North Carolina SPICE
Statewide Program for Infection Control & Epidemiology

CDC and CMS UPDATES- REVIEW of SARS-CoV-2 DIAGNOSTIC TEST

Evelyn Cook, RN, CIC
Associate Director (SPICE)
NC State Laboratory Public Health (NCDHHS)
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https://spice.unc.edu/

Centers for Disease Control and Prevention

CDC 24/7: Saving Lives, Protecting People™

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) – *September 23, 2022*

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 – *September 23, 2022*

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

- Strategies to Mitigate Healthcare Personnel Staffing Shortages – *September 23, 2022*

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Rescinds December 7, 2020, Enforcement Discretion for the Use of SARS-CoV-2 Tests on Asymptomatic Individuals Outside of the Test's Instructions for Use (QSO-22-25-CLIA) [9/26/22]

Nursing Home Visitation - COVID-19 (REVISED) (QSO-20-39-NH REVISED) [9/23/22]

Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements (QSO-20-38-NH REVISED) [9/23/22]

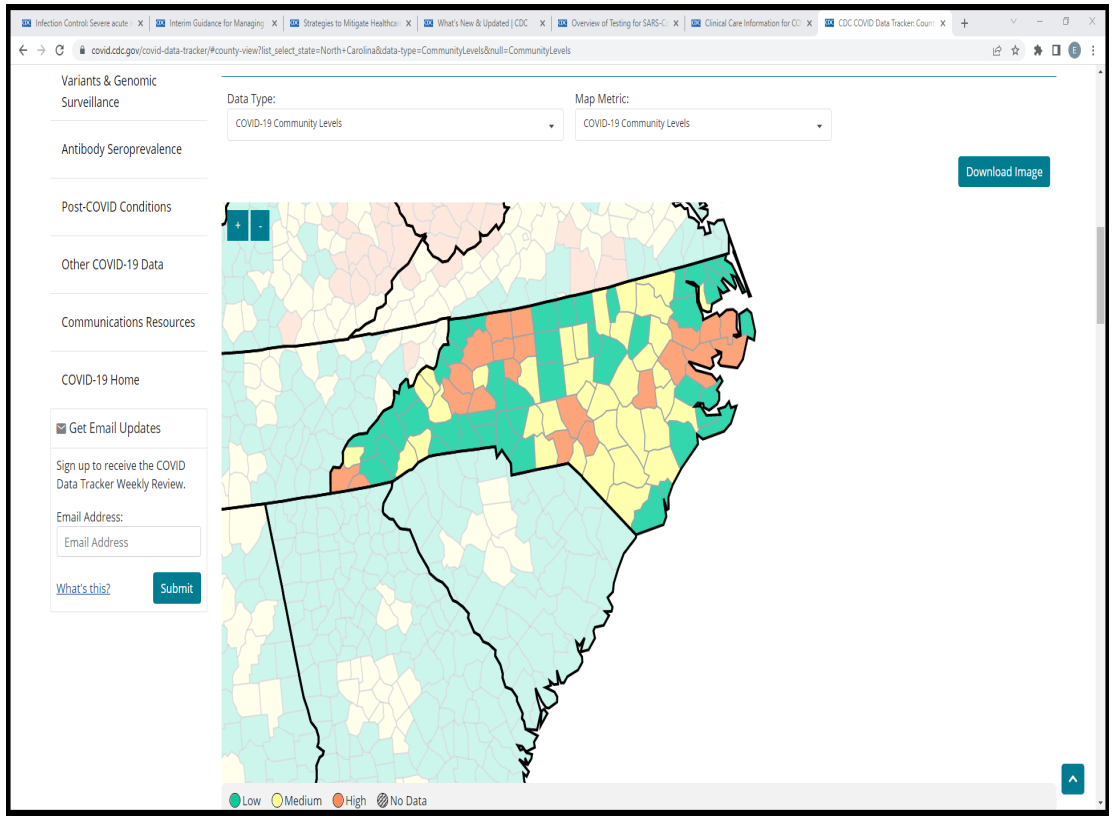
KEY CHANGES
9/23/2022

- Continuing to use **Community Transmission** (and not Community Levels) to inform select IPC measures
  - Allow for earlier intervention, before there is a strain on the healthcare system and better protect the individuals seeking care in these settings
- Vaccination status no longer used to inform source control, screening testing or post-exposure (e.g., work restriction, quarantine) recommendations
- Standalone guidance for nursing homes is being archived: any needed setting-specific recommendations being added to Section 3 of main IPC guidance

