Alaska Native Medical Center

Procedure Name: COVID-19 (novel Coronavirus) Procedure
Reference Policy: Infection Control and Employee Health Program Policy #1100

Contents

Background

SARS-CoV-2 is the novel coronavirus that causes COVID-19, a highly contagious predominantly respiratory illness. The virus is thought to have originated in bats at a market resulting in the outbreak which began in Wuhan, China, in November 2019. The presentation of COVID-19 is highly variable in severity, ranging from asymptomatic carriage, mild upper respiratory illness, to severe respiratory illness, and a post-infectious inflammatory syndrome. Refer to the ANMC Clinical Guideline that summarizes the most recent societal diagnostic and treatment guidelines. Vaccines granted by the FDA via emergency use authorization are available for eligible individuals. For more information on COVID-19 vaccines see the ANMC COVID-19 Vaccination Protocol. The SARS-CoV-2 virus is transmitted from human to human, predominantly from via respiratory droplets, and may be transmitted from individuals who are symptomatic or asymptomatic. In response to the COVID-19 pandemic numerous procedures and processes have been created to minimize exposure risk in the healthcare system and also preserve necessary personal protective equipment (PPE) in anticipation of its increased demand during the prolonged COVID-19 epidemic.

This overarching procedure will refer to other specific procedures for more details.

General Methods Employed to Prevent COVID-19 transmission at ANMC

1. Maintaining physical distance of at least 6 feet from others
2. Interact in well ventilated areas and outdoors when feasible
3. Frequent hand hygiene and surface disinfection
4. Employees and visitors staying home when ill
5. Wearing eye protection and face covering over mouth and nose
6. Not performing elective surgical procedures during crisis contingency
7. Maximizing use of video teleconferencing visits and phone visits
8. Phone call COVID-19 risk screening questions prior to scheduled appointments
9. Screening for COVID-19 symptoms on entry of buildings and instruct all visitors to avoid entering buildings when unwell
10. Alternative drive through and walk-up testing sites for COVID-19 testing for patients, staff, and household members; self-swab option for staff testing
11. Screening of all admissions with COVID-19 nucleic acid test
12. Active surveillance COVID-19 screening of inpatients by infection control
13. Following appropriate isolation precautions for PUIs and confirmed COVID-19 patients
14. Managing healthcare workers and staff who are ill, tested positive, or had close contact with a known COVID-19 patient
15. Workspace and waiting room assessments to add barriers and maintaining physical distancing
16. Offering work from home options and use of virtual meetings
17. Mandating vaccination for all staff
18. Recommending vaccination and reducing barriers for patients that are eligible

Patient COVID-19 Screening Questions

The following list of questions is asked via phone, on entry to the facility, and during the check in process.

- "Have you tested positive for COVID-19 in the last 10 days or been told to isolate or quarantine?
- "Do you have any symptoms consistent with COVID-19? [see Attachment 1, CDC Reference for Signs and Symptoms of COVID-19]

Patients that are suspected of showing signs or symptoms of COVID19 and that answer "Yes" to these questions are placed in Isolation using a single occupancy room if available. All patients and visitors are required to wear a mask unless a face covering causes a health risk, and stay physically separated from others by at least 6 feet. Patients are not to be turned away from expected medical care if screen questions are positive.

Personal Protective Equipment (PPE) for Patients with Suspected or Confirmed COVID-19
SARS-CoV-2 is transmitted predominantly by droplet and contact mechanisms. At ANMC we follow the Centers for Disease Control and Prevention (CDC) PPE recommendations when caring for patients infected with COVID-19. The level of PPE necessary is contingent on the level and type of patient care being delivered.

PPE Recommendations for patients with suspected or confirmed COVID-19:

- **Contact**, plus **Eye Protection** plus **N95 Respirator or PAPR**
    - Wear gown, gloves, eye protection, and N95 Respirator Mask or PAPR

Face shields are recommended as the preferred type of eye protection since a face shield covers the eyes, face, and mask. Face shields may be disinfected between uses. When PPE resources are a concern, follow conservation recommendations. Respirators are preferred and prioritized for healthcare workers caring for patients suspected or confirmed COVID-19, caring for patients during aerosolizing procedures, or other infectious processes requiring AIIR, such as TB.

