



CDC/IDSA Clinician Call

February 1, 2024

Welcome & Introductions



Dana Wollins, DrPH, MGC
Senior Vice President, Strategy
Infectious Diseases Society of America

- **100th** in a series of calls, initiated in 2020 as a forum for information sharing among frontline clinicians caring for patients with COVID-19.
- The views and opinions expressed here are those of the presenters and do not necessarily reflect the official policy or position of the CDC or IDSA. Involvement of CDC and IDSA should not be viewed as endorsement of any entity or individual involved.
- This webinar is being recorded and can be found online at www.idsociety.org/cliniciancalls.

Prevention & Treatment of Respiratory Tract Infections in Long-Term Care Facilities: Challenges & Solutions

COVID-19 Real-Time
Learning Network

Brought to you by **CDC** and  **IDSA**

1. Burden of RTIs in the Older Population: Current State



Elizabeth A. Mothershed, MS
Deputy Associate Director for Program Safety
Office of the Director
Division of Healthcare Quality Promotion
U.S. Centers for Disease Control and Prevention

2 Vaccination Uptake in Long-Term Care Facilities: The Current State



Hannah E. Reses, MPH
Vaccination Unit Lead
Surveillance Branch
Division of Healthcare Quality Promotion
U.S. Centers for Disease Control and Prevention



David Gifford, MD, MPH
Chief Medical Officer
Director, Center for Health Policy Evaluation in Long-Term
Care
American Health Care Association
National Center for Assisted Living

3. Treatment of RTIs in Long-Term Care Facilities



Michael L. Barnett, MD
Associate Professor
Department of Health Policy and Management
Harvard T.H. Chan School of Public Health Policy



Morgan J. Katz, MD, MHS
Assistant Professor of Medicine
Division of Infectious Diseases
Johns Hopkins University

4. Q&A/Discussion

Philip Dollard, MPH
Epidemiologist
U.S. Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic
Infectious Diseases
Division of Healthcare Quality Promotion

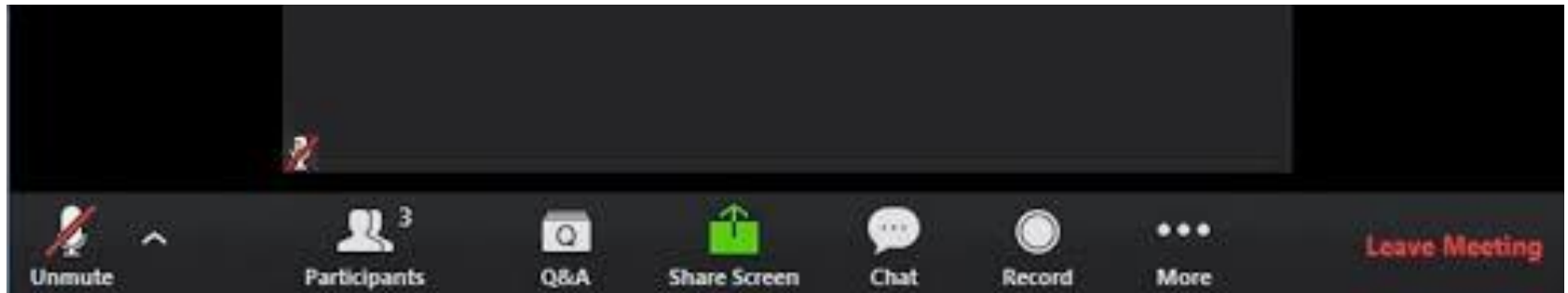


Meghan Pennini, PhD
Chief Vaccine and Therapeutics Officer
HHS Coordination Operations and Response Element
Administration for Strategic Preparedness & Response
U.S. Department of Health and Human Services

Question?
Use the “Q&A” Button



Comment?
Use the “Chat” Button



Burden of Respiratory Tract Infections in the Older Population: Current State

Elizabeth A. Mothershed, MS

Deputy Associate Director for Program Safety

Office of the Director

Division of Healthcare Quality Promotion

U.S. Centers for Disease Control and Prevention



Updated COVID-19, Influenza, and Respiratory Syncytial Virus (RSV) Cases & Hospitalizations among Nursing Home Residents

National Healthcare Safety Network (NHSN)

Elizabeth A. Mothershed, M.S.

Deputy Associate Director for Program Strategy

Office of the Director

Division of Healthcare Quality Promotion

Disclosures

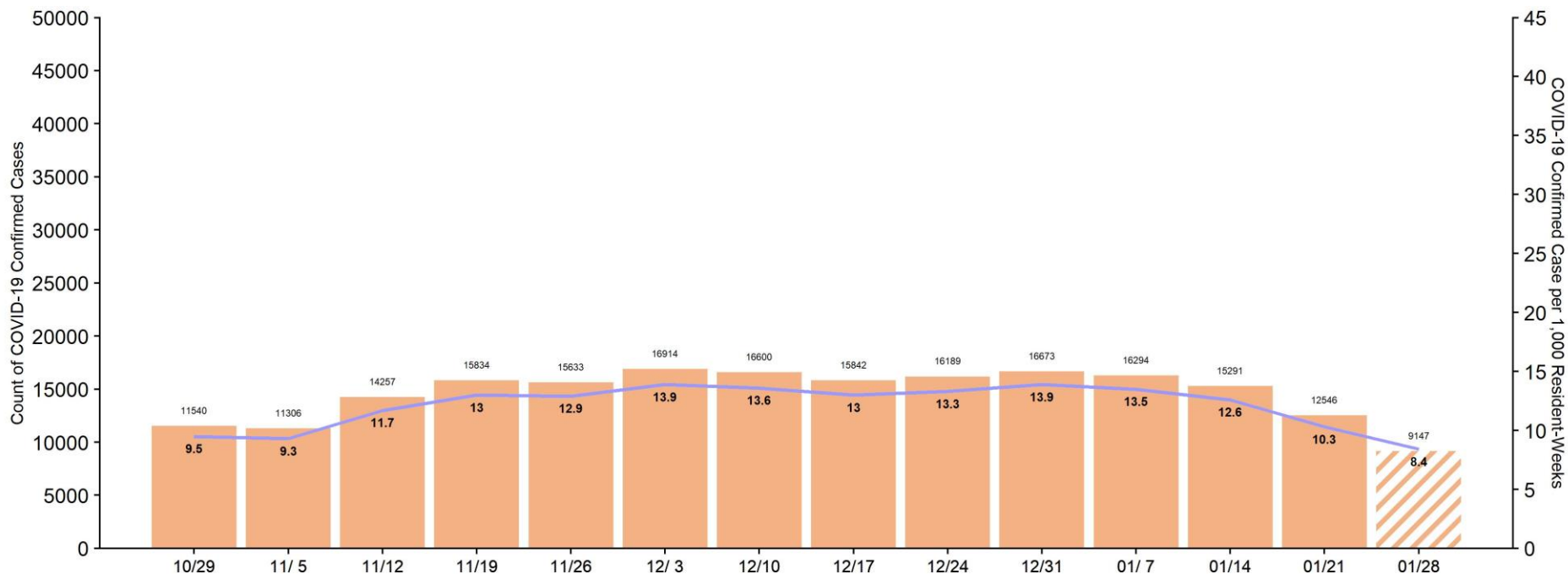
- Nothing to disclose

Background

- COVID-19 case reporting
 - Nursing homes required by CMS to report weekly, aggregate COVID-19 case data to the CDC's National Healthcare Safety Network (NHSN) since 12/2020
 - NHSN also collects data on COVID-19 hospitalizations of nursing home residents
 - Hospitalization is defined as any resident admitted to a hospital (for any reason) with a positive COVID-19 test within the past 10 days

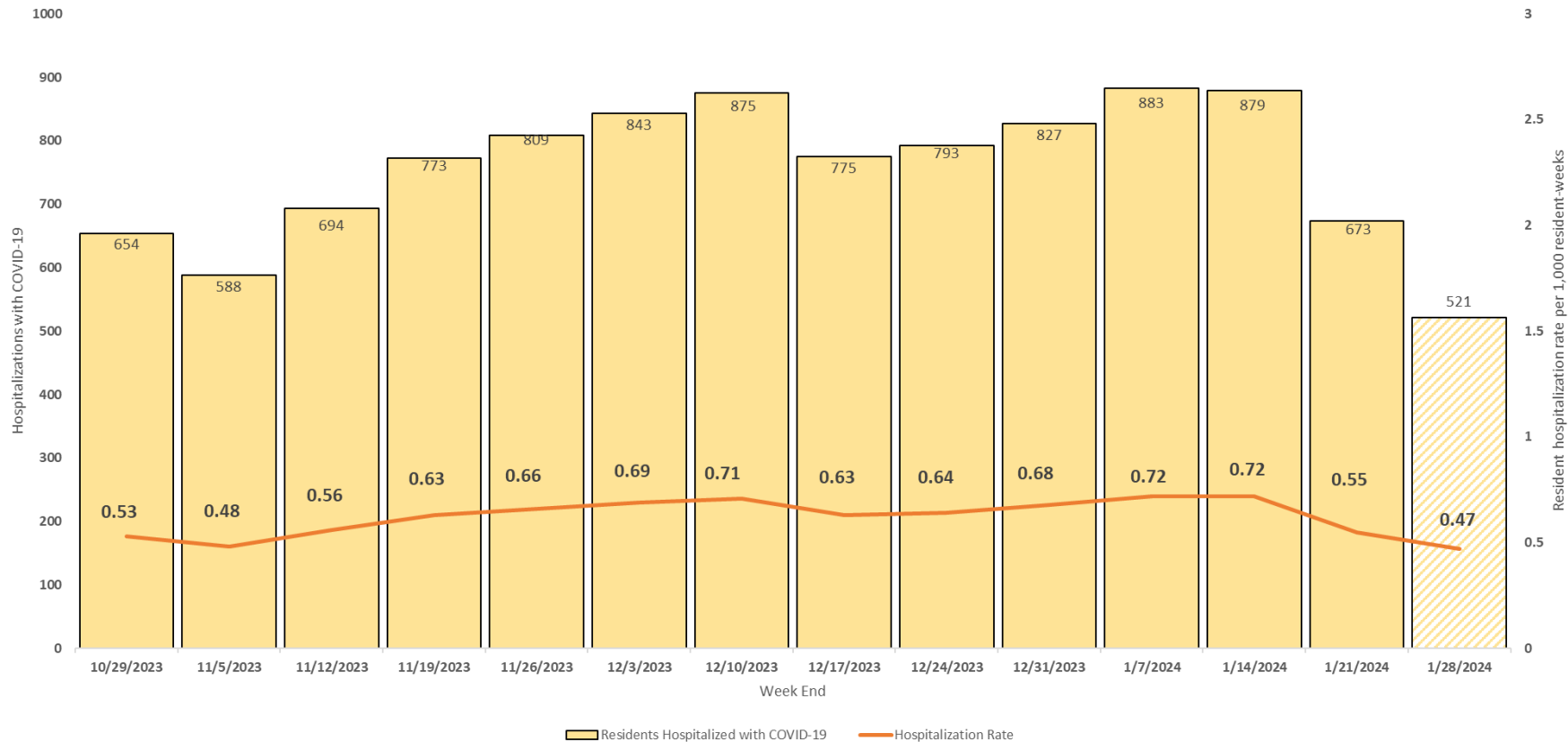
- Influenza and RSV case reporting
 - Nursing homes may **optionally** report RSV and influenza cases among residents since 10/2023

Skilled Nursing Facilities, COVID-19 Cases per 1,000 Resident-Weeks among Residents, National, Inferred Data* (Number of facilities = 15,242)



