# Occupational Health: Long Term Care Facilities March 2026

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## Disclosures

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- No financial relationships to disclose
- No off-label or investigational use of medications and/or devices
- The information and views set out in this presentation are those of the author and do not necessarily reflect the official opinion of the University of North Carolina at Chapel Hill or UNC Health

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## Objectives

- ACIP Updates
- Vaccines for HCPs (Pre-exposure prophylaxis)
- Post-exposure prophylaxis (Bloodborne Pathogens)
- COVID-19
- Employee Well-Being

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# ACIP Updates

Advisory Committee on Immunization Practices

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## ACIP April 2022 Update

- Hepatitis B Vaccines are now universally recommended for all adults aged 19 – 59 years old instead of based solely on risk factors. This reflects the rising cases of Hepatitis B since the nadir in 2014 and acknowledges that risk-based intervention misses people reluctant to disclose.
- Also note that ACIP recommendations for Hepatitis B screening were updated in March 2023 to include testing at least once per lifetime in addition to risk factor-based testing

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## ACIP Update

- General Update ACIP recommendations should be reviewed alongside other published recommendations
- With the ongoing lack of regularly scheduled meetings and reviews it has become necessary to look for resources that provide timely guidance.
  - *"With no current CDC Director and pending confirmation of a new CDC Director, these recommendations were adopted by the HHS Secretary on July 22, 2025, and are now official recommendations of the CDC."*

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# ACIP June 2022 Update

- **JYNNEOS for Monkeypox**
  - Two vaccines (JYNNEOS and ACAM2000) for orthopoxviruses (including MPX and smallpox). JYNNEOS w/ much less contraindications.
  - Pre- or post- exposure prophylaxis indications based on risk factors (generally intimate, prolonged contact)
  - Most healthcare workers do not need to get this vaccine. Exceptions include HCPs w high risk exposure (caring for +pt for prolonged period without PPE) and lab personnel handling specimens

https://www.cdc.gov/mmwr/volumes/71/wr/mm7122e1.htm

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# ACIP June 2025 Update

- Influenza
  - ACIP reaffirms the recommendations for routine annual influenza vaccination of all persons aged ≥ 6 months who do not have contraindications for the 2025-2026 season.
  - ACIP recommends only single-dose formulations of annual influenza vaccines that are free of thimerosal as a preservative for three populations:
    - Children 18 years or younger
    - Pregnant women
    - All adults

As of July 23, ACIP vote Thimerosal will be removed from all influenza vaccines – was only being utilized in multidose vials.

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# ACIP June 2023/2024 Update

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- RSV Vaccine (Abrysvo or Arexvy)
  - Single dose (for now), high efficacy over two RSV seasons
  - Can be coadministered with other vaccines
  - Adults 75+
  - Adults 60 – 74 at higher risk for severe illness and hospitalization
  - Got rid of shared decision-making
  - Abrysvo is also recommended for pregnant people 32 – 36 wks GA from Sept – Jan
  - When vaccinating nonpregnant adults, it should be done year-round (in contrast with pregnant people and babies only during RSV season)
  - Not affirmatively recommended for healthcare workers at this time unless they fall into another category

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# ACIP Polio

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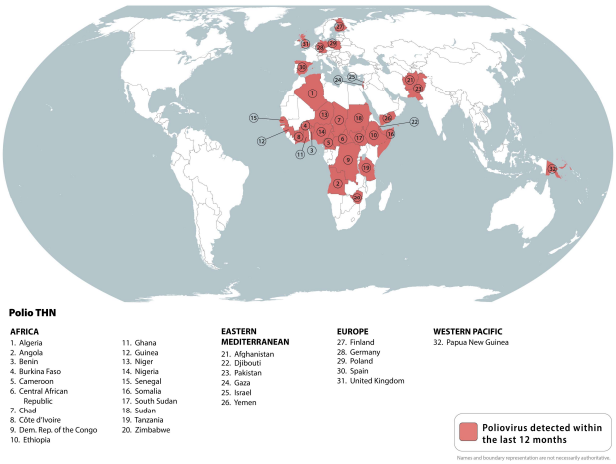
- Polio
  - New: Unvaccinated or partially vaccinated adults should complete primary series
    - Case of polio in 2022 in NY in an unvaccinated adult prompted this new recommendation
  - Unchanged: Fully vaccinated adults with exposure risk (travel to endemic area, etc) should get one booster
  - Current Implications – with the dissolution of USAID. Polio programs in many countries were discontinued and now seeing rising case numbers

https://www.cdc.gov/mmwr/volumes/72/wr/mm7249a3.htm

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# ACIP June 2024 Update

- **Pneumococcal Vaccines**
  - New availability of PCV21 (Merck Sharp & Dohme Corp.)
  - Don't forget PCV15 and PCV20 were approved in 2022.
  - PCV21 is interchangeable with PCV20, unless you are in the Western US where preference is PCV20 since it has serotype 4.
  - PCV13 is gone, and PPSV23 is really only used in conjunction with PCV15. Easiest is if you get either PCV20 or PCV21 on formulary.
  - Not affirmatively recommended for healthcare workers at this time unless they fall into another category

https://www.cdc.gov/mmwr/volumes/73/wr/mm7336a3.htm?s_cid=mm7336a3_w

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# ACIP June 2024 Update

**Adults ≥65 years old**
**Complete pneumococcal vaccine schedules**

| Prior vaccines | Option A | Option B |
|---|---|---|
| None* | PCV20 or PCV21 | PCV15 → ≥1 year† → PPSV23¶ |
| **PPSV23 only** at any age | ≥1 year → PCV20 or PCV21 | ≥1 year → PCV15 |
| **PCV13 only** at any age | ≥1 year → PCV20 or PCV21 | ≥1 year† → PPSV23 |
| **PCV13** at any age & **PPSV23** at <65 yrs | ≥5 years → PCV20 or PCV21 | ≥5 years§ → PPSV23 |

* Also applies to people who received PCV7 at any age and no other pneumococcal vaccines
¶ If PPSV23 is not available, PCV20 or PCV21 may be used
† Consider minimum interval (8 weeks) for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak (CSF) leak
§ For adults with an immunocompromising condition, cochlear implant, or CSF leak, the minimum interval for PPSV23 is ≥8 weeks since last PCV13 dose and ≥5 years since last PPSV23 dose; for others, the minimum interval for PPSV23 is ≥1 year since last PCV13 dose and ≥5 years since last PPSV23 dose

