IHCA Member Clinical Guidance Summary

March 23, 2021

QSO 20-38-NH **9-4-2021**

QSO 20-39-NH Revised **3-10-2021**

IDPH/DIA Long Term Care Visitation Guidance **3-11-2021**

IDPH Interim Guidance for New Admission or Return of Residents to LTC Facilities **3-18-2021**

CDC Updates Healthcare Infection Prevention & Control Recommendations in Response to COVID-19 Vaccination **3-10-2021**

CDC Interim US Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2 **3-11-2021**

CDC Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 Infection in Healthcare Settings **2-16-2021**

CDC Options to Reduce Quarantine Using Symptoms Monitoring & Testing **12-2-2020**

IDPH LTC Antigen Testing Guidance **11-16-2020**

IDPH LTC Staffing Guidance **11-3-2020**

Overview

Recent changes in CMS policies regarding nursing facility visitation, employee and resident quarantines and other practices after the vaccination of many LTC employees and residents has created many questions for further direction from providers. We urge IHCA members to download and/or print the documents linked above as this collective guidance should drive your operational and clinical practice. As of the date of this release, the documents above are the most recent versions released by DIA and IDPH, but we assume future updates may be issued and we will revise our guidance as needed.

The intent of this document is to provide clinical guidance and best practices for implementing the recent CMS changes.

Summary of new CMS visitation guidance

A revised version of **QSO 20-39-NH** was released on March 10, 2021. Here are the key points of the new guidance:

- The term fully vaccinated is defined as someone who has received all the required doses of the vaccine and is at or greater than 2 weeks from receiving the last dose.

- Visitor Screening – Visitors should be prohibited entry if they have had close contact with someone with COVID-19 infection in the prior 14 days, regardless of the visitor's vaccination status.
- Outdoor Visitation – Is still preferred even if both the resident and their visitors are fully vaccinated.
- Indoor Visitation – **Compassionate care visits should be always permitted.** Providers should also always allow indoor visitation and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note:). These scenarios include limiting indoor visitation for:
    - Unvaccinated residents if the nursing home's COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated;
    - Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the CDC criteria to discontinue Transmission-Based Precautions; or
    - Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

  Providers should continue to implement the Core Principles of COVID-19 Infection Prevention as outlined in the memo. With the continuation of these practices and if the resident is fully vaccinated, residents can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Visitors should physically distance from other residents and staff in the facility.
- Indoor Visitation During an Outbreak – Allows visitation during outbreaks that are confined to a specific area of the facility. (See further requirements later in this document.)
- Visitor Testing and Vaccination – Visitors are encouraged to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation.
- Compassionate Care Visits – As a reminder, compassionate care visits, and visits required under federal disability rights law, should always be allowed, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak. Visits should be done in accordance with infection control core practices.
- Federal and state surveyors and Ombudsman are not required to be tested or vaccinated (or show proof) and must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19.

Providers may also access a Fact Sheet prepared by CMS regarding the new guidance.

Screening essential health care workers

One of the most effective tools that nursing facilities can deploy to prevent COVID infections in your facility is the screening of all workers, contract employees and other health professionals on entrance. In recent months, several facilities have received actual harm and immediate jeopardy citations for inadequate screening of essential health care workers, particularly in facilities where employees self-screened. IHCA recommends that facility screening protocols ensure that symptomatic workers and individuals, or those who have had an actual exposure to COVID are evaluated or tested before being allowed to work. Review of facility screening practices to ensure effectiveness should be routinely conducted and documented. "Core Principles of COVID-19 Infection Prevention" as listed in QSO 20-39-NH Revised requires "Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g. temperature checks, questions about and observations of signs or symptoms), and denial of entry of

those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)." IHCA now has an updated staff screening form available here.

CDC guidance released on 3-10-2021, **Updates Healthcare Infection Prevention & Control Recommendations in Response to COVID-19 Vaccination**, and on 3-11-2021, Interim US Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2 which provide direction for facilities on work restrictions for fully vaccinated health care personnel who have had COVID-19 exposures or who have recently traveled.

