Key CDC and CMS COVID-19 Guidance for SNFs (As of May 27, 2022)

Community Transmission

With the increase in COVID-19 cases in Ohio communities and long-term care facilities over the past weeks, members are seeking guidance on outbreak, testing, personal protective equipment (PPE) use, and more. These requirements often are tied to prevalence of COVID-19 in the surrounding community. Confusion arises from the fact that the Centers for Disease Control and Prevention (CDC) has two different measures of community spread, Community Levels and Community Transmission. The two measures have very different results. On the Community Levels map, Ohio has mostly low spread. On the Community Transmission map, much of the state has high transmission with a few counties as substantial transmission.

According to the CDC guidance, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," for health care personnel (HCP), the Community Transmission map determines whether they need to wear eye protection in care areas regardless of the presence of COVID-19. Both high and substantial transmission (red or orange) trigger the eye protection recommendation.

Testing

The Centers for Medicare and Medicaid Services (CMS) has not updated the QSO-20-38-NH, on COVID-19 testing since March 10, 2022.

Table 1: Testing Summary

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, *regardless of vaccination status*, with signs or symptoms must be tested.	Residents, *regardless of vaccination status*, with signs or symptoms must be tested.
Newly identified COVID-19 positive staff or resident in a facility that can identify close contacts	Test all staff, *regardless of vaccination status*, that had a higher-risk exposure with a COVID-19 positive individual.	Test all residents, *regardless of vaccination status,* that had close contact with a COVID-19 positive individual.
Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts	Test all staff, *regardless of vaccination status,* facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility).	Test all residents, *regardless of vaccination status,* facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility).
Routine testing	According to Table 2 below	Not generally recommended

The QSO links testing frequency for HCP who are not up to date to the Community Transmission map.

Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission

Level of COVID-19 Community Transmission	Minimum Testing Frequency of Staff *who are not up-to-date*[+]
Low (blue)	**Not recommended**
Moderate (yellow)	**Once a week***
Substantial (orange)	**Twice a week***
High (red)	**Twice a week***

[+]Staff *who are up-to-date* do not need to be routinely tested.
*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

Remember also that CMS provides the following guidance on how to utilize the Community Transmission map, which specifically applies to testing but also can be used for eye protection:

> Facilities should monitor their level of community transmission every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above.
>
> - If the level of community transmission increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity level are met.
> - If the level of community transmission decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the level of community transmission has remained at the lower activity level for at least two weeks before reducing testing frequency.

OHCA has requested that ODH utilize Community Levels instead, as they are more advanced and focus on the severity of COVID-19 infections by incorporating hospitalization data. Moreover, they are in keeping with current public perception of the amount of danger from COVID-19. Eye protection is for the benefit of the wearer, not the resident, and the wearer is a member of the community. We will keep members informed of the department's response.

In addition, this routine testing includes all staff who are not "up-to-date." CDC guidance specifies when a person is considered up to date with their vaccinations. For the most part, up to date means having had all recommended boosters, which includes second boosters for people 50 and over and people who are severely or moderately immunocompromised. The guidance also clarifies that if a vaccinated person is not yet eligible for a booster, they are still considered up to date:

You are also considered up to date if

- You have completed your primary series – but are not yet eligible for a booster
- You have received 1 booster but are not recommended to get a 2nd booster
- You have received 1 booster but are not yet eligible for a 2nd booster

Stay up to date by getting all recommended boosters when you are eligible.

For the vaccine mandate, however, the regulations still use the term "unvaccinated." There is no requirement, at this time, for boosters.

PPE Requirements/Source Control

According to CDC's guidance for HCP, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," there are three options for source control for HCP:

- A NIOSH-approved N95 or equivalent or higher-level respirator OR
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR
- A well-fitting facemask.

Technically, approved alternatives are called "respirators approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators ...." Where does one find a list of such respirators? It is buried deep in the CDC guidance on mitigating shortages of N95s. Scroll down to "Crisis Capacity Strategies" and open the sub-item entitled "Use of respirators approved under standards used in other countries that are similar to NIOSH-approved respirators" for two lists of these masks. While the alternative respirators qualify for source control in health care settings, they should not be used in place of N95s in full PPE situations unless the facility is in crisis capacity for N95s.

The definitions of the term "facemask" in this and other CDC guidelines are not particularly clear. What is more important about use of facemasks for source control is that they are well-fitting, which essentially means that there are no significant gaps.

In addition, when caring for any resident who is in quarantine or isolation, HCP should wear full personal protective equipment (PPE), including eye protection and an N95 or higher respirator, not a facemask. If your facility has an uncontrolled outbreak, or you cannot determine the cause through contact tracing, then HCP should proceed as if the whole area in question is in quarantine, including wearing full PPE.

One of the recommendations in the HCP guidance could be misinterpreted by surveyors. The guidance states that in red or orange counties, staff members "can" wear N95s in two situations. One is when providing care for a resident who is not up to date and who is unable to use source control, if the area is poorly ventilated. The second is when there is "healthcare-associated SARS-CoV-2 transmission" in the facility (i.e., certain outbreak situations). CDC adds, "[t]o simplify implementation, facilities in counties with substantial or high transmission may consider implementing universal use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission." The language CDC used in this section ("can," "may consider") suggests that N95s are a preferred option in these situations, but not a true CDC recommendation (denoted by "should"). Surveyors should not enforce these options as requirements.

