# CMO REPORT

FROM THE DESK OF
**Amy Tucker, MD**, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

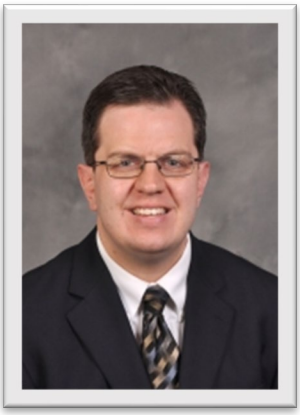
UPSTATE UNIVERSITY HOSPITAL

**July 18, 2022**

## COVID Update

| # Positive | # ICU | # Vent |
|---|---|---|
| 15 | 1 | 0 |

## Dr. Christopher Tanski Appointed as Associate Chief Medical Officer for Transfer Triage and Throughput



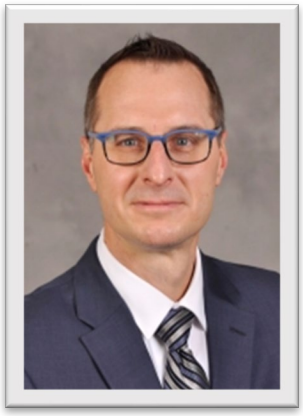
We are delighted to announce Dr. Christopher Tanski, an Emergency Medicine physician at Upstate, has been appointed as Associate Chief Medical Officer for Transfer, Triage and Throughput.

In this position, Dr. Tanski will continue medical oversight of the transfer center and work on initiatives related to throughput in all its forms. He will be responsible for working with the Clinical Operations Team to optimize movement of patients in, through and out of our healthcare system. Dr. Tanski will work closely with nursing and physician leadership across the institution to ensure we are able to provide timely care to all of the patients in our region.

Upstate has already made strides to positively impact throughput, including areas such as the Discharge Hospitality Center, TeleTracking, discharge pilot projects, revision of telemetry criteria, reviewing transfer processes, and also focused efforts on challenging patient discharges. Dr. Tanski will support those efforts and identify additional ways to ensure patients move through our healthcare system efficiently and safely. He will continue in his role as medical director of the ECLS service as well as seeing patients in our emergency departments.

Please join us in welcoming Dr. Tanski to his new role!

## Dr. Jeffrey Albright Appointed as Interim Director of Surgical Services



We are pleased to share that Dr. Jeffrey Albright, Assistant Professor of Surgery, has accepted the role of Interim Director of Surgical Services effective July 12, 2022.

In this new role, Dr. Albright will be responsible for working collaboratively with Nursing OR Leadership and the Perioperative Leadership Team to optimize OR utilization and efficiency across all Upstate surgical sites. His responsibilities will include managing operating room capacity and throughput, cost containment, community support networks, collaborations with primary care, pre-admission workups, perioperative care, and post-discharge care.

Additionally, Dr. Albright will work closely with the Surgical Department Chairs to establish surgical best practices and with the Perioperative Leadership Team to ensure appropriate

ALERT — IMMEDIATE ACTION REQUIRED
ADVISORY — PRIORITY BUT NOT FOR IMMEDIATE ACTION
UPDATE — FOR INFORMATION; UNLIKELY TO REQUIRE ACTION

scheduling of cases. He will also be involved with regulatory compliance, ensuring common practices and policies are in place at all Upstate surgical sites, and driving results for key performance metrics in surgery.

Please join us in welcome Dr. Albright to his new role!

## COVID Patient Placement

**A message from the Throughput Operations Team…**

Effective 7/11/22 0700, COVID patient placement changed from dedicated COVID units to all units being able to accept COVID patients with the exceptions of 2N, 4B, 7W, 5W, 10H, TCU and 11G (11G COVID admits for active hematology, oncology, or nephrology diagnoses). Please ensure staff have reviewed the donning and doffing education. Please refer to policy COV B-03 COVID-19: Bed Management and Throughput for additional guidance.

## COVID Vaccine for Toddlers

**By Dr. Steven Blatt**

I am excited to share the EPIC build for COVID vaccine for children 6 months – 5 years is complete. Upstate placed an order for vaccine with the New York State Vaccines for Children (VFC) program and expect it will arrive in about a week. The Moderna vaccine is 2 doses and the Pfizer vaccine is 3 doses. At this time, there are not studies stating which vaccine provides better immunity, so we have ordered Moderna as it has one less dose. The University Pediatric and Adolescent Center (UPAC) will offer 1-2 vaccine clinics, weekly, as long as there is a demand, and we will accept all patients. However, as we roll this out, we will focus on UPAC patients from any of our specialty clinics. Upstate Pediatrics in Baldwinsville is on a similar course. To the best of our knowledge, the county will not be organizing any community vaccination clinics.

## Monkey Pox Guidance

**By Christopher Dunham**

Upstate has now cared for a patient with confirmed monkeypox. Please see the attached document as an initial guidance document regarding a suspected monkey pox infection. This is a living document that will continue to be revised as new guidelines become available. For the latest information about monkey pox cases in the United States, please visit: https://www.cdc.gov/poxvirus/monkeypox/index.html

## NYS DOH Health Advisories

Please read the attached NYS DOH notifications regarding:

- Rebound After Paxlovid Treatment
- Updated COVID-19 Infection Prevention and Control Advisory
- Testing and Reporting of Mosquito- and Tick-Borne Illnesses

# CMO REPORT

FROM THE DESK OF
**Amy Tucker, MD**, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

**July 18, 2022**

- Legionellosis
- Updated COVID Vaccine Clinical Guidance for Vaccinating Individuals 6 months – 11 years old
- Monkeypox Cases Not Associated with Travel to Areas where Monkeypox is Enzootic

## CDC Health Alert: Updated Recommendations for Adenovirus Testing and Reporting of Children with Acute Hepatitis of Unknown Etiology

On May 11, 2022 the CDC issued a health alert to provide clinicians and public health authorities with updated information about an epidemiologic investigation of pediatric cases of hepatitis of unknown etiology in the United States. For information, please visit:

https://emergency.cdc.gov/han/2022/han00465.asp#:~:text=As%20of%20May%205%2C%202022,and%20five%20deaths%20under%20investigation

## Coffee with the CMO

All Upstate clinicians are invited to join me for **"Coffee with the CMO"**.

**Tuesday, August 2: 7:45 am – 8:30 am**
University Health Care Center (UHCC)
Fifth Floor Conference Rooms

Please see the attached flyer for details.

Mark your calendar and email Darcy DiBiase, Primary Care Liaison, at DiBiaseD@upstate.edu to reserve your spot!

## Are You a Physician Who Would Like a Stronger Professional & Social Connection with Your Colleagues?

**By Dr. Leslie Kohman**

Community Building at Upstate (CBU) is a new program intended to improve wellbeing and build a stronger sense of community among physicians at Upstate Medical University.

1. Would you be interested in meeting in a small group with colleagues to discuss issues you are facing at Upstate?

2. Are you primarily interested in meeting with colleagues from Community Hospital, University Hospital or doesn't matter/other?

3. Would you prefer your meeting time to be for breakfast, lunch, or dinner?

CMO REPORT

FROM THE DESK OF
Amy Tucker, MD, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

July 18, 2022

The groups (6-8 physicians, along with a facilitator from the Wellbeing Council or Medical Executive Committee) will come together over a meal (subsidized) in an informal environment for mutual support and enhanced self-awareness. Our goals are to cultivate a stronger sense of community within our medical staff, to increase professional and social connections, to enhance a sense of purpose for the participants, and to promote personal fulfillment in the practice of medicine. Our focus is on promoting professional satisfaction and making Upstate a place you can experience the joy of practicing medicine and find a long term professional home.

Commitment: Attend at least 4 monthly sessions over 6 months; groups may then decide to continue or disband.

Please send all responses to the above questions or any questions you may have to Deb Emerson at Emersond@upstate.edu. Thank you and we look forward to hearing from you.

## Clinical Documentation Improvement (CDI)

**By Dr. Emily Albert and Dr. Abha Harish; Co-Directors, CDI**

Documentation tools are available which may help you avoid a Query! Please see the attached CDI Tip for available tools to use when documenting Nutritional Status and Sepsis.

For questions, please email the CDI team at cdi@upstate.edu. Thank you to all providers for your strong work in improving documentation!

## Revised COVID-19 Policies of Special Interest for Clinicians

- COVID-19: Bed Management and Throughput (COV B-03): Updated COVID-19 routine and surge procedures. Moved surge procedures into appendix A. Moved appendix A and B into new appendix A section.

- Symptoms Screening, Masking and Physical Distancing during COVID-19 Pandemic (COV M-02): Updated statement pg.1 – screening process. Expanded Physical Distancing section to include Source Control with CDC reference table for mask protocols in Healthcare Facilities. Updated references.

- COVID-19 Exposure Protocol (COV P-01): Updated the protocol for staff exposure to SARS-CoV-2 based on NYSDOH guidance February 4, 2022. Changed policy title.

- PPE Requirements During COVID-19 Pandemic (COV P-08): Updated policy to remove the attends pad from the clean side at Community. Removed the re-use of N95. Clarified the definition of continuous use of an N95.

- Visitor Restriction During Prevalence of COVID-19 (COV V-08): Deleted "Visitor/support person will be asked to return home or to their vehicles to wait" from Procedure/Same Day Procedural area section. 3N waiting room is now open.

# CMO REPORT

FROM THE DESK OF
**Amy Tucker, MD**, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

**July 18, 2022**

## Reminder to Pick Up Your Medical Staff Gift


If you have not done so already, please stop by the Medical Staff Office (Room 1100 UH) to pick-up your medical staff gift!

If alternate locations or times are needed, please contact Nicole Cormier at CormierN@upstate.edu. We would be happy to get them to you!

## Outstanding Physician Comments

**Comments from grateful patients receiving care on the units and clinics at Upstate:**

**Adult Hematology Oncology:** I am so thankful for **Dr. Alina Basnet** for being so wonderful. **Dr. Sam Benjamin** has been very good. **Dr. Rahul Seth** is the best and I trust him completely.

**Boarders:** **Dr. Parth Desai** was amazing and took the extra time to listen and take all concerns into account and made sure I felt comfortable with his plan.

**Breast Care Center:** **Dr. Jayne Charlamb** was kind, caring, and honest about my health concerns. **Dr. Jayne Charlamb** was very patient and listened to me. She genuinely cared about my opinions and concerns. **Dr. Ranjna Sharma** is very compassionate. **Dr. Ranjna Sharma** made time for any questions or concerns that I had. I felt very confident in her abilities. Very comfortable environment. I'm sorry that **Dr. Prashant Upadhyaya** is leaving.

**Community Campus Emergency Department:** **Dr. Jennalee Cizenski** was very good about answering questions that I had. **Dr. Rishana Cohen** – good! **Dr. Risa Farber-Heath** was great!

**Community Campus – Virtual:** **Dr. Walter Hall** is very compassionate and kind. **Dr. Walter Hall's** call was right on time! He thoroughly explains my questions/concerns.

**ED at Community Hospital:** **Dr. Christine Courtney** was very kind and attentive.

**EU at Community Hospital:** **Dr. Carlos Muniz** was responsive and patient, explaining and answering our questions fully.

**Family Medicine:** **Dr. Rupali Singla** is an exceptional physician. Always listens, and explains things thoroughly. Very caring and compassionate.

**Family Medicine at Community:** **Dr. Igor Kraev** – excellent!

**Hyperbarics:** **Dr. Marvin Heyboer** really put me at ease.

ALERT — IMMEDIATE ACTION REQUIRED
ADVISORY — PRIORITY BUT NOT FOR IMMEDIATE ACTION
UPDATE — FOR INFORMATION; UNLIKELY TO REQUIRE ACTION

# CMO REPORT

FROM THE DESK OF
**Amy Tucker, MD**, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

**July 18, 2022**

**Inclusive Health Services:** **Dr. Elizabeth Asiago-Reddy** is always friendly and knowledgeable about any questions I might have. **Dr. Elizabeth Asiago-Reddy** was courteous, attentive, exceptionally knowledgeable, made me feel comfortable, amazing.

**Joslin Center for Diabetes:** **Dr. Roberto Izquierdo** – excellent!

**Multidisciplinary Programs Cancer Center:** **Dr. Jeffrey Albright** is a very impressive and honest doctor. I would say that from our first conversation I have been extremely impressed. **Dr. Lisa Lai**, **Dr. Abirami Sivapiragasam**, and **Dr. Anna Shapiro** – very special people. **Dr. Mark Marzouk** – very informative, took time to answer questions and made me very comfortable. **Dr. Thomas Vandermeer** took time to gather my history, listen to my concerns, and explain the plan. I am extremely confident in his plan of care. **Dr. Thomas Vandermeer** came in my room and spoke to me, took time, was comfortable and impressed with his bedside manner. **Dr. Jason Wallen** was very understanding and detailed. He showed me everything and that helped me understand the issue.

**Neurosurgery:** **Dr. Ali Hazama** – excellent and answered all my questions and concerns.

**Pediatric After Hours at Community:** **Dr. Marissa Smith** was knowledgeable and pleasant. **Dr. Marissa Smith** was excellent. She was friendly and directed questions to her in a way that she felt comfortable and was confidently able to answer without looking to me, Mom, for reassurance. **Dr. Marissa Smith** answered my questions and we felt very good about our next steps. Thank you!

**Pediatric Gastroenterology:** **Dr. Christopher Justinich** is so thorough and kind. **Dr. Marcus Rivera** was one of the best doctors we have ever visited, and we have seen many! He was caring, clear, and concise. He explained treatment options in a very understandable way. He was also kind and kid savvy. **Dr. Prateek Wali** was great at interacting with my infant daughter during exam. **Dr. Prateek Wali** is great! He has a wonderful bedside manner and is encouraging to my child as he follows the instructed regiment.

