UNMC[SM]

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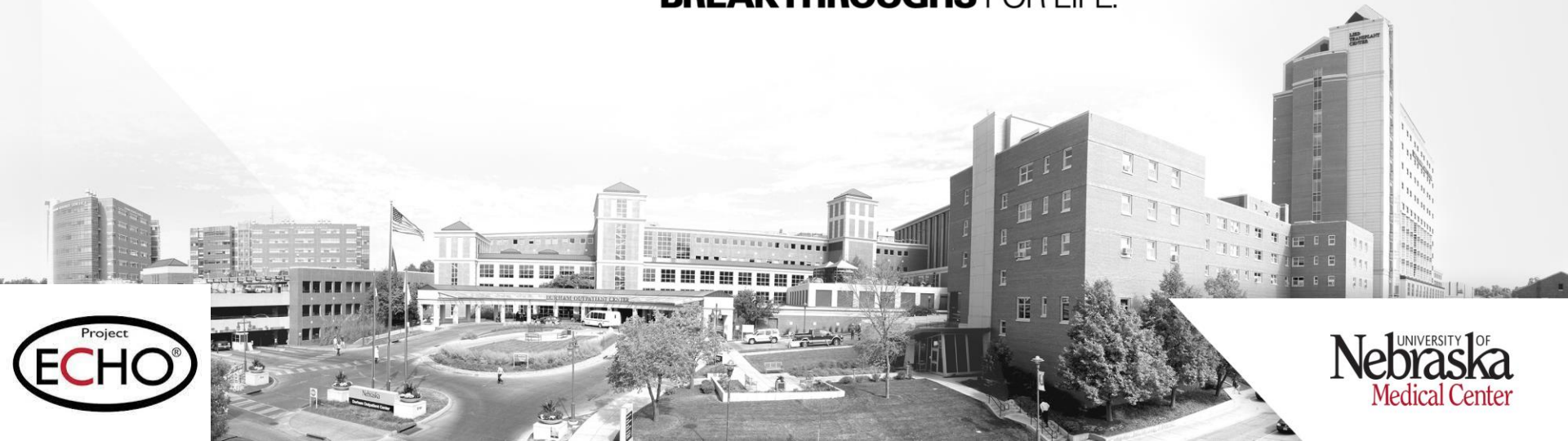


Project ECHO®

University of Nebraska Medical Center

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

Welcome to Session 25

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

Reminders

- Each healthcare organization is eligible to apply for **up to $2000 expense reimbursement**

- All the session presentation are available on our website

- 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.

https://www.unmc.edu/intmed/divisions/id/echo/health-equity/index.html

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, EdD
- Samantha Jones, Program Manager
- Dan Cramer, NP

CE Disclosures

Project ECHO®

UNMC

UNMC ID Health Equity and Quality Improvement ECHO Project

Topics:
HE Recap
IPC: Setting Up an Employee Health Program - COVID-19

Free Live ECHO Project
November 2, 2022
CID 57617

University of Nebraska Medical Center

TARGET AUDIENCE

This accredited continuing education 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:

- Describe key health equity concepts covered over the course of this ECHO Program.
- Discuss how COVID-19 vaccination status impacts employee health in health care settings
- Identify how best practices for isolation and precaution have evolved since the onset of COVID-19
- Describe how best practices in COVID-19 safety and prevention can mitigate the risk of transmission among health care employees

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. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive 1.5 general continuing education credits. Social work level of content: **Advanced**

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: I00052645 Approval Number: 220003492
To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE DECLARATION

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
The below faculty have nothing to disclose:

- Mahelet Kebede, MPH*
- Jasmine Marcelin, MD
- Richard Starlin, MD

*Faculty and Planning Committee member

Disclosures

PLANNING COMMITEE

M. Salman Ashraf, MBBS
Merck & Co, Inc: Industry funded research/investigator

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

The below planning committee members have nothing to disclose:

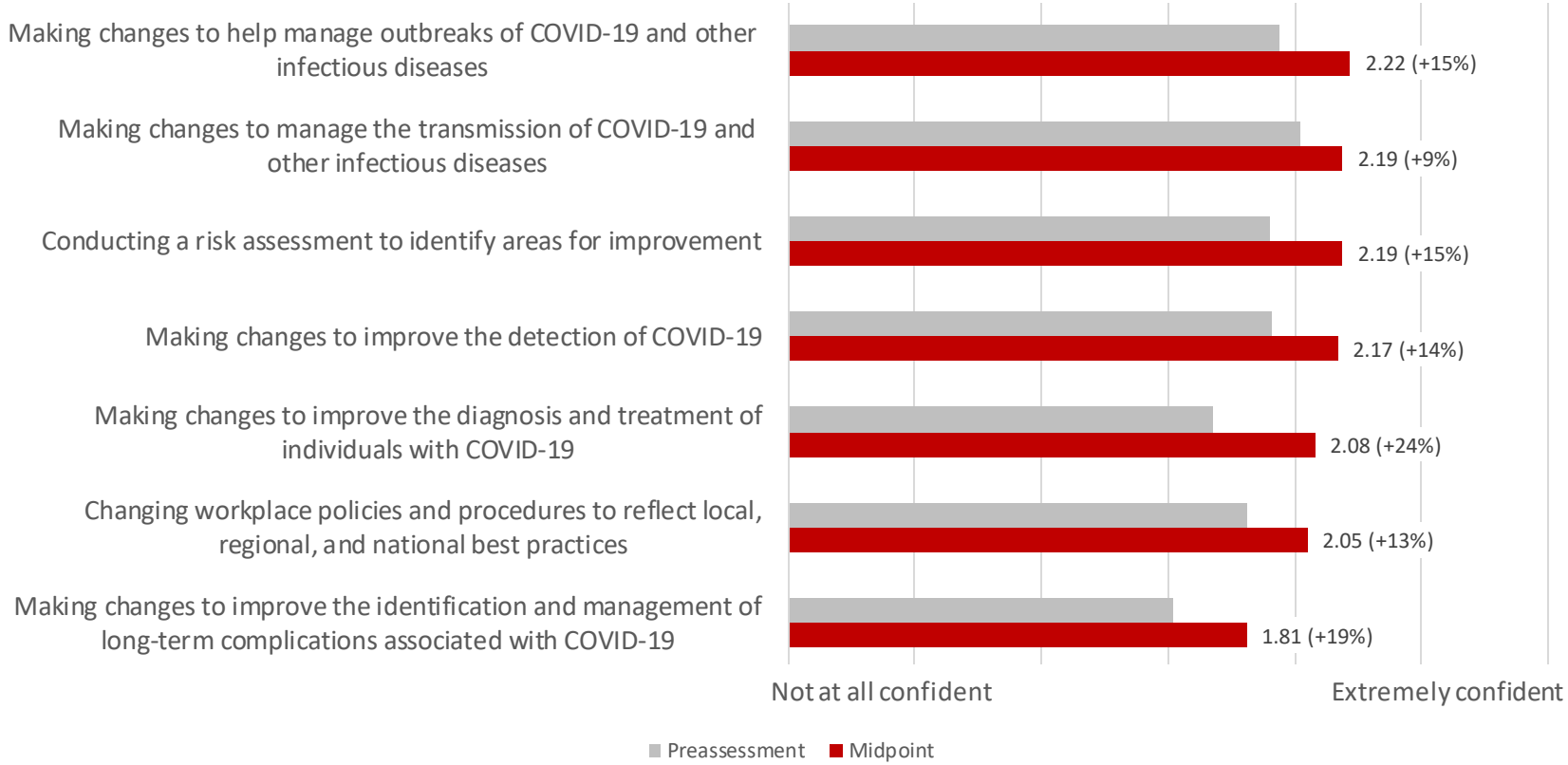
- Valeta Creason-Wahl, HMCC
- Precious Davis, MSN, BSN, RN
- Nada Fadul, MD
- Samantha Jones, CSW
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Jeff Wetherhold, M. Ed
- Bailey Wrenn, MA

www.unmc.edu/cce

POLL

Midpoint Evaluation

Infection Prevention and Control Competencies



Participant Interviews

- 30-45 minutes each
- Focused on how you hope to apply what you are learning to your work
- Helps us improve program content

Schedule an interview:

Poll Results

Health Equity Recap Session

Presenters: Dr. Jasmine Marcelin, Mahelet Kebede, MPH

Objective

- Describe key health equity concepts covered over the course of this ECHO Program

HE Topics

1. Foundational understanding: Session 1, November 3
2. Historical context: Session 4, December 15
3. Different forms of racism: Session 6, January 19
4. SDOH: Sessions 8 – 13, starting February 16
5. Communicating HE/emotional intelligence: Session 18, July 20
6. Organizational considerations to advance HE: Session 20, August 17
7. Utilizing data to assess health disparities: Sessions 21 – 22, starting September 7

