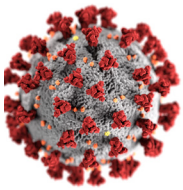
What you should know about COVID-19 to protect yourself and others



Know about COVID-19

- Coronavirus (COVID-19) is an illness caused by a virus that can spread from person to person.
- The virus that causes COVID-19 is a new coronavirus that has spread throughout the world.
- COVID-19 symptoms can range from mild (or no symptoms) to severe illness.

Know how COVID-19 is spread

- You can become infected by coming into close contact (about 6 feet or two arm lengths) with a person who has COVID-19. COVID-19 is primarily spread from person to person.
- You can become infected from respiratory droplets when an infected person coughs, sneezes, or talks.
- You may also be able to get it by touching a surface or object that has the virus on it, and then by touching your mouth, nose, or eyes.

Protect yourself and others from COVID-19

- There is currently no vaccine to protect against COVID-19. The best way to protect yourself is to avoid being exposed to the virus that causes COVID-19.
- Stay home as much as possible and avoid close contact with others.
- Wear a cloth face covering that covers your nose and mouth in public settings.
- Clean and disinfect frequently touched surfaces.
- Wash your hands often with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer that contains at least 60% alcohol.

Practice social distancing

- Buy groceries and medicine, go to the doctor, and complete banking activities online when possible.
- If you must go in person, stay at least 6 feet away from others and disinfect items you must touch.
- Get deliveries and takeout, and limit in-person contact as much as possible.

Prevent the spread of COVID-19 if you are sick

- Stay home if you are sick, except to get medical care.
- Avoid public transportation, ride-sharing, or taxis.
- Separate yourself from other people and pets in your home.
- There is no specific treatment for COVID-19, but you can seek medical care to help relieve your symptoms.
- If you need medical attention, call ahead.

Know your risk for severe illness

- Everyone is at risk of getting COVID-19.
- Older adults and people of any age who have serious underlying medical conditions may be at higher risk for more severe illness.

cdc.gov/coronavirus

CS 314937A 06/01/2020

10 things you can do to manage your COVID-19 symptoms at home

Accessible Version: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html

If you have possible or confirmed COVID-19:

1. **Stay home** from work and school. And stay away from other public places. If you must go out, avoid using any kind of public transportation, ridesharing, or taxis.

2. **Monitor your symptoms** carefully. If your symptoms get worse, call your healthcare provider immediately.

3. **Get rest and stay hydrated.**

4. If you have a medical appointment, **call the healthcare provider** ahead of time and tell them that you have or may have COVID-19.

5. For medical emergencies, call 911 and **notify the dispatch personnel** that you have or may have COVID-19.

6. **Cover your cough and sneezes.**

7. **Wash your hands often** with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.

8. As much as possible, **stay** in a specific room and **away from other people** in your home. Also, you should use a separate bathroom, if available. If you need to be around other people in or outside of the home, wear a cloth face covering.

9. **Avoid sharing personal items** with other people in your household, like dishes, towels, and bedding.

10. **Clean all surfaces** that are touched often, like counters, tabletops, and doorknobs. Use household cleaning sprays or wipes according to the label instructions.

cdc.gov/coronavirus

CS 315822-A 05/11/2020

Prevent the spread of COVID-19 if you are sick

Accessible version: https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html

If you are sick with COVID-19 or think you might have COVID-19, follow the steps below to care for yourself and to help protect other people in your home and community.

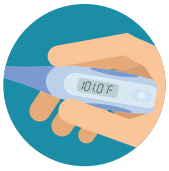
Stay home except to get medical care.

- **Stay home.** Most people with COVID-19 have mild illness and are able to recover at home without medical care. Do not leave your home, except to get medical care. Do not visit public areas.
- **Take care of yourself.** Get rest and stay hydrated. Take over-the-counter medicines, such as acetaminophen, to help you feel better.
- **Stay in touch with your doctor.** Call before you get medical care. Be sure to get care if you have trouble breathing, or have any other emergency warning signs, or if you think it is an emergency.
- **Avoid public transportation,** ride-sharing, or taxis.

Separate yourself from other people and pets in your home.

- **As much as possible, stay in a specific room** and away from other people and pets in your home. Also, you should use a separate bathroom, if available. If you need to be around other people or animals in or outside of the home, wear a cloth face covering.
  - See **COVID-19 and Animals if you have questions about pets:** https://www.cdc.gov/coronavirus/2019-ncov/faq.html#COVID19animals
  - Additional guidance is available for those **living in close quarters.** (https://www.cdc.gov/coronavirus/2019-hj ncov/daily-life-coping/living-in-close-quarters.html) and **shared housing** (https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/shared-housing/index.html).

Monitor your symptoms.



- **Symptoms of COVID-19 include fever, cough, and shortness of breath but other symptoms may be present as well.**
- **Follow care instructions from your healthcare provider and local health department.** Your local health authorities will give instructions on checking your symptoms and reporting information.

When to Seek Emergency Medical Attention

Look for **emergency warning signs*** for COVID-19. If someone is showing any of these signs, **seek emergency medical care immediately:**

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Bluish lips or face
- Inability to wake or stay awake

*This list is not all possible symptoms. Please call your medical provider for any other symptoms that are severe or concerning to you.

Call 911 or call ahead to your local emergency facility: Notify the operator that you are seeking care for someone who has or may have COVID-19.

Call ahead before visiting your doctor.

- **Call ahead.** Many medical visits for routine care are being postponed or done by phone or telemedicine.
- **If you have a medical appointment that cannot be postponed, call your doctor's office,** and tell them you have or may have COVID-19.

If you are sick, wear a cloth covering over your nose and mouth.