**Pediatric Surgery:** **Dr. Tamer Ahmed** was wonderful.

**Peds Neph, Rheum, Integrative Med:** **Dr. Heather Wasik** – outstanding!

**Pulmonology Clinic:** **Dr. Markus Gutsche** – friendly, explains results of tests clearly, informed me of a slight delay before being able to see me. **Dr. Birendra Sah** was very helpful, showed me the scans so I could see exactly what the mass looked like.

**Radiation Oncology:** I am totally satisfied with the medical care I am receiving from **Dr. Paul Aridgides** and his medical staff! I feel so very fortunate to have **Dr. Paul Aridgides** as my Radiation Oncologist. **Dr. Paul Aridgides** is so highly trained in his medical profession. **Dr. Paul Aridgides** is excellent and so very skilled in his field of medical profession! He explains everything about my medical condition! He answers all my questions! I am so very happy to have him for my medical doctor! The person who really impressed me the most was **Dr. Paul Aridgides**. His expertise as a Radiation Oncologist; and his friendly personality makes me feel so calm and confident! He is an outstanding Radiation Oncologist! I really liked meeting with **Dr. Dennis Kotlove** each week. He listened to my symptoms and always had a treatment for me to try. I liked that not all of his suggestions required a prescription. He seems like a very caring

doctor. **Dr. Anna Shapiro** was absolutely wonderful spending as much time as I needed in explaining questions that I had.

**SUNY Upstate – Virtual:** I am so impressed with **Dr. Michael Archer.** I have received excellent care. **Dr. Gennady Bratslavsky** is an amazing physician. He is a kind and caring professional who always shows he cares a great deal about my health and overall well-being. **Dr. Andrea Dvorak** was absolutely wonderful in helping us understand every part of her diagnosis. We can't thank her enough. Very happy with **Dr. William Elliott's** care and concern. He put me at ease. **Dr. Kaushik Govindaraju** waited patiently for me. **Dr. Kaushik Govindaraju** listed closely to me. **Dr. Oleg Shapiro** is a very competent MD. **Dr. J Trussell** is a good doctor. I am always pleased when I have an appointment with **Dr. Jason Wallen**. He always takes the time to explain and answer any questions I have. He is a well loved physician and we are so fortunate to have such a brilliant surgeon. **Dr. Jason Wallen** was awesome. He couldn't have been more helpful. **Dr. Ruth Weinstock** has always been informative and interested in helping me manage my diabetes.

**Surgery – UH:** **Dr. Michael Costanza** - excellent and answered all my questions and concerns. **Dr. Jason Wallen** was very patient and covered everything clearly.

**UHCC – Neurology:** **Dr. Sara Ali** is excellent! **Dr. Anuradha Duleep** is a very personable and caring physician. **Dr. Anuradha Duleep** is such an amazing person and doctor. She has helped me manage my disease so I could work with a disability. Now she is helping me ease into retirement. I am so thankful for her. **Dr. Anuradha Duleep** is so sensitive to my needs. Her care has made my quality of life much better. Thank you. **Dr. Anuradha Duleep**! **Dr. Corey McGraw** gave me a great first impression. He had a great bedside manner and was very thorough to explain to me in laymen terms what was going on. In addition, he wanted to order more tests before giving me a diagnosis. **Dr. Dragos Mihaila** always takes time, listens to our concerns, and answers my questions thoughtfully. **Dr. Dragos Mihaila** was very thorough and explained clearly all options. **Dr. Awss Zidan** is wonderful. **Dr. Awss Zidan** is very attentive and is reassuring.

**University Cardiology:** **Dr. Robert Carhart** is so nice and he listens to you. He makes you feel at ease. **Dr. Debanik Chaudhuri** has a very nice mannerism. He is always very willing to answer all my questions. I never feel rushed. **Dr. Hani Kozman** is the best! I can't say enough about him. He has been my wife's and my cardiologist for a long time. We are so blessed and fortunate to be able to have him as our heart doctor! I would definitely recommend him to anyone who needs an extremely knowledgeable and informative cardiologist! He not only does an outstanding job, he also puts our minds at ease when we see him for our appointments! I can honestly say, we both look forward to our visits with **Dr. Hani Kozman**! **Dr. Hani Kozman** is an amazing cardiologist! He definitely stands out!

**University Center for Vision Care:** **Dr. Robert Fechtner** took the time to explain the test results and answer all my questions. I was very impressed with him. **Dr. Robert Fechtner** was outstanding! Explained my condition and what stage I was at. Took the time to answer all my questions. **Dr. Preethi Ganapathy** is a great doctor who has helped me tremendously.

**University Geriatricians:** **Dr. Andrea Berg** always listens and gives great advice. Very compassionate. **Dr. Andrea Berg** – wonderful and impressive! **Dr. Sharon Brangman** has always been impressive. She treats my wife with great respect, speaks very clearly, and describes her assessment in a very understandable manner.

# CMO REPORT

FROM THE DESK OF
**Amy Tucker, MD**, MHCM, Chief Medical Officer, Upstate University Hospital
Associate Dean for Clinical Affairs, College of Medicine

UPSTATE UNIVERSITY HOSPITAL

**July 18, 2022**

**University Internists:** **Dr. Vincent Frechette** is an especially caring and comforting doctor, completely explains everything! I'm fortunate to have him treat me!!! Love **Dr. Sarah Lappin** – always very attentive and caring – great doctor! **Dr. Jessica Mayer** of course! She's amazing. Always so intent in her listening. She also takes excellent notes that I can refer to back in MyChart.

**Upstate Pediatrics:** **Dr. Tobey Kresel** and **Dr. Yekaterina Okhman** are the main two pediatricians that see my children. They are both very thorough and pay attention to every detail. They truly listen and then provide scientific evidence to either rule out or confirm my concerns. They listen and they TRULY work for the patient! They are friendly and courteous! They alleviate stress with detailed explanations. WILL NEVER GO ANYWHERE ELSE!! If they are still practicing when it comes time to become a grandparent, my grandchildren will come to this office!

**Upstate Brain and Spine Center:** **Dr. Harish Babu** saved my life, he is the best surgeon I've ever had (and have had many surgical procedures). **Dr. Harish Babu** is the absolute best at what he does, extremely good bedside manner. He is a genius and gave me my life back. **Dr. Ali Hazama** was very personable and informative during our pre-op meeting. He stopped to see me with positive, encouraging words before surgery and was very interested in my post-op progress. He gave me confidence that my minimal micro surgery was the right procedure for me.

**11E:** **Dr. Kim Wallenstein** and **Dr. Tamer Ahmed** – fabulous!

**12E:** **Dr. David Hansen** was amazing and finally gave us the attention to my son's medical needs we have been asking for. **Dr. Gloria Kennedy** was great at night with my child.


Best,

Amy

ALERT — IMMEDIATE ACTION REQUIRED
ADVISORY — PRIORITY BUT NOT FOR IMMEDIATE ACTION
UPDATE — FOR INFORMATION; UNLIKELY TO REQUIRE ACTION

# SUNY Upstate Monkey Pox PUI Initial Guidance Document: July 15st 2022

## Possible Case Presentation: (https://www.cdc.gov/poxvirus/monkeypox/symptoms.html)

1. Note: Monkey Pox is similar to but milder than the symptoms of smallpox. The main difference between symptoms of smallpox and monkeypox is that monkeypox causes lymph nodes to swell (lymphadenopathy) while smallpox does not.
2. The incubation period (time from infection to symptoms) for monkeypox is usually 7−14 days but can range from 5−21 days.
3. The illness begins with:
    a. Fever
    b. Headache
    c. Muscle aches
    d. Backache
    e. Swollen lymph nodes
    f. Chills
    g. Exhaustion
4. Within 1 to 3 days (sometimes longer) after the appearance of fever, the patient develops a rash, often beginning on the face then spreading to other parts of the body.
    a. Lesions progress through the following stages before falling off:
        i. Macules
        ii. Papules
        iii. Vesicles
        iv. Pustules
        v. Scabs
5. The illness typically lasts for 2−4 weeks

## Treatment:

1. Seek ID consult as soon as possible
2. For more information - https://www.cdc.gov/poxvirus/monkeypox/clinicians/treatment.html

## SUNY UPSTATE EMERGECNY DEPARTMENTS

### INTIAL COMMUNCIAITONS:

1. Triage RN or Frontline staff will notify the ED Charge RN **IMMEDIATELY**
2. **ED Charge RN will notify:**
    a. ED Attending,
    b. Pharmacy
    c. Administrative Supervisor
    d. Infection Prevention Service (number listed on AMION)
3. **ED Attending will**
    a. Notify and discuss PUI with Hospital Epidemiologist and/or Infection Prevention
4. **Administrative Supervisor will notify**
    a. Public Relations
    b. Environmental services shift supervisor
    c. Environmental Health and Safety staff on call
    d. Administrator on Call

### EXTERNAL COMMUNCAITONS:

1. All communications to external agencies (LHD, CDC, etc.) will be completed by the Hospital Epidemiologist and/or Infection Prevention.
    a. Healthcare providers must immediately report suspect cases of monkeypox to their local health department (LHD).
    b. Reporting should be to the county where the patient resides.

c. Outside of New York City, contact information is available at: https://www.health.ny.gov/contact/contact_information.
d. If you are unable to reach the LHD where the patient resides, please contact the NYSDOH Bureau of Communicable Disease Control at 518-473-4439 during business hours or 866-881-2809 evenings, weekends, and holidays.

**INTIAL ED ACTION ITEMS**:

1. If PUI triggers the infectious disease questions or is transported via EMS with suspicion of Monkey pox: *(see policy CM T-32 for more info)*
2. **BOTH AIRBORNE AND CONTACT PRECAUSTIONS MUST BE TAKEN (including eye ware)**
3. Patient Placement: **Negative Pressure is Required**
    a. Have patient don a surgical mask immediately
    b. If Downtown ED: Place patient in 34 if available.
        i. If occupied, place patient in any open room and make 34 available immediately
    c. If Community ED: Room 7 or if multiple PUI utilize GEM Care.
    d. If Pediatric Patient: Room 8
4. **REMOVE ALL UNNECESSARY ITEMS FROM PATIENT ROOM PRIOR TO PLACEMENT.** EVS will place two step on trash cans, with lids and appropriately labeled with biohazard labels.
5. **ALL PATIENT WASTE MUST BE KEPT IN THE PATEINT ROOM.**
6. List of ALL employees who have come in contact with PUI. (Utilize form #95395 developed for Covid)
7. Update as needed and ensure Employee Health & infection Prevention receives copy.
8. Request Category A waste barrels to be staged in ED by Environmental Services Supervisor.
9. All patient waste must be kept in room if possible or transported in Category A waste containers.
10. Immediately identify and dedicate staff for PUI (One RN/ One Physician) depending on patient condition
11. **If PUI is admitted:**
    a. Notify transport team of need for PPE if requested. Follow COV A-01 and COV B-03 appendix C.
    b. Coordinate patient transport with Environmental Services and Environmental Health and Safety
    c. Dedicate at least 5 RN to specific care of PUI for duration of stay.
    d. Consider Hospital at Home if possible.
12. **If PUI will be discharged:**
    a. ED Attending, Hospital Epidemiologist and NYSDOH/Onondaga County Public Health will discuss a telemedicine team to follow up with patient isolating at home.

# Outpatient/Clinic Areas

1. Patient Placement: Negative Pressure is required but if not possible place patient in secluded area or patient room. Request and utilize Air filtration machine.
2. **REMOVE ALL UNNECESSARY ITEMS FROM PATIENT ROOM PRIOR TO PLACEMENT.** EVS will place two step on trash cans, with lids and appropriately labeled with biohazard labels.
3. Have patient don a surgical mask immediately
4. If patient presents with a caregiver please separate caregiver from others in waiting room and staff until epidemiology is consulted.
5. Any staff member that interacts with PUI must don PPE (both contact and airborne precautions plus eyewear)
6. Create list of employees who have come in contact with PUI. Update as needed and ensure Employee Health & infection Prevention receives copy. (see exposure risk below)
7. Notify Unit Charge Nurse, Physician on duty as well as Clinic/outpatient manager.
8. Outpatient/ambulatory leadership will notify the AOC *(see policy DIS M-81 for more info)*
9. Physician on site will confirm patient meets PUI status with Hospital Epidemiologist as soon as possible. Notify the Infection Prevention Service (number listed on AMION) to facilitate this process.
10. Transportation to Hospital, if needed, will be coordinated with EMS, ED Attending & the Onondaga 911 Center per normal communications.

# Specimen Collection for Suspected Monkeypox

1. **Prior to specimen collection:**
    a. Notify the Infection Prevention Service (AMION)
    b. Infection Prevention will obtain approval for testing from the Onondaga County Health Department (315-435-3256)
    c. Once the above is complete and approval for testing has been granted:
    d. Obtain a specimen collection kit from Microbiology
        i. Downtown: 5th Floor Cancer Center, 4-4459
        ii. Community: Laboratory (located in basement), 492-5531
    e. Perform hand hygiene and don appropriate PPE.
    f. Label provided viral transport tubes with the patient's name and date of birth, date of collection, specimen source, and name of person collecting the specimen.

        **NOTE:** *Place only a single swab in each viral transport tube.*
2. Collect vesicular and pustular material
    a. Sanitize the patient's skin with an alcohol wipe and allow skin to dry.
    b. Use **two** swabs per lesion. Use only the swabs provided.
    c. Collect cells from the lesion base by vigorously swabbing or brushing lesion and break off at score line into a labeled viral transport tube; repeat with second swab and place in separate viral transport tube.
    d. Repeat this process with two new swabs on a second lesion for a total of four swabs per patient.
3. Collect blood per standard protocol – use the provided serum separator (gold top) tube.
4. Place tubes into the provided biohazard bag. Discard PPE and collection materials as biohazardous waste.
5. *Hand-deliver specimens to the laboratory **IMMEDIATELY** after collection*; do NOT use the pneumatic tube system.
6. These specimens are sent to the NYS Department of Health's Wadsworth Center laboratory in Albany for processing.

