Indiana Department of Health

COVID-19 GUIDANCE UPDATE

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OUR MISSION:

To promote, protect, and improve the health and safety of all Hoosiers.

OUR VISION:

Every Hoosier reaches optimal health regardless of where they live, learn, work, or play.

Updated documents from CDC and CMS 9-23-22

- Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC
- Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- Ref: QSO-20-38-NH REVISED 09/23/2022 (cms.gov)
- QSO-20-39-NH REVISED 09/23/2022 (cms.gov)

CMS guidance updates

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Guidance for Visitors

- Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19.
- Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation.
- For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet the criteria described in CDC healthcare guidance (e.g., cannot wear source control)
- During peak times of visitation and large gatherings (e.g., parties, events) facilities should encourage physical distancing
- If the nursing home's county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility could choose not to require visitors to wear face coverings or masks while in the facility, except during an outbreak.

Guidance for Visitors

- Regardless of the community transmission level, residents and their visitors when alone in the resident's room or in a designated visitation area may choose not to wear face coverings or masks and may choose to have close contact (including touch). Residents (or their representatives) and their visitors should be advised of the risks of physical contact prior to the visit.
    - If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.
- While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Also, visitors should physically distance themselves from other residents and staff, when possible.

Guidance for Residents

- While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. The safest approach is for everyone, particularly those at high risk for severe illness, to wear a face covering or mask while in communal areas of the facility.
- Remind residents (and the person accompanying them) to follow IP practices while leaving the building (for example, an excursion).

Staff Guidance

- Routine testing of asymptomatic staff is no longer recommended but may be performed at the discretion of the facility.
- Instruct facility staff, regardless of their vaccination status, to report any of the following criteria to occupational health or another point of contact designated by the facility so they can be properly managed:
  - a positive viral test for SARS-CoV-2,
  - symptoms of COVID-19, or
  - a higher-risk exposure to someone with SARS-CoV-2 infection

Healthcare facilities guidance from CDC

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Which facilities does this guidance apply to?

This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health. Assisted living facilities providing healthcare also should follow this guidance.

In general, long-term care settings (excluding nursing homes) whose staff provide non-skilled personal care similar to that provided by family members in the home (e.g., many assisted livings, and group homes), should follow community prevention strategies based on COVID-19 Community Levels, similar to independent living, retirement communities or other non-healthcare congregate settings. Residents should also be counseled about strategies to protect themselves and others, including recommendations for source control if they are immunocompromised or at high risk for severe disease.

Important changes

- Vaccination status is no longer used to inform source control, screening testing or post-exposure recommendations.
- Screening testing of asymptomatic healthcare personnel, including those in nursing homes, is at the discretion of the healthcare facility.
- Asymptomatic residents no longer require empiric use of transmission-based precautions following close contact with someone with SARS-CoV-2 infection. However, they must wear a facemask for 10 days, be tested, and be watched for the development of symptoms
- New admissions, if asymptomatic, are not required to be placed in transmission-based precautions upon admission irrespective of the vaccination status.
- Testing frequency after close contact or in an outbreak

Community transmission

Check community transmission weekly on the CDC data tracker.
Note: The transmission is different from the COVID-19 community level.

- If community transmission is high newly this week, implement guidance for high community transmission levels immediately.
- If the community transmission is decreasing, make sure the community transmission is not high for two weeks in a row before decreasing infection control practices to such a level.

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https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk&null=Risk

When community transmission high

- Source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter residents
  - HCP could choose not to wear source control when they are in well-defined areas that are restricted from resident access (e.g., staff meeting rooms) if they do not otherwise meet the criteria described below and Community Levels are not also high
  - When Community Levels are high, source control is recommended for everyone
- Consider NIOSH-approved particulate respirators with N95 filters or higher for the following
  - All aerosol-generating procedures
  - HCP working in other situations where additional risk factors for transmission are present, such as the resident is unable to use source control and the area is poorly ventilated.

When not in high transmission

- Healthcare facilities could choose not to require universal source control. Follow standard precautions (or precautions based on whether the resident in TBP or another type of precautions)
- Source control remains recommended for individuals if any of the following apply
  - Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with a runny nose, cough, sneeze);
  - Had close contact (residents and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure
  - Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days
  - Have otherwise had source control recommended by public health authorities
  - Facility policy
  - Based on personal preference, informed by their perceived level of risk for infection based on their recent activities (crowded event), the risk level for themselves or their household
  - HCP and healthcare facilities might also consider using or recommending source control when caring for residents who are moderately to severely immunocompromised.