Disparity vs. Equity

BOTH = reflection of systematic issues

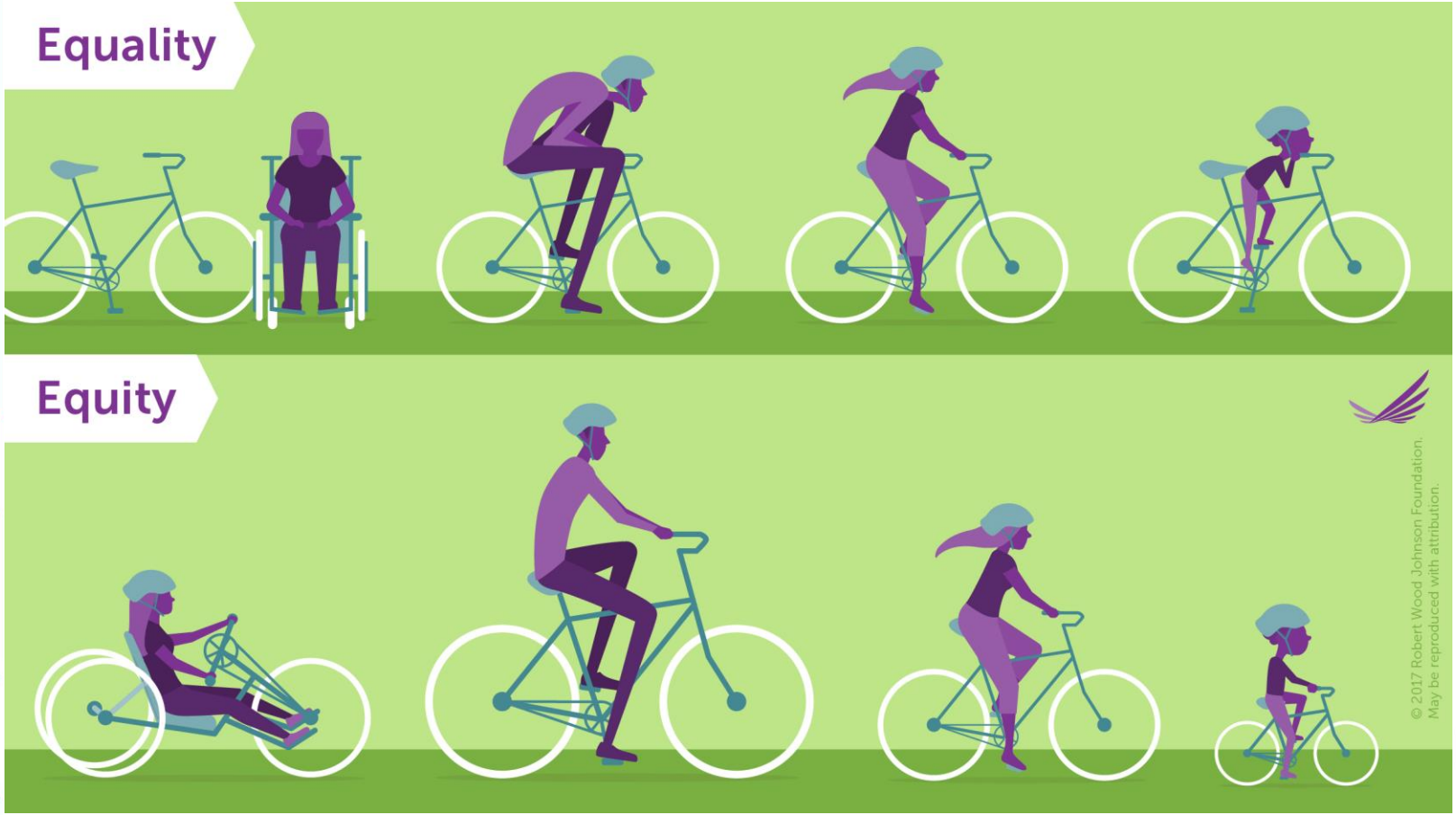
Health Equity

A *destination*

Health Disparity

Health *difference*

Graphic Source: Misty McPhetridge, BSSW


Equality
Equity
© 2017 Robert Wood Johnson Foundation.
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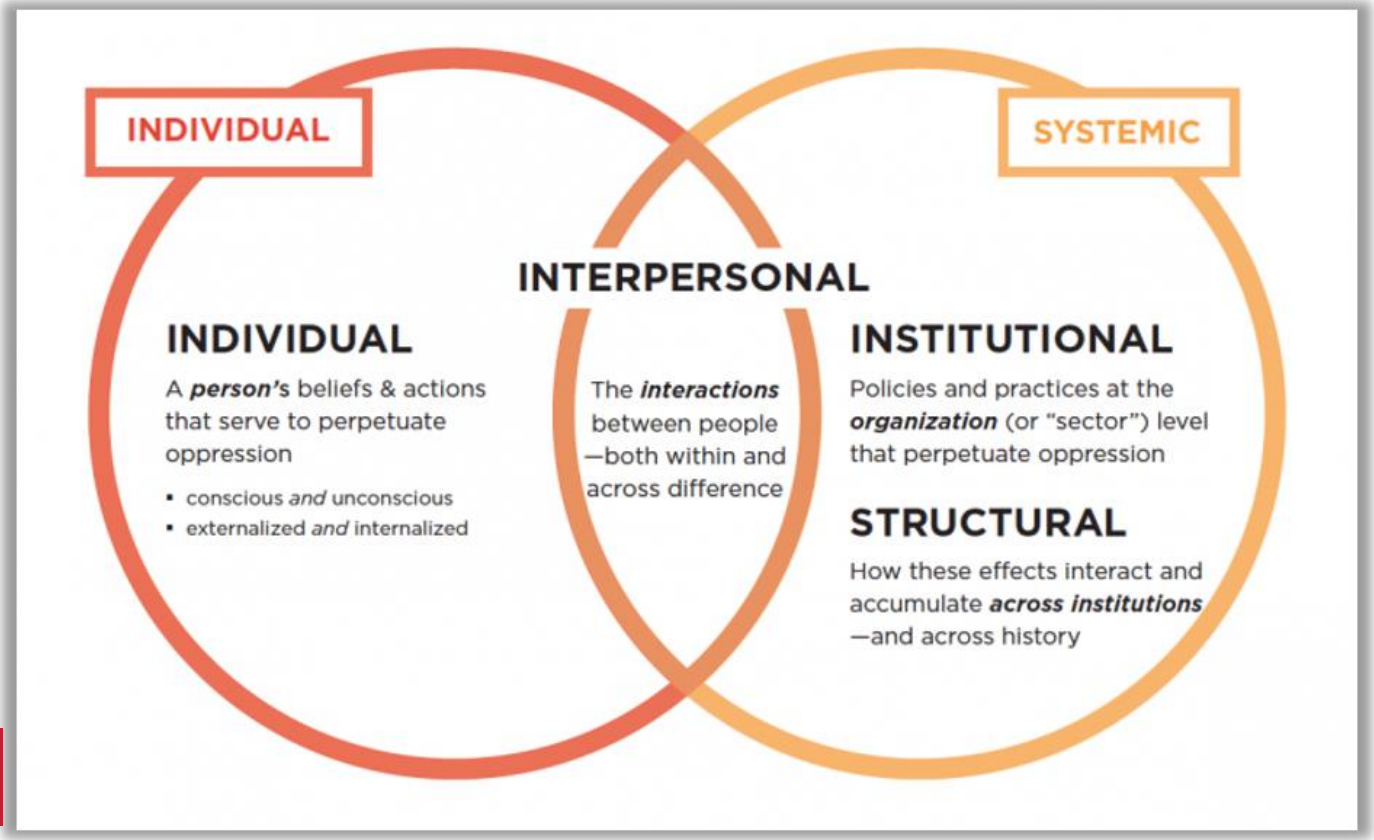
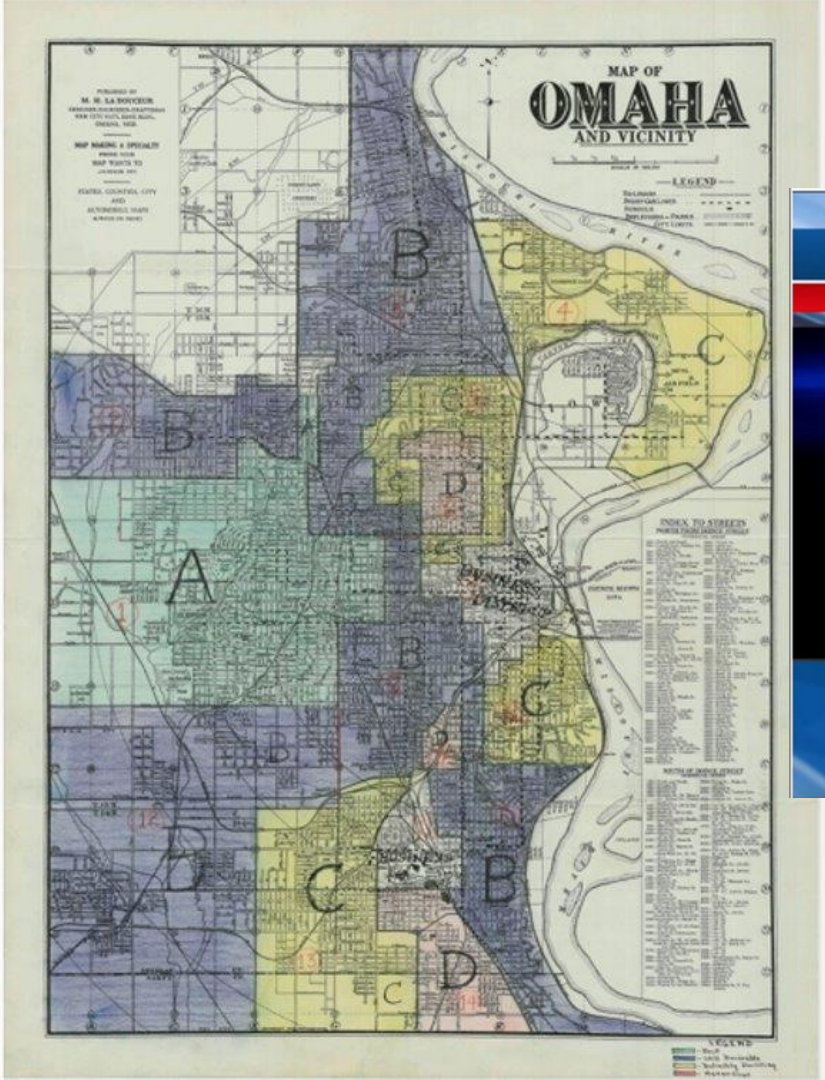
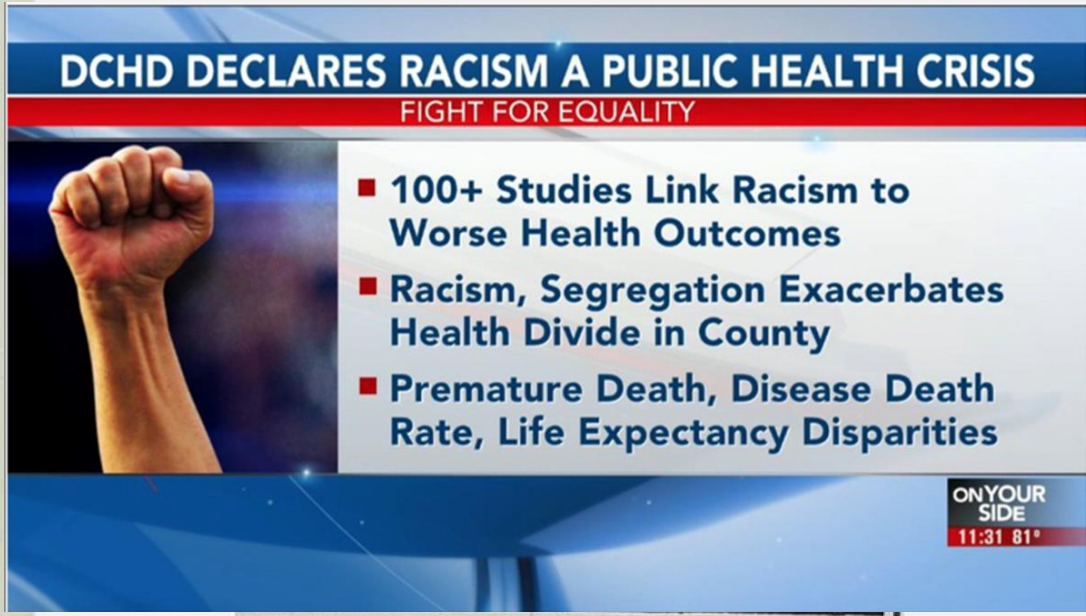
Redlining