- **You should wear a cloth face covering over your nose and mouth** if you must be around other people or animals, including pets (even at home).
- You don't need to wear the cloth face covering if you are alone. If you can't put on a cloth face covering (because of trouble breathing for example), cover your coughs and sneezes in some other way. Try to stay at least 6 feet away from other people. This will help protect the people around you.
- Cloth face coverings should not be placed on young children under age 2 years, anyone who has trouble breathing, or anyone who is not able to remove the covering without help.

Note: During the COVID-19 pandemic, medical grade facemasks are reserved for healthcare workers and some first responders. You may need to make a cloth face covering using a scarf or bandana.

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CS 316120-A 06/11/2020

Cover your coughs and sneezes.

- **Cover your mouth and nose** with a tissue when you cough or sneeze.
- **Throw used tissues** in a lined trash can.
- **Immediately wash your hands** with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.

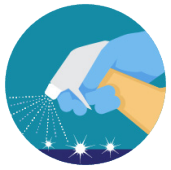
Clean your hands often.

- **Wash your hands often** with soap and water for at least 20 seconds. This is especially important after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- **Use hand sanitizer** if soap and water are not available. Use an alcohol-based hand sanitizer with at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- **Soap and water are the best option**, especially if your hands are visibly dirty.
- **Avoid touching** your eyes, nose, and mouth with unwashed hands.

Avoid sharing personal household items.

- **Do not share** dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people in your home.
- **Wash these items thoroughly after using them** with soap and water or put them in the dishwasher.

Clean all "high-touch" surfaces everyday.



- **Clean and disinfect** high-touch surfaces in your "sick room" and bathroom. Let someone else clean and disinfect surfaces in common areas, but not your bedroom and bathroom.
- **If a caregiver or other person needs to clean and disinfect** a sick person's bedroom or bathroom, they should do so on an as-needed basis. The caregiver/other person should wear a cloth face covering and wait as long as possible after the sick person has used the bathroom.

High-touch surfaces include phones, remote controls, counters, tabletops, doorknobs, bathroom fixtures, toilets, keyboards, tablets, and bedside tables.

- **Clean and disinfect areas that may have blood, stool, or body fluids on them.**
- **Use household cleaners and disinfectants.** Clean the area or item with soap and water or another detergent if it is dirty. Then use a household disinfectant.
  - Be sure to follow the instructions on the label to ensure safe and effective use of the product. Many products recommend keeping the surface wet for several minutes to ensure germs are killed. Many also recommend precautions such as wearing gloves and making sure you have good ventilation during use of the product.
  - Most EPA-registered household disinfectants should be effective.

When you can be around others after you had or likely had COVID-19

When you can be around others (end home isolation) depends on different factors for different situations.

- I **think or know I had COVID-19, and I had symptoms**
  - You can be with others after
    - 3 days with no fever

      AND
    - symptoms improved

      AND
    - 10 days since symptoms first appeared
  - Depending on your healthcare provider's advice and availability of testing, you might get tested to see if you still have COVID-19. If you will be tested, you can be around others when you have no fever, symptoms have improved, and you receive two negative test results in a row, at least 24 hours apart.
- **I tested positive for COVID-19 but had no symptoms**
  - If you continue to have no symptoms, you can be with others after:
    - 10 days have passed since test
  - Depending on your healthcare provider's advice and availability of testing, you might get tested to see if you still have COVID-19. If you will be tested, you can be around others after you receive two negative test results in a row, at least 24 hours apart.
  - If you develop symptoms after testing positive, follow the guidance above for "I think or know I had COVID, and I had symptoms."

COVID-19 Checklist

Ohio Department of Health

COVID-19 Checklist for Long-Term Care Facilities

Protecting Against COVID-19

Ohio Department of Health Director Amy Acton, M.D., MPH, is ordering all long-term care facilities in the state to notify residents and their families within 24 hours of a resident or staff member being diagnosed with COVID-19.
The state will provide an online list of long-term care facilities where someone has tested positive for the virus that causes the disease.

Dr. Acton also has ordered that all long-term care facilities suspend visitation.
The order:

- Provides exceptions for visitors of residents in end-of-life care, hospice employees, and clergy members.
- Allows access only to personnel who are necessary for the operation of facilities (such as staff, contracted and emergency healthcare providers, contractors conducting critical on-site maintenance, and governmental representatives and regulators and their contractors).
- Requires facilities to keep a log of all people who are granted access.

Centers for Medicare & Medicaid Services (CMS) guidance states that nursing homes should continue to admit residents they would normally admit, including residents who have been hospitalized, following the best practice of isolation to the extent possible for 14 days while monitoring for COVID-19 symptoms.

A nursing home can accept a resident diagnosed with COVID-19 and still under precaution as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot, it must wait until precautions are discontinued.

Dr. Acton also strongly recommends that all long-term care facilities immediately take the following actions:

☑ To reduce feelings of isolation, use telephone calls, videoconferencing, and other methods to connect residents with family and other former visitors. Consider having a communal laptop that residents can use for video chatting; disinfect between uses.

☑ Ask sick employees to stay home. Screen employees at the start of their shifts and

send home anyone who has signs or symptoms of COVID-19. Develop sick leave policies that allow employees to stay home if they have symptoms or a respiratory infection.

- ☑ Encourage good cough etiquette and hand hygiene. Retrain staff and residents on hand-washing and cough etiquette. Ensure staff wash their hands before and after every interaction with each resident. Consider posting visual reminders of proper hand-washing and cough etiquette. Place alcohol-based sanitizer both inside and outside of patient rooms, and make sure tissues are available.
- ☑ Cancel all group activities and communal dining.
- ☑ Remind residents to practice social distancing by staying 6 feet away from others whenever possible.
- ☑ At least once a day, screen residents for fever and respiratory symptoms, such as cough or shortness of breath.
- ☑ Separate ill residents to limit spread of disease. Separate residents with respiratory symptoms from other residents; however, do not allow residents with symptoms to interact unless the cause of their illness is confirmed to be the same.
- ☑ Use a consistent-assignment staffing model to reduce the number of different caregivers each resident encounters.
- ☑ Increase the frequency of cleaning, especially of shared surfaces, with EPA-registered hospital-grade disinfectants. Limit sharing of medical equipment.
- ☑ Also review Emergency Preparedness in Long-Term Care Facilities.

For additional information, visit coronavirus.ohio.gov.

For answers to your COVID-19 questions, call 1-833-4ASKODH (1-833-427-5634).

Additional resources:

- CDC COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#interim-guidance.
- CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html.
- CDC Strategies to Prevent COVID-19 Spread in LTCF: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-

facilities/prevent-spread-in-long-term-care-facilities.html.

- Health Care Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html.

For more information, visit: coronavirus.ohio.gov

Preparing for COVID-19 in Nursing Homes

Updated June 25, 2020

Print

Summary of Changes to the Guidance:

- **Tiered recommendations to address nursing homes in different phases of COVID-19 response**
- **Added a recommendation to assign an individual to manage the facility's infection control program**
- **Added guidance about new requirements for nursing homes to report to the National Healthcare Safety Network (NHSN)**
- **Added a recommendation to create a plan for testing residents and healthcare personnel for SARS-CoV-2**

Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including multidrug-resistant organisms (e.g., Carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP).

Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices.

The Centers for Medicare and Medicaid Services (CMS) recently issued Nursing Home Reopening Guidance for State and Local Officials that outlines criteria that could be used to determine when nursing homes could relax restrictions on visitation and group activities and when such restrictions should be reimplemented. Nursing homes should consider the current situation in their facility and community and refer to that guidance as well as direction from state and local officials when making decisions about relaxing restrictions. When relaxing any restrictions, nursing homes must **remain vigilant for COVID-19 among residents and HCP in order to prevent spread and protect residents and HCP** from severe infections, hospitalizations, and death.

This guidance has been updated and reorganized according to **core IPC practices** that should remain in place even as nursing homes resume normal practices, plus **additional strategies** depending on the stages described in the CMS Reopening Guidance or at the direction of state and local officials. This guidance is based on currently available information about COVID-19 and will be refined and updated as more information becomes available.

These recommendations supplement the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings and are specific for nursing homes, including skilled nursing facilities.

Additional Key Resources:

- Considerations for the Public Health Response to COVID-19 in Nursing Homes
- Interim Testing in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel
- Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes
- Considerations for Memory Care Units in Long-Term Care Facilities
- Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

Core Practices

These practices should remain in place even as nursing homes resume normal activities.

Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program.

- This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment.
- CDC has created an online training course that can be used to orient individuals to this role in nursing homes.

Report COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module weekly.

- CDC's NHSN provides long-term care facilities with a customized system to track infections and prevention process measures in a systematic way. Nursing homes can report into the four pathways of the LTCF COVID-19 Module including:
  - Resident impact and facility capacity
  - Staff and personnel impact
  - Supplies and personal protective equipment
  - Ventilator capacity and supplies
- Weekly data submission to NHSN will meet the CMS COVID-19 reporting requirements.

Educate Residents, Healthcare Personnel, and Visitors about COVID-19, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves.

- Provide information about COVID-19 (including information about signs and symptoms) and strategies for managing stress and anxiety.
- Regularly review CDC's Infection Control Guidance for Healthcare Professionals about COVID-19 for current information and ensure staff and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility. Including consultants is important, since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of COVID-19.
  - Reinforce sick leave policies, and **remind HCP not to report to work when ill.**

    - Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.
        - CDC has created training modules for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
    - Educate HCP about any new policies or procedures.
- Educate residents and families on topics including information about COVID-19, actions the facility is taking to protect them and/or their loved ones, any visitor restrictions that are in place, and actions residents and families should take to protect themselves in the facility, emphasizing the importance of hand hygiene and source control.
- Have a plan and mechanism to regularly communicate with residents, families and HCP, including if cases of COVID-19 are identified among residents or HCP.

Implement Source Control Measures.

- HCP should wear a facemask at all times while they are in the facility.
    - When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. **Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required.**
- Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above cloth face coverings should not be placed on children under 2.
- Visitors, if permitted into the facility, should wear a cloth face covering while in the facility.

Have a Plan for Visitor Restrictions.

- Send letters or emails to families reminding them not to visit when ill or if they have a known exposure to someone with COVID-19.
- Facilitate and encourage alternative methods for visitation (e.g., video conferencing) and communication with the resident

- Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry.
    - Screen visitors for fever (T≥100.0ºF), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility.
- Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.
- Have a plan for when the facility will implement additional restrictions, ranging from limiting the number of visitors and allowing visitation only during select hours or in select locations to restricting all visitors, except for compassionate care reasons (see below).

Create a Plan for Testing Residents and Healthcare Personnel for SARS-CoV-2.

- Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as viral testing or test) among residents and HCP in nursing homes.
- The plan should align with state and federal requirements for testing residents and HCP for SARS-CoV-2 and address:

    - Triggers for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, response to a resident or HCP with COVID-19 in the facility, routine surveillance)
    - Access to tests capable of detecting the virus (e.g., polymerase chain reaction) and an arrangement with laboratories to process tests
        - Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection and should not be used to inform IPC action.
    - Process for and capacity to perform SARS-CoV-2 testing of all residents and HCP
    - A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until symptom-based criteria are met for a symptomatic resident who refuses testing)
- Additional information about testing of residents and HCP is available:
    - CDC Strategy for COVID-19 Testing Nursing Homes.
    - Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Evaluate and Manage Healthcare Personnel.

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Create an inventory of all volunteers and personnel who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
- As part of routine practice, ask HCP (including consultant personnel and ancillary staff such as environmental and dietary services) to regularly monitor themselves for fever and symptoms consistent with COVID-19.
    - Remind HCP to stay home when they are ill.
    - If HCP develop fever (T≥100.0ºF) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace. Have a plan for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers).
    - HCP with suspected COVID-19 should be prioritized for testing.
- Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.
    - **Actively take their temperature*** and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
    - *Fever is either measured temperature >100.0ºF or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations.
    - HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.
- Develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
    - CDC has created guidance to assist facilities with mitigating staffing shortages.
    - For guidance on when HCP with suspected or confirmed COVID-19 may return to work, refer to Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)

Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices.

- Hand Hygiene Supplies:
    - Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). Unless hands are visibly soiled, an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations.
    - Make sure that sinks are well-stocked with soap and paper towels for handwashing.

- Respiratory Hygiene and Cough Etiquette:
  - Make tissues and trash cans available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
- Personal Protective Equipment (PPE):
  - Perform and maintain an inventory of PPE in the facility.
    - Identify health department or healthcare coalition contacts for getting assistance during PPE shortages. The Supplies and Personal Protective Equipment pathway in the NHSN LTCF COVID-19 Module can be used to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of PPE conservation strategies).
    - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.
  - Make necessary PPE available in areas where resident care is provided.
    - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.
    - Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
  - Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
  - Implement strategies to optimize current PPE supply ***even before shortages occur***, including bundling resident care and treatment activities to minimize entries into resident rooms. Additional strategies might include:
    - Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
      - Care must be taken to **avoid touching the respirator, facemask, or eye protection**. If this must occur (e.g., to adjust or reposition PPE), HCP should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others.
    - Prioritizing gowns for activities where splashes and sprays are anticipated (including aerosol-generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP.
      - **If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., *Clostridioides difficile*)**
    - Implement a process for decontamination and reuse of PPE such as face shields and goggles.
    - Facilities should continue to assess PPE supply and current situation to determine when a return to standard practices can be considered.
  - Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
  - Environmental Cleaning and Disinfection:
    - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas;
    - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
      - Use an EPA-registered disinfectant from List N on the EPA website to disinfect surfaces that might be contaminated with SARS-CoV-2. Ensure HCP are appropriately trained on its use.

Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19.

- Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
    - Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive).
    - Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. **Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated.**
- Have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them).
- Additional information about cohorting residents and establishing a designated COVID-19 care unit is available in the Considerations for the Public Health Response to COVID-19 in Nursing Homes

Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown.

- Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected.

Evaluate and Manage Residents with Symptoms of COVID-19.

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever (T≥100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below.
    - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
    - Contact information for the healthcare-associated infections program in each state health department is available here: https://www.cdc.gov/hai/state-based/index.html
    - Refer to CDC resources for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of patients with COVID-19 is described in the Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19). CDC has also developed guidance on Evaluating and Reporting Persons Under Investigation (PUI).
- **If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community,** follow the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed

Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. **This guidance should be implemented immediately once COVID-19 is suspected**

- Residents with suspected COVID-19 should be prioritized for testing.
- Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
  - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
  - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
- Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. **Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.**
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
  - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms.
- If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation**. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer**.
  - While awaiting transfer, residents should be separated from others (e.g., in a private room with the door closed) and should wear a cloth face covering or facemask (if tolerated) when others are in the room and during transport.
  - All recommended PPE should be used by healthcare personnel when coming in contact with the resident.
- Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is newly identified in the facility; this could also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.
- For decisions on removing residents who have had COVID-19 from Transmission-Based Precautions refer to the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

Additional Strategies Depending on the Facility's Reopening Status

These strategies will depend on the stages described in the CMS Reopening Guidance or the direction of state and local officials.

Implement Social Distancing Measures

- Implement aggressive social distancing measures (remaining at least 6 feet apart from others):
  - Cancel communal dining and group activities, such as internal and external activities.
  - Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene.
  - Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas.
- Considerations when restrictions are being relaxed include:

- Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate.
- Allowing for safe, socially distanced outdoor excursions for residents without COVID-19, including those who have fully recovered. Planning for such excursions should address:
  - Use of cloth face covering for residents and facemask by staff (for source control) while they are outside
  - Potential need for additional PPE by staff accompanying residents
  - Rotating schedule to ensure all residents will have an opportunity if desired, but that does not fully disrupt other resident care activities by staff
  - Defining times for outdoor activities so families could plan around the opportunity to see their loved ones

Implement Visitor Restrictions

- Restrict all visitation to their facilities except for certain compassionate care reasons, such as end-of-life situations.
  - Send letters or emails to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations.
  - Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.
  - Post signs at the entrances to the facility advising that no visitors may enter the facility.
  - Decisions about visitation for compassionate care situations should be made on a case-by-case basis, which should include careful screening of the visitor for fever or symptoms consistent with COVID-19. Those with symptoms should not be permitted to enter the facility. Any visitors that are permitted must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.
- Considerations for visitation when restrictions are being relaxed include:
  - Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).
  - Schedule visitation in advance to enable continued social distancing.
  - Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).

Healthcare Personnel Monitoring and Restrictions:

- Restrict non-essential healthcare personnel, such as those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers from entering the building.
  - Consider implementing telehealth to offer remote access to care activities.

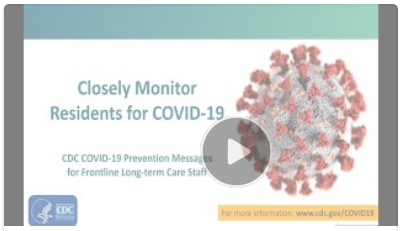
Definitions:

- **Healthcare Personnel (HCP)**: HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).
- **Source Control**: Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

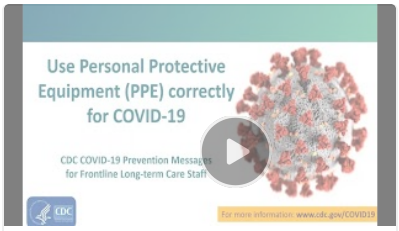
- **Cloth face covering**: Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer. Guidance on design, use, and maintenance of cloth face coverings is available.
- **Facemask**: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.
- **Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

Webinar Series - COVID-19 Prevention Messages for Long Term Care Staff

Clean Hands - Combat COVID-19



Closely Monitor Residents for COVID-19



PPE Lessons

Additional Resources

Sample Notification Letter to Residents and Families: COVID-19 Transmission Identified PDF | DOC

Long-term Care Facility Letter [1 page] to Residents, Families, Friends and Volunteers

CMS Emergency Preparedness & Response Operations

Supporting Your Loved One in a Long-Term Care Facility [472 KB, 1 page]

Infection Prevention Success Stories

Applying COVID-19 Infection Prevention and Control Strategies in Nursing Homes (Recorded Webinar)

Last Updated June 25, 2020
Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)

Updated July 17, 2020

Summary of Recent Changes as of July 17, 2020

- Except for rare situations, a test-based strategy is no longer recommended to determine when to allow HCP to return to work.
- For HCP with severe to critical illness or who are severely immunocompromised[1], the recommended duration for work exclusion was extended to 20 days after symptom onset (or, for asymptomatic severely immunocompromised[1] HCP, 20 days after their initial positive SARS-CoV-2 diagnostic test).
- Other symptom-based criteria were modified as follows:
  - Changed from "at least 72 hours" to "at least 24 hours" have passed *since last* fever without the use of fever-reducing medications
  - Changed from "improvement in respiratory symptoms" to "improvement in symptoms" to address expanding list of symptoms associated with COVID-19
- A summary of current evidence and rationale for these changes is described in a Decision Memo.

CDC guidance for SARS-CoV-2 infection may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Who this is for: Occupational health programs and public health officials making decisions about return to work for healthcare personnel (HCP) with confirmed SARS-CoV-2 infection, or who have suspected SARS-CoV-2 infection (e.g., developed symptoms of COVID-19) **but were never tested for SARS-CoV-2**.

HCP with symptoms of COVID-19 should be prioritized for viral testing with approved nucleic acid or antigen detection assays. When a clinician decides that testing a person for SARS CoV-2 is indicated, negative results from at least one FDA Emergency Use Authorized COVID-19 molecular viral assay for detection of SARS-CoV-2 RNA indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 RNA may be performed at the discretion of the evaluating healthcare provider, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists. For HCP who were suspected of having COVID-19 and had it ruled out, either with at least one negative test or a clinical decision that COVID-19 is not suspected and testing is not indicated, then return to work decisions should be based on their other suspected or confirmed diagnoses.

Decisions about return to work for HCP with SARS-CoV-2 infection should be made in the context of local circumstances. In general, a symptom-based strategy should be used as described below. The time period used depends on the HCP's severity of illness and if they are severely immunocompromised.[1]

A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Other Resources:

For guidance about assessment of risk and application of work restrictions for asymptomatic healthcare personnel (HCP) with potential exposure to patients, visitors, or other HCP with confirmed COVID-19, refer to the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.

Return to Work Criteria for HCP with SARS-CoV-2 Infection

Symptom-based strategy for determining when HCP can return to work.

HCP with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

HCP with severe to critical illness or who are severely immunocompromised[1]:

- At least 20 days have passed *since symptoms first appeared*
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: HCP who are **severely immunocompromised**[1] but who were **asymptomatic** throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.

As described in the Decision Memo, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, the more conservative period of 20 days was applied in this guidance. However, because the majority of severely or critically ill patients no longer appear to be infectious 10 to 15 days after onset of symptoms, facilities operating under critical staffing shortages might choose to allow HCP to return to work after 10 to 15 days, instead of 20 days.

Test-Based Strategy for Determining when HCP Can Return to Work.

In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised[1]) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

The criteria for the test-based strategy are:

HCP who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

HCP who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information.

Definitions

Cloth face covering: Textile (cloth) covers are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE, and it is uncertain whether cloth face coverings protect the wearer.** CDC has guidance available on design, use, and maintenance of cloth face coverings.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines):

Note: The studies used to inform this guidance did not clearly define "severe" or "critical" illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about when HCP with SARS-CoV-2 infection may return to work, the definitions in the National Institutes of Health (NIH) COVID-19 Treatment Guidelines are one option for defining severity of illness categories. The highest level of illness severity experienced by the HCP at any point in their clinical course should be used when determining when they may return to work.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Footnotes

[1]The studies used to inform this guidance did not clearly define "severely immunocompromised". For the purposes of this guidance, CDC used the following definition that was created to more generally address HCP occupational exposures.

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and require actions such as lengthening the duration of HCP work restrictions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect occupational health actions to prevent disease transmission.
- Ultimately, the degree of immunocompromise for HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Last Updated July 17, 2020
Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Updated July 17, 2020

Print

Who is this for: Healthcare facilities that may be experiencing staffing shortages due to COVID-19

What is it for: To assist healthcare facilities in mitigating healthcare personnel staffing shortages that might occur because of COVID-19.

Summary of Recent Changes as of July 17, 2020

- Referenced Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2, which provides considerations for performing post-exposure testing of HCP exposed to SARS-CoV-2

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety and providing resources to assist HCP with anxiety and stress.

There are Contingency and Crisis Capacity Strategies that healthcare facilities should consider in these situations. For example, if, despite efforts to mitigate, HCP staffing shortages occur, healthcare systems, facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that HCP with suspected or confirmed COVID-19 could return to work before the full Return to Work Criteria have been met. Several of the Crisis Capacity Strategies are dependent on HCP wearing a facemask for source control while at work. Given ongoing shortages of personal protective equipment (PPE), facilities should refer to and implement relevant Strategies for Optimizing the Supply of Facemasks.

Contingency Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. At baseline, healthcare facilities must:

- Understand their staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care.
- Be in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed.

Contingency capacity strategies for healthcare facilities include:

Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities.

- Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation and training to work in these areas that are new to them.
- Attempt to address social factors that might prevent HCP from reporting to work such as need for transportation or housing that allows for social distancing, particularly if HCP live with individuals with underlying medical conditions or older adults.
    - Consider that these social factors disproportionately affect persons from racial and ethnic groups also disproportionally affected by COVID-19 (e.g., African Americans, Hispanics and Latinos, and American Indians and Alaska Natives).
- Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
- As appropriate, request that HCP postpone elective time off from work. However, there should consideration for the mental health benefits of time off and that the burden of the disease and care-taking responsibilities may differ substantially among certain racial and ethnic groups.

Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with COVID-19.

Developing plans to allow asymptomatic HCP who have had an unprotected exposure to SARS-CoV-2 (the virus that causes COVID-19) but are not known to be infected to continue to work.

- These HCP should still report temperature and absence of symptoms each day before starting work.
- These HCP should wear a facemask (for source control) while at work for 14 days (this is the time period during which exposed HCP might develop symptoms, i.e., the current incubation period for the virus) after the exposure event. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19.

- When testing is readily available, performing post-exposure testing during the 14-day post-exposure period can be considered to more quickly identify pre-symptomatic or asymptomatic HCP who could contribute to SARS-CoV-2 transmission.
    - Facilities that elect to perform post-exposure testing of HCP should be aware that testing might be logistically challenging and has limitations. For example, testing only identifies the presence of virus at the time of the test. It is possible that HCP can test negative because they are very early in their infection when their sample is collected. In such situations, they could become infectious later and transmit the virus to others; for this reason, repeat testing could be considered. Also, when there is SARS-CoV-2 transmission occurring in the community, positive tests in HCP do not necessarily indicate transmission due to exposures in the workplace.
    - If testing of exposed HCP is instituted, test results should be available rapidly (i.e., within 24 hours), and there should be a clear plan to respond to results.

- If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.

If HCP are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all Return to Work Criteria. HCP with suspected SARS-CoV-2 infection should be prioritized for testing, as testing results will impact when they may return to work and for which patients they might be permitted to provide care.

Developing criteria to determine which HCP with suspected or confirmed COVID-19 (who are well enough and willing to work) could return to work in a healthcare setting before meeting all Return to Work Criteria—if staff shortages continue despite other mitigation strategies.

- Considerations include:
  - The type of HCP shortages that need to be addressed.
  - Where individual HCP are in the course of their illness (e.g., viral shedding appears to be higher earlier in the course of illness).
  - The types of symptoms they are experiencing (e.g., persistent fever).
  - Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
  - The type of patients they care for (e.g., immunocompromised patients or only patients with SARS-CoV-2 infection).
- As part of planning, healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is operating under crisis standards, the changes in practice that should be expected, and actions that will be taken to protect them from exposure to SARS-CoV-2 if HCP with suspected or confirmed COVID-19 are allowed to work.

Crisis Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are occurring, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care.

When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing
- If not already done, implement plans (see contingency capacity strategies above) to allow asymptomatic HCP who have had an unprotected exposure to SARS-CoV-2 but are not known to be infected to continue to work.
  - If HCP are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all Return to Work Criteria (unless they are allowed to work as described below).
- If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are well enough and willing to work but have not met all Return to Work Criteria to work. If HCP are allowed to work before meeting all criteria, they should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:
  1. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
  2. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
  3. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
  4. As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients *without* suspected or confirmed COVID-19.

  If HCP are permitted to return to work before meeting all Return to Work Criteria, they should still adhere to all

Return to Work Practices and Work Restrictions recommendations described in that guidance. These include:

- Wear a facemask for source control at all times while in the healthcare facility until they meet the full Return to Work Criteria and all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
  - Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
  - If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others.
- They should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until the full Return to Work Criteria have been met.
- They should self-monitor for symptoms and seeking re-evaluation from occupational health if respiratory symptoms recur or worsen.

Definitions

Cloth face covering: Textile (cloth) covers are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE and it is uncertain whether cloth face coverings protect the wearer.** CDC has guidance available on design, use, and maintenance of cloth face coverings.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators, including those intended for use in healthcare are certified by the CDC/NIOSH.

Last Updated July 17, 2020
Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

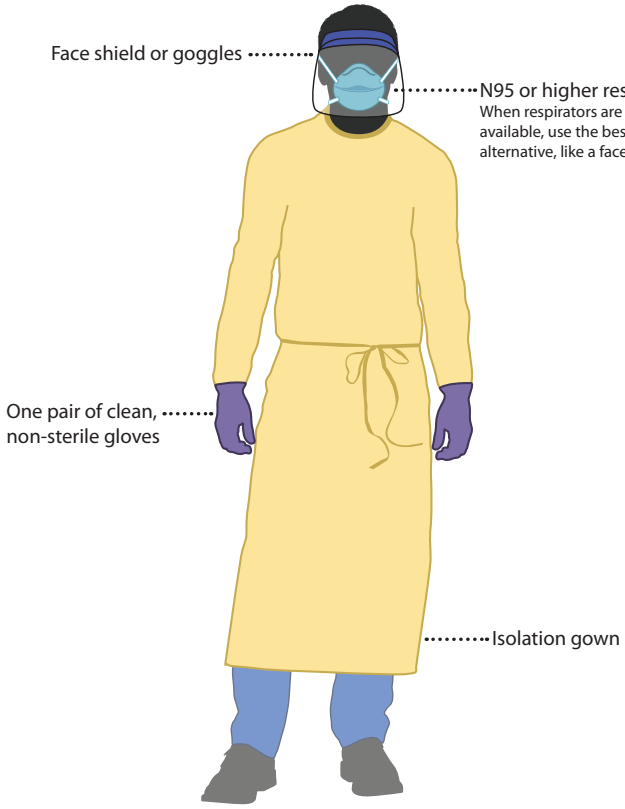
Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- **Receive comprehensive training** on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- **Demonstrate competency** in performing appropriate infection control practices and procedures.

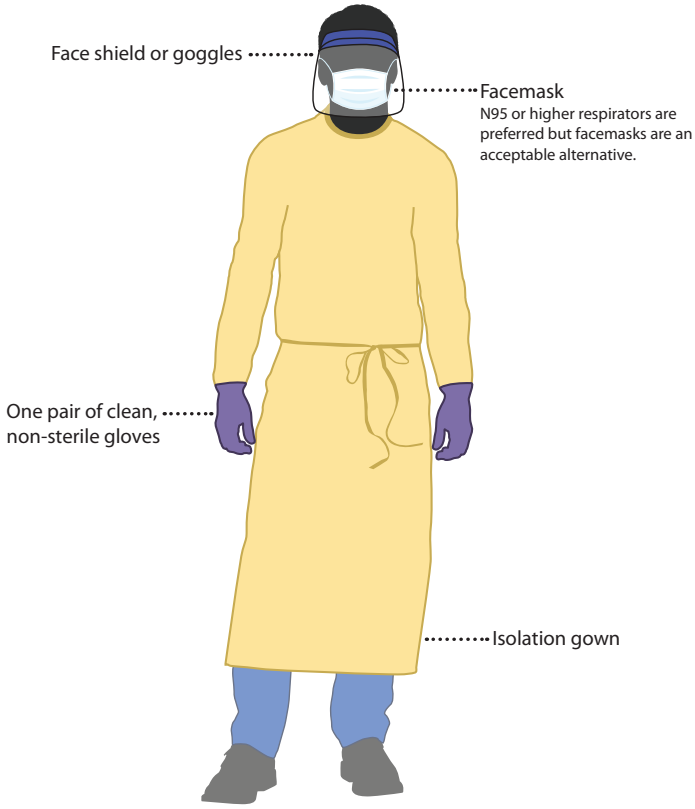
Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator



Acceptable Alternative PPE – Use Facemask



www.cdc.gov/coronavirus

CS 316124-A 06/03/2020

Donning (putting on the gear):

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. **Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
   - » **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
   - » **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. **Put on face shield or goggles.** When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **HCP may now enter patient room.**

Doffing (taking off the gear):

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
3. **HCP may now exit patient room.**
4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).*** Do not touch the front of the respirator or facemask.
   - » **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
   - » **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.
7. **Perform hand hygiene after removing the respirator/facemask** and before putting it on again if your workplace is practicing reuse.

Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices.

Updated COVID-19 Testing Guidance

On June 11, 2020, the Ohio Department of Health (ODH) updated COVID-19 testing guidance. This guidance applies to all COVID-19 testing in the state of Ohio.

The Centers for Disease Control and Prevention (CDC) has established priority groups for testing. Ohio has modified these groups to meet the specific needs of our state in light of changes in testing availability and evolving knowledge of COVID-19 and its impact on Ohioans. The state continues to emphasize testing of patients who are most severely ill, patients who are moderately ill with a high risk of complications — such as those who are elderly and those with serious medical issues — and individuals who are critical to providing care and service to those who are ill. Expanded test availability will allow individuals in lower risk tiers to be tested and help to further contain and respond to COVID-19 in Ohio. COVID-19 hospital preparedness zones/regions and community-based coalitions will work together to ensure equitable implementation of effective testing strategies that align with Ohio's cohesive statewide plan.

Testing is only one component of response to COVID-19. The role of testing is to quickly identify individuals infected with COVID-19, promptly isolate them and trace and quarantine any contacts to minimize spread of the virus to others. Testing does not change treatment in any way, nor does it replace comprehensive infection control and prevention activities.

As of June 11, testing may be made available to individuals described in all Priorities. The purpose of this prioritization is to assure access to testing for the most ill and vulnerable Ohioans and those who care for them and to limit the risk of spread in congregate living environments and communities. The prioritization also recognizes the appropriate use and preservation of personal protection equipment (PPE) across all health care and community settings to ensure safety.

Priority 1 is to ensure optimal and safe care for all hospitalized patients, lessen the risk of hospital-incurred infections, and ensure staff safety. Individuals in Priority 1 testing include:

- Hospitalized patients with symptoms.
- Healthcare workers with symptoms. This includes behavioral health providers, home health workers, nursing facility and assisted living employees, emergency medical technicians (EMTs), housekeepers and others who work in healthcare and congregate living settings.[1]

Priority 2 is to ensure that people at highest risk of complications from COVID-19 and those who provide essential public services are rapidly identified and appropriately prioritized in accordance with

the CDC's May 19 guidance for testing in nursing homes.[2] Individuals in Priority 2 testing include:

- Residents of long-term care facilities and other congregate living settings[1] who are symptomatic.
- Residents and staff of long-term care facilities and congregate living settings[1] who are asymptomatic with potential exposure to COVID-19 when a case is detected in a facility. The purpose of testing individuals who are exposed and asymptomatic is to facilitate more specific isolation and quarantine within the congregate living setting to reduce the risk of virus transmission to other residents.[3] In these cases, the extent of testing will be determined by the local health department in consultation with the facility medical director or other clinical leadership.
- Patients 65 years of age and older with symptoms.
- Patients with underlying conditions with symptoms.
    - Consideration should be given for testing racial and ethnic minorities with underlying illness, as they are disproportionately affected by adverse COVID-19 outcomes.
- First responders, public health workers, and critical infrastructure workers with symptoms.
- Other individuals or groups designated by public health authorities to evaluate and manage community outbreaks, including those within workplaces and other large gatherings.

