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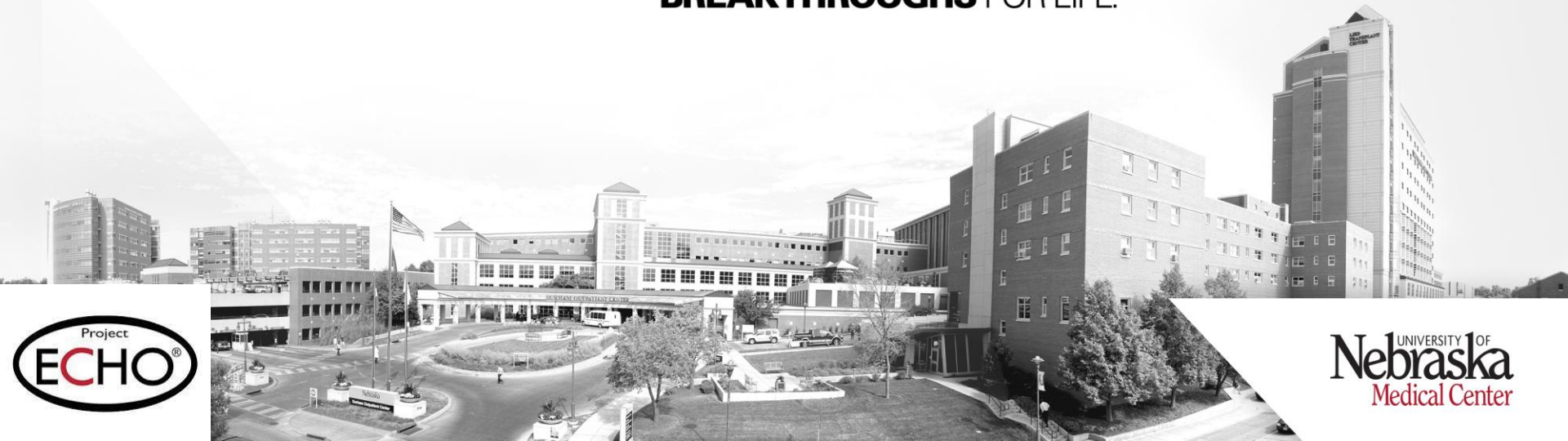

Project ECHO®

University of Nebraska Medical Center

UNMC ID ECHO Project to Reduce COVID-19 Health Disparities Through Quality Improvement

Welcome to Session 5

Project Funded by Nebraska DHHS through a CDC grant

Housekeeping Reminders

- Discussion makes sessions work best!
- Please stay muted unless you are speaking
- We love to see your face!
- Sessions will be recorded and available upon request
- Attendance is taken by filling the survey in the chat

- Reminder: Project ECHO collects registration, participation, questions and answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. This data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to create new initiatives.

Subject Matter Experts

Infectious Diseases Team

- M. Salman Ashraf, MBBS
- Erica Stohs, MD, MPH
- Anum Abbas, MD
- Kelly Cawcutt, MD, MS

Quality Improvement Team

- Jeff Wetherhold, QI Consultant
- Gale Etherton, MD
- Mahliqha Qasimyar, MD

Health Equity & Cultural Sensitivity Team

- Nada Fadul, MD
- Mahelet Kebede, HE & CS Consultant
- Shirley Delair, MD
- Jasmine Marcelin, MD
- Andrea Jones, MD
- Precious Davis, Case Manager
- Samantha Jones, Program Manager

*Ardis Reed, State QIN/QIO Representative

CE Disclosures

Project ECHO

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UNMC ID Health Equity and Quality Improvement ECHO Project

Topics: Long Term Complications of COVID-19 Infection (Part 1) and Cultural Attitudes (Part 2 & 3): Time, Space, Group Dynamics, Authority, Tasks, and Relationships

Free Live ECHO Project
January 5, 2022
CID 53866

University of Nebraska Medical Center

TARGET AUDIENCE

This live activity is intended for physicians, APPs, nurses, social workers, case managers, and anyone else interested in learning about health equity in underserved populations.

ACTIVITY DESCRIPTION

Achieving health equity, addressing COVID-19 disparities, and improving the health of all Nebraskans using a quality improvement approach are the goals for our newly launched educational initiative. This COVID-19-focused health equity and quality improvement educational series will use the ECHO model for training healthcare workers.

The course is being offered through the University of Nebraska Medical Center (UNMC) infectious diseases (ID) ECHO program and is funded by the Nebraska Department of Health and Human Services (DHHS) via a CDC grant.

EDUCATIONAL OBJECTIVES

At the conclusion of this live activity, the participants should be better able to:

- Identify the long-term complications associated with COVID-19 infection.
- Apply best practices in the management of long-term complications associated with COVID-19 infection to tests of change in your facility.
- Discuss how cultural values and beliefs impact engagement with COVID-19 prevention and control efforts.

REQUIREMENTS FOR SUCCESSFUL COMPLETION

In order to receive continuing education credit/credits, you must:

1. Participate in the live activity via ZOOM. Your attendance will be tracked by the course facilitator.
2. Complete the overall evaluation
    a. Instructions on how to access the overall evaluation will be provided on a quarterly basis.
    b. Continuing education credits will be issued for activities you attended.

For questions regarding evaluation and attendance, please contact Nuha Mirghani, MD, MBA, HCM at nmirghani@unmc.edu

ACCREDITED CONTINUING EDUCATION

In support of improving patient care, University of Nebraska Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

PHYSICIANS/PHYSICIAN ASSISTANTS

The University of Nebraska Medical Center designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSES/NURSE PRACTITIONERS

The University of Nebraska Medical Center designates this activity for 1.5 ANCC contact hour(s). Nurses should only claim credit for the actual time spent participating in the activity.

ACCREDITED CONTINUING EDUCATION

As a Jointly Accredited Organization, University of Nebraska Medical Center is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Nebraska Medical Center maintains responsibility for this course. Social workers completing this live activity receive 1.5 interactive continuing education credits.

: content: Intermediate

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).
Activity code: I00048902 Approval Number: 210004269
To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE INFORMATION

As a jointly accredited provider, the University of Nebraska Medical Center (UNMC) ensures accuracy, balance, objectivity, independence, and scientific rigor in its educational activities and is committed to protecting learners from promotion, marketing, and commercial bias. Faculty (authors, presenters, speakers) are encouraged to provide a balanced view of therapeutic options by utilizing either generic names or other options available when utilizing trade names to ensure impartiality.

All faculty, planners, and others in a position to control continuing education content participating in a UNMC accredited activity are required to disclose all financial relationships with ineligible companies. As defined by the Standards for Integrity and Independence in Accredited Continuing Education, ineligible companies are organizations whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The accredited provider is responsible for mitigating relevant financial relationships in accredited continuing education. Disclosure of these commitments and/or relationships is included in these activity materials so that participants may formulate their own judgments in interpreting its content and evaluating its recommendations.
This activity may include presentations in which faculty may discuss off-label and/or investigational use of pharmaceuticals or instruments not yet FDA-approved. Participants should note that the use of products outside currently FDA-approved labeling should be considered experimental and are advised to consult current prescribing information for FDA-approved indications.

All materials are included with the permission of the faculty. The opinions expressed are those of the faculty and are not to be construed as those of UNMC.