Using outbreak definitions in everyday practice

Many providers have been confused about and have expressed frustration regarding the multiple definitions of "outbreak status". While multiple definitions pose challenges for providers, it appears that these separate definitions, created by different governmental and regulatory agencies are unlikely to be merged into one definition since they were created for distinct agency actions and outcomes. IHCA provides this information as an attempt to clarify the differences.

CMS Definition of Outbreak Status

Page 4 of QSO 20-38-NH identifies an "outbreak" as "any new case" that arises in a facility. Quoting the QSO, **"an outbreak is defined as a new COVID-19 infection in any healthcare personnel or any nursing home-onset COVID-19 infection in a resident. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak."** This CMS definition is specific to testing, and once one new case is identified in a facility, the facility must begin test all staff and residents. Subsequent testing of all staff and residents that have tested negative must continue every 3-7 days until testing identifies no new cases of COVID-19 among staff or residents for a period of at least 14 days since the most recent positive result.

CMS QSO 20-39-NH Revised now allows indoor visitation to continue under certain circumstances when an outbreak occurs. It describes how providers, if able to segregate an outbreak to a specific area of the facility, may continue indoor visitation in other areas of the facility. The ability of a facility to segregate an outbreak to a single area of the facility will depend physical separations that exist in the current structure and staff who is dedicated specifically to that area etc. Not all facilities may be able to accommodate such segregation given their size and staffing abilities.

"When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing (described in QSO 20-38-NH) and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

- If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.
    - For example, if the first round of outbreak testing reveals two more COVID-19cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

- If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak but does not change any expectations for testing and adherence to infection prevention and control practices. If subsequent rounds of outbreak testing identify **one or more additional COVID-19 cases in other areas/units of the facility**, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing."

"Compassionate care visits, and visits required under federal disability rights law, should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak."

CMS requires state survey agencies to conduct **Focused Infection Control Surveys** in all facilities in "outbreak" status within 3 -5 days of the outbreak. A focused survey will be triggered by 1 new case of COVID in a facility which to date has not experienced a positive case or when 3 or more new cases are identified in a facility which has already experienced COVID cases.

IDPH Definition of Outbreak Status
On page 3-4 of IDPH/DIA's Long-Term Care Facilities Visitation and Testing document, dated 9-30-2020, the Departments defines "outbreak" as "**three resident cases within the same fourteen (14) day period."** This definition triggers more active engagement with state and local public health partners for the provision of technical support from local county health departments and IDPH staff. A facility who meets IDPH outbreak criteria may request testing support from the State Hygienic Lab.

Compassionate care visits

Since March providers have been struggling to define what resident situations would qualify for a "compassionate care visit". QSO 20-39-NH significantly expanded the situations which may be considered to qualify for those visits. Compassionate care is **NOT** limited to end of life situations. Some examples from the QSO are:

- A resident who was living with their family before admission and who is struggling with the environment and lack of physical family support.
- A resident who is grieving after a friend or family member passed away.
- A resident who needs cueing and encouragement with eating or drinking that was previously provided by a family or caregiver and is experiencing in weight loss or dehydration.
- A resident who used to talk and interact with others experiencing emotional distress and seldom speaking or crying more frequently (when they rarely cried in the past so a departure from normal behavior).

Compassionate care visits are allowed even during outbreak situations. It may be helpful that the facility interdisciplinary care plan team which includes the resident's physician consider requests for compassionate care visits. It would be prudent to examine these requests from a person-centered care

perspective and that care planning notes, and care plan revisions take place documenting the team's decisions.

Testing frequencies, false positives, and obtaining testing supplies

Determining testing frequencies

CMS QSO 20-28-NH provides provider guidance for the required routine and outbreak testing of staff and outbreak testing of residents based upon county positivity rates. CMS recommends that facilities choose a standardized day each week to check county positivity rates to determine testing frequencies. Providers may choose to use CMS positivity rates or IDPH positivity rates, but should identify which source used in your facility infection control documents. When conducting a weekly check of rates, if the facility's county has advanced to a higher positivity rate, the testing frequency should be increased that week. If county positivity rates have declined, the facility must wait for 2 weeks of that decline to move to a less frequent testing rate.