Reminders

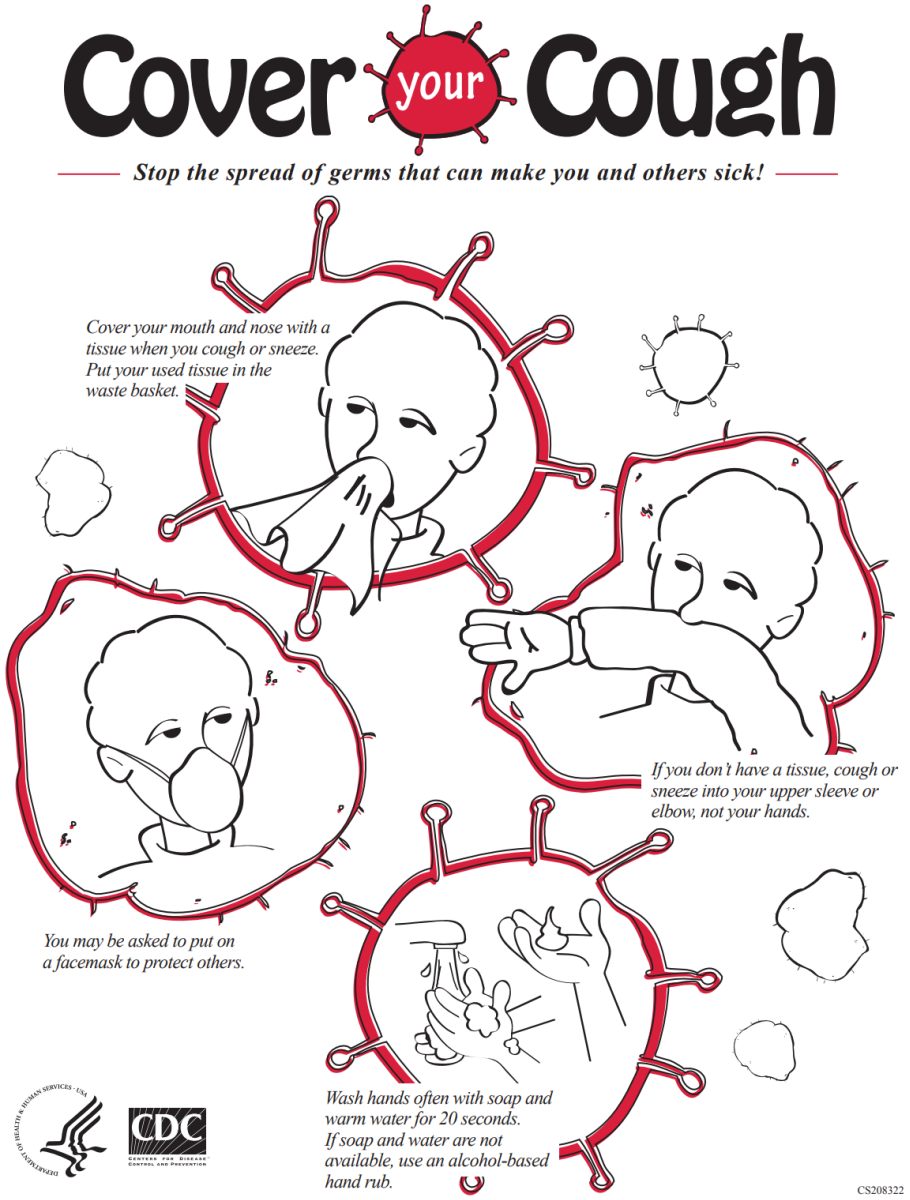
- Resident not in TBP: HCP can use eye protection if they choose to, it is not required (IDOH)
- Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses.
  - HCP, residents, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine
- Establish a process to identify and manage individuals with suspected or confirmed SARS-CoV-2 infection
  - Ensure everyone is aware of recommended IPC practices in the facility
  - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can let help ensure people know that they reflect current recommendations.

