CDC COVID-19 Guidelines for SNFs

September 19, 2023

COVID-19 is Spreading Again

- National (SNFs only, residents only)
  - June 11: 2,548 cases, 51 deaths
  - September 3: 9,700 cases, 152 deaths
  - 381% increase
- Ohio (all LTCFs, residents and staff)
  - June 15: 485 cases, 3 deaths
  - September 14: 1,279 cases, 0 deaths
  - 264% increase
- CDC/CMS guidelines have not changed

Current Guidelines

- SNF
  - “Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic” (May 8, 2023)
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
  - QSO-20-39 – “Nursing Home Visitation - COVID-19” (May 8, 2023)
  - https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf
- Assisted living
  - “Additional Information for Community Congregate Living Settings (e.g., Group Homes, Assisted Living)” (May 11, 2023)
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Outbreak Procedures

- Single new positive still constitutes an outbreak (“should be evaluated to determine if others in the facility could have been exposed”)
- Response options
  - Either contact tracing or broad-based approach (e.g., unit, floor, or other specific area(s) of the facility)
  - Broad-based approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission

Outbreak – Transmission-Based Precautions

- TBP for residents and work restrictions for HCP generally not necessary unless otherwise required
- However, source control should be worn by all individuals being tested in outbreak testing
- If spread within the facility is not controlled with initial interventions, give strong consideration to TBP (e.g., quarantine) for residents and work restrictions for HCP with higher-risk exposures

Outbreak Testing

- Test all residents and HCP regardless of vaccination status who are:
  - Identified as close contacts via contact tracing
  - On the affected unit(s) if using broad-based approach
- Three-test series (typically days 1, 3, 5)
  - Immediately (but not earlier than 24 hours after exposure)
  - If negative, again 48 hours after first negative test
  - If negative, again 48 hours after second negative test

Outbreak Testing Follow-Up

- If no additional cases identified during contact tracing or broad-based testing:
  - No further testing indicated
  - TBP for residents and work restrictions for HCP who met criteria can be discontinued under normal procedures
- If additional cases identified, give strong consideration to:
  - Shifting to broad-based approach if not already used
  - Quarantining residents in affected areas of facility
  - Continue testing on affected unit(s) or facility-wide every 3-7 days until no new cases for 14 days
  - If antigen testing is used, consider more frequent testing (every 3 days)

Visitation During Outbreak

- Visitation must be allowed
- Visitors should be counseled about potential to be exposed
- If indoor visitation is occurring in areas of the facility experiencing transmission:
  - Ideally it should occur in resident rooms
  - Residents and visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during visit

Vaccination

- Vaccine mandate and related requirements no longer in effect
- Remaining guidelines:
  - Encourage everyone to be up-to-date with all recommended COVID-19 vaccine doses (that is, newly-approved, updated vaccine)
  - HCP, patients, and visitors should be offered resources and counseled about importance of vaccination
- CDC definition of up-to-date applies for NHSN reporting
- Separate CMS regulation on educate-and-offer (42 CFR 483.80(d)(3)) requires facility to maintain documentation for residents and staff, including vaccination status for NHSN reporting

Screening

- Self-screening: Must establish process to make everyone entering facility aware of recommended actions if they have a positive test, symptoms, or close contact/higher-risk exposure
- For example:
  - Instruct HCP to report that they meet any of the criteria to designated point of contact
  - Provide guidance (e.g., posted signs at entrances) about recommended actions for patients and visitors who meet any of the criteria
- If visitor is positive or symptomatic, defer non-urgent visitation until they meet health care criteria to end isolation
- If visitor had close contact or another higher-risk situation and cannot wear source control or has other risk factors, defer non-urgent visitation until 10 days after exposure

