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 the 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 the transmission and replication cycle to create a variant strain. Variants could have differences with respect to their 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.
- **Up to date on COVID Vaccination:** Received additional dose and/or booster according to CDC guidance, or fully vaccinated and not due for booster yet.
- **Not up to date on COVID Vaccination:** Unvaccinated or fully vaccinated, but not received a booster as recommended by CDC.
- 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 the day of diagnosis. The only exception to this is that staff may test as described in the staffing strategies section to determine if they can return to work after 7 days of isolation.
- Community criteria to discontinue isolation and quarantine do not apply for visitors and vendors to the nursing homes. They must complete the full 10 days before they can visit.
- Day of exposure or close contact is day 0 when counting the duration of the quarantine.
- Day of the start of symptoms is considered day 0 when counting duration of isolation. In asymptomatic cases, the day of the positive test is day 0. If they develop symptoms later, the day of the start of symptoms is day 0.

- Antigen testing is preferred (over PCR) if testing symptomatic HCP who had confirmed COVID-19 infection in the prior 90 days.
- If tests are in short supply, they should be prioritized to diagnose infection.
- Follow this testing algorithm for residents to decide on the need for quarantine or isolation. Confirmatory testing should take place as soon as possible after the antigen test, and not longer than 48 hours after the initial antigen testing.
    - Considerations for Interpretation of Antigen Tests in Long-Term Care Facilities (CDC 1.15.21)
    - Antigen Test Algorithm for Congregate Settings (cdc.gov)
    - Interim Guidance for Antigen Testing for SARS-CoV-2 | CDC 1.20.22
    - Testing-algorithm-2.2.22.pdf
- 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 a staffing shortage.

- CDC guidance documents:
    - Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (CDC 2.2.22)
    - Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (CDC1.21.22)
    - Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 2.2.22)
    - QSO-20-39-NH REVISED (CMS 11.12.21)
    - QSO-20-38-NH REVISED (CMS 9.10.21)
    - Strategies to Mitigate Healthcare Personnel Staffing Shortages (CDC1.21.22)
    - Stay Up to Date with Your Vaccines | CDC 1.16.22

KEY INDICATORS TO FOLLOW

- Level of community transmission refers to the 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. CDC COVID Data Tracker
- 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 10 days.
- Visitors and vendors who have a positive viral test for COVID-19, symptoms of COVID-19, or meet the criteria for quarantine, should not enter the facility.
- 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 10 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 2.2.22)

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.

- All residents without a COVID-19 infection in the prior 90 days (irrespective of vaccination status) with close contact should be tested immediately, but not within 24 hours of 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.
  - Residents that are **up to date** with COVID-19 vaccine upon close contact do not need to be in TBP if asymptomatic unless they are moderately to severely immunocompromised.
  - Residents that are **not up to date** with COVID-19 vaccination upon close contact should be monitored in yellow zone and can be removed from TBP after 10 days if asymptomatic. Facilities could consider a test within 48 hours of planned discontinuation of TBP. These

residents could be removed from TBP after 7 days if asymptomatic and had a negative viral test within 48 hours prior to removal from TBP.

- 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.

- When a resident had known exposure, it should be discussed with facility medical director if candidate for post exposure prophylaxis.

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (CDC 1.21.22)

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (CDC 2.2.22)

Resources for Clinicians | combatCOVID.hhs.gov (CDC 12.23.21)

- Refer to staffing strategies section of this document for guidance for staff with exposure.

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

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 and be restricted from work as described in staffing strategies section in this document 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 2.2.22)

KNOWN COVID-19 CASE

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

- Testing-algorithm-2.2.22.pdf

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, needing hospitalization for COVID-19 or immunocompromising condition for up to 20 days.

A test-based strategy and (if available) consultation with infectious disease experts is now recommended for determining the duration of Transmission-Based Precautions for patients with COVID-19 infection who are moderately to severely immunocompromised. Test-based strategy involves having two negative tests at least 24 hours apart from clinical improvement, completion of recommended duration of isolation and resolution of fever without fever reducing medication.

- 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 and antiviral medications are 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 described in staffing strategies section in this document.

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 2.2.22)

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 2.2.22)

- 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.)
- If the resident or family member reports possible close contact with an individual with COVID-19 while outside of the nursing home, test the resident for COVID-19, regardless of vaccination status. A nursing home may also opt to test unvaccinated residents without signs or symptoms if they leave the nursing home frequently or for a prolonged length of time, such as over 24 hours.

Testing :

All Newly admissions and re-admissions regardless of vaccination status, should have a series of two **viral tests** for COVID-19 infection; immediately and, if negative, again 5-7 days after their admission.

Zone placement:

New admissions/re-admissions **if not up to date** on COVID-19 vaccination should be observed inTBP, yellow zone for 10 days. COVID-19 vaccination should also be offered. They should be moved to red zone if confirmed positive for COVID -19. They can be released to green zone after 10 days if asymptomatic.

- Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which of these residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission.

New admissions/re-admissions **if up to date** on COVID-19 vaccination do not need to be in TBP if they are asymptomatic, have not had prolonged contact with someone with known COVID-19.