Disclosures

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

FACULTY

Kelly Cawcutt, MD, MS
Becton Dickinson: Honorarium
CloroxPro: Medical writer

The below faculty have nothing to disclose:

- Precious Davis, MSN, BSN, RN*
- Mahelet Kebede, MPH*

**Indicates on the planning committee*

Disclosures

PLANNING COMMITTEE

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Merck & Co, Inc: Industry funded research/investigator

Nada Fadul, MD
ViiV Healthcare: Advisory Committee/Board

Erica Stohs, MD, MPH
ReViral Ltd.: Industry funded research/investigator

The below planning committee members have nothing to disclose:

- Valeta Creason-Wahl, HMCC
- Samantha Jones, CSW
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Jeff Wetherhold, M.Ed
- Bailey Wrenn, MA

www.unmc.edu/cce

Project ECHO

POLL

Current State of COVID-19 in Nebraska

Please Share Your Questions

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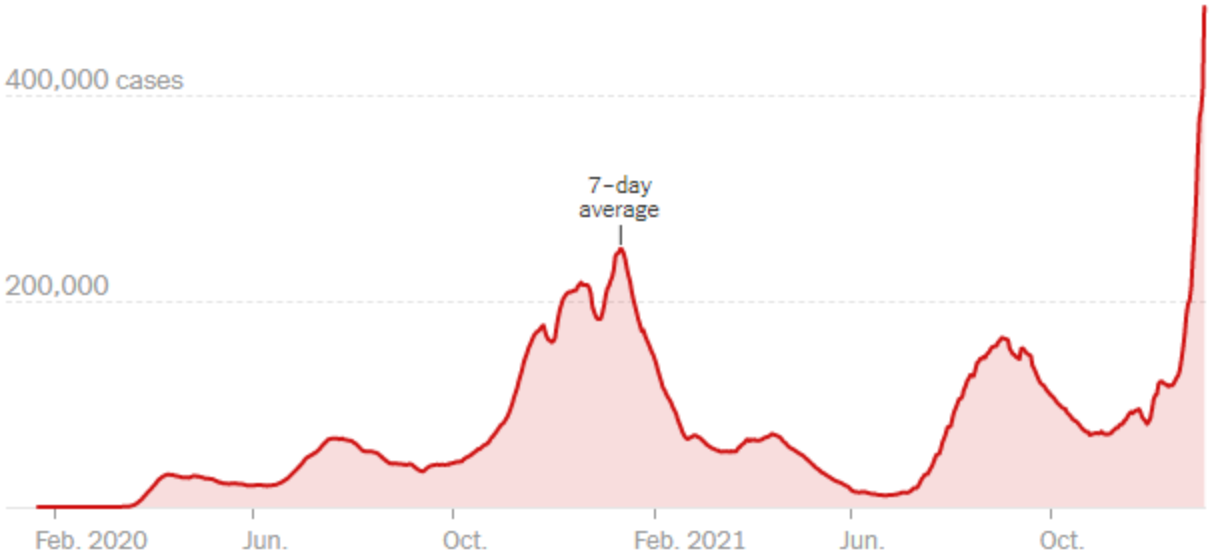
COVID-19 Updates

U.S. trends

All time | Last 90 days

New reported cases by day

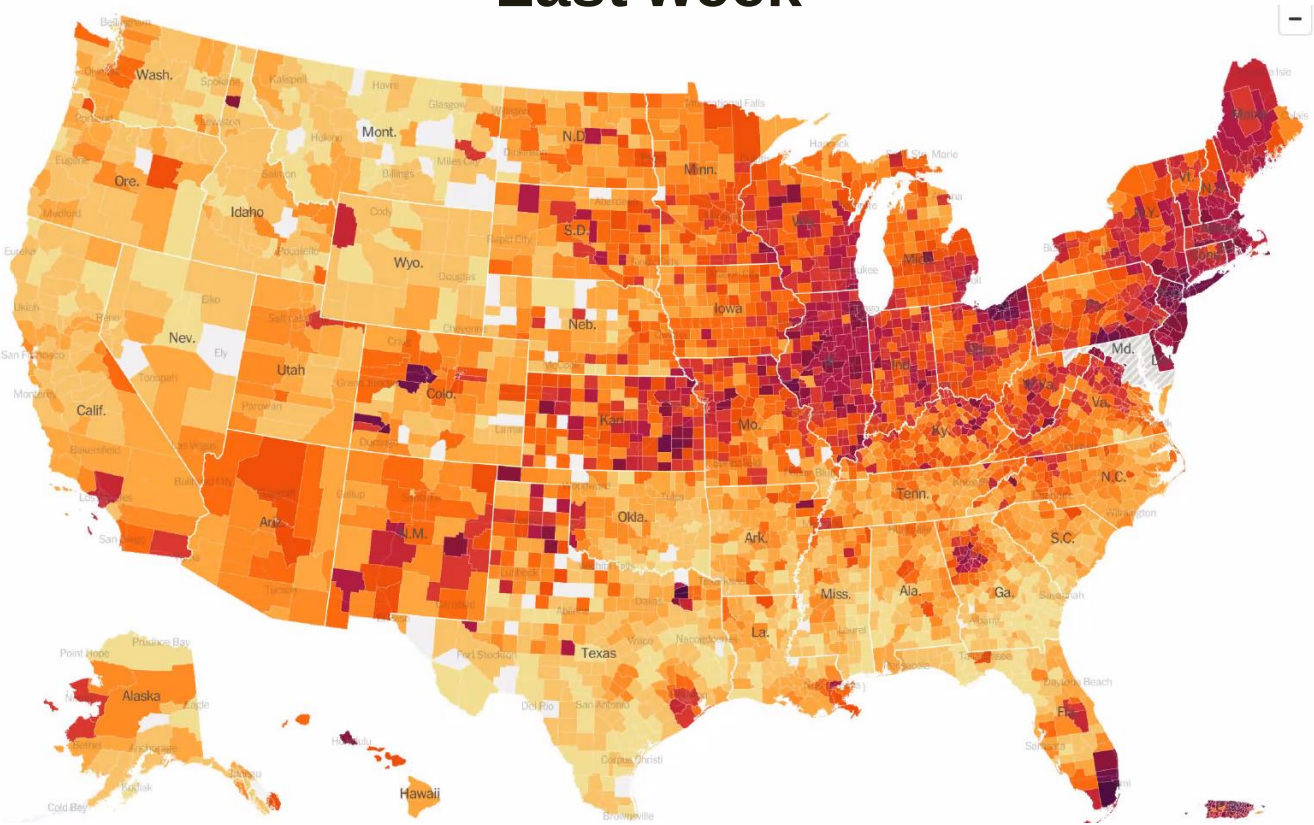


US is averaging >300,000 new cases per day for the FIRST time in the pandemic.
Monday alone: 1 million cases