See PPE Resources located on the Hub at anthcstaff.org/COVID-19-upates.

Universal Masking:
Universal masking is required for all staff, contractors, patients and visitors in all ANTHC buildings to best protect our staff, patients, and communities amid the COVID19 pandemic. Fully vaccinated staff are not exempt from this requirement.

To help ensure the health and safety of the campus community and the public, well fitting face coverings are required to be worn while in all ANTHC and ANMC buildings:

- Indoors– when not alone in a room, this includes entering and exiting all buildings, and common areas, such as hallways, stairways, restrooms, elevators and break rooms when not eating or drinking.
- Outdoors when within 6-feet from others
- Operating a company multiple-occupancy vehicle when within 6 feet from others

Clinical staff working in patient care areas and engaged direct patient care activities (e.g., performing exams, procedures, activities of daily living (ADLs), etc.), will wear hospital-approved PPE, in lieu of cloth face covering. In addition, staff will wear eye protection when working with patients. Face shields

provide a better level of protection since they cover the face and mask, and are recommended over other types of eye protection.

Face coverings are not required in any ANTHC building (both on and off campus) when:

- Working in a private office alone
- Working or spending time outdoors (e.g., walking, exercising) and at least a 6-foot distance can be maintained
- Operating a company single-occupancy vehicle
- Teleworking (i.e., not reporting onsite to a work location)
- Eating or drinking (however, a 6-foot physical distance between people is required when eating or drinking)

Face coverings are highly recommended when carpooling to work.

See the **Universal Masking Policy** located on the HUB: https://anthcstaff.org/covid-19-updates/

Eye Protection
Clinical staff working in patient care areas and engaged in direct patient care activities (e.g., performing exams, procedures, ADLs, etc.) will wear eye protection, preferably a face shield when performing patient care.

Guidance for PPE Conservation
The worldwide SARS-CoV-2 pandemic has put unprecedented demands on the international supply chains for PPE, and have made it extremely difficult for healthcare facilities to acquire adequate PPE supplies. CDC has described three levels of surge capacity related to PPE:

- **Conventional Capacity** – measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings.
- **Contingency Capacity –** measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare worker (HCW). These practices may be used temporarily during periods of expected PPE shortages.
- **Crisis Capacity –** strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known PPE shortages.

CDC's optimization strategies for PPE offer a continuum of options for use when PPE supplies are stressed, running low, or absent. Contingency and then crisis capacity measures augment conventional capacity measures, and are meant to be considered, and implemented, sequentially. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices.

ANMC PPE Surge Capacity and Operational Levels
ANMC has worked with local and state partners to develop strategies to identify and extend PPE supplies, so that recommended PPE will be available when needed most. ANMC has defined the three levels of PPE surge capacity, and has assigned PPE supply and usage triggers to each capacity level that

will serve to inform ANMC leadership what operational level can safely be achieved, given the availability of PPE.

- **Conventional Operations** – Normal operations. All services offered at pre-pandemic capacity. Disposable PPE used as single patient use. This operational level is color-coded as green in communications to staff.
- **Contingency Operations** – Some departure from normal practices. Selectively cancel elective and non-urgent procedures and appointments for which certain PPE is typically used by HCW. Stop single-use of PPE and commence extended-use of PPE. This operational level is color-coded as yellow in communications to staff.
- **Crisis Operations** – Significant departure from normal practices: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known PPE shortages. Cancel all elective and non-urgent procedures and appointments for which certain PPE is typically used by HCW. Stop all extended-use of PPE, and commence limited reuse of PPE. This operational level is color-coded as red in communications to staff.

PPE Conservation methods will be implemented in accordance with the ANMC Emergency Operations Plan.

Transmission-Based Isolation Precautions

The hospitalist and/or intensivist will ensure that the appropriate transmission-based isolation precautions are ordered once COVID-19 infection is suspected and/or confirmed. **Appropriate isolation signage will be posted at the door entry as soon as possible when COVID-19 infection is suspected or confirmed.** Limit staff who enter the patient room to essential personnel only. Restrict visitors. Cluster care to minimize the number of entries into the room and dedicate equipment when possible.

