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PUBLIC
HEALTH

Massachusetts Department of Public Health

Responding to COVID-19 Clusters in Long-term Care Facilities and Nursing Homes

General Recommendations

- A universal face mask policy should be in place for all staff.
- All staff reporting to work should be screened for symptoms of respiratory infection or fever.
 - This also applies to anyone entering the building.
- Residents should be screened at least twice per shift for symptoms.
- Visitors should be restricted.
 - This includes all volunteers and non-essential healthcare personnel.
- Group activities and group dining should be cancelled.
- Residents should stay in their rooms as much as possible.
- Emphasize hand hygiene for residents as well as staff.

What we are seeing...

Facilities do not have “just one” case....

Typically when a case is detected in a facility, whether it is a staff member or resident, multiple cases are subsequently identified.

Testing of Symptomatic Residents

- It is important to have a low threshold for testing.
- Symptoms observed in positive residents have included: fever (even low grade), oxygen saturation below baseline, diarrhea, malaise, sore throat, respiratory distress, cough, or altered mental status.
 - There have even been some reports of nausea and vomiting

Nursing Home Mobile Test Program

- Applies to nursing homes, rest homes, and ALFs
- Facilities must have an order from a licensed provider to order tests
- Administrator or designee calls: 617-366-2350
- Option 1: Testing by MA National Guard
 - Specimens will need to be accompanied by the MA SPHL requisition form
 - Results are reported out by MA SPHL to the ordering provider
- Option 2: Requesting testing kits for your facility
 - Use this option if a facility has HCP on-site that can obtain specimens for their residents
 - Testing Kits can be sent directly to the facility
 - Couriers are used to send kits and pick up kits
 - Specimens will need to be accompanied by a requisition provided by the Broad Institute
 - Results will be sent via a secure email from the Broad institute to the ordering provider

Best Practices when Cohorting

- **“Long-term care facilities must separate residents who are positive for COVID-19 from residents who are not, or have an unknown status. Whenever possible, long-term care facilities must establish a dedicated wing or unit that is separate from the rest of the facility and residents to care for COVID-19 positive residents. COVID-19-positive units must be capable of maintaining strict infection control practices and testing protocols. When possible, facilities must have separate staffing teams for COVID-19-positive and COVID-19-negative residents.”**
 - In the absence of available single-person rooms, cohorting may be necessary.
 - Avoid having a COVID-positive and an asymptomatic, non-tested (or non-positive) resident in the same room.
 - Avoid introduction to an unaffected part of the facility.

Cohorting: Best Case Scenario

Cohort 1: Area that is dedicated to COVID+ residents and is physically separated from other units by walls, doors, etc.

-It is always best to isolate a COVID-positive patient if possible.

Cohort 2: Area for symptomatic/presumed COVID/results pending

Cohort 3: Area that is designated as Quarantine.

-This is for asymptomatic roommates of those that tested COVID positive. Ideally, these individuals should be in private rooms.

Cohort 4: Area for asymptomatic individuals without known exposure

Ideally, designated staff work in each of these areas and do not float to different units within the facility.

Cohorting Alternative Strategy #1

- A “COVID” area that houses both COVID+ and symptomatic/presumed COVID/results pending
- A quarantine unit as previously described
 - *If the facility does not have a “quarantine” unit, then it might be best to keep asymptomatic roommates of those that are COVID+ or symptomatic/presumed COVID/results together.

If No Cohorting is Possible

- Create as much physical distance between COVID+ and symptomatic/presumed COVID/results pending and their roommate(s).
 - Separate the beds physically. Put up a curtain. Make sure high touch surfaces are cleaned more frequently, etc.

Required Personal Protective Equipment (PPE) for Suspect or Confirmed COVID-19 Residents

- Special droplet (Contact plus droplet) precautions (masks, eye protection, gowns, and gloves) should be worn by any HCP providing care to the resident or entering the resident's room.
- Respirators (e.g., N95 masks) are recommended when conducting procedures that are likely to generate aerosols (e.g., nebulizer treatments, sputum induction, open suctioning of airways).
- Hand hygiene should be performed when entering and leaving the room.
- Specimen collection (nasopharyngeal swab) should be performed in a private room with a closed door and the use of an N-95 respirator (or facemask if a respirator is not available), gloves, gown and eye protection.

Recommended Precautions for Suspect or Confirmed COVID-19 Residents

- Suspect or confirmed COVID-19 residents should remain on special droplet precautions (Contact plus droplet) until they have met either the test-based or non-test based strategy for discontinuation of isolation and precautions (assuming they have no other infectious disease for which precautions would be recommended).

Precautions for Quarantined Residents

- Quarantined residents should remain on special droplet precautions (Contact plus droplet) during their 14-day quarantine and have twice/shift checks for any symptom development.