See CDC for guidelines on adults 19-64 with chronic conditions
https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf

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# Vaccines Indicated for Healthcare Personnel

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## HCP Vaccination Recommendations

| Vaccination | Recommendation |
|---|---|
| COVID-19 | Everyone 6 months+ should get one dose of newest formulation ***(came out Fall of 2025 but did require attestation from patient for underlying condition requiring it)*** |
| Hepatitis B | If no prior dose, either 2 doses of Heplisav-B or 3-dose series of either Engerix or Recombivax Obtain serology 1-2 months after final dose |
| Influenza | Give 1 dose annually |
| MMR | HCP born in 1957 or later need 2-doses of MMR, 4 weeks apart if no prior immunity or vaccination. Before 1957, consider serology testing and dosing if needed |
| Varicella | If no prior infection, serologic immunity, prior vaccination, give 2 doses of varicella vaccine 4 weeks apart |
| Tetanus, diphtheria, pertussis | Give 1 dose to all who have not received previously. Each pregnancy. Booster every 10 years (Td or Tdap) |
| Meningococcal | Routinely to microbiologists/Technicians exposed to isolates of *N. Meningitidis* |

https://www.cdc.gov/vaccines-adults/recommended-vaccines/index.html

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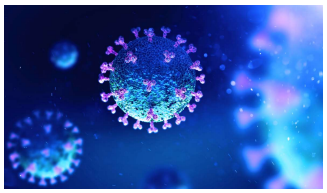
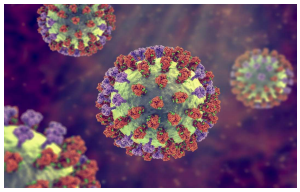
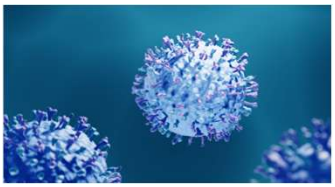
# COVID Vaccines

Is it not required anymore for healthcare personnel?

- The federal CMS regulation, which had required all HCPs to be covid vaccinated, has been retired. Individual hospitals, LTC companies, etc can decide to have it be an internal condition of employment if they wish. CMS no longer requires reporting of HCPs' vaccination rates.
- Yes, it is safe to receive COVID, flu and RSV shots at the same time!
- Make it as easy as possible for your staff and residents to get the latest COVID shots

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# Hepatitis B

- **Indications**
  - Universal; HCP with potential blood exposure (OSHA required offering OR signed refusal)
- **Administration**
  - Prior to administration do not routinely perform serologic screening for HB unless cost effective
  - After last dose in the series, test for immunity (>10 mIU/mL); if inadequate provide one more series and test again for immunity; if inadequate test consider as "non-responder"
  - If non-immune after two series, test for HBsAg

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# Hepatitis B

- HEPLISAV-B approved in late 2017
- Nonpregnant adults > 18 years of age
- Two doses one month apart
- Not studied in hemodialysis patients

**Table 7**
**Study 3: Seroprotection Rates of HEPLISAV-B and Engerix-B[a] (ages 18 - 70 years)**

| Age (years) | HEPLISAV-B[a] | | Engerix-B[a] | | Difference in SPRs (HEPLISAV-B minus Engerix-B) |
|---|---|---|---|---|---|
| | N | SPR (95% CI) | N | SPR (95% CI) | Difference (95% CI) |
| 18-29 | 174 | 100.0% (97.9, 100.0) | 99 | 93.9% (87.3, 97.7) | 6.1% (2.8, 12.6)* |
| 30-39 | 632 | 98.9% (97.7, 99.6) | 326 | 92.0% (88.5, 94.7) | 6.9% (4.2, 10.4)* |
| 40-49 | 974 | 97.2% (96.0, 98.2) | 518 | 84.2% (80.7, 87.2) | 13.1% (9.9, 16.6)* |
| 50-59 | 1439 | 95.2% (94.0, 96.3) | 758 | 79.7% (76.6, 82.5) | 15.5% (12.6, 18.7)* |
| 60-70 | 1157 | 91.6% (89.9, 93.1) | 588 | 72.6% (68.8, 76.2) | 19.0% (15.2, 23.0)* |

https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM584762.pdf

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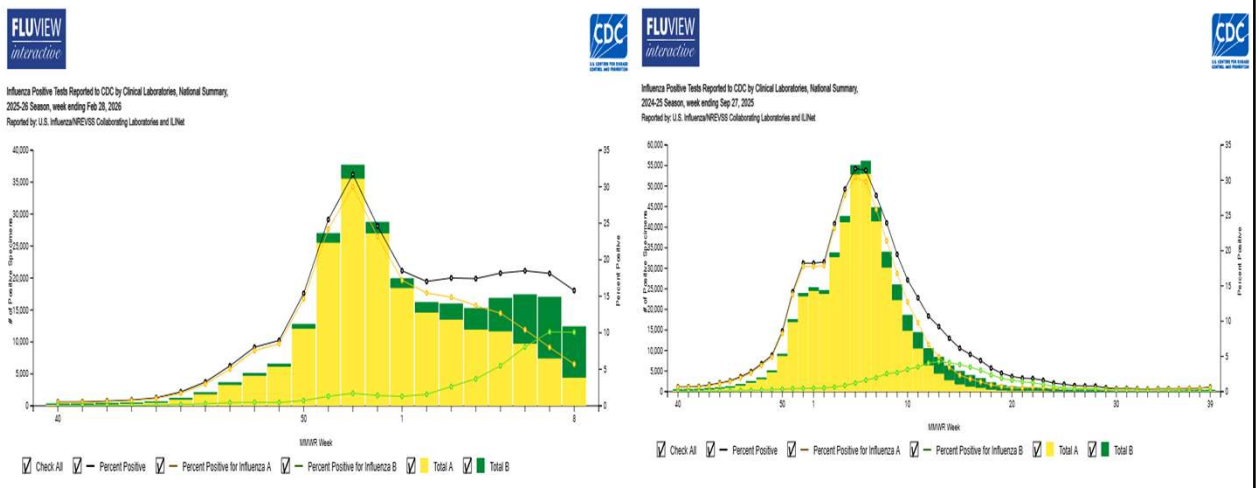
# Influenza Season 24-25 and current