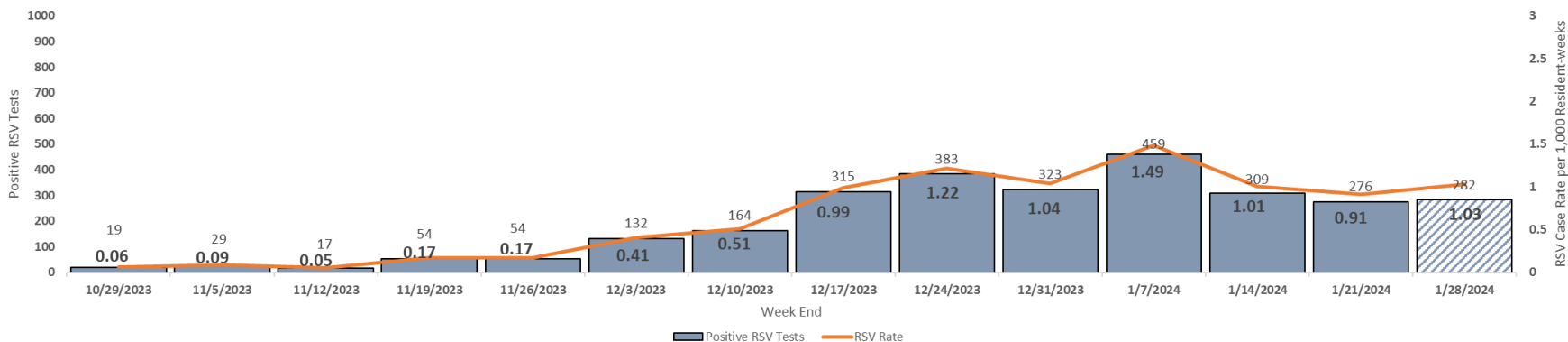
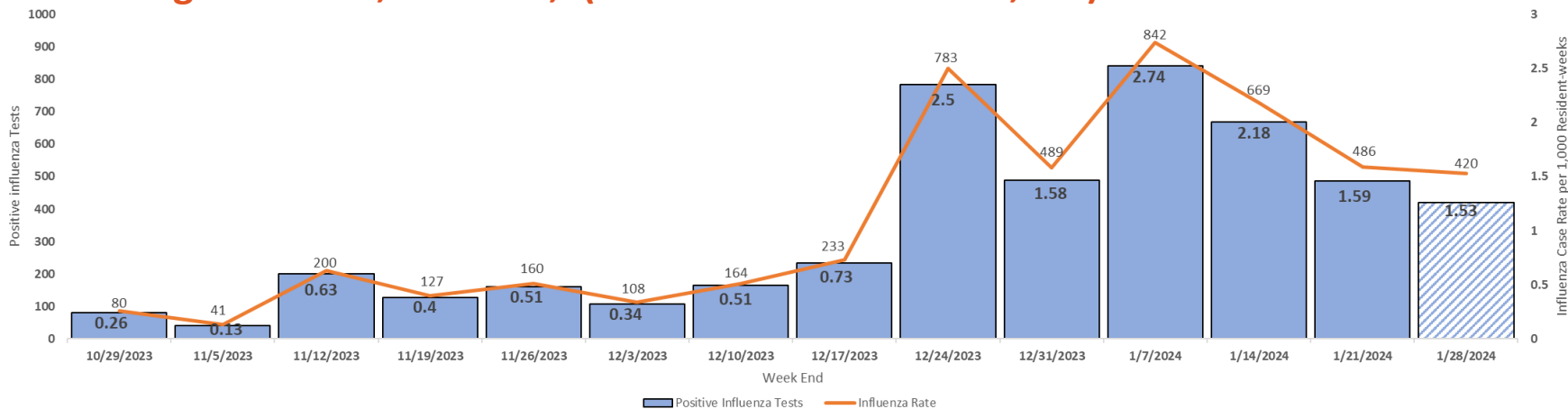
Inferred Data: For the purpose of best epidemiological understanding, data that fail quality checks or appear inconsistent with surveillance protocols are assigned a value based on their patterns of data-entry or excluded.

Skilled Nursing Facilities, Hospitalizations with COVID-19 per 1,000 Resident-Weeks among Residents, National, (Number of facilities = 15,242)





Skilled Nursing Facilities, Influenza and RSV Cases per 1,000 Resident-Weeks among Residents, National, (Number of facilities = 6,099)



*Number of facilities reporting may vary from week to week. ** Patterened fill represents data is likely still accruing, all data can be modified week-to-week by facilities.

Data are provisional until officially released from CDC – For Internal Use Only (FIUO) – For Official Use Only (FOUO) – Sensitive But Unclassified (SBU)

Vaccination Uptake in Long-Term Care Facilities: The Current State

Hannah E. Reses, MPH

Vaccination Unit Lead

Surveillance Branch

Division of Healthcare Quality Promotion

U.S. Centers for Disease Control and Prevention

David Gifford, MD, MPH

Chief Medical Officer

Director, Center for Health Policy

Evaluation in Long-Term Care

American Health Care Association

National Center for Assisted Living



Updated COVID-19, Influenza, and Respiratory Syncytial Virus (RSV) Vaccination among Nursing Home Residents

National Healthcare Safety Network (NHSN)

Hannah Reses, MPH

Vaccination Unit Lead

Surveillance Branch

Division of Healthcare Quality Promotion

Disclosures

- Nothing to disclose

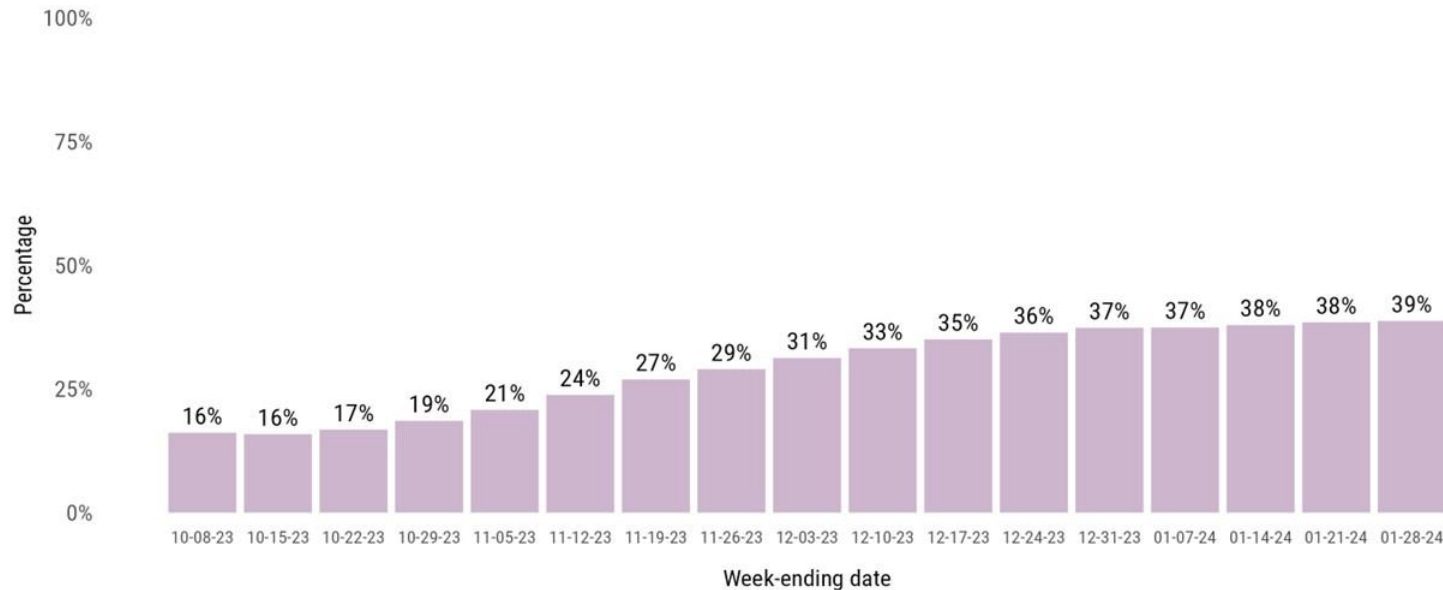
Background

- COVID-19 vaccination reporting
 - Nursing homes required by CMS to report weekly, aggregate COVID-19 vaccination data to the CDC's National Healthcare Safety Network (NHSN)
 - Reported in NHSN since December 2020
 - NHSN collects up-to-date (UTD) COVID-19 vaccination, currently defined in NHSN as the receipt of a 2023–24 updated COVID-19 vaccine; [surveillance definition of UTD defined by reporting quarter](#)
 - Educate on definition changes via webinars and targeted data quality outreach
- Influenza and RSV vaccination reporting
 - Nursing homes may optionally report RSV and influenza vaccination among residents
 - Reported in NHSN since October 2023
 - An estimated 91% of nursing homes residents are aged ≥ 60 years (i.e., eligible for RSV vaccination)
 - Nursing home residence is an important risk factor to consider in shared clinical decision-making

The percent of nursing home residents who received the updated COVID-19 vaccine has plateaued around 38-39% in recent weeks

Percentage of nursing home residents who are up to date with COVID-19 vaccination (N = 14,421 nursing homes)

Up to date defined as receipt of 2023-2024 Updated COVID-19 vaccine



Up to date calculation excludes individuals with medical contraindication from denominator.

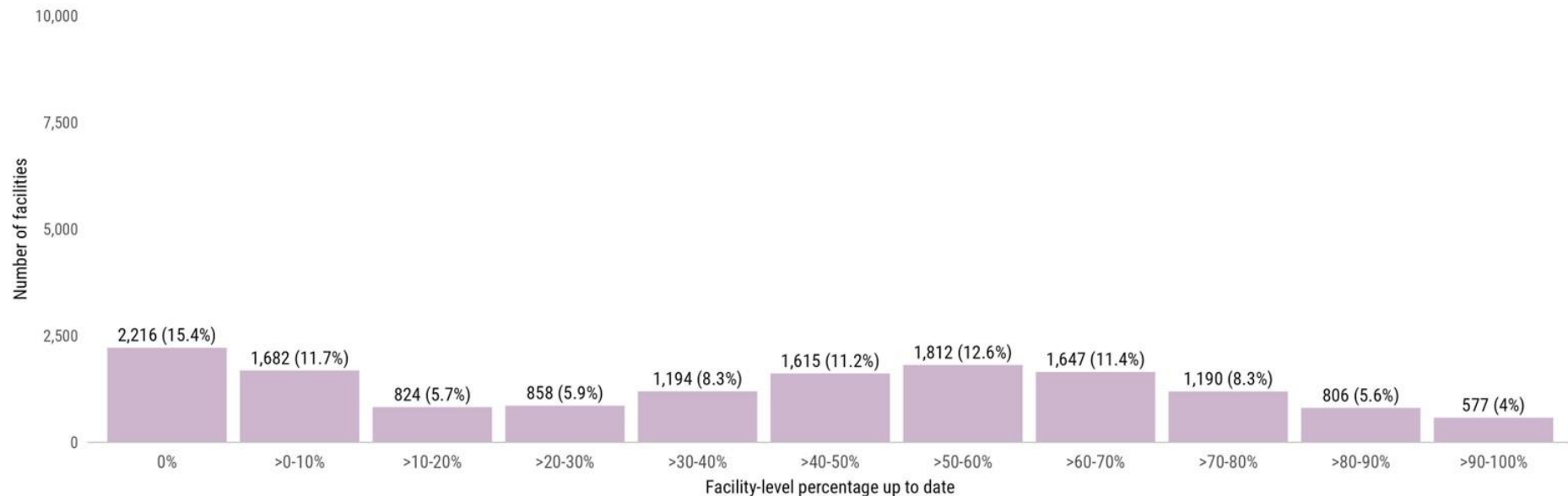
Data that fail certain quality checks or appear inconsistent with NHSN surveillance protocols are excluded.

The NHSN surveillance definition of up to date is updated quarterly to incorporate CDC guidance changes. See [here](#) for NHSN surveillance definitions, including up to date, by reporting quarter. Data for the most recent week are still accruing.

Most nursing homes report that $\leq 10\%$ or 40-70% of residents have received the updated COVID-19 vaccine

Facility-level percentage of nursing home residents who are up to date with COVID-19 vaccines

N = 14,421 nursing homes that have reported data for the week of 01/22/24 - 01/28/24 or the most recent week where data are available within the past two weeks



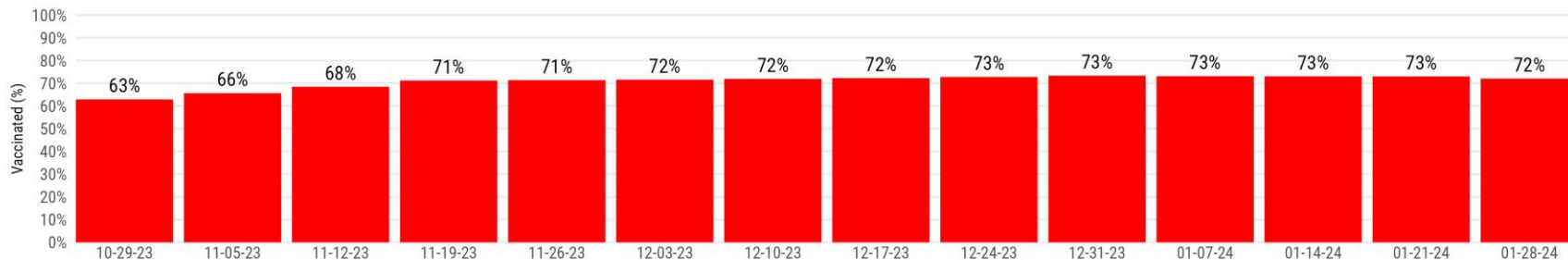
Up to date calculation excludes individuals with medical contraindication from denominator.
Data that fail certain quality checks or appear inconsistent with NHSN surveillance protocols are excluded.

