IHCA Member Clinical Guidance Summary

May 8, 2023

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LINKS TO GUIDANCE

The following links are the source documents used to formulate this document. Readers are encouraged to review the items contained within the links to gather additional information.

Centers for Medicare and Medicaid Services (CMS) Links:

QSO-20-39-NH "Nursing Home Visitation- COVID-19" (FAQ Included)

QSO-20-38-NH – (COVID-19 Testing Requirements) – EXPIRED on May 11, 2023.

QSO-20-19-NH "Interim Final Rule - COVID-19 Vaccine Immunization Requirements for Residents and Staff" (NOTE: CMS has announced the end of this IFR, but more information has not been shared.)

QSO-20-29-NH "Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes"

Centers for Disease Prevention and Control (CDC) Links:

CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings

CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

CDC Stay Up to Date with Your Vaccines

Symptoms of COVID-19

Protecting Healthcare Personnel (Provides PPE use instructions in detail.)

Iowa Department of Health and Human Services (HHS) Links:

Iowa HHS Weekly Respiratory Surveillance Reports

Link to subscribe to the weekly report:
https://public.govdelivery.com/accounts/IACIO/subscriber/new?topic_id=IACIO_2438

Overview

Ongoing updates and changes in The Center for Medicare and Medicaid Services' (CMS) guidance and The Centers for Disease Control and Prevention's (CDC) recommendations regarding nursing facilities' COVID-19 infection control practices have created many requests for further direction from providers. The Iowa Health Care Association (IHCA) urges its 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 CMS, CDC and Iowa Department of Health and Human Services (DHHS), but future updates may be issued, and this guidance will be revised as needed. The intent of this document is to provide clinical guidance and best practices for implementing the recent CMS changes.

CMS recommends the application of the Core Principles of COVID-19 Infection Prevention as noted below:

Core Principles of COVID-19 Infection Prevention and Control (IPC)

- 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 health care 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 criteria described in CDC health care guidance (e.g., cannot wear source control).
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose) in accordance with CDC guidance.
- 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).
- Cleaning and disinfecting of frequently touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of personal protective equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted following nationally accepted standards, such as CDC recommendations.

These core principles are consistent with the CDC guidance and should be adhered to at all times. Additionally, visitation should be person-centered, consider the residents' physical, mental and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear

Plexiglass dividers, curtains). Also, nursing homes should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

Vaccination

Vaccination is the best way to prevent the spread of the COVID-19 virus. CMS posts state- and facility-level resident and staff vaccination rates, along with other data on the CMS COVID-19 Nursing Home Data website.

Nursing facilities are required to educate and provide access to COVID-19 vaccines, as well as adhere to vaccination requirements for staff as noted in QSO-23-02-ALL, specifically Attachment A for nursing facilities. More specific information related to the vaccination mandate can be found in IHCA's Vaccination Mandate Guidance Summary. NOTE: CMS has announced that QSO-23-02-ALL will be expiring at the end of the federal public health emergency, May 11, 2023, but has not released regarding required actions of nursing facilities at this time.)

Level of Community Transmission

Effective May 12, 2023, CDC will no longer be publicizing Community Transmission Levels, which have been used to determine facility infection prevention and control measures since August 2020. Facilities are encouraged to use local data to inform their IPC practices. Sources of local data include Iowa HHS Weekly Respiratory Surveillance Reports or the CDC's COVID-19 County Check.

Personal Protective Equipment (PPE)

Use of PPE in nursing homes should be used both for source control and in situations where transmission-based precautions are necessary.

Source control:

Source control refers to the application of respirators or well-fitting masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Health care facilities should use facemasks as a form of source control but can also allow the use of respirators (which offer a higher level of protection) based upon individual preference or

their perceived level of risk (such as if they are at increased risk for severe disease). Note that respirators should be NIOSH approved with N95 filters or higher.

When used solely for source control, masks or respirators could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If used for transmission-based precautions, masks or respirators should be removed and discarded after caring for the infected patient.

The use of masks or respirators for source control is recommended for individuals who:

- Have suspected or confirmed COVID-19 infection or other respiratory illness (e.g. symptomatic)
- Had close contact with someone who has been confirmed positive for COVID-19 infection. In this situation, the exposed person should wear source control for ten days after the exposure.

Facility-wide or unit-specific (universal) source control is recommended in the following circumstances:

- For those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
- Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission (See Appendix)
- Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 county levels are high)

In addition to masks or respirators for source control, facilities should consider use of eye protection for all resident care encounters and respirators (N95s) for aerosol-generating procedures when there is a greater risk of COVID-19 transmission, such as when the local infection rates are high.

