North Carolina SPICE
Statewide Program for Infection Control & Epidemiology

SARS-COV-2 (COVID-19): UPDATED GUIDANCE

SENIOR LIVING ASSOCIATION

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February 25th, 2021

https://spice.unc.edu/

https://spice.unc.edu/ask-spice/

https://spice.unc.edu/webinar

SPICE EDUCATIONAL ACTIVITIES (CONGREGATE CARE SETTINGS)

- Quarterly Webinar(s):
  - Vaccine Hesitancy in HCP: Is There a Solution? **February 18th: 12 noon-1pm**
  - 2021: May, August, November
  - 2022: February, May and August
- Infection Control in Long Term Care Facilities:
  - March 29-31st , 2021
  - June 7-9th, 2021
- Provide 2-DVD set that includes 6 modules:
  - Antibiotic resistant bacteria, isolation precautions, environmental cleaning, preventing UTIs, preventing *C. difficile* and safe injection
- Infection Control Course:
  - Adult Care Homes and Assisted Living Facilities (12/31)
- Development of tool kits related to infection prevention

OBJECTIVES

Provide	Provide an overview of SARS-CoV-2 activity
Discuss	Discuss updated CDC guidance/recommendations
Discuss	Discuss visitation guidance

WHERE ARE WE?

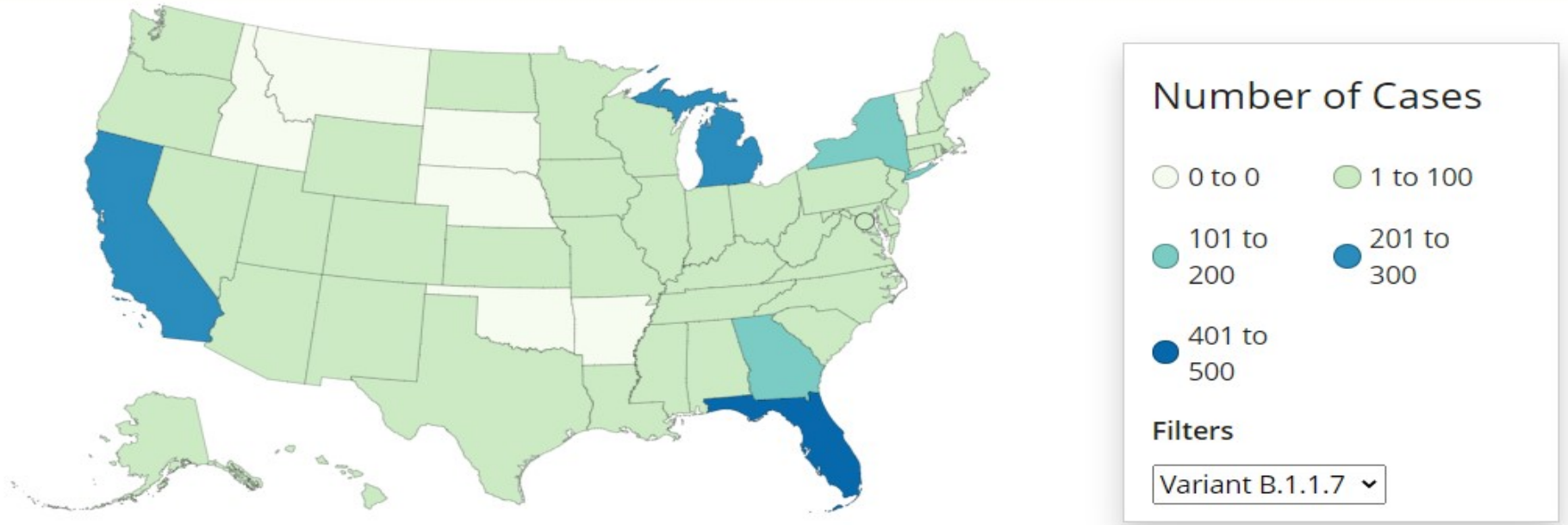
- Total Number of U.S. Cases
  - 28,065,327
- Total Number of U.S. Deaths
  - 501,181
- Total Vaccines Administered
  - 65.5 M