The NHSN surveillance definition of up to date is updated quarterly to incorporate CDC guidance changes. See [here](#) for NHSN surveillance definitions, including up to date, by reporting quarter. Data for the most recent week are still accruing.

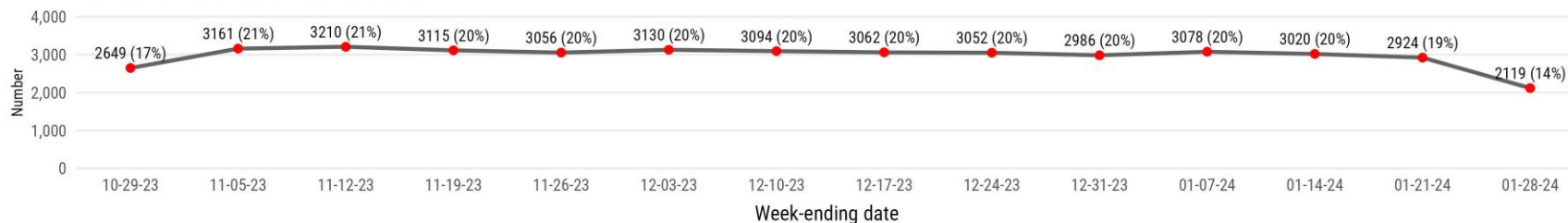
The percent of nursing home residents who received the influenza vaccine has remained near 72-73% for several months

Percentage of nursing home residents who received a 2023-2024 seasonal influenza vaccine

October 29, 2023 – January 28, 2024



Number of nursing homes reporting



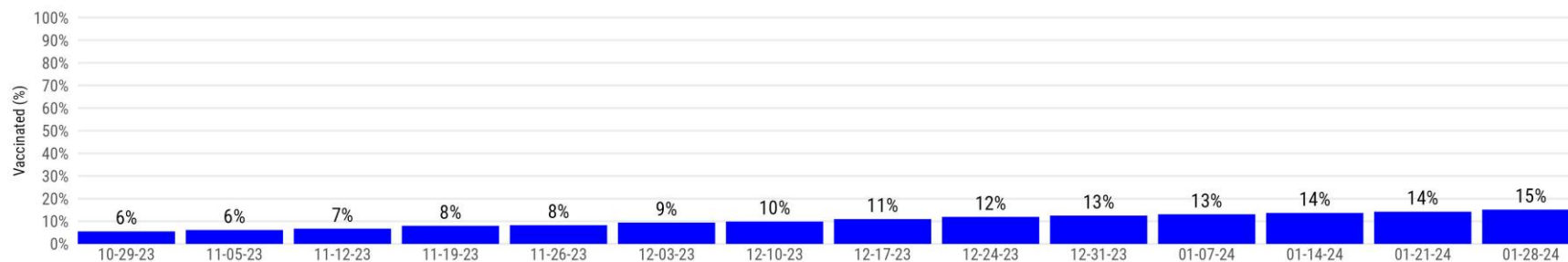
Individuals with medical contraindication to 2023-2024 seasonal influenza vaccine are excluded from denominator.

Data for the most recent week are still accruing.

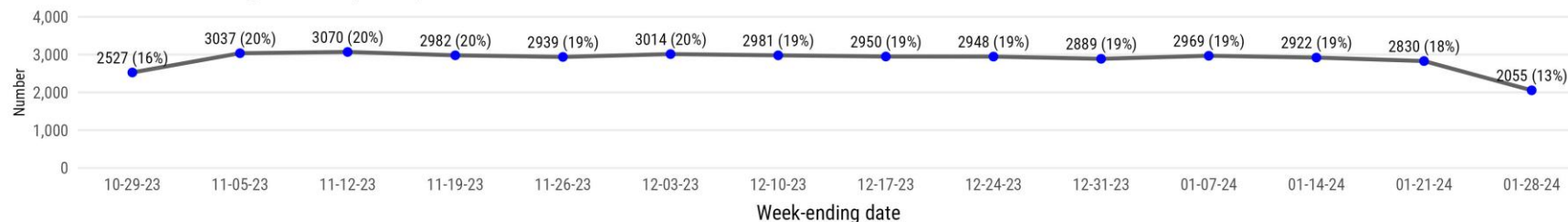
The percentage of nursing home residents who received the RSV vaccine has increased slowly

Percentage of nursing home residents who received the RSV vaccine

October 29, 2023 – January 28, 2024



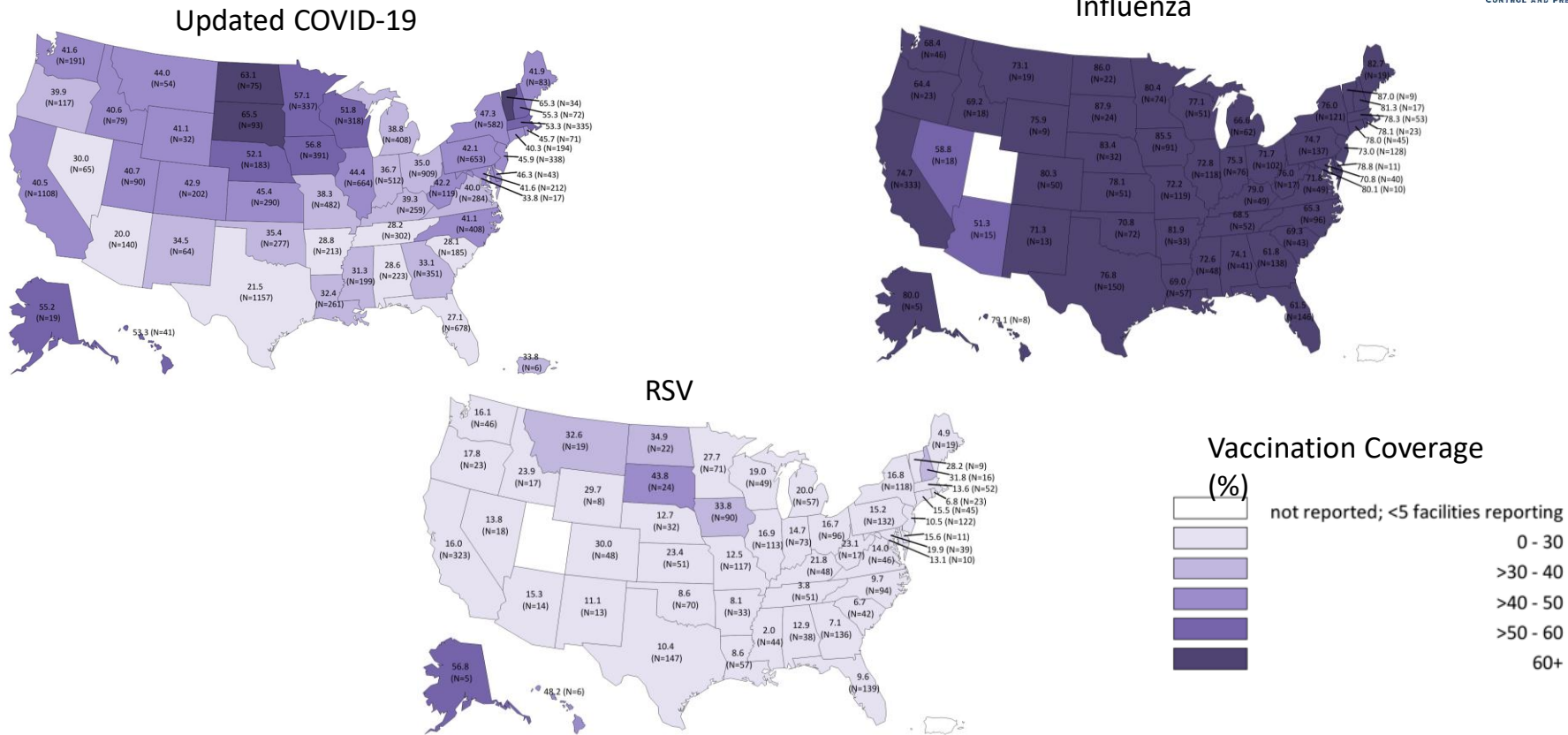
Number of nursing homes reporting



Individuals with medical contraindication to RSV vaccine are excluded from denominator.

Data for the most recent week are still accruing.

Percent of residents vaccinated by US jurisdiction



Data reported for the week of 1/22–1/28, or the most recent week where data are available within 2 weeks.

Interactive data at the national and state level on COVID-19 vaccination coverage in CMS-certified nursing homes is available here: [Nursing Home COVID-19 Vaccination Data Dashboard | NHSN | CDC](#)

N = number of facilities reporting

Data are provisional until officially released from CDC – For Internal Use Only (FIUO) – For Official Use Only (FOUO) – Sensitive But Unclassified (SBU)

Lessons about Vaccinations in LTC

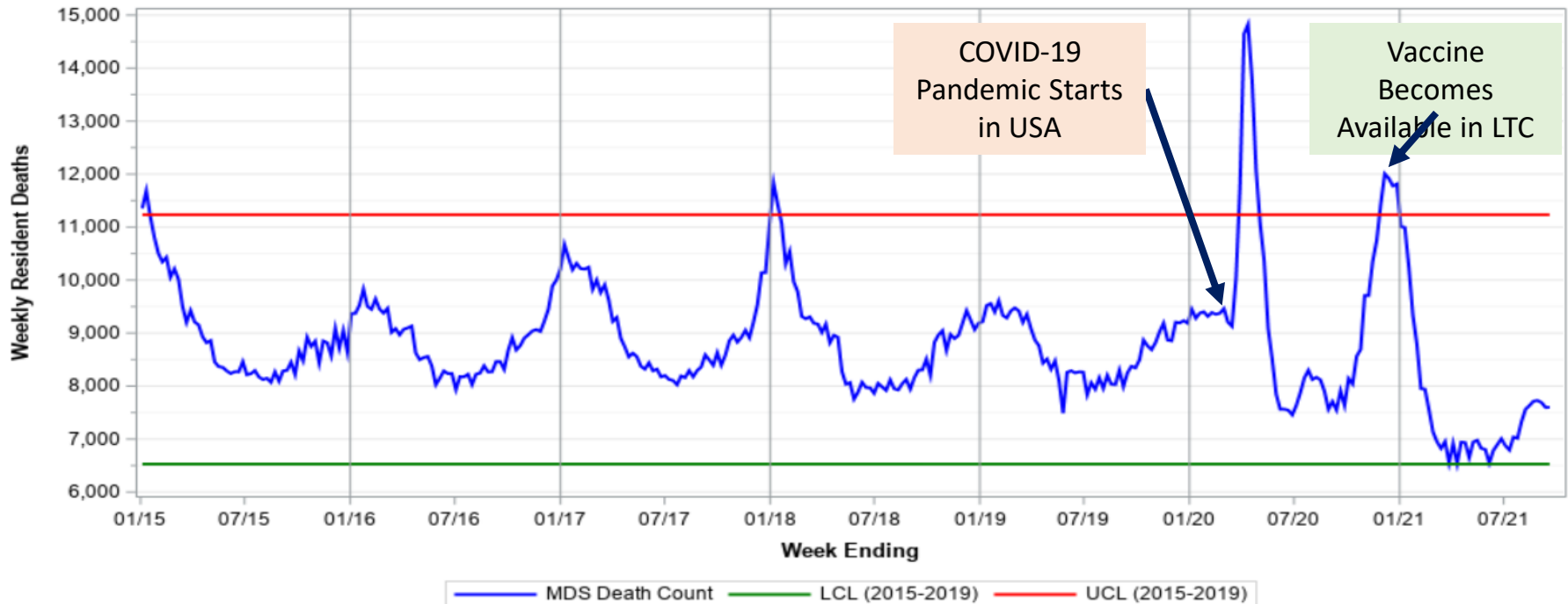
David Gifford MD MPH
Chief Medical Officer

AHCA[®]
AMERICAN HEALTH CARE ASSOCIATION

NCAL[®]
NATIONAL CENTER FOR ASSISTED LIVING

All Cause Deaths in LTC Track Respiratory Virus Season

Count of Deaths of SNF Residents per Week (Jan 2015 - Sep 2021)