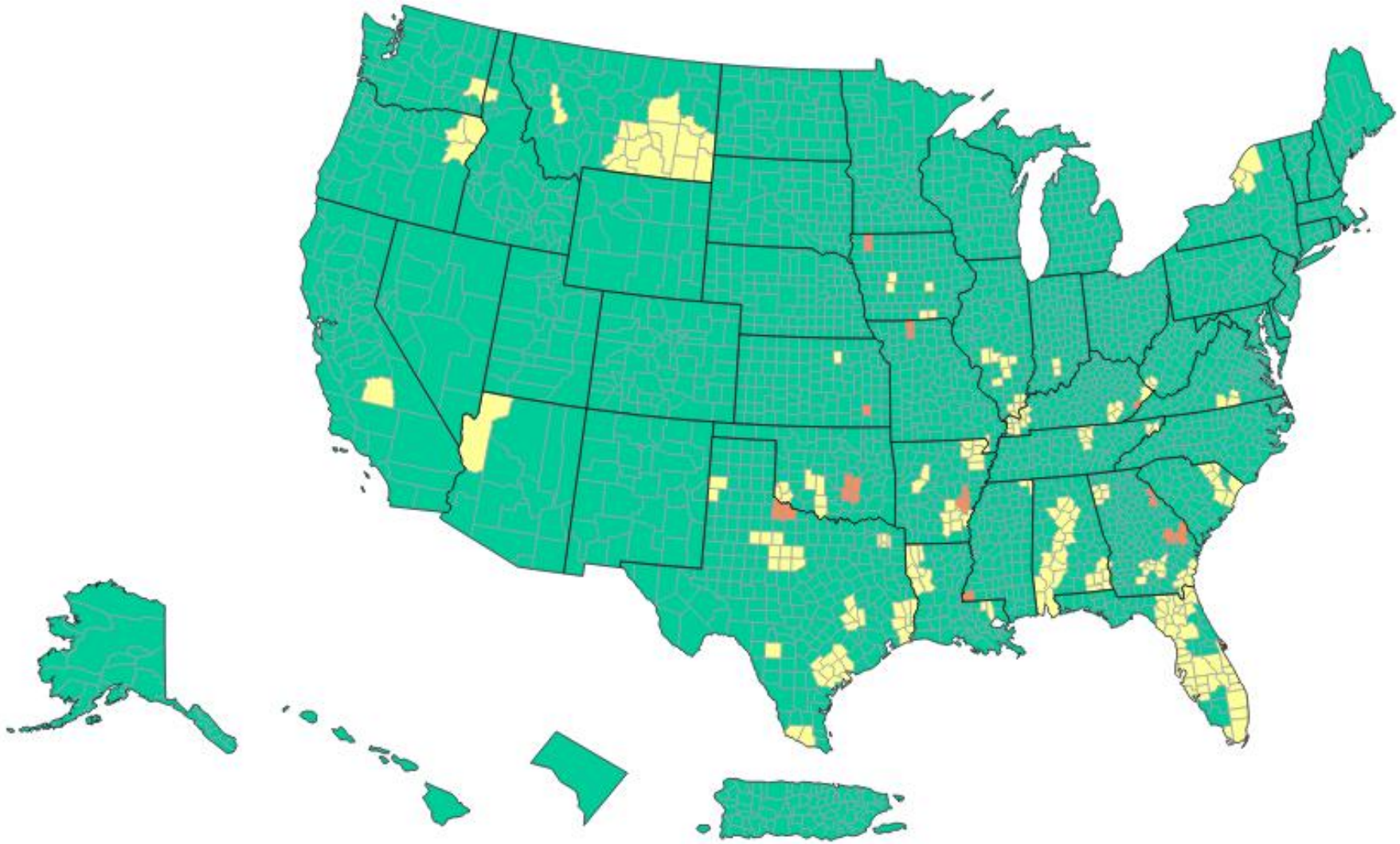
Masking (Source Control)

- Source control options:
  - N95 or higher respirator or
  - Respirator approved under standards in other countries similar to N95 or
  - Barrier face covering meeting ASTM standards or
  - Well-fitting facemask
- Length of use
  - Solely for source control for an entire shift unless it becomes soiled, damaged, or hard to breathe through
  - N95s, in circumstances where they are required, should be removed and discarded after each patient care encounter

Masking (Source Control)

- Source control recommended for individuals who:
  - Are COVID-19-positive or have symptoms
  - Had close contact/higher-risk exposure, for 10 days after exposure
- Source control recommended more broadly in following circumstances:
  - On unit/area experiencing outbreak of respiratory infection (can discontinue if no new cases for 14 days)
  - Facility-wide or targeted toward higher-risk areas or patient populations during periods of higher levels of community respiratory virus transmission
  - When recommended by local public health authorities
- Individuals may use mask or respirator even if not required, based on personal preference

Reported COVID-19 New Hospital Admissions Rate per 100,000 Population in the Past Week, by County – United States



Personal Protective Equipment

- N95s and eye protection (goggles or a face shield that covers the front and sides of the face) needed for:
  - Aerosol-generating procedures
  - Additional risk factors, such as patient unable to use source control and area poorly ventilated
  - COVID-19 transmission identified in an area of the facility
- Facilities in counties with higher levels of COVID-19 transmission may consider implementing universal use of N95s during all patient care encounters or in specific units or areas of the facility at higher risk
- HCP who enter room of a patient with suspected/confirmed COVID-19 should use full PPE (N95, gown, gloves, and eye protection)

Testing

- CMS QSO-20-38-NH rescinded
- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should be tested as soon as possible
- Three-test series for asymptomatic patients with close contact
- Testing generally not recommended for asymptomatic people who had COVID-19 in prior 30 days; antigen test recommended between 31-90 days
- Expanded screening testing (routine testing) of asymptomatic HCP without known exposure is at facility discretion

Return to Work

- “Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2” (September 23, 2022)
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
- Generally, symptom improvement (if applicable) plus testing
- Symptom improvement:
  - At least 24 hours have passed since last fever without fever-reducing medications
  - Symptoms (e.g., cough, shortness of breath) have improved