- Total Number of N.C. Cases
  - 849,630
- Total Number of N.C. Deaths
  - 11,074
- Total Vaccines Administered
  - > 2 M

Congregate Living Settings

	Cases	Deaths
Nursing Home	33,440	3,724
Residential Care Facility	15,835	1,157
Correctional Facility	12,757	88
Other	4,234	17
Not Living/Working in Congregate Living Settings	412,662	3,410

Emerging Variant Cases in the United States*†



Variant	Reported Cases in US	Number of States Reporting
B.1.1.7	1881	45
B.1.351	46	14
P.1	5	4

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HEALTHCARE PERSONNEL RETURN TO WORK CRITERIA *(FEB 16TH, 2021)*

- A test-based strategy is not recommended
- Symptom based strategy:

HCP with mild to moderate illness not severely immunocompromised	• **At least 10 days have passed since first symptom** • **At least 24 hours have passed since last fever (off medications** • **Symptoms (e.g., cough, SOB) have improved**
HCP who were asymptomatic and not severely immunocompromised	• At least 10 days have passed since first positive viral diagnostic test
HCP with severe to critical illness or who were severely immunocompromised	• At least 10 and up to 20 days have passed since first symptom • At least 24 hours have passed since last fever (off medications • Symptoms (e.g., cough, SOB) have improved • Consider consultation with infection control experts

https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.htm

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STRATEGIES TO MITIGATE HCP SHORTAGE

- Contingency (shortages are anticipated):
  - Hire additional staff, postpone elective time off
  - Plans to allow asymptomatic HCP who have high risk unprotected exposure but are not known to be infected to continue to work onsite during the 14-day post-exposure
- Crisis: (no longer enough staff to provide safe patient care):
  - **As a last resort** implement criteria to allow HCP confirmed to have COVID-19 who are well enough to work but have not met all return-to-work criteria to work:
    - Restrict from severely immunocompromised patients
    - Perform job duties where they do not interact with other
    - Provide direct care to persons with confirmed COVID-19 preferably cohort setting
    - **As a last resort** allow HCP to provide direct care for persons without suspected or confirmed COVID-19

https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

DISCONTINUING QUARANTINE HCP

- Prolonged close contact with a person with confirmed COVID-19
  - Exclude from work for 14 days <u>after last exposure</u>
  - Advise to self-monitor for fever or symptoms consistent with COVID-19
  - If symptoms occur immediately contact occupational health program
  - Test initially and if negative again at 5–7-day interval (should still be excluded if negative)

Exposure	Personal Protective Equipment Used	Work Restrictions
HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed COVID-19[3]	• HCP not wearing a respirator or facemask[4] • HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask • HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure[1]	• Exclude from work for 14 days after last exposure[5,6] • Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19[7] • Any HCP who develop fever or symptoms consistent with COVID-19[7] should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

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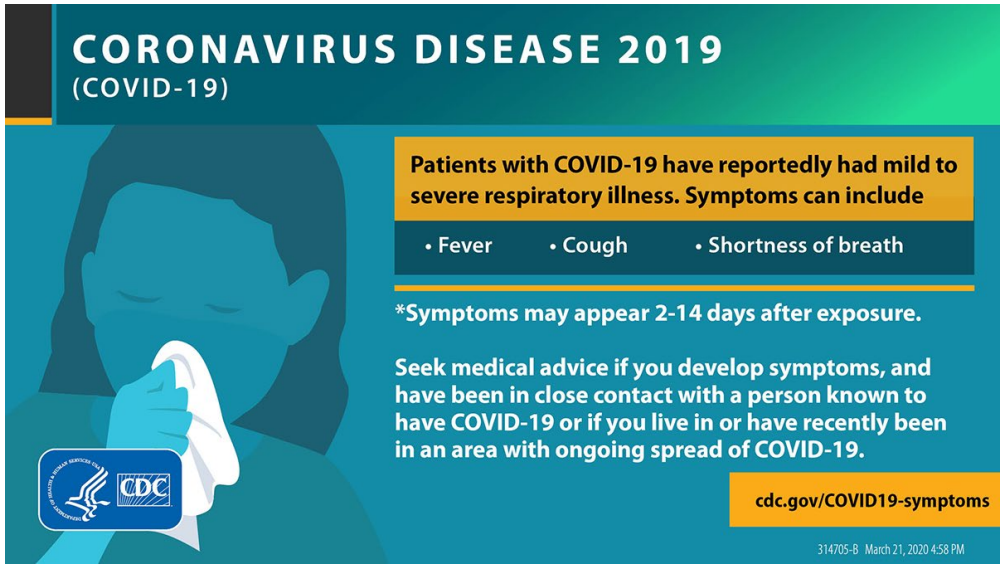
OPTIONS TO REDUCE QUARANTINE
DECEMBER 2ND, 2020