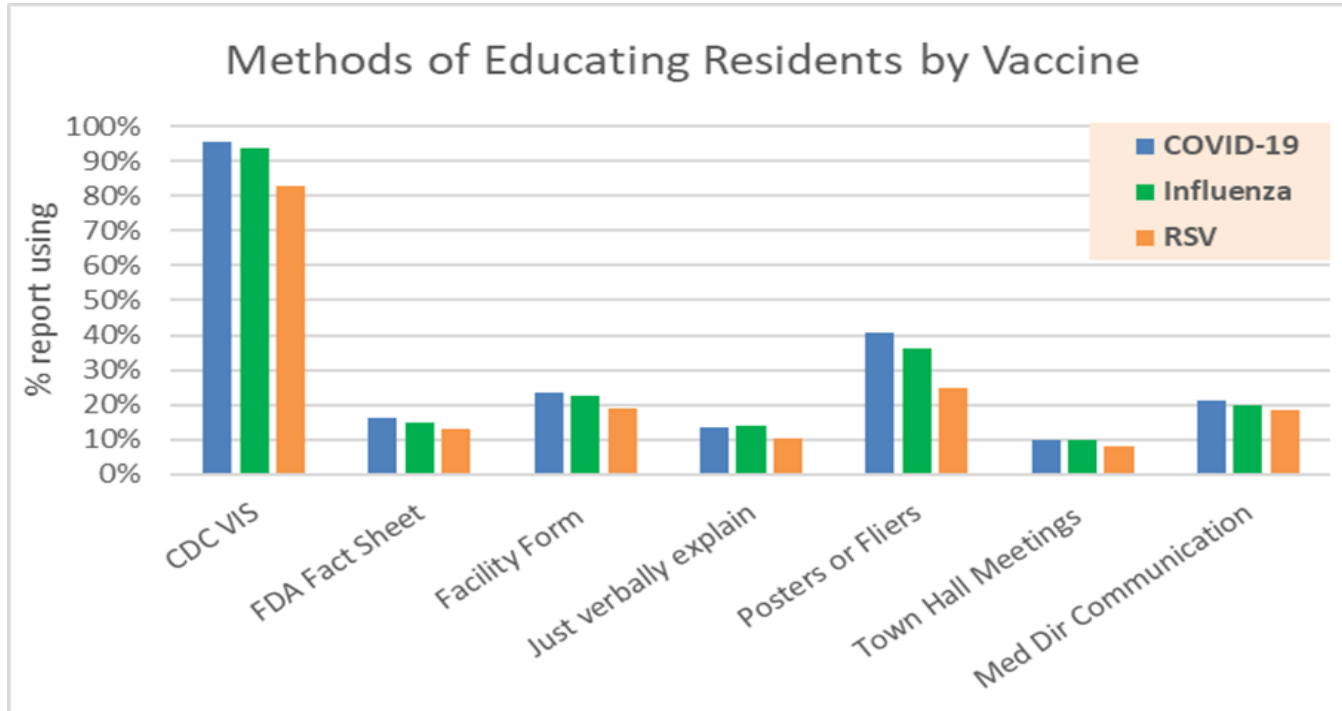


Source: Minimum Data Set (MDS) 3.0 Resident Assessments

Everyone's Role to vaccinate high risk individuals

- Older Americans are not getting vaccinated prior to admission
 - 90% of all admissions to nursing homes come from a hospital
 - In 22-23 and 23-24 season <10% received COVID-19 vaccine prior to transfer to SNFs
 - 2/3rds of residents who did not receive was due to family declining the vaccine
 - Resident vaccination rates are equivalent or slightly higher than community vaccination rates

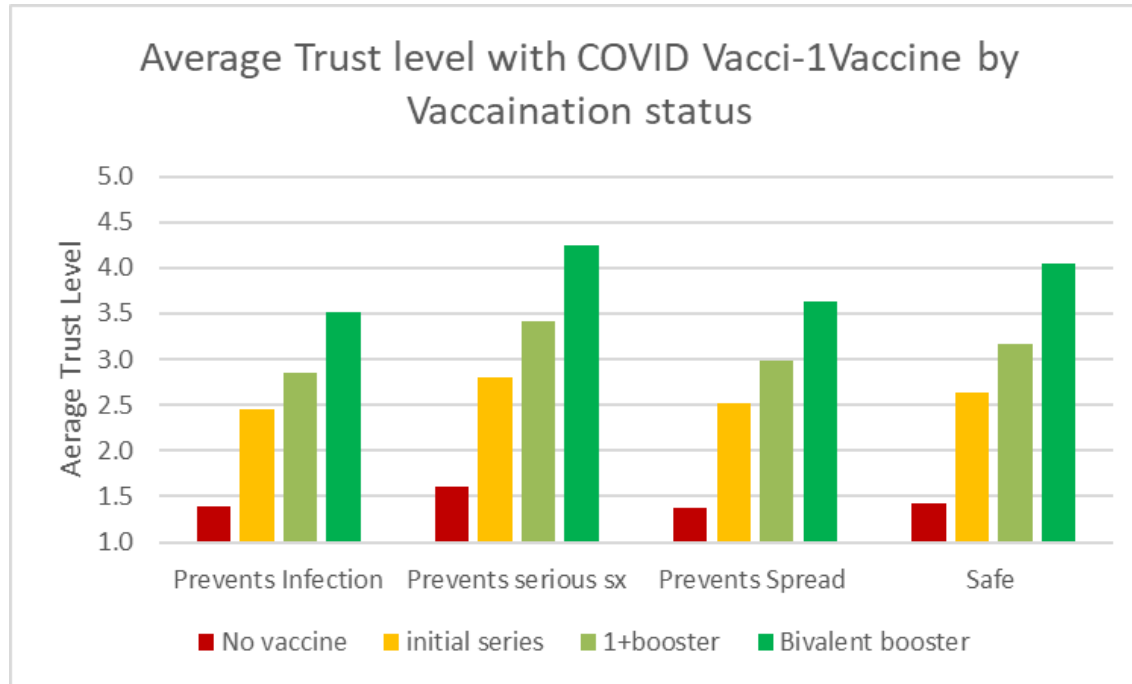
CDC VIS is the method residents are educated about the risk and benefits



Dominant Reasons Residents Decline Vaccines

- Ask nursing homes to report of the last 10 residents who decline how many provided the following reasons:
 - COVID is not as severe
 - Family declines
 - Natural Immunity from prior infection
 - Too many vaccines already
 - Safety of Vaccine
- Less frequent reasons included
 - Concerns about reactogenicity
 - Concern with side-effects (e.g cardiac or neurologic)
 - Vaccine will give me an infection

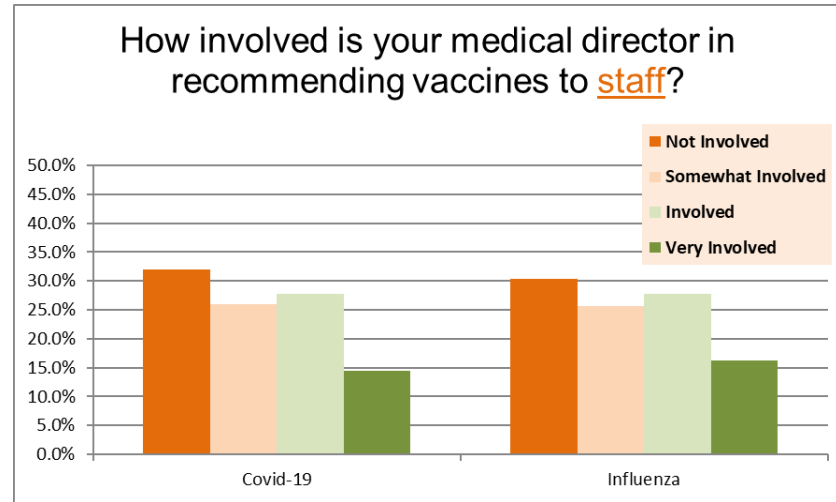
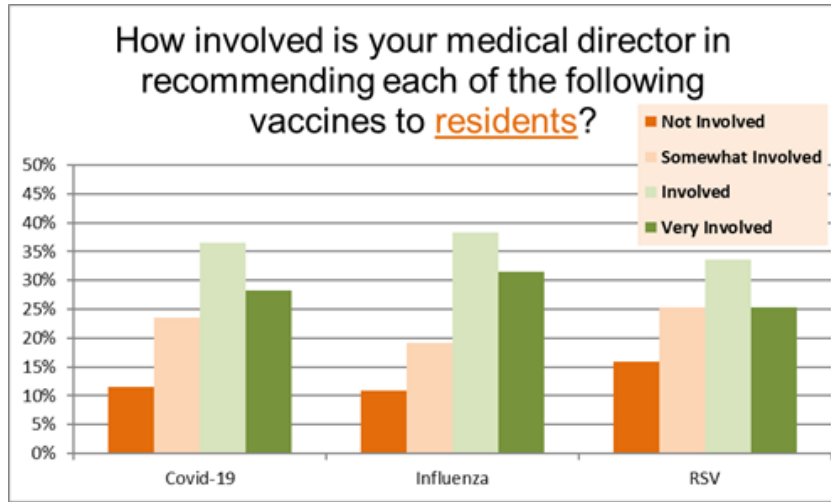
Demand is Low Because of Distrust



Reasons Staff Decline COVID-Influenza Vaccines

- Facilities were twice as likely to report that 5 or more staff out of last 10 who decline COVID vs Influenza provided following reasons:
- COVID-19 is less serious as it used to be (35% vs 18%),
- Already have prior immunity (18% vs 9%)
- Concerned with side effects effecting their heart (22% vs 8%)
- Worried about safety of the vaccine (51% vs 23%)
- Worried get COVID/Flu from the vaccine (12% vs 25%)

Physician Engagement in Educating Resident & Staff



Contact Information

David Gifford MD MPH
Chief Medical Officer
American Health Care Association
1201 L St. NW
Washington DC 20005
Dgifford@ahca.org
202-898-3161
www.ahcancal.org

Treatment of Respiratory Tract Infections in Long- Term Care Facilities

Michael L. Barnett, MD

Associate Professor

Department of Health Policy and Management

Harvard T.H. Chan School of Public Health Policy

Morgan J. Katz, MD, MHS

Assistant Professor of Infectious
Diseases

Johns Hopkins University

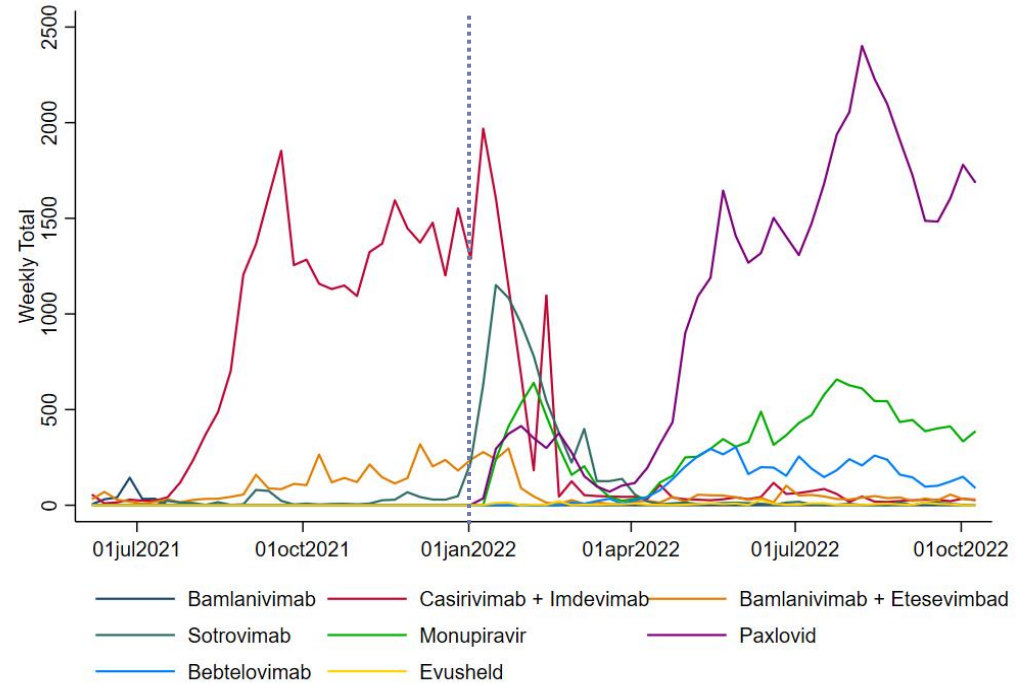


Outpatient COVID-19 Treatments in SNFs *CDC/IDSA Clinician Call, February 2024*

Michael L. Barnett, Associate Professor
Harvard T. H. Chan School of Public Health Policy

Brief history of outpatient COVID treatment options

- ▶ Very dynamic landscape for COVID-19 treatment
- ▶ Monoclonal antibodies used to be very effective (no longer)
- ▶ Key transition date – December 2021, when two oral therapies became available via EUA
- ▶ Oral therapies can lower risk of hospitalization or death by up to 90%



