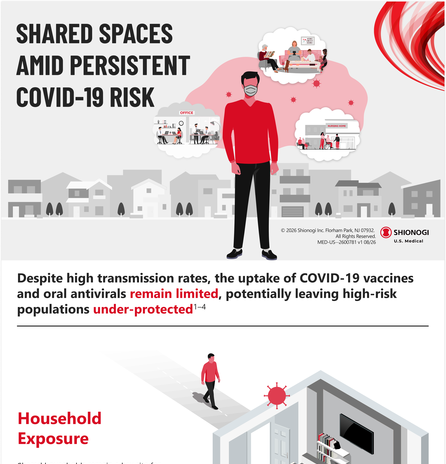
SHARED SPACES AMID PERSISTENT COVID-19 RISK



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Despite high transmission rates, the uptake of COVID-19 vaccines and oral antivirals remain limited, potentially leaving high-risk populations under-protected[1–4]

Household Exposure

Shared households remain a key site for SARS-CoV-2 transmission[5,6]

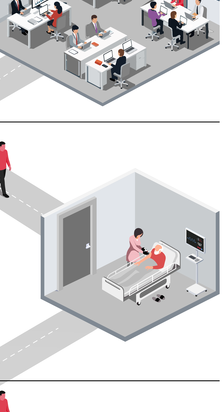
Learn more



Long-Term Care: Shared Spaces Increases Shared Risks

Long-term care brings some of the most vulnerable patients into one shared space. Despite elevated risk, protective measures for residents and staff could be inadequate due to resource, staffing, and infection-control challenges[11–14]

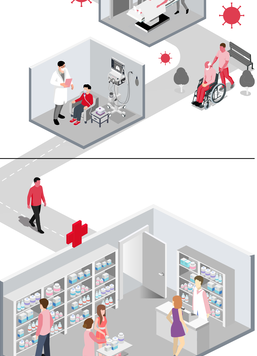
Learn more



Beyond the Acute Illness

With ongoing exposure, more infections can mean greater risk of long-term consequences[16]

Learn more



Elevated Risk May Lead to Severe COVID-19 Outcomes

Older adults, individuals with underlying medical conditions, and immunocompromised individuals are at an elevated risk of severe COVID-19 outcomes[28]

Learn more



Cumulative Risk

Individuals with two or more comorbidities are at a higher risk of COVID-19-related hospitalization compared with individuals who are immunocompromised without other conditions[41]

Learn more

Importance of COVID-19 Interventions

Limited uptake of effective COVID-19 interventions could lead to more people with diminished protection and potentially higher rates of severe disease and preventable hospitalizations[1–4,31]

Learn more

Early Management of COVID-19

Early management of COVID-19 with oral medicines may help control SARS-CoV-2 infection in households and other closed settings[34–37]

Reach out to your MSL to learn more about COVID-19 and the potential of early intervention

Abbreviations: CDC, Centers for Disease Control and Prevention; COVID-19, coronavirus disease 2019; ICU, intensive care unit; LTCF, long-term care facility; MSL, medical science liaison; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; U.S., United States.

