PENNSYLVANIA DEPARTMENT OF HEALTH
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UPDATE: Interim Infection Prevention and Control
Recommendations for Healthcare Settings during the
COVID-19 Pandemic

DATE:	9/21/2021
TO:	Health Alert Network
FROM:	Alison Beam, JD, Acting Secretary of Health
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This transmission is a "Health Update": provides updated information regarding an incident or situation; unlikely to require immediate action.

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This HAN Update provides comprehensive information regarding infection prevention and control for COVID-19 in healthcare settings based on changes made by CDC on September 10, 2021.The content of this HAN has been re-organized to more closely align with the formatting of CDC guidance, but contains similar content to previously available HANs. **This update replaces PA-HAN-563, PA-HAN-554, PA-HAN-544 and PA-HAN-521**.
Major additions and edits in this version include:

- Added options for fully vaccinated persons to forgo source control in limited situations in healthcare facilities in counties with low to moderate community transmission.
- Removed quarantine recommendations for fully vaccinated patients who have had close contact with someone with SARS-CoV-2 infection, in most circumstances. An emphasis remains on testing and source control for these patients for 14 days following exposure.
- Clarification of the recommended intervals for testing asymptomatic persons following exposure to someone with SARS-CoV-2 infection.
- Compiled several healthcare guidance documents, including guidance for dental settings (PA-HAN-521), hospital outbreak response (PA-HAN-544) and the discontinuation of Transmission-based Precautions for COVID-19 (PA-HAN-554).

If you have additional questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

This guidance has been updated based on currently available information about COVID-19 and the current situation in Pennsylvania. It applies to all persons regardless of COVID-19 vaccination status, unless otherwise indicated. **This HAN replaces PA-HAN-563, PA-HAN-554, PA-HAN-544, and PA-HAN-521**. If you have questions about this guidance, please contact DOH at **1-877-PA-HEALTH (1-877-724-3258)** or your local health department. This guidance is not intended for non-healthcare settings (e.g., schools) OR for persons outside of healthcare settings.

Defining Community Transmission of SARS-CoV-2

Several of the IPC measures (e.g., use of source control, screening testing) are influenced by levels of SARS-CoV-2 transmission in the community. Two different indicators in CDC's COVID-19 Data Tracker are used to determine the level of SARS-CoV-2 transmission for the county where the healthcare facility is located. If the two indicators suggest different transmission levels, the higher level of community transmission should be selected.

1. **RECOMMENDED ROUTINE INFECTION PREVENTION AND CONTROL (IPC) PRACTICES DURING THE COVID-19 PANDEMIC**

DOH recommends using the following additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection (See Section 2 for additional practices that should be used when caring for patients with suspected or confirmed SARS-CoV-2 infection).

A. **Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection**
- Ensure everyone is aware of recommended IPC practices in the facility.
  - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations.
- Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed:
  1) A positive viral test for SARS-CoV-2;
  2) Symptoms of COVID-19, or
  3) Who meets criteria for quarantine or exclusion from work.
  Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the 3 above criteria before entering the facility.
- Healthcare personnel (HCP), even if fully vaccinated, should report any of the 3 above criteria to occupational health or another point of contact designated by the facility. Recommendations for evaluation and work restriction of these HCP are in PA-HAN-596.
- Visitors meeting any of the 3 above criteria should generally be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively. Additional information about visitation for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from CMS.
- Patients meeting any of the three above criteria should be managed as described in Section 2.

- Unvaccinated HCP, patients and visitors should be [offered resources and information](#) about the importance of receiving the COVID-19 vaccine.

B. Implement Source Control Measures

[Source control](#) refers to 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 they are breathing, talking, sneezing or coughing.

Source control options for HCP include:
- A NIOSH-approved N95 or equivalent or higher-level respirator,
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated), OR
- A well-fitting facemask.

When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged or hard to breathe through. If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved N95 or equivalent or higher-level respirator during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed using proper doffing technique and discarded after the patient care encounter and a new one should be donned.

Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for **everyone in a healthcare setting**. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission or who have:
- Not been fully vaccinated;
- Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze);
- Are fully vaccinated but had close contact (patients and visitors) or a higher-risk exposure (for HCP; per [PA-HAN-596](#)) with someone with SARS-CoV-2 infection for 14 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission (i.e., outbreak);
- Moderate to severe immunocompromise; or
- Otherwise had source control and physical distancing recommended by public health authorities.