# Room Cleanup/Terminal Cleaning:

1. **Don appropriate PPE**
2. EVS & EHS will coordinate removal of waste from ED, patient rooms to designated holding area.
    a. UH holding area will be room 2828A, hot room.
    b. Community Room 4246
3. EVS will stage and store waste, pending Infection Prevention update for handling. EVS will work with current contractor to ensure waste is removed per regulatory requirements and specifications.
4. Hospital Areas:
    a. Patient Room will be cleaned to UH guidelines and follow CDC recommendations as needed.
    b. Department must call the EVS Supervisor UH Via Vocera 4-1400, CC 4-200.
    c. They will need to Identify the type of isolation.
    d. Also, if there is a need for the negative pressure rooms in the EDs to expedite. Rooms PEDS room 8, or Adult room 34. At CC, this is the GEM CARE space.
5. Output/Clinic Areas:
    a. Contact Landlords to request appropriate cleaning is focused on that space after hours.
    b. If outpatient areas are unable to facilitate cleaning with the landlord please escalate to Environmental services Leadership
    c. The PUI room cleaning process and dwell time should be discussed with EVS Manager, Infection Prevention or epidemiologist prior to specific room being used for another patient.
    d. Managers with questions can call: EVS OFFICE 315-464-6576, ask to speak to an EVS Manager.

6. Consider all patient waste Category A until proven otherwise.
7. Packaging of Untreated Monkeypox Medical Waste (per NYSDOH Advisory 5/31/22)
    a. There are two clades of monkeypox virus: The West African clade and the Central African clade.
    b. The current position of the USDOT is to hold untreated RMW generated from suspected cases of monkeypox and wait until testing confirms the diagnosis and identifies the clade.
    c. If the Central African clade of monkeypox is identified, untreated RMW being shipped for off-site treatment must include enhanced packaging and shipped as Category A waste
    d. . If the West African clade of monkeypox is identified, then the untreated RMW being shipped for off-site treatment must be packaged and shipped as Category B.
    e. In general, Category A waste requires triple packaging that may include one or two leakproof primary bags, contained in a secondary leakproof rigid package, and then over packed in a rigid outer package such as a corrugated cardboard box or a disposable poly drum. An absorbent packing material is necessary for liquids.
    f. Category B waste packaging is as above for category A except that an additional leakproof bag may be used instead of an inner rigid package.
        i. Note: packaging and transport of Category A or B waste may otherwise be determined by USDOT and may also require a special permit from USDOT that includes additional packaging and marking requirements
8. Category A or B waste and RMW must be treated prior to disposal in NYS. Commercial treatment and disposal facilities must have a 6 NYCRR Part 360 permit and be specifically authorized by the NYSDEC to accept Category A or B waste for treatment or disposal.
9. For questions regarding approvals for treating medical waste on-site in a hospital or clinical laboratory, contact the NYSDOH Regulated Medical Waste Program at rmwp@health.ny.gov.
10. For questions regarding the commercial treatment or disposal of Category A or B waste and RMW, contact the NYSDEC at swmfprogram@dec.ny.gov and for questions regarding transport of these wastes, contact the NYSDEC at transport@dec.ny.gov.
11. Note: transport of Category A or B waste and RMW requires a 6NYCRR Part 364 medical waste transporter permit. Waste transported both in and out of state must be transported directly to a facility properly permitted to manage the waste.

## Monitoring Exposed Healthcare Professionals (per CDC website 6/22/2022)

1. CONSULT INFECTION PROVENTION and/or EMPLOYEE STUDENT HEALTH WHENEVER MAKING A RISK DETERMINATION.
2. Any healthcare worker who has cared for a monkeypox patient should be alert to the development of symptoms that could suggest monkeypox infection, especially within the 21-day period after the last date of care.
3. Healthcare workers who have unprotected exposures (i.e., not wearing PPE) to patients with monkeypox do not need to be excluded from work duty, but should undergo active surveillance for symptoms, which includes measurement of temperature at least twice daily for 21 days following the exposure.
4. Prior to reporting for work each day, the healthcare worker should be interviewed regarding evidence of fever or rash.
5. Healthcare workers who have cared for or otherwise been in direct or indirect contact with monkeypox patients while adhering to recommended infection control precautions may undergo self-monitoring or active monitoring as determined by the local health department.
6. Transmission of monkeypox requires prolonged close contact with a symptomatic individual.

7. Brief interactions and those conducted using appropriate PPE in accordance with Standard Precautions & Airborne Precautions are not high risk and generally do not warrant post-exposure prophylaxis

| Degree of Exposure | Recommended Actions | Exposure Characteristics |
|---|---|---|
| **HIGH** | Monitoring & postexposure prophylaxis is recommended | Unprotected contact between a person's skin or mucous membranes and the skin, lesions, or bodily fluids from a patient (e.g., any sexual contact, inadvertent splashes of patient saliva to the eyes or oral cavity of a person, ungloved contact with patient), or contaminated materials (e.g., linens, clothing) -OR- Being inside the patient's room or within 6 feet of a patient during any procedures that may create aerosols from oral secretions, skin lesions, or resuspension of dried exudates (e.g., shaking of soiled linens), without wearing an N95 or equivalent respirator (or higher) and eye protection -OR- Exposure that, at the discretion of public health authorities, was recategorized to this risk level (i.e., exposure that ordinarily would be considered a lower risk exposure, raised to this risk level because of unique circumstances) |
| **INTERMEDIATE** | MONITORING and/or postexposure prophylaxis – Informed clinical decision making recommended on an individual basis to determine whether benefits of PEP outweigh risks | Being within 6 feet for 3 hours or more of an unmasked patient without wearing, at a minimum, a surgical mask -OR- Activities resulting in contact between sleeves and other parts of an individual's clothing and the patient's skin lesions or bodily fluids, or their soiled linens or dressings (e.g., turning, bathing, or assisting with transfer) while wearing gloves but not wearing a gown -OR- Exposure that, at the discretion of public health authorities, was recategorized to this risk level because of unique circumstances (e.g., if the potential for an aerosol exposure is uncertain, public health authorities may choose to decrease risk level from high to intermediate) |
| **LOW or Uncertain** | MONITORING | Entered the patient room without wearing eye protection on one or more occasions, regardless of duration of exposure -OR- During all entries in the patient care area or room (except for during any procedures listed above in the high-risk category), wore gown, gloves, eye protection, and at minimum, a surgical mask -OR- Being within 6 feet of an unmasked patient for less than 3 hours without wearing at minimum, a surgical mask -OR- Exposure that, at the discretion of public health authorities, was recategorized to this risk level based on unique circumstances (e.g., uncertainty about whether Monkeypox virus was present on a surface and/or whether a person touched that surface) |

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

May 24, 2022

TO: Healthcare Providers, Hospitals, Local Health Departments, Family Planning Providers, Emergency Rooms, Community Health Centers, College Health Centers, Community-Based Organizations, Internal Medicine, FamilyMedicine, Pediatric, Adolescent Medicine, Dermatology, Infectious Disease, and PrimaryCare Providers

FROM: New York State Department of Health (NYSDOH)

# HEALTH ADVISORY: COVID-19 Rebound After Paxlovid Treatment

## SUMMARY

- See attached HAN from the Centers for Disease Control and Prevention (CDC): COVID-19 Rebound After Paxlovid Treatment
- Paxlovid continues to remain the treatment of choice for appropriate patients with mild to moderate symptoms early in the course of their disease for those that are at risk for serious illness.
- COVID-19 rebound after Paxlovid treatment has been reported and was known to be present during the initial EUA studies.
- Covid generally presents with a mild illness that resolves without further treatment. This was seen both in the treatment and placebo arms of the initial studies at approximately the same rate of 2%.
- The trajectory of the COVID-19 rebound viral illness is that after being treated with Paxlovid and testing negative for COVID-19, you subsequently test positive for COVID-19 with symptoms consistent with COVID-19.
- Per the CDC, additional treatment with further antiviral is unnecessary at this time.
- Regardless of recent treatment if a person tests positive, they must follow the CDC's guidance on isolation . You can end re-isolation after 5 days if you are fever-free for 24 hours without the use of fever-reducing medication and your symptoms are improving.
- The infected individual should wear a mask for a total of 10 days after their most recent positive test.
- Prevention continues to be critical; staying up to date with vaccination is an important tool in reducing the risk of contracting COVID-19 thus lowering risk of serious illness and complications.

This is an official

# CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
May 24, 2022, 9:00 AM ET
CDCHAN-0467

## COVID-19 Rebound After Paxlovid Treatment

**Summary**
The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory to update healthcare providers, public health departments, and the public on the potential for recurrence of COVID-19 or "COVID-19 rebound." **Paxlovid continues to be recommended for early-stage treatment of mild to moderate COVID-19 among persons at high risk for progression to severe disease**. Paxlovid treatment helps prevent hospitalization and death due to COVID-19. COVID-19 rebound has been reported to occur between 2 and 8 days after initial recovery and is characterized by a recurrence of COVID-19 symptoms or a new positive viral test after having tested negative. **A brief return of symptoms may be part of the natural history of SARS-CoV-2 (the virus that causes COVID-19) infection in some persons, independent of treatment with Paxlovid and regardless of vaccination status**. Limited information currently available from case reports suggests that persons treated with Paxlovid who experience COVID-19 rebound have had mild illness; there are no reports of severe disease. There is currently no evidence that additional treatment is needed with Paxlovid or other anti-SARS-CoV-2 therapies in cases where COVID-19 rebound is suspected.

Regardless of whether the patient has been treated with an antiviral agent, risk of transmission during COVID-19 rebound can be managed by following CDC's guidance on isolation, including taking other precautions such as masking.

Staying up to date with COVID-19 vaccination lowers the risk of getting COVID-19 and helps prevent serious outcomes of COVID-19, such as severe illness, hospitalization, and death.

**Background**
Paxlovid (nirmatrelvir tablets; ritonavir tablets) is a prescription oral antiviral drug that reduces the risk of hospitalization and death for patients with mild-to-moderate COVID-19 who are at risk of disease progression and severe illness (1). It is available under Emergency Use Authorization (EUA) by the U.S. Food and Drug Administration (FDA) for adults and pediatric patients (12 years of age and older weighing at least 40 kilograms or 88 pounds). Treatment should be initiated as soon as possible and within 5 days of symptom onset among persons eligible to receive the treatment under the EUA who:

- Test positive for SARS-CoV-2 infection;
- Have mild to moderate illness;
- Have one or more risk factors for progression to severe disease;
- Do not require hospitalization due to severe or critical COVID-19 at the time of treatment initiation; and
- Do not have evidence of severe renal or hepatic impairment.

Recent case reports document that some patients with normal immune response who have completed a 5-day course of Paxlovid for laboratory-confirmed infection and have recovered can experience recurrent illness 2 to 8 days later, including patients who have been vaccinated and/or boosted (were up to date with COVID-19 vaccination) (2-4). These cases of COVID-19 rebound had negative test results after Paxlovid treatment and had subsequent positive viral antigen and/or reverse transcriptase polymerase chain reaction (RT-PCR) testing. Both the recurrence of illness and positive test results improved or resolved (median of 3 days) without additional anti-COVID-19 treatment. Based on information from the case reports, COVID-19 rebound did not represent reinfection with SARS-CoV-2 or the development of

resistance to Paxlovid; also, no other respiratory pathogens were identified among known cases. Possible transmission of infection during COVID-19 rebound has been described (3); however, it remains unknown whether the likelihood of transmission during rebound differs from the likelihood of transmission during the initial infection.

In the Paxlovid clinical trial, a small number of participants had one or more positive SARS-CoV-2 RT-PCR test results after testing negative, or an increase in the amount of SARS-CoV-2 detected by PCR, after completing their treatment course (5). This finding was observed in persons administered Paxlovid and in persons given placebo. There was no increased occurrence of hospitalization or death, and there was no evidence that the rebound in detectable viral RNA was the result of SARS-CoV-2 resistance to Paxlovid (5).

COVID-19 rebound is characterized by a recurrence of symptoms or a new positive viral test after having tested negative. People with COVID-19 rebound should follow CDC recommendations regarding isolation of infected patients regardless of treatment with an antiviral agent and/or previous isolation after the initial infection. People with recurrence of COVID-19 symptoms or a new positive viral test after having tested negative should restart isolation and isolate again for at least 5 days. Per CDC guidance, they can end their re-isolation period after 5 full days if fever has resolved for 24 hours (without the use of fever-reducing medication) and symptoms are improving. The individual should wear a mask for a total of 10 days after rebound symptoms started. Some people continue to test positive after day 10 but are considerably less likely to shed infectious virus. Currently, there are no reports of severe disease among persons with COVID-19 rebound. Paxlovid continues to be recommended for early-stage treatment of mild to moderate COVID-19 among persons at high risk for progression to severe disease.