- Quarantine can end after Day 10:
  - Without testing and if no symptoms have been reported during daily monitoring
- Quarantine can end after Day 7:
  - When diagnostic testing resources are sufficient and available
  - Diagnostic specimen tests negative
  - Specimen collected and tested within 48 hours before time of planned quarantine
  - No symptoms reported during daily monitoring

- Quarantine cannot be discontinued earlier than after Day 7

Planned day after which quarantine is completed and can be discontinued	Residual post-quarantine transmission risk (%) with and without diagnostic testing of a specimen within 48 hours before time of planned discontinuation of quarantine					
	No testing		RT-PCR testing		Antigen testing	
	Median	Range	Median	Range	Median	Range
7	10.7	10.3-22.1	4.0	2.3-8.6	5.5	3.1-11.9
10	1.4	0.1-10.6	0.3	0.0-2.4	1.1	0.1-9.5
14	0.1	0.0-3.0	0.0	0.0-1.2	0.1	0.0-2.9

- Are the alternatives to the 14-day quarantine recommended for healthcare facilities?
  - Given the need for often extensive and close contact between patients and healthcare personnel, a 14-day quarantine period continues to be recommended for patients receiving healthcare and healthcare personnel with exposures to SARS-CoV-2 warranting quarantine or work restrictions, respectively.
  - This option maximally reduces post-quarantine transmission risk and is the strategy with the greatest collective experience at present.
  - HCF could consider alternatives as a measure to mitigate staffing shortages, space limitations or PPE supply shortage but due to the special nature of healthcare settings, **NOT AS A PREFERRED OPTION**



https://www.cdc.gov/coronavirus/2019-ncov/communication/graphics-buttons.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control

AFTER THE VACCINE: WHAT HAPPENS?

- Limited information on how much the vaccine might reduce transmission and how long protection lasts

- CDC continues to recommend vaccinated persons should continue to follow **current guidance** to protect themselves and others, including wearing a mask, staying at least 6 feet away from others, avoiding crowds, avoiding poorly ventilated spaces, covering coughs and sneezes, and washing hands often.
  - ***However, vaccinated persons with an exposure to someone with suspected or confirmed COVID-19 are not required to quarantine if they meet CDC criteria***

- Added, as contingency strategies options to allow (2/14)
  - **Asymptomatic** *fully vaccinated* HCP who 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.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

As an exception to the above guidance "no longer requiring quarantine for fully vaccinated persons", ***vaccinated inpatients and residents in healthcare settings should continue to quarantine following an exposure*** *to someone with suspected or confirmed COVID-19; outpatients should be cared for using appropriate Transmission-Based Precautions.*

https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

UNIVERSAL SOURCE CONTROL

- Residents/family members wear their own well-fitting form of source control upon arrival and through out their stay
- Residents may remove while in their rooms but wear when around others or leaving their room
- Healthcare personnel should wear well-fitting source control **AT ALL TIMES** while they are in the facility, including breakrooms or other spaces where they might encounter co-workers