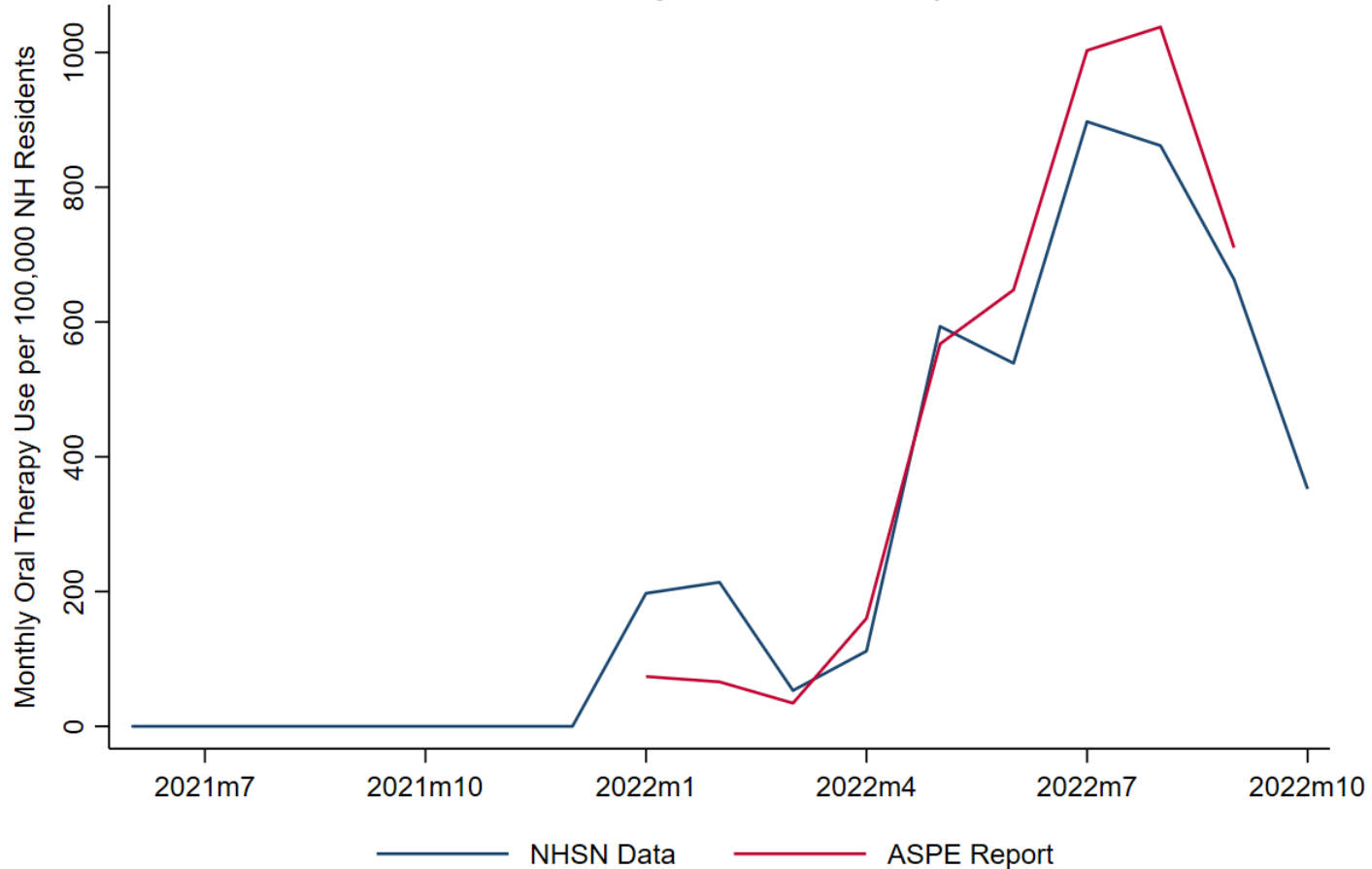
Study questions

- ▶ What is the probability of getting any outpatient treatment for COVID-19 over time?
 - ▶ Did this probability change with introduction of oral treatment options?
- ▶ What characteristics at the individual, provider, and facility/system level explain differences in use across groups?

Data Sources

- ▶ SNFs
 - ▶ CMS COVID-19 Nursing Home Database via National Healthcare Safety Network (NHSN)
 - ▶ Other data from CMS payroll-based journal, public SNF/provider compare files
- ▶ Medicare FFS claims, 100% for 2022
- ▶ Comparison to IQVIA data used in HHS ASPE report
 - ▶ NHSN should be more accurate for SNF use, self-reported at SNF level for all patients

NHSN vs. LTC Pharmacy Claims Per Capita Treatments

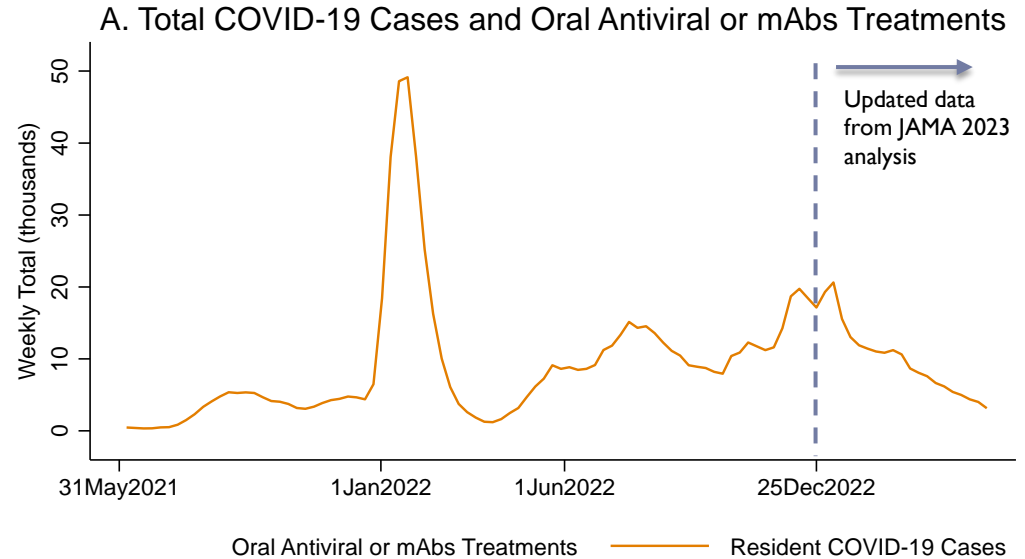


SNF analysis: outcomes and study variables

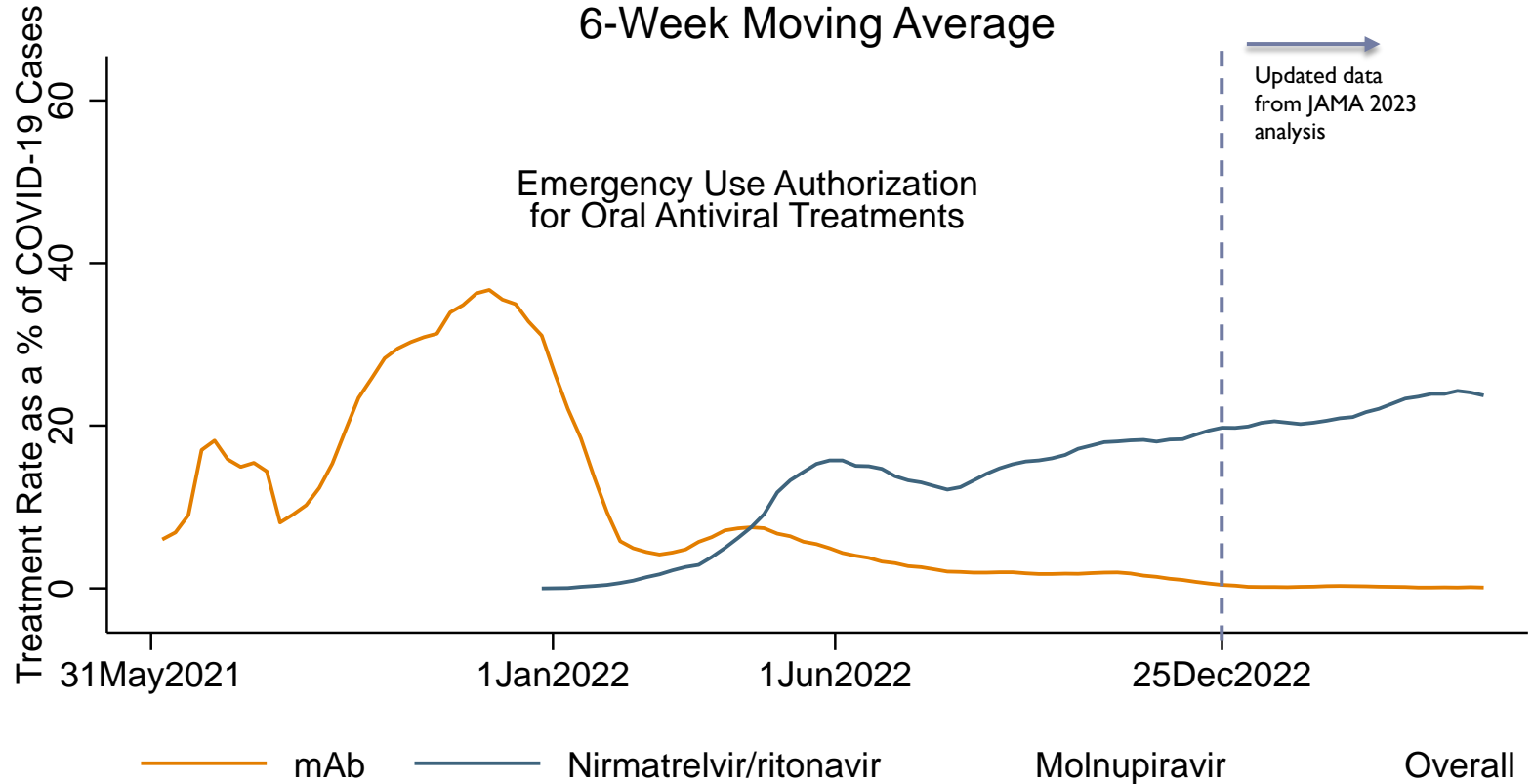
- ▶ Weekly number of SNF residents treated with any outpatient COVID therapy (IV or oral)
 - ▶ Treatment rate as # of treatments over # of new COVID-19 cases
 - ▶ SNF-level treatment rates
- ▶ Other covariates
 - ▶ SNF characteristics – for profit, chain, quality rating, staffing levels, etc.
 - ▶ Resident characteristics – race, dual eligibility, etc.
 - ▶ Geriatrician on staff
 - ▶ Vaccination rates
- ▶ To test independent association of characteristics with COVID-19 treatment, fit either linear probability models or logistic models predicting SNF use of treatment

Treatment volume and rates in SNFs

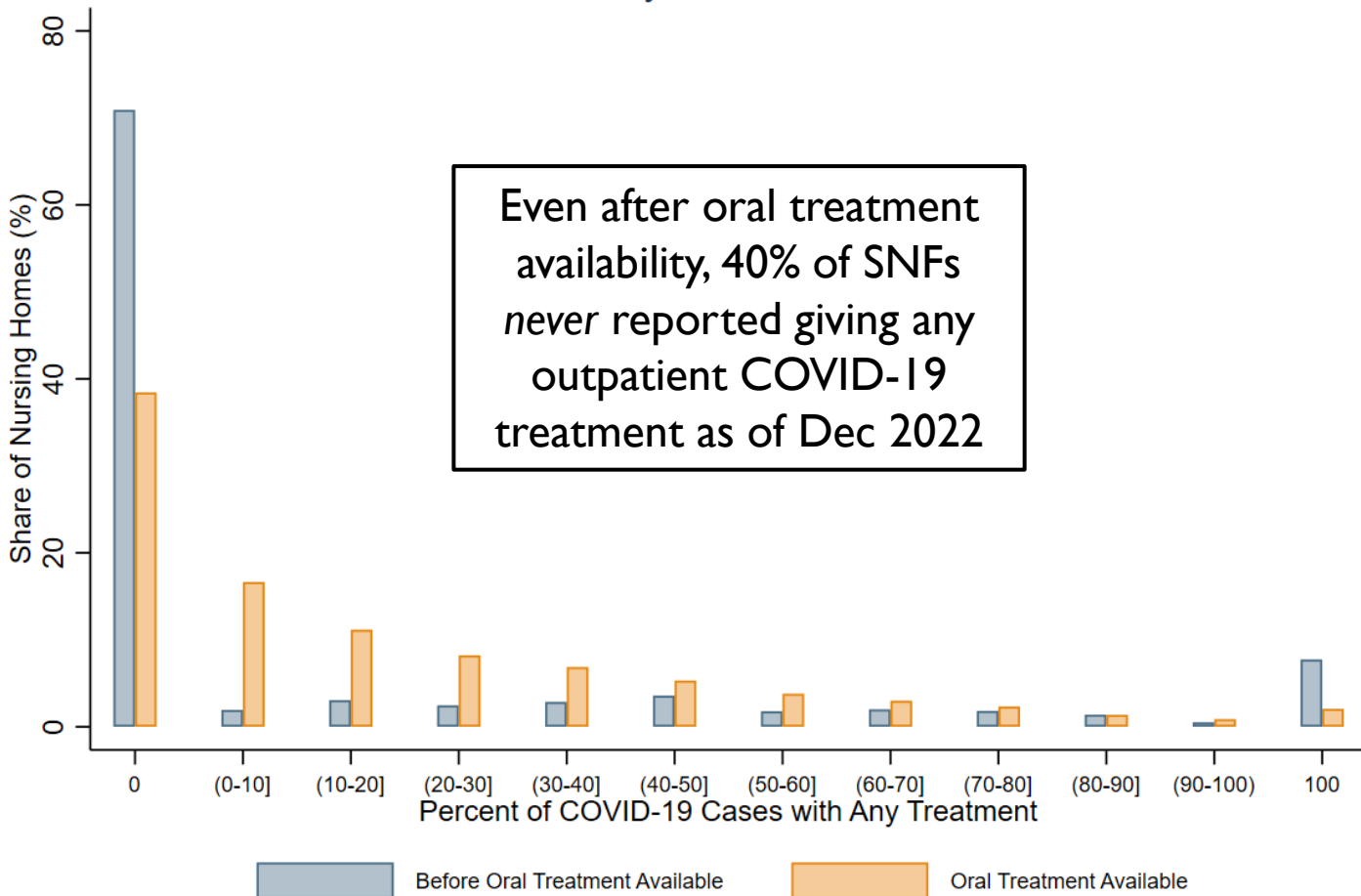
- ▶ Despite the enormous potential for COVID-19 antiviral therapy, it remained vastly underused
- ▶ Only 18% of COVID-19 cases in SNFs in 2021-2022 received one of these treatments
- ▶ Virtually all SNF residents qualify for treatment



