Division of Long Term Care

Long-term Care COVID-19 Clinical Guidance

INTRODUCTION

COVID-19 clinical guidance related to long-term care facilities is based on the congregate setting, increased susceptibility of elderly population to respiratory illness, current knowledge on the disease, infection prevention principles and prophylactic/ therapeutic options.

COVID-19 is caused by SARS COV-2 virus. The virus spreads from person to person via respiratory droplets. People who are closer than 6 feet from the infected person are most likely to get infected. Individuals can acquire the virus by touching the eyes, nose, mouth with virus on the hands.

COVID-19 can have varied manifestations ranging from asymptomatic to severe disease. Asymptomatic individuals can also transmit the virus, whether or not they develop symptoms later. The virus can mutate during transmission and replication cycle to create a variant strain. Variants could have differences with respect to ability to transmission, disease severity, vaccine effectiveness and response to therapeutics.

How Coronavirus Spreads (CDC 7.14.21)

GUIDING PRINCIPLES

- An individual is considered fully vaccinated two weeks after completion of the vaccine series, according to emergency use authorization or approval guidance by U.S. Food and Drug Administration.
- Immunocompromised should follow the guidance for unvaccinated individuals even after being fully vaccinated. Discuss with the resident's physician or specialist if you are unable to determine whether an individual is immunocompromised.
- An individual with confirmed COVID-19 in the last 90 days needs to be tested only if symptomatic. The 90-day count starts from day of diagnosis.
- Follow this testing algorithm for placement of the resident in the correct zone or for assessment of return to work for staff.
    - Considerations for Interpretation of Antigen Tests in Long-Term Care Facilities (CDC 1.15.21)
- Individuals in transmission-based precautions (TBP) cannot have visitors other than compassionate care or an essential family caregiver.
- Testing in this document means a viral test (point of care/antigen or PCR/NAAT), not an antibody test.
- Strategies described under CDC guidance may be used in case of staffing shortage.
- CDC guidance documents:
    - Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (CDC 9.10.21)
    - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (CDC 9.10.21)

- Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)
- QSO-20-39-NH REVISED (CMS 4.27.21)
- QSO-20-38-NH REVISED (CMS 9.10.21)
- Strategies to Mitigate Healthcare Personnel Staffing Shortages (CDC 3.10.21)

KEY INDICATORS TO FOLLOW

- County positivity based on CDC COVID Data Tracker can affect visitation based on resident vaccination rate.
  - CDC COVID Data Tracker
- Facility resident vaccination rates can affect indoor visitation for an unvaccinated resident based on county positivity Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (CDC 9.10.21). QSO-20-39-NH REVISED (cms.gov) 4.27.21 Refer to visitation section on COVID-19 Regulatory Visitation and Activities Guidance for LTC
- Level of community transmission refers to facility's county level of COVID-19 transmission. This metric uses two indicators for categorization 1. Total number of new cases per 100,000 persons within the last 7 days and 2. Percentage of positive diagnostic and screening nucleic acid amplification tests (NAAT) during the last 7 days), which can be found on the Centers for Disease Control and Prevention (CDC) COVID-19 Integrated County View site. If the two indicators suggest different transmission levels, the higher level is selected. QSO-20-38-NH REVISED (CMS 9.10.21)
- Routine testing frequency based on CMS NH testing guidelines
  - QSO-20-38-NH REVISED (CMS 9.10.21)

PREVENT THE INTRODUCTION OF COVID-19 INTO YOUR FACILITY

Long-term care centers should take preventive measures every day to contain the spread of COVID-19. **Screening could be done by an individual or by implementing an electronic monitoring system in which an individual can self-report before entering the facility.**

- Screen all healthcare personnel (HCP) each shift, and screen all visitors and vendors entering the facility for known diagnosis or symptoms of COVID-19 and for any history of being a close contact or exposed to COVID-19 positive or symptomatic person in the preceding 14 days.
- Post signs at the entrance instructing visitors not to visit if they have symptoms of COVID-19 infection, known COVID-19 diagnosis or exposure to someone with COVID-19 in the preceding 14 days.
- Ensure sick leave policies allow employees to stay home if they have symptoms of COVID-19 infection.
- Assess residents for symptoms of COVID-19 infection upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.