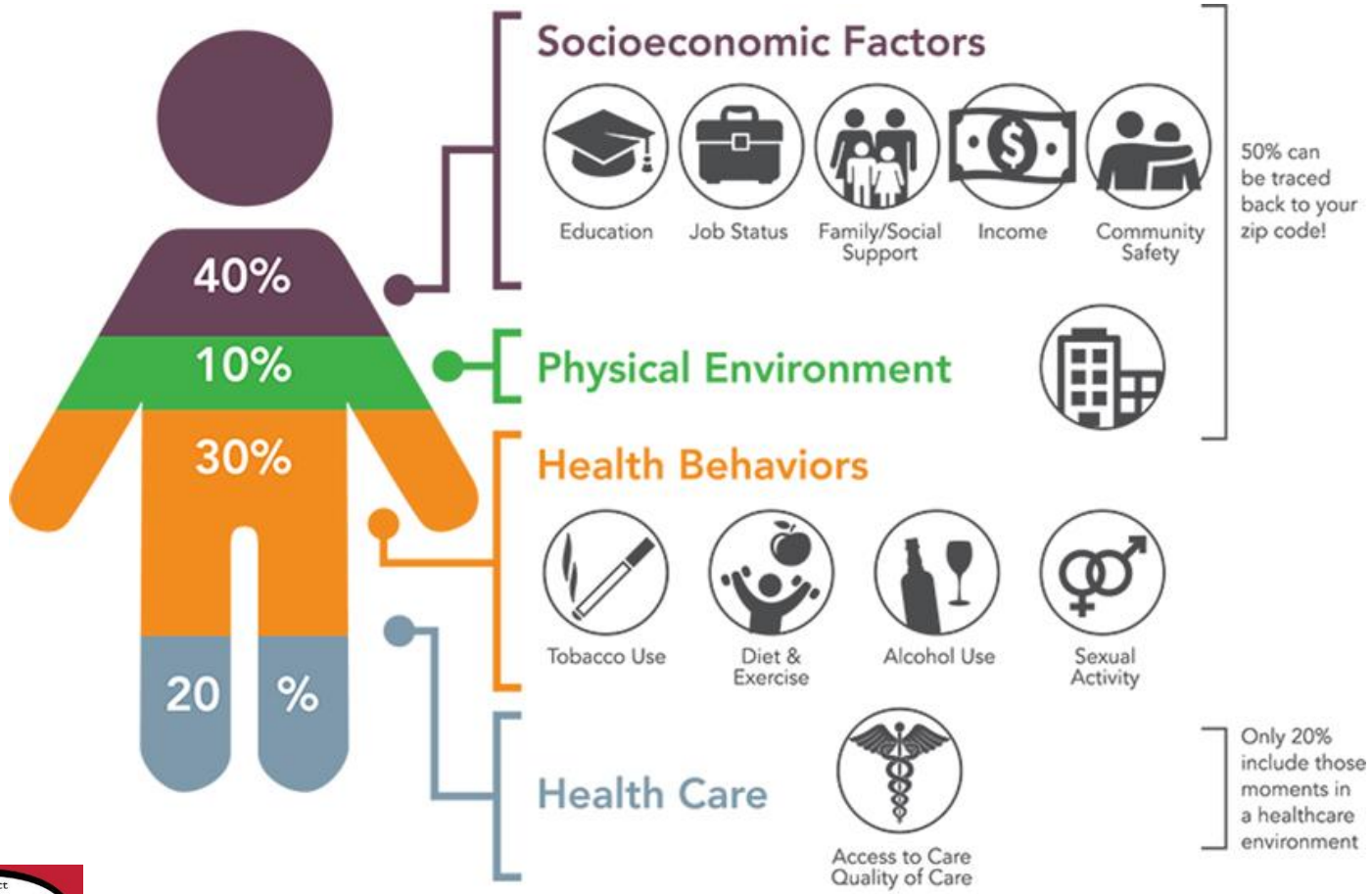
Forms of Racism




MAP OF
OMAHA
AND VICINITY
LEGEND
INDEX TO STREETS


DCHD DECLARES RACISM A PUBLIC HEALTH CRISIS
FIGHT FOR EQUALITY
100+ Studies Link Racism to Worse Health Outcomes
Racism, Segregation Exacerbates Health Divide in County
Premature Death, Disease Death Rate, Life Expectancy Disparities
ON YOUR SIDE
11:31 81°

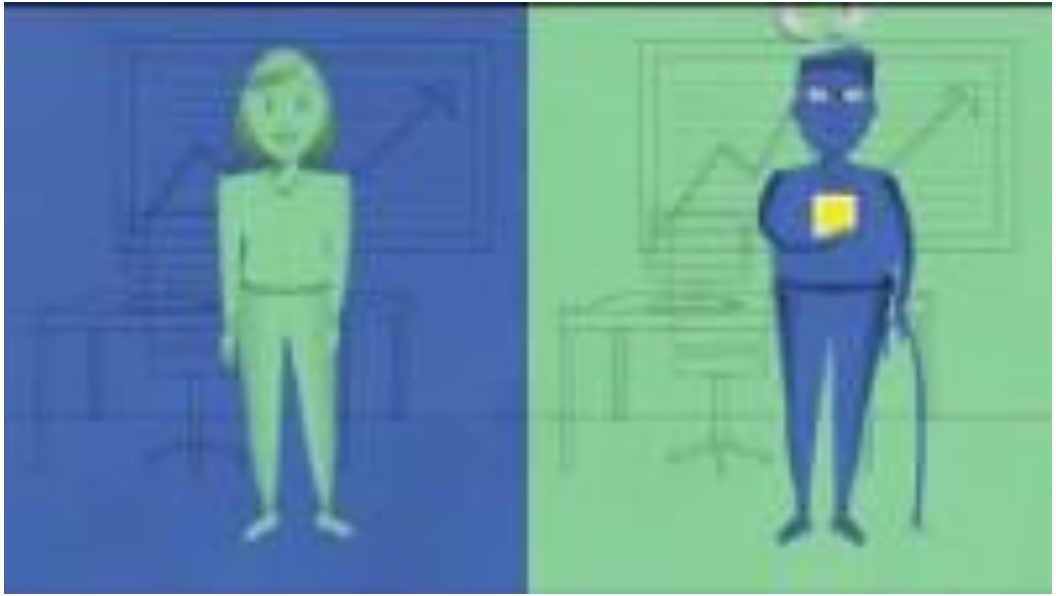

LEGEND
- Best
- Still Desirable
- Definitely Declining
- Hazardous



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Guess Which Determinant…?

Intersectionality



Health Equity Communications Concepts

- Systemic social and health inequities
- Community engagement
- Intersectional
- Recognize and reflect the diversity of the community
- Literacy, especially health literacy

Source: CDC'S Health Equity Guiding Principles for Inclusive Communication

Which HE Communication Concept is This?

Using active verbs, plain language (4th grade reading level), and accessible channels and formats.

Avoid implying that a person or community is responsible for increased risk of adverse outcomes.


Innovation


Teamwork


Excellence


Accountability


Courage


Healing

Be Extraordinary Together					
Curiosity Level of Listening	Behavioral Styles Appreciation Filters	Blue Chips	Accountability	Assume Positive Intent	Gratitude Be Here Now

Zero Harm					
Clarifying Questions SBAR Technique	Structured Hand-offs	Know Why & Comply Validated and Verify	Self-check Using STAR	Speak Up with CUS	Peer Check

Equity					
Blind Spots Biases	Dimensions of Diversity	Inclusion	Motivated Awareness	Inclusive Integrity	Cultural Humility

Energy

Mood Elevator

At Your Best

Slide by Ada Wilson, JD

Disparities Data

Examples of additional data sets can include, but are not limited to:

- Race, ethnicity and language
- Clinical data from all affiliated and unaffiliated providers, including social needs data.
- ???

What are additional examples of disparities data?

Assessing Data

Investigate patterns in health disparities with queries.

PROCESS query example (treatment, procedure, encounter):

- Percentage of patients with chronic health conditions who filled prescriptions/written prescriptions, by ZIP code.

*What is an **OUTCOMES** query example?*

COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities

COVID-19 Inequities

Many social, political and environmental factors• affect community health and contribute to adverse health outcomes, social inequities, and health inequities. The COVID-19 pandemic has further exacerbated existing inequities, with many people suffering from chronic illnesses and other conditions that increase their risk to severe illness. In addition, the lack of investment in addressing barriers to healthy and productive lives in marginalized communities leads to many other health and social consequences. Below are examples of some key interdependent drivers of disease inequities. A multi-sectoral approach is needed to reduce the impact of COVID-19 and other health issues among marginalized, vulnerable, and underserved communities.

Discriminatory Policies

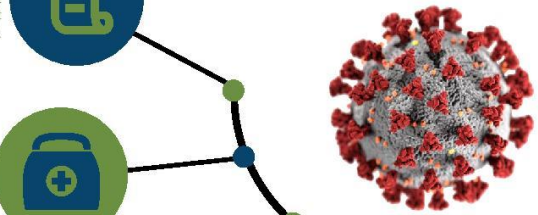
Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare[1].

Limited Access to Essential Services and Resources

Barriers towards health insurance, childcare, sick leave, paid leave, or access to PPE, among others, make some demographics more prone to COVID-19 inequities[2].

History of Racism & Social Discrimination

Systemic racism and other forms of social discrimination (e.g., xenophobia, gender discrimination, bias against the LGBTQI+ community) have contributed to discriminatory policies, limited investment in community well-being, lack of access to quality healthcare, and a poor sense of trust between communities and health and social systems[1, 3].



Poverty

For many people living in poverty, health is one of many priorities. Too many commitments, such as multiple jobs or concerns with access to food and shelter, make issues such as preventative health seem less urgent[9].

Overcrowded Living Conditions

Many groups live in overcrowded conditions such as: multi-generational homes or nursing homes, prisons, homeless shelters, or other kinds of group "homes." This can make it difficult to social distance and increase the risk for COVID-19. Of great importance are factors such as unemployment which can lead to homelessness, and therefore increased vulnerability to COVID-19[1, 4].

Chronic Stress

Continued stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications[5].

Low Health Literacy & Misinformation

Many people from ethnically and racially diverse communities as well as people of low SES didn't have the opportunity to develop skills to identify credible news sources, which has been shown to correlate with low health statuses[6].

Mistrust

Insufficient community engagement, combined with misinformation or a lack of consistent information as well as a history of discrimination, causes many marginalized communities to lack trust towards health and social services[7, 8].

