Answers to Frequently Asked Questions About COVID-19 Information for Nursing Homes

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General

Is COVID-19 still a reportable disease?

COVID-19 remains a reportable illness. At the national level, COVID-19 is a notifiable disease, and the US Centers for Disease Control and Prevention (CDC) requires RIDOH to report.

In Rhode Island, COVID-19 remains reportable. RIDOH relies on the partnership with providers and facilities to uphold Rhode Island's "Reporting and Testing of Infectious, Environmental, and Occupational Diseases" regulation [216-RICR-30-05-1].

By tracking COVID-19 cases and outbreaks that are reported, RIDOH can direct resources and formulate policies that best serve our communities, including older adults and nursing homes. This information can inform national policies when further reported to the CDC.

Why are nursing homes recommended to base decisions on COVID-19 infection prevention and control protocols on COVID-19 transmission in the community rather than the presence of COVID-19 in the facility (like influenza)?

Updated CDC guidance stresses that increasing COVID-19 community transmission has been one of the strongest indicators of increasing COVID-19 incidence in nursing homes throughout the pandemic. COVID-19 remains a highly contagious disease which may be transmitted before symptoms develop. As COVID-19 community transmission increases the potential for encountering asymptomatic or pre-symptomatic people with COVID-19 infection also likely increases. This makes it challenging to control transmission in nursing homes.

Facility-level infections may not accurately capture the risk to nursing home residents due to the bidirectional (regular coming and going) visitation of nursing home residents with family residing in the community. Using county-specific transmission rates provides a more comprehensive assessment of risk for nursing home residents.

COVID-19 disproportionately impacts people who are residents in nursing homes: people age 65 and older, as well as people who have compromised immune systems, comorbidities, and who are not up to date with COVID-19 vaccines. It is important to note that as science and data evolves regarding COVID-19, so will the guidance and recommendations.

Healthcare Personnel

Are recommendations for use of N-95s and face shields/goggles by healthcare personnel (HCP) based on vaccination status or previous infection history?

Eye protection recommendations are not based on an individual's vaccination status. As per CDC guidance, Nursing Homes should use source control for HCP during patient care encounters when COVID-19, or other respiratory virus transmission, is increasing in the community: such as when COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings

How is a "patient care encounter" different than a "patient care area?"

A patient care encounter refers to the provision of care or resident interaction. A patient care area is any area that a patient has normal access to, and can be expected to be traversed through or in.

Why are N-95 masks and goggles universally recommended for staff during patient care encounters in nursing homes (rather than the single-use policies in hospitals and other settings)?

The CDC guidance and subsequent RIDOH recommendations advise that staff wear N-95 masks and eye protection during patient care encounters during periods of higher COVID-19, or other respiratory virus transmission, in the community.

There are several factors that inform this recommendation, including the increased mortality for older adults, the nature of close contact in long-term care settings, the residents' ability to participate in mitigation strategies, the variety of ventilation systems available in this setting, and the presence of emerging variants.

Source Control (Masking)

What are the latest recommendations and requirements for personal protective equipment (PPE) for staff, residents, and visitors?

Nursing homes should consider masks for everyone in areas of patient care.

Nursing homes should consider broad use of respirators and eye protection by staff in patient care encounters when COVID-19, or other respiratory virus transmission, is increasing in the community: such as when COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings.

Additionally, staff should follow recommendations for masking at all community transmission levels when exposed to someone with COVID-19 infection or an uncontrolled outbreak in the facility.

Rhode Island regulations (216-RICR-20-15-7) require that healthcare workers are up to date with their COVID-19 vaccines or wear a NIOSH-approved N-95 mask while working in healthcare facilities when COVID-19 community transmission (case rates) is greater than or equal to 50 cases per 100,000 people per week.

Should long-term residents wear masks when not in their rooms?

Everyone in nursing homes, including residents, should use source control (masking) when COVID-19, or other respiratory virus transmission, is increasing in the community: such as when COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings.

As age (specifically 65 and older) remains one of the key predictors for worse outcomes due to COVID-19 illness, CDC and RIDOH strongly encourage residents to mask in common areas or when in close contact with others.