Once a facility has one identified positive case of COVID moving the facility to "outbreak" status, testing frequency of staff must be adjusted and the addition of residents to testing must occur. Outbreak testing requires that all staff and residents who have previously tested negative be tested every 3-7 days. When deciding the frequency of testing in the outbreak spectrum of 3-7 days, providers should consider the number of staff or residents who tested positive. If more than one case is identified, clinical factors may indicate a need for more frequent testing. If a potential false positive test triggered outbreak status, a less frequent test range may be clinically indicated. The facility should also consider the positivity rate of the county at the time of the outbreak. Staff testing frequency for outbreak status should never be less than required for current positivity testing requirements.

Handling of potential false positive antigen testing results

IHCA worked in conjunction with IDPH and DIA to develop effective provider guidance for dealing with potential false positive antigen test results for **asymptomatic** staff and residents. On November 16, 2020 IDPH released an updated version of LTC Antigen Testing Guidance that specifically allows a positive antigen test to be reclassified as "false positive" if the facility receives one negative PCR test within 48 hours of the original antigen test.

Based upon IDPH guidance, IHCA advises the following measures for suspicious positive test antigen tests, i.e. one that occurs in an **asymptomatic** individual where there is no COVID in the facility, no known exposure, and/or low county positivity rates:

1. Collect a swab for PCR testing immediately but no later than 48 hours after the antigen test and submit for lab testing.
2. Treat the tested individual as presumptive positive until both PCR test results have returned. Employees should be quarantined at home; residents should be placed in quarantine at the facility.
3. While awaiting PCR results the facility may delay reporting the results to families and to the NHSN until confirmatory results are received. Plans should be made to start testing of residents as outlined in QSO 20-38-NH but may be delayed until the PCR result is obtained. The risk of delaying resident testing while waiting for PCR confirmatory testing should be carefully considered by the facility depending on your circumstances.

4. If the PCR results are positive, the antigen test is confirmed, and the facility should proceed according to IDPH and CDC guidance for isolation and CMS guidance for outbreak testing and other procedures.
5. If the PCR test is negative, the provider should file these results with facility testing logs and make administrative notes on all infection control actions and decisions made during the confirmatory testing period.

The linked guidance provides not only written guidance but also a testing algorithm for providers. Questions on testing may be addressed to IDPH at Hai-ar@idph.iowa.gov.

Accessing testing supplies

QSO 20-38-NH describes the nursing facility's obligation to obtain testing supplies for staff and resident testing. Providers are free to use any combination of tests, whether rapid antigen testing or PCR's to meet those requirements. As described previously on member calls and in IHCA Bulletins, providers who are unable to obtain testing materials after multiple attempts to acquire supplies should document all supply efforts and notify local public health officials and IDPH of their lack of testing supplies. IHCA members can access a listing of laboratories offering testing services here.

Cohorting residents and dedicated staffing

CDC and IDPH guidance have consistently recommended that facilities have 3 separate areas for the cohorting of residents when at all possible:

1. Isolation area for known positive COVID patients
2. Quarantine area for residents with undiagnosed active respiratory symptoms, those residents with COVID-19 pending test results, and any other residents with an unknown COVID status including all new admissions, regardless of source
3. Currently healthy and asymptomatic residents

Many providers find themselves in the position of being unable to provide 3 sets of dedicated staff. Facilities finding themselves in that situation should carefully consider their ability to accept new admissions. However, a facility in outbreak status may also need 3 distinct care areas as well. Here are some considerations for facilities in those circumstances:

- Residents isolated for COVID-19 must have dedicated staff.
- If unable to provide dedicated staff for quarantined residents, the staff members who enter the quarantine unit should be limited and should strictly adhere to CDC conventional PPE usage guidelines.
- Look at methods to creatively use licensed nursing personnel for isolation and quarantine areas. Consider using management nursing personnel during day and evening shifts. Schedule assessments at the end of the shift if possible and have the nurse leaving shift do those assessments and then exit the facility rather than caring for other residents.