1) CDC, 2020
2) Pew Research Center, 2020
3) Health Affairs, 2020
4) NY Times, 2020
5) NIMH, 2020
6) Harvard, 2020
7) L.C. Cooper and D.C. Crews, 2020
8) J. Jaiswal, C. LoSchiavo, and D. C. Perlman, 2020
9) CDC, 2020

https://www.healthequityinitiative.org/

HEI Health Equity Initiative
JOIN THE MOVEMENT

Infection Prevention & Control: COVID-19 Updates for Healthcare Personnel

Presenter: Richard Starlin, MD

Assistant Professor, Division of Infectious Diseases

Associate Medical Director Employee Health, Nebraska Medicine

Project ECHO

UNMC

Objectives

1. Discuss how COVID-19 vaccination status impacts employee health in health care settings

2. Identify how best practices for isolation and precaution have evolved since the onset of COVID-19

3. Describe how best practices in COVID-19 safety and prevention can mitigate the risk of transmission among health care employees

COVID Vaccination Benefits

- Vaccines available in the United States are safe and effective at protecting people from getting seriously ill, being hospitalized, and even dying
- Getting children and teens vaccinated against COVID-19 can help keep them from getting very sick if they do get COVID-19
- COVID-19 vaccines can offer added protection to people who had COVID-19, including protection against being hospitalized from a new infection, especially as variants continue to emerge
- As with vaccines for other diseases, people are protected best when they stay up to date with the recommended number of doses and boosters, when eligible

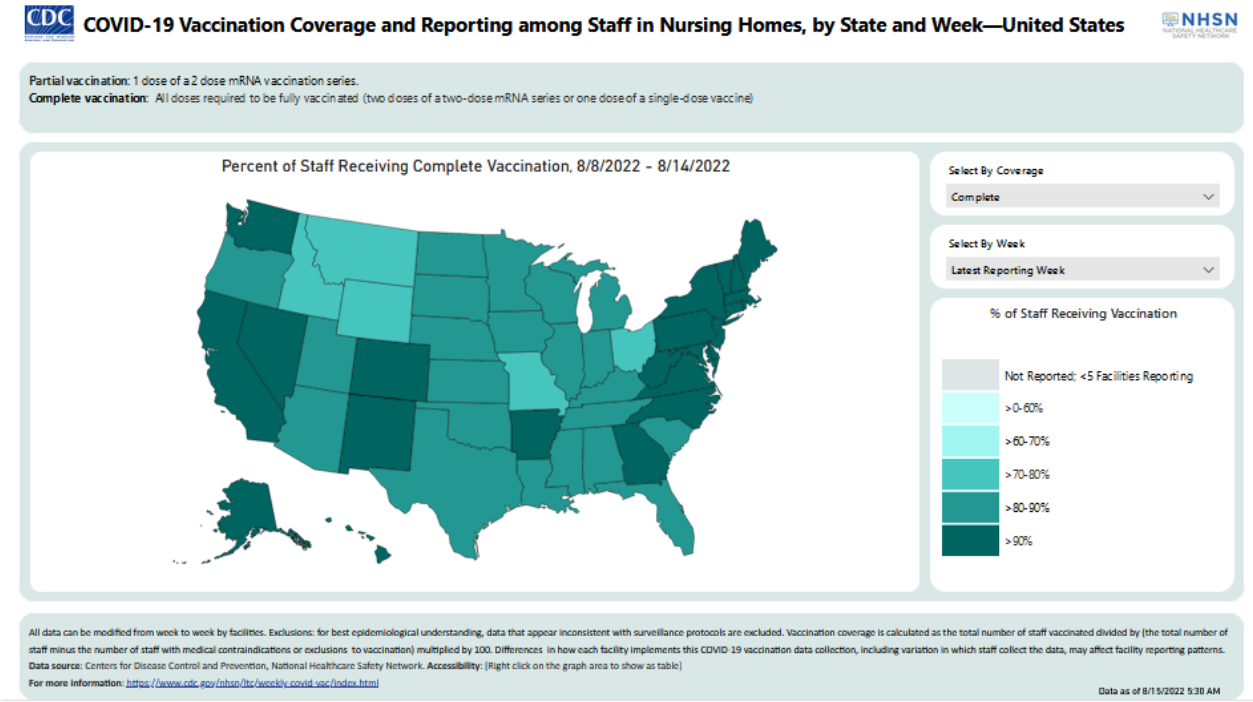
COVID Vaccination for HCPs

- Mandate for healthcare providers only includes primary series of vaccinations currently
- Disparities in COVID-19 vaccine uptake among health care workers-Primary series of vaccinations
    - https://doi.org/10.1016/j.vaccine.2022.03.045
    - Significant disparities in actual vaccination rates among different HCPs
    - Physicians and advanced practice staff were more likely to be vaccinated than nurses and support staff
    - Black HCWs had lower vaccination rates even after controlling for other factors

COVID Vaccination

- Complete primary series

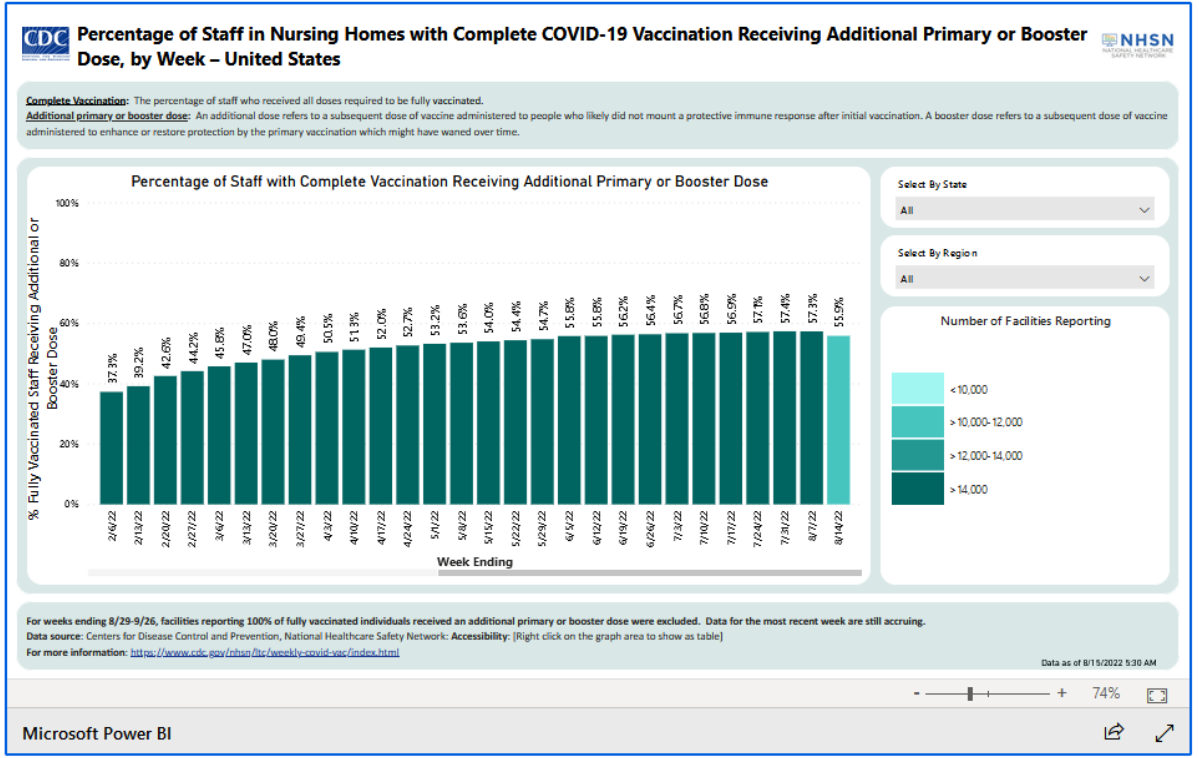
COVID-19 Vaccination Coverage and Reporting among Staff in Nursing Homes, by State and Week — United States



COVID Vaccination

- Healthcare Providers
  - Boosters

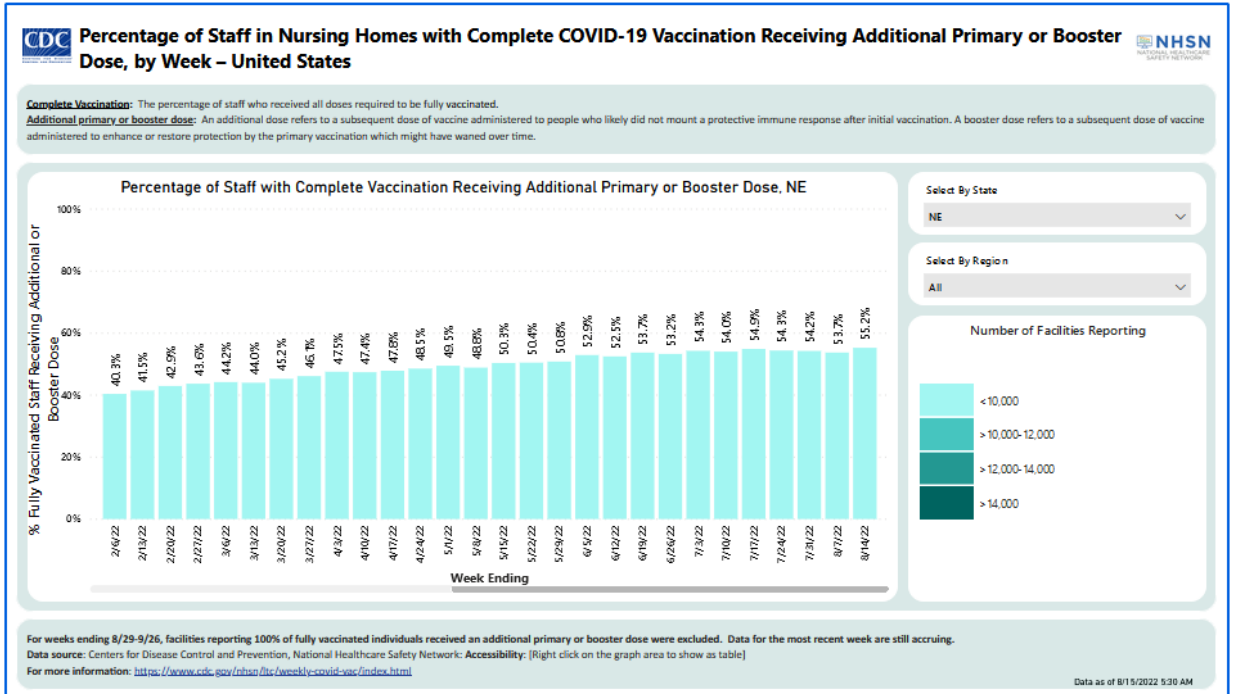
Percentage of Staff in Nursing Homes with Complete COVID-19 Vaccination Receiving Additional Primary or Booster Dose, by Week — United States



COVID Vaccination

- Healthcare Providers
  - Boosters - Nebraska

Percentage of Staff in Nursing Homes with Complete COVID-19 Vaccination Receiving Additional Primary or Booster Dose, by Week — United States



COVID Vaccination

- Healthcare Providers- why does it matter to be up to date?