Weekly U.S. Influenza Surveillance Report | CDC

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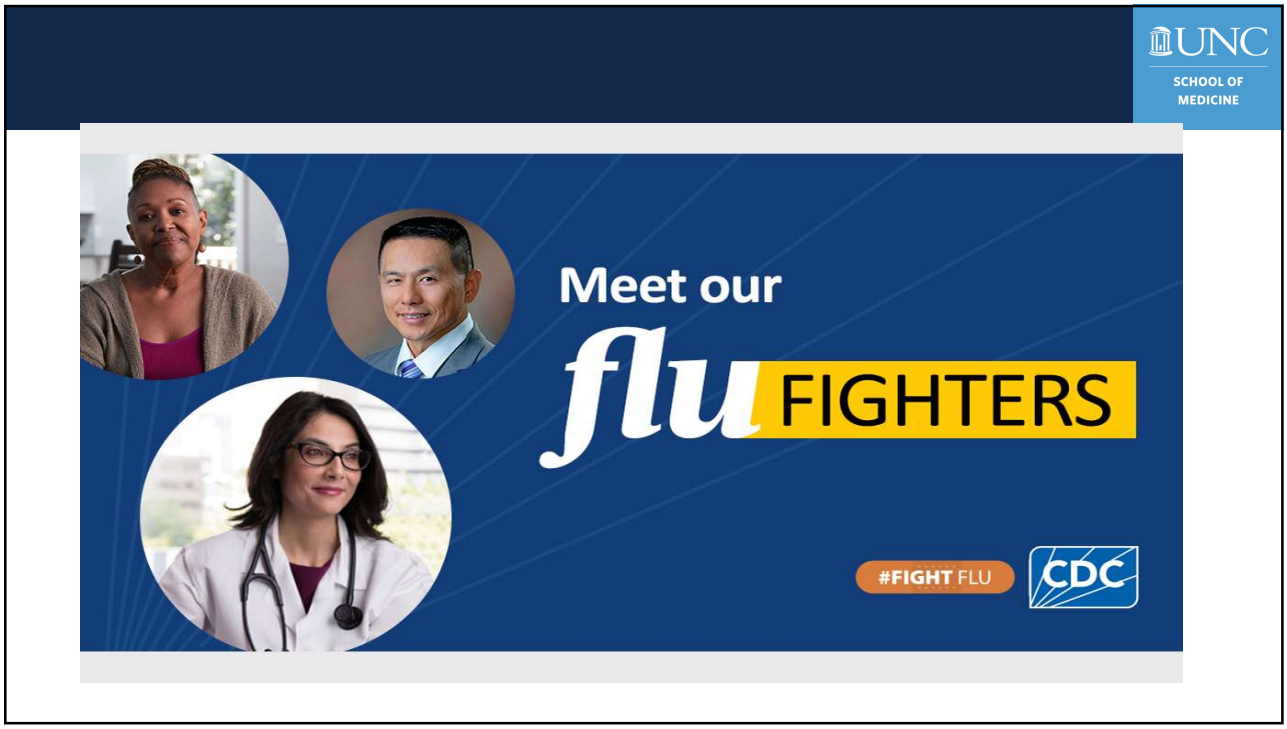
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Meet our
flu FIGHTERS
#FIGHT FLU
CDC

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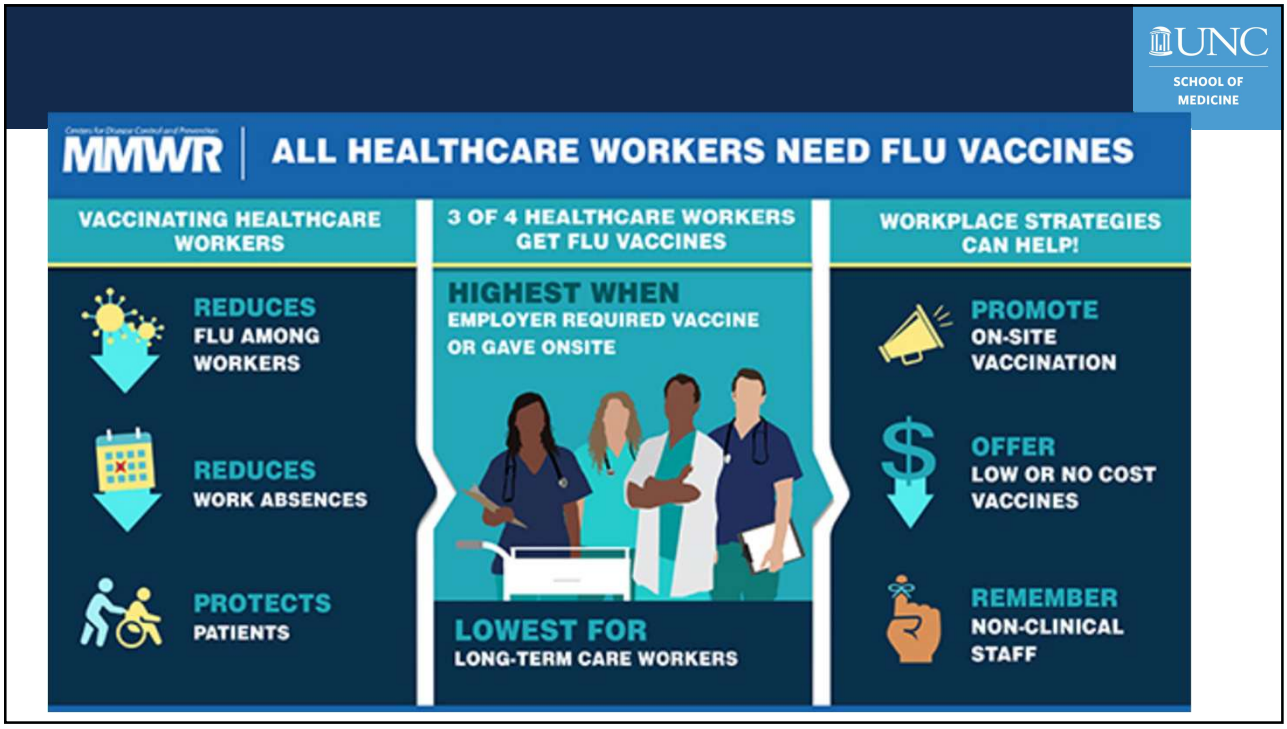
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MMWR
ALL HEALTHCARE WORKERS NEED FLU VACCINES
VACCINATING HEALTHCARE WORKERS
REDUCES FLU AMONG WORKERS
REDUCES WORK ABSENCES
PROTECTS PATIENTS
3 OF 4 HEALTHCARE WORKERS GET FLU VACCINES
HIGHEST WHEN EMPLOYER REQUIRED VACCINE OR GAVE ONSITE
LOWEST FOR LONG-TERM CARE WORKERS
WORKPLACE STRATEGIES CAN HELP!
PROMOTE ON-SITE VACCINATION
OFFER LOW OR NO COST VACCINES
REMEMBER NON-CLINICAL STAFF