B. Oral Antiviral or mAbs Treatment Rates by Type 6-Week Moving Average

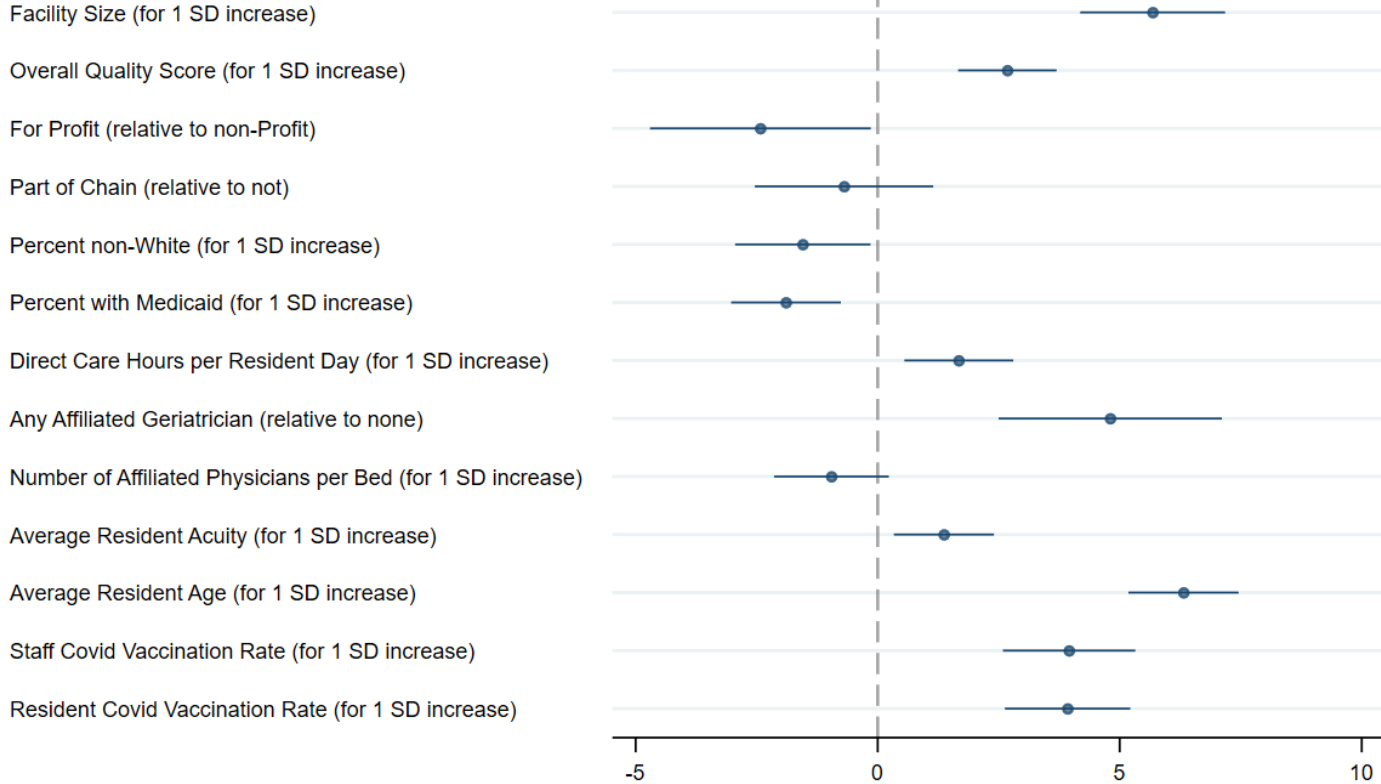


C. Facility Treatment Rates



Estimated Change in Probability of Any COVID Therapy Use by SNF Characteristics

← Less Likely to use | More Likely to use →



SNFs more likely to use any COVID-19 treatment were:

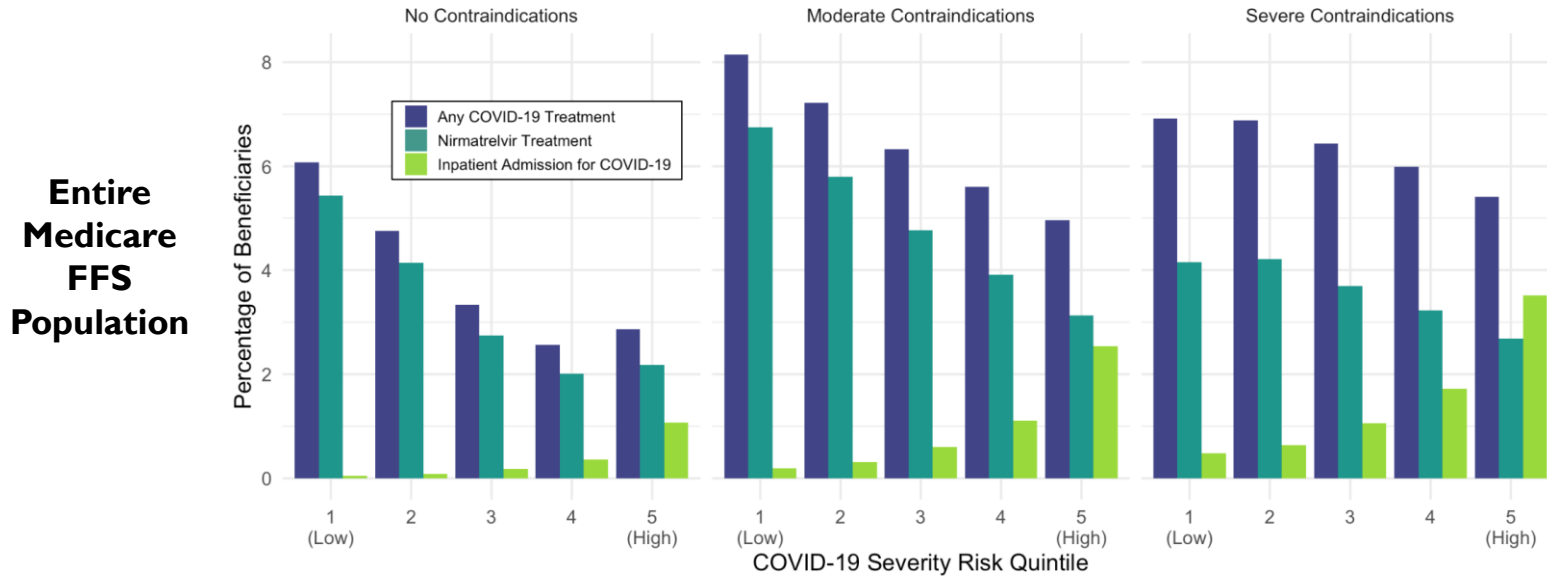
- Larger
- More white
- Higher star rating
- Better staffed
- Had a geriatrician
- Better vaccination coverage

Change in Probability of Any Covid Therapy Use (pp)

Medicare FFS analysis: outcomes and study variables

- ▶ **Per capita** rate of any outpatient COVID therapy (IV or oral)
 - ▶ Captured all observed + unobserved COVID cases (41% of oral prescription fills had no associated COVID-19 diagnosis)
- ▶ **Beneficiary covariates (beyond standard demographics)**
 - ▶ Predicted COVID-19 mortality score (in quintiles)
 - ▶ Linear regression predicting death within 30 days of COVID diagnosis in 2021 data
 - ▶ Treatment contraindications for Paxlovid (none, mild, moderate, severe)
- ▶ **Simulation analysis of Paxlovid re-allocation**
 - ▶ Modeled a scenario where number of Paxlovid doses in 2022 was constant, but re-allocated according to COVID-19 mortality risk
 - ▶ Assumed that 60% of COVID-19 diagnoses were observed in claims, and a 70% reduction in mortality, 40% in hospitalization

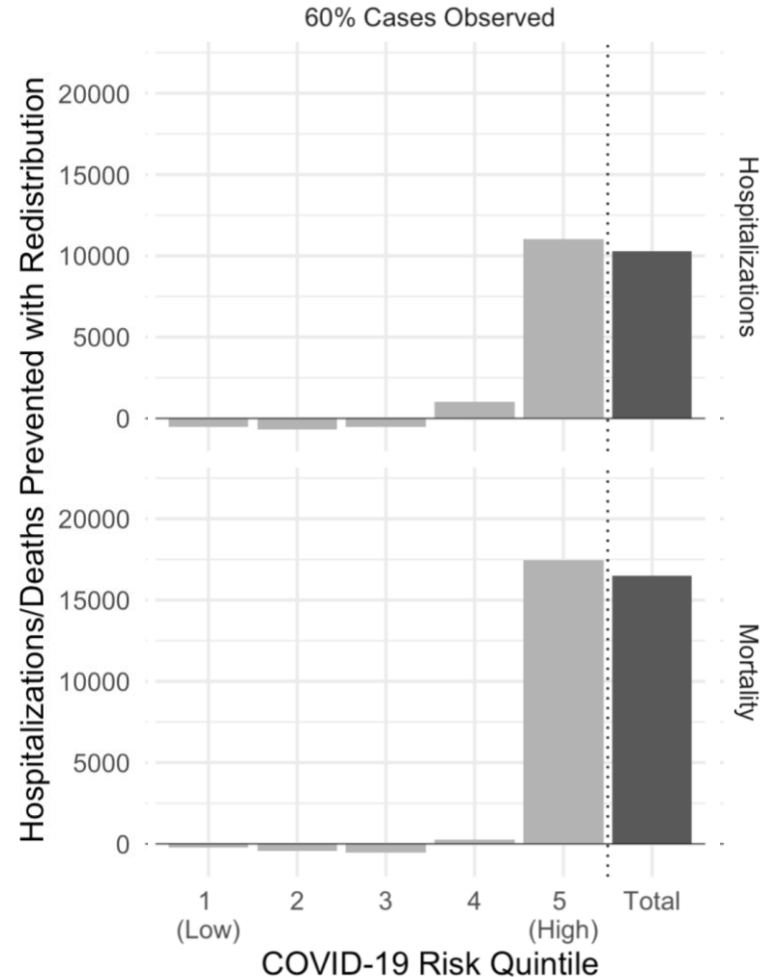
In Medicare, treatment use is not tied to clinical risk



- ▶ Not contraindications (higher use than no contraindication group)
- ▶ Not visits or testing (higher use in lower treatment groups)
- ▶ Not primary care practice (PCP fixed effects make minor change in observed disparities)

Simulated re-allocation of rx

- ▶ What if we took the same 6.0% rate per capita and re-allocated in proportion to mortality risk?
- ▶ Dramatic difference for the highest risk group, which had least use
- ▶ Quintiles 1-4 have small drops in prevented mortality/hospitalization (i.e. worse outcomes)
- ▶ Overall, corresponds to 16.3% drop in overall mortality



Implications for policy

- ▶ No clinical justification for this pattern of treatment
- ▶ There may be a formidable gap in quality of medical providers at SNFs adapting to new conditions
- ▶ SNFs are already crushed with regulation, so non-financial, non-administrative approaches may be least burdensome, e.g. individual clinical feedback on treatment levels and what might be expected.