**Recommendations for Healthcare Providers**

For patients with COVID-19 rebound

- There is currently no evidence that additional treatment for COVID-19 is needed for COVID-19 rebound. Based on data available at this time, patient monitoring continues to be the most appropriate management for patients with recurrence of symptoms after completion of a treatment course of Paxlovid.
- Advise people with COVID-19 rebound to follow CDC's guidance on isolation and take precautions to prevent further transmission. Patients should re-isolate for at least 5 days. Per CDC guidance, they can end their re-isolation period after 5 full days if fever has resolved for 24 hours (without the use of fever-reducing medication) and symptoms are improving. The patient should wear a mask for a total of 10 days after rebound symptoms started.
- Consider clinical evaluation of patients who have COVID-19 rebound and symptoms that persist or worsen.
- Healthcare providers are encouraged to report cases of COVID-19 rebound to Pfizer after Paxlovid treatment using the following online tool: Pfizer Safety Reporting and to FDA MedWatch. Complete and submit a MedWatch form, or complete and submit FDA Form 3500 (health professional) by fax (1-800-FDA-0178). Call 1-800-FDA-1088 for questions.

For patients just diagnosed with COVID-19

- Healthcare providers should counsel patients on available COVID-19 treatment options, particularly for those patients at increased risk of developing severe COVID-19.
- Paxlovid should be considered for any patient who meets the eligibility criteria. For information on Paxlovid eligibility, refer to FDA's Fact Sheet for Healthcare Providers.
- Due to the potential for severe drug-drug interactions with the ritonavir component of Paxlovid, it is strongly suggested that healthcare providers not experienced in prescribing this drug refer to the Fact Sheet for Healthcare Providers, the Paxlovid Patient Eligibility Screening Checklist Tool for Prescribers, and the NIH Statement on Paxlovid Drug-Drug Interactions | COVID-19 Treatment Guidelines. Healthcare providers can also contact a local clinical pharmacist or infectious disease specialist for advice.

- For further information on the use of Paxlovid, CDC recommends healthcare providers continue to closely follow NIH's COVID-19 Treatment Guidelines, the Assistant Secretary for Preparedness and Response Public Health Emergency COVID-19 Therapeutics site, and IDSA's Guidelines on the Management of Patients with COVID-19.

**Recommendations for Public Health Departments and Public Health Jurisdictions**

- State and local health departments should be aware of COVID-19 rebound and disseminate the recommendations for healthcare providers and the public.
- Health departments should communicate to individuals about measures to prevent further transmission. The phenomenon of COVID-19 rebound reiterates the importance of following CDC's isolation guidance. Isolation should be restarted after the onset of rebound symptoms or a positive test result. Per CDC guidance, people can end re-isolation after 5 full days with resolution of their fever for 24 hours (without the use of fever-reducing medication) and if their symptoms are improving. The individual should wear a mask for a total of 10 days after rebound symptoms started.
- Health departments should communicate ongoing and up to date information on therapeutics for COVID-19 and their availability to healthcare providers within their jurisdiction.

**Recommendations for the Public**

- You may be experiencing COVID-19 rebound if you have been diagnosed in the past 2 weeks and have recovered from COVID-19 and then experience recurrent COVID-19 symptoms or develop newly positive test results after recovery.
- If you experience COVID-19 rebound, you should follow CDC's isolation guidance. Isolate again and restart the recommended 5-day isolation period at the time of recurrence of symptoms or a new positive COVID-19 test result. You can end re-isolation after 5 days if you are fever-free for 24 hours without the use of fever-reducing medication and your symptoms are improving. You should also wear a mask for 10 days after rebound.
- Contact a healthcare provider if your COVID-19 rebound symptoms persist or worsen.
- Consult with your healthcare provider if you have additional questions about your treatment.
- You are encouraged to report a possible case of COVID-19 rebound after Paxlovid treatment to Pfizer using the following online tool: Pfizer Safety Reporting.

**For More Information**

- FDA Updates on Paxlovid for Health Care Providers | FDA
- Paxlovid Patient Eligibility Screening Checklist Tool
- FDA Paxlovid Emergency Use Authorization letter
- COVID-19 Treatment Guidelines: What's New
- COVID-19 Treatment Guidelines: Antiviral Therapy
- NIH Statement on Therapies for High-Risk, Nonhospitalized Patients | COVID-19 Treatment Guidelines
- NIH Statement on Paxlovid Drug-Drug Interactions | COVID-19 Treatment Guidelines
- Pfizer Safety Reporting

**References**


1. Hammond J, Leister-Tebbe H, Gardner A, Abreu P, Bao W, Wisemandle W, et al. Oral Nirmatrelvir for High-Risk, Nonhospitalized Adults with COVID-19. *New Engl J Med* 2022; 386(15): 1397-1408.
2. Gupta K, Strymish J, Stack G, Charness M. Rapid relapse of symptomatic omicron SARS CoV-2 infection following early suppression with nirmatrelvir/ritonavir. 26 April 2022, PREPRINT (Version 1) available at Research Square [https://doi.org/10.21203/rs.3.rs-1588371/v1].
3. Charness M, Gupta K, Stack G, Strymish J, Adams E, Lindy D, Mohi H, Ho D. Rapid relapse of symptomatic omicron SARS CoV-2 infection following early suppression with

nirmatrelvir/ritonavir. 13 May 2022, PREPRINT (Version 2) available at Research Square [https://doi.org/10.21203/rs.3.rs-1588371/v2].
4. Carlin AF, Clark AE, Chaillon A, Garretson AF, Bray W, Porrachi M, et al. Virologic and Immunologic Characterization of COVID-19 Recrudescence after Nirmatrelvir/Ritonavir Treatment. 18 May 2022, PREPRINT (Version 1) available at Research Square [https://doi.org/10.21203/rs.3.rs-1662783/v1].
5. Food and Drug Administration. FDA Updates on Paxlovid for Health Care Providers. Available at: https://www.fda.gov/drugs/news-events-human-drugs/fda-updates-paxlovid-health-care-providers. Accessed on May 12, 2022.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# MEMORANDUM

**To:** **All healthcare settings including hospitals, nursing homes, home healthcare, diagnostic and treatment centers, physician offices, dental offices, local health departments, and office-based surgery practices.**

**From:** **NYSDOH**

**Date:** **May 31, 2022**

**Subject:** **Transmittal Memo**

1) This guidance is a revision of the May 18, 2022 “Health Advisory: Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic” with updates to the elective surgery pre-procedure testing component.

2) The May 18, 2022 guidance regarding the elective surgery pre-procedure testing component is not being enforced at this time.

3) The Department recommends that you continue to follow the May 12, 2021 Updated Guidance for Resumption of Non-Essential Elective Surgeries and Non-Urgent Procedures in Hospitals, Ambulatory Surgery Centers, Office-Based Surgery Practices, and Diagnostic and Treatment Centers regarding pre-procedure testing until you can implement revised guidance dated May 31, 2022, not to extend beyond the effective date for the revised guidance of June 24, 2022.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

**DATE:** **May 31, 2022**

**TO:** **All healthcare settings including hospitals, nursing homes, home healthcare, diagnostic and treatment centers, physician offices, dental offices, local health departments, and office-based surgery practices.**

**FROM:** **New York State Department of Health (NYSDOH)**

***** UPDATED *** Health Advisory: Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic**
**This guidance supersedes guidance of May 18, 2022.**

**Please distribute immediately to:**
Administrators, Infection Preventionists, Hospital Epidemiologists, Medical Directors and Nursing Directors

The purpose of this advisory is to provide an update on the infection prevention and control recommendations that all healthcare settings in New York should follow during the COVID-19 pandemic. Except for when alternate NYSDOH guidance is available, NYSDOH recommends that all healthcare settings adhere to the infection prevention and control guidance issued by the Centers for Disease Control and Prevention (CDC) in *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.*

This Health Advisory supersedes the NYSDOH May 3, 2021, Health Advisory "**** Revised *** Discontinuation of Transmission-Based Precautions for Patients with COVID-19 Who Are Hospitalized or in Nursing Homes, Adult Care Facilities, or Other Congregate Settings with Vulnerable Residents".* CDC infection prevention and control guidance provides recommendations for the duration of transmission-based precautions for patients and residents with suspected or confirmed COVID-19 and those who meet the criteria for transmission-based precautions based on close contact with someone with SARS-CoV-2 infection.

This advisory also supersedes the NYSDOH May 12, 2021, *"Updated Guidance for Resumption of Non-Essential Elective Surgeries and Non-Urgent Procedures in Hospitals, Ambulatory Surgery Centers, Office Based Surgery Practices and Diagnostic and Treatment Centers"* and updates the pre-elective procedure testing guidance for hospitals, ambulatory surgery centers, office-based surgery practices, and diagnostic and treatment centers as follows:

- CDC currently states that pre-elective procedure SARS-CoV-2 viral testing before elective surgery or procedures by hospitals, ambulatory surgery centers, office-based surgery practices, and diagnostic and treatment centers is at the discretion of the facility (*Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic)*.

- However, the current NYSDOH expectation is that while facilities have discretion in how they implement testing, facilities must have a testing policy in place, and facilities' policies will require testing of all patients when Community Transmission Rates are **moderate, substantial, or high** in the facility's community and its typical service area, except those asymptomatic patients who have recovered from laboratory-confirmed SARS-CoV-2 infection during the previous 90 days. As of this writing, Community Transmission Rates are **high** throughout New York State.
- When Community Transmission Rates in a facility's community and typical service area are categorized as **"low",** facility policies regarding testing are completely discretionary, and testing is not required. Facilities' testing policies may include special consideration for patients traveling long distances for care, such as from high transmission areas.
- Note that Community Transmission Rates are for the use of healthcare facilities and are different from CDC's COVID-19 Community Levels.
- Facilities' testing policies should be designed to maximize detection of infected patients using the facilities' best judgment and considering local laboratory capabilities, turnaround time, testing availability at sites with a limited service laboratory permit (e.g., rapid antigen or rapid molecular tests), availability of and ability to conduct home tests, and pre-procedure patient preparation.
- Testing can be done using any nucleic acid amplification test (NAAT) or antigen test authorized by the U.S. Food & Drug Administration. Acceptable test sites include the surgical facility, laboratory, local health department, pharmacy, home, local healthcare provider, or other testing site.
- Facilities' testing policies should balance test sensitivity with the ability to logistically accomplish testing in a reasonable manner to provide safety to both patients and staff. For example:
    - If PCR is used, then the timing should consider the turnaround time, weekend/holiday testing availability, etc. If these factors lead to testing several days before the procedure, then a different testing option might be preferable.
    - If antigen testing is used, with a typically shorter turnaround time but lower sensitivity than PCR, especially for asymptomatic individuals and early in the course of infection, then it becomes even more important that testing occur as close in time before the procedure as feasible.
- If the pre-procedure testing protocol includes use of at-home test kits, consideration should be made for the fact that many manufacturers' instructions for asymptomatic individuals involve serial testing (i.e., 2 tests, typically 1-2 days apart). Facility policies should include procedures to ascertain that the patient's at-home test(s) were performed on the correct person, in accordance with the package insert instructions, and within the appropriate timeframe (e.g., a photograph of the completed test(s) and an attestation from the patient).
- If providers choose to test patients who have recovered from SARS-CoV-2 infection in the prior 90 days, an antigen test instead of a NAAT is recommended because some people may remain NAAT positive but not be infectious during this period. There is no need to test patients who are asymptomatic and recently recovered to prove they are now negative.
- Pre-procedure testing is not required before non-scheduled emergent surgeries or procedures, which are not elective. However, in these situations, a thorough screening and history should be obtained when feasible, and appropriate precautions implemented.
- Providers should adhere to other CDC SARS-CoV-2 testing recommendations in the *Interim Infection Prevention and Control Recommendations for Healthcare Personnel*

*During the Coronavirus Disease 2019 (COVID-19) Pandemic, Perform SARS-CoV-2 Viral Testing*, including recommendations for testing of patients with symptoms of SARS-CoV-2 infection and patients with close contact to someone with SARS-CoV-2 infection.

- **The effective date of this new pre-procedure testing guidance is June 24, 2022**.

Facilities should follow applicable CDC and NYSDOH guidance regarding patient visitation with adherence to the more stringent guidance. Available guidance includes the visitation recommendations in the *CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic* and (except for the updates below), the NYSDOH June 7, 2021, *Interim Health Advisory: Updated COVID-19 Updated Guidance for Hospital Visitation and Non-Hospital Employed Patient Support*. Updates to the June 7, 2021 advisory are as follows:

- Visitors must undergo symptom checks upon entering the facility and shall be denied entry if they report symptoms of COVID-19, a positive viral test for SARS-CoV-2 in the prior 10 days, or close contact with someone with SARS-CoV-2 infection in the prior 10 days. Facilities should have an established process to identify and manage individuals with suspected or confirmed SARS-CoV-2 infection, regardless of vaccination status (e.g., individual screening on arrival at the facility or system in which individuals can self-report any of the above before entering the facility).

- Once in the facility, visitors should generally remain in the patient's room throughout the visit, except when directed to leave by hospital staff. When in other areas of the facility outside the patient's room (e.g., cafeteria, waiting area, rest room), visitors must be appropriately distanced from other patients or staff. Facilities should develop policies and procedures to ensure that visitors adhere to guidance from NYSDOH on use of source control by visitors.

In addition, all nursing homes should follow requirements of the Centers for Medicare & Medicaid Services (CMS) and should review the supplemental CDC guidance: *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes*

Healthcare facility personnel are advised to regularly and frequently review the NYSDOH website, the New York State Health Commerce System, the CDC *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic* and, for nursing homes, the *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes* for updates to NYS and CDC guidance.

Recommendations for adult care facilities in New York are available in the April 18, 2022 NYSDOH Health Advisory, "*Infection Prevention and Control Recommendations for Adult Care Facilities During the Coronavirus Disease 2019 (COVID-19) Pandemic*".