Transmission-based precautions:

Transmission-based precautions (TBP) should be applied when caring for a resident who has suspected or confirmed COVID-19 infection. Health care personnel (HCP) who enter the room of a resident on TBP should adhere to standard precautions, as well as wear a NIOSH-approved respirator (N95), gown, gloves, and eye protection (i.e., goggles or face shield that covers the front and sides of the face).

Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134).

Respirators should be used for:

- Aerosol-generating procedures when the resident is symptomatic or positive for COVID-19.
- Aerosol-generating procedures when there is increased risk of COVID-19 transmission (i.e., increased transmission in the community)
- Care provided to a COVID-19 positive resident, as indicated in transmission-based precautions

Additional information about PPE use can be found at the CDC's website, Protecting Healthcare Personnel – HAI.

Individuals Entering the Facility

Active screening of visitors and staff is no longer required.

Visitors: Nursing facilities should provide guidance at entrances about recommended actions for visitors who have had a positive COVID-19 test, are symptomatic for COVID-19 and/or have had close contact with someone confirmed to be infected with COVID-19 within the past 10 days. Any visitor who has been positive for COVID-19 or has symptoms should be advised to defer their visit, if non-urgent, until they meet the criteria to discontinue isolation as discussed in a later section of this document. A visitor who has been exposed to someone confirmed positive for COVID-19 should wear a mask for the duration of their visit. If they are not able to wear source control, their visit, if not urgent, should be deferred.

Facilities should 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). Suggested visual alert found here: https://www.cdc.gov/flu/pdf/protect/cdc_cough.pdf

While not required, facilities are encouraged to offer testing for visitors, if feasible.

Facilities should continue to educate and encourage visitors to become vaccinated. Facilities cannot require that visitors are vaccinated, show proof of vaccination or test for COVID-19 prior to visiting.

Health care personnel: Facility staff should be educated to report symptoms of COVID-19, a higher-risk exposure, and a positive test for COVID-19 to a designated point of contact to allow the facility to respond according to their policy. Active entry screening of staff is no longer required.

Surveyors from any state or federal agency (DIA, CMS, fire marshal, etc.) or accrediting agency who arrive on-site to conduct a survey are expected to adhere to the Core Principles of COVID-19 Infection Prevention. Surveyors also should not enter a facility if they have a positive test for COVID-19, are symptomatic or meet the criteria for quarantine. Facilities are not permitted to restrict facility access to surveyors based upon vaccination status nor can they ask a surveyor for proof of their vaccination status. If facilities have concerns related to surveyors and infection control practices, they are encouraged to contact the agency from which the surveyor has been sent.

Nursing facilities should maintain records of prior screening processes and outcomes for a minimum of five years.

Testing of Health Care Personnel (HCP) and Residents

*Testing is not recommended for asymptomatic staff or residents who have recovered from COVID-19 infection within the last 30 days. Testing of symptomatic individuals who have recovered from COVID-19 infection within the past 31-90 days can be considered and should be completed using an antigen test. NAAT testing (PCR) for those who have recovered from COVID is not recommended as NAAT (PCR) tests may remain positive for much longer than a person is considered contagious.

Routine testing of staff and residents
Routine testing of asymptomatic health care personnel (staff) and residents is no longer recommended.

Testing of symptomatic staff or residents
Any individual (staff or resident) who has signs or symptoms of COVID-19 must be tested as soon as possible.

When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.

- 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 work restrictions 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 second negative antigen test taken 48 hours after the first negative test.

Infection Prevention and Control Precautions for Residents: While test results are pending, residents with signs or symptoms should be placed into transmission-based precautions (TBP). Once test results are obtained, the facility must take the appropriate actions based upon the outcome of the test.

Infection Prevention and Control Precautions for Staff: Health care personnel (HCP) who are symptomatic for COVID-19, regardless of vaccination status, must be restricted from the facility pending test results. Staff who are found to be positive for COVID-19 should follow the guidance presented in a different section of this document. Staff who do not test positive but have symptoms should follow facility policy to determine when they can return to work.

Testing of staff and residents with an exposure

Guidance in this section refers to staff who may have had a higher-risk exposure and residents with close contact either in the community or in the facility.

Close contact is defined as being within six feet of a COVID positive individual for 15 minutes or more within a 24-hour period.