While it is generally safest to implement universal use of source control for everyone in a healthcare setting, the following allowances could be considered for **fully vaccinated individuals** (who do not otherwise meet the criteria described above) in healthcare facilities **located in counties with low to moderate community transmission**. Fully vaccinated people might choose to continue using source control if they or someone in their household is immunocompromised or at [increased risk for severe disease,](#) or if someone in their household is unvaccinated.

- **Fully Vaccinated HCP in Areas of Low to Moderate Transmission**:
  - Consistent with [guidance for the community](#) could choose to not wear source control or physically distance when they are in well-defined areas that are restricted from patient access, if consistent with the policy of the facility (e.g., staff meeting rooms, kitchen).

- They **should wear source control** when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors or reception desks, even if patients aren't there at the time).
- **Patient Visitation in Areas of Low to Moderate Transmission:**
  - **Indoor visitation** (in single-person rooms; in multi-person rooms when roommates are not present; or in designated visitation areas when others are not present): The safest practice is for patients and visitors to wear source control and physically distance, particularly if either the patient or the visitors are at risk for severe disease or are unvaccinated.
    - If the patient and all their visitor(s) are fully vaccinated, they can choose not to wear source control and to have physical contact.
    - Visitors should wear source control when around other patients or HCP, regardless of vaccination status.
  - **Outdoor Visitation**: If either the patient or a visitor is unvaccinated, they should wear source control and physically distance. In general, fully vaccinated people do not need to wear a mask outdoors. Fully vaccinated people might choose to wear a mask in crowded outdoor settings or if they or someone in their household is immunocompromised.
- **Fully Vaccinated Residents in Nursing Homes in Areas of Low to Moderate Transmission:**
  - Nursing homes are healthcare settings, but they also serve as a home for long-stay residents and quality of life should be balanced with risks for transmission. In light of this, consideration could be given to allowing asymptomatic fully vaccinated residents who have not been exposed to COVID-19 in the previous 14 days, to <u>not</u> use source control when in communal areas of the facility; however, residents at <u>increased risk for severe disease</u> should still consider continuing to practice physical distancing and use of source control.

C. Implement Universal Use of Personal Protective Equipment for HCP in Areas of Substantial or High Transmission

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in <u>counties</u> with **substantial or high transmission** should also use PPE as described below:

- NIOSH-approved N95 or equivalent or higher-level respirators should be used instead of a facemask for:
  - All aerosol-generating procedures (refer to <u>Which procedures are considered aerosol generating procedures in healthcare settings?</u>).
  - All surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract).
- Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated.
- Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

D. Encourage Physical Distancing

In situations when unvaccinated patients could be in the same space (e.g., waiting rooms, cafeterias, dialysis treatment room), arrange seating so that patients can sit at least 6 feet apart, especially in counties with substantial or high transmission. This might require scheduling appointments to limit the number of patients in waiting rooms, treatment areas or participating in group activities.

E. Optimize the Use of Engineering Controls and Indoor Air Quality

- Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (e.g., physical barriers at reception/triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas).
- Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in all shared spaces.
    - o Guidance on ensuring that ventilation systems are operating properly is available in the following resources:
        - ▪ Guidelines for Environmental Infection Control in Health-Care Facilities
        - ▪ American Society of Heating, Refrigerating and Air-Conditioning Engineers; (ASHRAE) resources for healthcare facilities, which also provides COVID-19 technical resources for healthcare facilities; and
        - ▪ Ventilation in Buildings, which includes options for non-clinical spaces in healthcare facilities.

F. Perform SARS-CoV-2 Testing

- Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test as soon as possible.
- Testing is not recommended for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.
- Asymptomatic HCP with a higher-risk exposure (per PA-HAN-596) and patients with close contact with someone with SARS-CoV-2 infection, **regardless of vaccination status**, should have a series of two viral tests for SARS-CoV-2 infection.
    - o **If the date of a discrete exposure is known,** testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure.
    - o **If the date of a discrete exposure is NOT known** (for example, a household exposure with an undefined start date), testing is recommended immediately and, if negative, again 5–7 days after the first test. If the exposure is ongoing, as often occurs in household exposure, additional testing may be warranted.
- Guidance for work restrictions for HCP with higher-risk exposures are in PA-HAN-596.
- Guidance for use of Transmission-Based Precautions (quarantine) for patients with close contact with someone with SARS-CoV-2 infection are described in Section 2.
- Testing considerations for healthcare facilities with an outbreak of SARS-CoV-2 are described below for dialysis, hospital, outpatient, dental and other healthcare facility types.
    - o For long-term care facilities refer to PA-HAN-570 or its successor and CMS Guidance for nursing homes QSO-20-38-NH.
- For skilled nursing facilities, conduct routine testing of HCP as outlined in CMS Guidance for nursing homes QSO-20-38-NH for unvaccinated HCP.
- Performance of pre-procedure or pre-admission viral testing is at the discretion of the facility. The yield of this testing for identifying asymptomatic infection is likely low when performed on vaccinated individuals or those in counties with low or moderate transmission. However, these results might continue to be useful in some situations (e.g., when performing higher risk