EXPOSURE

Exposure or close contact is defined as an interaction for a cumulative total of 15 minutes or more in 24 hours, fewer than 6 feet distance with a known COVID-19 case starting from two days before the onset of symptoms or positive test if asymptomatic.

Follow the same guidance if the exposure occurred during performance of an aerosol generating procedure, even if it is fewer than 15 minutes.

Increase monitoring of residents with exposure including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry and respiratory exam to identify and quickly manage serious infection.

- Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 in Nursing Homes (CDC 9.10.21)

From exposure to development of symptoms can take anywhere between two and 14 days.

- COVID-19 Control Measures 410-IAC-1

HCP wearing proper PPE caring for a known COVID-19 case is not considered an exposure.

- Residents with close contact should be tested at two days from exposure, and if negative should be tested again at 5-7 days after exposure.
  - Asymptomatic residents with close contact do not need to be tested or put in TBP if they had a confirmed COVID-19 infection in the last 90 days.
  - Fully vaccinated residents with close contact do not need to be in TBP if asymptomatic unless they are moderately to severely immunocompromised.
  - Unvaccinated residents with known exposure to COVID-19 should be monitored in yellow zone TBP for the full 14 days. Testing negative does not warrant movement back to green zone until 14 days have passed.
    - Refer to **COVID-19 LTC Infection Control Guidance**.
    - Refer to **Symptomatic Individuals** and **Known COVID-19** sections of this guidance if symptoms occur or the resident tests positive for COVID-19.
- Unvaccinated staff with exposure to COVID-19 should be excluded from work for 14 days, recommended to undergo testing at two days, if negative again at 5-7 days after exposure.
- Fully Vaccinated staff with a high-risk exposure should undergo testing at two days, and if negative again at 5-7 days after exposure, and **do not need to be restricted from work if asymptomatic.** Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure. They must use universal source control while in the facility for 14 days from exposure.
- HCP with COVID-19 in the past 90 days **do not need to be restricted from work** due to high-risk exposure **if asymptomatic**. They must use universal source control while in the facility for 14 days from exposure.
- When a resident had known exposure, it should be discussed with facility medical director if candidate for post exposure prophylaxis. (Currently monoclonal antibody therapy is available under emergency use authorization).
  - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (CDC 9.10.21)
  - Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (CDC 9.10.21)
  - Resources for Clinicians | combatCOVID.hhs.gov
  - Strategies to Mitigate Healthcare Personnel Staffing Shortages (CDC 3.10.21)

Staff must refer to CDC guidance below for any update prior to any travel.

- Domestic Travel During COVID-19 (CDC 8.25.21)

- International Travel During COVID-19 (CDC 8-25.21)
- COVID-19 Travel Recommendations by Destination (CDC 9.21.31)

SYMPTOMATIC INDIVIDUALS

Symptoms may appear 2-14 days after exposure to the virus. COVID-19 can have severe manifestations including organ system failure, need for hospitalization and can result in death.

- COVID-19 Control Measures 410-IAC-1

Guidance for symptomatic individuals is same irrespective of the vaccination status.

- Residents with symptoms of COVID-19 at any time should be tested immediately and be placed in TBP until they meet criteria for discontinuation of TBP, irrespective of their vaccination status. If an alternate diagnosis is identified and COVID-19 is excluded, follow the guidance for the alternate diagnosis.
- Staff with symptoms of COVID-19 should be tested immediately and be restricted from work until isolation is completed if it is a COVID-19 case, or until COVID-19 has been ruled out according to Considerations for Interpretation of Antigen Tests in Long-Term Care Facilities (CDC 1.15.21). Staff with symptoms can return to work if alternate diagnosis is identified when such diagnosis poses no work or infection control restrictions.
- "Consider testing for pathogens other than COVID-19 and initiating appropriate infection prevention precautions for symptomatic older adults". Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)

KNOWN COVID-19 CASE

Known COVID-19 case is an individual with a positive COVID-19 test based on the algorithm.

