Infection Control Consultants of New Mexico

FAQs COVID-19: 9/20/23

The following links and IC best practices were used to provide examples for these FAQs. These FAQs do not replace using the guidance provided by CMS, CDC, State Public Health, or your facility Policies.

CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (May 8, 2023)
(Note, this CDC May 8th recommendations also points back to several other documents, including the September23rd, 2022 document, the CDC statistics on COVID cases, Community data guidance for ALFs and more.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#print

CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (Sept. 23, 2022)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

CMS VISITATION GUIDANCE(Revised 05/08/2023)
https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

CMS SOM – You should all have a copy

OSHA Fit Testing N95 Respirator Toolkit and Standard
https://www.cdc.gov/niosh/npptl/hospresptoolkit/default.html
https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134

NM County Hospital Admission rate, and additional COVID statistics
https://covid.cdc.gov/covid-data-tracker/#maps_new-admissions-rate-county

NM Reporting requirements, not addressed in this FAQ
https://www.srca.nm.gov/parts/title07/07.004.0003.html

1. **Do we still have to screen visitors and HCP?**
    a. Yes, per CDC IC Recommendations 5/8/23 update and CMS QSO -20-39-NH Rev. 5/8/23 "Establish a process to identify and manage all individuals with suspected or confirmed COVID-19 infection."
        i. Everyone entering the facility must be made aware of actions to take to prevent transmission (provide education or posters) if they have any of the three criteria.
            1. Positive test
            2. COVID-19 symptoms
            3. Close contact with COVID-19 individual, or Higher-risk Exposure (for HCP) See descriptions below.

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

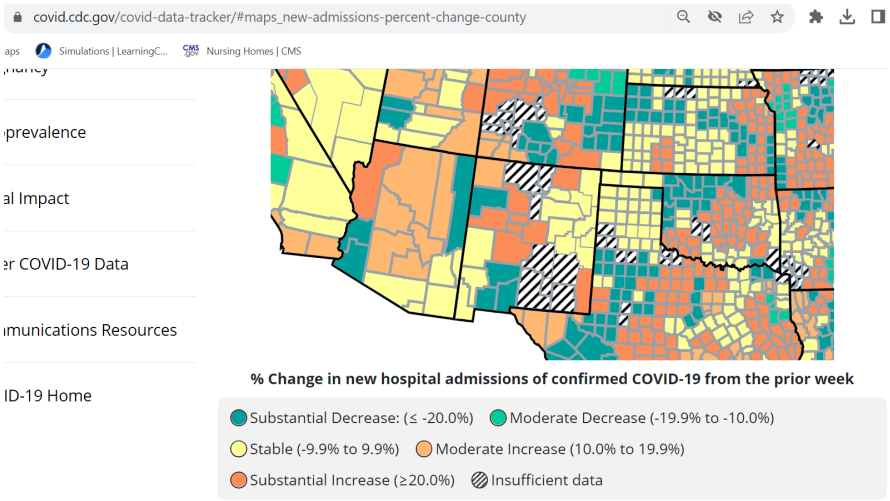
- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask).
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask.
- HCP was not wearing all recommended PPE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

Clost Contact is defined as being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with COVID-19 infection.

The guidance documents reference to visitation also discusses options such as offer testing to visitors, suggesting the use of outdoor, or virtual visits, delaying visits, suggestions for increasing ventilation indoors to decrease risks during high incidence of disease, offering or allowing visitors to wear source control and many more Infection Prevention principles to prevent outbreaks at the facility from staff and visitors.
The CMS QSO 20-39-NH Rev 5/8/23 updated the visitation guidance after the PHE ended, and it has many more recommendations and requirements around visitation. Note, visitation can occur UNLESS it increases the risk for other residents, (for instance if the visitor had COVID-19, was actively coughing, refused to wear source control and was entering other resident rooms) per 42 CFR 483.10(f)(2) and (4).

2. **If we have no cases of COVID-19 in either staff or residents at our facility, are respirators required?** (NOTE, if N95s are used, eye protection is needed also)
    a. First, what is the transmission level in the community? If it is low, then respirators are not required in the absence of cases or an outbreak or if you are not caring for someone with an airborne transmitted disease such as COVID-19, (except where you suspect the patient may have COVID-19, or is being screened for COVID-19, or awaiting results of a COVID-19 test, or has symptoms)
    b. As transmission increases, respirators MUST be considered for use when.
        i. You work in a high-risk area, such as the ER, Urgent Care, where exposure may be likely.
        ii. Aerosol-generating procedures are performed (see CDC list)
        iii. Surgical procedures that generate infectious aerosols involving the lungs, nosed, throat, oropharynx, and respiratory tract)
        iv. Those with risk for COVID-19 are unable to wear source control and the area is poorly ventilated.