General questions or comments about this advisory can be sent to: covidhospitaldtcinfo@health.ny.gov, covidnursinghomeinfo@health.ny.gov, or icp@health.ny.gov.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

**June 9, 2022**

**TO: Healthcare Providers, Hospitals, and Local Health Departments (LHDs)**

**FROM: New York State Department of Health (NYSDOH)**
**Bureau of Communicable Disease Control (BCDC)**

**HEALTH ADVISORY: TESTING AND REPORTING OF MOSQUITO- AND TICK-BORNE ILLNESSES**

*Please distribute to the Infection Control Department, Emergency Department, Infectious Disease Department, Obstetrics/Gynecology (including Nurse Practitioners and Midwives), Family Medicine, Travel Medicine Service, Pediatrics, Director of Nursing, Medical Director, Laboratory Service, Pharmacy, and all patient care areas.*

NYSDOH is reminding healthcare providers of the procedures for testing and reporting of mosquito- and tick-borne illnesses. Providers are reminded to ask patients about outdoor activities as part of routine telehealth, outpatient, and inpatient assessments. Prompt recognition of and treatment for tick-borne diseases is crucial to minimizing morbidity and mortality. Health care provider recognition of mosquito-borne illnesses is also a key component of mosquito-borne disease surveillance activities and can assist public health authorities with appropriate implementation of interventions, including mosquito control activities. NYSDOH is therefore advising physicians on the procedures to test and report suspected cases of mosquito-borne illnesses, including West Nile virus (WNV), eastern equine encephalitis (EEE), dengue fever, chikungunya, Zika virus, and yellow fever virus as well as tick-borne illnesses including Lyme disease, babesiosis, anaplasmosis, ehrlichiosis, and Rocky Mountain spotted fever.

## SUMMARY

- Mosquito-borne (arboviral) illnesses:
  - During the mosquito season (early summer until late fall), healthcare providers should consider mosquito-borne infections in the differential diagnosis of any patient with clinical evidence of viral encephalitis or viral meningitis.
  - All cases of suspected viral encephalitis should be reported immediately to the LHD of the county where the patient resides.
  - Dengue, chikungunya, and/or Zika virus should be suspected year-round in patients presenting with fever, arthralgia, myalgia, rash, or other illness consistent with infection and recent travel to endemic areas[i].
  - Yellow fever should be considered in the differential diagnosis of any adult or pediatric patient with clinical evidence of fever, nausea, vomiting, epigastric pain, jaundice, renal insufficiency, and cardiovascular instability along with recent travel to Africa, South America, or any other area with risk of yellow fever virus transmission[ii].

    - NYSDOH provides testing for many domestic and travel-associated viruses. The tests performed will depend on the clinical characteristics, patient status, travel history, and availability of commercial testing.

- Tick-borne illnesses:
    - Tick-borne disease symptoms vary by type of infection and can include fever, fatigue, headache, and rash.
    - While Lyme disease continues to be the most prevalent tick-borne disease in New York State (NYS), other tick-borne diseases, including babesiosis and anaplasmosis, are spreading geographically within the State. Prompt recognition of and treatment for these diseases is crucial to minimizing morbidity and mortality.
    - Clinicians are reminded to use NYS-permitted commercial laboratories for routine tick-borne disease testing. Public health testing is available for more complex cases; however, specimens should not be sent to NYSDOH without first consulting the LHD of the patient's county of residence or BCDC.
- Providers should report cases of tick-borne and mosquito-borne diseases to the LHD of the patient's county of residence as soon as possible after diagnosis.

**BACKGROUND**

Domestic mosquito-borne diseases, such as EEE and WNV, continue to occur annually in NYS. EEE is regarded as one of the most serious mosquito-borne diseases in the United States because of its high mortality rate. WNV continues to be detected across NYS each year, occasionally resulting in human fatalities. A critical component of mosquito-borne disease surveillance activities is the rapid detection and timely reporting of potential cases by medical providers.

In NYS, dengue, chikungunya, and Zika virus infections are associated with travel to endemic areas; however, there is the potential for local transmission of these viruses if *Aedes albopictus* (Asian tiger) mosquitoes feed on infected persons during their viremic period after the person is infected in and returns from an endemic area.

Travelers are reminded to visit the CDC Travel Notice page prior to travel as the page informs travelers and clinicians about current health issues that impact travelers' health, like disease outbreaks, special events or gatherings, and natural disasters, in destinations around the world. Currently, the CDC has issued a Level 2 Travel Alert for Nigeria and Ghana due to ongoing outbreaks of yellow fever. Additional information is available at https://wwwnc.cdc.gov/travel/notices#warning.

Lyme disease continues to be the most prevalent tick-borne disease in NYS with over 140,000 cases estimated since 1986. The tick that carries the bacteria that causes Lyme disease (black-legged/deer tick) can also carry pathogens that cause babesiosis and anaplasmosis. Disease surveillance trends for both of these diseases show an expanding geographic range beyond the Hudson River Valley to areas farther north and west than has been seen in previous years; case numbers are steadily increasing as well. The seasonal pattern seen in Lyme disease is also seen with ehrlichiosis which is transmitted by the Lone Star tick. Rocky Mountain spotted fever (RMSF), transmitted by the American dog tick, is more rare than other tick-borne diseases, but cases continue to be reported across NYS annually. Powassan encephalitis, a tick-borne viral illness that can cause encephalitis or meningitis, is reported each year in NYS as well, although case numbers are very low, generally 1-5 cases per year.

A recent introduction to NYS, the Asian longhorned tick (*Haemaphysalis longicornis*) continues to be identified in parts of the Hudson River Valley, New York City, and Long Island. Although bites from these ticks have been known to cause human illness in other countries, to date no harmful pathogens have been found in Asian longhorned ticks collected in the United States. With ongoing testing of ticks collected in the United States, it is likely that some ticks will be found to contain pathogens that can be harmful to people. However, we do not yet know if these ticks are able to pass these pathogens along to people and make them ill. Additional information is available at https://www.cdc.gov/ticks/longhorned-tick/index.html.

**REPORTING CASES OF ARBOVIRAL AND TICK-BORNE ILLNESS**

Under NYS Public Health Law 2102 and 10 NYCRR 2.10, health care providers must ***immediately report*** by telephone any patient with suspected viral encephalitis. The report should be made to the LHD of the patient's county of residence. Viral meningitis is also reportable under public health law, but immediate notification is not required.

Other suspected presentations of arboviral infection, including those associated with dengue, chikungunya, Zika virus, and yellow fever are also reportable. Prompt reporting of suspected cases with no travel history is particularly important as these may indicate local transmission and the need for public health intervention.

Provider reporting requirements also apply to patients who are diagnosed and treated based solely or in part on clinical presentation and history.

**SPECIMEN COLLECTION AND REFERRAL FOR TESTING**

The NYSDOH's Wadsworth Center laboratories offer testing for domestic mosquito-borne viruses, including WNV and EEE. Cerebrospinal fluid (CSF) and serum testing by polymerase chain reaction (PCR) is more sensitive early in infection, while serology testing (for antibody) will better detect cases that are beyond the viremic phase. Therefore, ideally, both CSF and acute/convalescent serum specimens should be submitted for testing when neuroinvasive disease is suspected. Otherwise, acute and convalescent serum specimens can be used for diagnosis. Convalescent specimens should be drawn at least 3 weeks after acute specimens. Instructions on the collection and submission of clinical specimens can be found at http://www.wadsworth.org/programs/id/virology/services/arbovirus-testing.

Testing for dengue (PCR and serology), chikungunya (PCR and serology), and Zika virus (PCR and serology) is available through a number of NYS-permitted commercial laboratories and the Wadsworth Center. Specimens should not be sent to the Wadsworth Center for testing without first consulting the LHD of the patient's county of residence or BCDC.

Testing for yellow fever is available through Wadsworth Center and a limited number of specialized laboratories nationally. Specimens should not be sent to the Wadsworth Center for yellow fever testing without first consulting the LHD of the patient's county of residence or BCDC.

In consultation with LHDs or BCDC, public health testing is available for non-routine or specialized tick-borne disease testing. Depending upon the disease, testing may involve whole blood smear examination, PCR, or serologic testing. Confirmation of cases of tick-borne disease via collection of both acute and convalescent serum specimens is necessary unless the virus has been detected with a specific PCR assay. Further information on accessing public health testing for tick-borne disease can be obtained by calling your LHD or BCDC.

Providers are reminded to utilize NYS-permitted commercial laboratories for routine testing of patients with suspected Lyme disease. A two-tier testing protocol is recommended by CDC and NYSDOH for Lyme disease. It is important to note that serologic tests for Lyme disease are insensitive during the first few weeks of infection. Collection of convalescent sera may be required for serologic diagnosis. During the early stage, patients with an erythema migrans rash may be diagnosed clinically.

## YELLOW FEVER VACCINATION

Yellow fever vaccine is recommended for people aged ≥9 months who are traveling to or living in areas with risk for yellow fever virus transmission as determined by persistent or periodic yellow fever virus transmission. In addition, some countries require proof of yellow fever vaccination for entry. For country-specific yellow fever vaccination recommendations and requirements, see https://wwwnc.cdc.gov/travel/yellowbook/2020/preparing-international-travelers/yellow-fever-vaccine-and-malaria-prophylaxis-information-by-country

Because of the risk of serious adverse events after yellow fever vaccination, clinicians should only vaccinate people who are at risk of exposure to yellow fever virus or who require proof of vaccination to enter a country.

As of April 5, 2021, Sanofi Pasteur announced that YF-VAX (yellow fever vaccine) is once again available for purchase in the United States; YF-VAX is the only yellow fever vaccine licensed for use in the United States. Providers with a current Yellow Fever Vaccination Stamp issued by their state or territorial health department may now order YF-VAX from the manufacturer. A map of clinics with yellow fever vaccine can be found at: https://wwwnc.cdc.gov/travel/yellow-fever-vaccination-clinics/search

Additional detailed information on yellow fever vaccination can be found at: https://wwwnc.cdc.gov/travel/yellowbook/2018/infectious-diseases-related-to-travel/yellow-fever

## ADDITIONAL INFORMATION

Additional information on mosquito and tick-borne diseases can be found at:
**http://www.health.ny.gov/diseases/west_nile_virus/**
**http://www.health.ny.gov/diseases/communicable/arboviral/fact_sheet.htm**
**http://www.health.ny.gov/diseases/communicable/lyme/index.htm**
**http://www.health.ny.gov/diseases/zika_virus/**
**http://www.cdc.gov/Dengue/**
**http://www.cdc.gov/chikungunya/**
**http://www.cdc.gov/zika/**
**https://wwwnc.cdc.gov/travel/diseases/yellow-fever**

If you have any questions regarding this information, please contact your LHD or the NYSDOH Bureau of Communicable Disease Control at (518) 473-4439 or via email at bcdc@health.ny.gov. Contact information for LHDs is available at http://www.nysacho.org/i4a/pages/index.cfm?pageid=3713.

---

[i] A map of the current geographic distribution of dengue can be found at: http://www.healthmap.org/dengue/en/
A map of the current geographic distribution of chikungunya can be found at: http://www.cdc.gov/chikungunya/
A map of the current geographic distribution of Zika virus can be found at: http://www.cdc.gov/zika/

[ii] A map of the current geographic distribution of yellow fever can be found at: https://www.cdc.gov/yellowfever/maps/index.html

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

**DATE:** June 29, 2022

**TO**: Healthcare Providers, Healthcare Facilities, Clinical Laboratories, and Local Health Departments (LHDs)

**FROM**: New York State Department of Health (NYSDOH)
Bureau of Communicable Disease Control (BCDC)

**HEALTH ADVISORY: LEGIONELLOSIS**

*For All Clinical Staff in Internal Medicine, Pulmonary and Intensive Care Medicine, Geriatrics, Primary Care, Infectious Diseases, Emergency Medicine, Family Medicine, Laboratory Medicine, and Infection Control/Epidemiology*

**SUMMARY**

- **New York State has a high burden of legionellosis. Medical provider recognition of the possibility of Legionnaires' disease (LD), Pontiac fever or extrapulmonary legionellosis coupled with culture of respiratory secretions is critical to the identification of community clusters.**
- **Legionellosis occurs year-round, with increased incidence during the summer and early fall. Local health departments (LHDs) investigate cases to identify potential time-space clusters of cases.**
- **LD cannot be distinguished from other causes of pneumonia on clinical or radiologic grounds, including the virus that causes COVID-19. In hospitalized or at-risk patients with suspected pneumonia, test for *Legionella* infection especially if testing for other respiratory infections has been negative.**
    - **Culture of the organism from respiratory secretions or tissues is the gold standard for LD diagnosis and is the only way to identify and link clinical case(s) to a potential environmental source.**
- **Confirmed *Legionella* isolates from any clinical specimen[1] should be submitted to the Department's Wadsworth Center Laboratories for serogrouping and whole genome sequencing.**
- **Report legionellosis cases promptly to the LHD[2] where the patient resides.**
    - **If you are unable to reach the LHD, please contact the NYSDOH BCDC at 518.473.4439 during business hours or 866.881.2809 evenings, weekends, and holidays.**

[1] https://www.wadsworth.org/sites/default/files/WebDoc/CDRG%20NYState%202020_101920%202.pdf
[2] https://www.health.ny.gov/contact/contact_information/

## Epidemiology

Between 2018-2021, there were 4,146 legionellosis cases reported statewide. In 2019 NYS reported more cases of legionellosis than any other state.[3] In 2021, NYS investigated 28 community-acquired and 19 facility-related LD investigations, clusters or outbreaks. The statewide incidence rate was 5.5 cases per 100,000 population, with the highest geographic burden among counties located in Western New York. The national case-fatality rate is estimated to be 10% for community-acquired and 25% for healthcare-acquired LD[4].

## Information for Healthcare Providers, Facilities and Clinical Laboratories

Testing for *Legionella* guides clinical treatment and assists LHDs and NYSDOH with detecting outbreaks and linking cases to potential environmental sources of *Legionella*. This is especially critical for persons at higher risk for LD, including but not limited to persons aged 50 years or older, current, or former smokers, persons with chronic lung disease, immunocompromising conditions, systemic malignancy, or comorbid conditions such as diabetes or renal/hepatic failure, and persons with a history of travel, care at a healthcare facility, or exposure to hot tubs.

