Date: Aug 10, 2021

COVID-19 Public Health Recommendations: Clinical Care, and Healthcare Infection Prevention and Control

The recommendations in this document are not mandatory unless otherwise required by federal or state law, rule, or regulation, but should be followed to the extent possible in order to slow and stop the spread of COVID-19.

Oregon OSHA (OR-OSHA) adopted Oregon Administrative Rule (OAR) 437-001-0744 addressing COVID-19 Workplace Risks. The requirements in the rule were written with the intent to mitigate COVID-19 in all workplaces in Oregon. It is important to be familiar with OAR 437-001-0744, as several work practices addressed in this document as recommendations are required by OR-OSHA's rule. Language in this document is intended to provide context and direction around infection prevention and control practices in our state and does not exempt health care providers or settings from comply with OR-OSHA's rule.

In addition, Providers must continue to comply with all applicable federal, state and local laws.

Key terms

- **Healthcare setting**: Refers to any place where health care, including physical or behavioral health care is delivered and includes, but is not limited to any health care facility or agency licensed under ORS 441 and 443, such as hospitals, ambulatory surgical centers, birthing centers, special inpatient care facilities, long-term acute care facilities, inpatient rehabilitation facilities, inpatient hospice facilities, nursing homes and assisted living facilities, home health care, hospice, in-home care, vehicles or temporary sites where health care is delivered (e.g., mobile clinics, ambulances), and outpatient facilities, such as dialysis centers, physician offices, urgent care centers, counseling offices, offices that provide complementary and alternative medicine such as acupuncture, homeopathy, naturopathy, chiropractic and osteopathic medicine, and other specialty centers.

- **Healthcare personnel (HCP):** Refers to paid and unpaid persons serving in health care settings who have the potential for direct or indirect exposure to patients or potentially infectious materials, including body substances (e.g., blood, tissue and specific body fluids) and includes, but is not limited to, emergency medical service (EMS) personnel, nurses, nursing assistants, home health care personnel, hospice personnel, in-home caregivers, physicians, technicians, therapists, phlebotomists, pharmacists, traditional health workers, counselors, students and trainees, contractual staff not employed by the

OHA 2288J_R (08/10/2021)

health care setting and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing and volunteer personnel).

- **Face covering:** Refers to a cloth, paper or disposable face covering that covers the nose or mouth. It includes medical-grade face masks.

- **Face mask:** Refers to a medical-grade face mask.

- **Prolonged close contact:** Refers to proximity within 6 feet of an individual with SARS-CoV-2 infection for a cumulative total of 15 minutes or more over a 24-hour period.

- **Source control:** Refers to use of a face covering or face mask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing.

- **Essential travel:** Travel that is for the purposes of:
    - Work such as, but not limited to, critical infrastructure or supply chains support, economic services, health care services, security;
    - Study as part of enrollment in an educational institution;
    - Participation in K-12 school sports, adult, youth and club sports; or
    - A family emergency.

- **Non-essential travel:** Travel that is for the purposes of tourism, recreation or any other purpose that does not fit the definition of "essential travel".

The Centers for Disease Control and Prevention (CDC) has published:

- [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.](#)

- [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.](#)

- [Steps Healthcare Facilities Can Take Now to Prepare for COVID-19](#)

- [Interim Guidance for Healthcare Facilities: Managing Operations During the COVID-19 Pandemic](#).

All providers should review these websites frequently, as recommendations may change.

Clinical presentation and risk factors

Symptoms of COVID-19 include fever, cough, shortness of breath, fatigue, myalgia, and headache. Less common symptoms include sore throat, diarrhea, and loss of smell and taste. Fever is likely during the clinical course, but some data indicate that fewer than half of hospitalized COVID-19 patients present with fever. Severity of illness may worsen in the second week of infection. Atypical presentations have been described in older adults and persons with comorbidities. CDC has provided details on the [clinical presentation of COVID-19](#).

Older patients and those with chronic medical conditions are at higher risk for severe disease. In addition, CDC reports that among COVID-19 cases, the most common underlying health conditions were cardiovascular disease (32%), diabetes, (30%), and chronic lung disease (18%). Hospitalizations were six times higher and deaths 12 times higher among those with reported underlying conditions compared with those with none reported. Nationally, the case fatality rate is approximately 1.8%.

Children are less likely to have severe illness, compared to adults. However, some develop a post-infectious phenomenon, multi-system inflammatory syndrome in children (MIS-C) (More information: New England Journal of Medicine: Multisystem Inflammatory Syndrome in U.S. Children and Adolescents).

RNA from the virus that causes COVID-19 (SARS-CoV-2) has been identified from patients who never develop symptoms (asymptomatic) and in patients before symptoms develop (pre-symptomatic). Transmission from persons without symptoms is thought to account for a significant proportion of COVID-19 cases.