3. **Who needs to wear a mask? (Source Control)?**
    a. It should be considered and allowed when:
        i. Those who choose to due to their risks (baby or elder at home) or immune compromised status (chemotherapy, or were not able to get vaccinated, for instance) can always choose to wear a mask, or N95 respirator (if fit-tested).
        ii. Personal preference when in large crowds
        iii. Poor ventilation exists.
        iv. The source control can be worn for the entire shift unless soiled or damaged.
    b. Source control is recommended when:
        i. Respiratory disease symptoms, suspected or confirmed COVID-19
        ii. Close contact (patient or visitor) or Higher- risk exposure (HCP) for 10 days after the exposure. (See definitions of close contact and high-risk exposure)
        iii. For 14 days after an outbreak (no new cases have been identified)
        iv. In ERs, Urgent Care, Oncology units, High Community transmission,
        v. Consider when hospital admission levels are high (see CDC link to determine admission rate in your county)



        vi. Also, consider mask wearing for large communal events such as holiday parties, health fairs etc., as the risks in large groups may be higher.

    c. Additionally, staff who have had a high-risk exposure should wear source control, but can continue to work if;
        i. They remain asymptomatic.
        ii. They test negative on day 1, 3 and 5
        iii. (If they cannot test, or wear source control, restrict for 10 days)
        iv. You should consider restrictions for high-risk exposures on units with moderately or severely immune compromised patients.
    d. Immune compromised residents may want to wear masks when out of their rooms, when going to appointments, or at larger gatherings for additional protection.

4. **When are N95 respirators required to be worn by staff?**
    a. If the facility is in COVID-19 outbreak, all staff in areas where COVID-19 patients might be should wear N95 respirators.
    b. Is eye protection required?
        i. Anytime you are wearing an N95 respirator, eye protection is warranted as tear ducts lead to the respiratory system and viral particles can enter and cause infection through this path.
    c. Anyone caring for a COVID-19 positive resident should wear N95 respirator and eye protection.
    d. Do I have to wear an N95 respirator in my office during the outbreak?
        i. It depends on if residents enter your office, if there is uncontrolled lateral transmission in the building, whether you have an office mate, and if you keep your door closed to residents who may walk by. For instance, if your office is away from the patient care units, and they do not need to pass it to exit the building, and the outbreak has been confined to residents on one wing, then taking off your respirator in the office alone with the door closed would be reasonable.
5. **I am a health care worker and have COVID-19, when can I return to work?**

A + HCP can return to work WHEN	Asymptomatic	Mild to Moderate Illness	Severe to Critical Illness
Immune competent	7 days have passed since the first symptoms IF a negative test is obtained up to 48 hours prior to returning to work. Or 10 days if the testing is not performed prior to return to work. Or 10 days if the tests at 5&7 was positive	Same as Asymptomatic, PLUS At least 24 hours since last fever without fever- reducing medication. AND Symptoms are improving	At least 10 days and up to 20 days *since symptoms first appeared,* AND At least 24 hours *since last fever* without fever-reducing medication AND Symptoms have improved. (Or test-based strategy used below)
Moderately or severely compromised	Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total	Resolution of fever without fever-reducing medications,	Resolution of fever without fever-reducing medications,

	of two negative specimens) tested using an antigen test or NAAT.	AND Improvement in symptoms AND Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.	AND Improvement in symptoms AND Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

6. **We are EXTREMELY short-staffed, can a COVID-19 worker come back to work any sooner than 7 days?**
    a. If all other contingencies have been exhausted to mitigate staffing shortages, staff could come back as early as day 5, IF
        i. 5 days have passed since first symptoms
        ii. 24 hours without fever and no fever reducing medications
        iii. Symptoms have improved
        iv. and wear source control until at least day ten 10 after exposure AND the outbreak is over. (of course, respirator use would be in place if the outbreak were ongoing).
        v. In addition, facilities may choose to confirm with one negative NAAT test or 2 negative antigen test 48 hours apart.

    b. If extreme crisis staffing still exists, HCP who have not resolved infection and have not met criteria could possibly
        i. Work remotely, away from people
        ii. Only work with confirmed COVID-19 positive individuals
        iii. Consult with Epi/PH

    c. See Link for full detail / crisis staffing; https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