Original Investigation | Infectious Diseases

August 2, 2022

Association of Receiving a Fourth Dose of the BNT162b Vaccine With SARS-CoV-2 Infection Among Health Care Workers in Israel

Matan J. Cohen, MD, PhD[1]; Yonatan Oster, MD[2]; Allon E. Moses, MD[2]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2022;5(8):e2224657. doi:10.1001/jamanetworkopen.2022.24657

COVID-19 Resource Center

COVID Vaccination

- Breakthrough COVID-19 infections in 4-dose recipients vs 3-dose recipients measured by a polymerase chain reaction test result positive for SARS-CoV-2. Health care workers were tested based on symptoms or exposure

- A total of 29 611 Israeli HCWs (19 381 [65%] female; mean [SD] age, 44 [12] years) had received 3 vaccine doses between August and September 2021; of these, 5331 (18%) received the fourth dose in January 2022 and were not infected by the first week after vaccination

COVID Vaccination

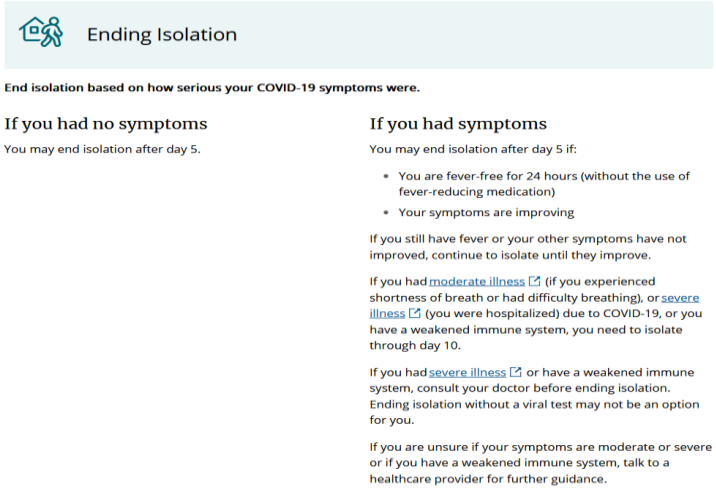
- Overall breakthrough infection rates were 368 of 5331 (7%) in the 4-dose group and 4802 of 24280 (20%) in the 3-dose group (relative risk, 0.35; 95% CI, 0.32-0.39)

- In both groups, no severe disease or death occurred

- Conclusion: In this cohort study, the fourth BNT162b2 vaccine dose resulted in a reduced breakthrough infection rate among hospital staff. This reduction was lower than that observed after the third dose; nevertheless, considering the high infectivity of the Omicron variant, which led to critical medical staff shortages, a fourth vaccine dose should be considered to mitigate the infection rate among HCWs

Isolation and Precautions for People with COVID-19

- If you test positive for COVID-19, stay home for at least 5 days and isolate from others in your home. You are likely most infectious during these first 5 days



Ending Isolation

End isolation based on how serious your COVID-19 symptoms were.

If you had no symptoms

You may end isolation after day 5.

If you had symptoms

You may end isolation after day 5 if:

- You are fever-free for 24 hours (without the use of fever-reducing medication)
- Your symptoms are improving

If you still have fever or your other symptoms have not improved, continue to isolate until they improve.

If you had moderate illness (if you experienced shortness of breath or had difficulty breathing), or severe illness (you were hospitalized) due to COVID-19, or you have a weakened immune system, you need to isolate through day 10.

If you had severe illness or have a weakened immune system, consult your doctor before ending isolation. Ending isolation without a viral test may not be an option for you.

If you are unsure if your symptoms are moderate or severe or if you have a weakened immune system, talk to a healthcare provider for further guidance.

- This information is intended for a general audience. Healthcare professionals should see Ending Isolation and Precautions for People with COVID-19

https://www.cdc.gov/coronavirus/2019-ncov/your-health/isolation.html

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

"Up to Date" with all recommended COVID-19 vaccine doses is defined in Stay Up to Date with Your Vaccines | CDC

For more details, including recommendations for healthcare personnel who are iimmunocompromised, have severe to critical illness, or are within 90 days of prior infection, 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
Up to Date and Not Up to Date	10 days OR 7 days with negative test†, if asymptomatic or mild to moderate illness (with improving symptoms)	5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)	No work restriction, with prioritization considerations (e.g., types of patients they care for)

Work Restrictions for Asymptomatic HCP with SARS-CoV-2 Exposures

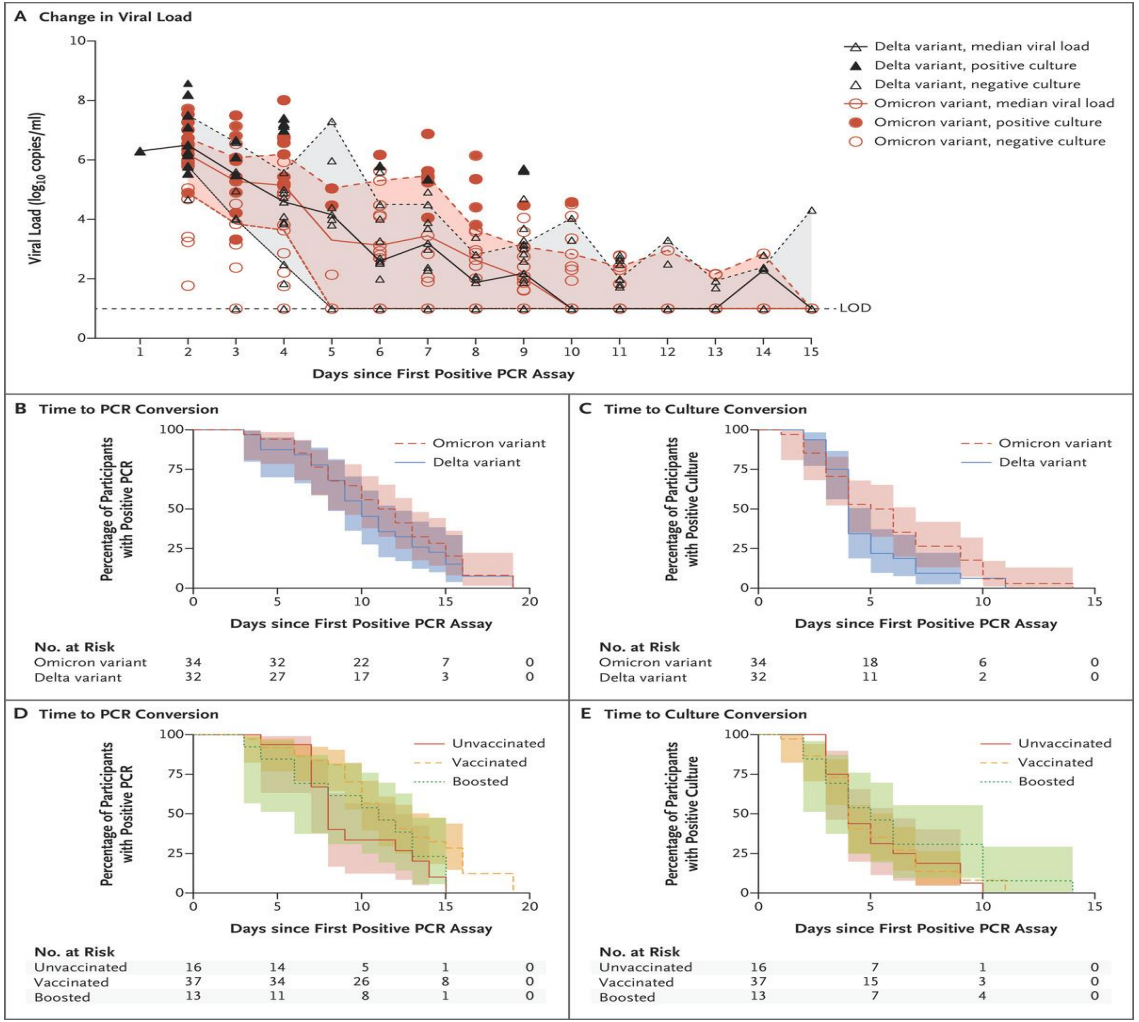
Vaccination Status	Conventional	Contingency	Crisis
Up to Date	No work restrictions, with negative test on days 1‡ and 5–7	No work restriction	No work restriction
Not Up to Date	10 days OR 7 days with negative test†	No work restriction with negative tests on days 1‡, 2, 3, & 5–7 (if shortage of tests prioritize Day 1 to 2 and 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

Duration of Shedding of Culturable Virus in SARS-CoV-2 Omicron (BA.1) Infection

- The viral decay kinetics of the omicron variant and the duration of shedding of culturable virus have not been well characterized
- Longitudinal sampling of nasal swabs for determination of viral load, sequencing, and viral culture in outpatients with newly diagnosed coronavirus disease 2019
- 66 participants, including 32 with samples that were sequenced and identified as the B.1.617.2 (delta) variant and 34 with samples that were sequenced and identified as the omicron subvariant BA.1, inclusive of sub lineages
- In this longitudinal cohort of participants, most of whom had symptomatic, no severe Covid-19 infection, the viral decay kinetics were similar with omicron infection and delta infection
- Although vaccination has been shown to reduce the incidence of infection and the severity of disease, they did not find large differences in the median duration of viral shedding
- data suggest that some persons who are infected with the omicron and delta SARS-CoV-2 variants shed culturable virus more than 5 days after symptom onset or an initial positive test



Boucau et al. N Engl J Med 2022;387:275-2

RAT and Leaving Isolation

JAMA Network Open

Research Letter | Infectious Diseases

Duration of Symptoms and Association With Positive Home Rapid Antigen Test Results After Infection With SARS-CoV-2

Lisa A. Cosimi, MD; Christina Kelly, MS; Samantha Esposito, MSc; Scott Seitz, PhD; Jacquelyn Turcinovic, BS; John H. Connor, PhD; Deborah Hung, MD, PhD

Introduction

Current US Centers for Disease Control and Prevention COVID-19 guidance for nonimmunocompromised individuals allows ending isolation after 5 days if the individual is asymptomatic or afebrile with improving symptoms.[1] Culturable virus, currently the best proxy for transmissibility, is reported after day 5.[2] It has been proposed that rapid antigen tests (RATs) might assist in determining isolation periods. However, while RATs correlate with culture positivity during early infection,[3,4] there are minimal data after day 5, when persistent RAT positivity has been reported.[5,6] We sought to compare rates of RAT positivity, COVID-19 symptoms, and positive viral culture starting day 6 after a COVID-19 diagnosis.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Duration of Symptoms and Association With Positive Home Rapid Antigen Test Results After Infection With SARS-CoV-2