Reminders

- Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
  - a positive viral test for SARS-CoV-2
  - symptoms of COVID-19, or
  - close contact with someone with SARS-CoV-2 infection (for residents and visitors) or a higher-risk exposure (for healthcare personnel (HCP)).
- People, particularly those at high risk for severe illness, should wear the most protective form of source control they can that fits well and that they will wear consistently

Visual alert

https://www.cdc.gov/flu/pdf/protect/cdc_cough.pdf



New admissions

- Screen new admissions for a history of close contact in the prior ten days and for symptoms of COVID-19 (IDOH)
- New admissions, if asymptomatic, are not required to be placed in transmission-based precautions upon admission irrespective of the vaccination status
- If the community transmission levels are high, new residents should be tested upon admission, 48 hours later, and again 48 hours later. Admission testing at lower levels of Community Transmission is at the discretion of the facility.
- They should also be advised to wear source control for the 10 days following their admission

Residents with Close Contact

- Do not cohort them with confirmed COVID-19
- No TBP, but they should wear a mask for 10 days. No restriction on communal activities.
- Watch for the development of any symptoms of COVID-19. If symptomatic, follow the guidance for the symptomatic.
- If a resident needs an aerosol-generating procedure (AGP) during the first 10 days after close contact with COVID-19, they must be in TBP while they are undergoing the AGP.
    - HCP should wear PPE accordingly while administering AGP. Anyone entering that room should wear NIOSH-approved particulate respirators with N95 filters or higher for one hour after AGP ends. (IDOH)
- Asymptomatic residents with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests (days 1, 3, and 5 counting the day of exposure as day 0).
    - Do not test those with COVID-19 in the last 30 days if asymptomatic
    - Consider testing with an antigen test for those with COVID-19 in the last 31-90 days

Residents with Close contact- empiric TBP

- **Empiric transmission-based precautions following close contact (for 7 days with negative tests or 10 days if not tested) may be considered if**
  - Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
  - Resident is moderately to severely immunocompromised
  - Resident is residing on a unit with others who are moderately to severely immunocompromised
  - Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions
- **Test serially.** Use other infection prevention measures: hand hygiene, distancing, and consider keeping in a room for the most part. Resort to TBP as the last step (IDOH).

HCP with higher-risk exposure

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged close contact with a resident, visitor, or HCP with confirmed SARS-CoV-2 infection and either of the following happened:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

HCP with higher-risk exposure

- No work restriction, but they should wear a well-fitting facemask for ten days, undergo a series of three viral tests (days 1, 3, and 5)
  - Do not test those with COVID-19 in the last 30 days if asymptomatic
  - Consider testing with antigen test for those with COVID-19 in the last 31-90 days
- May consider restriction from work (for 7 days with negative tests, or 10 days if not tested) if
  - HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure
  - HCP is moderately to severely immunocompromised
  - HCP cares for or works on a unit with residents who are moderately to severely immunocompromised
  - HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Resident with confirmed COVID-19

- Dedicate medical equipment (or clean per manufacturer's recommendations or facility policy before using on other)
- Avoid AGP if possible, and limit the number of HCP present in the room if performed
- Limit visitors into the room. If a visit is happening, the facility should counsel the risks and use PPE per facility policy
- TBP for 10-20 days (or based on test-based strategy if immunocompromised as per ID) (same as previous guidance)

Staff with Confirmed COVID-19

Asymptomatic:

- At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7)
- *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

Mild to moderate:

- At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), 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.
- *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

Staff with Confirmed COVID-19

Severe or critical:

- 10-20 days (and improving symptoms and no fever) or test-based strategy (same as previous guidance)

Rebound:

- If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

Symptomatic individual

- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.
- TBP for residents (work restriction for staff) until ruled out for COVID-19 or an alternate reason is found.
- Discontinue TBP for residents (work restriction for staff) if COVID-19 is excluded by the following methods.
    - If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT.
    - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or a second negative antigen test taken 48 hours after the first negative test.
    - If not tested, stop TBP (or work restriction) at 10-20 days of the start of symptoms.
- Test for alternate pathogens and follow the recommendations if an alternate diagnosis is found.