7. **Why do we have to wear masks and respirators if the Public Health Emergencies have expired and the LODs requiring it have been retired?**
    a. Hippocratic Oath, first do no harm, best practice, and guidance from CDC as well as CMS regulation (and more I suspect)
        b. CMS SOM §483.80 Infection Control
        The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.
8. **Does the vaccination status play a role in whether we test or isolate or work restrict?**
    a. No, as the variants mutate, those who are vaccinated can become infected and transmit disease, however, vaccine still demonstrates it protects from severe disease and long COVID.
9. **Who should be tested for COVID-19?**
    a. Anyone, staff or patients with symptoms, ASAP!
    b. Asymptomatic patients who had close contact with a COVID-19 positive individual unless they have recovered in the last 30 days.
        i. If they had COVID in the last 90 days, use an antigen(RAPID, CLIA) test, not NAAT(PCR).
    c. Preadmission testing is NOT required, but you can decide to perform it if you wish.
    d. Perhaps individuals who would be at great risk if they developed disease.
    e. As part of a decision process for cohorting.
10. **What does testing normally entail?**
    a. Test anyone symptomatic immediately
    b. When testing patients who were exposed, test 24 hours after exposure, then 48 hours after that (if negative) and 48 hours after that (if negative again). Basical test at day 1, 3 and 5 where exposure is day 0.
    c. In general, <u>asymptomatic</u> HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status.
    d. Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. However higher risk exposed HCP should have a series of three viral tests for SARS-CoV-2 infection.
        i. Testing is recommended (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be on day 1 (where day of exposure is day 0), day 3, and day 5.
        ii. Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

11. What are the recommendations for patients who may have been exposure to COVID-19 but are asymptomatic?

a. In general, asymptomatic patients do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These patients should still wear source control and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.
b. Examples of when empiric Transmission-Based Precautions following close contact may be considered include:
    a. Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure.
    b. Patient is moderately to severely immunocompromised.
    c. Patient is residing on a unit with others who are moderately to severely immunocompromised.
    d. Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.
c. Patients placed in empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the following time periods.
    a. Patients can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
    b. If viral testing is not performed, patients can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

12. A. **What does up to date vaccination mean?**

B. **Do healthcare workers have to be up to date with COVID-19 vaccinations?**

a. A person who has received one updated 2023-2024 Pfizer BioNtech or Moderna COVID-19 vaccine. (Next year it would likely be the 2024-2025 equivalent vaccine)
b. There is no mandate federally or in the state of NM at this time for healthcare workers to receive the most recent COVID-19 vaccination, however organizations might require that their workers receive vaccination.

    NOTE: The updated 2023-2024 booster is effective against the two most common strains seen in the US, and early indication suggests it prevents severe illness from the newest variant which has significant mutations from the previous variants. So, continue to vaccinate. Not only can vaccination prevent severe illness, but by decreasing disease, it can decrease future mutations that MAY be more dangerous!

    NOTE: The old bivalent booster is no longer being authorized and facilities should not continue to administer those and dispose of them as medical waste.

    NOTE: The influenza vaccine can be administered at the same time as COVID-19 vaccines

13. What PPE is needed to collect specimens?

a. An N95, Eye Protection, Gloves and Gown. In some instances, the gown could be omitted if there is a barrier between you and the person from which you are obtaining the sample, e.g., some facilities had small windows.

14. What masks can be used for source control?

a. A NIOSH-approved particulate respirator with N95 filters or higher.
b. A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated).
c. A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; OR
d. A well-fitting facemask.

15. Do we need to suspend communal activities during the outbreak?

a. Not necessarily, communal, and therapeutic activities remain important for the wellbeing and recovery of residents.
b. Those who are positive or have symptoms should be isolated while recovering.
c. If significant uncontrolled lateral transmission is ongoing despite mitigation strategies, then communal activities should likely be suspended until the mechanisms of transmission are determined and mitigated.
d. Communal activities can continue in some cases, such as, on units where no cases were identified after the recommended testing, socially distanced communal activities, outside communal activities, activities with asymptomatic or COVID-19 negative individuals who can wear source control, and/or socially distance.

   Asymptomatic exposed residents undergoing testing, who can wear source control and maintain distance, and good hygiene can attend communal activities, especially in cases where omission from such would be detrimental, in accordance with QSO 20-39-NH Rev 5/8/23.

See Next Page

16. When can a COVID + resident be removed from transmission-based precautions/isolation?

A + patient can be removed from Transmission based precautions when	Asymptomatic	Mild to Moderate Illness	Severe to Critical Illness
Immune competent	10 days have passed since the first symptoms since first positive test.	Same as Asymptomatic, PLUS At least 24 hours since last fever without fever- reducing medication AND Symptoms are improving	At least 10 days and up to 20 days *since symptoms first appeared,* AND At least 24 hours *since last fever* without fever-reducing medication AND Symptoms have improved. (Or test-based strategy used below)
Moderately or severely compromised	Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.	Resolution of fever without fever-reducing medications, AND Improvement in symptoms AND Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.	Resolution of fever without fever-reducing medications, AND Improvement in symptoms AND Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.