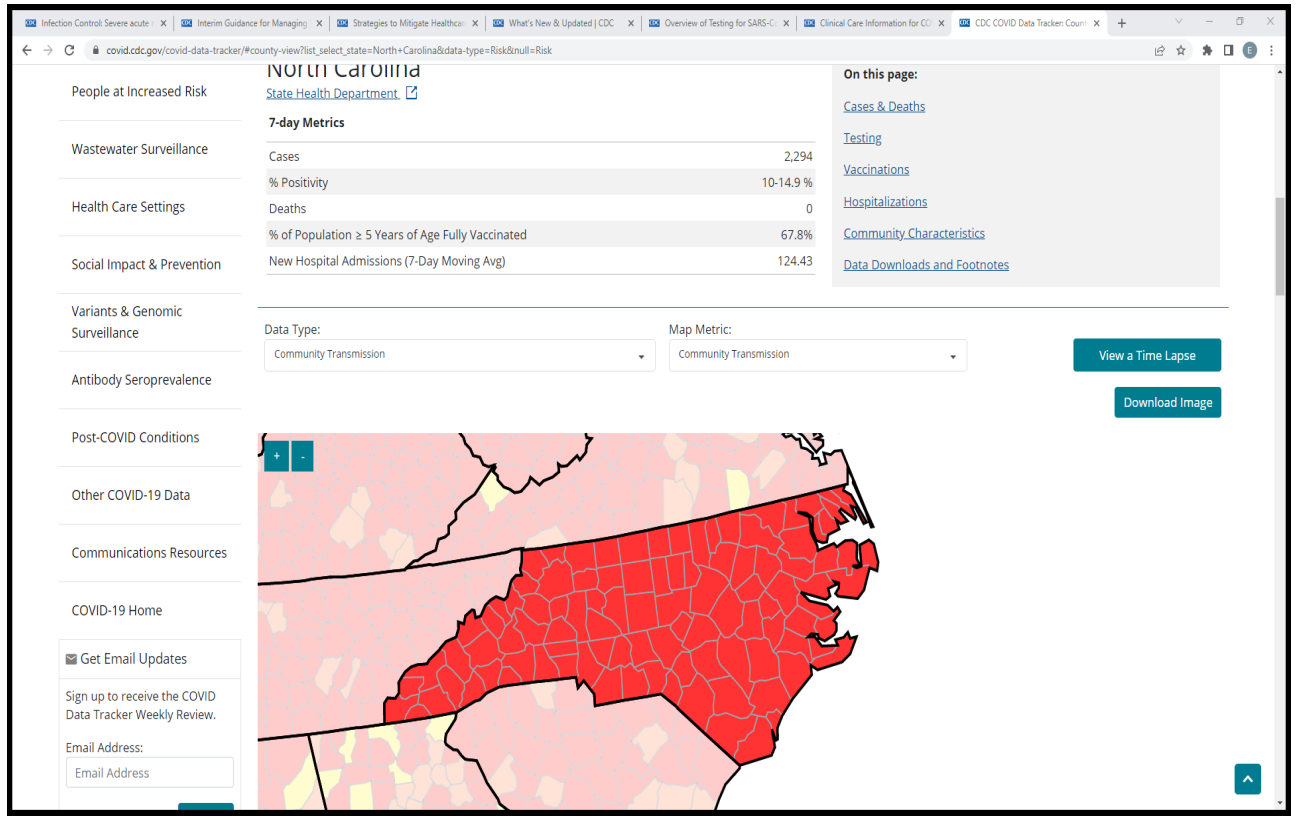
INTERIM INFECTION PREVENTION AND CONTROL RECOMMENDATIONS FOR HEALTHCARE PERSONNEL DURING THE CORONAVIRUS DISEASE 2019 (COVID-19) – *SEPTEMBER 23, 2022*

- Guidance is applicable to all U.S. settings where healthcare is delivered (including nursing homes and home health).
- Not intended for non-healthcare settings (e.g., restaurants) and not for persons outside of healthcare settings.
- Defining Community Transmission of SARS-CoV-2:
  - ***Community Transmission*** is the metric currently recommended to guide select practices in healthcare settings
  - Select IPC measures (e.g., use of source control, screening testing of nursing home admissions) are influenced by levels of SARS-CoV-2 transmission in the community.
  - Community Transmission metric is different from the ***COVID-19 Community Level*** metric used for non-healthcare settings

