Winter is Coming – PALTC
Preparedness for COVID's Next Surge

This meeting will be recorded and will be available at www.fmda.org/journalclub.php
Respiratory viral threat: Current score and blitz

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Alliant Health Solutions (QIO)
Northeast Georgia Health System
• Assess the current threat
• Review the evidence-based resources available to us
• Plan our blitz against the respiratory viral threat
• Discuss common questions/ myths
Confirmed COVID-19 Cases among Residents and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week—United States

* Data are likely accruing, all data can be modified from week-to-week by facilities.

For the purpose of creating this time-series graph, data that fail certain quality checks or appear inconsistent with surveillance protocols are assigned a value based on their patterns for data entry or excluded from analysis.

Data source: Centers for Disease Control and Prevention, National Healthcare Safety Network. Accessibility: [Right click on the graph area to show as table]

For more information: [https://www.cdc.gov/nhsn/ltc/coid19/index.html](https://www.cdc.gov/nhsn/ltc/coid19/index.html)
Resident cases: FL
Confirmed COVID-19 Cases among Staff and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week—United States
COVID-19 Deaths among Staff and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week — United States
Wastewater surveillance
### Variant data

#### Region 4 - Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

<table>
<thead>
<tr>
<th>WHO label</th>
<th>Lineage #</th>
<th>US Class</th>
<th>%Total</th>
<th>95%PI</th>
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<td>7.2-10.0%</td>
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<td>2.6-14.5%</td>
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<td>1.1-1.9%</td>
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</table>

#### Collection date, week ending

- 9/17/22
- 9/24/22
- 10/1/22
- 10/8/22
- 10/15/22
- 10/22/22
- 10/29/22
- 11/5/22
- 11/12/22
- 11/19/22
- 11/26/22
- 12/3/22
- 12/10/22
- 12/17/22

#### HHS Region 4: 12/11/2022 – 12/17/2022 NOWCAST

#### HHS Region 4: 9/11/2022 – 12/17/2022
Influenza Like Activity

- https://www.cdc.gov/flu/weekly/index.htm
Flu hospitalizations

**In this figure, weekly rates for all seasons prior to the 2022-23 season reflect end-of-season rates. For the 2022-23 season, rates for recent hospital admissions are subject to reporting delays, as shown in the shaded area. As hospitalization data are received each week, prior case counts and rates are updated accordingly.**
In the 2022-2023 season, the overall rate of RSV-associated hospitalizations was 30.4 per 100,000 people.
RSV surveillance by age:

In the 2022-2023 season, the overall rate of RSV-associated hospitalizations was 30.4 per 100,000 people.
Discussion of data on effectiveness of vaccine and treatment for COVID-19
An updated (bivalent) COVID-19 booster provides **additional protection** against symptomatic COVID-19 illness*

COVID-19 spread has increased during the last two winters; stay up to date with COVID-19 vaccination

* Among immunocompetent adults with COVID-19-like symptoms, the vaccination status of 121,887 adults with a positive COVID-19 test was compared to that of 238,939 adults with a negative COVID-19 test
Lower case count: Bivalent boosters

People aged 12 and older vaccinated with an updated (bivalent) booster had:

- 14.9X lower risk of dying from COVID-19 in September 2022, and
- 3.2X lower risk of testing positive for COVID-19 in October 2022, compared to unvaccinated people.