- Considerations for Interpretation of Antigen Tests in Long-Term Care Facilities (IDOH 1.15.21)

Facility-onset case: Following the definition from CMS (QSO-20-30-NH): "A COVID-19 case that originated in the facility; not a case where the facility admitted an individual from a hospital with known COVID-19 positive status, or an individual with unknown COVID-19 status that became COVID-19 positive within 14 days after admission."

Community acquired case: A staff member who was exposed to COVID-19 outside of the facility and did not enter the facility while potentially infectious.

- Nursing Home COVID-19 Testing FAQs (CMS 8.26.20)

RESIDENTS

Residents with mild to moderate COVID-19 should be isolated in red zone for 10 days, and those with severe COVID-19 or immunocompromising condition for 20 days.

- Increase monitoring of residents with known COVID-19 including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and quickly manage serious infection.

- Known COVID-19 resident cases should be discussed with facility medical director regarding treatment options (monoclonal antibody therapy is available under emergency use authorization).
  - Resources for Clinicians | combatCOVID.hhs.gov

HEALTHCARE PERSONNEL

Known COVID-19 staff cases should be isolated at home and should follow the return-to-work criteria as designated by CDC updated guidance:

- Staff with mild to moderate COVID-19 and no immunocompromised condition can return to work after 10 days if fever free for 24 hours without medications, and improved symptoms.
- Those with severe illness or if immunocompromised, may return to work 20 days from date of diagnosis if fever free for 24 hours without medication and improved symptoms.
- In case of staffing shortage, the facilities with active COVID-19 cases can continue to allow asymptomatic COVID-positive HCP to work in the COVID-19 unit (red zone) of the facility.
  - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (CDC 9.10.21)

STAFFING SHORTAGES

To address staffing shortage, facilities may use the following strategies according to CDC guidance. See the full guidance on CDC website before implementing strategies staffing shortages.

- Adjust staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities.
- Develop regional plans to identify alternate care sites with adequate staffing to care for patients with COVID-19 infection.
- Allowing asymptomatic HCP who have had a higher-risk exposure to SARS-CoV-2 (the virus that causes COVID-19) but are not known to be infected to shorten their duration of work restriction as described in Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing (CDC 12.2.20). Facilities should understand that shortening the duration of work restriction might result in additional transmission risks. These HCP should still report temperature and absence of symptoms before each day before starting work. If these HCP develop symptoms consistent with COVID-19, they should stop working and notify their supervisor or occupational health services prior to leaving work.

Crisis Capacity Strategies to Mitigate Staffing Shortages:

- Implement regional plans to transfer patients with COVID-19 to alternate care sites with adequate staffing.
- Allow asymptomatic HCP who are not fully vaccinated and have had a higher-risk exposure to SARS-CoV-2 but are not known to be infected to continue to work onsite throughout their 14-day post-exposure period. Follow for symptoms as above.

If staffing shortages continue despite other mitigation strategies, as a last resort consider allowing HCP with suspected or confirmed SARS-CoV-2 infection who are well enough and willing to work but have not met all Return to Work Criteria to work. When in crisis capacity, IDOH recommends that asymptomatic HCP with suspected or confirmed COVID-19 may work on COVID-19 unit (red zone) until they meet the Return to Work Criteria. Once they meet return to work criteria, they can be assigned to any unit.