- Starting on day 6, individuals newly testing positive tests for SARS-CoV-2 completed an online demographic survey, daily symptom logs, and RAT self-testing. Day 0 was the day of positive SARS-CoV-2 test or symptom onset, whichever came first
- On day-6, anterior nasal and separate oral swabs were collected from a convenience sample of 17 individuals (42.5%) for viral culture
- 40 individuals enrolled, 36 (90.0%) had received a primary vaccine series and first booster dose
- Omicron variant vastly predominant at this time

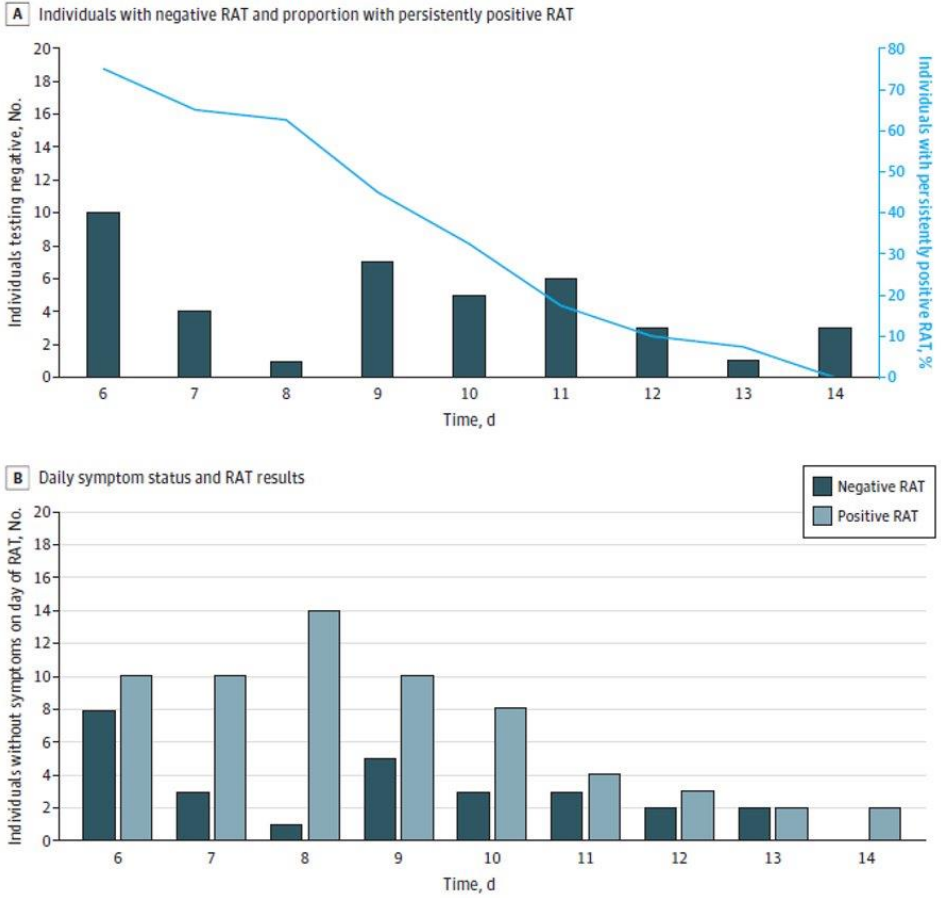
Duration of Symptoms and Association With Positive Home Rapid Antigen Test Results After Infection With SARS-CoV-2

- Only 10 participants (25.0%) had a negative RAT result on day 6, and all had negative results by day 14
- There were no correlations between day of first negative RAT result and age, time since last vaccine, or cycle threshold value at diagnosis
- Seventeen individuals were tested for viral culture on day 6, 12 of whom also had a positive RAT result. Of the 12, 6 had positive culture results (5 anterior nasal and 1 oral)
- Of the 6 individuals with positive cultures, 2 reported improving symptoms and 2 reported unchanged symptoms, whereas 2 never reported symptoms. Seven of the 9 reporting no symptoms on day 6 (78%) had negative culture results.

Duration of Symptoms and Association With Positive Home Rapid Antigen Test Results After Infection With SARS-CoV-2

- On day 6
  - 75% continued to have positive RAT
  - 35% had culturable virus
  - Everyone with a negative day-6 RAT result had a negative viral culture
  - 50% of those with a positive RAT result had culturable virus
- These data suggest that a negative RAT result in individuals with residual symptoms could provide reassurance about ending isolation
- However, a universal requirement of a negative RAT result may unduly extend isolation for those who are no longer infectious
- Meanwhile, a recommendation to end isolation based solely on the presence of improving symptoms risks releasing culture-positive, potentially infectious individuals prematurely

Figure. Rapid Antigen Test (RAT) and Viral Culture Results



Take Homes

- SARS CoV-2 is not gone. We need to have policies for HCPs around it.
- Experts predict a COVID surge later this fall, but many expects it will not be as significant as prior years. However, history has shown predicting the COVID pandemic has proven extremely difficult.
- Develop and follow a strategy around COVID for HCPs that is based on science and data.
- Strongly encourage vaccination as the best means to protect work force from COVID infection and complications.
- COVID shedding can persist for days, even after clinical improvement. The impact on transmission is unclear, but assume transmission is still possible.
- Do not forget about Influenza vaccine as well...

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- Duration of Shedding of Culturable Virus in SARS-CoV-2 Omicron (BA.1) Infection. July 21, 2022. N Engl J Med 2022; 387:275-277. DOI: 10.1056/NEJMc2202092
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Discussion

Discussion Questions

1. How are environmental services (EVS) roles structurally different from clinical and/or administrative roles in your facility?

2. How might these structural factors impact EVS staff members' ability to adhere to best practices for COVID-19:
    - Isolation and precaution
    - Transmission and safety
    - Vaccination

3. What SDOH considerations might help to mitigate the impact of those structural barriers to adherence?

Current State of COVID-19 in Nebraska

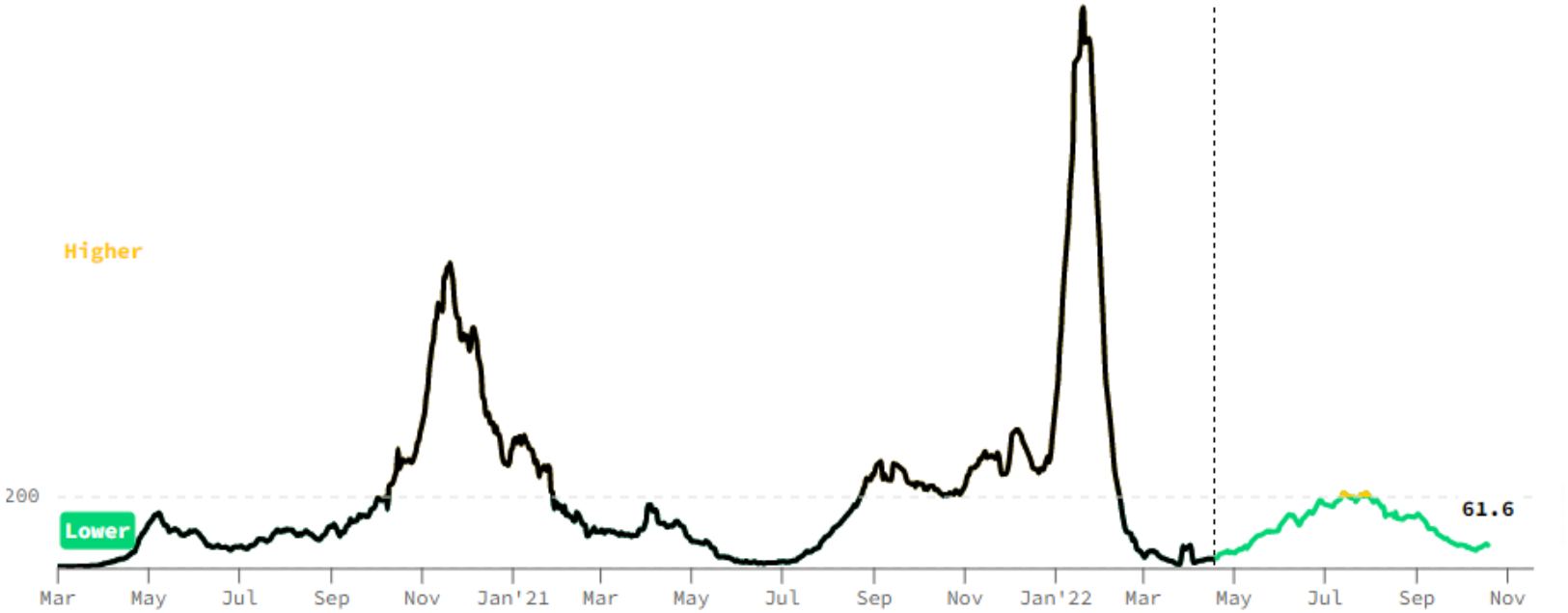
Project ECHO®

UNMC

Nebraska COVID-19 Statistics

Community risk level metrics

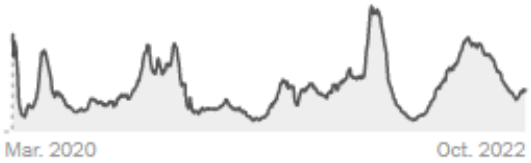
WEEKLY NEW REPORTED CASES	WEEKLY COVID ADMISSIONS	PATIENTS W/ COVID
61.6 PER 100K	6.0 PER 100K	3.9% OF ALL BEDS



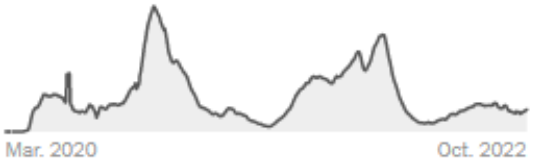
https://covidactnow.org/us/nebraska-ne/?s=41312879