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# Influenza vaccines

- ACIP recommendations
  - One annual dose for all persons ≥ 6 months of age (sometimes 2 doses for kids)
  - Required for residents and HCP in ECFs in NC (1 N.C. Gen. Stat. Ann. § 131E-113(a))
  - Required in SC LTC (S.C. Code Ann. Regs. 61-17)

https://www.cdc.gov/flu/pdf/professionals/acip/acip-2021-22-summary-of-recommendations-updated.pdf

Long-term-care-toolkit.pdf (cdc.gov)

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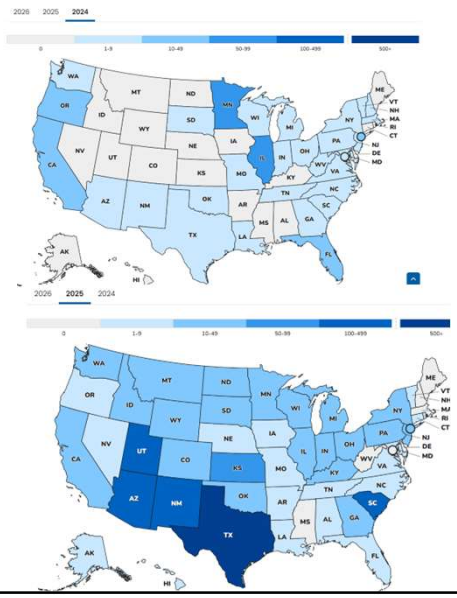
# Measles is back

U.S. Cases

| | 2026 To date | 2025 Full year |
|---|---|---|
| **Total Cases** | **1281** | **2283** |
| Age | | |
| Under 5 years | 291 (23%) | 584 (26%) |
| 5-19 years | 698 (54%) | 1014 (44%) |
| 20+ years | 286 (22%) | 672 (29%) |
| Age unknown | 6 (0%) | 13 (1%) |
| Vaccination Status | | |
| Unvaccinated or Unknown | 93% | 93% |
| One MMR dose | 4% | 3% |
| Two MMR doses | 4% | 4% |

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# Measles in NC


NC Measles Outbreaks

If you suspect a case of measles in your facility, call your local health department or NC Epi On Call 919-733-3419 IMMEDIATELY 24/7 (not days or hours later)

Highly contagious: 9 out of 10 susceptible ( not immune) people who are exposed will contract measles

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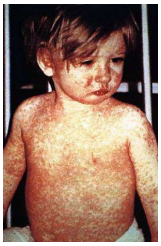
# Measles, Mumps, Rubella (MMR)

- **Measles**
  - Born before 1957: Consider immune (except during outbreak): Born after 1957: 2 doses
  - Immunity = Appropriate immunizations or positive serology
- **Mumps**
  - Born before 1957: Consider immune (except during outbreak): Born after 1957: 2 doses.
  - 3rd dose considered in outbreak settings.
  - Immunity = Appropriate immunizations or positive serology
- **Rubella**
  - 1 dose of MMR
  - Immunity = Appropriate immunizations or positive serology

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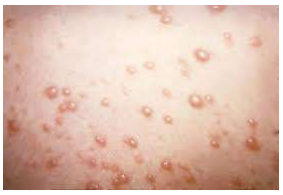
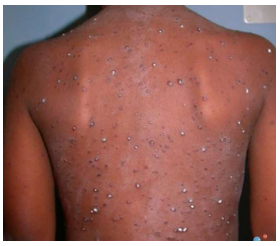
# Varicella

- **Special consideration should be given to those who have close contact with**
  - Persons at high risk for severe disease (e.g., immunocompromised persons)
  - Persons are at high risk for exposure or transmission (e.g., teachers of young children, college students, military recruits, international travelers)
- **Immunity**
  - 2 doses of vaccine (gold standard), positive serology. Could also accept history of varicella if lab confirmed or epi-linked, but verbal report "I had chicken pox as a kid" doesn't count.
  - Receiving Shingrix vaccine does not count as immunity for varicella





https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm

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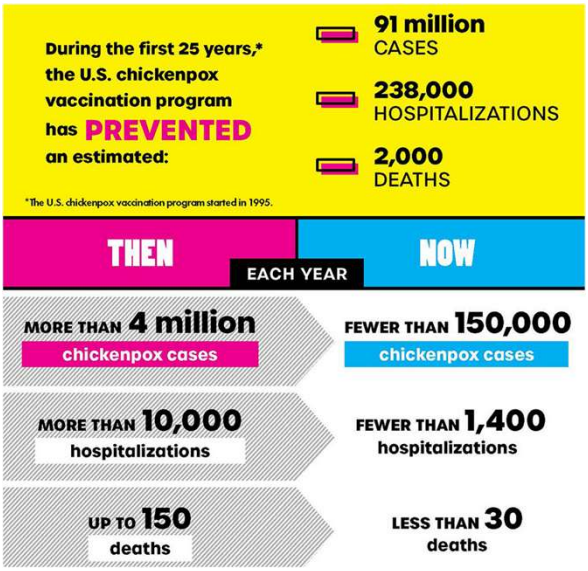
# Varicella

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## Tetanus-diphtheria-acellular pertussis (Tdap)

- **Substitute 1 dose Tdap for all adults when Td booster due if no history of Tdap.**
  - May be used to provide tetanus PEP
  - Provide to all adults with exposure to young children (no delay after Td)
  - Also recommended for pregnant people in each pregnancy (preferably 27-36 weeks gestational age)
  - Only one dose of Tdap is required, employees who are 10 years out from Tdap can be boosted with Td or Tdap (but preference is Tdap).