SARS-CoV-2 is believed to spread mainly between people in close contact through respiratory droplets produced by coughs and sneezes. When people are in enclosed spaces, and in particular when ventilation is poor, COVID-19 can also be spread by airborne transmission. The virus may also spread when a person touches another person (e.g., a handshake) or possibly a surface or an object (e.g., a doorknob or handrail) that has virus on it, and then touches their mouth, nose or eyes with unwashed hands. The virus can survive on surfaces for hours to days but can be rendered inactive by routine cleaning and disinfection procedures. (See "Environmental Infection Control in Healthcare Setting" Section.)

Clinical management and treatment

Not all patients with COVID-19 infection require hospital admission. If supportive care at home is considered, clinicians should ensure the patient is medically stable, has appropriate caregivers available, and is able to self-isolate safely at home. CDC has provided additional recommendations for home care in Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19).

COVID-19 EUA treatment information is available via Coronavirus Disease (COVID-19) updates from FDA.

The National Institutes of Health (NIH) and the Infectious Diseases Society of America (IDSA) have also developed treatment guidelines.

General recommendations for all healthcare settings

Personal protective equipment (PPE) for healthcare personnel

PPE policies should, first and foremost, protect those in the healthcare setting from exposure. Oregon OHSA Administrative Rule 437-001-0744 addresses PPE requirements in all Oregon workplaces. Section 4 of that rule addresses specific requirements for settings with higher risk of exposure, including healthcare facilities. PPE supplies should be used responsibly to ensure they are available for patients and procedures for which they are most needed. PPE strategies

OHA 2288J_R (08/10//2021)

should be supplemented by source control, including placement of a face covering or face mask on patients, rapid identification of patients with symptoms compatible with COVID-19, and isolation in a private room with the door closed. Effective hand hygiene, masking (for source control) and standard precautions should always be used by all HCP.

[CDC Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19)](#) recommends the use of N95[1] or higher-level respiratory protection, eye protection (goggles or face shield), gown, and gloves when entering the room of patients with suspected or confirmed COVID-19.

If the PPE burn rate exceeds the supply that can be obtained:

- Medical-grade facemasks remain an acceptable alternative when N95 or higher-level respiratory protection is not available for care of a patient that does not involve aerosol-generating procedures (See "Recommendations for Aerosol-Generating Procedures").

- Facilities should implement tiered PPE optimization strategies as outlined in CDC's [Optimizing Personal Protective Equipment (PPE) Supplies](#), and OHA/OR-OSHA [Use of PPE by Healthcare Personnel in Resource-Constrained Settings.](#)

- See "Managing PPE Supply Issues" section for emergency supply request processes.

Recommendations for aerosol-generating procedures

Aerosol-generating procedures (AGPs) have been associated with an increased risk of transmission in healthcare settings. (See Appendix I for a list of AGPs.)

If medically reasonable, AGPs for patients with suspected or confirmed COVID-19 or with known exposure to COVID-19 should be delayed.

When conducting (or assisting with) AGPs for patients with suspected or confirmed COVID-19 or known exposure to COVID-19, HCP should use standard, contact, and airborne precautions, including:

- N95 respirator[1] or higher respiratory protection (includes powered air-purifying respirators [PAPRs])

- Eye protection (face shield or goggles)

- Gown

- Gloves

This aligns with requirements in Oregon OHSA Administrative Rule 437-001-0744. To minimize risk associated with these procedures, AGPs should be planned and bundled, when possible. Only HCP required for the procedure should be present. Whenever possible, AGPs should be performed in an airborne infection isolation room (AIIR). If a hospital is treating

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[1] N95 respirators should be used by HCP who have been medically cleared, trained, and fit-tested in the context of a facility's [Respiratory Protection Program](#). A [user seal check](#) should be performed each time an N95 is put on.

multiple suspected or confirmed cases of COVID-19, AIIRs should be prioritized for those with serious illness.

When moderate or higher spread is occurring in the community and COVID-19 status is unknown, broad use of N95 or higher-level respiratory protection and eye protection is recommended for AGPs listed in Appendix I. Of note, Oregon OHSA requires employers to provide PPE for aerosol-generating healthcare or post-mortem procedures in accordance with CDC's "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic." The rule allows for clinical judgment regarding the need for Transmission-based Precautions during AGPs for patients without suspected COVID-19 infection or exposure when the county COVID-19 risk level is classified as "minimal." See Oregon's COVID 19 Public Heath Indicators - Community Spread webpage.

Testing for evidence of COVID-19 infection is sometimes used to stratify transmission risk in making decisions about timing for elective procedures. It is also sometimes used to make decisions about transmission-based precautions and use of PPE in performing aerosol-generating procedures for asymptomatic patients. In either setting, this practice has limitations due to issues with test sensitivity: A negative test at a single point in time does not ensure absence of COVID-19 infection. Use of nucleic acid amplification tests with higher sensitivity and obtaining specimens as close to the time of the planned procedure may mitigate some of these concerns.

Infectious aerosols may remain in the air following AGPs. Once a patient has been discharged or vacated a room where a high-risk AGP was conducted, HCP (includes environmental service personnel) should avoid room entry for a period after aerosol-generation has ceased or continue to wear N95-level or higher respiratory protection and eye protection (goggles or face shield) to provide time for contaminant removal. Facilities can assess room air changes per hour to inform duration of this period by using the CDC Airborne Contaminant Removal Table.Discontinuation of transmission-based precautions for hospitalized patients

Transmission-based precautions are discussed in the previous sections ("Personal Protective Equipment (PPE) for Healthcare Personnel" Section).