COMMUNITY LEVEL



COMMUNITY TRANSMISSION



RECOMMENDED PRACTICES

- Encourage everyone to remain up to date with all recommended COVID-19 vaccines
- Ensure everyone is aware of recommended IPC practices in the facility
  - Post visual alerts at the entrance and in strategic places-include instructions about IPC recommendations (Hand Hygiene, when to use source control)
  - Establish a process to make everyone aware of recommended actions if they have:
    - A positive viral test
    - Symptoms of COVID-19
    - Close contact with someone infected (patients, residents, visitors) OR a higher-risk exposure (for healthcare personnel (HCP)

	High	Not High
Community Transmission	• Source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients/residents • Could choose not to wear source control when in well-defined areas restricted from patient/resident **access if they don't otherwise meet criteria** and community levels are not high	• Healthcare facilities can choose not to require universal source control. • However even if source control is not universally required it remains recommended for individuals in a HC setting who: • Have suspected/confirmed COVID-19 or other respiratory infection (runny nose, cough etc.,) • Had exposure (close contact or higher-risk) wear for 10 days • Reside or work in a facility experiencing an outbreak (discontinue when no new cases for 14 days) • Recommended by public health
Community Level	• Source control recommended for **everyone**	***Even if not otherwise required by the facility, individuals should always be allowed to wear source control based on personal preference***

SUMMARY OF RECENT CHANGES

- Vaccination status is no longer used to inform source control, screening testing, or post-exposure recommendations
- Updated circumstances when use of source control is recommended
- Updated circumstances when universal use of personal protective equipment should be considered
  - Facilities located in counties where community transmission is high should also **consider** ~~(use~~)having HCP use PPE as described below:
    - NIOSH-approved particulate respirators ~~(should be used)~~ for all AGP, all surgical procedures posing a higher risk of transmission, in other situations where additional risk factors for transmission are present
    - Eye protection (~~should be~~) worn during all patient care encounters.

SUMMARY OF RECENT CHANGES

- Vaccination status is no longer used to inform source control, screening testing, or post-exposure recommendations
- Updated circumstances when use of source control is recommended
- Updated circumstances when universal use of personal protective equipment should be considered
- Updated recommendations for testing
  - Anyone with even mild symptoms, regardless of vaccination status
  - Asymptomatic patients with close contact or HCP with higher risk exposure
  - Screening of asymptomatic HCP at the discretion of Healthcare facility (including NH)
  - Testing generally not recommended for asymptomatic individuals who have recovered in the prior **30** days

Testing is recommended immediately 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.

SUMMARY OF RECENT CHANGES

- Updated, in general asymptomatic patients/residents no longer require use of TBP following close contact
  - Should still wear source control for 10 days
  - Tested

Examples of when empiric TBP may be considered:

Unable to be tested or wear source control

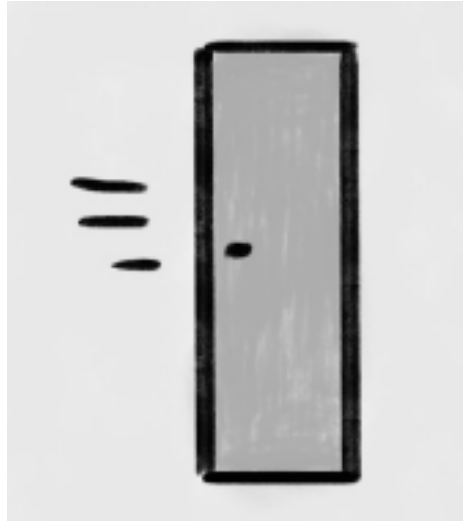
Moderately to severely immunocompromised OR residing on a unit with someone who is

Residing on a unit with ongoing transmission not controlled with initial interventions