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html

How NOT to wear a mask

Around your neck

On your forehead

Under your nose

Only on your nose

On your chin

Dangling from one ear

On your arm

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html

UNIVERSAL USE OF PERSONAL PROTECTIVE EQUIPMENT

Understanding the Difference

HCP working in facilities in communities with moderate to substantial transmission:

- N95 used for aerosol generating procedures (AGP)
- Source control
  - N95
  - A well-fitting facemask (e.g., selection of a facemask with a nose wire to help the facemask conform to the face; selection of a facemask with ties rather than ear loops; use of a mask fitter; tying the facemask's ear loops and tucking in the side pleats; fastening the facemask's ear loops behind the wearer's headexternal icon; use of a cloth mask over the facemask to help it conform to the wearer's face)
- Eye protection


UNC
HEALTH

	Conventional: **Normal Supply** **(incorporate the anticipated number of persons for whom PPE should be worn by HCP)**	**Contingency:** **Temporarily instituted during periods of expected shortage**	**Crisis:** **Not commensurate with standard US standards; periods of known shortages**
Face mask	**Source control:** • Used until soiled or damaged or hard to breathe through • Discard after removal **PPE:** • Removed and discarded after each person encounter	Extended use of facemasks as PPE: • Discard whenever removed and always at the end of the workday	Limited re-use with extended use: • No maximum number of uses
N95s (respirators)	Resume conventional practices	Extended use; ideally discarded after extended use (shift) • Consider use of face shield or facemask during **AGPs-splashes and sprays**	Limited re-use with extended use: • No more than 5 dunning's • Consider use of face shield or facemask during **AGPs-splashes and sprays**

N95 RESPIRATOR

- During times of increased demand for N95 filtering facepiece respirators (FFRs), hospitals or other medical facilities may want to protect these devices from surface contamination in order to prolong their use.
- When protection against surface contamination is needed, **CDC recommends wearing a cleanable face shield over an N95 FFR.**
- ***Wearing a surgical mask or cloth covering over an FFR, such as an N95, is not approved or recommended by NIOSH because it is not consistent with the conditions of the approval, therefore voiding the certification, however this is a strategy that can be used in a crisis situation, as described in the CDC strategies for Optimizing the Supply of N95 Respirators***

https://blogs.cdc.gov/niosh-science-blog/2020/06/16/covering-n95s/

RESPIRATORS

- Healthcare providers who are in close contact with an LTCF resident with suspected or confirmed SARS-CoV-2 infection must use a NIOSH-approved N95 FFR or equivalent or higher-level respirator (29 CFR 1910.134)
- Whenever respirators are required, employers must implement a written, worksite-specific respiratory protection program (RPP), including medical evaluation, fit testing, training, and other elements, as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134).

https://www.osha.gov/sites/default/files/respiratory-protection-covid19-long-term-care.pdf

https://www.osha.gov/sites/default/files/respiratory-protection-covid19-compliance.pdf

	Conventional: **Normal Supply** **(incorporate the anticipated number of persons for whom PPE should be worn by HCP)**	**Contingency:** **Temporarily instituted <u>during periods of expected shortage</u>**	**Crisis:** **Not commensurate with standard US standards; <u>periods of known shortages</u>**
Eye Protection	Resume conventional practices: • Shift from disposable to reusable	Extended use • Removed, cleaned if visible soiled or hard to see through	Prioritize eye protection: • Activities where splash/splatter anticipated • Prolonged face to face close contact
Gowns	Resume conventional practices: • Reusable (cloth) gowns	Prioritize gowns for higher risk activities: • AGP • Close/prolonged contact	Extended use: • COVID-19 unit only

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VISITATION
CORE PRINCIPLES OF COVID-19: INFECTION PREVENTION

- Screening
- Hand Hygiene
- Face covering
- Social Distancing
- Signage
- Cleaning and disinfecting
- Appropriate staff use of PPE
- Effective cohorting of residents
- Resident and staff testing