https://www.nytimes.com/interactive/2021/us/covid-cases.html

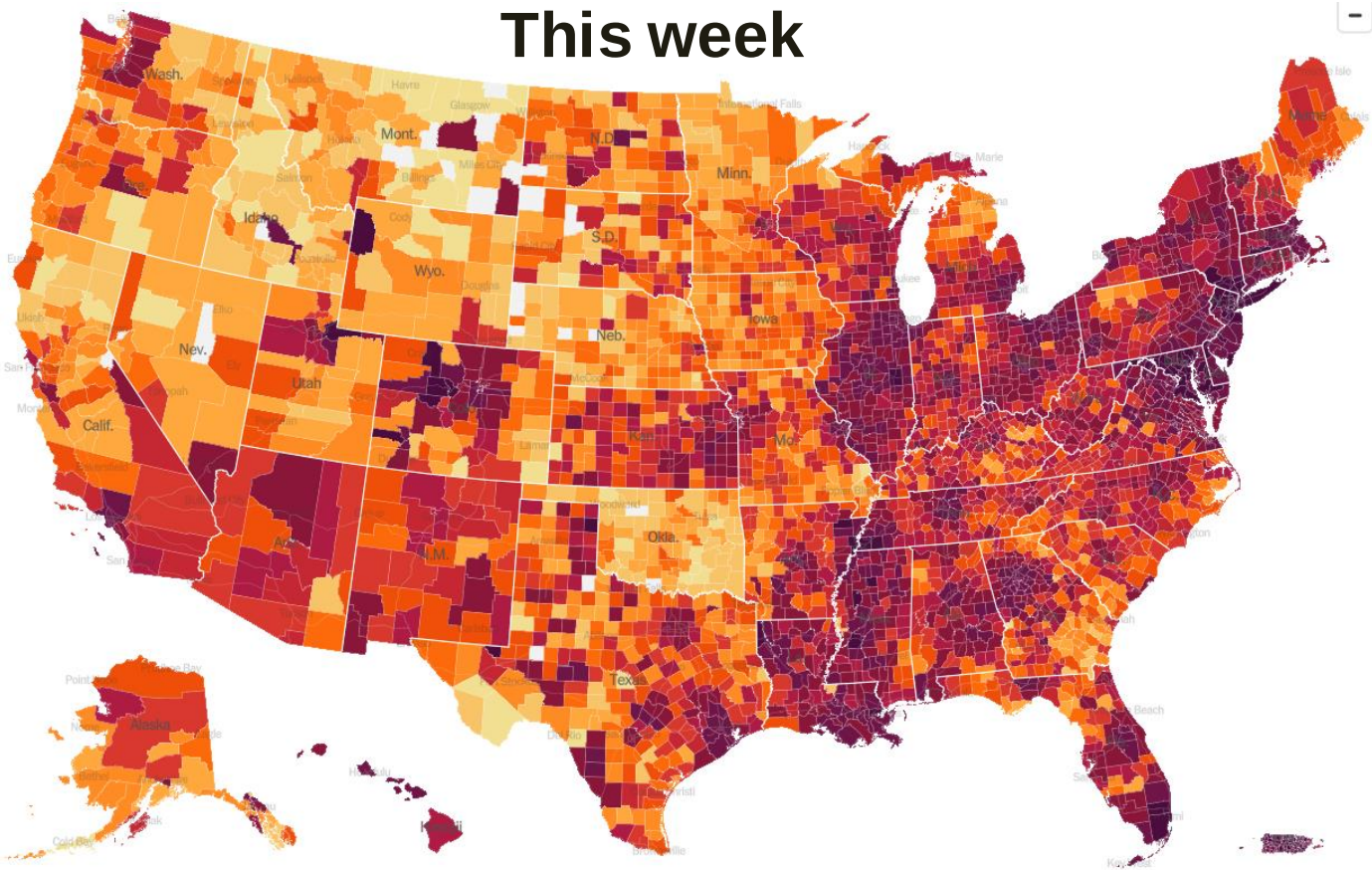
COVID-19 Updates

Last week



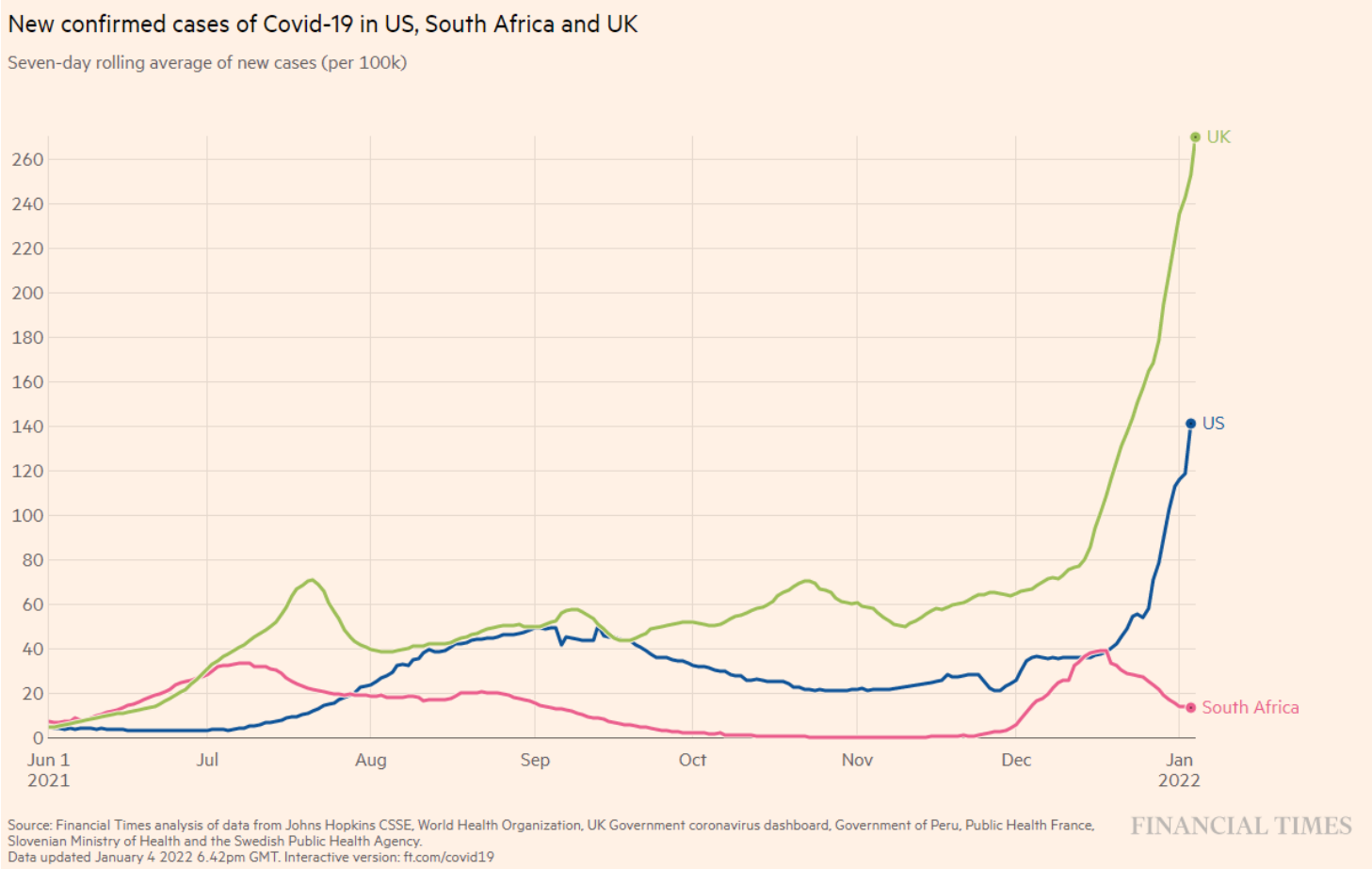
https://www.nytimes.com/interactive/2021/us/covid-cases.html