procedures on unvaccinated people) to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used).

G. Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others

Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. Guidance on assessing the risk for exposed patients and HCP is available in the [Healthcare Infection Prevention and Control FAQs for COVID-19](#).

When an HCP is identified as infected with COVID-19, anyone who had prolonged close contact should be considered potentially exposed. The use of a [facemask](#) for source control and adherence to other recommended IPC measures by the HCP help to reduce, but not eliminate, the risk of transmission. The following should be considered when determining which patients are at higher risk for transmission and might be prioritized for notification, evaluation and testing:

- [Facemask](#) use by the patient – Mirroring the [risk assessment guidance for healthcare personnel](#), patients not wearing a facemask would likely be at higher risk for infection compared to those that were wearing a facemask.
- Type of interaction that occurred between the patient and infected provider – An interaction involving manipulation or prolonged close contact with the patient's eyes, nose, or mouth (e.g., intubation, dental cleaning) likely poses higher risk of transmission to the patient compared to other interactions (e.g., blood pressure check).
- PPE used by infected HCP – HCP wearing a [facemask](#) (or respirator) and face shield that extends down below the chin might have had better source control than wearing only a facemask.
- Current status of patient – Is the patient currently admitted to a hospital or long-term care facility? These individuals, if infected, can be at higher risk for severe illness and have the potential to expose large numbers of individuals at risk for severe disease.

If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. For example, in an outpatient dialysis facility with an open treatment area, testing should ideally include all patients and HCP. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCP and patients on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.

Guidance for outbreak response in nursing homes is described in [PA-HAN-570](#) or its successor.

Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities. Outbreak reporting requirements for hospitals in Pennsylvania are given in [PA-HAN-540](#).

2. RECOMMENDED INFECTION PREVENTION AND CONTROL (IPC) PRACTICES WHEN CARING FOR A PATIENT EXPOSED TO COVID-19 OR WITH COVID-19 INFECTION

Guidance in this section applies to all healthcare facilities and may be applicable in non-healthcare congregate settings. Additional guidance is available for long-term care facilities in

PA-HAN-570 and PA-HAN-568 or their successors and is designed to add additional elements of protection for vulnerable populations in these facility types.

The IPC recommendations described below apply to:
- Patients with symptoms of COVID-19 (even before results of diagnostic testing);
- Asymptomatic patients who have met the criteria for Transmission-Based Precautions (quarantine) based on close contact with someone with SARS-CoV-2 infection; and
- Patients with SARS-CoV-2 infection.

However, quarantined patients and those with suspected infection should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing. Options for shortening the duration of quarantine are provided in PA-HAN-583, although these options are not preferred for healthcare settings.

Note: In general, the following patients who are asymptomatic do not require use of Transmission-Based Precautions (quarantine) for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection:
- A. Fully vaccinated patients; or
- B. Patients who have had SARS-CoV-2 infection in the last 90 days.

However, there may be circumstances when Transmission-Based Precautions (quarantine) for these patients might be recommended (e.g., patient is moderately to severely immunocompromised, or if the initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result). In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated patients on affected units and work restriction of fully vaccinated HCP with higher-risk exposures. Facilities should follow additional recommendations made by the local public health department in response to an epidemiologic assessment.

A. Patient Placement
- Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom.
- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shifts.
  - Only patients with the same respiratory pathogen should be housed in the same room.
- Limit transport and movement of the patient outside of the room to medically essential purposes.
- Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

B. Personal Protective Equipment
- HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). This is also known as Transmission-based Precautions for COVID-19.
- Additional information about using PPE is available from CDC in Protecting Healthcare Personnel.

C. Aerosol Generating Procedures (AGPs)

- Procedures that could [generate infectious aerosols](#) should be performed cautiously and avoided if appropriate alternatives exist.
- AGPs should take place in an airborne infection isolation room (AIIR), if possible.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.