SOME RECOMMENDATIONS DID NOT CHANGE

CARING FOR A PATIENT/RESIDENT WITH SUSPECTED/CONFIRMED SARS-COV-2 INFECTION

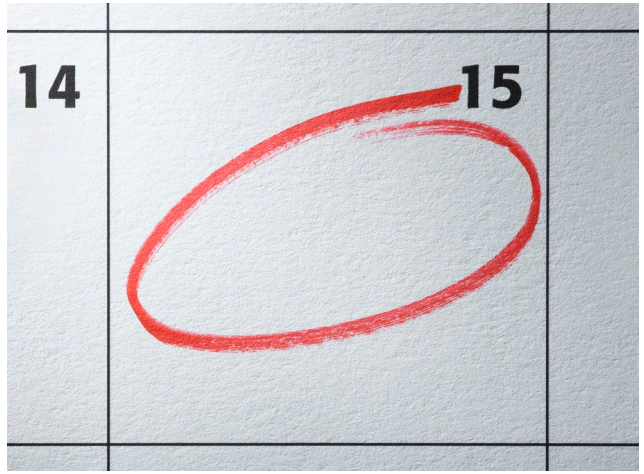
- Placement:
  - Place in a single-person room. The door should be kept closed **(if safe to do so).**
  - Dedicated bathroom
  - Consider dedicated unit and dedicated staff
  - Limit transport



- Transmission-based precautions (TBPs)
  - Use full PPE for care, including NIOSH approved N95 or higher-level respirator, gown, gloves, eye protection
  - AGPs should take place in an airborne infection isolation room (AIIR) if possible

DURATION OF TBP FOR CONFIRMED COVID-19

- Symptoms:
  - 10 days passed since first symptom **and**
  - At least 24 hours since last fever (without fever reducing medications) **and**
  - Symptoms improved
- Asymptomatic:
  - 10 days have passed since first positive viral test
- Moderately to severely immunocompromised:
  - Test based strategy can be added-to determine when precautions can be discontinued



In general, patients who are hospitalized for SARS-CoV-2 infection should be maintained on TBP for the time period described for patients with severe to critical illness (10-20 days)

NURSING HOMES

- Managing admissions and residents who leave the facility
  - In general, admissions in counties where community transmission is high should be tested
  - Testing at lower levels of community transmission is at the discretion of the facility
  - They should be advised to wear source control for the 10 days following their admission
  - Residents who leave the facility for ≥ 24 hours should be managed as an admission
  - Empiric use of TBP is generally not necessary

ASSISTED LIVING, GROUP HOMES AND OTHER RESIDENTIAL CARE SETTINGS

- In general, long-term care settings (excluding nursing homes) whose staff provide non-skilled personal care* similar to that provided by family members in the home (e.g., many assisted livings, group homes), should follow community prevention strategies based on COVID-19 Community Levels, similar to independent living, retirement communities or other non-healthcare congregate settings.
- ***Visiting or shared healthcare personnel who enter the setting to provide healthcare to one or more residents (e.g., physical therapy, wound care, intravenous injections, or catheter care provided by home health agency nurses) should follow the healthcare IPC recommendations in this guidance.***
- In addition, if staff in a residential care setting are providing in-person services for a resident with SARS-CoV-2 infection, they should be familiar with recommended IPC practices to protect themselves and others from potential exposures including the hand hygiene, personal protective equipment and cleaning and disinfection practices outlined in this guidance.

INTERIM GUIDANCE FOR MANAGING HEALTHCARE PERSONNEL WITH SARS-COV-2 INFECTION OR EXPOSURE TO SARS-COV-2

- In general, asymptomatic HCP who have had higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2
  - Wear well-fitting source control, self monitor and not report to work if ill (report symptoms)
- If positive can return to work:
  - At least 7 days have passed ***since symptoms*** first appeared if a negative viral test is obtained within 48 hours prior to returning **OR** 10 days if testing is not performed or if test is positive at day 5-7 **AND** At least 24 hours have passed since last fever without use of meds **AND** Symptoms have improved.
  - If asymptomatic at least 7 days have passed since first positive test if a negative viral test is obtained within 48 hours prior to returning to work **OR** 10 days if testing is not performed or test is positive at day 5-7

STRATEGIES TO MITIGATE HEALTHCARE PERSONNEL STAFFING SHORTAGES

- Conventional strategies were updated to advise that, in most circumstances, asymptomatic HCP with higher-risk exposures do not require work restrictions, ***regardless of vaccination status.***
- Contingency-staffing shortages anticipated
  - At least **5** days have passed since first symptom (or test if asymptomatic) **AND** at least 24 hours since last fever **AND** symptoms have improved
  - Always adhere to all recommended IPC strategies
  - Patients if tolerated should wear source control while interacting with HCP
- Crisis strategies-experiencing staffing shortages
  - Restrict from contact with patients who are moderately to severely immunocompromised
  - Prioritize duties *(no patient contact, direct care for + patients, direct care for suspected +, last resort care for patients without SARS-CoV-2 infection)*