COVID-19 Updates

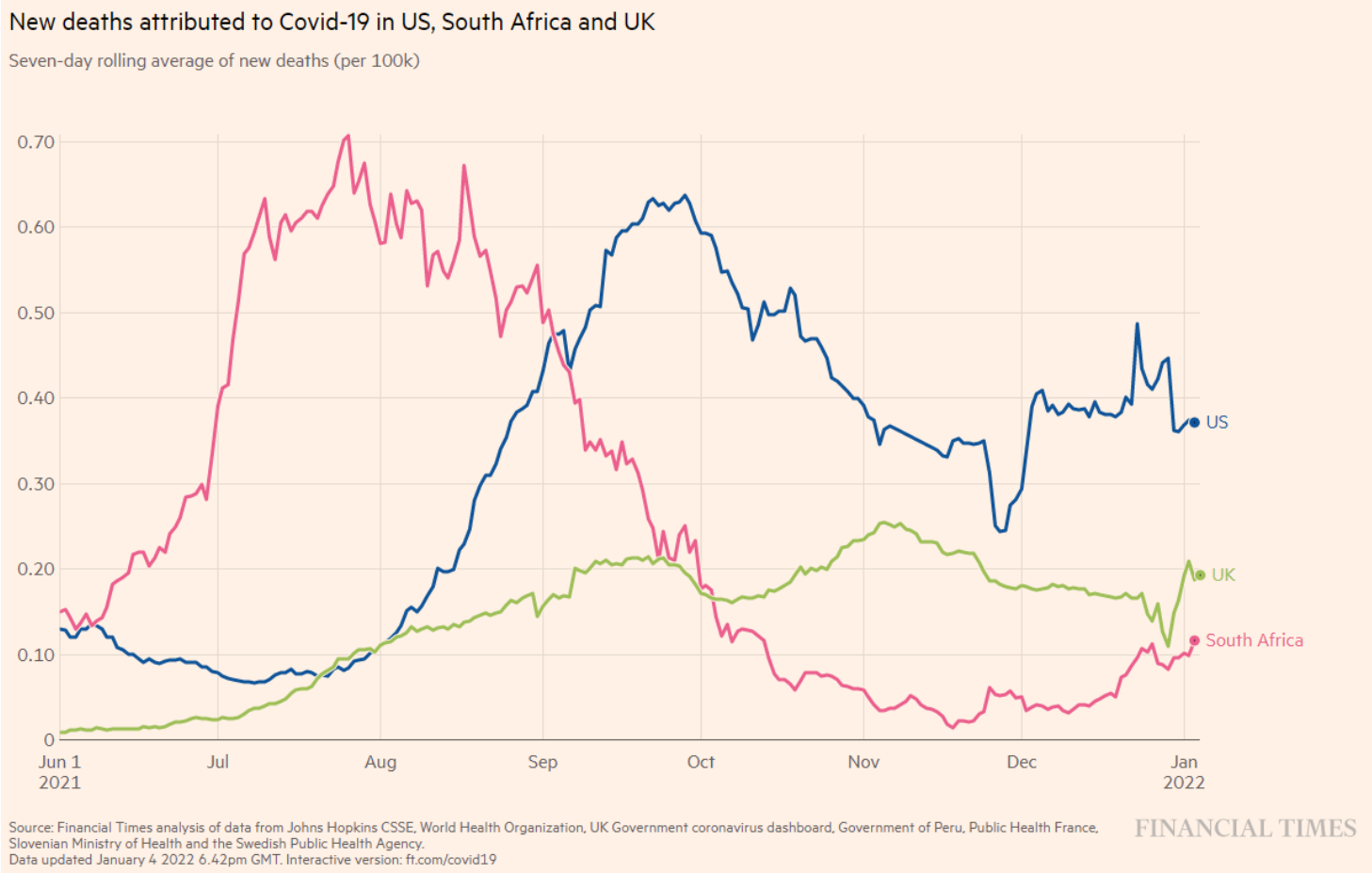


https://www.nytimes.com/interactive/2021/us/covid-cases.html

COVID-19 Updates



COVID-19 Updates

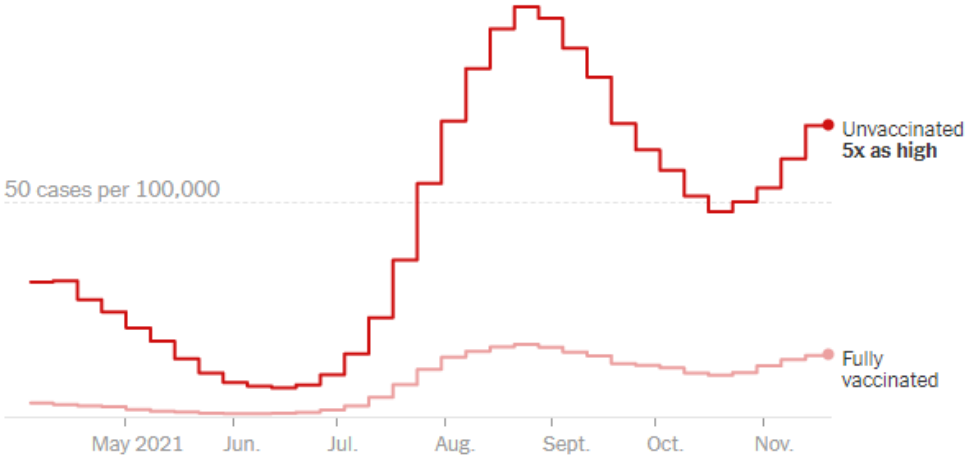


COVID-19 Updates

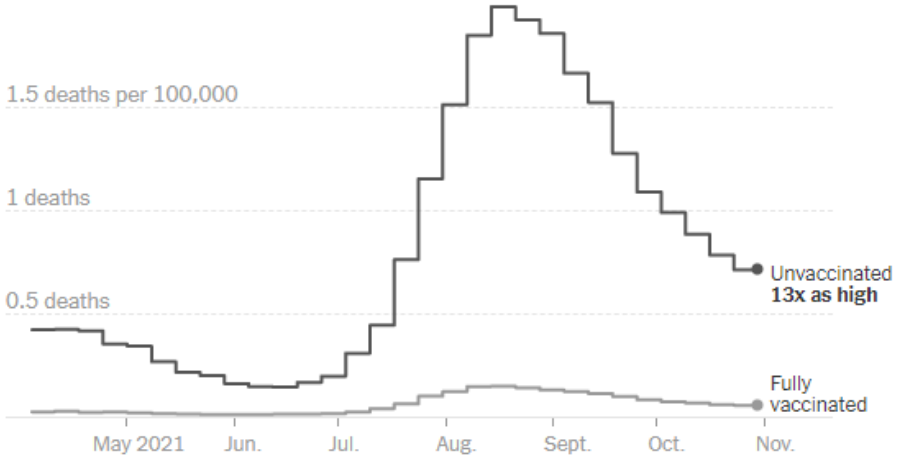
Rates for vaccinated and unvaccinated

Data from the Centers for Disease Control and Prevention shows that people who are unvaccinated are at a much greater risk than those who are fully vaccinated to test positive or die from Covid-19. These charts compare age-adjusted average daily case and death rates for vaccinated and unvaccinated people in New York City and the 26 states that provide this data.

Average daily cases



Average daily deaths



https://www.nytimes.com/interactive/2021/us/covid-cases.html

COVID-19 Updates

Omicron Updates

- Detected in all 50 states
- Transmission: Most transmissible variant to date: Ro=9
    - 2x delta, 3x original
- Severity: Milder course, especially if vaccinated BUT
- Hospitalization surge anticipated
- Health care limitation: staff out for COVID-19
- CDC Updates on Isolation

CDC Shortens Isolation Period

If test positive:

- Quarantine x5 days. Wear a mask x5 more days.
- Don't leave quarantine unless fever resolves & symptoms better.

If exposed:

- If vaccinated, wear a mask x10 days. Test on day 5.
- If unvaccinated, not boosted or recently vaccinated, quarantine x5 days, mask x5 more days or mask x10 days. Test on day 5 if possible.

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https://www.cdc.gov/media/releases/2021/s1227-isolation-quarantine-guidance.html

Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

HCP are considered "boosted" if they have received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC. HCP are considered "vaccinated" or "unvaccinated" if they have NOT received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC.

For more details, including recommendations for healthcare personnel who are immunocompromised, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).

Work Restrictions for HCP With SARS-CoV-2 Infection

Vaccination Status	Conventional	Contingency	Crisis
Boosted, Vaccinated, or Unvaccinated	10 days OR 7 days with negative test†, if asymptomatic or mildly symptomatic (with improving symptoms)	5 days with/without negative test, if asymptomatic or mildly symptomatic (with improving symptoms)	No work restriction, with prioritization considerations (e.g., asymptomatic or mildly symptomatic)