OHA has adopted CDC's guidance for Discontinuation of Transmission-Based Precautions for patients with confirmed COVID-19. Note that the test-based strategy is no longer recommended (exceptions noted below).

Symptom-based strategy for discontinuing transmission-based precautions.

Patients 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

OHA 2288J_R (08/10//2021)

Note: For patients who are **not severely immunocompromised** and who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Patients with [severe to critical illness](#) or who are [severely immunocompromised](#):

- At least 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

Note: For **severely immunocompromised** patients who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.

A test-based strategy could be considered for severely immunocompromised patients if there was concern about shedding longer than 20 days. Test-based strategy criteria can be found in CDC's [Discontinuation of Transmission-Based Precautions](#) guidance.

Additional considerations:

- Meeting criteria for discontinuation of transmission-based precautions is not a prerequisite for discharge.

  - The decision to send the patient home should be made in consultation with the patient's clinical care team, and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations. Guidance on [implementing home care of persons who do not require hospitalization](#) and the [discontinuation of home isolation for persons with COVID-19](#) is available.

  - If a medically stable patient will be discharged to a long-term care facility and transmission-based precautions are still necessary, they should go to a facility with the ability to adhere to infection prevention and control recommendations for care of patients with COVID-19.

- If a patient tests negative for COVID-19, but a higher level of clinical suspicion for COVID-19 exists, consider maintaining transmission-based precautions and repeating the test.

Universal source control and eye protection

Fever and symptom screening may not capture all infected individuals due to the range of clinical presentations associated with SARS-CoV-2, which include mild and asymptomatic infections. These individuals, as well as COVID-19 patients during the pre-symptomatic phase, may be able to transmit the virus while unaware that they are infected.

These recommendations are not intended to serve as a basis for denying care to a patient when that patient or the patient's caregiver is unable to wear a face covering or mask for medical reasons. Care should be provided with appropriate precautions for health care providers, other staff and members of the public.

OHA 2288J_R (08/10//2021)

This guidance is not intended to serve as a basis for denying emergency medical care to anyone, regardless of whether the individual is wearing a face covering or mask.

Universal measures to prevent healthcare-associated spread of SARS-CoV2 include:

While the Governor has rescinded many of the Executive Orders, the declaration of emergency remains in effect and masks are still required in health care settings. See [Mask, Face Covering, and Face Shield Requirements for Health Care Offices.](#) See also Executive Order 21-15. In addition, health care offices must continue to follow all applicable state and federal regulatory requirements related to masking, including Oregon-OSHA rules addressing COVID-19 workplace risks.

- **Source control (i.e., universal masking) for patients and visitors.** Healthcare facilities should have policies in place requiring all individuals who enter the facility to don a face covering or face mask while in the building. Though a face covering or face mask is preferred, if neither is available or tolerated by a patient, face shields can be used. If a patient cannot tolerate any form of face covering due to a medical condition, strict physical distancing should be observed until the patient can be placed in a room or an area that minimizes risk to others.

- **Source control (i.e., universal masking) for HCP.** HCP must comply with applicable state requirements regarding wearing a face covering or face mask while they are in a healthcare setting.

  - HCP should ensure that the mask covers their nose and mouth at all times. HCP should avoid touching the outside (contaminated) surface of the mask. If HCP must adjust the mask, hand hygiene should be performed before and immediately after adjustment.

  - N95s or higher-level respiratory protection should replace face masks for patient care that warrants a higher level of protection (See "PPE for Healthcare Personnel" Section). Filtering facepiece respirators with exhalation valves are not recommended for source control. Risk of COVID-19 transmission to a patient through exhaled breath from an asymptomatic HCP wearing a PAPR or elastomeric respirator when the HCP has had no known exposure to a person with infectious COVID-19 is considered low. Use of a respirator during an AGP is intended to protect the healthcare provider from an aerosol generated from the patient. There is no similar risk of aerosol generation from the healthcare provider, and the benefit of protection to HCP is felt to outweigh the low risk to the patient. Use of powered air-purifying respirators and elastomeric respirators in dental and other healthcare settings is acceptable. Additional mitigating measures (use of hoods with PAPRs or filtering material over exhalation valves of elastomeric respirators) may further decrease the likelihood of transmission. In procedures requiring sterile fields, alternatives to respirators with exhalation valves are recommended.

- **Universal eye protection for HCP.** Wearing eye protection in addition to a face mask or an N95 respirator ensures the eyes, nose, and mouth are all protected from exposure to respiratory droplets during encounters in healthcare settings or when providing patient care elsewhere.

OHA 2288J_R (08/10//2021)

- HCP should consider the proactive use of eye protection in addition to universal masking, particularly in scenarios where patients are unable to wear a face covering (e.g., assisting with feeding or showering). In scenarios with moderate or higher levels of community spread of COVID-19, eye protection is recommended for all patient care.
- Long-term care facilities should refer to Oregon Department of Human Service policies regarding universal eye protection, available via Provider Alerts page.