References: 1. WHO. https://www.who.int/publications/m/item/covid-19-global-risk-assessment-v6. Accessed July 28, 2026; 2. Scott A, et al. *Open Forum Infect Dis*. 2023;10:ofad500.591; 3. Appannal HJ, et al. *Infect Dis Ther*. 2024;13(7):1705–1722; 4. CDC. https://www.cdc.gov/respiratory-viruses/data/research-behavioral-social-drivers.html. Accessed July 22, 2026; 5. Maldwell JT, et al. JAMA Netw Open. 2024;7(12):e2450421; 6. Ma KC, et al. *MMWR Morb Mortal Wkly Rep*. 2022;71(5):188–192; 7. Ferguson NM, et al. *Nature*. 2006;442(7101):448–452; 8. Yin W, et al. *Nat Commun*. 2024;15(1):1008; 10. Sumuvuman DM, et al. *BMC Infect Dis*. 2025;25(1):215; 11. Gravenstein S, et al. *Sr Care Pharm*. 2024;41(5):167–180; 12. Franklin D, et al. *MMWR Morb Mortal Wkly Rep*. 2024;73(15):339–344; 13. WHO. https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020-1. Accessed July 21, 2026; 14. U.S. Department of Health and Human Service. https://aspr.hhs.gov/documents/evaluation/980kOR-161-20-04002.pdf. Accessed July 22, 2026; 15. Cortes Zamora EB, et al. *Am J Geriatr Psychiatry*. 2022;30(4):431–443; 16. Zhang H. *Lancet Respir Med*. 2024;12(1):55–66; 17. CDC. https://www.cdc.gov/long-covid/php/surveillance/index.html. Accessed July 28, 2026; 18. CDC. https://www.cdc.gov/long-covid/signs-symptoms/index.html. Accessed July 22, 2026; 19. Hou Y, et al. *Open Forum Infect Dis*. 2024;11(10):ofae606; 20. Ioannou GN, et al. *JAMA Intern Med*. 2024;184(5):476–482; 21. Ioannou GN, et al. *JAMA Intern Med*. 2024;184(5):483–491; 22. Ioannou GN, et al. *Hub Sch Rheum Dis*. 2023;1:100006; 23. Izquierdo N, et al. *EBioMedicine*. 2020;110:105778; 24. Kuzan PFC, et al. *Respir Res*. 2023;24(1):51; 25. Marsico CM, et al. *Brain*. 2024;147(7):2542–2551; 26. Chuang M-H, et al. *BMC Med*. 2024;22(1):360; 27. Lu JY, et al. *Sci Rep*. 2024;14(1):3741; 28. Leblee A, et al. *Biomedicines*. 2024;12(9):2065; 29. Chen I-M, et al. *Sci Rep*. 2025;15(1):17024; 30. Gai E, et al. *PLoS One*. 2021;16(10):e0259156; 31. Ma KC, et al. *JAMA Netw Open*. 2026;9(2):e2557415; 32. Wiegand RE, et al. *JAMA Intern Med*. 2026;e263936; 33. Wiegand RE, et al. *JAMA Netw Open*. 2026;9(6):e2625152; 34. O'Brien MP, et al. *N Engl J Med*. 2021;385(13):1184–1195; 35. Cohen MS, et al. *JAMA*. 2021;326(21):2140–55; 36. Matrajt L, et al. *BMC Infect Dis*. 2022;22(1):682; 37. Ma B-H M, et al. *JAMA Netw Open*. 2023;6(4):e231887.

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Household Exposure



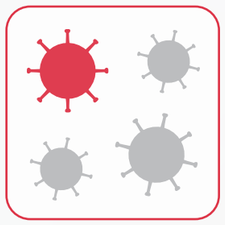
Households are key sites for **SARS-CoV-2 transmission**[5,6]

Secondary attack rates for the Omicron variant range from[6,7] **43%–47%**





Even **asymptomatic** individuals can spread SARS-CoV-2[8]



The risk of reinfection was greatest with Omicron due to **waning immunity and virus evolution**[9]

Households are high-risk settings for **SARS-CoV-2 transmission**, which could be facilitated by prolonged and repeated close contact, shared indoor spaces, and difficulty in implementing prevention measures[5,7,8,10]

SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

Close ×

Long-Term Care: Shared Spaces Increases Shared Risk



SARS-CoV-2 transmission follows community trends and often occurs between staff and residents[11]

Despite available tools,

84%

of outbreaks in LTCFs lasted more than 42 days[11,*]

1 in 6

individuals hospitalized for COVID-19 is an LTCF resident[11,*]

Fewer than

1 in 5

LTCF residents received antivirals and/or monoclonal antibody for COVID-19[11,*]

Mortality was

↑4.6x

higher for LTCF residents than for community-dwelling individuals[11,*]

The COVID-19 pandemic was associated with high psychological impact in older adults in LTCFs[15]

Three months after the beginning of the COVID-19 pandemic, the prevalence of clinically significant psychological symptoms were[15,†]