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PREVENTION RECOMMENDATIONS VISITATION-OUTDOOR

- Outdoor visitation preferred
- Should be facilitated routinely (aside from weather conditions etc.,)
- Create assessable and safe spaces (courtyards, use of tents)
- Face coverings-universal source control
- Limit number and size of visits
- Reasonable limits on the number of individuals visiting

PREVENTION RECOMMENDATIONS VISITATION-INDOOR

- No new onset cases in the last 14 days and not currently conducting **outbreak testing**
- Screening of residents, staff and visitors
- Face coverings-universal source control
- Restrict indoor visitation to resident room or other area designated by facility
- Visitors limit interactions with others
- Availability of alcohol-based hand sanitizer
- Designated area cleaned (EPA registered disinfectant) after each visit
- Allow for privacy

COMPASSIONATE CARE

- Does not exclusively refer to “end of life”
- Other examples:
  - A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
  - A resident who is grieving after a friend or family member recently passed away.
  - A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
  - A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).
- Allowed during outbreak
- Conducted using social distancing, ***however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines, and for a limited amount of time.***

PREVENTION RECOMMENDATIONS

COMMUNAL DINING

- Ensure 6 feet of space between each individual and each table
- Stagger mealtimes
- Plate food versus family style
- Reduce (eliminate) condiments
- HH before and after
- Area sanitized after each meal

INDOOR/GROUP ACTIVITIES

- Adhere to HH and source control
- Limit group size-social distancing
- Clean and sanitize activity equipment
- Outdoor activities:
  - Ensure appropriate supervision
  - Need for sunscreen, hydration, appropriate clothing

https://files.nc.gov/covid/documents/guidance/Guidance-on-Outdoor-Visitation-for-Larger-Residential-Settings.pdf

VACCINATION
COVID-19

- The First two Covid-19 Vaccines released by FDA, Emergency Use Authorizations (EUA), both 2 dose vaccines:

  - Pfizer-BioNTec

  - Moderna

VACCINATION
COVID-19

	Pfizer & BioNTech	Moderna
Type	mRNA (virus genetic code)	mRNA (virus genetic code)
Antigen	Spike protein, 30 µg	Spike protein, 100 µg
Doses	Two injections, **21 days apart**	Two injections, **28 days apart**
Study participants	~44,000	~30,000
Age	**≥16 years**	**≥18 years**
Effectiveness	~95% (~50% after 1 dose)	~95%
Long-term storage	**-75 °C**	**-20 °C** (up to 6 months)
Administration	Intramuscular (IM)	Intramuscular (IM)
Stability when mixed	6 hours	6 hours

POTENTIAL SIDE EFFECTS

- Inform about the potential side effects and that they are normal
- Potential Side Effects:
  - **Local**: pain, redness, swelling at the injection site
  - **Systemic**: fever, muscle or joint aches, malaise
- Generally occur within 1-3 days following vaccine and resolve within 1-3 days of onset
- May be more pronounced after the second dose

Reactogenicity reported to v-safe

Local and systemic reactions, day 0-7*,†	All vaccines %	Pfizer- BioNTech dose 1 %	Pfizer-BioNtech dose 2 %	Moderna dose 1 %
Pain	70.7	67.7	74.8	70.1
Fatigue	33.4	28.6	50.0	29.7
Headache	29.4	25.6	41.9	26.0
Myalgia	22.8	17.2	41.6	19.6
Chills	11.5	7.0	26.7	9.3
Fever	11.4	7.4	25.2	9.1
Swelling	11.0	6.8	26.7	13.4
Joint pain	10.4	7.1	21.2	8.6
Nausea	8.9	7.0	13.9	7.7