Higher-risk exposure is defined as an HCP who had prolonged (15 minutes or more in a 24-hour period) with a person who confirmed positive for COVID-19 **and** one of the following:

- 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 exposures and residents with close contact should have a series of three viral tests. Antigen tests are preferred. The first test should be done immediately (but no sooner than 24 hours after the exposure). If the first test is negative, a second test should be administered 48 hours later. If the second test is negative, a third and final test should be administered 48 hours after the second test. This testing could often occur on days 1, 3 and 5 after a higher-risk exposure.

Restriction of HCP from the workplace is no longer determined based upon vaccination status. HCP with higher-risk exposures may continue to work, should wear source control for 10 days after their exposure, be tested as noted above, and continue to self-monitor for symptoms. If

symptoms appear, the HCP should not report to work, but should notify the designated facility contact for further instructions.

Residents with close contact should be tested as noted above, wear a mask for 10 days, and be monitored for symptoms. Empiric use of transmission-based precautions (quarantine) is not required, but should be considered if the resident is:

- Unable to be tested or wear source control for 10 days
- Moderately or severely immunocompromised
- Residing on a unit with residents who are moderately or severely immunocompromised
- Residing on a unit where a COVID outbreak is not controlled with initial interventions

Outbreak investigation testing

Once a facility has identified a new positive staff case of COVID-19 or a nursing home onset COVID-19 infection, the facility should initiate testing to investigate if other positive cases exist.

Outbreak investigation testing is not required when a resident is admitted with known COVID infection or when a resident develops COVID infection while in empiric TBP after an exposure, given that the resident was placed into TBP immediately following the exposure.

Testing in response to a positive case should begin as soon as possible. Facilities have the option to perform outbreak investigation testing through two approaches - contact tracing or broad-based (e.g. facility-wide) testing. These two strategies are outlined in this section.

If the facility can identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If potential contacts cannot be identified or managed with contact tracing, or if contact tracing fails to halt transmission, a broad-based approach to testing should be used.
Testing of symptomatic individuals should be completed first and then perform testing, either by contact tracing or using a broad-based approach, as noted below.

	Testing Trigger	Staff	Residents
CONTACT TRACING APPROACH	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.
BROAD-BASED APPROACH	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	Test all residents, regardless of vaccination status, facility-wide

		specific location where the new case occurred (e.g., unit, floor or other specific area(s) of the facility).	or at a group level (e.g., unit, floor or other specific area(s) of the facility).

Outbreak investigation testing OPTION 1 - Contact tracing approach
Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with an individual with SARS-CoV-2 infection. All HCP who have had a higher-risk exposure and residents who have had close contact, regardless of vaccination status, should be tested according to the guidance given in the section "Testing of Staff or Residents with an Exposure."

If no additional cases are identified, no further testing is indicated.

If testing reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify any additional COVID-19 cases. 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.

Outbreak investigation testing OPTION 2 - Alternative, broad-based approach
If a facility is not able 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, as soon as possible using the testing approach outlined in "Testing of Staff and Residents with an Exposure."

In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for residents who are up to date with vaccinations and work restriction of health care personnel who are up to date with vaccinations with higher-risk exposures.

If no additional cases are identified during the broad-based testing, no further testing is indicated.

If additional cases are identified, testing should continue on the affected unit(s) or facility-wide every three to seven days until there are no new cases identified for 14 days.

Refusal to test
Staff:

Facilities must have procedures in place to address staff who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return-to-work criteria are met. If outbreak investigation testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed. The facility should follow its occupational health policies with respect to any asymptomatic staff who refuse routine testing.

Residents:

Residents (or resident representatives) may exercise their right to decline COVID-19 testing. In discussing testing with residents, staff should use person-centered approaches when explaining the importance of testing for COVID-19. Facilities must have procedures in place to address residents who refuse testing.

Procedures should ensure that residents who have signs or symptoms of COVID-19 and refuse testing are placed on TBP until the criteria for discontinuing TBP have been met.

Clinical discussions about testing may include alternative specimen collection sources that may be more acceptable to residents than nasopharyngeal swabs (e.g., anterior nares). Providing information about the method of testing and reason for pursuing testing may facilitate discussions with residents or resident representatives.

Testing safety considerations

During specimen collection, facilities must maintain proper infection control and use recommended PPE, which includes a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves and a gown when collecting specimens.

The CDC has provided guidance on proper specimen collection:

- Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html
- CDC's Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html.

For additional guidance, see CDC's Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings.