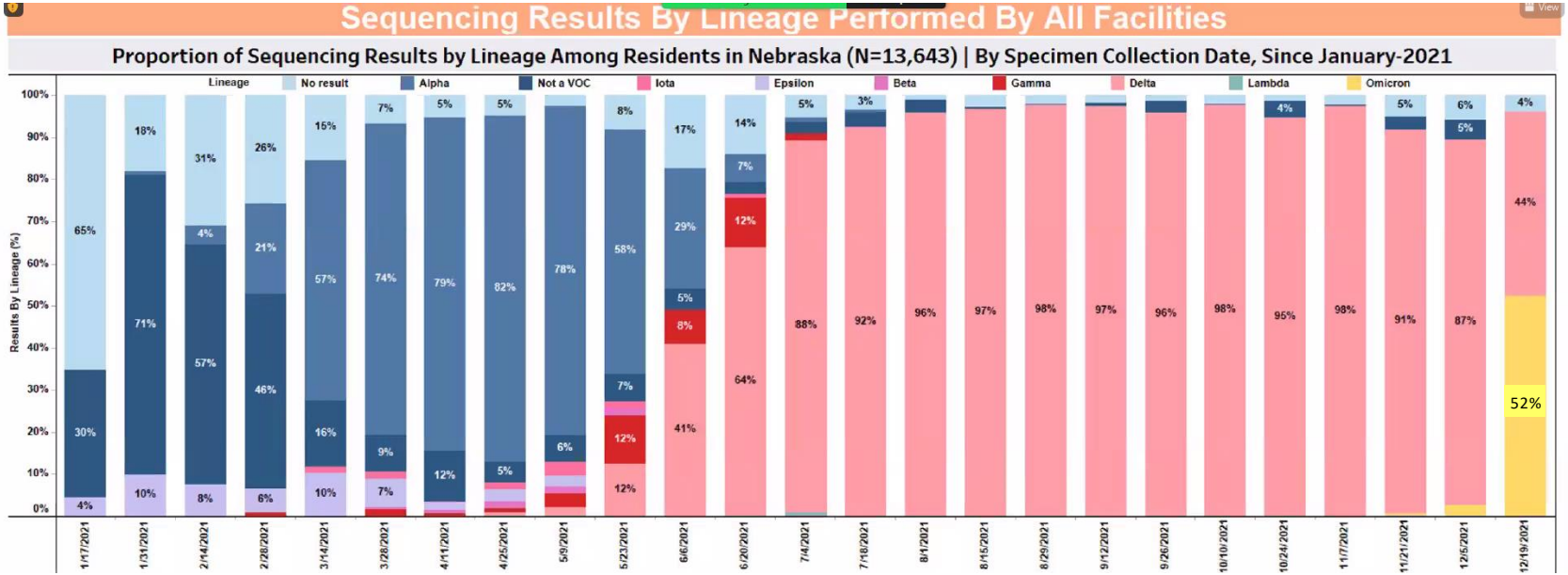
Work Restrictions for Asymptomatic HCP with Exposures

Vaccination Status	Conventional	Contingency	Crisis
Boosted	No work restrictions, with negative test on days 2‡ and 5–7	No work restrictions	No work restrictions
Vaccinated or Unvaccinated, even if within 90 days of prior infection	10 days OR 7 days with negative test	No work restriction with negative tests on days 1‡, 2, 3, & 5–7	No work restrictions (test if possible)

†Negative test result within 48 hours before returning to work

‡For calculating day of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0

COVID-19 NE Updates



- Rapid spread: 52% of samples tested in last 2 weeks are omicron
- Therapeutics – Health Alert Network re: prioritization tiers
  - Antivirals
  - Monoclonal antibodies

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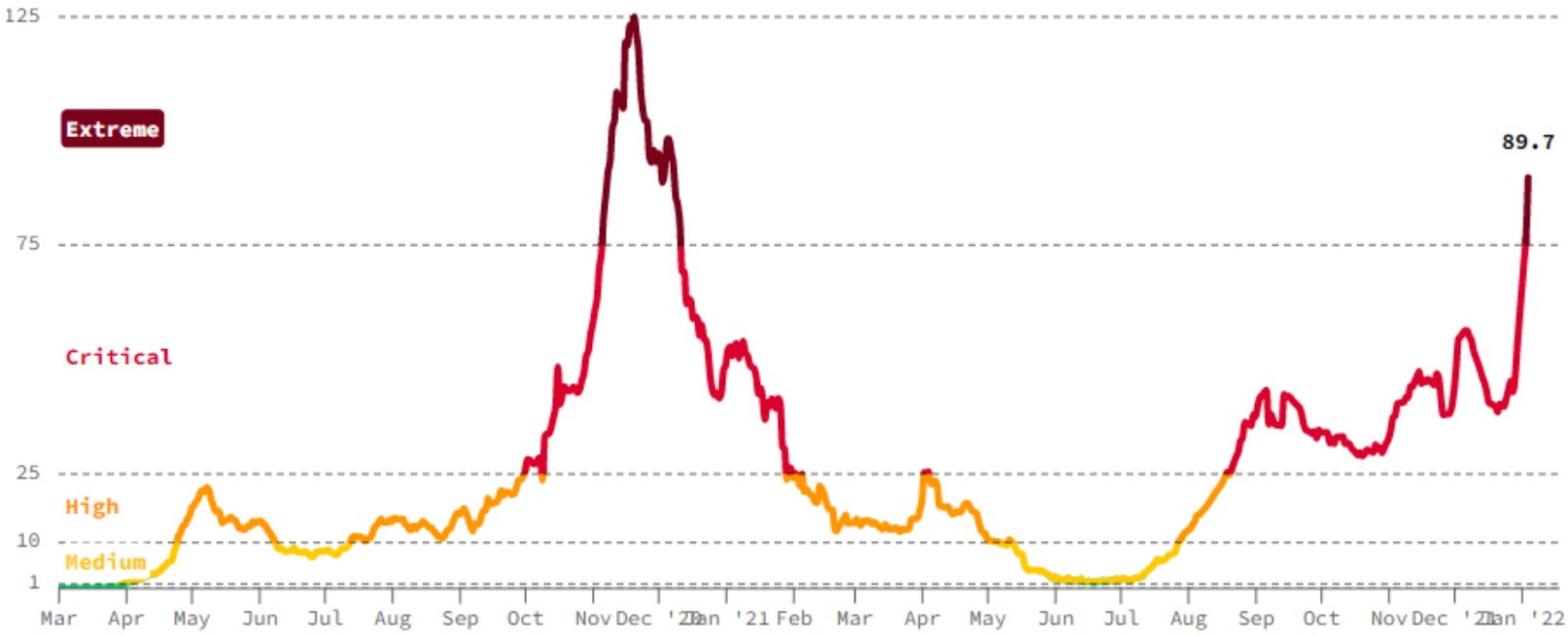
Nebraka HAN: https://dhhs.ne.gov/pages/Health-Alert-Network.aspx
Visual courtesy of Matt Donahue, NE DHHS

Cases

DAILY NEW CASES
• **89.7** PER 100K

INFECTION RATE
• **1.30**

POSITIVE TEST RATE
• **25.1%**



Over the last week, Nebraska has averaged 1,735 new confirmed cases per day (**89.7** for every 100,000 residents). About this data

Share

Nebraska Statistics

Week	Daily New Cases/ 100K	Infection Rate	Positive Test Rate	Number of Hospitalizations	ICU Capacity Used	*Vaccinated 1+
11/01/21	29.6	1.03	12.8%	413	80%	61%
11/15/21	44.0	1.15	14.8%	455	86%	62%
12/1/21	38.1	0.94	17.6%	545	80%	64%
12/15/21	47.4	1.01	16.2%	637	85%	65%
1/5/22	**89.7**	**1.30**	**25.1%**	532	84%	66.7%

*Percent of the entire state population vaccinated, regardless of eligibility/age.

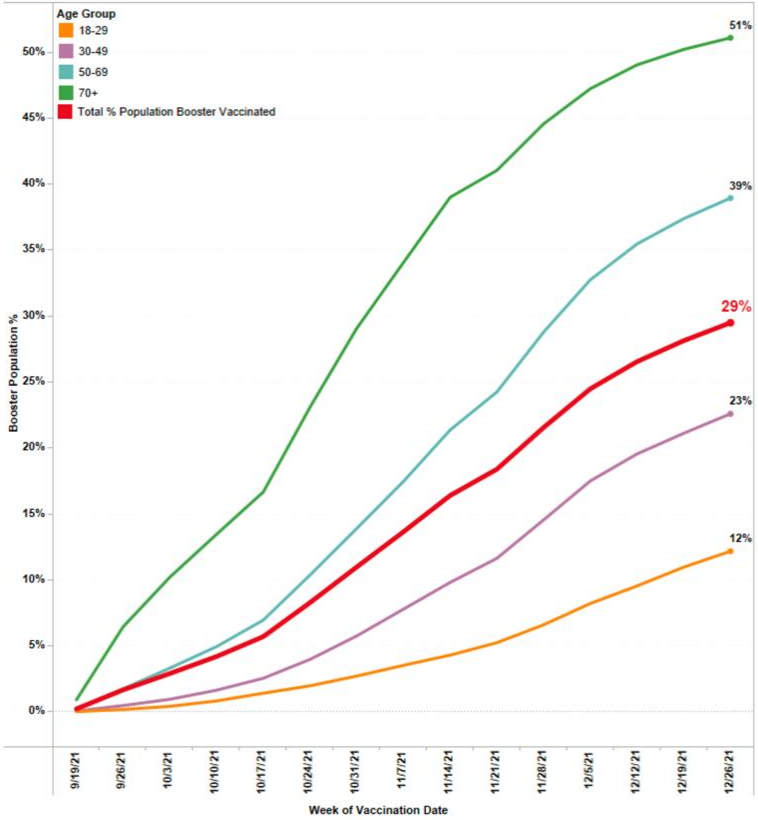
https://covidactnow.org/us/nebraska-ne/?s=24951410
https://datanexus-dhhs.ne.gov/views/Covid/1_DailyCharts?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