Updated quarantine guidance

Based upon IDPH guidance and new CDC guidance, new quarantine procedures are as follows:

LTC Residents – New admissions and returns to the facility

1. If an asymptomatic patient has tested positive for COVID-19 and completed their isolation period within the last 90 days, the patient should not be quarantined when they are admitted to or return to a facility unless they develop COVID-19 symptoms.
2. Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility if they are fully vaccinated and have not had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days.
3. Fully vaccinated inpatients and residents in healthcare settings should continue to quarantine following prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with SARS-CoV-2 infection using CDC recommended Transmission-Based Precautions.
    - Although not preferred, healthcare facilities could consider waiving quarantine for fully vaccinated patients and residents following prolonged close contact with someone with SARS-CoV-2 infection as a strategy to address critical issues (e.g., lack of space, staff, or PPE to safely care for exposed patients or residents) when other options are unsuccessful or unavailable. **These decisions should be made after consultation with IDPH.**
4. All other new admissions or residents returning to the facility with unknown COVID status should be quarantined for a minimum of the first 14 days of their stay.

LTC Residents - Medical appointments and family leave high risk exposure statement

1. IDPH and DIA no longer require residents who leave the facility for routine care procedures, medical appointments, ER visits of up 23 hours or outpatient surgical procedures to be quarantined for 14 days upon return.
2. Likewise, residents who leave the facility with families for less than 24 hours are not arbitrarily required to quarantine for 14 days.
3. **All residents who leave the facility for any reason should be evaluated upon return for the possibility of "high risk exposures" defined as being in close contact with person deemed COVID positive without PPE for more than 15 minutes in a 24-hour period or If attending a large gathering where social distancing and masks were not worn and COVID transmission is likely. Quarantine upon return should always be considered, whatever the leave circumstances, when a "high risk exposure" may have occurred.**
4. Providers are required to have a policy and procedure for observation of residents who leave the facility for frequent treatment such as dialysis.
5. Residents should be screened for COVID-19 symptoms when leaving the facility for an appointment and within one-hour of returning to the facility. Continue daily resident screening each shift thereafter. The resident must wear a cloth face covering or facemask when they leave their room and during transport. The facility must share the resident's COVID-19 status with the transportation service and medical facility. Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. Transportation equipment shall be sanitized between transports.

LTC Staff

CDC guidance, **Updates Healthcare Infection Prevention & Control Recommendations in Response to COVID-19 Vaccination,** released on 3-10-2021 states the following:

The following recommendations are based on what is known about currently available COVID-19 vaccines. These recommendations will be updated as additional information, including regarding the

ability of currently authorized vaccines to protect against infection with novel variants and the effectiveness of additional authorized vaccines, becomes available. This could result in additional circumstances when work restrictions for fully vaccinated HCP are recommended.

- Fully vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure. Work restrictions for the following fully vaccinated HCP populations with higher-risk exposures should still be considered for:
    - HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact level of protection provided by the COVID-19 vaccine. However, data on which immunocompromising conditions might affect response to the COVID-19 vaccine and the magnitude of risk are not available.
- HCP who have traveled should continue to follow CDC travel recommendations and requirements, including restriction from work, when recommended for any traveler.

Employers are also urged to consult this CDC guidance, **CDC Interim US Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2** about health care worker exposures.

CDC guidance on reducing quarantine in exposed individuals

On December 2, 2020 The Centers for Disease Control and Prevention (CDC) updated its guidance relating to reducing the length of time for quarantine in certain scenarios. Iowa Department of Public Health (IDPH) has indicated that the new quarantine guidance from CDC should be applied in the long-term care setting.