Nebraska COVID-19 Statistics

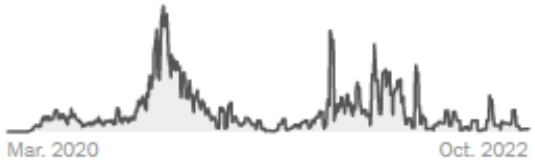
Test positivity rate



Hospitalized



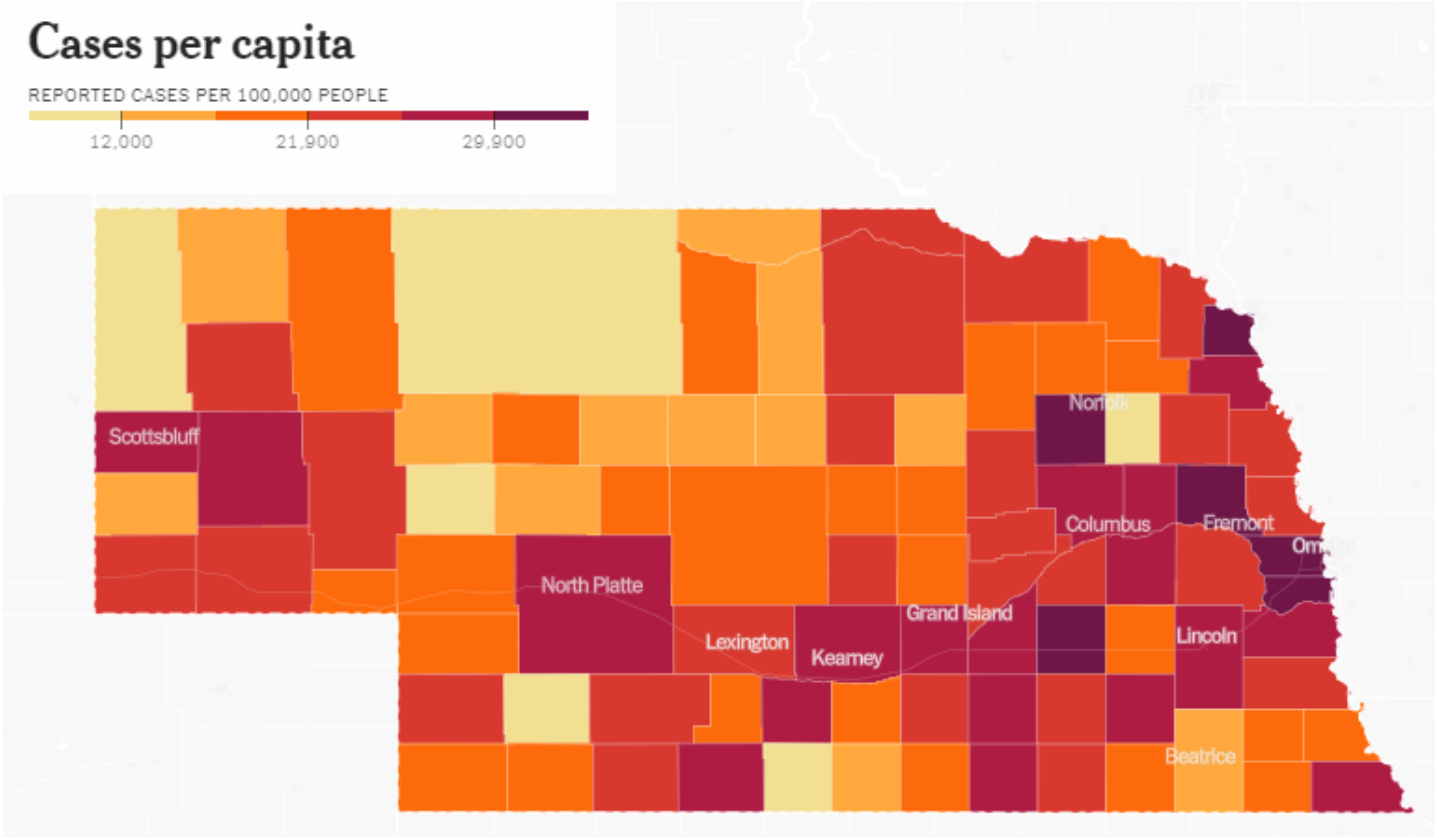
Deaths



	DAILY AVG. ON OCT. 30	PER 100,000	14-DAY CHANGE
Cases	179	9	+19%
Test positivity	13%	—	—
Hospitalized	177	9	+12%
In I.C.U.s	23	1	+33%
Deaths	<1	<1	+33%

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

Nebraska COVID-19 Statistics



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

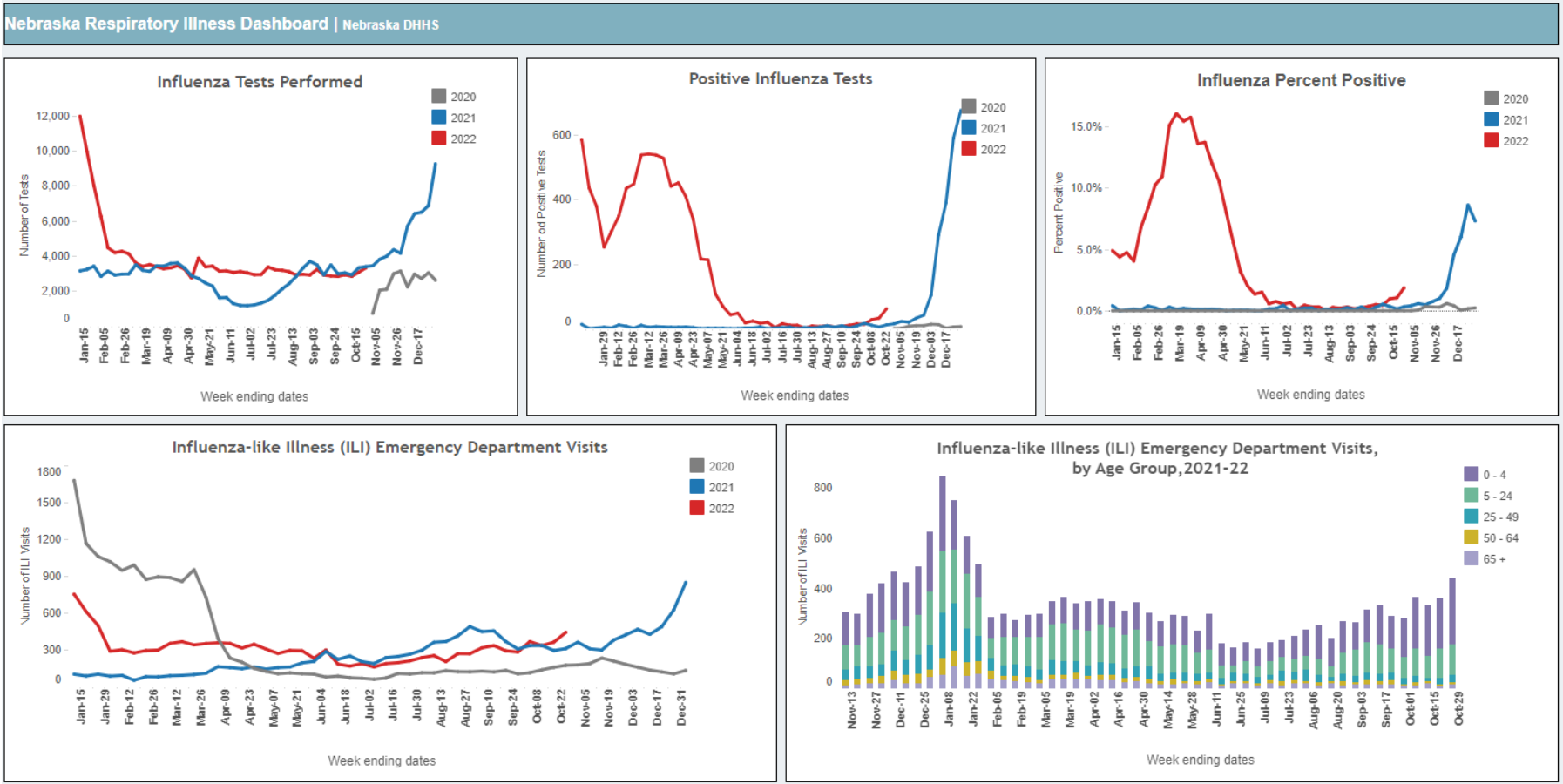
Nebraska COVID-19 Statistics

Week	Weekly Cases*	Weekly Admits*	COVID-19 Hospitalizations	% COVID Hospitalizations
10/5/22	63.3	6.3	175	3.4%
10/19/22	54.3	4.4	160	3.1%
11/2/22	61.6	6.0	177	3.9%

*Per 100,000. [1]Percent of entire state population vaccinated. [2]Source prior to June 2022 was NE DHHS, % based on age 5y+. June/July. [3]Source for June 2022 -present: COVID Act Now & NYTimes based on entire state population.

https://covidactnow.org/us/nebraska-ne/?s=24951410
https://www.nytimes.com/interactive/2020/us/covid-19-vaccine-doses.html