Universal use of PPE does not eliminate the need for physical distancing among HCP in the workplace. Special care to maintain physical distancing is needed for encounters between healthcare personnel when universal PPE cannot be worn (e.g., meal breaks, leaving the facility, etc.) as these unprotected scenarios provide an opportunity for transmission.

CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-2019) Pandemic provide additional information.

Extended use of personal protective equipment

Extended use refers to wearing the same mask (face mask or respirator), or eye protection (goggles or face shield), for repeated encounters with several different patients, without removing them between encounters. Extended-use protocols can be used as contingency strategies to address supply-line interruptions and enable prolonged use of PPE for source control or during cohorted patient care. Extended use is best suited to situations wherein multiple patients are infected with the same pathogen and patients are placed together in dedicated areas. If extended-use protocols are in place, HCP should take care not to touch their mask and eye protection. If adjustment is needed, they must perform hand hygiene before and immediately after adjustment. Extended use of eye protection can be applied to disposable and reusable devices. Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through. Reprocessing should follow manufacturer instructions (for reusable models) or a method comparable to CDC's recommendations (for disposable models).

Note that extended use of gowns should be reserved for the serial care of patients within a separate COVID-19 unit. Contaminated gowns should not be worn in common or nursing station areas as this may lead to spread via environmental contamination. It should not be used for care of patients known to be infected or colonized with another pathogen.

Additional information about optimizing the use of PPE is available from the OHA Interim Guidance: Use of Personal Protective Equipment by Health Care Personnel in Resource-Constrained Settings.

Work exclusion determinations
Exclusion of HCP with suspected or confirmed COVID-19

All HCP should self-monitor for illness consistent with COVID-19 and should be screened for fever and symptoms prior to each shift.

OHA 2288J_R (08/10//2021)

HCP should be excluded from the workplace if they test positive via a COVID-19 viral (nucleic acid or antigen) test or have any of the following symptoms:

- Measured temperature >100.0° F or subjective fever
- Cough
- Shortness of breath
- Vomiting or Diarrhea
- Loss of taste or smell

If symptoms develop at work, HCP should withdraw from patient-care activities immediately and notify their supervisor or occupational health services prior to leaving work.

See "HCP Return-To-Work Considerations" Section below.

See "Mitigating Staffing Shortages" Section below.

Exclusion of HCP with COVID-19 exposure or recent travel

Work exclusion for asymptomatic HCP is recommended following exposures or travel for which quarantine is currently recommended. Table 1 details work exclusion recommendations in various scenarios and considerations for COVID-19 testing. Note that Table 1 does not apply to symptomatic individuals. Anyone with symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test immediately.

High-risk occupational exposures include the following:

- Providing patient care that included AGPs without all recommended elements of full PPE (respirator, eye protection, gown, and gloves).
- Prolonged, close contact with an <u>unmasked patient, visitor, or HCP</u> without a face mask or respirator and eye protection (goggles or face shield).
- Prolonged, close contact with a <u>masked patient, visitor, or HCP</u> without a face mask or respirator.

Household exposures to a person with COVID-19 should be considered high-risk as they typically involve prolonged, unprotected, and close-proximity contacts.

Quarantine and risk exclusion periods, if applicable, should begin 14 days following travel or the last known exposure to an infected individual in isolation.

Non-essential travel should be avoided during the COVID-19 pandemic. When it cannot be deferred or delayed until the traveler is fully vaccinated, guidance for save travel practices and testing requirements for return to the United States can be found via CDC's Travel guidance.

Additional CDC resources for assessing risk are available in the <u>Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19</u>.

See "Mitigating Staffing Shortages" Section.

Table 1. Work restriction and home quarantine recommendations for healthcare personnel (HCP) after COVID-19 exposure or travel.

COVID-19 exposure or travel history	COVID-19 vaccination and recent infection status	Work restriction for asymptomatic HCP?	Home quarantine for asymptomatic HCP?	Testing recommendations for asymptomatic HCP *Symptomatic HCP should receive a viral test immediately*
Domestic travel outside of Oregon and Southwest Washington	Fully vaccinated‡	NO	NO	N/A
	Laboratory-confirmed infection within last 3 months	NO	NO	N/A
	Not fully vaccinated, nor recovered from COVID-19 in past 3 months	YES, for non-essential travel	YES, for non-essential travel	HCP should seek viral testing 1–3 days before travel and 3–5 days post-travel.
International travel	Fully vaccinated‡	NO	NO	HCP should seek viral testing 3–5 days post-travel.
	Laboratory-confirmed infection within last 3 months	NO	NO	N/A
	Not fully vaccinated, nor recovered from COVID-19 in past 3 months	YES	YES	HCP should seek viral testing 1–3 days before travel and 3–5 days post-travel.
Community exposure	Fully vaccinated‡	NO*	NO	HCP should seek viral testing 3–5 days post-exposure.
	Laboratory-confirmed	NO*	NO	N/A