- Strategies to Mitigate Healthcare Personnel Staffing Shortages (CDC 3.10.21)

If possible, HCP should be designated and avoid working on both the COVID-19 unit and other units during the same shift. Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 in Nursing Homes (CDC 9.10.21)

1. Assure that red and yellow zone is clearly marked, and each resident's door has TBP signage for proper PPE
2. Recommend using conventional PPE for all staff who cross zones during their shift. See the guidance in COVID-19 Infection Control Guidance in Long Term Care Facilities section of SOP:
3. Staff may be shared in the red and yellow zone as your first mitigation, working from yellow zone to red zone.
4. If you must use same staff for green, yellow, and red zones, perform frequent infection control rounds to assure proper PPE donning, doffing and hand hygiene. Ideally work in green zone first, then yellow then red zone.
5. Consider staffing with vaccination status of your team in mind.
6. Assure full cohorting of equipment and supplies per zone.
   Refer to Crisis Capacity Staffing from CDC - Strategies to Mitigate Healthcare Personnel Staffing Shortages (CDC 3.10.21)

ASSESSMENT OF RESIDENTS

- Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximetry.
- Because some of the symptoms are similar, it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections, based on symptoms alone. Consider testing for pathogens other than COVID-19 and initiating appropriate infection prevention precautions for symptomatic older adults.
- Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least three times daily to identify and quickly manage serious infection.
  - QSO-20-38-NH (CMS 9.10.21)
  - Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)

NEW ADMISSIONS/RE-ADMISSIONS

A resident going outside the facility for more than 24 hours is considered a re-admission. Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)

- Upon admission or re-admission, individuals should be screened for symptoms of COVID-19 and potential exposure during the 14 days prior to admission or re-admission. (Please refer to symptomatic individuals and exposure sections above.)
- Unvaccinated new admissions/re-admissions should be observed in TBP, yellow zone for full 14 days even if they have negative test. They should be moved to red zone if confirmed positive for COVID -19. They can be released to green zone after 14 days if asymptomatic.

- Fully vaccinated new admissions/re-admissions do not need to be in TBP if they are asymptomatic, have not had prolonged contact with someone with known COVID-19.
- All new admissions should be given a point-of-care (POC) test upon admission to the facility. If positive, but no symptoms or known exposure, must be followed up with a PCR test. Individuals with positive POC test should stay in yellow zone and moved to red zone if PCR positive.
- Residents with confirmed COVID-19 in the last 90 days do not need to be in TBP due to new admission or re-admission. They do not need to be tested if asymptomatic due to new admission or re-admission.
- All re-admissions should be monitored for symptoms and facilities may consider POC testing at day 3-5 upon return based on screening or high-risk activities.

If the hospital tested someone within 24 hours prior to discharge, receiving facility can skip testing upon arriving to the facility and make zone placement decisions based on the hospital test. If any new symptoms or exposure since the last test, receiving facility should test again. Facilities should not require a hospital to test a patient for COVID-19 before discharge if there is no clinical indication to test.

OUTBREAKS

Outbreak is defined as a single staff case or any single facility onset resident case. During outbreak consider increasing monitoring of all residents from daily to every shift, to detect new symptoms more rapidly. Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)

Exclude testing for those with previous COVID-19 infection in the last 90 days, unless symptomatic.

If healthcare-associated transmission is suspected, facilities might consider expanded testing of HCP and residents as determined by the distribution and number of cases throughout the facility and ability to identity close contacts.

Option 1:

- If the facility is able to identify all close contacts of the individual with COVID-19, it could choose to conduct focused testing based on known close contacts.
- **If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection**, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection.
    - A facility-wide or group-level [e.g., unit, floor, or other specific area(s) of the facility] approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.

If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below for alternative approaches to individual contact tracing

Option 2:

If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility).

- **Unvaccinated residents and HCP:**
  - Unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.
  - Close contacts, if known, should be managed as described in Exposure Section.
- **Fully vaccinated residents and HCP:**
  - Fully vaccinated residents should be tested; they do not need to be restricted to their rooms or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection.
  - For guidance about work restriction for fully vaccinated HCP who have higher-risk exposures, refer to Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2 (CDC 9.10.21).
  - 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 fully vaccinated residents and work restriction of fully vaccinated HCP with higher-risk exposures
- If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days and no further testing is indicated.
- **If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days.**
  - **If antigen testing is used, more frequent testing (every 3 days), should be considered."**

Refusal to test:

If outbreak testing has been triggered and an unvaccinated 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 and local jurisdiction policies with respect to any asymptomatic unvaccinated staff who refuse routine testing.