58%

Depressive symptoms

29%

Anxiety symptoms

19%

Post-traumatic stress disorder symptoms

93%

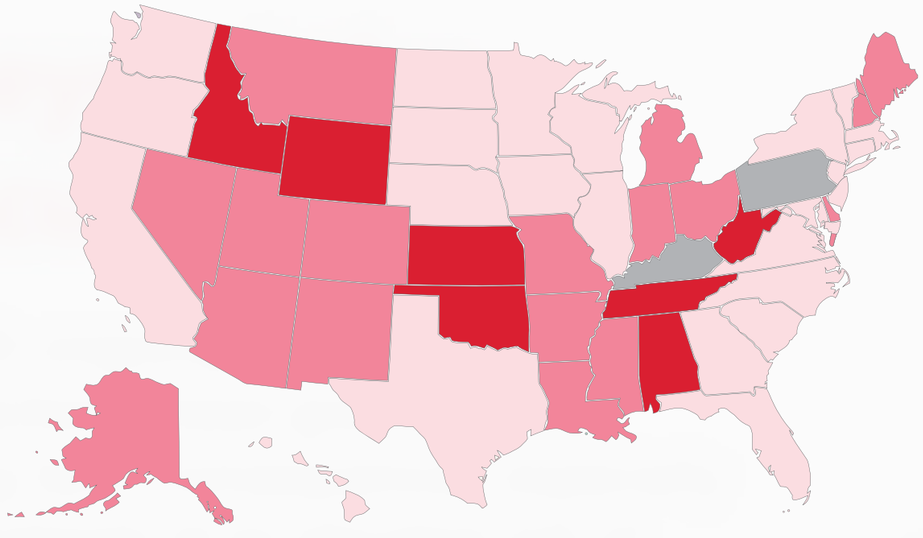
Sleep disturbances

*A systematic review of 43 articles with data from the Omicron-predominant period (since November 1, 2021).[11]
†Data from the COVID-A, a longitudinal cohort study of 215 residents from five LTCFs in Albacete, Spain that collected baseline data between March and June 2020 and three-month follow-up data between June and September 2020.[15]

COVID-19, coronavirus disease 2019; LTCF, long-term care facility; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

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Beyond the Acute Illness

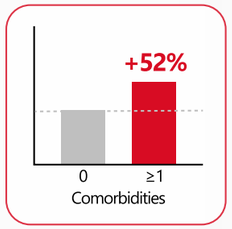


According to the CDC, the prevalence of Long COVID varies by state over time, with reported 2023 rates of[17,*]

2.9%–9.7%



As per CDC, the **most common symptoms** of Long COVID include fatigue, brain fog, and post-exertional malaise[18]



Individuals with at least 1 comorbidity have a **52% higher odds** of having Long COVID[19,†]



Individuals with Long COVID may experience **higher reinfection rates and worsening symptoms** post-Omicron than those living without Long COVID[16]

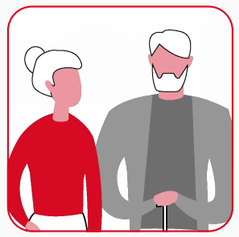
*Prevalence of self-reported experience of Long COVID among adults in the U.S. in 2023.[17]
†Pooled estimate based on a meta-analysis of 17 studies.[19]

CDC, Centers for Disease Control and Prevention; COVID, coronavirus disease; U.S., United States.

Close ✕

Elevated Risk May Lead to Severe COVID-19 Outcomes

Risk factors for severe COVID-19 outcomes include[20]



Age (≥50 years)



Underlying medical conditions

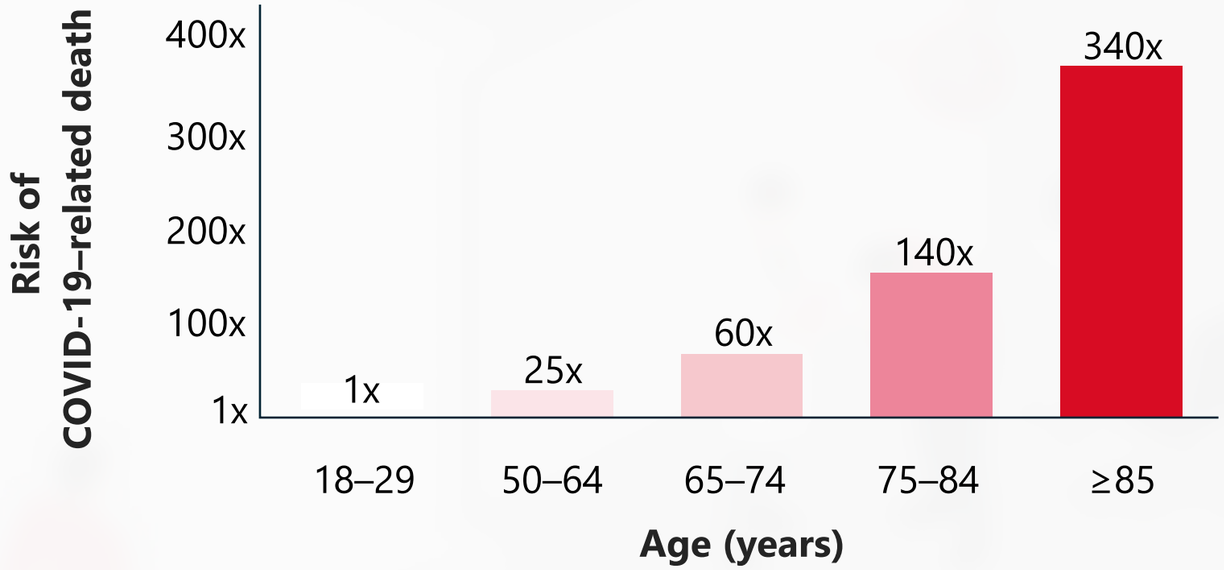


Vaccination status



Race, ethnicity, and socioeconomic factors

The risk of COVID-19 related death increases markedly with increasing age[20,*]