	infection within last 3 months			
	Not fully vaccinated, nor recovered from COVID-19 in past 3 months	YES	YES	Testing recommended immediately and 5–7 days after exposure.
Household exposure	Fully vaccinated‡	Facility discretion *Strongly consider if staffing allows**	NO	Testing recommended immediately and 5–7 days after exposure.
	Laboratory-confirmed infection within last 3 months	NO*	NO	N/A
	Not fully vaccinated, nor recovered from COVID-19 in past 3 months	YES	YES	Testing recommended immediately and 5–7 days after exposure.
LOW-risk exposure in healthcare setting	Fully vaccinated‡	NO	NO	N/A
	Laboratory-confirmed infection within last 3 months	NO	NO	N/A
	Not fully vaccinated, nor recovered from COVID-19 in past 3 months	NO	NO	N/A
HIGH-risk exposure in healthcare setting	Fully vaccinated‡	NO*	NO	Testing recommended immediately and 5–7 days after exposure.

		NO*	NO	N/A
	Laboratory-confirmed infection within last 3 months	NO*	NO	N/A
	Not fully vaccinated, nor recovered from COVID-19 in past 3 months	YES	YES	Testing recommended immediately and 5–7 days after exposure.

Adapted from figure: 3/3/2021, by Dawn Nolt, MD, MPH

‡ >2 weeks after 2nd dose in a 2-dose vaccine series, or >2 weeks after single dose vaccine.

*Where feasible, consider underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might reduce protection provided by the COVID-19 vaccine.

HCP education

The following are topic areas to guide education for HCP regarding COVID-19 exposure and work exclusion:

Provide HCP resources for self-care. HCP face tremendous challenges during a crisis like the COVID-19 pandemic. Depression, anxiety, and insomnia have been documented among HCP potentially exposed to COVID-19. Educate HCP about mental health and self-care resources. Examples:

- CDC Guidance for Stress and Coping
- Disaster Distress Helpline
- American Medical Association Managing Mental Health During COVID-19
- American Psychiatric Nurses Association Guidance for Managing Stress and Self-Care
- Physician Support Line

Educate all HCP about the need to monitor themselves for symptoms. Given the potential for community-based exposures or unrecognized exposures in the healthcare system, all HCP should be instructed to monitor for fever and other symptoms of COVID-19.

Develop plan for what HCP will do if they become symptomatic. Points of contact should be established for HCP if they become ill. Educate HCP to self-isolate in their home should they become symptomatic, unless they need to seek medical care. Provide instructions for testing.

Discuss why these steps are being taken. If work exclusion is necessary, using non-punitive language convey why work exclusions are essential to prevent healthcare-associated infections.

Discuss when it would be appropriate to return to work. See "HCP Return-to-Work Considerations" Section.

HCP return-to-work considerations

OHA has adopted CDC's Return-to-Work Criteria for HCP with SARS-CoV-2 Infection. Note that the test-based strategy is no longer recommended for routine return-to-work criteria.

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:

- 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** 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.

Key practices for HCP returning to work include:

- Wear a face mask for source control at all times while in the healthcare facility. (See "Universal Use of PPE" Section)
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette principles (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 or healthcare provider if respiratory symptoms recur or worsen.

A test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy was used. It could also be considered for severely immunocompromised HCP if there was concern about viral shedding longer than 20 days. Test-based strategy criteria and additional information about Return-to-Work can be found in CDC Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection guidance.

Mitigating staffing shortages

When staffing shortages are present, asymptomatic HCP with high-risk occupational exposures for which quarantine would typically be recommended may, in consultation with

OHA 2288J_R (08/10//2021)

their occupational health program, work during their quarantine period if they remain asymptomatic and have not tested positive for COVID-19. The decision to work during quarantine should consider the risk of the identified exposure. If not fully vaccinated, they should otherwise observe quarantine outside of work. See CDC guidance for tiered Strategies to Mitigate Healthcare Personnel Staffing Shortages.

In a **crisis scenario only**, the usual standard of care for return-to-work for asymptomatic HCP with COVID-19 may not be able to be followed due to critical HCP staffing shortages. If available staffing, despite all other available accommodations (use of SERV-OR or Medical Reserve Corps volunteers, hiring from staffing agencies, etc.), is insufficient to provide needed patient care, healthcare facilities, with approval from local public health officials, *may* determine that HCP with asymptomatic, laboratory-confirmed COVID-19 infections could potentially return to work earlier than specified above, as long as they follow all recommended return-to-work practices.

When county-level COVID-19 activity is widespread, healthcare facilities can consider temporarily forgoing contact tracing for exposures in a healthcare setting in favor of universal source control for asymptomatic HCW, IPC education and PPE donning/doffing training, screening for fever and symptoms of COVID-19 before every shift, and broad testing efforts.

Exposures to HCP with suspected or confirmed COVID-19

Healthcare facilities should have a process for notifying the local public health authority (LPHA) about known or suspected cases of COVID-19 and should establish a plan, in consultation with LPHAs, for how exposures in a healthcare facility will be investigated and how contact tracing will be performed. Healthcare facilities may take the lead on contact tracing and exposure investigations but should continue to consult with LPHA as needed.