If a new admission/readmission receives a booster dose upon admission to a facility or within 24 hours prior to admission, they can come out of TBP provided they had:

1. No close contact in the 10 days prior to admission and
2. Asymptomatic and
3. Tested negative at admission and 24 hours after admission and
4. Not immunocompromised

They should still undergo testing at 5-7 days like all new admissions.

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.

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 2.2.22)

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).

- **Residents that are not up to date with COVID-19 vaccination:**
  - Residents that are **not up to date** 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.
- **Residents that are up to date on vaccination:**
  - Residents that are up to date 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 restrictions for HCP that are up to date who have higher-risk exposures, refer to staffing strategies section of this document.
  - 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 that are up to date and work restriction of HCP that are up to date 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 2.2.22)
- 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 who leave the facility for 24 hours or longer should generally be managed as a re-admission.

Facilities must permit residents to leave the facility as they choose. Residents and any individuals accompanying the resident should be reminded to adhere to the core principles of infection control while outside the facility (face mask, physical distancing and hand hygiene). Individuals should be screened for COVID-19 symptoms and for exposure to known COVID-19 after each excursion and follow appropriate guidance under “symptomatic individuals” and “exposure” sections above.

A nursing home may also opt to test unvaccinated residents without signs or symptoms if they leave the nursing home frequently or for a prolonged length of time, such as over 24 hours. Facilities might consider quarantining unvaccinated residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention measures.

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.

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 2.2.22)

- QSO-20-38-NH (CMS 9.10.21)
- QSO-20-39-NH REVISED (CMS 11.12.21)

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.
- Residents with close contact should be tested immediately, but not before 24 hours from exposure, if negative get repeat tested at 5-7 days from exposure.
- Staff that is **up to date** with COVID-19 vaccination with high exposure should be tested immediately, but not before 24 hours exposure, if negative get repeat tested at 5-7 days from exposure.
- Staff that is **not up to date** with vaccination upon high risk exposure should be tested and quarantined as described in staffing strategies section on this document.
  - Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (CDC 2.2.22)
  - QSO-20-38-NH REVISED (CMS 9.10.21)

Testing Trigger	Staff	Residents
Symptomatic individual identified	All 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 2 if unable to contact trace	Option 1: Test all staff, vaccinated and unvaccinated, that had a higher-risk exposure with a COVID-19 positive individual. Option 2: 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].	Options 1: Test all residents, vaccinated and unvaccinated, that had close contact with a COVID-19 positive individual. Option 2: 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 2.2.22)

STAFFING STRATEGIES

When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency or crisis capacity strategies to plan and prepare for mitigating this problem. These include:

- Adjust schedules, hire additional HCP, rotate HCP to positions that support patient care activities.
- Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection.
    - Considerations for determining which HCP should be prioritized for this option include:
    - The type of HCP shortages that need to be addressed.
    - Where individual HCP are in the course of their illness (e.g., viral shedding is likely higher earlier in the course of illness).
    - The types of symptoms they are experiencing (e.g., persistent fever, cough).
    - Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment
    - The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than immunocompromised patients).

- *Use **contingency recommendations** below **when significant shortages are anticipated**.*
- *Use **crisis recommendations** below **when the ability of the facility to provide care for the entire population (not just COVID) is compromised.***

Staffing strategies after HCP had a high-risk exposure

If HCP used all the recommended PPE during contact with a COVID-19 individual, it is not considered a high-risk exposure. High-risk exposure is defined as contact longer than 15 minutes cumulative in 24 hours with any individual with confirmed COVID-19 infection in **ANY** of the following situations.

- HCP did not use a respirator mask during the contact period with an individual with COVID-19
- **HCP used a face mask, but the COVID -19 contact individual did not wear a cloth mask or face mask (new)**
- HCP did not use eye protection and COVID-19 contact individual did not wear a cloth mask or face mask
- HCP did not use any of the recommended PPE (gown, gloves, eye protection, and respirator) during an aerosol-generating procedure of a COVID-19 contact individual

After high-risk exposure	Up to date on Covid Vaccination or COVID-19 infection in the last 90 days	Not up to date on COVID Vaccination
All strategies of staffing	• ***Monitor for symptoms*** • ***Follow infection control principles*** • ***Mask at all times for 10 days while in presence of any person in the facility*** • ***Test if symptoms*** • ***Isolate if symptoms or if positive test***	• ***Monitor for symptoms*** • ***Follow infection control principles*** • ***Mask at all times for 10 days while in presence of any person in the facility*** • ***Test if symptoms*** • ***Isolate if symptoms or if positive test***
Conventional strategy	Viral test immediately, but not before 24 hours of exposure. If negative, repeat the test at 5-7 days after exposure No restriction from work	Viral test immediately, but not before 24 hours of exposure. If negative, repeat the test at 5-7 days after exposure Return after 10 days Or Return after 7 days if no symptoms and negative viral test at 5-7 days
Contingency strategy	Same as conventional, but skip testing	No work restriction but test on days 1, 2, 3, 5-7
Crisis strategy	Same as conventional, but skip testing	No work restrictions, test as possible

In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to using more stringent work restrictions for healthcare personnel with higher-risk exposures.