D. Visitation

- For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, state, and federal regulations related to visitation and act in accordance with their facility's written policy. Visitation guidance for [nursing homes](#) and [intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities](#) is available from CMS.
  - o Counsel patients and their visitor(s) about the risks of an in-person visit.
  - o Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
- 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.
- Visitors should be instructed to only visit the patient's room. They should minimize their time spent in other locations in the facility.

E. Duration of Transmission-Based Precautions

A symptom-based strategy for discontinuing Transmission-Based Precautions is preferred in most clinical situations.

The criteria for the **symptom-based strategy** are:

Patients with mild to moderate illness who are not moderately to severely immunocompromised:

- At least 10 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.

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 diagnostic test.

Patients with severe to critical illness or who are moderately to severely immunocompromised:

- At least 10 days and up to 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.
- Consider consultation with infection control experts.

A test-based strategy could be considered for some patients (e.g., those who are moderately to severely immunocompromised) in consultation with local infectious diseases experts if concerns exist over the patient being infectious for more than 20 days. Limitations of the test-based strategy are described elsewhere.

The criteria for the **test-based strategy** are:

Patients who are symptomatic:

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

Patients who are not symptomatic:

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

The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with suspected SARS-CoV-2 infection can be made based upon having negative results from at least one respiratory specimen tested using an FDA-authorized COVID-19 viral test.

- If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2 RNA.
- If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made using the symptom-based strategy described above.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.

Discharge of Patients with COVID-19 from a Healthcare Facility
Patients should be discharged from the healthcare facility whenever clinically indicated.

- If discharged to home
  - Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions. Information on ending home isolation can be found here.

- If discharged to a skilled nursing facility or other long-term care facility (e.g., personal care home, assisted living facility)
  - The receiving facility should be made aware of the COVID diagnosis and information provided on the status of isolation (i.e., completed on day x).

F. Environmental Infection Control

- Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
  - All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean 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 SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.
  - Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles [more information (to include important footnotes on its application) on clearance rates under differing ventilation conditions is available]. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

3. SETTING-SPECIFIC CONSIDERATIONS

In addition to the recommendations described in the guidance above, here are additional considerations for the settings listed below.

A. Dialysis Facilities

Considerations for Patient Placement
- Patients on dialysis with suspected or confirmed SARS-CoV-2 infection or who have reported close contact should be dialyzed in a separate room with the door closed.
  - Hepatitis B isolation rooms can be used if: 1) the patient is hepatitis B surface antigen positive or 2) the facility has no patients on the census with hepatitis B infection who would require treatment in the isolation room.
- If a separate room is not available, patients with confirmed SARS-CoV-2 infection should be cohorted to a specific well-ventilated unit or shift (e.g., consider the last shift of the day). Only patients with confirmed SARS-CoV-2 infection should be cohorted together:
  - In the context of an outbreak or an increase in the number of confirmed SARS-CoV-2 infections at the facility, if a separate shift or unit is not initially available, efforts should be made to create specific shifts or units for patients with confirmed SARS-CoV-2 infection to separate them from patients without SARS-CoV-2 infection.

Additional Guidance for Use of Isolation Gowns
- When caring for patients with suspected or confirmed SARS-CoV-2 infection, gowns should be worn over or instead of the cover gown (e.g., laboratory coat, gown, or apron with incorporate sleeves) that is normally worn by hemodialysis personnel.

Cleaning and Disinfecting Dialysis Stations
- Current procedures for routine cleaning and disinfection of dialysis stations are appropriate for patients with SARS-CoV-2 infection.

- Internal disinfection of dialysis machines is not required immediately after use unless otherwise indicated (e.g., post-blood leak). It should be done according to the dialysis machine manufacturer's instructions (e.g., at the end of the day).

B. Emergency Medical Services

Considerations for vehicle configuration when transporting a patient with suspected or confirmed SARS-CoV-2 infection:
- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
- When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
    - Before entering the isolated driver's compartment, the driver (if they were involved in direct patient care) should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
    - Close the door/window between these compartments before bringing the patient on board.
    - During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
    - If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.
    - Some vehicles are equipped with a supplemental recirculating ventilation unit that passes air through high-efficiency particulate air (HEPA) filters before returning it to the vehicle. Such a unit can be used to increase the number of air changes per hour (per NIOSH [Health Hazard Evaluation Report 95–0031–2601](#)).
    - After patient unloading, allowing a few minutes with ambulance module doors open will rapidly dilute airborne viral particles.
- If a vehicle without an isolated driver compartment must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting to create a pressure gradient toward the patient area.
    - Before entering the driver's compartment, the driver (if they were involved in direct patient care) should remove their gown, gloves and eye protection and perform hand hygiene to avoid soiling the compartment. They should continue to wear their NIOSH-approved N95 or equivalent or higher-level respirator.

