CDC UPDATED INFECTION PREVENTION GUIDANCE
COVID-19- SEPTEMBER 10TH, 2021

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Defining Community Transmission of SARS-CoV-2

Several of the IPC measures (e.g., use of source control, screening testing) are influenced by levels of SARS-CoV-2 transmission in the community. Two different indicators in CDC’s COVID-19 Data Tracker are used to determine the level of SARS-CoV-2 transmission for the county where the healthcare facility is located. If the two indicators suggest different transmission levels, the higher level is selected.
### Table 2. Level of Community Transmission

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Low</th>
<th>Moderate</th>
<th>Substantial</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative number of new cases per 100,000 persons within the last 7 days*</td>
<td>&lt;10</td>
<td>10-49</td>
<td>50-99</td>
<td>≥100</td>
</tr>
<tr>
<td>Percentage of NAATs that are positive during the last 7 days†</td>
<td>&lt;5%</td>
<td>5%-7.9%</td>
<td>8%-9.9%</td>
<td>≥10.0%</td>
</tr>
</tbody>
</table>

Indicators should be calculated for counties or core based statistical areas, although in rural areas with low population density, multiple jurisdictions might need to be combined to make the indicators more useful for decision-making. The indicators listed can be found by county on CDC's [COVID Data Tracker Website](https://covid.cdc.gov/covid-data-tracker/#county-view) under “county view”.

* Number of new cases in the county (or other administrative level) in the last 7 days divided by the population in the county (or other administrative level) and multiplying by 100,000.

† Number of positive tests in the county (or other administrative level) during the last 7 days divided by the total number of tests resulted in the county (or other administrative level) during the last 7 days. [Calculating Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Laboratory Test Percent Positivity: CDC Methods and Considerations for Comparisons and Interpretation](https://covid.cdc.gov/covid-data-tracker/#county-view)

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**As of Sept 15th**

Community Transmission in the US

**Sept 20th**
CDC UPDATED GUIDANCE –

September 10th, 2021

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (Nursing Homes and LTCFs)
CDC UPDATED GUIDANCE – September 13th, 14th and 16th

- Strategies for Optimizing the Supply of Eye Protection – September 13th
- \(^1\)Ending Isolation and Precautions for People with COVID-19: Interim Guidance - September 14th
- Strategies for Optimizing the Supply of N95 Respirators – September 16th

\(^1\)No changes-combined HC and home isolation; included evidence for expanding recommendations to include children
INTERIM INFECTION PREVENTION AND CONTROL RECOMMENDATIONS FOR HEALTHCARE PERSONNEL (HCP) DURING THE CORONAVIRUS DISEASE 2019 (COVID-19) PANDEMIC

‑ Source Control
  ‑ Fully vaccinated HCP working in facilities located in counties with low to moderate community transmission could choose not to wear source control in well-defined areas where patients access is restricted

‑ Post exposure quarantine
  ‑ Fully vaccinated asymptomatic patients do not require TBPs (quarantine) following close contact with someone with SARS-CoV-2 infection
  ‑ Patients who have had SARS-CoV-2 infection in the last 90 days

Clarified recommended intervals for post exposure testing

- Testing is recommended immediately,
  **but not earlier than 2 days after the exposure**-if negative test again at 5-7 days after the exposure
- Includes patients and HCP regardless of vaccination status
- Not recommended for people who have had SARS-CoV-2 infection

Content from other CDC guidance

- Recommendations for fully vaccinated HCP, patients and visitors
- SARS-CoV-2 testing
- Duration of TBP for patients with SARS-CoV-2 infection
- Dental, dialysis and EMS guidance as well

Return to work after infection

- Criteria for symptom-based strategy for determining when HCP with SARS-CoV-2 infection could return to work
- Criteria for test-based strategy for determining when HCP with SARS-CoV-2 infection could return to work
- Clarified the table for higher risk exposure and work restriction applied to unvaccinated HCP

Clarified recommended intervals of testing after high-risk exposure

- Fully vaccinated series of two viral tests
- Not recommended for asymptomatic HCP recovered from SARS-CoV-2 within 90 days
- Fully vaccinated should use universal source control while in HCP facility for 14 days-then may default to routine source control recommendations.

INTERIM INFECTION PREVENTION AND CONTROL RECOMMENDATIONS TO PREVENT SARS-COV-2 SPREAD IN NURSING HOMES (NURSING HOMES AND LONG-TERM CARE FACILITIES)

- **Outbreak Response:**
  - Perform contact tracing
  - Alternative broad-based approach

- **Expanded screening testing of HCP**
  - Fully vaccinated exempt
  - Unvaccinated HCP continue expanded screening testing based on level of community transmission

Recommendations for quarantine of residents' post exposure

- **Unvaccinated** quarantine for 14 days even with negative test
- **Fully vaccinated** do not need to be quarantined—should wear source control and be tested
- Residents with SARS-CoV-2 infection in the past 90 days do not need to be quarantined

Visitation Guidance
- Per CMS guidance
STRATEGIES FOR OPTIMIZING THE SUPPLY OF EYE PROTECTION

Updated 9/13

➤ In areas of substantial to high transmission in which HCP are using eye protection for all patient/resident encounters, extended use of eye protection may be considered a conventional capacity strategy

➤ Eye protection should be removed, cleaned¹ and disinfected if it becomes visibly soiled or difficult to see through
  ➤ If disposable is cleaned and disinfected dedicate to one HCP
  ➤ All eye protection should be discarded if damaged

¹CDC’s protocol or IFUs

Contingency capacity strategies:

- Beyond anticipated shortages, added that increased feasibility and practicality may also be considered in decisions to implement extended use for healthcare personnel (HCP) who are sequentially caring for a large volume of patients with suspected or confirmed SARS-CoV-2, including those cohoeted in a SARS-CoV-2 unit, those placed in quarantine, and residents on units impacted during a SARS-CoV-2 outbreak.

- Expected shortages can consider temporarily suspending annual fit testing.

Criss capacity strategies:

- Removed NIOSH approved filtering facepiece respirators that have passed the manufacturer’s recommended shelf life and removed decontaminated respirators from scope of authorization.

- Added clarification and example for limited re-use.

SUMMARY

- Fully vaccinated residents and/or patients with close contact to someone with SARS-CoV-2 infection do not have to be quarantined unless symptomatic.
- Asymptomatic HCP and patients/residents with close contact to someone with SARS-CoV-2 infection, regardless of vaccination status should have a series of 2 viral test-immediately (not sooner than 2 days after exposure) and day 5-7 after exposure.
- Nursing homes can use contact tracing approach in outbreaks.
- Fully vaccinated HCP in nursing homes do not have to undergo serial testing based on community transmission.
- Unvaccinated HCP should be tested based on community transmission.
In communities with substantial to high transmission where HCP are using eye protection for all patient encounters expanded use can be considered a conventional strategy.

Extended wear of N95s can be considered for HCP who are sequentially caring for a large volume of patients/residents with suspected/confirmed SARS-CoV-2 infection (quarantine hall, COVID-19 hall and units impacted by outbreak). Do not have to anticipate shortages-contingency strategies.