The risk of severe COVID-19 outcomes increases as the number of underlying medical conditions increases[21]

↑ **4.7x** higher risk of COVID-19 hospitalization in adults with **≥3 conclusive high-risk conditions** compared with individuals with one conclusive high-risk comorbidity[†]

*These data include all deaths in the U.S. that occurred throughout the pandemic, from February 2020 to July 1, 2022, including deaths among unvaccinated individuals.[20]
[†]This retrospective, non-interventional cohort study used adjudicated medical and pharmacy claims data from 10,631,427 individuals in the U.S. from the Optum Clinformatics® Data Mart Database.[21]

COVID-19, coronavirus disease 2019; U.S., United States.

Close ×

Cumulative Risk

Impact on underlying medical conditions

COVID-19 may **worsen underlying medical conditions**, leading to increased morbidity and mortality[22–25]

Risk of new-onset conditions

Patients with COVID-19 may experience **new-onset, relapsing, or remitting** conditions following their infection[25–29]

Stacking comorbidities



Stacking comorbidities by both risk level and number of conditions increases COVID-19–related healthcare utilization[21]

Younger adults with immunocompromised conditions are at an increased risk of COVID-19-related hospitalization vs those aged ≥65 years without high-risk conditions[21,*]

↑395x

higher risk of mortality in individuals aged **<50 years with ≥5 comorbidities** compared with those without comorbidity[30,†]

*This retrospective, non-interventional cohort study used adjudicated medical and pharmacy claims data from 10,631,427 individuals in the U.S. from the Optum Clinformatics® Data Mart Database.[21]
†This retrospective cohort study was conducted in 167,500 individuals diagnosed with COVID-19 between January 15 and December 31, 2020, from the health administrative databases in Ontario, Canada.[30]

COVID-19, coronavirus disease 2019; U.S., United States.

Close ×

Importance of COVID-19 Interventions

COVID-19 vaccines are effective against preventing severe disease outcomes across age groups, including[31]



Hospitalization



Supplemental oxygen therapy



Acute respiratory failure



ICU admission



Invasive mechanical ventilation or death

However, despite the availability of COVID-19 vaccines, many people remain under-protected, due to

Limited vaccination uptake

16% of adults (aged ≥18 years) have received the updated 2025–2026 COVID-19 vaccines[4,*]

Waning vaccine effectiveness over time

↓51% decrease in vaccine effectiveness against hospitalization from 7–59 days to 180–299 days post vaccination[32,†]

Limited vaccine effectiveness among immunocompetent adults

55% estimated vaccine effectiveness against COVID-19–associated hospitalizations among immunocompetent adults aged ≥18 years[33,‡]

*CDC COVID-19 vaccination coverage estimates as of February 20, 2026.[4]
†The case-control study included patient encounters with a COVID-19–like illness discharge diagnosis code and a molecular or antigen SARS-CoV-2 test within 10 days before to 3 days after the encounter date, from September 5, 2024, to September 2, 2025.[32]
‡Patient data were obtained from the Virtual SARS-CoV-2, Influenza, and Other Respiratory Viruses Network, an electronic medical record–based network of health care systems in 7 U.S. states from September 3 to December 31, 2025. The median [interquartile range] time since 2025–2026 COVID-19 vaccine dose receipt, 46 [26–68] days.[33]

CDC, Centers for Disease Control and Prevention; COVID-19; coronavirus disease 2019, ICU, intensive care unit, SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; U.S., United States.

Close ✕

Early Management of COVID-19



Early management of COVID-19 with oral medicines may help control SARS-CoV-2 infection in households and other closed settings[34–37]

COVID-19, coronavirus disease 2019.

Early Management of COVID-19

Early intervention may help reduce the risk of developing COVID-19, and may help:

- **Reduce viral load**[34,35]
- **Decrease symptom duration**[34]
- **Protect high-risk individuals**[35]



Early management of COVID-19 with oral medicines may help control SARS-CoV-2 infection in households and other closed settings[34–37]

COVID-19, coronavirus disease 2019.