Empiric treatment of community-acquired pneumonia in hospitalized patients should include adequate coverage for *Legionella* with either a macrolide (e.g., azithromycin) or a respiratory fluoroquinolone (e.g., levofloxacin). Full detail on treatment regimens is available from the Infectious Diseases Society of America[5] and the American Thoracic Society[6]. Respiratory tract specimens for *Legionella* culture should ideally be obtained before initiation of antibiotics, although antibiotics should not be delayed in order to obtain a specimen.

Pontiac fever is a less severe illness than LD. Pontiac fever symptoms typically include fever and muscle aches. Symptoms begin between a few hours to 3 days after exposure to *Legionella* and usually last less than a week. Persons with Pontiac fever do not have pneumonia.

Extrapulmonary legionellosis is rare. However, *Legionella* has been identified as the cause of clinical infections as diverse as endocarditis, wound infections, joint infections, and graft infections, among others. A diagnosis of extrapulmonary legionellosis is made when there is clinical evidence of disease at an extrapulmonary site and diagnostic testing indicates evidence of *Legionella* at that site.

Additional information is available at the Centers for Disease and Control and Prevention's Legionellosis Resource Site[7].

## Diagnostic Testing

- **Culture** of the organism from lower respiratory secretions or tissues is the gold standard for diagnosis. Culture has the added benefit of allowing comparison of clinical isolates and environmental isolates to identify a potential source of infection in the setting of a potential outbreak. When ordering culture, specify the intent to identify Legionella as laboratory procedures for identifying this organism are different from standard respiratory specimen cultures. Please note the following regarding the diagnosis of legionellosis:
    - Sputum or bronchoalveolar lavage fluid are preferred for culturing.
    - *Legionella* culture requires specialized media (buffered charcoal yeast extract

[3] https://wonder.cdc.gov/nndss/static/2019/annual/2019-table2i.html
[4] https://www.cdc.gov/legionella/health-depts/healthcare-resources/cases-outbreaks.html
[5] https://doi.org/10.1086/425921
[6] https://www.atsjournals.org/doi/full/10.1164/rccm.201908-1581ST
[7] https://www.cdc.gov/legionella/index.html

agar {BCYE}).
    - Please specifically request that the clinical specimen be cultured for *Legionella* (not a general respiratory bacterial culture) and alert your microbiology laboratory that legionellosis is in the differential diagnosis.
- **Polymerase chain reaction (PCR)** can be performed on sputum or pathologic specimens with a high degree of sensitivity and specificity. PCR can detect *Legionella pneumophila* serogroup 1 as well as other *Legionella* species and subgroups. However, availability may be limited.
- **Urine antigen testing (UAT)** is widely available as a rapid method for detecting *Legionella*. UAT is most sensitive for detecting *L. pneumophila* serogroup 1. Although *L. pneumophila* serogroup 1 accounts for most legionellosis cases, a negative UAT does not rule out infection due to other *Legionella* species and serotypes. Furthermore, UAT does not allow for molecular comparison of organisms to help identify linked clusters of cases and determine the environmental source. When ordering UAT, clinicians should obtain respiratory specimens for culture to diagnose legionellosis.
- **Serologic** diagnosis is less useful for diagnosing acute infection and requires paired sera, collected 3–4 weeks apart, to detect a fourfold rise in antibody titer to a level >1:128. A single antibody titer is not diagnostic for legionellosis; convalescent serum must be obtained for comparison. It is important to note that because paired sera are required, results are delayed and thus may not be useful for acute case diagnosis or active outbreak investigations.

**Public Health Reporting**

- Report cases promptly to the LHD[2] where the patient resides. If you are unable to reach the LHD, please contact the NYSDOH BCDC at 518.473.4439 during business hours or 866.881.2809 evenings, weekends, and holidays.
- Clinical or epidemiological questions should be directed to your LHD or the NYSDOH BCDC at 518.473.4439 and epiLegionella@health.ny.gov.

Questions regarding clinical or epidemiological information should be directed to your LHD or the NYSDOH BCDC at 518.473.4439 and epiLegionella@health.ny.gov.

Questions regarding environmental issues should be directed to your LHD or the NYSDOH Bureau of Water Supply Protection at 518.402.7650 and wsca.legionella@health.ny.gov.

CDC resources: https://www.cdc.gov/legionella/resources/guidelines.html

ASHRAE updated guidelines: https://www.ashrae.org/about/news/2020/ashrae-publishes-updated-legionella-guideline

| | |
|---|---|
| **From:** | Joyce S. Mackessy |
| **To:** | Joseph M. Burczynski; Nancy Daoust; Marylin Galimi; Amy Tucker; Zachary Shepherd; Matthew Glidden; Gregory P. Conners; Scott Jessie; Melissia Wheeler; Paul R. Suits |
| **Cc:** | Joyce S. Mackessy; Nicole Cormier; Beth Erwin; Heidi Chapman |
| **Subject:** | Update to Advisory: NYS PROVIDER WEBINAR - UPDATED COVID vaccine clinical guidance for vaccinating individuals 6 months-11 years old - Recording |
| **Date:** | Tuesday, July 5, 2022 4:37:30 PM |

# UPDATED COVID vaccine clinical guidance for vaccinating individuals 6 months-11 years old

**From:** NYSDOH HEALTH NOTIFICATION <notify01@health.ny.gov>
**Sent:** Tuesday, July 5, 2022 2:03 PM
**To:** Joyce S. Mackessy <MackessJ@upstate.edu>
**Subject:** [EXTERNAL] Update to Advisory: NYS PROVIDER WEBINAR - UPDATED COVID vaccine clinical guidance for vaccinating individuals 6 months-11 years old - Recording

Type: Update to Advisory
Description of Update to Advisory: NYS PROVIDER WEBINAR - UPDATED COVID vaccine clinical guidance for vaccinating individuals 6 months-11 years old - Recording
Source Organization: NYSDOH
Authorizing Person: J'nelle Oxford
Sender's Jurisdiction: State
Notification ID: 108934
Date of Update to Advisory: 07/05/2022

To: Prevention Partners including Local Health Departments, Healthcare Providers, and Healthcare Facilities

From: New York State Department of Health (NYSDOH), Bureau of Immunization

Last week's NYS Provider Webinar titled "**UPDATED COVID vaccine clinical guidance for vaccinating individuals 6 months-11 years old**" was a great success. For your continued reference, this webinar was recorded and is available here: https://coronavirus.health.ny.gov/health-provider-webinars

This Provider Webinar offered a high-level summary of the most recent changes to COVID-19 vaccine authorization through the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC), including COVID-19 vaccine approvals for those 6 months-11 years old. This presentation also shared details regarding the vaccine options for various age groups and described resources that will support your role in administering the COVID-19 vaccine to your patient population.

**We urge providers to actively engage in the program and administer the COVID-19 vaccine to the pediatric population.** If you are an enrolled provider, but have not begun ordering and vaccinating, please do so now. If you are not yet enrolled, please view the instructions linked below so that you can start receiving and administering the COVID-19 vaccine.

To enroll:

Providers in NYS, outside of NYC, must enroll in the NYS COVID-19 Vaccination Program through the Health Commerce System application "COVID-19 Vaccine Program Provider Enrollment" and may review the NYSDOH COVID-19 Vaccination Program Enrollment Letter for additional guidance. Providers in NYC must enroll in the NYC Department of Health and Mental Hygiene (NYCDOHMH) program through the City Immunization Registry (CIR) registration page.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

July 8, 2022

TO: Healthcare Providers, Hospitals, Local Health Departments, Laboratories, Sexual Health Providers, Family Planning Providers, Emergency Rooms, Community Health Centers, College Health Centers, Community-Based Organizations, and Internal Medicine, Family Medicine, Pediatric, Adolescent Medicine, Dermatology, Infectious Disease, and Primary Care Providers

FROM: New York State Department of Health (NYSDOH) Bureaus of Communicable Disease Control (BCDC) and Healthcare Associated Infections (BHAI)

# HEALTH ADVISORY: MONKEYPOX CASES NOT ASSOCIATED WITH TRAVEL TO AREAS WHERE MONKEYPOX IS ENZOOTIC

## SUMMARY


- Historically, monkeypox was considered an uncommon zoonotic viral disease rarely found in the United States.
- Since May 14, 2022, numerous people diagnosed with monkeypox have been reported in several countries that do not normally have monkeypox, including the United States, United Kingdom, Spain, Portugal, and Canada.
- Regardless of gender identity, birth sex, sex of sex partner(s), travel, and/or specific risk factors, providers should be alert for patients who have rash illnesses consistent with monkeypox.
- Clinicians suspecting monkeypox infection should strictly adhere to infection control practices and must immediately notify their local health department (LHD).
- This health advisory replaces prior NYSDOH monkeypox health advisories.
- Key updates include, but are not limited to:
    - Testing at Commercial and Public Health Laboratories
    - NYS Vaccine Strategy (outside of NYC)
    - Infection Control Guidelines
    - Packaging and Treatment of Monkeypox Medical Waste
    - Monkeypox Treatment Options

**Background and Clinical Presentation of Monkeypox**

Monkeypox is a rare disease of the orthopoxvirus family that is caused by infection with the monkeypox virus.

Symptoms of monkeypox can include a flu-like prodrome followed by a rash. In some cases, the rash may start first followed by other symptoms, while others only experience a rash. These rashes can appear like pimples or blisters often in mucosal areas such as the mouth and anogenital or rectal areas which may remain limited to these areas or even spread to the face, torso, or extremities. Lesions go through different stages of healing and typically lasts 2-4 weeks. The progression of these lesions can be seen here: Centers for Disease Control and Prevention (CDC) Monkeypox Clinical Recognition webpage).

There can be a significant amount of pain associated with symptoms. Pain may interfere with basic functions such as eating, urination, and defecation which can cause distress and compound problems for the patient. Co-infections with sexually transmitted infections, group A strep infection, and other viruses have also been reported. With the presentation of symptoms, it is important to evaluate for and treat other potential infections as deemed appropriate.

**Spread and At-Risk Populations**

Monkeypox can be spread in a variety of ways. This virus is historically zoonotic in nature from infected animals that either scratch/bite an individual or by eating meat/products that are infected. The most common way individuals spread monkeypox is through direct contact with infectious rash, scabs, and/or body fluids. It is possible to also contract monkeypox through respiratory secretions during face-to-face contact, or during intimate physical contact. Spread can also happen by touching clothing or linens that have been contaminated with infectious rash or body fluids.

Although this is NOT considered a sexually transmitted infection, as described above, monkeypox can spread during intimate physical contact between individuals. People who can get pregnant are also at risk since this virus can spread to their fetus through the placenta.

## REPORTING

Healthcare providers **must immediately report suspect cases of monkeypox to their LHD**.

Reporting should be to the LHD in the county in which the patient resides.

New York City residents suspected of monkeypox infection should be reported to the NYC Health Department Provider Access Line (PAL) at 866-692-3641. Outside of New York City, contact information is available at: https://www.health.ny.gov/contact/contact_information.

If you are unable to reach the LHD where the patient resides, please contact the NYSDOH Bureau of Communicable Disease Control at: 518-473-4439 during business hours or 866-881-2809 evenings, weekends, and holidays.

## TESTING AT COMMERCIAL LABORATORIES

Testing for Orthopoxvirus is now available at LabCorp (PFI 2502) using dry swab specimens and will be available shortly at four other national laboratories including: Aegis Sciences Corporation (PFI 9512); Mayo Clinic (PFI 3263 and PFI 8221); Quest Diagnostics Nichols Institute (PFI 2478); and Sonic Healthcare (PFI 8922). Questions about testing at these facilities should be directed to the appropriate

laboratory. Contact information for laboratories can be found by searching the laboratory PFI number at: https://www.wadsworth.org/regulatory/clep/approved-labs.

NYSDOH Wadsworth Center recently released streamlined guidance for the validation of molecular detection assays for Orthopoxvirus and/or monkeypox virus. This guidance is available for clinical laboratories that have a Clinical Laboratory Evaluation Program permit and are interested in building this capability. The guidance can be found at: https://www.wadsworth.org/monkeypox-testing-guidance

**TESTING AT PUBLIC HEALTH LABORATORIES**

Testing for monkeypox is also available at NYSDOH Wadsworth Center and the New York City Public Health Laboratory. **Specimen collection and submission must be coordinated with the LHD and/or NYSDOH. Within NYC, coordination must be done in consultation with the NYC Department of Health and Mental Hygiene (NYSDOHMH).**

NYSDOH Wadsworth Center will accept specimens collected and transported in viral transport media (VTM) OR collected and transported dry. Specimens in VTM can be tested for orthopoxvirus, varicella zoster virus, and herpes simplex viruses I and II. Specimens collected dry can only be tested for orthopoxvirus. Testing for other viruses should be done locally.

The New York City Public Health Laboratory will only accept specimens collected and transported dry. They will only be tested for orthopoxvirus. Testing for other viruses should be done locally.