Additional CDC Guidance on Precautions

- When there are cases in the facility or sustained transmission in the community, CDC recommends the facilities consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator or, if not available, a facemask) for the care of all residents, regardless of presence of symptoms.

Discontinuation of Transmission-Based Precautions

Test-based strategy.

1. Resolution of fever without the use of fever-reducing medications **and**
2. Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
3. Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens)

Non-test-based strategy.

1. At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
2. At least 7 days have passed *since symptoms first appeared*

Strategies to Optimize PPE

The screenshot shows the CDC website page for 'Strategies to Optimize the Supply of PPE and Equipment'. The page features a search bar at the top right with 'Coronavirus' entered. Below the search bar is a navigation menu with 'All A-Z Topics'. The main content area is titled 'Strategies to Optimize the Supply of PPE and Equipment' and includes a sidebar with a table of contents: Symptoms & Testing, Prevent Getting Sick, Daily Life & Coping, If You Are Sick, and People Who Need Extra Precautions. The main text describes the use of Personal Protective Equipment (PPE) by healthcare personnel (HCP) to protect themselves, patients, and others. To the right of the text are three highlighted boxes: 'Eye Protection', 'Isolation Gowns', and 'Facemasks'.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>



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Memorandum

TO: Health Care Facility Chief Executive Officers and Administrators
Occupational Health Program Leaders
Emergency Medical Service Directors

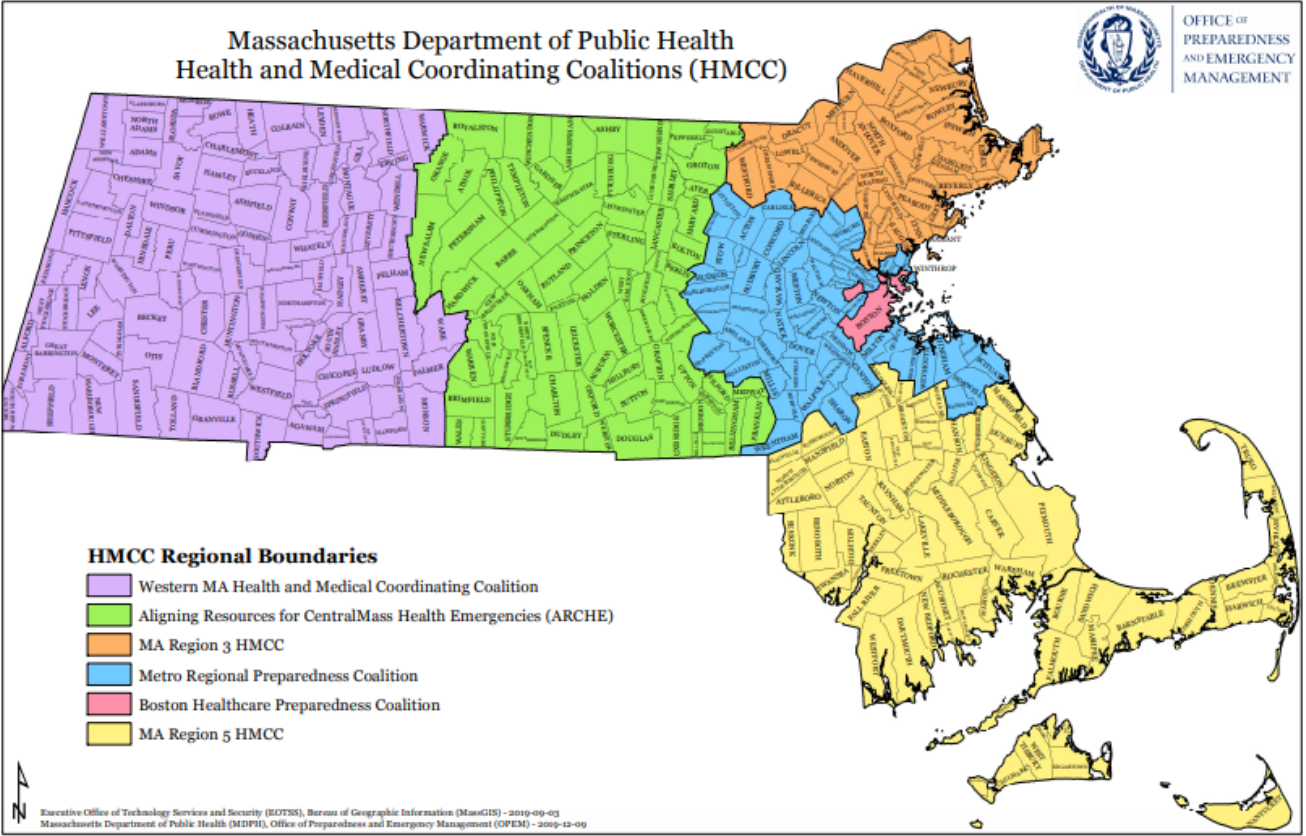
FROM: Elizabeth Daake Kelley, MPH, MBA, Director
Bureau of Health Care Safety and Quality