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## Meningococcal Vaccine

- Recommended for adults had high risk of disease (persistent complement deficiency, functional or anatomic asplenia, or HIV infection (adolescents)).
  - Two vaccines series are needed: MenACWY and Serogroup B (MenB)
- MenACWY
  - Immunosuppressed – 2 doses of MenACWY and boosters every 5 years, 2 or 3-dose MenB
  - **Microbiologists – 1 dose, booster every 5 years (MenACWY), 2 or 3-dose MenB**
    - **Now they could get the combo MenABCWY vaccine when both are indicated**
  - Anatomic/functional asplenia patients should be vaccinated against MenACWY/MenB

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# Tuberculosis Surveillance

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TAKE ON TB

**To eliminate tuberculosis (TB), we must prioritize groups at increased risk of TB**

**Living in congregate settings is a risk factor for TB disease:**


Homeless Shelters

Correctional Facilities

Long-term Care Facilities

**www.cdc.gov/tb**

CDC Centers for Disease Control and Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

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# Testing/ Treatment

- **Baseline (preplacement) screening and testing.** All U.S. healthcare personnel should have baseline TB screening, including an individual risk assessment, which is necessary for interpreting any test result. IGRAs (quant gold or T spot) or TB skin tests can be used. Follow CDC algorithm for interpretation.
- **Serial screening and testing for health care personnel without LTBI is NOT indicated.** In the absence of known exposure or evidence of ongoing TB transmission, U.S. healthcare personnel (as identified in the 2005 guidelines) without LTBI should not undergo routine serial TB screening or testing at any interval after baseline (e.g., annually.) Could consider annual screening with high-risk groups like respiratory therapists.
- **Healthcare personnel with LTBI and no prior treatment** should be offered, and strongly encouraged to complete treatment with a recommended regimen, including short-course treatments unless a contraindication exists

Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR Morb Mortal Wkly Rep 2019;68:439–443. DOI: http://dx.doi.org/10.15585/mmwr.mm6819a3external icon.

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# NC TB Policy Manual

- **SARS-CoV-2 Vaccine and TB testing**
  - TB screening with skin test or interferon gamma release assay may be performed regardless of timing of SARS-CoV-2 vaccination (and visa versa). – Jan 28 2021 memo
- **Patients in long term care facilities**
  - Testing upon admission (two-step TST or IGRA). Annual screening which can be accomplished by a verbal elicitation of symptoms.
    - 10A NCAC 41A .0205; 10A NCAC 13D .2202 &.2209
- **Long term care facility employees**
  - Testing upon employment (two-step for TST or IGRA) and after any exposures. Annual education & DFS regulations require an annual screening which can be accomplished by a verbal elicitation of symptoms.
    - 10A NCAC 41A .0205; 10A NCAC 13D .2202 & .2209; OSHA

https://epi.dph.ncdhhs.gov/cd/lhds/manuals/tb/COVIDvaxMemo01282021.pdf

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## Fit Testing

- If employees may need to wear respirators as part of their PPE (i.e. for caring for COVID patients), then they need to be annually fit tested through your respiratory protection program.
- Medical clearance for N95s is not complicated – there really aren't medical conditions which affirmatively preclude the use of an N95 except anatomical challenges.
- If someone can not be fit tested, do you have a plan for the alternative?

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## Bloodborne Pathogens

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# Bloodborne Pathogens

- Approximately 385,000 needle sticks and other sharps-related injuries to hospital-based healthcare personnel each year.
- 58 total known occupationally acquired HIV cases in HCPs; all but 1 were prior to 1999.
- 88% (50/57) of the documented cases of occupational HIV transmission from 1985-2004 involved a percutaneous exposure. Of those, 45/57 involved a hollow-borne needle.
- 41% of sharp injuries occur during use; 40% after use/before disposal; 15% during/after disposal

https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6353a4.htm

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# Steps for Prevention


- Needleless devices
- Single-hand recappin
- Handwashing station
- Sharps containers
- Laundry
- Disposal of contaminated material
- Mask, eye protection, gloves, & face shields
- ACCOUNTABILTY AND AUDITS

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## OSHA Bloodborne Pathogens Standard

- Employers must establish a written exposure control plan and provide annual training
- Mandates use of universal precautions (all body fluids assumed contaminated except sweat)
- Employers must utilize engineering and work practice controls to minimize/eliminate exposure

**(e-CFR 1910.1013)**

https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030

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## OSHA Bloodborne Pathogens Standard

- Requires offering hepatitis B vaccine to persons with the potential for exposure
- Testing of exposed employees for Hepatitis B and HIV
- Post-exposure prophylaxis must be immediately available as per CDC guidelines
- All work-related needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material are OSHA-reportable regardless of the source patient disease status.

OSHA Occupational Safety and Health Administration

**(e-CFR 1910.1013)**

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# Bloodborne Pathogens

- **Risk (percutaneous exposure)**
  - HBV
    - 22.0 – 30.0% ($HBeAG^+$)
    - 1.0 – 6.0% ($HBeAG^-$)
  - HCV
    - 1.8%
  - HIV
    - 0.3% (1 in 300)
- **Risk (mucous membrane)**
  - HBV
    - Yes (rate unknown)
  - HCV
    - Yes (rate unknown but very small)
  - HIV
    - 0.1% (1 in 1000)
    - < 0.1% (non-intact skin)

RISK

- Test source for hepatitis B (HBsAg), hepatitis C (HCV PCR), HIV (4th gen, HIV antibodies and p24 antigen)
- Provide hepatitis B prophylaxis, if indicated
- Provide follow-up for hepatitis C, if indicated
- If source HIV+ or at "high risk" for HIV, offer employee HIV prophylaxis per CDC protocol