In scenarios where patients may have been exposed to HCP with COVID-19, a risk assessment should be carried out by a facility-designated individual or team that is:

1) Qualified by education, training, and experience or certification;

2) Responsible for carrying out facility infection prevention and control protocols;

3) Available to serve as primary point of contact for the facility regarding COVID-19 outbreaks.

The risk assessment should align with CDC guidance and take into account:
- presence of HCP symptoms; and
- proximity and duration of encounters; and
- use of personal protective equipment by the HCP and patient masking.

Features of higher risk exposures:
- Longer duration of exposure (>15 min)
- HCP close contact with patient airway, e.g., intubation, pharyngeal examination, bronchoscopy, or laryngoscopy

OHA 2288J_R (08/10//2021)

- Patient unmasked

Features of lower risk exposures:

- Shorter duration of exposure (<15 min)
- No close contact with airway or mucous membrane
- Patient masked

Facilities must notify contacts of HCPs with COVID-19 if *any* of the following are true:

- The HCP with COVID-19 did not wear appropriate PPE or perform appropriate infection control (e.g., hand hygiene) during the encounter
- The HCP worked while febrile (defined as ≥100° F) or actively coughing
- The patient resides in or will be transferred to a congregate care setting

Managing PPE supply issues

Healthcare facilities should develop processes to facilitate ongoing PPE inventory, ensuring that facility supply-chain managers and infection prevention staff are in communication about PPE shipment or order delays as well as increased PPE needs to support training, fit testing, and patient care. Should a potential PPE shortage be identified, the following steps should be taken:

1) Review guidance on PPE supply optimization and implement conservation strategies as appropriate. See the following guidance:

   a. OHA/Oregon-OSHA's Use of PPE by Healthcare Personnel in Resource-Constrained Settings. *Provides a tiered approach to PPE optimization strategies organized by type of PPE and level of shortage.*

   b. CDC's Optimizing Supply of Personal Protective Equipment. *Includes optimization strategies for N95 respirators, PPE FAQs, and contingency and crisis scenario PPE considerations.*

2) Define severity of the shortage. Note when interruptions in clinical operations would occur if the shortage were to persist.

3) Determine whether other PPE vendors can be used and review current contract specifications. Potential supplier options available here.

4) Leverage mutual-aid agreements and memoranda of understanding (MOUs) to obtain PPE supply from healthcare partners.

5) If all internal and partner-based options to obtain sufficient PPE supply have been exhausted, contact your local public health authority.

Note: Oregon OHSA Administrative Rule 437-001-0744 further requires that the infection control plan include "The procedures the employer will use to ensure that there is an

adequate supply of masks, face coverings, or face shields and personal protective equipment (including respirators) necessary to minimize employee exposure to COVID-19."

Environmental infection control in healthcare settings

Dedicated medical equipment should be used for patients with suspected or known COVID-19. Routine cleaning and disinfection procedures (i.e. pre-cleaning of surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings. EPA's list of COVID-19 disinfectants is available to support appropriate disinfectant selection. Oregon OHSA Administrative Rule 437-001-0744 requires employers in all workplaces to clean or sanitize surfaces at certain frequencies. The rule further requires employers in healthcare settings to develop procedures for routine cleaning and disinfection that are appropriate for SARS-CoV-2 and follow standard practices for disinfection and sterilization of medical devices contaminated with SARS-CoV-2, as described in CDC's *Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008*.

Testing guidance

Updated OHA COVID-19 Public Health Recommendations COVID Testing for Health Care Providers is available at OHA website and is updated regularly to reflect changes in testing capacity and priorities.

Visitor policy recommendations

Healthcare settings should review regulatory agency (e.g. Centers for Medicare & Medicaid Services) guidance for requirements related to visitation. This section is intended to provide general infection control recommendations to support safe visitation. For more information about regulatory guidelines, please see: OHA Health Facility Licensing & Certification Resources, Nursing Home Visitation – COVID-19, and Assisted Living Facilities/Residential Care Facilities Provider Alert.

Recommended infection prevention and control practices before and during visitation in healthcare facilities:

- **Promote vaccination among HCP and patients.** Full vaccination of visitors is preferred, but not required.

- **Inform prospective visitors about risks.** Risks associated with visitation should be explained to patients/residents and visitors so they can make informed decisions about participation. Prospective visitors should be aware that the facility may need to restrict or limit visitation to maintain infection control core principles, as consistent with regulatory guidelines. Facilities should ensure access to alternative mechanisms for patient or resident and visitor interactions (e.g., video-call applications).

- **Restrict entry for those with suspect or confirmed COVID-19 or known exposure**. Regardless of vaccination stratus, visitors should be restricted from visiting if they have current SARS-CoV-2 infection, symptoms of COVID-19, prolonged close contact with someone with SARS-CoV-2 infection in prior 14 days, or if they have otherwise met criteria for quarantine.