Nebraska COVID-19 Vaccinations

Fully vaccinated: 65%. Boosted: 29%

Vaccinations (Boosters)

Cumulative % Population with Additional Booster Dose Administered, by Age Group and Week, Nebraska



Total % Population with Additional Booster Dose Administered, by LHD and Age Group

LHD short	18-29	30-49	50-69	70+	Grand Total
Central	8%	16%	35%	49%	25%
Dakota	4%	8%	28%	42%	18%
Douglas	16%	27%	44%	56%	33%
East Central	7%	13%	33%	48%	24%
Elkhorn Logan Valley	6%	14%	34%	50%	25%
Four Corners	7%	17%	37%	55%	28%
Lincoln/Lancaster	16%	33%	51%	61%	36%
Loup Basin	6%	11%	28%	40%	23%
North Central	5%	10%	23%	39%	20%
Northeast	5%	13%	27%	41%	20%
Panhandle	4%	11%	26%	39%	20%
Public Health Solutions	8%	16%	38%	55%	30%
Sarpy/Cass	14%	24%	39%	48%	29%
South Heartland	6%	16%	35%	52%	27%
Southeast	7%	16%	36%	51%	28%
Southwest	5%	9%	25%	39%	20%
Three Rivers	10%	21%	40%	54%	31%
Two Rivers	6%	16%	33%	50%	24%
West Central	5%	11%	27%	40%	20%
Grand Total	12%	23%	39%	51%	30%

About the Data

Data Sources: Numerator is NESIIS Extract. Population data from CDC Bridged Race Population Estimates, 2019. Data are preliminary and may differ from local, state, or federal sources. Vaccinations administered outside the state of Nebraska or by federal partners (DOD, VA, IHS) are not included. Other vaccination data sources may use different population data to calculate rates.Therefore, vaccination rates here may be lower than rates posted on other sites.

Booster dose is administered when a person has completed their vaccine series and protection against against virus has decreased over time. According to CDC, individuals who recieved a Pfizer-BioNTech or Moderna vaccine the following populations are eligible for a booster shot at 6 months or more after their intial series ->65 yr age group,>18 yrs living in long-term care setting, underlying medical conditons, residents in high-risk settings.For individuals, who received Janssen vaccine, booster shots are recommmended for >18 yrs who were vaccinated two months ago. The heterologous vaccine use for Pfizer, Moderna and Janssen was authorized by FDA.

Questions & Answers

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Poll Results

Debrief

For our previous session:

What have you done, or do you hope to do, with this content?

For today's session:

Do you have questions or concerns that we can address?

Session Objectives

1. Recognize the long-term complications associated with COVID-19 infection.
2. Identify resources in your facility or community that can be leveraged to improve care for those with long-term complications.
3. Reflect on how their own cultural values and beliefs impact their engagement with COVID-19 prevention and control efforts.

Case Study

- A patient comes into your clinic complaining that they are tired and having trouble breathing.
- The patient is a migrant worker and non-English speaker who was diagnosed with COVID-19 ten weeks ago as part of an outbreak in the meatpacking facility where they work. They are unvaccinated and experienced mild symptoms during their initial infection.
- Prior to infection, the patient was healthy and regularly worked 10-12 hours/day. They are now worried that they can't work for as long as they used to and might lose their job.

Infection Prevention & Control- Long COVID

Presenters: Kelly Cawcutt, MD, MS ,FACP, FIDSA, FCCM

Medical Director of Medical Quality

Associate Medical Director of Infection Control & Hospital Epidemiology

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What Are Your First Thoughts?

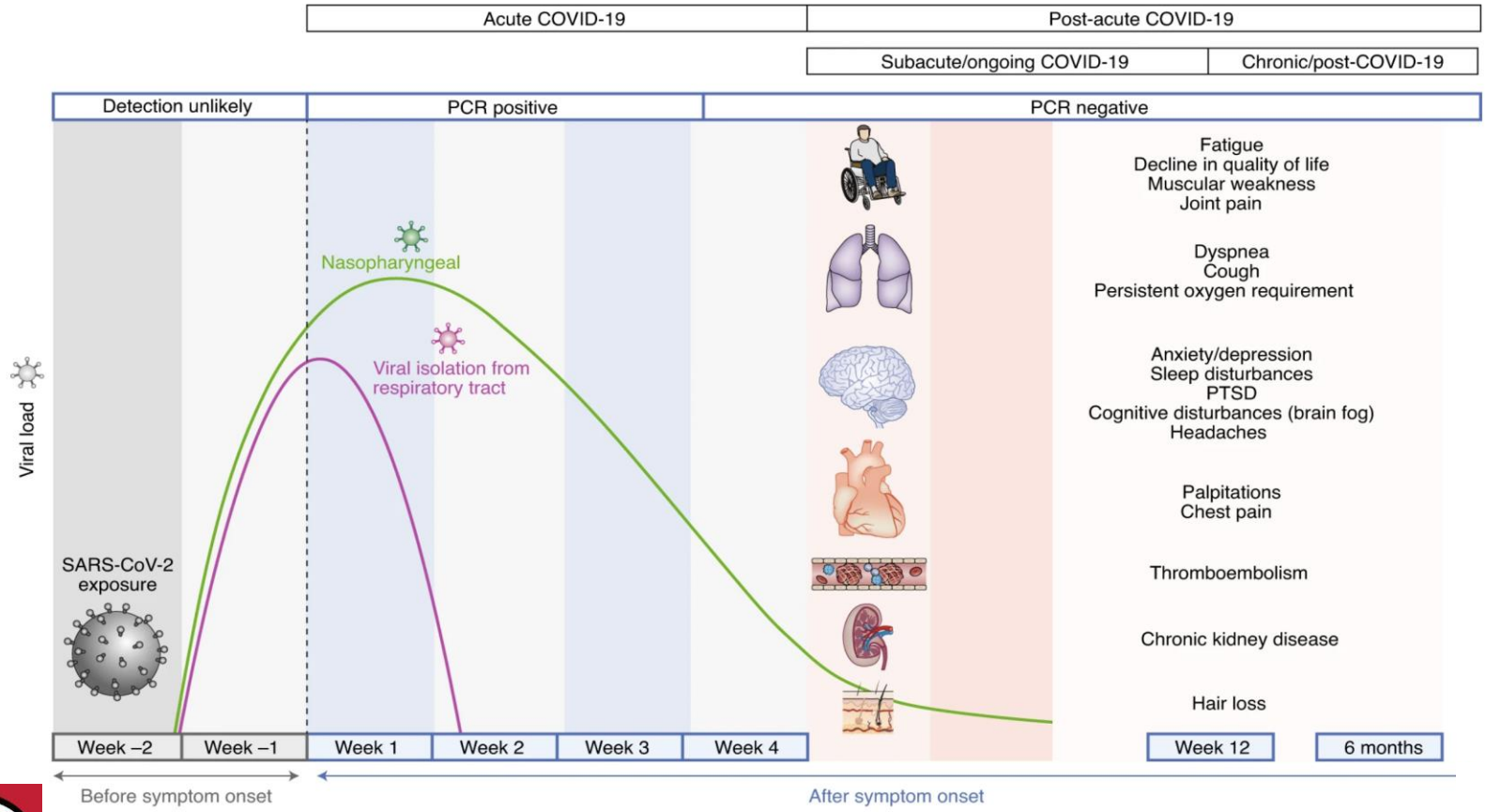
- Consider for a moment if you have an immediate reactions, opinions, or judgements
- How worried are you about these symptoms? What do you think they are?

