reporting among Residents in Nursing Homes, by Week—United States

Data are not displayed if less than 5 facilities reported in a state during the time period of interest. All data can be modified from week-to-week by facilities. Exclusions: For best epidemiological understanding, data that appear inconsistent with surveillance protocols are excluded. Vaccination coverage is calculated as the total number of residents vaccinated divided by (the total number of residents minus the number of residents with medical contraindications or exclusions to vaccination) multiplied by 100. Differences in how each facility implements this COVID-19 vaccination data collection, including variation in which staff collect the data, may affect facility reporting patterns. Definitions: Partial vaccination: 1 dose of vaccination series. Complete vaccination: All doses required for vaccination

Data source: Centers for Disease Control and Prevention, National Healthcare Safety Network

For more information: https://www.cdc.gov/nhsn/ltc/weekly-covid-vac/index.html

Accessibility: [Right click on the graph area to show as table]
COVID-19 Vaccination Coverage and Reporting among Staff in Nursing Homes, by State and Week—United States

Percent of Staff Receiving Vaccinations by Coverage Type during the Week of 6/28/2021 - 7/4/2021

All data can be modified from week-to-week by facilities. Exclusions: For best epidemiological understanding, data that appear inconsistent with surveillance protocols are excluded. Vaccination coverage is calculated as the total number of staff vaccinated divided by (the total number of staff minus the number of staff with medical contraindications or exclusions to vaccination) multiplied by 100. Differences in how each facility implements this COVID-19 vaccination data collection, including variation in which staff collect the data, may affect facility reporting patterns.


Data source: Centers for Disease Control and Prevention, National Healthcare Safety Network

For more information: [https://www.cdc.gov/nhsn/ltc/weekly-covid-vac/index.html](https://www.cdc.gov/nhsn/ltc/weekly-covid-vac/index.html)

Accessibility: [Right click on the graph area to show as table]
Weekly NHSN COVID-19 Vaccination Data Module Alert

- ‘COVID-19 Vaccination Summary Data Alerts’ will appear on the NHSN homepage.

- Implemented to flag if vaccination rates are less than or equal to 10 percent for reporting weeks starting March 1, 2021 through the present.
CMS Targeted COVID-19 Training for Frontline Nursing Home Staff & Management Learning

- Available through the CMS Quality, Safety & Education Portal (QSEP).
- Can be completed on a cell phone
- Frontline nursing home staff modules:
  - Module 1: Hand Hygiene and PPE
  - Module 2: Screening and Surveillance
  - Module 3: Cleaning the Nursing Home
  - Module 4: Cohorting
  - Module 5: Caring for Residents with Dementia in a Pandemic
- 3 hours total training time

- Management staff modules:
  - Module 1: Hand Hygiene and PPE
  - Module 2: Screening and Surveillance
  - Module 3: Cleaning the Nursing Home
  - Module 4: Cohorting
  - Module 5: Caring for Residents with Dementia in a Pandemic
  - Module 6: Basic Infection Control
  - Module 7: Emergency Preparedness and Surge Capacity
  - Module 8: Addressing Emotional Health of Residents and Staff
  - Module 9: Telehealth for Nursing Homes
  - Module 10: Getting Your Vaccine Delivery System Ready
- 4 hours total training time
CMS Targeted COVID-19 Training for Frontline Nursing Home Staff & Management Learning

• CMS says it’s not permitted to put their trainings in Relias or any other training program.

• There is no way, that we are aware of, to get any of the CMS training that was completed in another platform recognized in the QSEP platform.

• Therefore, the staff will have to re-take the sessions for your facility to get a 100% complete in the CMS system.

• Remember to build in time for new staff to do the training.
NHSN RESOURCES

• TMF NHSN resources: NHSN Resources

• CDC NHSN COVID19 Module: https://www.cdc.gov/nhsn/ltc/covid19/index.html
LTC Connect
July 22 - 1:30-2 p.m. CT

• Topic: Vaccine Hesitancy: Concerns with Fertility and Pregnancy

• Register: LTC Connect

• Speaker: Gloria Richard-Davis, MD, MBA, NCMP, FACOG, with the University of Arkansas Medical Sciences (UAMS).
Reach out to us at: nhnetwork@tmf.org to submit requests for assistance with NHSN reporting problems or quality improvement assistance.
State Long-Term Care Ombudsman Program

Statewide phone: 800-252-2412
• Statewide email: ltc.ombudsman@hhs.texas.gov

State Ombudsman: Patty Ducayet, 737-704-9075 (or) patty.ducayet@hhs.Texas.gov

Bi-Weekly Facebook Live Q&A for Families of LTC Residents: Every other Wednesday (on weeks with no NF Provider webinar), 12:15 to 12:45 https://www.facebook.com/texasLTCombudsman?fref-ts
COVID-19 Q&A

Panelist

Bijendra Bhandari
Clinical Policy Specialist
Policy & Rules
Long-term Care Regulation

• Questions from Last Week
• Reminders
Q&A

Can NFs require that staff receive the COVID-19 vaccine?

State rules do not prohibit a facility from making COVID-19 vaccination a condition of employment. That is a decision a facility should make in consultation with its legal counsel and human resources professionals.

The COVID-19 vaccine cannot be mandated through state or federal rules since the vaccines are approved through the FDA’s emergency use authorization (EUA). However, the EUA does not affect a business’s ability to require vaccination for employees.
Reminders

**GovDelivery Alerts**
Don’t forget to sign up for GovDelivery alerts [https://service.govdelivery.com/accounts/TXHHS/subscriber/new](https://service.govdelivery.com/accounts/TXHHS/subscriber/new).
Select “Nursing Facility Resources” as a topic option to receive webinar updates.

**CMS/CDC COVID-19 Training**
CMS is offering free online training for nursing facilities related to COVID-19.
Click here to view currently available pre-recorded trainings.

Facilities also have access to the [CMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management](https://www.cms.gov/COVID-19).
Questions?

For more information:
Email: LTCRPolicy@hhs.texas.gov
Phone: 512-438-3161
Thank you!

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