Accessing testing supplies

Providers are free to use any combination of tests, whether rapid antigen testing or PCRs to meet those requirements. Providers who possess a CLIA Certificate of Waiver will continue to receive testing supplies from the U.S. Department of Health and Human Services (HHS) until further notice is provided. These allocations are based upon the local infection data and bed count in the facility.

Reporting individual COVID-19 test results
Reporting of individual COVID-19 testing outcomes is no longer required.

Facilities should continue to record all test results, both positive and negative, within their organization's tracking processes to document compliance with testing requirements and recommendations as outlined in the testing section.

The requirement to report aggregate information to NHSN remains unchanged and will continue to be required of nursing facilities until December 31, 2024. Although required data points may change over time, NHSN reporting will continue until further guidance is issued.

Patient Placement

Residents with confirmed SARS-CoV-2 infection should be placed in a single-person room. The door should be kept closed (if safe to do so). Ideally, the resident should have a dedicated bathroom.

If cohorting, only residents with the same respiratory pathogen should be housed in the same room. Multidrug-resistant organisms (MDRO) colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.

Facilities could consider designating entire units within the facility, with dedicated HCP, to care for residents with SARS-CoV-2 infection when the number of residents with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these residents during their shifts. Dedicated units and/or HCP might not be feasible due to inadequate staffing levels. When this is the case, residents confirmed with COVID should be cared for in single-person rooms and staff should remove PPE before caring for other residents who are not infected.

Duration of Transmission-Based Precautions for COVID+ Residents

For a resident with a positive COVID-19 test, the following guidelines should be used when determining how long a resident should remain in isolation (using transmission-based precautions):

Residents 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.

Residents 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.

Residents with severe illness or those who are moderately to severely immunocompromised should be in isolation for at least 10 days. This time frame could be extended to up to 20 days. Consultation with the resident's physician or the facility medical director to determine when to end isolation for those residents who experience severe illness or are moderately or severely immunocompromised should occur.

While not recommended, residents who are on transmission-based precautions (TBP) or quarantine can still receive visitors. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated). Before visiting residents, who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the Core Principles of Infection Prevention. Facilities may offer well-fitting facemasks or other appropriate PPE, if available; however, facilities are not required to provide PPE for visitors.

New admissions and residents who return to the facility after greater than 24 hours
Pre-admission COVID-19 testing can be done at the discretion of the facility. Although not required, facilities may choose to test newly admitted residents or those that leave the facility for greater than 24 hours at their discretion.

Empiric use of TBP (quarantine) is not necessary for newly admitted residents or those who leave the facility for greater than 24 hours.

If a resident does leave the facility, residents should be screened upon return for signs or symptoms of COVID-19:

- If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, see the CDC's guidance for residents who have had close contact for next steps regarding testing and quarantine.
- If the resident develops signs or symptoms of COVID-19 after the outing, see the CDC's guidance for residents with symptoms of COVID-19

Communal Dining, Group Activities and Resident Outings

Facilities are encouraged to continue communal dining and activities to foster a healthy quality of life for residents. Communal activities and dining do not have to be paused during an outbreak investigation unless directed to do so by the state or local health department. Residents on transmission-based precautions should not participate in communal activities or dining until they have met the criteria to end TBP.

Visitors may eat with a resident if the resident (or representative) and the visitor are aware of the risks and adhere to the Core Principles of Infection Prevention.

Visitation Guidance

Residents have the right to receive visitors of their choosing. They also have the right to restrict visitation if they choose. If a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk, the resident must be allowed to receive visitors as he/she chooses.

Outdoor visitation guidance

Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios or parking lots, including the use of tents, if available. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor visitation guidance

Facilities must always allow visitation, both inside and outside, and for all residents. While previously allowed, facilities can no longer limit the frequency and length of visits for residents, the number of visitors or require advance scheduling of visits.

Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the Core Principles of COVID-19 Infection Prevention and does not increase risk to other residents.

Visitation during an Outbreak Investigation

Visitation may still occur during an outbreak investigation. Visitors must be educated about the risks of exposure to COVID-19 and adhere to IPC practices. Visits should ideally occur in the resident's room, the resident and their visitor should wear source control, and physically distance, if possible.

When an outbreak investigation is occurring, facilities should limit visitor movement in the facility. Visitors should go directly to the resident's room upon entry.

Questions regarding this guidance can be directed to Brenda Irlbeck (brenda@iowahealthcare.org) or through the Iowa Health Care Association office at 515-978-2204.