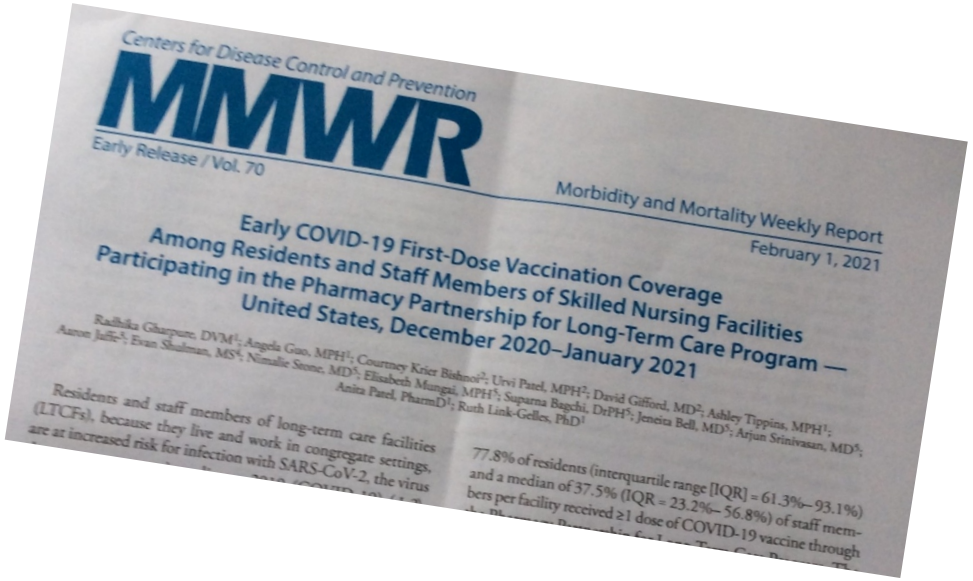
* v-safe data lock point 1/14/2021, 5:00 AM ET
† Reported on at least one health check-in completed on days 0-7 after receipt of vaccine

VACCINE HESITANCY IS REAL

- Published February 1st, 2021

- Studied receipt of vaccine in first month of Pharmacy Partnership for LTC Program with data from NHSN and CMS

- 77.8 % of residents and 37.5% of staff members per facility received ≥1 dose of vaccine through Pharmacy Partnership for LTC Program



Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 70

February 1, 2021

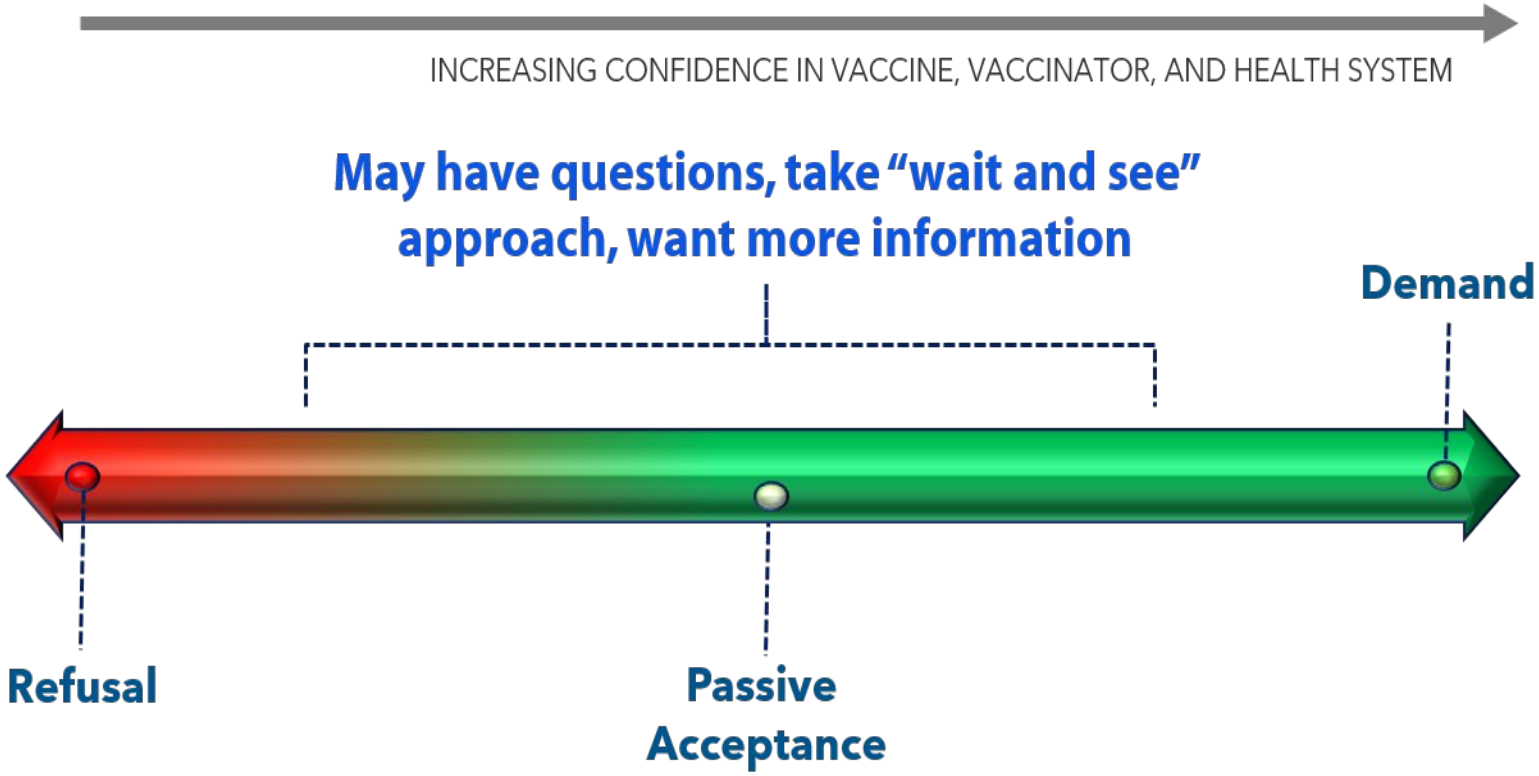
Early COVID-19 First-Dose Vaccination Coverage Among Residents and Staff Members of Skilled Nursing Facilities Participating in the Pharmacy Partnership for Long-Term Care Program — United States, December 2020–January 2021