Additional considerations when performing AGPs on patients with suspected or confirms SARS-CoV-2 infection:
- If possible, consult with medical control before performing AGPs for specific guidance.
- Bag valve masks (BVMs) and other ventilatory equipment should be equipped with HEPA filtration to filter expired air.
- EMS systems should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive-pressure ventilation.
- If possible, the rear doors of the stationary transport vehicle should be opened, and the HVAC system should be activated during AGPs. This should be done away from pedestrian traffic.
- If possible, discontinue AGPs prior to entering the destination facility or communicate with receiving personnel that AGPs are being implemented.

C. Dental Facilities
- Dental healthcare personnel (DHCP) should regularly consult their state [dental board](#) and state or local health departments for current information and recommendations and

requirements specific to their jurisdictions, which might change based on level of community transmission in the county where their healthcare facility is located.

- Postpone all non-urgent dental treatment for: 1) patients with suspected or confirmed SARS-CoV-2 infection until they meet criteria to discontinue Transmission-Based Precautions and 2) patients who meet criteria for quarantine until they complete quarantine.
    - o Dental care for these patients should only be provided if medically necessary. Follow all recommendations for care and placement for patients with suspected or confirmed SARS-CoV-2 infection.
    - o If a patient has a fever strongly associated with a dental diagnosis (e.g., pulpal and periapical dental pain and intraoral swelling are present) but no other symptoms consistent with COVID-19 are present, dental care can be provided following the practices recommended for routine health care during the pandemic.
- When performing aerosol generating procedures on patients who are not suspected or confirmed to have SARS-CoV-2 infection, ensure that DHCP correctly wear the recommended PPE (including a NIOSH-approved N95 or equivalent or higher-level respirator in counties with substantial or high levels of transmission) and use mitigation methods such as four-handed dentistry, high evacuation suction, and dental dams to minimize droplet spatter and aerosols.
    - o Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.
- Dental treatment should be provided in individual patient rooms whenever possible.
- For dental facilities with open floor plans, to prevent the spread of pathogens there should be:
    - o At least 6 feet of space between patient chairs.
    - o Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).
    - o Operatories should be oriented parallel to the direction of airflow if possible.
    - o Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.
    - o Ensure to account for the time required to clean and disinfect operatories between patients when calculating your daily patient volume.

D. Nursing Homes

Additional considerations for nursing homes are available in PA-HAN-568 and PA-HAN-570 or their successors.

DEFINITIONS:

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Healthcare settings: refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, inpatient rehabilitation 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.

Source control: Use of well-fitting cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Cloth masks, facemasks, and respirators should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing a cloth mask, facemask, or respirator safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their cloth mask, facemask, or respirator without assistance. Face shields alone are not recommended for source control.

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal protective equipment (PPE) appropriate for use by healthcare personnel as the degree to which cloth masks protect the wearer might vary.** Guidance on design, use, and maintenance of cloth masks is available.

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

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

Airborne Infection Isolation Rooms (AIIRs):
- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 12 air changes per hour (6 air changes per hour are allowed for AIIRs last renovated or constructed prior to 1997.
- Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

Fully vaccinated is defined in the CDC Interim Public Health Recommendations for Fully Vaccinated People.

Unvaccinated refers to a person who does not fit the definition of "fully vaccinated," including people whose vaccination status is not known, for the purposes of this guidance.

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the CDC Interim Clinical Considerations for Use of COVID-19 Vaccines.

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise and not clearly affect decisions about need for or duration of Transmission-Based Precautions if the individual had close contact with someone with SARS-CoV-2 infection. However, fully vaccinated people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility, even when not otherwise recommended for fully vaccinated individuals.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Close contact: Being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines) The studies used to inform this guidance did not clearly define "severe" or "critical" illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the [National Institute of Health (NIH) COVID-19 Treatment](#) Guideline are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions.

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

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

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

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

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

If you have additional questions about this guidance, please contact DOH at 1-877-PA- HEALTH (1-877-724-3258) or your local health department.

This information is current as of September 21, 2021 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.