What Is It?

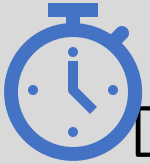
- Post-Viral Infection Syndrome
- Does not require severe acute COVID to develop
- Persistent & Prolonged Symptoms
- Multisystem pathophysiology
- Often requires multidisciplinary care

Fig. 1: Timeline of post-acute COVID-19.

From: Post-acute COVID-19 syndrome



Nalbandian, A., Sehgal, K., Gupta, A. *et al.* Post-acute COVID-19 syndrome. *Nat Med* **27,** 601–615 (2021).

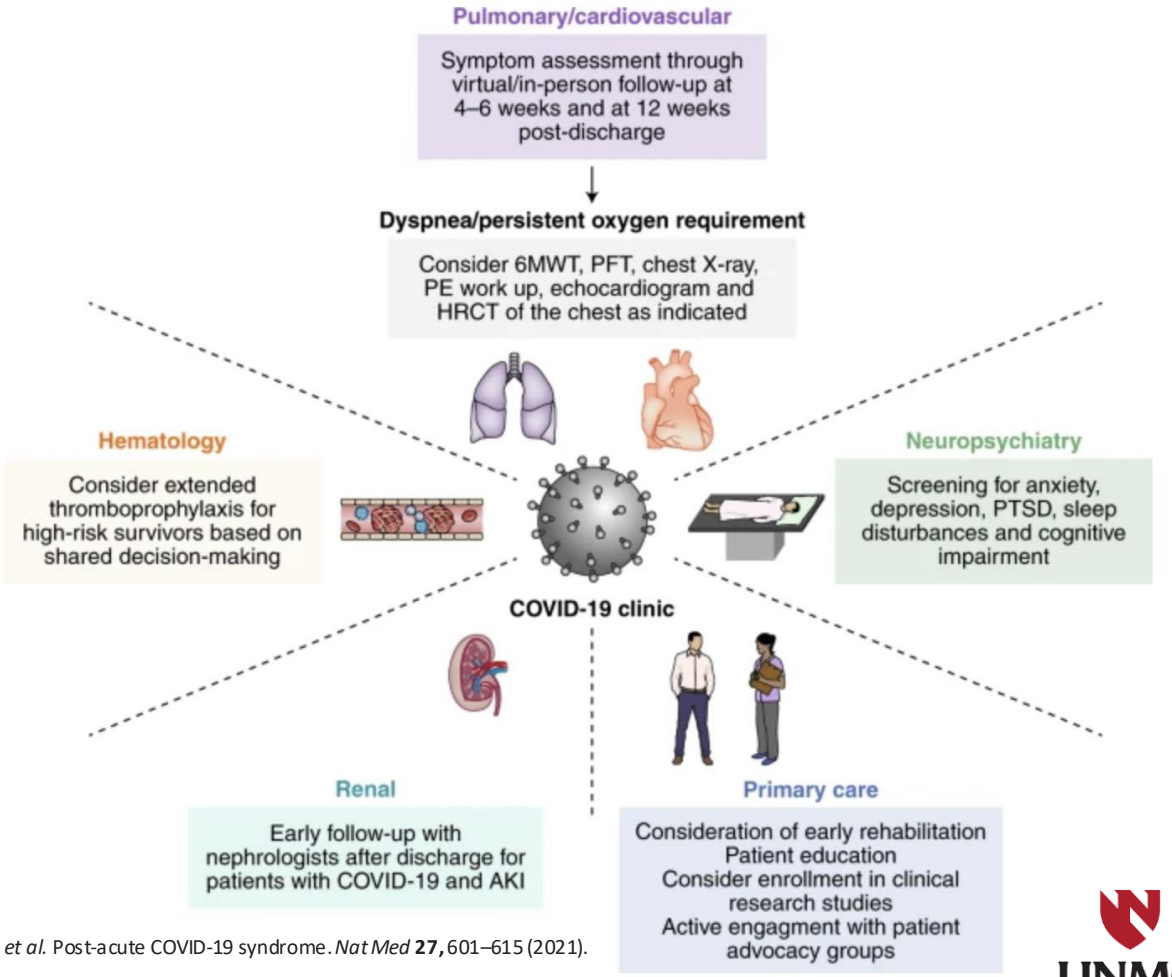


Duration of Symptoms

- Months of symptoms before improvement (6-9 months is not uncommon)

Treatment

Fig. 2: Interdisciplinary management in COVID-19 clinics.



Nalbandian, A., Sehgal, K., Gupta, A. *et al.* Post-acute COVID-19 syndrome. *Nat Med* **27,** 601–615 (2021).

Access to Care

- Equity and access to post-covid care may be limited for many reasons
  - Lack of recognition from patients and healthcare workers alike may prevent appropriate evaluation and care
  - Access to specialists with experience may be very limited geographically
  - Costs of care and insurance coverage may prevent access

Guidance on “Long COVID” as a Disability Under the ADA, Section 504, and Section 1557

Although many people with COVID-19 get better within weeks, some people continue to experience symptoms that can last months after first being infected, or may have new or recurring symptoms at a later time.[1] This can happen to anyone who has had COVID-19, even if the initial illness was mild. People with this condition are sometimes called “long-haulers.” This condition is known as “long COVID.”[2]

In light of the rise of long COVID as a persistent and significant health issue, the Office for Civil Rights of the Department of Health and Human Services and the Civil Rights Division of the Department of Justice have joined together to provide this guidance.

This guidance explains that long COVID can be a disability under Titles II (state and local government) and III (public accommodations) of the Americans with Disabilities Act (ADA),[3] Section 504 of the Rehabilitation Act of 1973 (Section 504),[4] and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557).[5] Each of these federal laws protects people with disabilities from

https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/guidance-long-covid-disability/index.html#footnote10_0ac8mdc

Prevent Long COVID By Preventing Acute COVID

Do the best you can until you know better. Then when you know better, do better."

— Maya Angelou

Tweet

Monica Verduzco-Gutierrez, MD @MVGutierrezMD · 20h

Patient with #LongCOVID said she was seen in a specialists office & they told her they never heard of #longCOVID 😭

This is the worst. How are persons supposed to get good care? We must educate. Please tell me you know about this, #medtwitter?

28 63 363

Key Take-Aways

- Recognize that Long COVID exists & is common
- Many, and any, organ system can be impacted
- You do not need severe disease acutely to have long COVID
- We need to normalize this for patients, educate our healthcare teams, and access resources and care as able for these patients
- We must recognize our own risk of biased beliefs

Resources & References (ES entered, can delete)

- https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html
- https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/guidance-long-covid-disability/index.html#footnote10_0ac8mdc
- Davis, Hannah E., et al. "Characterizing long COVID in an international cohort: 7 months of symptoms and their impact." *Available at SSRN 3820561* (2021).
- Nalbandian, A., Sehgal, K., Gupta, A. *et al.* Post-acute COVID-19 syndrome. *Nat Med* **27,** 601–615 (2021). https://doi.org/10.1038/s41591-021-01283-z