Radhika Gharpure, DVM[1]; Angela Guo, MPH[1]; Courtney Krier Bishnoi[2]; Urvi Patel, MPH[2]; David Gifford, MD[2]; Ashley Tippins, MPH[1]; Aaron Jaffe[3]; Evan Shulman, MS[4]; Nimalie Stone, MD[5]; Elisabeth Mungai, MPH[1]; Suparna Bagchi, DrPH[5]; Jeneita Bell, MD[5]; Arjun Srinivasan, MD[5]; Anita Patel, PharmD[1]; Ruth Link-Gelles, PhD[1]

Residents and staff members of long-term care facilities (LTCFs), because they live and work in congregate settings, are at increased risk for infection with SARS-CoV-2, the virus

77.8% of residents (interquartile range [IQR] = 61.3%–93.1%) and a median of 37.5% (IQR = 23.2%–56.8%) of staff members per facility received ≥1 dose of COVID-19 vaccine through

VACCINE HESITANCY



https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html#slides

STILL IMPORTANT!

RESOURCES FOR INFECTION PREVENTION RECOMMENDATIONS

- CDC Considerations for Preparing for COVID-19 in Assisted Living Facilities
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- CDC Considerations for Memory Care Units in LTCFs
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html
- Considerations for Retirement Communities and Independent Living Facilities
  - https://www.cdc.gov/coronavirus/2019-ncov/community/retirement/considerations.html
- CDC Preparing for COVID in Nursing Homes
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
- CDC Responding to COVID in Nursing Homes
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

RESOURCES FOR INFECTION PREVENTION RECOMMENDATIONS

- Return to Work Criteria for HCP with SARS-CoV-2 Infection-2/16/2021
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- Strategies to Mitigate Staffing Shortages-2/16/2021
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
- NCDHHS Guidance on Visitation, Communal Dining and Indoor Activities for Larger Residential Setting
  - https://files.nc.gov/covid/documents/guidance/Guidance-on-Outdoor-Visitation-for-Larger-Residential-Settings.pdf
- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Questions??