Residents and staff can continue to quarantine for 14 days, as that is CDC recommendation. However, the CDC issued this new guidance to increase overall compliance due to the burden of quarantine requirements. The entire CDC Guidance is available here. The key changes to quarantine recommendations are:

- **Ten days** - Quarantine can end after day 10 without testing and if no symptoms have been reported during daily monitoring.
- **Seven days** - Quarantine can end after day seven if there is a negative test which occurs no earlier than day five and no symptoms have been reported.
- In all cases, a shorter quarantine time can only be used if the following criteria are met:
    - No clinical evidence of COVID-19 via daily symptom monitoring during the entire time of quarantine;
    - Daily symptom monitoring continues through day 14; and
    - The individual has been counseled regarding the need to adhere strictly through day 14 to all recommended non-pharmaceutical interventions (masks etc.). Residents and staff should be told to self-isolate immediately and contact their health care provider if they develop any symptoms.

Documenting Visitor Screening and Visits

Facilities should ensure that all visits, indoor or outdoor, are recorded on a visitor log should contact tracing be needed in the future. The visitor log should include the name, date, time of the visit, and contact information for the visitor. Visitor screening for signs and symptoms of COVID-19, as described in the program's visitation and infection control policies, should be completed prior to allowing any visitation and documented on a visitor screening sheet. A record of each visitor's screening should be

kept with each daily visitor log. Members may wish to use the most recent "IHCA COVID-19 Screening Checklist for Visitors" and the "Visitor Log" template found on the IHCA Coronavirus Member Resources webpage under Visitor Guidance. Visitors unable to pass the screening or comply with infection control practices like masks should refrain from visiting. If visitors cannot supply their own PPE, programs should provide the needed supplies prior to visitation.

Indoor visitation guidance

Recently revised QSO 20-39-NH provides specific information for LTC facilities regarding infection control practices that should be always observed when conducting visitation.

Core Principles of COVID-19 Infection Prevention

1. Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days regardless of the visitor's vaccination status
2. Hand hygiene (use of alcohol-based hand rub is preferred)
3. Face covering or mask (covering mouth and nose)
4. Social distancing at least six feet between persons
5. Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
6. Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
7. Appropriate staff use of Personal Protective Equipment (PPE)
8. Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
9. Resident and staff testing conducted as required by QSO-20-38-NH.

More QSO guidance:

- Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention.
- If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors.
- During indoor visitation, 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. Visits for residents who share a room should not be conducted in the resident's room, if possible.
- For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.
- CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection, including physical distancing (maintaining at least

6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. ***We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility.***

Other indoor visitation considerations:

- If your facility is limiting the number of visits conducted at a time, make sure you meet the regulatory requirements found in the QSO allowing visits for all residents at a time that works for families.
- Designate a bathroom that is used for visitors only.
- Providers may consider screening visitors at the entrance (outside) or from the visitor's automobile. This prevents a visitor who does not pass the screening from encountering residents or other staff members.
- Instructions for parking will need to be well understood as well as the facility entrance and exit for visitation.
- Entrance and exits should be supervised.
- Items brought for the resident will need to have a process for labeling and delivery.
- Create a cleaning protocol that allow times between visits for disinfection of the area with an approved disinfectant and describes who is responsible to ensure cleaning takes place.
- Visits may be conducted in resident rooms if desired or in facility designated visitation areas. It is essential that visitors be either accompanied or directed to resident rooms or visitation areas to prevent encounters with other residents.
- If visits take place in a resident room, the roommate should not be present during the visit. QSO 20-39-NH states, "Situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention".
- You should have capability of washing hands and/or using alcohol-based hand rub near the entrance of the facility. Instructions for mask, hand hygiene and appropriate social distance must be understood by all visitors including the consequences of violating these procedures.
- Consider what you might do to improve air quality and decrease air transmission of the virus during visits. Cracking a window for increased ventilation or investing in air purifiers may be helpful.
- Providers may offer testing for visitors, but you are not allowed to prevent a visitor who otherwise screens COVID negative from entering for visitation.
- You may wish to determine vaccination status of visitors and use this time to encourage vaccine acceptance information. However, you may not refuse a visitor entrance based upon vaccination status.