SUBJECT: Comprehensive Personal Protective Equipment (PPE) Guidance

DATE: April 5, 2020

<https://www.mass.gov/info-details/covid-19-guidance-and-directives#health-care-professionals-&-organizations->

Requesting PPE from your HMCC



<https://www.mass.gov/service-details/learn-about-the-health-and-medical-coordinating-coalitions>

Recommendations for HCP Exposed to Suspect COVID-19 Positive Resident

- HCP should use the exposure risk assessment table to evaluate their exposure and if indicated, be excluded from work.
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
 - If COVID-19 testing is negative for the resident, HCP can return to work.
 - If testing is positive, HCP should continue to follow the recommendations in the ‘HCP Exposures’ table, monitor themselves for symptoms, and if indicated, continue the 14-day quarantine.

HCP with Potential Exposure Guidance

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 (until 14 days after last potential exposure)	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a COVID-19 patient who was wearing a facemask (i.e., source control)			
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves ^a	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None

Prolonged close contact with a COVID-19 patient who was not wearing a facemask (i.e., no source control)			
HCP PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection ^b	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing gown or gloves ^{a,b}	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator) ^b	Low	Self with delegated supervision	None

HCP=healthcare personnel; PPE=personal protective equipment

^aThe risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient).

^bThe risk category for these rows would be elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>

Guidance for Exposed Asymptomatic HCP and EMS



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To: Health Care Facilities and Providers and Emergency Medical Services Providers

From: Catherine M. Brown, DVM, MSc, MPH, State Epidemiologist
Larry Madoff, MD, Medical Director, Bureau of Infectious Disease and Laboratory Sciences

Date: April 2, 2020

RE: Revised Guidance for Allowing Asymptomatic Health Care Personnel and Emergency Medical Technicians to Work Following a Known Exposure to COVID-19

Guidance for Exposed Asymptomatic HCP and EMS (Continued)

The health care facility/provider or EMS provider is required to:

- Ensure HCPs/EMTs report temperature and absence of symptoms prior to starting work each day;
- Ensure HCPs/EMTs don a facemask for the entire time that they are at work for the 14 days after the exposure event;
- Direct that if HCPs/EMTs 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;
- Prohibit HCPs/EMTs with even mild symptoms consistent with COVID-19 from working while they are symptomatic and, in accordance with DPH guidelines, test for COVID-19
 - HCPs/EMTs must remain out of work while awaiting COVID-19 test results;
- Using clinical judgment avoid having HCP care for high risk patient, including immunocompromised patients, for the 14 days after the exposure event; and
- Consider having HCPs/EMTs work shorter shifts (i.e. 8 hours) as there is early evidence that shorter shifts may be protective.

Guidance for Exposed Asymptomatic HCP and EMS (Continued)

- An asymptomatic HCP/EMS who is being tested for COVID-19 can continue to work *unless* they have a positive result. If the HCP/EMS test positive they would then be excluded from work for 7 days (applying the non-test-based strategy).

Return to Work Criteria for HCP with Suspect or Confirmed COVID-19

Test-based strategy.

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens).

Non-test-based strategy.

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 7 days have passed *since symptoms first appeared*

* If HCP were never tested for COVID-19 but have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Return to Work Practices and Restrictions for Suspect or Confirmed HCP

After a suspect or confirmed HCP returns to work, they should:

- Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in [CDC's interim infection control guidance](#) (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

***Note:** This applies to HCP who are lab-confirmed cases of COVID-19, as well as individuals who meet clinical criteria but did not undergo testing. However, if HCP were never tested for COVID-19 but have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Additional Support for Cluster Investigations

- Epidemiologists are being assigned to clusters to serve as a resource for the LBOH and the Facility
 - LBOHs should still be in communication with the facility
- Surveyors are being assigned to LTCFs across the Commonwealth
 - Surveyors can provide support in addressing PPE shortages and staffing shortages as well as technical expertise

MAVEN and your Cluster

- Ensure that confirmed cases associated with your cluster (HCP & residents) are linked to your cluster event
 - If you learn of a confirmed HCP associated with a facility and the HCP resides outside of your town, please share the event with the neighboring town. The LBOH in the neighboring town should conduct contact tracing (household contacts etc.) on their confirmed case. If you need help sharing events, you can reach out to your assigned Epi.
 - If you create the cluster, PLEASE put notes in the event indicating what the situation is.

MAVEN Variables of Top Priority

- Ensure confirmed cases are linked to the cluster event
- QP2
 - Race/Ethnicity
 - Employer Name & Occupation (for HCP)
- QP3
 - Was case hospitalized?
 - Outcome:
 - This is where deaths are captured.
- QP5
 - Employed at/visited/admitted to a health care facility?
 - Is case a health care worker?