- **Visitors should follow recommended infection prevention and control practices**. Visitors should follow source-control recommendations (See "Universal Source Control and Eye Protection") and facility PPE policies. Hand hygiene should be performed before and after visitation with patient or resident. Visitors should receive education about these policies before visiting.

- **Visitors should be encouraged to follow state and local precautions to reduce risk of COVID-19**. To reduce the risk of introducing COVID-19 to patients, HCP, and others in the healthcare environment, visitors should make a good-faith effort to abide by all state and local public health recommendations to reduce their risk of acquiring COVID-19.

- **Physical distancing**. Visitors should follow facility policy regarding physical distancing with the person they are visiting. Physical distancing should be observed with HCP as well as with other individuals in the facility. Visitors should be instructed to visit only the patient room or designated visitation area; they should not go to other locations in the facility. If patient or resident is in a shared room, visits should be conducted in a separate visitation area, or the roommate should not be present during the visit. If neither are feasible, recommended infection control practices, including physical distancing and source control, should be practiced. Facilities may need to limit the total number of visitors in the facility to maintain physical distancing.

- **Environmental disinfection**. Cleaning and disinfection of high-touch surfaces in visitation areas should be done frequently. Visitors should be instructed to limit surfaces touched.

- **Avoid visitation during high-risk clinical activities.** Visitors should not be present during aerosol-generating procedures.

- **Post-visitation notification.** Visitor should be instructed to notify the healthcare facility if they develop fever or symptoms consistent with COVID-19 or test positive for COVID-19 within 2 days of leaving the facility.

Additional information related to infection control during visitation is available via CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.

Tracking COVID-19 vaccination in healthcare settings

All healthcare facilities are strongly encouraged to track vaccination status of healthcare providers and long-term inpatients or residents for the purposes of 1) tracking progress and

identifying vaccination gaps to improve vaccination coverage; 2) to assist in making occupational health determinations (See "Exclusion of HCP with COVID-19 exposure or recent travel" Section); and 3) to assist public health in investigating COVID-19 outbreaks in healthcare settings. The U.S. Equal Employment Opportunity Commission has provided technical assistance and questions and answers related to COVID-19 and the Americans with Disabilities Act (ADA), the Rehabilitation Act, and other equal employment opportunity laws.

To track vaccination progress in healthcare settings OHA has adapted tracking tools that auto-calculate helpful summary metrics.

OHA 2288J_R (08/10//2021)

Long-term care facilities, including nursing facilities, assisted-living facilities, and residential care facilities, are required by OAR 411-061 to report COVID-19 vaccination summary metrics to OHA. Vaccination Tracking Tools specific to long-term care settings are available:

- Staff Vaccination Tracking Tool
- Resident Vaccination Tracking Tool

Guidance for outpatient and urgent-care settings (not including emergency departments)

Outpatient facilities triage and evaluation

Outpatient facilities commonly see patients with COVID-19-like symptoms. OHA offers the following guidance in order to reduce the potential risk of community spread of COVID-19 through outpatient facilities:

For all patients:

1) **Screening:** When any patient calls to schedule a visit, screen the patient by phone for (1) fever or acute respiratory symptoms, (2) domestic or international travel within the last 14 days to areas with high prevalence of COVID-19, and (3) contact with someone with known or suspected COVID-19 or ill with respiratory symptoms. Delay routine or non-urgent visits until symptoms have resolved. See additional guidance below for patients with acute respiratory illness or fever.

2) **Separating well from ill patients:** Primary care practices should use strategies to separate well visits from sick visits. This could include:

   a. Scheduling sick visits and preventive care visits during different times of the day;

   b. Reducing crowding in waiting rooms, by asking patients to remain outside (e.g., staying in their vehicles until called into the facility for their appointment, or setting up outdoor triage screening); and

   c. For multi-facility practices, identifying separate locations for preventive visits only.

3) **Immunizations:** As counties reopen, HCP should identify children and adolescents who have missed well-child visits or recommended vaccinations and contact them to schedule immunizations. Providers may consider creating "drive up" immunization delivery systems (e.g., in-car parking lot vaccinations) for patients who are due for routine immunizations.

For patients with acute respiratory illness or fever (See figure 1 for additional guidance):

1) Consider using telemedicine to evaluate these patients when appropriate.

2) In general, any patient with symptoms consistent with COVID-19 should be tested. For detailed testing guidance, including priority groups if resources are limited, please see COVID-19 Public Health Recommendations COVID Testing for Health Care Providers.

OHA 2288J_R (08/10//2021)

3) Providers are encouraged to use "drive-through" dedicated COVID-19 testing sites.

4) For patients requiring in-person clinical evaluation, consider alternative routes of entry/exit and alternative waiting areas in order to minimize interaction with other patients and healthcare workers.

5) Implement respiratory hygiene and cough etiquette. Patients should wear a face covering or face mask during their visit. (See "Universal Source Control and Eye Protection" Section.) Masks should be readily available at all entries/exits, and clear signage in relevant languages should reinforce their use.

6) Patients should not wait in lobbies or waiting rooms. Immediately place patients in a private room with the door closed. If available, consider use of an AIIR, prioritizing AIIR use for those with severe respiratory illness. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.