Outbreak

- An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed.
  - An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP is discontinued.
- Outbreak testing may be contact tracing based on broad-based

Outbreak investigation

Individuals that are part of the outbreak investigation

- Should wear source control for 10 days. No restriction on communal activities
- If asymptomatic, they are not required to be placed in transmission-based precautions irrespective of the vaccination status
- If residents who are part of an outbreak investigation and testing need to undergo an aerosol-generating procedure (AGP), they must be in TBP while they are undergoing the AGP
    - HCP should wear PPE accordingly while administering AGP. Anyone entering that room should wear NIOSH-approved particulate respirators with N95 filters or higher for one hour after AGP ends. (IDOH)

Outbreak investigation

- Test on days 1, 3, and 5 (Do not test those with COVID-19 in the last 30 days if asymptomatic. Consider testing with an antigen test for those with COVID-19 in the last 31-90 days.)
  - If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated.
  - If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on the affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.
- Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility. If indoor visitation is occurring in areas of the facility experiencing transmission, it should ideally occur in the resident's room. The resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit.

Staffing strategies

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Staffing strategies

If using contingency or crisis staffing:

- Consider symptoms that are persistent, and what kind of work they do.
- Follow the symptoms to act accordingly if worsening symptoms.
- Wear a well-fitting face mask at all times (including break rooms) until they meet the criteria to return to work, and distance themselves from others if taking off the mask to eat or drink.
- To the extent possible, they should practice physical distancing from others.
- **Residents should wear source control (if tolerated) while care is being delivered by these HCP.**

Contingency:

- HCP with mild to moderate COVID-19 illness who are not moderately to severely immunocompromised: Return to work after five days, if no fever (for 24 hours without fever reducing medications) and improving symptoms.
  - May consider requiring a negative PCR test or series of two negative tests 48 hours apart. (Keep in mind PCR can stay positive longer).
- Asymptomatic COVID-19: Return to work after five days. May consider requiring a negative PCR test or series of two negative tests 48 hours apart.

Crisis

Allowing HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, if they are well enough and willing to work even if they have not met all the contingency return to work criteria.

- Consider which day after infection, keeping in mind they are more infectious in the early part of the illness.
- Don’t assign to care for immunocompromised.
- Consider duties in the following order:
  - Non-resident care
  - Care of residents with confirmed COVID-19
  - Care of residents with suspected COVID-19
  - Care of others

Testing summary

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	*Not generally recommended*	Not generally recommended

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From IDOH

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Notes

- The frequency of resident assessment should be according to usual LTC guidance (May consider increasing frequency if outbreak, high transmission, or other conditions at the facility's discretion)
- Can have more than one entry into the facility if you have appropriate visual alerts with instructions about IPC recommendations (e.g., when to use source control and perform hand hygiene, etc.) at every entrance

Summary of Guidance specific from IDOH

- Not a TBP resident: HCP can use a face shield if they choose to, it is not required
- If a resident needs an aerosol-generating procedure (AGP) during the first 10 days after close contact with COVID-19, they must be in TBP while they are undergoing the AGP. The same applies to residents needing AGP after close contact with COVID-19.
    - HCP should wear PPE accordingly while administering AGP. Anyone entering that room should wear NIOSH-approved particulate respirators with N95 filters or higher for one hour after AGP ends.
- May consider empiric transmission-based precautions following close contact in some situations per slide 20. Use other infection prevention measures: hand hygiene, distancing, and consider keeping in a room for the most part. Resort to TBP as the last step.
- Screen new admissions for a history of close contact in the prior ten days and for symptoms of COVID-19

Facility's own policies

- **Facilities to write their policies considering the following (Examples only)**
- **When**? Based on situations (outbreak, community transmission, etc.)
- **What**? Require daily assessment of residents, Require Visitor screening requirement at the entrance, have a person to monitor for wearing source controls, HCP wear N95 for all AGP. Testing new admissions upon admission or serially.
- **Who and where?** Depending on whom they serve. A facility can have stricter infection prevention policies based on the residents they serve, on a wing or unit with high-risk individuals, vaccination rates, and/or other factors specific to the facility.
- **Special situations to address irrespective of transmission**: HCP and healthcare facilities might also consider using or recommending source control when caring for residents who are moderately to severely immunocompromised.

Questions?

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