Our team

- ▶ **HSPH**

- ▶ Ben Sommers
- ▶ Yonatan Grad

- ▶ **HMS**

- ▶ David Grabowski
- ▶ Ateev Mehrotra
- ▶ Andrew Wilcock

- ▶ **Rochester**

- ▶ Brian McGarry* (lead author, SNF analysis)

- ▶ **Colorado**

- ▶ Stephen Kissler

Acknowledgements

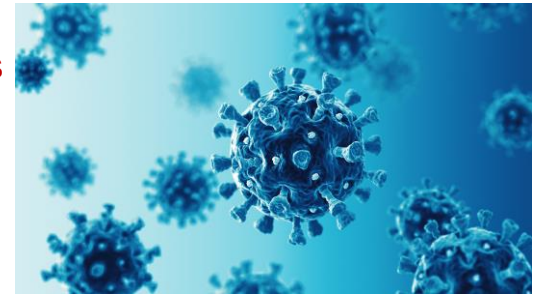
- ▶ Thank you again to co-authors
- ▶ And grateful for NIA funding:
 - ▶ K23 AG058806
 - ▶ K01 AG078441
 - ▶ R01 AG075507
- ▶ Contact:
 - ▶ mbarnett@hsph.harvard.edu
 - ▶ @ml_barnett

CDC/IDSA Clinician Call

Testing and Treatment for COVID-19 in Long-Term Care



Morgan Katz, MD, MHS
Assistant Professor of Infectious Diseases
Johns Hopkins University



Disclosures

- Consultant for HealthCare Quality Innovators
- Grant funding from CDC and AHRQ
- Legal Expert Witness work

Objectives



**REVIEW HOW TESTING
AND TREATMENT HAS
CHANGED FOR COVID-19**



**DISCUSS WHEN TO TEST
FOR COVID-19 WITH
CASE PRESENTATIONS**



**REVIEW TREATMENT
RECOMMENDATIONS
FOR COVID-19**

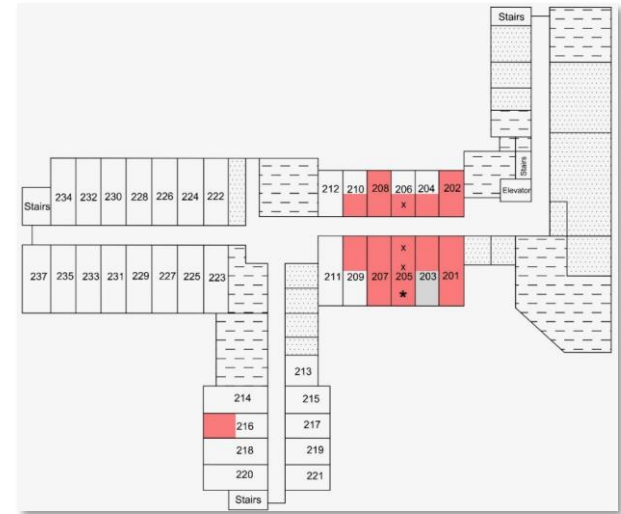
Test Early, Identify Asymptomatic Cases and Isolate

Late Response

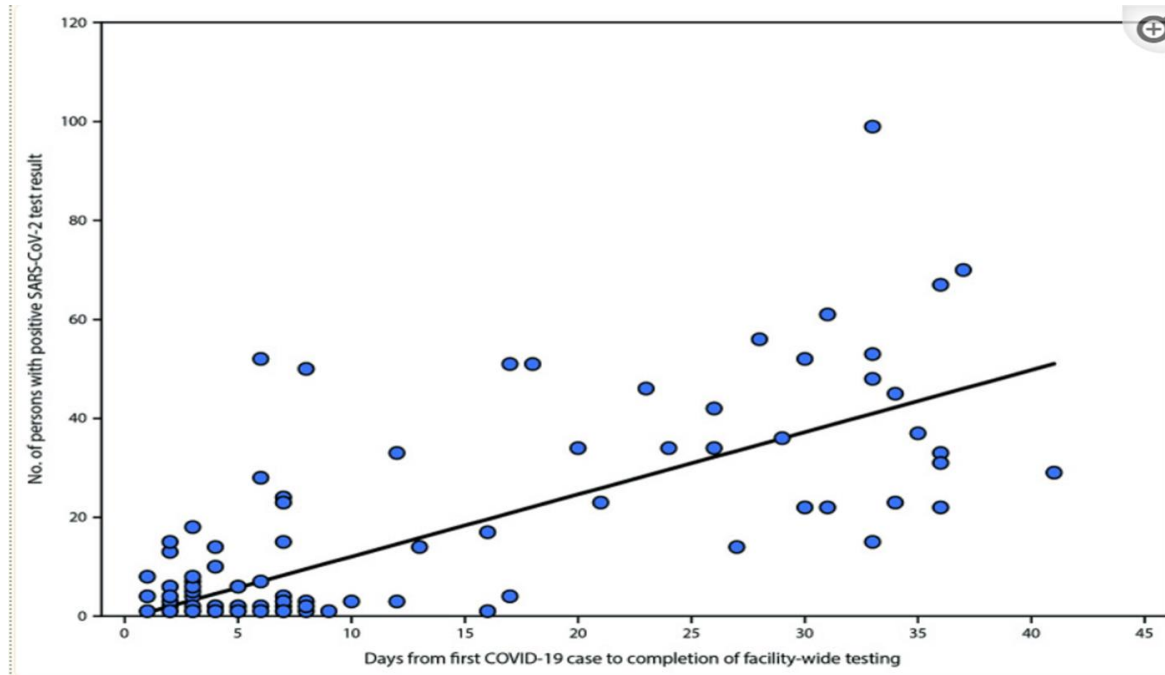


Universal Testing performed after 12 residents tested positive, 3 transferred to hospital

Early Response



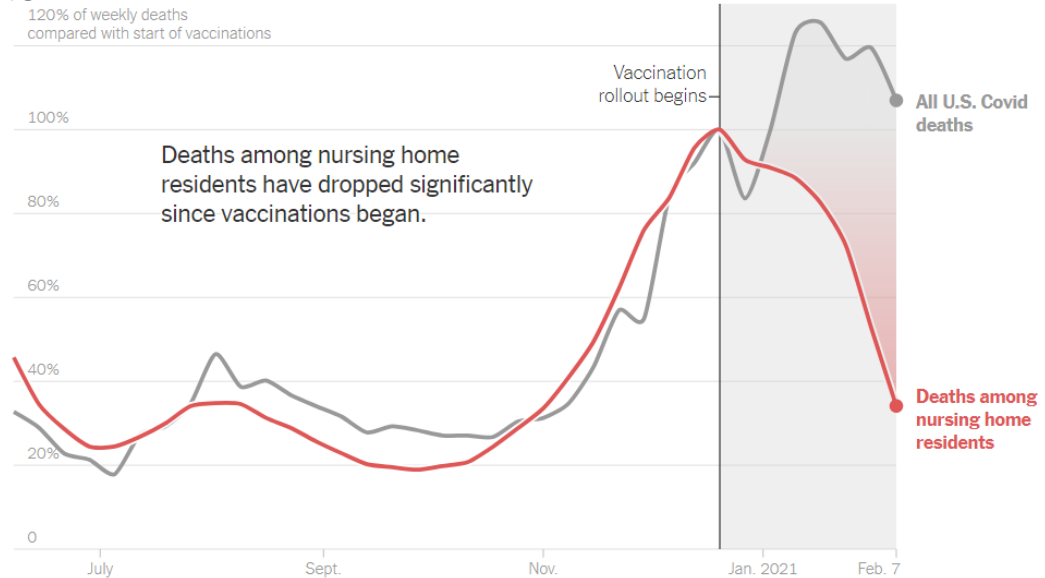
Rise in Cases the Longer We Wait for Facility-wide Testing



MMWR Morb Mortal Wkly Rep. 2020 Aug 14; 69(32): 1095–1099.
Published online 2020 Aug 11. doi: 10.15585/mmwr.mm6932e5

Guidance has changed now that we have other measures of protection

- Adequate rapid testing and PCR tests with quick turnaround times
- Respiratory protection plans
- **VACCINATION!**
- Treatment



Source: [New York Times database](#); U.S. Department of Health and Human Services - Data shown is normalized compared with the weekly deaths for the week ending Dec. 20, 2020 and is through Feb. 7.

Case example

**85 year old resident with new onset fatigue, anorexia, and a fall.
CNA noticed they “do not look right”
Mild stuffy nose and dry cough**

Next steps:

- a. Test for influenza and SARS-CoV-2
- b. Test for SARS-CoV-2
- c. Place on transmission-based precautions and test for SARS-CoV-2 and influenza
- d. Increase monitoring and watch the resident

The resident tests positive for SARS-CoV-2

- You call the department of health and notify them of the positive case and continue isolation with airborne and contact precautions.
- What are your next steps in testing?
 - a. Test everyone in the facility
 - b. Perform contact tracing and test all exposed residents and staff once
 - c. Perform contact tracing and test all exposed residents and staff on days 1, 3, and 5
 - d. Transfer the resident out and close the outbreak.

When to test for SARS-CoV-2

- Anytime someone has symptoms
 - Antigen test- must be repeated at 48 hours in symptomatic resident OR confirm negative with PCR test
 - PCR test- no need to repeat test
- When someone has been exposed (days 1,3,5)
- What are symptoms?
 - Not only respiratory symptoms- older adults with COVID-19 may present with vague symptoms
 - Anorexia
 - New or worsening malaise
 - Diarrhea/nausea/vomiting
 - Falls, dizziness or acute change in mental status
 - Headache
- Remember, when influenza is circulating, test symptomatic residents for *both viruses- positive SARS-CoV-2 does not preclude concurrent influenza infection*
- Place resident on transmission-based precautions while awaiting test results
- If confirmed positive: **Airborne and contact precautions**
 - Gown, gloves, fit-tested N-95, eye protection when entering room

Outpatient treatment for COVID-19

- Options for outpatient therapy:
 - **Paxlovid*** - 5-day course of oral therapy **within 5 days of symptom onset**
 - 89% lower risk of hospitalization or death compared with placebo
 - **Remdesivir** - 3-days IV therapy **within 7 days of symptom onset**
 - 87% lower risk of hospitalization or death compared with placebo
 - **Molnupiravir *** *alternative therapy* - 5 day oral therapy **within 5 days of symptom onset**
 - 31% reduction in hospitalization or death compared with placebo

How does antiviral therapy work?

- Prevents the virus from replicating inside of the body
- MUST be given early in order to work effectively
- Purpose is *to prevent hospitalization and death*, not to decrease symptoms or to help patients recover faster
- The decision to prescribe should be made based on a patient's risk factors for severe disease, *regardless of symptom severity*.