If outbreak testing has been triggered and an asymptomatic resident refuses testing, the facility should be extremely vigilant, such as through additional monitoring, to ensure the resident maintains appropriate distance from other residents, wears a face covering, and practices effective hand hygiene until the procedures for outbreak testing have been completed. Residents who refuse testing may require TBP based on symptoms or vaccination status.

Do not initiate outbreak testing based on a staff member having a community acquired case, i.e. exposed to COVID-19 outside of the facility and did not enter the facility while potentially infectious.

- Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)
- Nursing Home COVID-19 Testing FAQs (CMS)
- QSO-20-38-NH REVISED (CMS 9.10.21)

REPORTING REQUIREMENTS

All COVID-19 cases and deaths must be reported within 24 hours to IDOH as per the guidance document.

- LTC Facility Data Submission Guidelines Updated (IDOH 12.21.20)

RESIDENTS LEAVING THE BUILDING

Residents should adhere to the core principles of infection control while outside the facility. Facilities may consider testing asymptomatic residents who leave the facility frequently, such as for dialysis or chemotherapy. In most circumstances, quarantine is not recommended for residents who leave the facility for fewer than 24 hours (e.g., for medical appointments, community outings with family or friends) and **do not** have close contact with someone with COVID-19 infection. Individuals should be screened for COVID-19 symptoms and for exposure to known COVID-19 after each excursion.

For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.

- Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)
- QSO-20-38-NH (CMS 9.10.21)

TESTING

- Outbreak testing based on ability to contact trace as described in OUTBREAKS section above
- Routine testing based on community transmission according to CMS memo QSO-20-38-NH
- Symptomatic residents need to be tested irrespective of previous COVID-19 infection and vaccination status.
- Exposed residents should be tested at two days from exposure, if negative get repeat tested at 5-7 days from exposure.
- Vaccinated staff with high exposure should be tested at two days from exposure, if negative get repeat tested at 5-7 days from exposure.
- Unvaccinated staff with exposure should be tested and quarantined.
  - Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)
  - QSO-20-38-NH REVISED (CMS 9.10.21)

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, *vaccinated and unvaccinated*, with signs or symptoms must be tested	Residents, *vaccinated and unvaccinated*, with signs or symptoms must be tested
Outbreak (Any new facility onset staff or resident case) Option 1 if facility can identify all close contacts; OR	Option 1: Test all staff, vaccinated and unvaccinated, that had a higher-risk exposure with a COVID-19 positive individual. Option 2:	Options 1: Test all residents, vaccinated and unvaccinated, that had close contact with a COVID-19 positive individual. Option 2:

Option 2 if unable to contact trace	Test all staff, vaccinated and unvaccinated, 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, vaccinated and unvaccinated, facility-wide or at a group level [e.g., unit, floor, or other specific area(s) of the facility].
Routine testing	According to Table 2 below	Not generally recommended.

Level of COVID-19 community transmission	**Minimum Testing Frequency of *Unvaccinated Staff****
Low(blue)	Not recommended
Moderate (yellow)	Once a week*
Substantial (orange)	Twice a week*
High (red)	Twice a week*

**Vaccinated staff do not need to be routinely tested.*
*This frequency presumes availability of POC testing on-site at the nursing home or where off-site testing turnaround time is less than 48 hours.

"The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week. Facilities should monitor its level of community transmission every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above.

- If the level of community transmission increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity level are met.

- If the level of community transmission decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the level of community transmission has remained at the lower activity level for at least two weeks before reducing testing frequency."

QSO-20-38-NH REVISED (CMS 9.10.21)

**If unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the three days before their shift (including the day of the shift). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 9.10.21)