Quarantine/Isolation

CDC recommends quarantining residents who have close contact with an infected person if the resident is not up to date. They can be released from quarantine after 10 days or after 7 days with a negative test unless they develop symptoms.

CDC recommends quarantining new admissions who are not up to date even if they test negative upon admission. Previously, only unvaccinated admissions needed to be quarantined.

CDC applies to visitors the criteria for releasing residents from transmission-based precautions (that is, the 10-day rule), not the community criteria for discontinuing isolation/quarantine (the 5-day rule). This change may require you to adjust your screening process for visitors to ask about COVID-19 within the previous 10 days.

Patients with mild to moderate illness who are *not* moderately to severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 10 days have passed since the date of their first positive viral test.

Patients with severe to critical illness and who are *not* moderately to severely immunocompromised:

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

The guidelines call for testing new admissions (including residents who leave for more than 24 hours) twice, immediately upon admission/return and 5-7 days afterward.

CDC also recommends testing asymptomatic residents twice, regardless of vaccination status, if they have close contact with someone with COVID-19. The testing should be done immediately (but 24 hours or more after exposure) and 5–7 days after exposure.

CDC notes that if you are testing a person who had COVID-19 in the previous 90 days (such as a staff member for return-to-work purposes), you should use an antigen test.

The guidelines recommend quarantining residents who are not up to date during an outbreak. Residents who are up to date should wear source control and should be tested as applicable under the facility's outbreak investigation approach.

Notification

- Notify the health department promptly about any of the following:
  - ≥ 1 residents or HCP with suspected or confirmed SARS-CoV-2 infection
  - Resident with severe respiratory infection resulting in hospitalization or death
  - ≥ 3 residents or HCP with acute illness compatible with COVID-19 with onset within a 72-hour period
- Find the contact information for the healthcare-associated infections program in your state health department, as well as your local health department.
- Notify HCP, residents, and families promptly about identification of SARS-CoV-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions.
- Report SARS-CoV-2 infections, facility staffing and supply information, and point of care testing data to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module weekly. CDC's NHSN provides long-term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way.
  - Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements.

Outbreak

One new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak.

- The approach to an outbreak investigation should take into consideration whether they can perform contact tracing, vaccination acceptance rates of staff and residents, whether the positive is staff or resident, whether there are others with suspected or confirmed infection, and the extent of potential exposures.
- Consider increasing monitoring of all residents from daily to every shift.

Nursing home-onset SARS-CoV-2 infections refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:

- Residents who were known to have SARS-CoV-2 infection on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
- Residents who were placed into Transmission-Based Precautions (quarantine) on admission and developed SARS-CoV-2 infection while in quarantine.

HCP and residents with symptoms of COVID-19:

- Symptomatic HCP, regardless of vaccination status, should be restricted from work pending evaluation for SARS-CoV-2 infection.
- Symptomatic residents, regardless of vaccination status, should be restricted to their rooms and cared for by HCP using a NIOSH-approved N95 or equivalent or higher-

level respirator, eye protection (goggles or a face shield that covers the front and sides of the face) gloves, and a gown pending evaluation for SARS-CoV-2 infection.

Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-CoV-2 infection. (Contact tracing starts 2 days before the infected person developed symptoms, or the date they were tested if they do not have symptoms, until they started isolation.):

- All HCP who had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested.
- Residents who are close contacts should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection. Management decisions will depend on if they are up to date with all recommended COVID-19 vaccines.
- HCP with higher-risk exposures should be managed as described in the Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2. Decisions about work restriction will depend on if they are up to date with all recommended COVID-19 vaccine doses.
- If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued.
    - A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
    - If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below for alternative approaches to individual contact tracing.

Alternative, broad-based approach:

- If a facility does not have the ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility).
- Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5-7 days later.
- Residents who are close contacts should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection. Management decisions will depend on if they are up to date with all recommended COVID-19 vaccines.
- HCP with higher-risk exposures should be managed as described in the Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2. Decisions about work restriction will depend on if they are up to date with all recommended COVID-19 vaccine doses.
- If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for residents who are not up to date with all recommended COVID-19 vaccine doses can be discontinued after 14 days and no further testing is indicated.
- If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of residents who are not up to date with all recommended COVID-19 vaccine doses, until there are no new cases for 14 days.

    - If antigen testing is used, more frequent testing (every 3 days), should be considered.

Indoor visitation during an outbreak response:

- Facilities should follow guidance from CMS about visitation.
- Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility.
- Indoor visitation should ideally occur only in the resident's room, the resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible).
- Source control and physical distancing recommendations should also be followed for residents who are up to date with all recommended COVID-19 vaccine doses.
- Outdoor visitation could be allowed, but residents should wear well-fitting source control (if tolerated), maintain physical distancing from others, and not linger in common spaces when moving from their rooms to the outdoors.