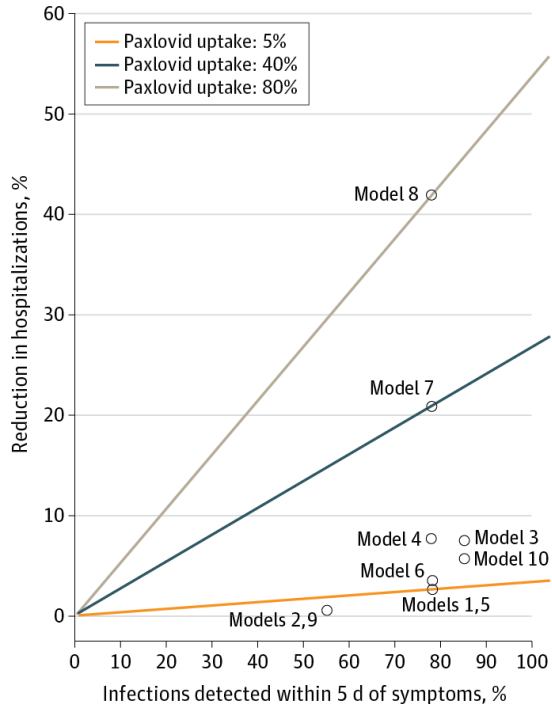
Most COVID-19 disease does not become severe until days 7-10

Table 2. Clinical and Utilization Outcomes Among Patients by Activation Status

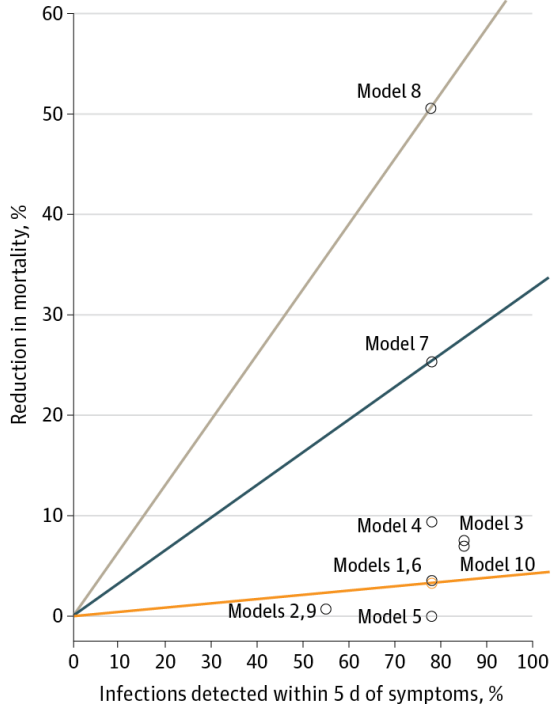
Outcome	Patients, No. (%)		P value
	Activated (n = 5364)	Not activated (n = 4014)	
Hospitalized	128 (2.4)	158 (3.9)	<.001
Length of stay, mean (SD), d	4.44 (4.43)	7.14 (8.63)	.001
Time from symptoms to hospitalization, mean (SD), d	9.84 (3.69)	8.47 (4.21)	.004
Time from positive test to hospitalization, mean (SD), d	6.67 (3.21)	5.24 (3.03)	<.001
Intensive care utilization	15 (0.3)	44 (1.1)	.001
30-d Mortality	4 (0.1)	24 (0.6)	.001
90-d Mortality	10 (0.2)	26 (0.6)	.001

Modeling reduction in hospitalization and mortality with Paxlovid uptake

A Reduction in hospitalization via test-to-treat initiative



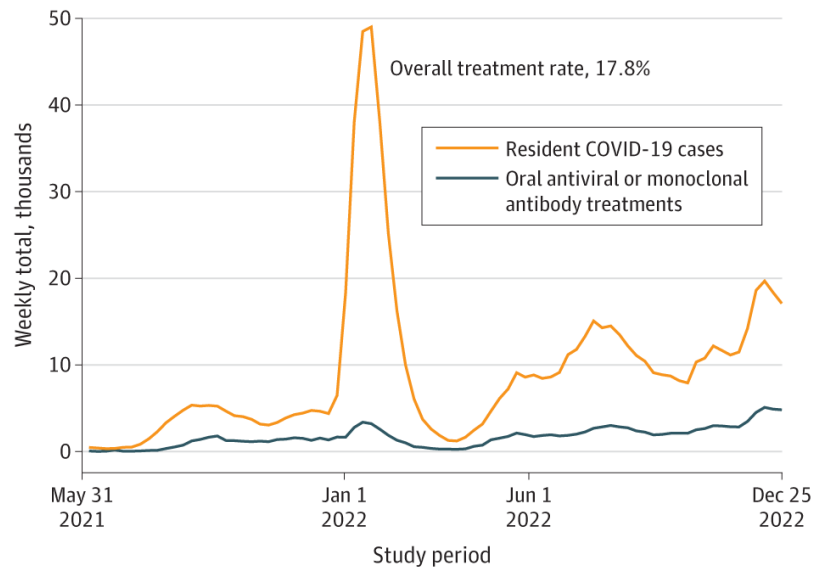
B Reduction in mortality via test-to-treat initiative



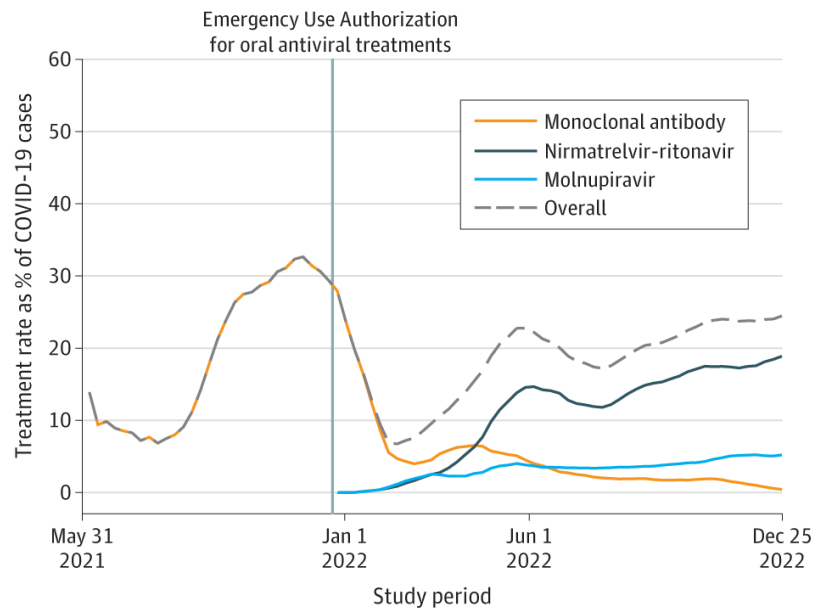
Khunte M, Kumar S, Salomon JA, Bilinski A. Projected COVID-19 Mortality Reduction From Paxlovid Rollout.

COVID-19 treatment underused in nursing homes

A Total COVID-19 cases and treatments



B Treatment rates by type, 6-wk moving average





nesday 8th November 2023 - join us online for the **Liverpool Masterclass in Antiviral Pharmacology 2023**. Click for programme and free reg

If a drug is not listed below it cannot automatically be assumed it is safe to coadminister.

COVID Drugs	Co-medications	Drug Interactions
<input type="text" value="paxlovid"/>	<input type="text" value="atorvastatin"/>	<input type="checkbox"/> Check COVID/COVID drug interactions
		Reset Checker
<input checked="" type="radio"/> A-Z <input type="radio"/> Class <input type="radio"/> Trade	<input checked="" type="radio"/> A-Z <input type="radio"/> Class	Switch to table view Results Key
<input checked="" type="checkbox"/> Nirmatrelvir/ritonavir (5 days) ⓘ	<input checked="" type="checkbox"/> Metoprolol ⓘ	Potential Interaction
<input checked="" type="checkbox"/> Nirmatrelvir/ritonavir (5 days) ⓘ	<input checked="" type="checkbox"/> Atorvastatin ⓘ	Nirmatrelvir/ritonavir (5 days)
<input type="checkbox"/> Nirmatrelvir/ritonavir (extended administration; 10 days or longer) ⓘ	<input checked="" type="checkbox"/> Atorvastatin ⓘ	Atorvastatin
		Look for alternatives →

Risk of rebound should not prevent treatment

- Rebound=Recurrence of signs or symptoms or a new positive viral test result after initial recovery from COVID-19.
- A systematic review, including one randomized controlled trial, found **no** significant differences regarding risk of rebound in treated vs. untreated individuals
- Factors which may increase risk for rebound:
 - Age 18-65 (vs. >65)
 - High Comorbidity prevalence
 - Concomitant corticosteroid treatment
- **No** hospitalizations or deaths were reported in those who experienced rebound, and symptoms were mild

Takeaways



Test for both SARS-CoV-2 and influenza in residents with respiratory symptoms, place on precautions while awaiting results



USE the treatment based on risk, not symptoms- most residents who develop severe disease take a turn at day 7, and you have missed the window to start therapy



HINT: ALL nursing home residents likely qualify for treatment



Interactions can be easily checked and in most cases, do not preclude therapy.

Q&A/ Discussion

Programs Provide Free or Low-cost Options for COVID-19 Outpatient Antiviral Therapeutics

PAXLOVID (nirmatrelvir packaged with ritonavir)

- Patients, caregivers, provider or pharmacists can enroll patients for these programs for free or low cost Paxlovid via [Pfizer's Paxcess website](#). No one needs to pay full price for Paxlovid. Everyone on Medicare, Medicaid and uninsured have access for free, either directly at the counter or **via enrollment in the PAP**.
- Publicly insured and uninsured patients receive **free Paxlovid through December 31, 2024**, with the U.S. government (USG) **Patient Assistance Program (PAP)** operated by Pfizer. This program uses USG-procured Paxlovid inventory and includes any patient who is:
 - Publicly insured, including through Medicaid or Medicare (with or without Part D, Part B, or Part C and inclusive of Medicare Advantage)
 - Uninsured
- Patients with private (commercial) insurance can use the Pfizer co-pay savings program for Paxlovid at little or no cost

LAGEVRIO (molnupiravir)

- The [MerckHelps Patient Assistance Program](#) provides Lagevrio free of charge to patients who meet eligibility criteria and who, without assistance, could not otherwise afford the product. Learn more at [MerckHelps.com/Lagevrio](#)

In addition, federal entities, including HRSA-supported health centers, Indian Health Service health centers, and others, have continued access to free, USG-procured Paxlovid and Lagevrio supply for their patients.

VEKLURY (remdesivir) for outpatient use

- Gilead has an Advancing Access® program to help eligible patients. Learn more here: [Advancing Access® program](#)

Selected Resources

Program Links:

- This webinar is being recorded and can be found with the slides online at <https://www.idsociety.org/cliniciancalls>
- COVID-19 Real-Time Learning Network: <https://www.idsociety.org/covid-19-real-time-learning-network/>
- Vaccine FAQ: <https://www.idsociety.org/covid-19-real-time-learning-network/vaccines/vaccines-information--faq/>

Dr. Reses

- <https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf>
- <https://www.cdc.gov/nhsn/covid19/ltc-vaccination-dashboard.html>

Dr. Barnett

- <https://aspe.hhs.gov/reports/covid-19-antivirals-utilization>
- <https://jamanetwork.com/journals/jama/fullarticle/2807529>

Dr. Katz

- <https://www.cdc.gov/flu/professionals/diagnosis/testing-management-considerations-nursinghomes.htm>
- <https://www.covid19treatmentguidelines.nih.gov/management/clinical-management-of-adults/nonhospitalized-adults--therapeutic-management/>
- <https://www.covid19-druginteractions.org/checker>

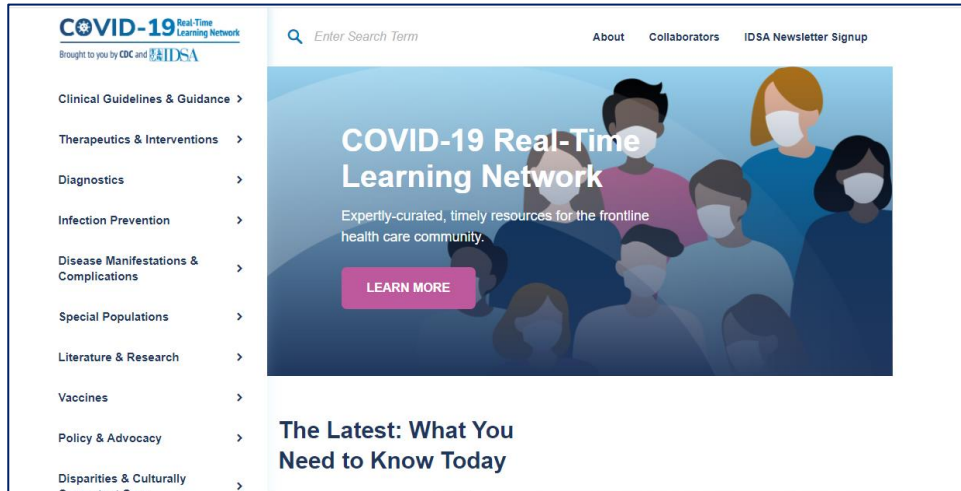
Dr. Panini

- <https://paxlovid.iassist.com/>
- <https://www.merckhelps.com/>
- <https://merckhelps.com/LAGEVRIO>
- <https://www.veklury.com/patient-support/>

COVID-19 Real-Time Learning Network

Brought to you by CDC and IDSA

An online community bringing together information and opportunities for discussion on latest research, guidelines, tools and resources from a variety of medical subspecialties around the world.



Specialty Society Collaborators

American Academy of Family Physicians
American Academy of Pediatrics
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American Geriatrics Society
American Thoracic Society
Pediatric Infectious Diseases Society
Society for Critical Care Medicine
Society for Healthcare Epidemiology of America
Society of Hospital Medicine
Society of Infectious Diseases Pharmacists

www.COVID19LearningNetwork.org

@RealTimeCOVID19

#RealTimeCOVID19

THANK YOU

We want to hear from you!

Please complete the post-call survey.

A recording of this call, slides and the answered Q&A will be posted at

www.idsociety.org/cliniciancalls

-- library of all past calls available --

Contact Us:

Dana Wollins (dwillins@idsociety.org)

Deirdre Lewis (dlewis@idsociety.org)