Staffing strategies when HCP has COVID-19

Symptom onset day or test positive day in asymptomatic is day 0. Count duration of isolation starting from the next day after symptom onset or the test date if asymptomatic.

If symptoms start after a positive test while asymptomatic, count the next day after the onset of symptoms as day 1 of isolation. (New)

<table>
<tr><th colspan="3">CONVENTIONAL STAFFING STRATEGIES</th></tr>
<tr><th colspan="3">Not moderately to severely immunocompromised HCP with COVID-19</th></tr>
<tr><th>Asymptomatic</th><th>Mild to moderate illness</th><th>Severe to Critical illness</th></tr>
<tr><td rowspan="2">Return to work after 10 days (or
7 days if negative viral test within 48 hours of work)</td><td rowspan="2">Return to work after 10 days (or 7 days with negative viral test within 48 hours of work),
AND
Fever free for 24 hours without fever-reducing medication
AND
Symptoms have improved</td><td>20 days after the start of symptoms
AND
Fever free for 24 hours without fever-reducing medication
AND
Symptoms have improved</td></tr>
<tr><td>May consider test-based strategy as used in moderate to severely immunocompromised (see below)</td></tr>
</table>

<table>
<tr><th colspan="2">CONVENTIONAL STAFFING STRATEGIES</th></tr>
<tr><th colspan="2">Moderate to severely immunocompromised HCP with COVID-19
(Consider a consultation with an infectious disease specialist)</th></tr>
<tr><th>Asymptomatic</th><th>Symptomatic</th></tr>
<tr><td>Return to work after 10-20 days of isolation
AND
Two negative viral tests collected at least 24 hours apart</td><td>Return to work after 10-20 days of isolation
AND
Fever free for 24 hours without fever-reducing medication
AND
Improving symptoms
AND
Two negative viral tests collected at least 24 hours apart</td></tr>
</table>

CONTINGENCY AND CRISIS STAFFING STRATEGIES	
Positive COVID infection	**ALL HCP regardless of vaccination status, booster status or previous infection**
Conventional	Depends on the severity of illness and immune status of the HCP (see the above tables)
Contingency	Return to work after 5 days with or without negative viral test, if asymptomatic or mild symptoms that are improving and fever free for 24 hours without fever-reducing medication • ***Follow infection control principles*** • ***Physically distance from others at all times till you meet return to work criteria*** • ***Use respirator or well fitting mask at all times in presence of any person while in the facility until you meet return to work criteria***
Crisis	No work restrictions, with prioritization consideration (asymptomatic or mildly symptomatic)- Try to staff in the following sequential priority: **nonresident care duties, red zone, yellow zone, as a last resort in the green zone** • ***Follow infection control principles*** • ***Physically distance from others at all times till you meet return to work criteria*** • ***Use respirator or well-fitting mask at all times while in presence of any person in the facility until you meet return to work criteria***

Healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is operating under crisis standards, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill critical staffing needs.

- **If HCP are requested to work before meeting all criteria, they should be restricted from contact with moderately to severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:**
  - If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services. **(Nonresident area work).**
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting. **(Red zone).**
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with suspected SARS-CoV-2 infection. **(Yellow zone).**
  - As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients without suspected or confirmed SARS-CoV-2 infection. **(Green zone).** If this is being considered, this should be used only as a bridge to longer-term strategies that do not involve the care of uninfected patients by potentially infectious HCP. Strict adherence to all other recommended infection prevention and control measures (e.g., use of a respirator or well-fitting facemask for source control) is essential.

Strategies to Mitigate Healthcare Personnel Staffing Shortages (CDC 1.21.22)
Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (CDC 1.21.22)
COVID-19 Quarantine and Isolation (CDC 12.9.21)

Summary table

Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

"Up to Date" with all recommended COVID-19 vaccine doses is defined in Stay Up to Date with Your Vaccines | CDC

For more details, including recommendations for healthcare personnel who are iimmunocompromised, have severe to critical illness, or are within 90 days of prior infection, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).

Work Restrictions for HCP With SARS-CoV-2 Infection

Vaccination Status	Conventional	Contingency	Crisis
Up to Date and Not Up to Date	10 days OR 7 days with negative test†, if asymptomatic or mild to moderate illness (with improving symptoms)	5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)	No work restriction, with prioritization considerations (e.g., types of patients they care for)

Work Restrictions for Asymptomatic HCP with SARS-CoV-2 Exposures

Vaccination Status	Conventional	Contingency	Crisis
Up to Date	No work restrictions, with negative test on days 1‡ and 5–7	No work restriction	No work restriction
Not Up to Date	10 days OR 7 days with negative test†	No work restriction with negative tests on days 1‡, 2, 3, & 5–7 (if shortage of tests prioritize Day 1 to 2 and 5-7)	No work restrictions (test if possible)

†Negative test result within 48 hours before returning to work
‡For calculating day of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0

CDC

cdc.gov/coronavirus