Cultural Sensitivity: Cultural Values and Attitudes

Presenters: Mahelet Kebede, MPH

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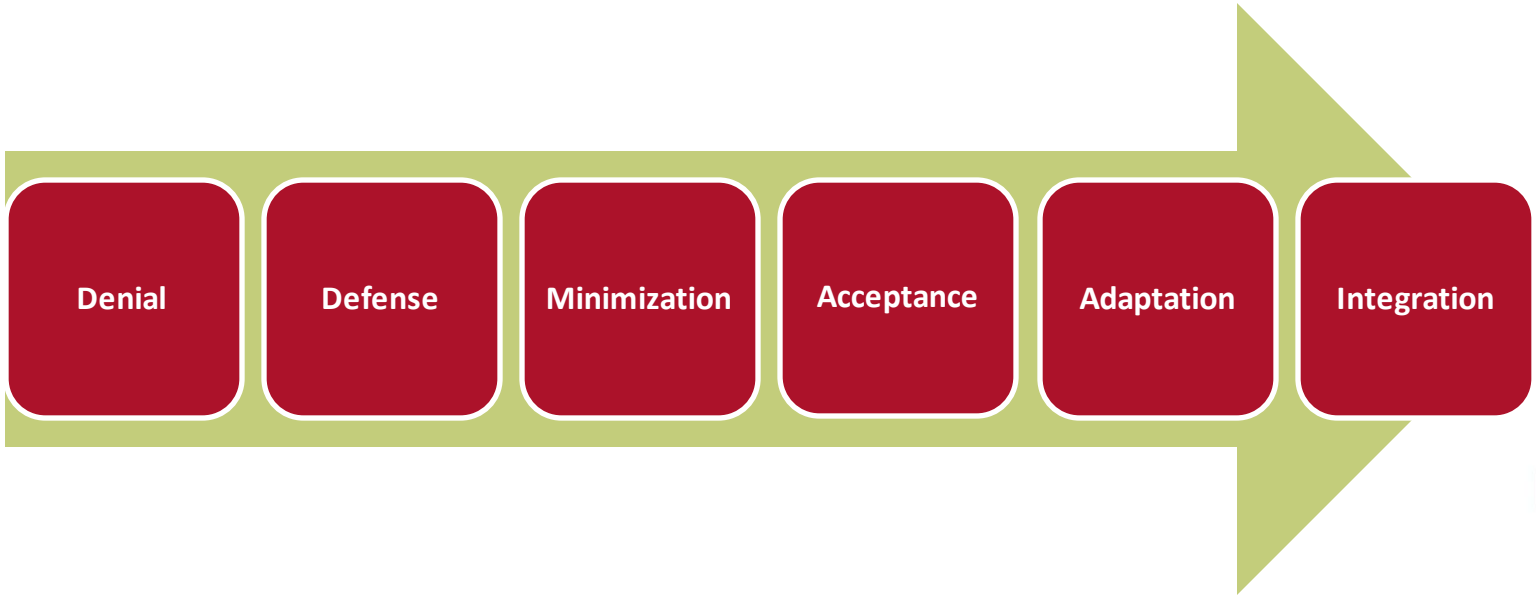
Cultural Sensitivity Stages

Milton Bennett's Framework to understand various stages of cultural sensitivity



CS Stages

Denial

People don’t recognize cultural differences and experience. They believe their culture is the only “real” one and they tend to interact in homogenous groups and to stereotype everyone else.

Defense

People recognize some differences but see them as negative because they assume their culture is the most evolved, the best one.

CS Stages (cont.)

Minimization

Individuals are unaware that they are projecting their own cultural values. They see their own values as superior. They think that the mere awareness of cultural differences is enough.

Acceptance

People can shift perspectives to understand that the same “ordinary” behavior can have different meanings in different cultures. They may not agree or even like the differences they observe but they are interested in finding out and learning about another culture.

CS Stages (cont.)

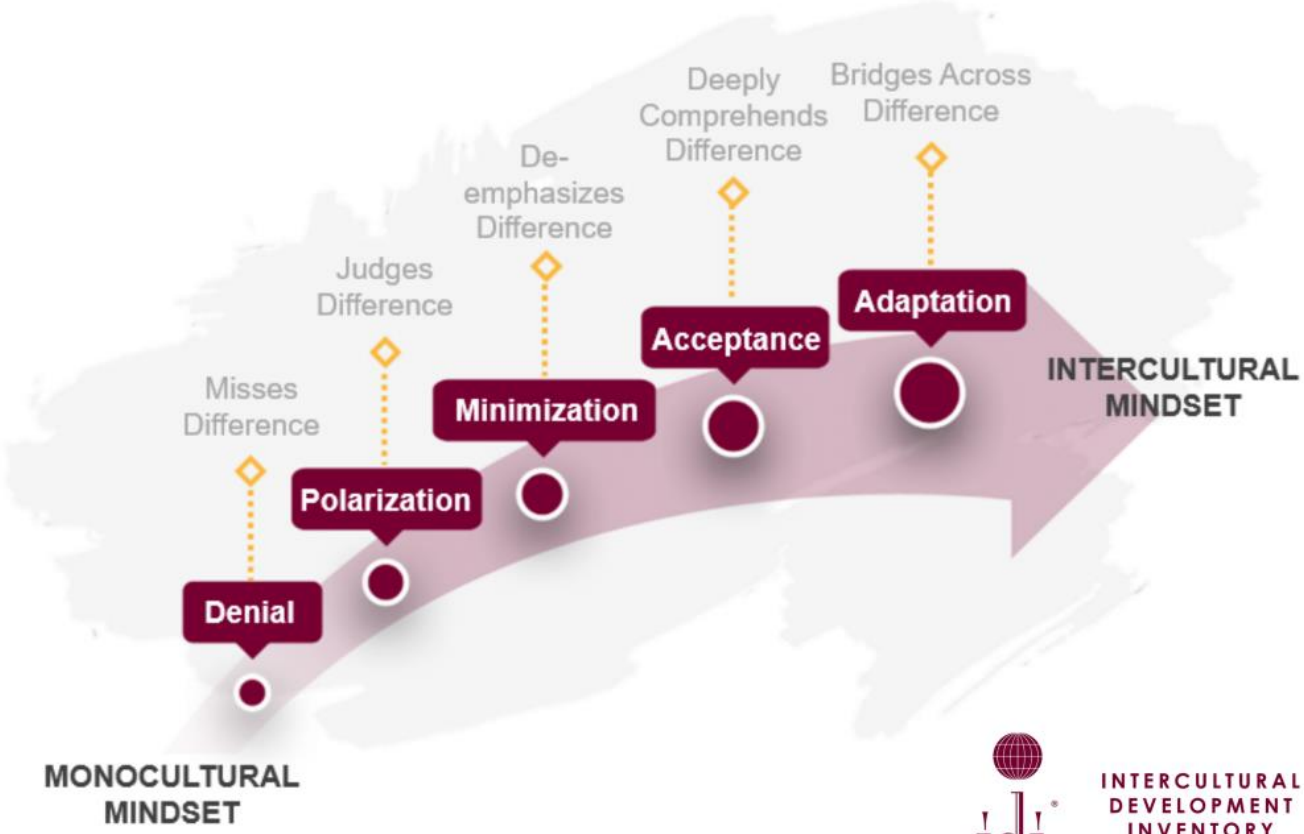
Adaptation

Individuals become more competent in their ability to communicate with other cultures. They can evaluate other people's behavior from these people's frame of reference and can adapt behavior to fit the norms of a different culture.

Integration

People who are at this stage of cultural sensitivity can shift easily from one cultural frame of reference to another. They develop empathy for other cultures.

Intercultural Development Continuum (IDC™)



INTERCULTURAL DEVELOPMENT INVENTORY

Call to Action

Reflect

Do the values and/or beliefs of your institution reflect the values of the diverse population you serve?

What can you do to instill the diverse values or beliefs of the population you serve in the work you do at your facility?

Case Study

Case Study

- A patient comes into your clinic complaining that they are tired and having trouble breathing.
- The patient is a migrant worker and non-English speaker who was diagnosed with COVID-19 ten weeks ago as part of an outbreak in the meatpacking facility where they work. They are unvaccinated and experienced mild symptoms during their initial infection.
- Prior to infection, the patient was healthy and regularly worked 10-12 hours/day. They are now worried that they can't work for as long as they used to and might lose their job.

Discussion

1. Has your thinking about this case changed during our session today? If so, how?
2. What systems-level barriers might be impacting this patient?
3. What cultural considerations might be relevant to this encounter?

POLL

Wrap-Up

1. You will receive today's presentation, in addition to a one-page key-takeaways document and next session's agenda through email.

2. Next session will be on January 19th on *"**Infection Prevention & Control Risk Assessments, and Cultural Sensitivity: Different Forms of Racism (i.e., Structural, Medical, Interpersonal, etc.)"***.

3. If you'd like to share a case with us, kindly send it by Monday, January 17th.

Poll Results

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Thank You