Residents with compromised immune systems or those at high risk for severe disease should be counseled about strategies to protect themselves and others, including recommendations for source control.

What's the difference between COVID-19 hospital admission levels and the two earlier indicators of increasing community transmission, wastewater monitoring and percentage of all Emergency Department visits with a COVID-19 diagnosis regarding staff masking?

Updated CDC guidance, and subsequent RIDOH information, recommend that nursing homes consider a few different factors when making decisions about masking for staff. One important factor is when COVID-19, or other respiratory virus transmission, is increasing in the community. **COVID-19 wastewater monitoring and percentage of all Emergency Department visits with COVID-19 diagnosis are two indicators that provide early signals when COVID-19 is increasing in the community**. While CDC recommends the general population, and all settings, consider universal masking when COVID-19 hospital admission level (HALs) is high.

These data are updated weekly by 10 a.m. on Friday mornings on RIDOH's COVID-19 Data Response Portal. Find more detailed information about these data and indicators in the "Data Notes" section at the end of the web page.

Can nursing homes require visitors and residents to wear masks?

No. Nursing homes have a responsibility to educate, encourage, and model best practices for infection prevention and control. Residents and visitors may decide to remove source control during a visit when in a private area (away from staff and other residents).

Why is source control recommended for 10 days when the incubation period for COVID-19 infection is 14 days?

The CDC chose a period for source control that captures the duration that people are most likely to transmit infection.

The CDC's definition of incubation period is broad as to include almost everyone with incubating infection. Source control can be defined more narrowly as the risk of transmission is highest early in infection.

Screening

Should residents be screened for COVID-19 symptoms daily?

Symptom screening is at the facility's discretion and the policy and processes implemented may vary by facility. RIDOH's Center for COVID-19 Epidemiology (CCE) strongly encourages daily COVID-19 symptom screening for residents.

CDC recommends that during an outbreak, facilities should screen visitors for signs and symptoms in accordance with national standards and/or health department recommendations. Screening may be conducted by active or passive (i.e., self-screening) means.

Empiric Transmission-Based Precautions

How do empiric transmission-based precautions differ from isolation and/or quarantine?

Empiric transmission-based precautions are measures of infection prevention and control used in addition to standard precautions. Empiric transmission-based precautions are used when a patient or resident has a known or suspected infection with a pathogen that requires additional measures of precaution. Isolation is used when someone has tested positive for an illness, such as COVID-19. Quarantine was previously used when someone was identified as a close contact exposure.

Isolation

Why is the isolation period 10 to 20 days for people who have compromised immune systems (i.e., most residents) and 7 days with a negative test result for people who do not have compromised immune systems (i.e., staff)?

People with compromised immune systems may harbor viruses longer than other individuals and may also continue to shed virus for longer periods of time. Consulting with a healthcare professional can help to determine duration of isolation in these situations.

The CDC recommends that people with moderately or severely compromised immune systems isolate for at least 20 days, consult with a provider, and use a test-based strategy before ending isolation. This is recommended because people who are moderately or severely immunocompromised may remain infectious up to or beyond 20 days. A longer isolation period, along with appropriate testing and consultation with a provider, can help to reduce the risk of transmission from those with compromised immune systems to fellow residents.

Precautions When Someone in the Facility Tests Positive for COVID-19

Should residents be moved if they share a room with someone who tests positive for COVID-19?

Exposed residents, including roommates, who test **negative** for COVID-19 should be moved to a different room to prevent risk from continued exposure. Using a cohort approach to exposed residents who test negative for COVID-19 is acceptable.

Isolating infected individuals in a private room with a private bath remains best practice for anyone who tests positive for COVID-19. Using a cohort approach for residents who test positive for COVID-19 is acceptable.

What are the recommendations for group activities and gatherings, such as main dining room, hairdresser, and such, when the facility has an outbreak (one or more positive cases of COVID-19)?

During outbreak situations, group activities, gatherings, hairdresser, and communal dining should be assessed by each facility, based on current COVID-19 positivity rates within a facility in consultation with RIDOH staff. Modifications to group activities may be made, such as increasing the distance between residents in groups, using a cohort approach, and improving ventilation if group activities are continued.