CDC, 2003

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# Post-exposure Pathway

| Infection Status of Source Patient ↓ | Baseline Labs | 2 Weeks | 4 Weeks | 6 Weeks | 4 Months | 6 Months |
|---|---|---|---|---|---|---|
| DATE: → | __/__/____ | __/__/____ | __/__/____ | __/__/____ | __/__/____ | __/__/__ |
| **HIV positive** | HIV test – 4th generation | Lab - only if baseline abnormal or clinical indication | | HIV test - 4th generation | HIV test - 4th generation | |
| **HBsAg positive** | • If source positive and HCP unknown, need HBsAb.<br>• If HBsAb ≥12 mIU/mL - testing complete.<br>• If HBsAb <12 mIU/mL, need anti-HBc & HBsAg at baseline | | | | | • Anti-HBc<br>• HBsAg |
| **Hepatitis C RNA PCR positive** | Anti-HCV (Hepatitis C antibody) | Lab - only if baseline abnormal or clinical indication | | HCV RNA PCR | Anti-HCV (Hepatitis C antibody) | |
| **Unknown source** | • HIV test – 4th generation<br>• If source unknown and HCP HBsAb unknown, need HBsAb.<br>• If HBsAb ≥12 mIU/mL - testing complete.<br>• If HBsAb <12 mIU/mL, need anti-HBc & HbsAg at baseline<br>• HCV antibody | Lab - only if baseline abnormal or clinical indication | | • HIV test – 4th generation<br>• HCV RNA PCR | • HIV test – 4th generation<br>• Anti-HCV (Hepatitis C antibody) | • Anti-HBc<br>• HBsAg |

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# Current HIV PEP

- 10A NCAC 41A .0202
- CONTROL MEASURES – HIV
  - When the source case is known, the attending physician or occupational health provider responsible for the exposed person shall notify the healthcare provider of the source case that an exposure has occurred.
  - This healthcare provider shall arrange HIV testing of the source person (unless known to be HIV+) and notify the OHS provider of the test results.
  - Source patient consent is **not required**

http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2041%20-%20epidemiology%20health/subchapter%20a/10a%20ncac%2041a%20.0202.html

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# Current HIV PEP

- Three-drug regiment
  - Tenofovir-emtricitabine (Truvada) + raltegravir (Isentress) for 4 weeks (28 days)
  - Other regiments are available for known HIV-source patients with specific drug resistance but these cases are rare.
  - Start within 72 hours
  - Baseline HIV, 6 weeks, 4-6 months

  - Are there other drugs- YES – consider costs and compliance

Kuhar, D. T., Henderson, D. K., Struble, K. A., Heneine, W., Thomas, V., Cheever, L. W., Gomaa, A., Panlilio, A. L., & US Public Health Service Working Group. (2013). Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. *Infection Control and Hospital Epidemiology*, *34*(9), 875–892. https://doi.org/10.1086/672271

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# Hepatitis B

- Universal; HCP with potential blood exposure (OSHA required or HCP may decline)
  - No need to routinely obtain Hep B titers if an employee has documented vaccine series and a positive titer
  - In practice, we usually titer and give a booster if titer is < 10 mIU/mL
  - For known non-responders, with exposure they should get Hepatitis B Immune Globulin (HBIG) within 24 hours (up to 7 days after exposure)

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# Hepatitis B

| | HBsAg | Anti-HBc | HBsAb* |
|---|---|---|---|
| Acute infection | Positive | IgM positive | Negative |
| Infection resolved | Negative | IgG Positive | Positive |
| Chronic infection | Positive | IgG Positive | Negative |
| Vaccinated | Negative | Negative | Positive |
| Susceptible | Negative | Negative | Negative |

Otero, William, Parga, Julián, & Gastelbondo, Johanna. (2018). Serology of hepatitis B virus: multiple scenarios and multiple exams. *Revista colombiana de Gastroenterología*, 33(4), 411-422. https://doi.org/10.22516/25007440.327

https://www.cdc.gov/pinkbook/hcp/table-of-contents/index.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/pubs/pinkbook/hepb.html#Epidemiology

**Postexposure Management of Health Care Personnel after Occupational Exposure to Blood and Body Fluids, by Health Care Personnel HepB Vaccination and Response Status**

| HepB Vaccination and Response Status | Postexposure testing results for source patient (HBsAg) | Postexposure testing results for HCP (anti-HBs) | HBIG* postexposure prophylaxis | Vaccination postexposure prophylaxis | Postvaccination Serologic Testing† |
|---|---|---|---|---|---|
| Documented responder§ after complete series (3 or more doses) | No action needed | No action needed | No action needed | No action needed | No action needed |
| Documented nonresponder¶ after 2 complete series | Positive/ unknown | ** | 2 doses HBIG separated by 1 month | No action needed | No action needed |
| | Negative | No action needed | No action needed | No action needed | No action needed |
| Response unknown after a complete series | Positive/ unknown | less than 10 mIU/mL** | 1 dose HBIG | Initiate revaccination | Yes |
| | Negative | less than 10 mIU/mL | None | Initiate revaccination | Yes |
| | Any result | greater than or equal to 10 mIU/mL | No action needed | No action needed | No action needed |
| Unvaccinated/ incompletely vaccinated or vaccine refusers | Positive/ unknown | ** | 1 dose HBIG | Complete vaccination | Yes |
| | Negative | No action needed | None | Complete vaccination | Yes |

*HBIG should be administered intramuscularly as soon as possible after exposure when indicated. The effectiveness of HBIG when administered greater than 7 days after percutaneous, mucosal, or nonintact skin exposures is unknown. HBIG and HepB vaccine should be administered in separate anatomic injection sites.

†Should be performed 1 to 2 months after the last dose of the HepB vaccine series (and 4 to 6 months after administration of HBIG to avoid detection of passively administered anti-HBs) using a quantitative method that allows detection of the protective concentration of anti-HBs (greater than or equal to 10 mIU/mL).

§A responder is defined as a person with anti-HBs greater than or equal to 10 mIU/mL after 3 or more doses of HepB vaccine.

¶A nonresponder is defined as a person with anti-HBs less than 10 mIU/mL after 2 complete series of HepB vaccine.