Return to Work - Testing

- Basic timeline
  - At least 7 days after first positive test/symptoms if negative test obtained within 48 hours before returning to work
  - At least 10 days if testing not performed or positive test at day 5-7
- HCP with severe/critical illness need 10-20 days since symptoms first appeared
- Either NAAT (molecular) or antigen test may be used, but on antigen testing, HCP should have a negative test on day 5 and again 48 hours later
- For moderately/severely immunocompromised HCP:
  - At least two consecutive negative tests at least 48 hours apart
  - Consultation with infectious disease specialist recommended

HCP with Higher-Risk Exposure

- Includes both workplace and community exposure
- Work restriction generally not required if asymptomatic
- Three-test series, source control required
- Reasons why work restriction might be necessary:
  - HCP unable to be tested or wear source control
  - HCP moderately/severely immunocompromised
  - HCP works with moderately/severely immunocompromised patients
  - HCP works on unit experiencing uncontrolled outbreak

What About Contingent and Crisis Staffing?

- “Strategies to Mitigate Healthcare Personnel Staffing Shortages” (September 23, 2022)
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
- Contingent staffing status lowers return-to-work timeframe to 5 days, if symptoms (if any) have improved
- Crisis staffing eliminates return-to-work timeframe altogether, as a last resort
- BEWARE
  - Other measures required of contingency/crisis buildings to address staffing
  - Considerations and precautions required for bringing back HCP early
  - Carefully review and document these things

Admissions/Readmissions

- Admission testing is at the discretion of the facility.
- Residents who leave the facility for 24 hours or longer should generally be managed as admissions
- TBP generally not necessary for admissions or residents who leave facility for less than 24 hours and are not positive, symptomatic, or exposed

Care for COVID-19 Patients

- Private rooms
  - Ideally, residents should be placed in a private room with a dedicated bathroom and the door kept closed (if safe to do so)
  - If limited single rooms are available or if numerous residents are simultaneously identified to be positive, exposed, or symptomatic, residents should remain in their current location
- Cohorting
  - Only patients with the same respiratory pathogen should be housed together
  - Patients with symptoms (not confirmed positive) should not be cohorted with positive patients

Care for COVID-19 Patients

- COVID-19 unit
  - Facilities could consider designating entire units, with dedicated HCP, when the number of patients with COVID-19 is high
  - “Dedicated” means HCP are assigned to care only for these patients during their shifts
  - Dedicated units or HCP might not be feasible due to staffing crises or a small number of COVID-19 patients
- Limit transport and movement of patients outside of their rooms to medically essential purposes
- Communicate information before transferring patients with COVID-19 to other health care facilities

Asymptomatic Patients with Close Contact

- TBP generally not required
- Should still wear source control and be tested
- Consider TBP for these patients under same circumstances as work restrictions for asymptomatic HCP with higher-risk exposure
- If placed in TBP, can be discontinued:
  - After day 7 (count the day of exposure as day 0) if no symptoms and negative testing
  - If not tested, after day 10 if no symptoms.

Visitation with COVID-19 Patients

- Visitation must be allowed
- For safety of visitors, encourage limiting in-person visitation while patient is infectious
- Counsel patients and visitors about risks of in-person visits
- Encourage alternative mechanisms such as video-call applications on cell phones or tablets, when appropriate
- Provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE
- Instruct visitors to only visit the patient room and minimize time spent in other locations in the facility

Discontinuing TBP

- In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below
- For symptomatic patients who are not moderately/severely immunocompromised:
  - At least 10 days since symptoms first appeared (up to 20 days if severe/critical illness) and
  - At least 24 hours since last fever without fever-reducing medications and
  - Symptoms (e.g., cough, shortness of breath) have improved
- For severe/critical cases, the test-based strategy described for moderately/severely immunocompromised patients below can be used to inform duration of isolation
- For asymptomatic patients who are not moderately/severely immunocompromised, at least 10 days since first positive test

Discontinuing TBP – Immunocompromised Patients

- Test-based strategy: At least two consecutive negative antigen or NAAT tests 48 hours apart and
- If symptomatic:
  - Resolution of fever without fever-reducing medications and
  - Symptoms (e.g., cough, shortness of breath) have improved and
- If available, consultation with infectious disease specialist

Notification/Reporting Requirements

- Ensure everyone is aware of recommended IPC practices in the facility via visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias)
- Regulation on notifying residents/families (42 CFR 483.80(g)(3) still in place, but CMS in QSO-23-13-ALL announced that they are exercising discretion not to enforce this requirement
- NHSN reporting still required through at least December 31, 2024:
- Infectious disease notification requirements to local health department

Environmental Infection Control

- Use dedicated medical equipment for care of COVID-19 patients
- Clean and disinfect non-dedicated, non-disposable medical equipment according to manufacturer's instructions and facility policies
- Use routine cleaning and disinfection procedures (e.g., cleaners and water to pre-clean surfaces prior to applying EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label)
- Manage laundry, food service utensils, and medical waste in accordance with routine procedures
- Post-discharge, refrain from entering the vacated room without all recommended PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles