All Healthcare Settings COVID-19 Outbreak Response Guidance

Upon review of your outbreak and taking into consideration many factors, including transmission, exposures, and case counts, we have determined that your facility meets outbreak criteria for COVID-19. This guidance is applicable to all U.S. settings where healthcare is delivered (including home health). **This guidance is not intended for non-healthcare settings (e.g., restaurants) and not for persons outside of healthcare settings.** A facility must go 14 days without a new positive case or exposure to close the outbreak. Please verify outbreak closure with local public health.

Outbreak Definition:
Adopted from the Council for Outbreak Response: Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens (CORHA) guidance document:
https://corha.org/assets/documents/COVID-19-HC-Outbreak-Definition-Guidance_January-2024.pdf.

	Acute Care Hospitals and Critical Access Hospitals	**Long-Term Care Facilities (LTCF) and Long-Term Acute Care Hospitals**
Outbreak Definition	≥2 cases of probable* or confirmed COVID-19 among patients 4 or more days after admission for a non-COVID condition, with epi-linkage¶ OR ≥2 cases of suspect†, probable* or confirmed COVID-19 among HCP†† **AND** ≥1 case of probable* or confirmed COVID-19 among patients 4 or more days after admission for a non-COVID condition, with epi-linkage§,¶	≥2 cases of probable* or confirmed COVID-19 among residents, with epi-linkage¶ OR ≥2 cases of suspect†, probable* or confirmed COVID-19 among HCP†† **AND** ≥1 case of probable* or confirmed COVID-19 among residents, with epi-linkage§,¶ AND no other more likely sources of exposure for at least 1 of the cases

*Probable case is defined as a person meeting presumptive laboratory evidence. Presumptive laboratory evidence includes the detection of SARS-CoV-2 specific antigen in a clinical or post-mortem specimen using a diagnostic test performed by a CLIA-certified provider (includes those tests performed under a CLIA certificate of waiver).
†Suspect case is defined as a person meeting supportive laboratory evidence OR meeting vital records criteria with no confirmatory or presumptive laboratory evidence for SARS-CoV-2. Supportive laboratory evidence includes the detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight.
††Healthcare Personnel (HCP), defined by CDC, 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)(6). Facilities should prioritize investigations of cases in HCPs whose duties require them to have close contact with patients or visitors. Healthcare facility infection prevention or occupational health personnel should, wherever feasible, interview HCP with COVID-19 to identify likely sources of exposure and assess whether there are epi-linkages with other HCP or patient cases.
¶Epi-linkage among patients or residents is defined as overlap on the same unit or ward, or other patient care location (e.g., radiology suite), or having the potential to have been cared for by common HCP within a 7-day time period of each other. Determining epi-linkages requires judgment and may include weighing evidence whether or not patients had a common source of exposure. §Epi-linkage among HCP is defined as having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility. Determining epi-linkages requires judgment and may include weighing evidence whether or not transmission took place in the facility, accounting for likely sources of exposure outside the facility.
‖ During periods of surge and high community transmission rates, it may be impossible to determine whether HCP case exposures and transmission occurred within or outside the facility. However, hospitals should still report suspected outbreaks.
If resident tests negative for both influenza and SARS-CoV-2, consider testing with a multiplex respiratory viral panel.

Healthcare settings refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others.

Helpful Resources:

- Last Updated 6/24/2024: Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC
- Last Updated 4/18/2024: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- Last Updated 9/23/2022: Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
- Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE) (cms.gov)
- **For LTCFs (last updated 5/8/2023):** QSO-20-39-NH Visitation REVISED (cms.gov)
- The Montana Department of Public Health and Human Services (MT DPHHS) Infection Control and Prevention (ICP) and Healthcare-Associated Infections (HAI) Section provides free, non-regulatory infection control assessments and outbreak consultations to all healthcare settings in Montana. If interested, please contact your local/tribal public health jurisdiction or the ICP/HAI Section at Erika.Baldry@mt.gov.

1. **Recommended Routine IPC Practices for Healthcare (HC) settings**
    a. COVID-19 is a reportable condition in Montana (https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/policies/a10d456a-4ef9-43d1-a9a8-93d7b010e4ed). A single case **must** be reported to your local/tribal public health jurisdiction.
    b. A single new case of COVID-19 in any HCP, patient, or resident should be evaluated to determine if others in the facility could have been exposed. Proper testing and source control based on the contact investigation should be implemented.
    c. Encourage everyone to remain up to date with all recommend COVID-19 vaccine doses.
    d. Facilities should post visual alerts at the entrance and in strategic places (waiting areas, elevators, cafeterias). Alerts should include instructions about current IPC recommendations. Dating alerts can help ensure people know that they reflect current recommendations.
    e. Establish a process to make everyone aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
        i. A positive viral test for COVID-19,
        ii. Symptoms of COVID-19, OR
        iii. Close contact to someone with COVID-19
2. **Source Control**
    a. **Source Control:** Refers to the use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when breathing, talking, sneezing or coughing.
    b. Source control is recommended for individuals (e.g., staff, visitors, patients) in healthcare settings who:
        i. Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
        ii. Had close contact (patients and visitors) or a higher-risk exposure (healthcare personnel [HCP]) with someone with SARS-CoV-2 infection, for 10 days after their exposure

c. Source control options for HCP include:
    i. NIOSH-approved respirator
    ii. Respirator approved under standards used in other countries that are similar to NIOSH-approved N95s (these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated)
    iii. A barrier face covering that meets ASTM F3502-21 requirements
    iv. A well-fitting facemask
d. When used solely for source control, any of the options listed above could be used for the entire shift unless they become soiled, damaged, or hard to breathe through.
e. Recommended during an outbreak response (can be discontinued as a mitigation measure once no new cases have been identified for 14 days)
f. Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances:
    i. By those residing or working on a unit or area of the facility experiencing a COVID-19 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
    ii. Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission
    iii. Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high)
    iv. https://dphhs.mt.gov/publichealth/cdepi/diseases/Pan-Respiratory/Pan-RespiratoryDashboard

3. Considerations for Implementing Broader Use of Masking in Healthcare Settings:

a. As COVID-19 transmission increases in a community, the potential for encountering asymptomatic or pre-symptomatic patients with COVID-19 also increases. Healthcare facilities could consider implementing broader use of respirators and eye protection by HCP during patient care encounters.
b. Use of well-fitting masks in healthcare settings are an important strategy to prevent the spread of respiratory viruses.
c. Facilities should consider several factors when determining how and when to implement broader mask use. These factors include the types of patients cared for in their facility, input from stakeholders, plans from other facilities in the jurisdiction, and what data are available to make decisions.

4. Personal Protective Equipment

a. HCP who enter the room of a patient with suspected or confirmed COVID-19 should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection.
b. When entering an isolation room, don PPE prior to entering and doff prior to exiting in accordance with CDC guidance (PPE-Sequence.pdf (cdc.gov)).

5. **Visitation**
    a. Visitors with confirmed COVID-19 or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation.
    b. For visitors with close contact that put them at higher risk, it is safest to defer non-urgent in-person visitation until 10 days after their close contact.
    c. Patients should be encouraged to limit in-person visitation while they are infectious.
        i. Counsel patients and their visitor(s) about the risks of in-person visitation
        ii. Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets
    d. Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
    e. Visitors should be instructed to only visit the patient room.

6. **Testing**
    a. Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.
    b. Asymptomatic patients with close contact
        i. Series of 3 viral tests (day 1, 3, and 5 with the day of exposure = 0)
    c. Testing is not generally recommended for asymptomatic people who have recovered from COVID-19 in the prior 30 days. Testing should be considered for those who have recovered from COVID-19 in the prior 31-90 days (recommended that an antigen test is used)
    d. If performing outbreak testing, facilities should determine if contact-tracing testing or broad-based testing is appropriate.
        i. Contact Tracing Testing: Testing individuals identified as a close contact (series of 3 viral tests on day 1, 3, and 5 with the day of exposure = 0).
        ii. Broad-Based Testing: Preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. This includes testing all staff and residents regardless of vaccination status as part of outbreak response. Test every 3-7 days.
        iii. If antigen testing is used, more frequent testing (every 3 days), should be considered.

7. **Patients Being Evaluated for COVID-19 due to signs/symptoms**
    a. Consult your local public health department when ruling out a positive case (i.e., determining if someone was a false positive).
    b. The decision to discontinue empiric transmission-based precautions (TBP) by excluding the diagnosis of COVID-19 can be made based upon having negative results from at least one viral test.
        i. If using NAAT (PCR), a single negative is sufficient in most circumstances (if suspicion is high, repeat testing).
        ii. If using an antigen test, a negative result should be confirmed by a NAAT (PCR), or second negative antigen taken 48 hours after the first negative.
        iii. If an individual was infected in the prior 90 days, rapid antigen testing is preferred over a PCR test.
8. **Close Contact**
    a. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC

i. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be **2 days before symptom onset** through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions
ii. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.
iii. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.

b. In general, asymptomatic individuals do not require empiric use of TBPs following close contact (within 6 feet for 15 minutes or more over a 24-hour period).
    i. Examples when empiric TBP following close contact may be considered:
        1. Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
        2. Patient is moderately to severely immunocompromised
        3. Patient is residing on a unit with others who are moderately to severely immunocompromised
    ii. Patients placed on empiric TBP based on close contact with someone with COVID-19 should be maintained in TBPs for the following time periods:
        1. Patients can be removed from TBP after day 7 following the exposure (exposure=day 0) if they do not develop symptoms and all viral testing as described in in the testing section (see #6) is negative
        2. If viral testing is not performed, patients can be removed from TBPs after day 10 following the exposure (count the day of the exposure as day 0) if they do not develop symptoms
c. Individuals who had close contact should wear source control and those who have not had COVID in the prior 30 days should be tested as described in the testing section (see #5).