Lower death rate: Bivalent booster

https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status
Flu vaccine effective in decreasing risk of severe symptoms and hospitalization by ~50% for admitted patients, it decreased ICU admission and duration of hospitalization.
Infection control

- https://doi.org/10.1093/infdis/jiac195
Treatment: Paxlovid
Real-world data shows early treatment for COVID-19 helps prevent hospitalization

Adults* prescribed Paxlovid for mild-to-moderate COVID-19 were 51% less likely to be hospitalized than those who weren’t

* regardless of vaccination status

IF YOU HAVE COVID-19 SYMPTOMS:

1 TEST
Use a self-test, locate a test site, or find a Test to Treat location

2 TALK
If you test positive, talk to a health care professional about treatment

3 TREAT
Start treatment within 5 days

bit.ly/mm7148e2

MMWR
NOVEMBER 22, 2022
Nirmatrelvir and the Risk of Post-Acute Sequelae of COVID-19

Survival probability of post-acute sequelae in nirmatrelvir and no treatment control group.

a. post-acute sequelae of COVID-19 (PASC); b. death; c. hospitalization; d. composite outcome of death or hospitalization. Outcomes were ascertained 30 days after the SARS-CoV-2 positive test until the end of follow-up. Survival probability presented for nirmatrelvir (purple, N=9217) and control group (orange, N=47,123). Shaded areas are 95% confidence intervals.
Early treatment (HAN- Dec 20)

• **First-line therapy,**
  - ritonavir-boosted nirmatrelvir (Paxlovid™) or
  - remdesivir (Veklury®),

• **Second-line therapy,**
  - molnupiravir (Lagevrio™)

Bebtelovimab
Therapeutics

• (1) are aged 50 years and older, or
• (2) have an underlying condition, or
• (3) have moderate to severe immunosuppression,

Regardless of their vaccination status, all of these groups of people should be tested for SARS-CoV-2 as soon as possible after symptom onset and receive treatment within 5 to 7 days of symptom onset with one of several treatment options.
COVID-19 Risk Continuum

**Age (years)**
- <30
- 30-49
- 50-69
- ≥70

**Medical Conditions**
- None
- 1
- 2
- 3+

**Vaccination Status**
- Full vaccination plus boosting
- Full vaccination
- Partial vaccination
- Unvaccinated

**Immunosuppression**
- None
- Corticosteroids
- Biologics (e.g., anti-tumor necrosis factor)
- Antimetabolites (e.g., mycophenolate)
- Lymphodepletion (e.g., anti-CD20*)
- Solid organ transplant
- AIDS
- Stem cell transplant
- Hematological malignancy

Sociodemographic factors and non-pharmaceutical interventions affect exposure risk

Original illustration by Dr. William Werbel. Adapted for the COVID-19 Real-Time Learning Network.
CLINICAL SURVEILLANCE
• Low threshold for testing
  Expand surveillance symptoms
  Increase frequency

TEST
• COVID-19 Ag test + Flu/RSV/COVID-19 PCR

Transfer to COVID-19 unit
Institute standing orders (lab, Supp Rx, monitor) (communication to IP, CP, MD, DON, Adm)
• IP - contact tracing, PPE determination, freq of testing
• CP - assessment for Pax/Lagevrio - d/w MD create recommendations - communication to individual providers
• MD, DON, Adm - Vaccine boost, comm to fam
DATE: November 22, 2022
TO: State Survey Agency Directors
FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)
SUBJECT: The Importance of Timely Use of COVID-19 Therapeutics

Memorandum Summary

- Providers and suppliers, especially those delivering care in congregate care settings, should ensure their patients and residents are protected against transmission of COVID-19 within their facilities, as well as receiving appropriate treatment when tested positive for the virus.

- Further, all providers and suppliers should continue to implement appropriate infection control protocols for COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html) and Influenza (https://www.cdc.gov/flu/professionals/infectioncontrol/index.htm).

- This memo discusses the importance of the timely use of available COVID-19 therapeutics, particularly for high-risk patients who test positive for the virus.
Discuss common questions/ myths

The reaction to bivalent is higher: NO

The reaction to coadministration is worse: NO

Figure 2

Solicited injection site reactions (A) and solicited systemic reactions (B) occurring up to 7 days after injection (immunogenicity analysis set)

Error bars show 95% CIs. Coadministration QIV-HD shows the solicited reactions observed in the QIV-HD-injected limb of participants in the coadministration group. Coadministration mRNA-1273 shows the solicited reactions observed in the mRNA-1273-injected limb of participants in the coadministration group. QIV-HD=high-dose quadrivalent influenza vaccine.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8803382/
Bivalent booster does not prevent illness: It DOES
We have to wait 3 months after COVID-19 to give bivalent: NO can give as soon as noncontagious

Can I get vaccinated against COVID-19 while I am currently sick with COVID-19?