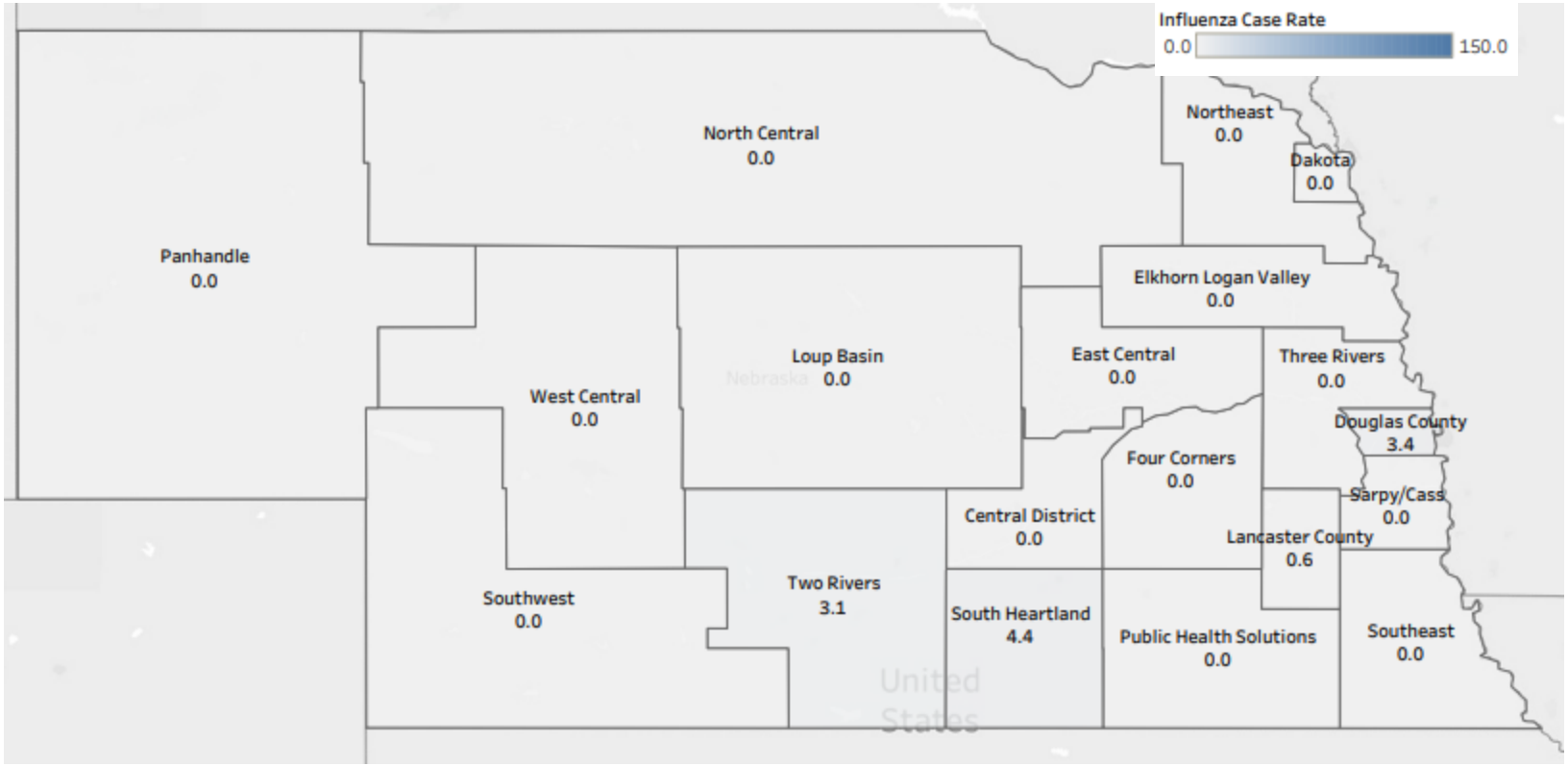
Nebraska Influenza Statistics



https://atlas-dhhs.ne.gov/Atlas/Respiratory_Illness

Nebraska Influenza Statistics

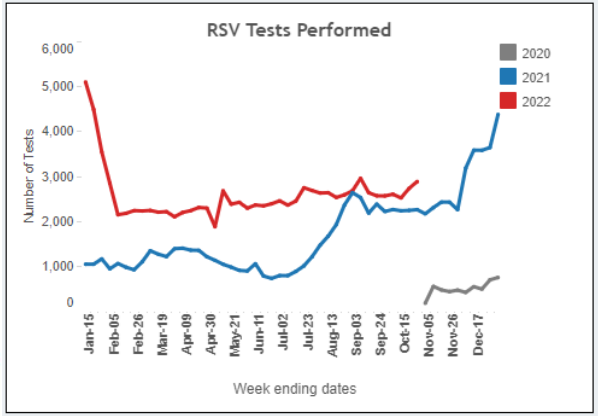
Influenza Case Rate per 100,000 by Local Health Department per Week 41

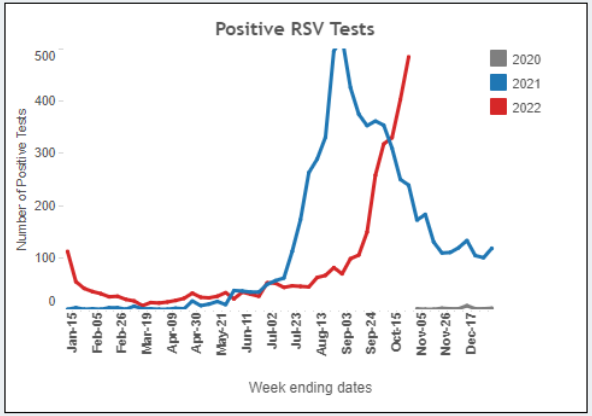


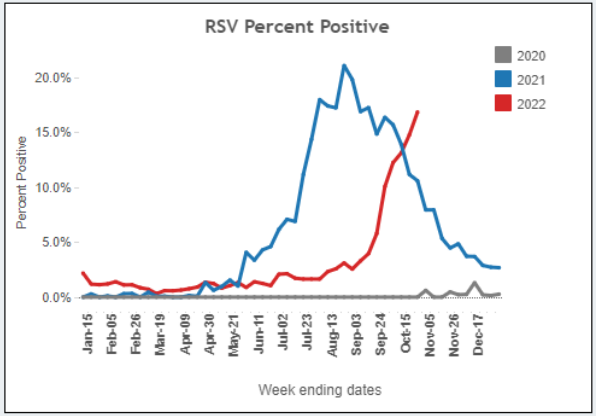
https://dhhs.ne.gov/Flu%20Documents/Report.pdf

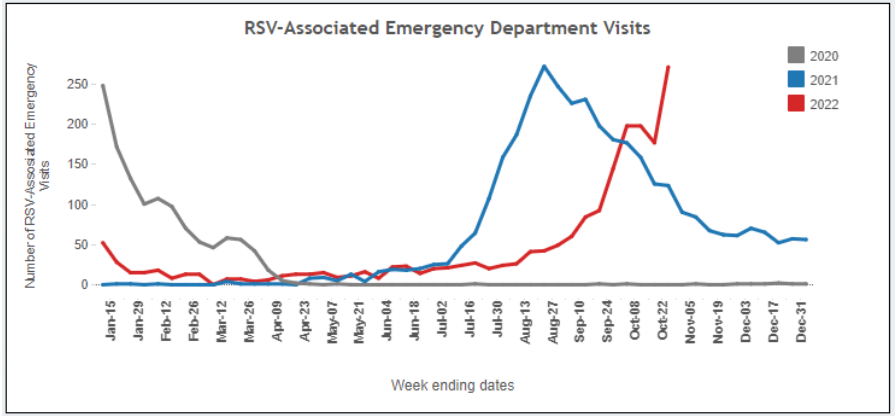
Nebraska RSV Statistics

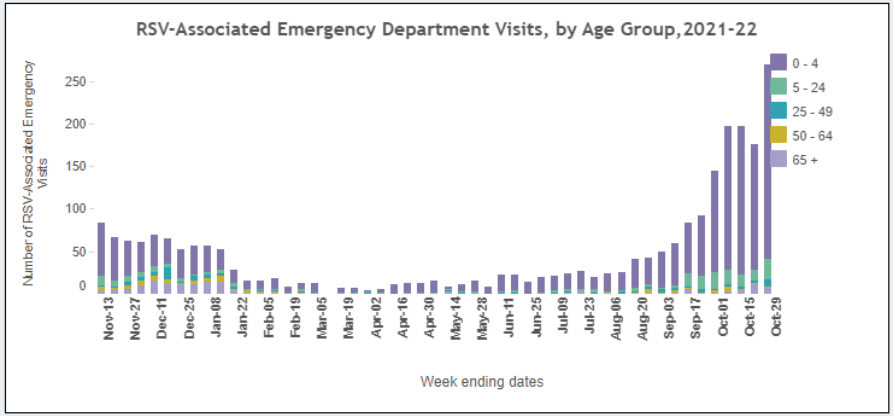
Nebraska Respiratory Illness Dashboard | Nebraska DHHS







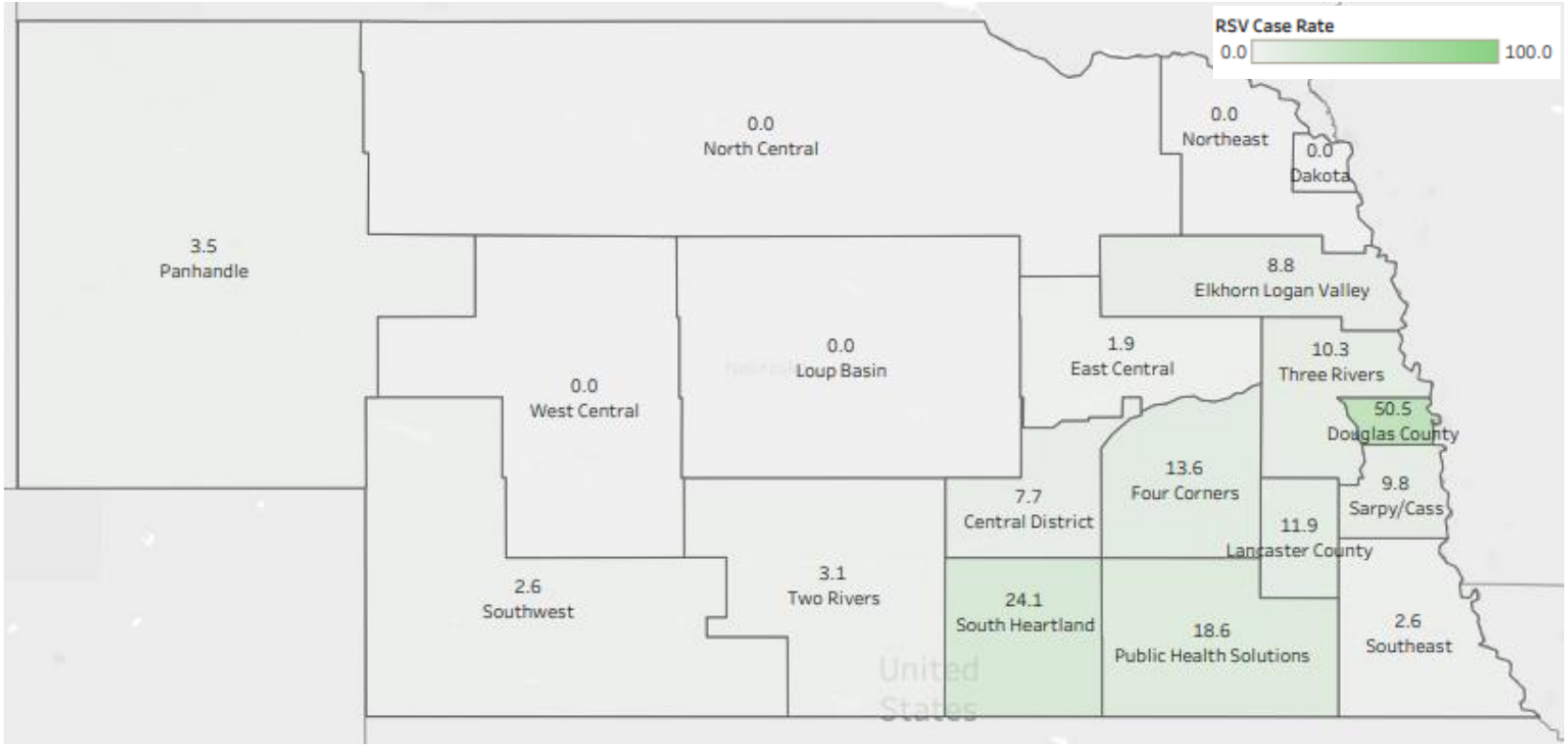




https://atlas-dhhs.ne.gov/Atlas/Respiratory_Illness

Nebraska RSV Statistics

RSV Case Rate per 100,000 by Local Health Department per Week 41



https://dhhs.ne.gov/Flu%20Documents/Report.pdf

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 **November 16th** on:

- Cultural Sensitivity: ***Sexual Orientation***
- Quality Improvement: ***How can you facilitate discussions about change?***

Poll Results

Thank You!