7) HCP evaluating patients suspected to have COVID-19 should don appropriate personal protective equipment (PPE). See "Personal Protective Equipment for Healthcare Personnel" Section.

8) Consider strategies to minimize the number of HCP interacting with patients, e.g., alternative check-in procedures and asking providers to room patients directly.

9) It is unknown how long SARS-CoV-2 persists in various environments, but contact-based transmission is believed to play some role in the spread of the virus. The patient room should be appropriately cleaned and disinfected between patients. See "Environmental Infection Control in Healthcare Settings" Section. If medical needs are non-urgent, attempt to schedule those with respiratory illness for the end of the day when possible.

Recommendations for hospitals (includes emergency departments [EDs] and inpatient settings)

Hospital triage and evaluation

Symptom, travel, and exposure screening
All patients should be screened for (1) fever or acute respiratory symptoms, (2) domestic or international travel within the last 14 days to areas with high prevalence of COVID-19, and (3) contact with someone with known or suspected COVID-19 or ill with respiratory symptoms.

Though travel to geographic areas with sustained transmission is no longer the primary mode of exposure to the virus that causes COVID-19, we recommend continued implementation of a travel screen that identifies those with international travel in the last 14 days (30 days is also a reasonable time frame). This will facilitate identification of travel-associated cases and those at risk for other serious travel-associated infections; and support ongoing high-impact pathogen preparedness in the healthcare setting.

OHA 2288J_R (08/10//2021)

Rapid triage

When possible, instruct patients to call ahead and inform clinic or hospital staff when they have respiratory symptoms. Remind patients to adhere to respiratory etiquette and to don a cloth face covering or face mask upon entry to the facility. Ensure that PPE and an appropriate room are available to minimize exposure to other patients and providers. Identify a separate, well-ventilated space. (Prioritize AIIR use for those with severe respiratory illness.) Instruct patients to remain at least six feet from others and to observe respiratory etiquette, including placement of a face covering.

Place signs or posters at entryways, requesting that patients don a cloth face covering or face mask and apply hand sanitizer if they have fever, cough, or difficulty breathing.

Communication plans

Develop an internal communication plan to alert key internal staff (e.g., hospital epidemiologists, infection preventionists, frontline staff, occupational health, laboratory, nursing supervisors, leadership, etc.) promptly about known or suspected cases of COVID-19.

A confirmed case of COVID-19 must be reported to the local public health authority (LPHA) within 24 hours. (See LPHA contact information available at: www.healthoregon.org/lhddirectory)

Recommendations for collection and submission of postmortem specimens

Autopsy procedures should be performed with standard, contact, and airborne precautions with eye protection (goggles or a face shield) due to the likelihood for aerosol generation.

For specimen collection, infection control, and biosafety considerations for a deceased person under investigation, see CDC's Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation for COVID-19. Oregon OHSA

requires employers to provide PPE for potentially aerosol-generating post-mortem procedures in accordance with CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.

Resources for specialized healthcare providers and settings

Long-term care facilities (LTCFs)

- See previous sections for detailed guidance for all healthcare settings.
- See OHA COVID-19 Healthcare Partner Resources webpage for LTCF-specific updates regarding COVID-19 and the LTCF COVID-19 Response Toolkit.
- CDC resources:
  - Responding to Coronavirus (COVID-19) in Nursing Homes
  - Testing Guidelines for Nursing Homes
  - Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2

OHA 2288J_R (08/10//2021)

- Considerations for Memory Care Units in Long-term Care Facilities
- Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities
- Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

Outpatient hemodialysis facilities

- See previous sections for detailed guidance for all healthcare settings.
- CDC resources:
  - Infection Prevention and Control for Outpatient Hemodialysis Facilities
  - Coronavirus Disease 2019 (COVID-19) Outpatient Dialysis Facility Preparedness Checklist
- CMS guidance for dialysis facilities

First responders

See OHA COVID-19 Healthcare Partner Resources webpage for COVID-19 updates specific to emergency medical services (EMS), law enforcement and public safety answering points (PSAPs).

See CDC guidance for first responders, including emergency medical services (EMS), law enforcement, and emergency management officials.

Appendix I

High-risk aerosol-generating procedures[2] include:

- Intubation, extubation, and related procedures such as manual ventilation and open suctioning

- Cardiopulmonary resuscitation

- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)

- Bronchoscopy

- Surgery and post-mortem procedures involving high-speed devices if involves the respiratory tract or paranasal sinuses

- Some dental procedures (such as high-speed drilling)

- Non-invasive ventilation (NIV) such as bi-level positive airway pressure (BiPAP) and continuous positive airway pressure ventilation (CPAP)

- High-frequency oscillating ventilation (HFOV)

- High-flow nasal oxygen (HFNO), also called high-flow nasal cannula

- Induction of sputum

- Medication administration via continuous nebulizer

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Health Information Center at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us.

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[2] Note: Currently, there is insufficient evidence to produce a comprehensive list of aerosol-generating procedures. This list is provisional and will continue to be updated with the evidence base.

OHA 2288J_R (08/10//2021)