**Specimen Collection**

| | *FOR SPECIMENS COLLECTED FROM **NYS** RESIDENTS AND TESTED AT THE **NYSDOH WADSWORTH CENTER*** | *FOR SPECIMENS COLLECTED FROM **NYC** RESIDENTS AND TESTED AT THE **NYC PUBLIC HEALTH LABORATORY*** |
|---|---|---|
| Specimen Types | 1. Swab in viral transport media (VTM) or dry swab. Collect two samples from each of two lesions, for a total of 4 samples. | 1. **Dry** Swab ONLY (two for each lesion). Collect two samples from each of two lesions, for a total of 4 samples. |
| Collection | 1. Identify two (2) lesions per patient to sample, preferably from different locations on the body and/or with differencing appearances. **(A total of four swabs should be collected).**<br>2. Collect the sample using the sterile swab, by scrubbing the base of the lesion vigorously enough to ensure that cells from the lesion are collected. Use separate sterile swabs (synthetic-Dacron, nylon, polyester, Rayon).<br>3. Storage containers: Place each swab in tubes containing VTM (can be | 1. Identify two (2) lesions per patient to sample, preferably from different locations on the body and/or with differencing appearances. **(A total of four swabs should be collected).**<br>2. Collect the sample using the sterile swab, by scrubbing the base of the lesion vigorously enough to ensure that cells from the lesion are collected.<br>3. Storage containers: Place each swab (break off stick if necessary) in its own sterile container (i.e., conical tube or |

| | | |
|---|---|---|
| | tested for more viruses) OR place swabs in a dry sterile container (can only be tested for orthopoxvirus). See below for more information. | urine cup). (Reminder, **do not add or store in viral or universal transport media.**)<br><br>For additional information on specimen collection refer to the **Specimen collection, storage, and transport instructions** section on the Instructions for Submission of Specimens for Monkeypox Testing to the New York City Public Health Laboratory guidance located here: https://www1.nyc.gov/assets/doh/downloads/pdf/labs/monkeypox-specimen-testing.pdf |
| Submission information | A Wadsworth Center Infectious Disease Request Form **must** accompany all samples; Remote Order Entry on the Health Commerce System is preferred.<br><br>Label all tubes and swab holders with the patient's name, unique identifier, date of collection, source of specimen (vesicle/pustule) and name of person collecting the specimen.<br><br>Specimens should be stored and shipped refrigerated or frozen. Should not be shipped at ambient temperature.<br><br>Refer to the online test request/requisition page on the Wadsworth Center website for more information on remote ordering: https://www.wadsworth.org/electronic-test-request-reporting-new | A New York City Public Health Test Requisition (available upon request) **must** accompany each sample/ collection site.<br><br>Label all tubes and swab holders with the patient's name, unique identifier, date of collection, source of specimen (vesicle/pustule), collection site, and name of person collecting the specimen.<br><br>Refer to **Test ordering instructions** on the NYC PHL guidance document at https://www1.nyc.gov/assets/doh/downloads/pdf/labs/monkeypox-specimen-testing.pdf.<br><br>Briefly, go to https://a816-phleorder.nyc.gov/PHLeOrder/ and perform the following<br><br>1. Sign in using credentials or register as a new user.<br>2. Fill out required information and add the following to the specified fields: a. Test: Clinical Poxvirus b. Specimen Container: Swab c. Specimen Source: Other d. Specimen Source Other: Skin or Lesion + site of lesion swabbed (e.g., Left arm) e. Fill in both collection date and collection time fields (required). 3. Communicate with your clinical laboratory that specimens are to be delivered to PHL and that an eOrder has been submitted. |

| | | |
|---|---|---|
| Shipping Address | Dr. Christina Egan<br>DAI 3021, Biodefense Laboratory,<br>Wadsworth Center, NYS Dept. of Health 120 New Scotland Avenue<br>Albany, NY 12208 | Dr. Scott Hughes<br>New York City Public Health Lab<br>Biothreat Response Unit<br>455 1st Avenue<br>New York, NY 10016 |
| Questions | Call the Wadsworth Center Biodefense Laboratory at 518-474-4177 (business hours)<br>or the duty officer 866-881-2809 (after hours). | Call the NYC Biothreat Response Laboratory at 212-671-5834 (business hours) or Poison Control at 212-764-7667; ask for PHL duty officer (after hours). |

**Specimen Collection**

To collect vesicular and pustular material:

1. Perform hand hygiene and don gloves, gown, face, and eye protection.
2. Sanitize the patient's skin with an alcohol wipe and allow skin to air dry (do not "wave" the site to facilitate drying).
3. For swabs in tubes containing VTM (NYS), label a swab holder and remove swab from the outer sheath. Collect cells from the lesion base by 1) vigorously swabbing or brushing lesion with two separate sterile synthetic swabs (Dacron, nylon, polyester, or Rayon); 2) Place each swab in a separate sterile tube containing VTM. Secure each tube with parafilm.
4. For the dry swabs (NYC and NYS) label a swab holder and remove swab from the outer sheath. Collect cells from the lesion base by 1) vigorously swabbing or brushing lesion with two separate sterile dry polyester, nylon, or Dacron swabs; 2) Break off end of applicator of each swab into a 1.5- or 2-mL screw-capped tube with O-ring or place each entire swab in a separate sterile container. Do not add or store in viral or universal transport media.
5. Repeat this process on different lesions.
    a. For NYS there should be two specimens collected for each lesion: two sets of plastic tubes from each lesion for a total of 4 tubes.
    b. For NYC there should be two swabs for each lesion
6. After specimen collection is completed, all personal protective equipment (PPE) worn by the specimen collector and all waste generated during the specimen collection (e.g., alcohol wipes, holders, etc.) should be discarded according to facility's usual procedures for what is considers regulated medical waste (I.e., there are no changes to what is considered regular waste versus regulated medical waste when caring for someone with suspect or confirmed orthopox/monkeypox). All sharp devices used to open vesicles (e.g., needles, blades, etc.) used to open vesicles should be disposed of in an appropriate sharps container. Hand hygiene should be performed before and immediately after specimen collection and following removal of PPE. Alcohol-based hand sanitizers are preferred unless hands are visibly soiled. If hands are visibly soiled, hand hygiene should be performed using soap and water.
7. Other sample types such as serum and whole blood may also be requested.

Please note: Monkeypox virus can be cultivated in several cell culture types routinely used by the viral testing laboratory. Although laboratories should not attempt to isolate this virus, if you become aware that your laboratory has isolated monkeypox using cell culture, you should **immediately** contact the Wadsworth Center or the NYC PHL.

**VACCINATION**

JYNNEOS (aka: IMVANEX, IMVAMUNE) is licensed by the US FDA as a 2-dose series for the prevention of monkeypox among adults ages 18+. If given within 4 days of exposure, this vaccine may reduce likelihood of infection, and within 14 days may reduce severity of symptoms. JYNNEOS is available only via the federal National Strategic Stockpile and is being made available by the federal government for the primary purpose of post-exposure prophylaxis (PEP) among those with a possible recent exposure to monkeypox. PEP may be further divided into two strategies:

1) PEP for an exposed contact of a suspected or confirmed monkeypox case, and

2) Broader community distribution for persons who are not known to be exposed contacts of a suspected/confirmed case but have behavioral/epidemiological criteria consistent with a possible recent exposure. CDC has called this strategy "PEP++".

In the United States and in New York, there is currently a limited supply of JYNNEOS vaccine, although more vaccine is expected in the coming weeks and months. NYSDOH is rolling out vaccine in a phased approach, as it becomes available, in accordance with CDC guidance. Currently, JYNNEOS for both PEP uses are available through NYSDOH distributions via Local Health Departments.

For #1 above, people who are identified by an LHD as exposed to a suspected or confirmed monkeypox case in the past 14 days will work directly with their LHD and healthcare provider to discuss obtaining the JYNNEOS vaccine.

For #2 above, community-distributed PEP for those with recent qualifying behavioral/epidemiological criteria, NYSDOH's approach is consistent with CDC guidance and limited supply, currently in 2 phases:

- Phase 1 (July 11 through about July 15) offers a limited amount of vaccine doses and is focused on reaching those at high risk of a recent (within the past 14 days) exposure to monkeypox.
    - According to CDC, those at high risk of a recent exposure to monkeypox may include members of the gay, bisexual, transgender and gender non-conforming community and other communities of men who have sex with men who have engaged (in the past 14 days) in intimate or skin-to-skin contact with others in areas where monkeypox is spreading.
    - This includes those who have had skin-to-skin contact with someone in a social network experiencing monkeypox activity, including men who have sex with men who meet partners through an online website, digital application ("app"), or social event (e.g., a bar or party).

  The following counties outside of New York City have received doses for Phase 1 distribution: Nassau, Rockland, Saratoga, Suffolk, Sullivan, and Westchester. These doses are being administered through specific points of distribution only. Please refer patients to county webpages to learn more about options for scheduling an appointment.

- Phase 2 (after July 15 and through the summer) will offer a modestly expanded supply of vaccine doses and also focus on those at high risk of a recent exposure (within the past 14 days), where vaccination can reduce risk of infection and decrease symptoms if infection has occurred.

As the vaccine program evolves, additional information on the program (outside of NYC), dose availability, and clinical guidance will be made available at https://health.ny.gov/monkeypox.

For information on the NYC vaccine program, please visit: https://www1.nyc.gov/site/doh/health/health-topics/monkeypox.page#vax.

**INFECTION CONTROL GUIDELINES**

Standard Precautions should be applied for all patient care, including for patients with suspected monkeypox. If a patient seeking care is suspected to have monkeypox, infection prevention and control personnel should be notified immediately. Activities that could resuspend dried material from lesions, e.g., use of portable fans, dry dusting, sweeping, or vacuuming should be avoided.

A patient with suspected or confirmed monkeypox infection should be placed in a single-person room; special air handling is not required. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom. Transport and movement of the patient outside of the room should be limited to medically essential purposes. If the patient is transported outside of their room, they should use well-fitting source control (e.g., medical mask) and have any exposed skin lesions covered with a sheet, wound dressing, or gown. Intubation and extubation and any procedures likely to spread oral secretions should be performed in an airborne infection isolation room (AIIR).

PPE used by healthcare personnel who enter the patient's room should include gown, gloves, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), and a NIOSH-approved particulate respirator equipped with N95 filters or higher.
For more information on infection prevention and control of monkeypox, please visit the CDC website at https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html or the monkeypox main information page at https://www.cdc.gov/poxvirus/monkeypox/index.html.

**Update: PACKAGING AND TREATMENT OF MONKEYPOX MEDICAL WASTE**
In June 2022, the U.S. Department of Transportation (USDOT) released additional guidance on the handling of regulated medical waste (RMW) from suspected or confirmed cases of monkeypox. The USDOT June 2022 guidance can be found at: https://www.phmsa.dot.gov/transporting-infectious-substances/planning-guidance-handling-category-solid-waste.

The previous position of the USDOT was that facilities should hold untreated RMW generated from suspected cases of monkeypox and wait until testing confirms the diagnosis and identifies the clade before disposing of the waste.

However, the USDOT, in conjunction with other Federal partners, has issued new guidance indicating that during the ongoing 2022 multi-national outbreak of West African clade monkeypox, if clinician teams determine that a patient does not have known epidemiological risk for the Congo Basin clade of monkeypox (e.g. history of travel to the Democratic Republic of the Congo, the Republic of Congo, the Central African Republic, Cameroon, Gabon, or South Sudan in the prior 21 days) it is appropriate to manage waste from suspected monkeypox patients as RMW. If the Congo Basin clade of monkeypox is excluded, medical waste does not have to be held pending clade confirmation and medical waste needs to be packaged, transported, and treated as RMW. The waste must be packaged in accordance with 49 CFR § 173.197, labelled as United Nations (UN) 3291, Regulated medical waste (Monkeypox waste), and treated by incineration or by autoclaving at 121°C/250°F for at least 30 minutes.

Additional information can be found on the Centers for Disease Control and Prevention (CDC) web site at: https://www.cdc.gov/csels/dls/locs/2022/06-21-2022-lab-advisory-interagency_partners_update_planning_guidance_disposal_shipment_material_suspected_contain_monkeypox_virus.html

However, if epidemiological risk factors indicate a risk for Congo Basin clade, waste should be managed as a Category A infectious substance pending clade confirmation. If testing shows any clades except the West African clade, it needs to be packaged, transported, and treated as Category A waste. The waste must be packaged in accordance with 49 CFR § 173.196, labelled as United Nations (UN) 2814, Infectious substances, affecting humans (Monkeypox waste), and managed as Category A waste.

## TREATMENT OPTIONS

### Mild to Moderate Disease-Low risk for severe disease

- Supportive care including fluids and wound hygiene/care
- Analgesics as needed
- Topical or aerosolized diphenhydramine (Benadryl) or lidocaine for lesion associated pruritus and pain respectively

### Supportive Care

This first level of care includes the maintenance of fluids, pain management, treatment of bacterial superinfections of skin lesions, and treatment of any possible co-occurring sexually transmitted or superimposed bacterial skin infections.

Skin lesions should be kept clean and dry to prevent further secondary infection. Pruritus can be treated with an oral antihistamines and topical agents such as calamine lotion, cortisone 10, or petroleum jelly.
For oral lesions, prescription medicated mouthwashes can be used to manage pain. Oral antiseptics are helpful in keeping lesions clean. Topical gels such as benzocaine/lidocaine can be used for temporary relief, while eating and drinking.

Proctitis can occur with or without lesions and is often manageable with supportive care, stool softeners may be beneficial. Topical gels such as benzocaine/lidocaine can be used for temporary relief as well. Sitz baths can also be used for proctitis. Pain management may be beneficial utilizing over-the-counter medication such as acetaminophen or prescription medications (narcotics risk constipation). Additionally, proctitis may cause rectal bleeding, which should be evaluated by a healthcare provider.
Nausea and vomiting can be controlled with the use of anti-emetic as deemed appropriate. Diarrhea should be managed through proper hydration and electrolyte replacement.