No. You should wait to be vaccinated until after you complete your isolation period. People who have symptoms will end isolation at a different time than people who do not have symptoms. This also applies to people who have been vaccinated but get COVID-19 before getting any additional or booster doses. Additionally, you may consider delaying your next vaccine (primary dose or booster) by 3 months from when your symptoms started or, if you had no symptoms, when you received a positive test.
We need to withhold vaccine drive if there is outbreak: No, there is even more urgency
I have to wait for vaccine clinics to give vaccine: NO

- Reach out to your QIO (quality improvement organization)
  - [https://qioprogram.org/locate-your-qio](https://qioprogram.org/locate-your-qio)
- Become a self provider for bivalent (Medical Directors) (GA)
  - [https://dph.georgia.gov/covid-vaccine-information-providers](https://dph.georgia.gov/covid-vaccine-information-providers)
- Fill out this LTCF COVID-19 Vaccine Bivalent Booster Administration Assistance Survey (GA)
  - [https://www.surveymonkey.com/r/LTCFVaxAssist](https://www.surveymonkey.com/r/LTCFVaxAssist)
Therapeutics Myth:
Need to wait for symptoms to develop: NO
Paxlovid causes rebound: Anecdotal

**Viral and Symptom Rebound in Untreated COVID-19 Infection**

Rinki Deo, Manish C. Choudhary, Carlee Moser, Justin Ritz, Eric S. Daar, David A. Wohl, Alexander L. Greninger, Joseph J. Eron, Judith S. Currier, Michael D. Hughes, Davey M. Smith, Kara W. Chew, Jonathan Z. Li, the ACTIV-2/A5401 Study Team

doi: https://doi.org/10.1101/2022.08.01.22278278

- Viral rebound 12%
- Symptom rebound 24%
Paxlovid causes rebound: Anecdotal
ICYMI: HAN Dec 14

• When an influenza outbreak is not occurring, prioritize oseltamivir for early treatment of influenza in residents of congregate settings such as long-term care facilities (LTCFs), who test positive for influenza.

• In the setting of laboratory confirmed influenza outbreaks in LTCFs:
  • Early empiric antiviral treatment of suspected influenza in residents is recommended[4]. Once an influenza diagnosis is confirmed through testing, post-exposure antiviral chemoprophylaxis of exposed residents is recommended [4].
  • Because institutional outbreaks can be prolonged, consider using a limited duration treatment dosage (twice daily for 5 days) for post-exposure oseltamivir instead of extended use of oseltamivir chemoprophylaxis (once daily), with ongoing active daily monitoring and influenza testing for all residents with new illness signs and symptoms.
  • If oseltamivir is not available, baloxavir, zanamivir, or peramivir may be used for treatment of influenza.
  • Although baloxavir may be used for treatment, there are no available data on using baloxavir in LTCFs for treatment or post-exposure chemoprophylaxis.

https://emergency.cdc.gov/han/2022/pdf/CDC_HAN_482.pdf?ACSTrackingID=USCDC_S11-DM95716&ACSTrackingLabel=HAN%20482-%20COCA%20Subscribers&deliveryName=USCDC_S11-DM95716
Updated CDC Guidance Rests on Up-to-date Vaccine Status for Staff and Residents

- Up-to-date vax
- PPE and Infection Control
- Testing and Pax
Eye on the ball: Vax and Pax Blitz

- Bivalent 15X lower
- Paxlovid 89% lower
- Flu vaccine 50% lower
- Tamiflu 71% lower