9. Patient Placement

a. Place a patient with suspected or confirmed COVID-19 in a single-person room (with a dedicated bathroom)
    i. If cohorting, only patients with the same respiratory pathogen should be housed in the same room. MDRO colonization status and/or presence of other communicable disease should be taken into consideration.
b. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with COVID-19 when the number of patients with COVID-19 is high.
c. Limit transport and movement of the patient outside of the room to medically essential purposes

10. Duration of TBPs for patients with COVID-19

a. In general, patients who are hospitalized for COVID-19 should be maintained in TBPs for the time period described for patients with severe to critical illness.

- **Patients with mild to moderate illness who are *not* moderately to 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

- **Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:**
  - At least 10 days have passed since the date of their first positive viral test.
- **Patients with severe to critical illness and who are *not* moderately to severely immunocompromised:**
  - At least 10 days and up to 20 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
  - The test-based strategy as described for moderately to severely immunocompromised patients below can be used to inform the duration of isolation.

11. Environmental Infection Control

a. Dedicated medical equipment should be used when caring for a patient with suspected or confirmed COVID-19
   i. All non-dedicated, non-disposable medical equipment used for the patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
   ii. Routine cleaning and disinfection procedures are appropriate for COVID-19 (Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a *difficile* sporicidal agent is recommended to disinfect the rooms of patients with *C. difficile* infection)).
   iii. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

12. Nursing Home Specific Guidance

a. See the outbreak definition at the beginning of this document.
b. Admission testing is at the discretion of the facility.
c. Residents who leave the facility for 24 hours or longer should generally be managed as an admission. Empiric use of TBPs is generally not necessary for admissions or for residents who leave the facility for less than 24 hours.

13. Assisted Living, Group Homes, and Other Residential Care Settings (excluding nursing homes) Guidance

a. In general, long-term care settings whose staff provide non-skilled personal care (i.e., non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing) should follow community prevention strategies based on COVID-19 Community Levels, similar to independent living, retirement communities or other non-healthcare congregate settings.
b. Visiting or shared HCP who enter the setting to provide healthcare to one or more residents should follow the HC IPC recommendations.
c. As a reminder, per 37.114.203 : REPORTABLE DISEASES AND CONDITIONS - Administrative Rules of the State of Montana (mt.gov), outbreaks in institutional and congregate settings are reportable to your local public health jurisdiction.

d. 37.106.2855 : INFECTION CONTROL - Administrative Rules of the State of Montana (mt.gov)

Healthcare Personnel Guidance

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC

1. **Exposure:** In most circumstances, HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for COVID-19.
    a. Higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 and:
        i. HCP was not wearing a respirator (or if wearing a facemask, the person with COVID-19 was not wearing a cloth mask or facemask)
        ii. HCP was not wearing eye protection if the person with COVID-19 was not wearing a cloth mask or facemask
        iii. HCP was not wearing all recommended PPE during an aerosol-generating procedure
    b. Following a high-risk exposure, HCP should:
        i. Have a series of 3 viral tests for COVID-19 (day 1, 3 and 5 with date of exposure= day 0)
        ii. Testing is not recommended for asymptomatic people who have recovered from COVID-19 in the prior 30 days. Testing (rapid antigen) should be considered for those who have recovered in the prior 31-90 days.
    c. Examples of when work restriction may apply for exposed, asymptomatic HCP:
        i. HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure
        ii. HCP is moderately to severely immunocompromised
        iii. HCP cares for or works on a unit with patients who are moderately to severely immunocompromised
        iv. HCP works in a unit experiencing ongoing COVID-19 transmission that is not controlled with initial interventions
    d. If work restriction is recommended, HCP can return to work:
        i. HCP can return to work after day 7 following the exposure (exposure= day 0) if they do not develop symptoms and viral testing is negative
        ii. If viral testing is not performed, HCP can return to work after day 10 (exposure= day 0) if they are asymptomatic

2. Return to Work Criteria for HCP

- **HCP with mild to moderate illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
    - At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7)*,* **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.

    *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

- **HCP who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
    - At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

      *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

- **HCP with severe to critical illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:**
    - At least 10 days and up to 20 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.
    - The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

3. **Strategies to Mitigate HCP Staffing Shortages** (Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC)
    a. Contingency Staffing
        i. HCP with mild to moderate illness who are not moderately to severely immunocompromised:
            1. At least 5 days have passed (return day 6) since symptoms first started (day 0), **and**
            2. At least 24 hours have passed since last fever without the use of fever-reducing medications, **and**
            3. Symptoms have improved
    b. Crisis Staffing
        i. If HCP are requested to return to work before meeting all return-to-work criteria, they should adhere to the following:
            1. Self-monitor for symptoms and seek re-evaluation if symptoms recur or worsen
            2. Until they meet the conventional return to work criteria:
                a. Wear a respirator or well-fitting facemask at all times, even when they are in non-patient areas
                b. Practice physical distancing, to the extent possible
                c. Patients should wear well-fitting source control when interacting with HCP
                d. Staff that are deemed still infectious should only work with residents who are currently on transmission-based precautions due to active COVID-19 infection.