### Moderate to Severe Disease – or people at high risk for development of severe disease

- Currently no treatments are approved specifically for monkeypox, however multiple agents have been developed for smallpox which may be beneficial in treating monkeypox
- Four agents available for treatment
  - Tecovirimat (TPOXX)
  - Vaccinia Immune Globulin Intravenous (VIGIV)
  - Cidofovir (Vistide)
  - Brincidofovir (CMX001 or Tembexa)

### Tecovirimat (TPOXX)

Tecovirimat (TPOXX) is a renally excreted antiviral targeting the Orthopoxvirus envelope wrapping protein. TPOXX is FDA approved for the treatment of smallpox in children and adults and available in oral and intravenous formulations. There is no data for the effectiveness of TPOXX in treating monkeypox infections in people. Since the monkeypox virus is of the same genus as the smallpox, it is believed that the similarities in morphology will allow TPOXX to be effective against monkeypox. In animal studies, TPOXX was found to reduce the risk of death. In people, efficacy was limited to drug levels in blood and a few case studies, while a case series of individuals infected with Monkeypox virus included on patient treat with TPOXX showed that the medication may shorten the duration of illness and viral shedding (Adler et al., 2022).

TPOXX can only be obtained from the Centers for Disease Control and Prevention, which holds a non-research Expanded Access Investigational New Drug (EA-IND) Protocol for tecovirimat to be used on presumed and confirmed cases of monkeypox. Informed consent from the patient is necessary to receive tecovirimat. (See here for more information.
www.accessdata.fda.gov/drugsatfda_docs/label/2022/214518s000lbl.pdf )

**Who Should Receive Tecovirimat**

This course of treatment may be considered in people infected with monkeypox virus that meet the following:

- With severe disease
- At high risk of severe disease
    - Immunocompromised
    - Pediatric populations
    - Pregnant or breastfeeding individuals
    - People with history or presence of skin conditions
    - People with one or more complication from infection
- With infections deviating from normal involving implantation in eyes, mouth, or other anatomic areas where infection might become a special hazard

**Who should not receive Tecovirimat**

Under the EA-IND, people who are ineligible for tecovirimat treatment are those who are unwilling to signed informed consent documentation as well as those with a known allergy to the drug or its components

**Absorption and Adverse Effects of Tecovirimat**

**Oral tecovirimat**: Absorption of this drug is dependent on adequate intake of a full, fatty meal. For adults, the standard dosing is 600mg every 12 to 14 hours. This will require taking 3 pills every 12 hours, for most adults. Therefore, it is important for the adult to tolerate consistent intake of meals twice a day. Reported adverse effects include headache (12%), nausea (5%), abdominal pain (2%), and vomiting (2%). Neutropenia was found in one study participant.

**IV tecovirimat**: IV tecovirimat should not be administered to those with severe renal impairment (CrCL <30 mL/min). For this population, the oral formulation is still an option. IV tecrovirimat should also be used with caution for those with moderate (CrCL 30-49 mL/min) or mild (CrCL 50-80 mL/min) renal impairment as well as those less than 2 years of age given immature renal tubular function. Reported adverse effects of IV tecovirimat include infusion site pain (19%), infusion site swelling (39%), infusion site erythema (23%), infusion site extravasation (19%), and headache (15%).

**What is Required from Clinicians/Healthcare Providers**

When administering tecovirimat there are certain documentation requirements under an EA-IND that must be met. Providers may be contacted for further follow-up if necessary. These requirements include:

- Informed consent prior to treatment initiation
- FDA Form 1572
    - Complete within 3 calendar days by the responsible clinician/healthcare provider along with a CV of the treating physician
- Patient intake form to provide patients baseline condition at time of treatment
- Adverse event form
- Clinical outcomes form
    - To report treatment duration and patient's clinical outcome upon completion
- Photos of lesions
    - 1 prior and 1 during treatment (between days 7 and 14) with dates indicated

**Requesting Tecovirimat**
Tecovirimat is only available through the federal Strategic National Stockpile. For facilities that are interested in prescribing tecovirimat for patients eligible under the EA-IND criteria, medication must be requested through the Centers for Disease Control State and territorial health authorities can direct their requests for medical countermeasures for the treatment of monkeypox to the CDC Emergency Operations Center (770-488-7100).

**Other medications and treatment options:**

**Vaccina Immune Globulin Intravenous (VIGIV):** Vaccinia Immune Globulin Intravenous (VIGIV) is an FDA approved treatment for the complications following vaccinia vaccination. The CDC's expanded access protocol allows for the use of VIGIV for the treatment of Orthopoxviruses (including monkeypox) in an outbreak. Effectiveness data is not available of VIG in treatment of monkeypox virus infection. There is no known benefit in treatment of monkeypox and is also unknown if a person with severe monkeypox infection will benefit from treatment with VIG. However, VIGIV use may be considered in severe cases. VIVIG may also be considered for prophylactic use in exposed individuals with severe T-cell dysfunction for which smallpox vaccination following exposure to monkeypox virus is contraindicated. VIGIV is not commercially available but can be made available through the Strategic National Stockpile (SNS) for the treatment of smallpox vaccine complications in patients with serious clinical manifestations. (See www.fda.gov/media/78174/download for full dosing, administration, reactions, and contraindications)

**Cidofovir (Vistide):** Cidofovir (Vistide) is an intravenous, renally excreted antiviral targeting the cytomegalovirus (CMV) DNA polymerase. Cidofovir is FDA approved for the treatment of CMV retinitis in patients with Acquired Immunodeficiency Syndrome (AIDS). The CDC's expanded access protocol allows for the use of Cidofovir for the treatment of orthopoxviruses (including monkeypox) in an outbreak. Effectiveness data is not available for Cidofovir in treating human cases of monkeypox. However, it has shown to be effective against Orthopoxvirus in *in vitro* and animal studies. It is unknown if a person with severe monkeypox infection will benefit from treatment with Cidofovir, its use may be considered in such instances. Brincidofovir may be a safer option over Cidofovir. Serious renal toxicity or other adverse events have not been observed during treatment of cytomegalovirus infections with Brincidofovir as compared to treatment using Cidofovir. Given Cidofovir's use in CMV disease, it may be also available outside the CDC's access protocol. Currently, cidofovir is stockpiled by the SNS and would be made available under the appropriate regulatory mechanism.
(See www.accessdata.fda.gov/drugsatfda_docs/label/1999/020638s003lbl.pdf for full dosing, administration, reactions and contraindications)

**Brincidofovir (CMX001 or Tembexa):** Brincidofovir (CMX001 or Tembexa) is an oral, hepatically excreted antiviral targeting the smallpox DNA polymerase. Brincidofovir is FDA approved for the treatment of human smallpox disease in adult and pediatric patients, including neonates. Effectiveness data is not available for Brincidofovir in treating cases of monkeypox in people. However, it has shown effectiveness against orthopoxviruses in *in vitro* and animal studies. The CDC is currently developing an Expanded Access for an Investigational New Drug (EA-IND) for Brincidofovir use for treatment for monkeypox. (Brincidofovir is currently unavailable from the United States' Strategic National Stockpile (SNS)).

**References**

Adler H, Gould S, Hine P, Snell LB, Wong W, Houlihan CF, Osborne JC, Rampling T, Beadsworth MB, Duncan CJ, Dunning J. Clinical features and management of human monkeypox: a retrospective observational study in the UK.
*The Lancet Infectious Diseases*. 2022 May 24. https://doi.org/10.1016/S1473-3099(22)00228-6
CDC. Guidance for Tecovirimat Use Under Expanded Access Investigational New Drug Protocol during 2022 U.S. Monkeypox Cases. https://www.cdc.gov/poxvirus/monkeypox/clinicians/Tecovirimat.html
CDC. Treatment information for Healthcare Professionals.
https://www.cdc.gov/poxvirus/monkeypox/clinicians/treatment.html
European Medicines Agency. Tecovirimat.
https://www.ema.europa.eu/en/medicines/human/EPAR/tecovirimat-siga
Food and Drug Administration. Tecovirimat package insert.
https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/214518s000lbl.pdf
Titanji B, Tegomoh B, Nematollahi S, Konomos M, Kulkarni PA. Monkeypox - A Contemporary Review for Healthcare Professionals. *Open Forum Infectious Diseases.* 2022.
https://doi.org/10.1093/ofid/ofac310
World Health Organization. Clinical Management and Infection Prevention and Control for Monkeypox – Interim Rapid Response Guidance. June 10, 2022. https://www.who.int/publications/i/item/WHO-MPX-Clinical-and-IPC-2022.1

## ENVIRONTMENTAL INFECTION CONTROL - FOR HEALTHCARE SETTINGS

Standard cleaning and disinfection procedures should be performed using an EPA- and DEC-registered hospital-grade disinfectant with an emerging viral pathogen claim. Products with Emerging Viral Pathogens claims may be found on EPA's List Q. Follow the manufacturer's directions for concentration, contact time, and care and handling.

Soiled laundry (e.g., bedding, towels, personal clothing) should be handled in accordance with recommended [PDF – 241 pages] standard practices, avoiding contact with lesion material that may be present on the laundry. Soiled laundry should be gently and promptly contained in an appropriate laundry bag and never be shaken or handled in manner that may disperse infectious material.

Activities such as dry dusting, sweeping, or vacuuming should be avoided. Wet cleaning methods are preferred.

Management of food service items should also be performed in accordance with routine procedures.

Detailed information on environmental infection control in healthcare settings can be found in CDC's Guidelines for Environmental Infection Control in Health-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [section IV.F. Care of the environment].

Infection Control: Healthcare Settings | Monkeypox | Poxvirus | CDC

# COFFEE WITH THE CMO

All Upstate providers are invited to gather with colleagues for an update from Upstate's Chief Medical Officer, Amy Tucker. An open Q&A and reception to follow.

**COFFEE AND WRAPPED TO-GO BREAKFAST TREATS WILL BE OFFERED.**

## UNIVERSITY HOSPITAL

Cancer Center
First Floor
Conference
Rooms

**Tuesday, June 28:**
**7:45 am – 8:30 am**

## COMMUNITY HOSPITAL

Community Room,
Room #0124,
across from
the cafeteria.

**Thursday, July 14:**
**7 am – 7:45 am**

## UHCC

Fifth Floor
Conference
Rooms

**Tuesday, August 2:**
**7:45 am – 8:30 am**

## MARK YOUR CALENDAR AND RESERVE YOUR SPOT:

**RSVP** Darcy DiBiase, Primary Care Liaison | dibiased@upstate.edu

UPSTATE
UNIVERSITY HOSPITAL

UPSTATE
UNIVERSITY HOSPITAL

# CDI Tip of the Month – June 2022

**Applies to all providers**

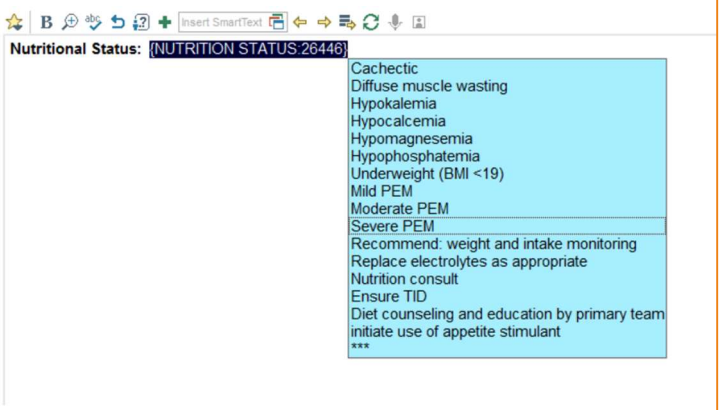
**Documentation Tools are available which may help you avoid a Query!**

*Please remember that these tools are available for use when documenting Nutritional Status and Sepsis*

## NUTRITION STATUS SMART PHRASE

**This is a SMART Phrase we first mentioned in January, developed in collaboration to help improve your documentation of nutrition conditions**

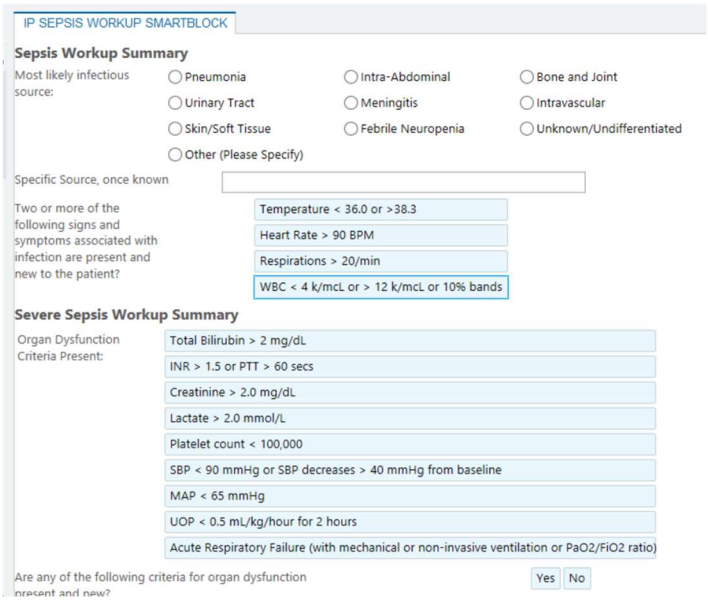
1. Type ***.nutritionalstatus*** which gives you the drop-down menu seen in this image. You can select multiple (all appropriate) options, by clicking on them.




## Sepsis Note

*Two different ways to access the sepsis note*

1. In any note type ***.sepsisworkup***, a Smartblock will open up. Just click it and you are in the sepsis note!
2. Click create Notewriter and select procedures. A list of procedures will open up, type in the empty box ***sepsis*** and Smartblock opens up, click it and you are in the sepsis note.




## Keep in Mind

*As a licensed independent provider, you have the final say. It is your patient and diagnostic decision making is yours to make, we just want to help you document it more completely.*
*If you need help please reach out to a member of the CDI Team!*

June 2022

cdi@upstate.edu