Priority 3 is to test individuals with and without symptoms in implementing healthcare services across all healthcare settings. The purpose of Priority 3 testing is to minimize risk of post-procedure complications and transmission of COVID-19. Individuals in Priority 3 testing include:

- Individuals receiving essential surgeries and procedures, including those who were reassessed after a delay.
- Individuals receiving all other medically necessary procedures.
- Individuals receiving non-essential/elective surgeries and procedures, effective June 2.

Priority 4: Individuals in the community to decrease community spread, including individuals with symptoms who do not meet any of the above categories.

Priority 5: Asymptomatic individuals not mentioned above.

[1] Congregate living settings are those where more than six people reside with a propensity for rapid person-to-person spread, including but not limited to: assisted living facilities, nursing facilities, Ohio Veterans Homes, residential mental health and substance use treatment facilities, psychiatric hospitals and group home settings, developmental centers, intermediate care facilities and group homes for individuals with intellectual disabilities, facilities operated by the Ohio Department of Youth Services, facilities operated by the Department of Rehabilitation and Corrections, homeless and domestic violence shelters, and jails.

[2] The CDC's May 19 "Testing Guidance for Nursing Homes" states: when one case is detected in a nursing home, there are often other residents and healthcare personnel who are infected with SARS-CoV-2 (the virus that causes COVID-19) and can continue to spread the infection, even if they are asymptomatic. Testing all residents and healthcare personnel as soon as there is a new confirmed case in the facility will identify infected individuals quickly to allow rapid implementation of

infection prevention and control interventions (e.g., isolation, cohorting, use of personal protective equipment). If testing capacity is limited, CDC suggests directing testing to residents and healthcare personnel on the same unit or floor of a new confirmed case. If testing all residents on the same unit or floor also is not possible, CDC suggests directing testing to symptomatic residents and healthcare personnel and residents who have known exposure to a case (e.g., roommates of cases or those cared for by a known positive healthcare worker).

[3] Following testing for this group:

- Exposed but asymptomatic residents who test negative still should be quarantined for 14 days and monitored for symptoms, as they could test positive later during the 14-day incubation period.
- Exposed but asymptomatic staff who test negative should be assessed to determine need for quarantine and symptom monitoring based on CDC guidance for public health management of exposure in healthcare personnel. They may be permitted to work, adhering to CDC strategies to mitigate healthcare staffing shortages.
- Exposed but asymptomatic staff who test positive should remain off work for ten (10) days following the date of the test, assuming they remain asymptomatic. Under certain circumstances they may be permitted to work, adhering to CDC strategies to mitigate healthcare staffing shortages.

Ohio Department of Health Laboratory
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CLIA Certification # 36D0655844
Phone: 888-634-5227
Fax: 614-387-1505
Email: odhlabs@odh.ohio.gov

Microbiology Specimen Submission Form

Note: Fields marked with an asterisk (*) must be completed. Please print.

Section 1: Patient Information

Patient Name* (Last, First, MI)			Date of Birth* (mm/dd/year)
Address		County	Sex* ☐Female ☐ Male
City	State	Zip	Chart or* Patient ID#

Section 2: Submitter Information

Agency* Name			Contact* Name
Address			Fax* Number
City	State	Zip	Phone* Number

Section 3: Specimen Information (Complete all that apply)

Collection* Date	Onset* Date	ODH Outbreak#
Specimen* Type ☐Clinical ☐ Isolate	Submitter* Specimen ID#	Agent* Suspected

***Specimen Site (Check all that apply)**

☐ Abscess-Specify (☐ Aspirate ☐ Swab)	☐ Respiratory, Upper-Specify (☐ NP swab ☐ OP swab)	☐ Tissue-Specify:_____
☐ Blood-Specify (☐ Plasma ☐ Whole)	☐ Respiratory, Lower-Specify Below:	☐ Urine
☐ Body Fluid-Specify Below: ☐ CSF ☐ Other:_____	☐ Sputum (☐ Induced ☐ Expectorated) ☐ BAL ☐ TA For mycobacteria only: ☐ Processed ☐ Unprocessed	☐ Wound-Specify:_____
	☐ Stool-Specify Below: ☐ Cary Blair ☐ Enteric Broth ☐ 10% Formalin ☐ Bulk	☐ Other:
☐ Serum-Specify (☐ Acute ☐ Conv.)		

Section 4: Exam Requested (Check all that apply) **ODH approval required prior to submission; Contact 614-995-5599

Microbiology			
☐ Biothreat Agent-Specify Below:	☐ *Clostridium botulinum***	☐ *Neisseria meningitidis*	☐ *Shigella*
	☐ Enteric Pathogen Panel**	☐ Norovirus**	☐ *Vibrio*
☐ Bacterial Strain Typing**	☐ *Escherichia coli* (STEC)	☐ *Salmonella*	☐ *Yersinia*
☐ *Campylobacter*	☐ *Listeria monocytogenes*	☐ Other:	

Mycobacteriology		
☐ Mycobacterial Smear and Culture	☐ *M. tuberculosis* Nucleic Acid Amplification (NAA)	☐ *M. tuberculosis* , Genotyping only
☐ Mycobacterial Identification	☐ *M. tuberculosis* Susceptibility Testing (SM, INH, RIF, EMB, PZA)	☐ Other:

Parasitology			Virology	
☐ *Cryptosporidium*	☐ *Giardia*	☐ Other:	☐ Respiratory Virus	☐ Other:

Comments:

For Use by the Ohio Department of Health Laboratory Only

Date Received	**Date Reported**
Fee Due MI	ODH LAB ID
Exemption	