If areas or units are not affected, those activities may continue. Quality of life is an important consideration to be balanced with risk of transmission and infection.

Admissions (new residents and those returning from leave longer than 24 hours)

As admissions are no longer required to quarantine, how should nursing homes admit new residents and those returning from leave longer than a full day?

All admissions (new admissions and residents returning from a leave that was longer than 24 hours) should **wear a mask for 10 days.** While admissions testing is at the discretion of the facility, RIDOH strongly encourages nursing homes to consider testing for all new admissions/residents returning to the facility after more than 24 hours. This is recommended due to the vulnerability of populations served by most nursing homes in Rhode Island. Data show that **age remains the strongest risk factor for severe COVID-19 outcomes**.

If nursing homes use admissions testing, residents should **test negative on three antigen tests taken 48 hours apart (days 1,3, and 5)**. No additional precautions are recommended for admissions who are not up to date with COVID-19 vaccines and/or are arriving from an in-patient hospitalization.

The facility is encouraged to use empiric transmission-based precautions if: the person admitted cannot follow recommendations for testing or wear a mask for 10 days, the person admitted has a moderately or severely compromised immune system, or the person admitted is on a unit with an uncontrolled outbreak.

Should nursing homes test admissions on the day of arrival and again later despite exposure and/or vaccination status?

Yes. CDC and RIDOH recommend new admissions (and residents who return after more than 24 hours) use source control for 10 days. RIDOH recommends that new admissions also test on days 1, 3, and 5 regardless of vaccination status. This is now recommended because data show immunity wanes over time and previous infection or outdated vaccination status does not offer as much protection against transmission.

Visitation

Should visitors be screened before entering nursing homes?

Centers for Medicare and Medicaid Services (CMS), CDC, and RIDOH all recommend screening visitors, staff, and residents. Screening processes may differ across facilities and may be active or passive (i.e., self-screening).

Testing

How do nursing home staff report self-tests (taken off-site)?

Self-test results should be reported in the self-test portal by the person tested. Facilities should provide staff with the self-test result portal link portal.ri.gov/s/selftest and encourage them enter their results.

In addition to encouraging staff to enter their results in the self-test result, RIDOH requires nursing homes to notify RIDOH as soon as possible of known positive test results by sending an email with name, date of birth, test type, and test date to RIDOH.COVID19LTC@health.ri.gov.

Outbreaks

Is the definition of "outbreak" likely to change (i.e., more than one case)?

RIDOH's recommendations are consistent with CDC* definitions of an outbreak for long-term care settings: An outbreak is defined as one case of COVID-19 when one or more facility-acquired positive cases are confirmed via testing, in a resident, healthcare worker, or other non-resident.

It is still important to have a low threshold to assess and intervene for vulnerable populations such as nursing home residents. While this may evolve over time, RIDOH is not aware of plans to change the definition at this time.

* Note that CMS guidance now directs long-term care settings to follow CDC, national, and local public health guidance for testing: QSO-20-38-NH EXPIRED 5/11/2023.

Vaccination

Does Rhode Island use CDC's recommendations for staying up to date with COVID-19, including the bivalent vaccine booster if eligible?

Yes. Rhode Island remains aligned with CDC's recommendations to stay up to date with COVID-19 vaccines.

For the best protection against COVID-19, everyone should stay up to date with their COVID-19 vaccines. This means getting all recommended doses−including bivalent doses when individuals are eligible.

For COVID-19 vaccine recommendations by age, please see this CDC web page. For COVID-19 vaccine recommendations for people who have weakened immune systems, please see this CDC web page.

Rhode Island regulations (216-RICR-20-15-7) require that healthcare workers and ALR workers who are not up to date with their COVID-19 vaccines wear a NIOSH-approved N-95 mask while working in healthcare facilities when COVID-19 community transmission (case rates) is greater than or equal to≥ 50 cases per 100,000 people per week. For more information on these regulations, please visit covid.ri.gov/vaxrequirement. Please note that this regulation is currently under revision as part of a standard review process.