**HCP who have anti-HBs less than 10 mIU/mL, or who are unvaccinated or incompletely vaccinated, and sustain an exposure to a source patient who is HBsAg-positive or has unknown HBsAg status, should undergo baseline testing for HBV infection as soon as possible after exposure and follow-up testing approximately 6 months later. Initial baseline tests consist of total anti-HBc; testing at approximately 6 months consists of HBsAg and total anti-HBc.

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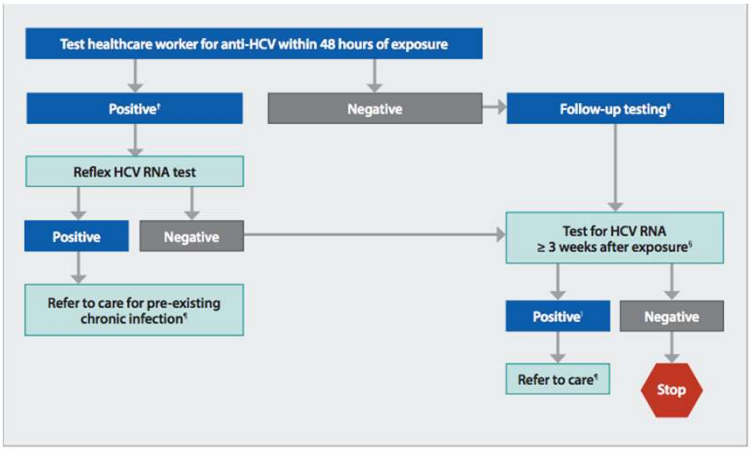
# Hepatitis C

- No post-exposure prophylaxis
- Source patients should be tested by Hep C PCR

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# Follow-up Testing

- Hepatitis B
  - Not required if employee has immunity
- HIV
  - Dependent on source patient and available testing
- Hepatitis C
  - Dependent on source patient, test for HCV antibodies and HCV RNA

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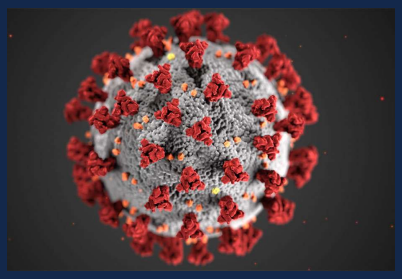
# Occupational Health and COVID



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## COVID Presentations- How do we track?

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### Early Indicators

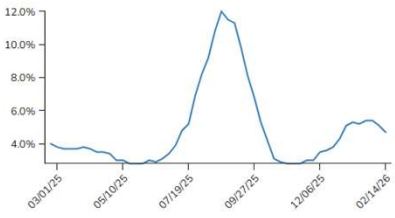
Test positivity (the percentage of total reported tests that are positive) and the percentage of total emergency department visits due to COVID-19 are key metrics to assess the impact of COVID-19 on communities. For public health professionals, these metrics act as early indicators of potential increases in COVID-19 activity.

% Test Positivity

4.7%

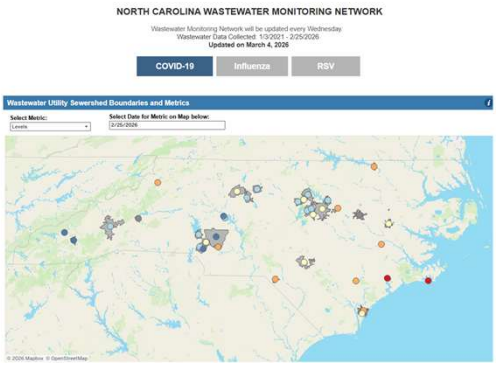
Week ending 2026-02-14

Previous Week 5.1%




These early indicators represent a portion of national COVID-19 tests and emergency department visits. Wastewater information also provides early indicators of spread.

Note the trends for COVID 19- trending during Summer months




https://covid.cdc.gov/covid-data-tracker/#datatracker-home

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# COVID Control Recommendations

**Updated June 24 2024**

- Encourage all employees to remain up to date on COVID-19 vaccines, including provision of resources
- Establish a process to identify and manage individuals with suspected or confirmed COVID
- Implement source control measures (changed from earlier recommendations)
- Implement universal use of personal protective equipment for HCP
- Optimize use of engineering controls and indoor air quality
- Perform SARS-CoV-2 viral testing
- Create a process to respond to COVID exposures among HCP and others

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

https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

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# COVID Control Recommendations (In Flux)

- Establish a process to identify and manage individuals with suspected or confirmed COVID
  - For HCPs, they should report any of the following three criteria to your Occupational Health:
    - Positive test for COVID
    - Symptoms of COVID
      - HCPs with even mild symptoms need a test!
      - Positive antigen test (like a home test) is sufficient; no need to retest with PCR
      - Negative antigen test is NOT sufficient and needs confirmatory PCR
      - Don't forget about flu and RSV!
      - Should not be working until at least 24 hrs without fever of any cause off antipyretics
    - Close contact to COVID

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

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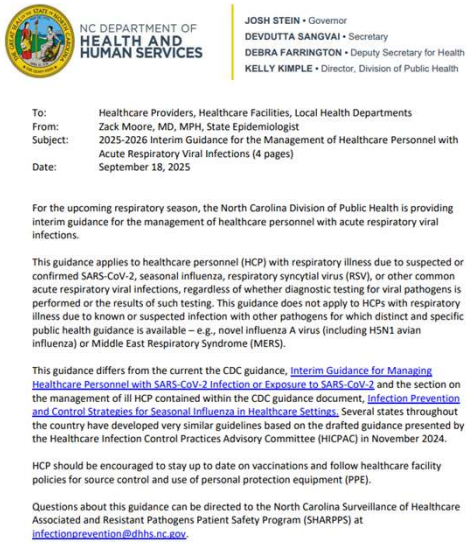
# COVID-19+ HCP Return to Work CHANGE



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
DEBRA FARRINGTON • Deputy Secretary for Health
KELLY KIMPLE • Director, Division of Public Health

To: Healthcare Providers, Healthcare Facilities, Local Health Departments
From: Zack Moore, MD, MPH, State Epidemiologist
Subject: 2025-2026 Interim Guidance for the Management of Healthcare Personnel with Acute Respiratory Viral Infections (4 pages)
Date: September 18, 2025

For the upcoming respiratory season, the North Carolina Division of Public Health is providing interim guidance for the management of healthcare personnel with acute respiratory viral infections.

This guidance applies to healthcare personnel (HCP) with respiratory illness due to suspected or confirmed SARS-CoV-2, seasonal influenza, respiratory syncytial virus (RSV), or other common acute respiratory viral infections, regardless of whether diagnostic testing for viral pathogens is performed or the results of such testing. This guidance does not apply to HCPs with respiratory illness due to known or suspected infection with other pathogens for which distinct and specific public health guidance is available – e.g., novel influenza A virus (including H5N1 avian influenza) or Middle East Respiratory Syndrome (MERS).

This guidance differs from the current the CDC guidance, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 and the section on the management of ill HCP contained within the CDC guidance document, Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings. Several states throughout the country have developed very similar guidelines based on the drafted guidance presented by the Healthcare Infection Control Practices Advisory Committee (HICPAC) in November 2024.

HCP should be encouraged to stay up to date on vaccinations and follow healthcare facility policies for source control and use of personal protection equipment (PPE).

Questions about this guidance can be directed to the North Carolina Surveillance of Healthcare Associated and Resistant Pathogens Patient Safety Program (SHARPPS) at infectionprevention@dhhs.nc.gov.

"This guidance applies to all healthcare settings; however, it does not apply to nursing homes regulated under the NC Division of Health Service Regulation (DHSR) Nursing Home Licensure and Certification Section. These facilities are still required to develop and implement policies and procedures that are in line with currently posted CDC guidance."

NC DHSR Nursing Home Guidance

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# Asymptomatic HCPs w COVID exposures

- For asymptomatic HCP who have a known or suspected exposure to a respiratory virus:
- • Work restrictions are not necessary.
- • HCP should wear source control from the day of first exposure through the 5th day after
- last exposure.***
- • HCP should monitor for development of signs or symptoms of a viral respiratory
- infection for 5 days after their last exposure.
- o Any HCP who develops mild signs or symptoms of a viral respiratory infection
- should follow guidance as described in the "Mild Suspected or Confirmed
- Infection" section above.
- ***Where day 0 is the day of last exposure.

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# Respiratory Illnesses on the Rise

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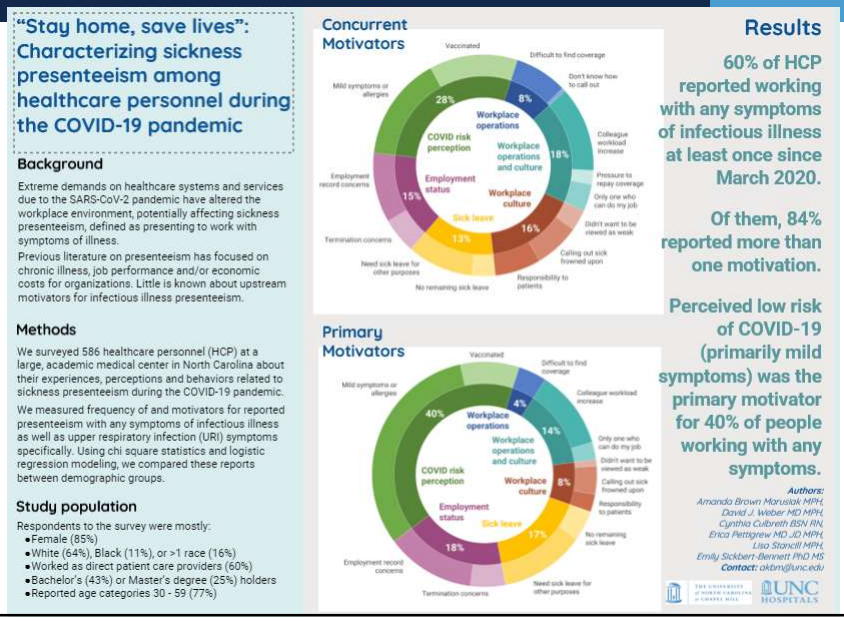
- Presenteeism is a major threat to patient and employee health



"Stay home, save lives": Characterizing sickness presenteeism among healthcare personnel during the COVID-19 pandemic

**Background**

Extreme demands on healthcare systems and services due to the SARS-CoV-2 pandemic have altered the workplace environment, potentially affecting sickness presenteeism, defined as presenting to work with symptoms of illness.

Previous literature on presenteeism has focused on chronic illness, job performance and/or economic costs for organizations. Little is known about upstream motivators for infectious illness presenteeism.

**Methods**

We surveyed 586 healthcare personnel (HCP) at a large, academic medical center in North Carolina about their experiences, perceptions and behaviors related to sickness presenteeism during the COVID-19 pandemic.

We measured frequency of and motivators for reported presenteeism with any symptoms of infectious illness as well as upper respiratory infection (URI) symptoms specifically. Using chi square statistics and logistic regression modeling, we compared these reports between demographic groups.

**Study population**

Respondents to the survey were mostly:
- Female (85%)
- White (64%), Black (11%), or >1 race (16%)
- Worked as direct patient care providers (60%)
- Bachelor's (43%) or Master's degree (25%) holders
- Reported age categories 30 - 59 (77%)

Concurrent Motivators



Primary Motivators



**Results**

60% of HCP reported working with any symptoms of infectious illness at least once since March 2020.

Of them, 84% reported more than one motivation.

Perceived low risk of COVID-19 (primarily mild symptoms) was the primary motivator for 40% of people working with any symptoms.

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UNC HOSPITALS

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# Employee Well-being

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- Could be its own lecture
- Taking good care of employees benefits all: patients, employees, and the business (safer environment, lower turnover, less staffing shortages)
- Physical and mental well-being
  - Living wages and robust benefits
  - Parental leave
  - Comprehensive DEI (diversity, equity, and inclusion) trainings and meaningful reflections in workplace policies/practices, not just lip service
  - Safety from workplace violence
  - Fair PTO policies that disincentivize presenteeism
  - Access to resources for burnout, moral injury

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## Employee Well-being – do they know what to do?

- In the Occupational Health arena- fear comes into play…
- How are you educating and addressing next steps for employee health?

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# Thank You!

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