Categories include:

- **Respirator (N95/PAPR)** plus **Contact** plus **Eye Protection**
- **Respirator (N95/PAPR)** plus **Modified Contact** plus **Eye Protection**
  (for those patients co-infected with *C. diff* for example)
- **Airborne** plus **Contact** plus **Eye Protection** plus **Respirator (N95/PAPR)**
  (when aerosol-generating procedures anticipated)
- **Airborne** plus **Modified Contact** plus **Eye Protection** plus **Respirator (N95/PAPR)**
  (when aerosol-generating procedures anticipated AND patient co-infected with *C. diff* for example)

Patient Placement

CDC makes recommendations on the placement of patients with suspected or confirmed COVID-19 infections. If admitted, ideally place the patient in a single-person room with the door closed. Patients with confirmed COVID-19 may be cohorted in a dual occupancy room. Ideally, if space allows, PUIs are not cohorted in dual occupancy rooms due to unknown COVID-19 status.
For patients in dual occupancy rooms keep the patient at least 6 feet apart and with the curtain fully pulled between them. Items will not be shared. Equipment will be disinfected between patient uses.

Airborne Infection Isolation Rooms (AIIR) should be reserved for patients who will be undergoing aerosol-generating procedures.

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation).
- 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.

AIIR Permanent Locations and Time Required for removal of airborne infectious particles after patient leaves the room. Staff may enter room sooner if needed and if all appropriate PPE is worn. Additional temporary AIIR rooms available. Contact Facilities to confirm the ventilation status of rooms.

ROOM NUMBER	Time required for removal of infectious particles
CCU Room 209 CCU Room 210 CCU Room 214 CCU Room 215 CCU Room 220	*69 minutes*
Flex Unit Room 275	*35 minutes*
ED Exam Room 10 ED Exam Room 14	*69 minutes*
ED Bay 7-9	*Contact Facilities*
L&D Room 4	*69 minutes*
PACU PAR2	*69 minutes*
Peds Ante Room 236	*41 minutes*
Peds Room 236 Peds Room 239* Peds Room 240*	*69 minutes*
4E 401 4E 403 4E 404 4E 406	*69 minutes*
4E Ante Room 406	*41 minutes*
4W 417 4W 419 4W 420 4W 422	*69 minutes*
4W Ante Room 422	*41 minutes*
5E 501 5E 503 5E 504	*69 minutes*

ROOM NUMBER	Time required for removal of infectious particles
5E 506	
5E Ante Room 506	*41 minutes*
5W 517 5W 519 5W 520 5W 522	*69 minutes*
5W Ante Room 522	*41 minutes*

Additional rooms and spaces at ANMC may be converted to negative pressure for airborne isolation purposes:

- Generally, inpatient rooms are converted to AIIR with an outside window using portable HEPA units/window fans
    - Contact facilities 24/7 if conversion needed
    - Portable HEPA units stored on 3rd floor.
    - Window fans with exhaust to outside air

Limit transport and movement of the patient outside the room for medically essential purposes.

Communicate information about patients with or suspected of COVID-19 to units prior to transport.

When COVID-19 patient census dictates, ANMC will designate COVID-19 units with dedicated staff, equipment, and supplies.

Patients should wear a mask when someone enters the room, if safely able to do so.
HCWs will remind patients to don a mask when someone enters the room.

Transportation of COVID-19 patient or PUI
Prior to transporting patient, notify the receiving unit or team first and indicate what type of transmission-based precautions are necessary. During transport, the patient will wear a mask (if not intubated or otherwise unable) and perform hand hygiene.

Staff with direct contact with the patient will wear all appropriate PPE (At a minimum: gown, gloves, N95 respirator/PAPR, and eye protection).

A separate staff member who is not in direct contact with the patient will assist by opening doors, pressing elevator buttons, clearing crowded halls, etc. This staff member should wear at minimum a N95/PAPR and eye protection. Transport patient directly to a private room. Limit transport to other areas for medically necessary treatments/tests only.

Supply
Contact Central Supply for supply needs, 729-2540. PPE supplies are monitored.

COVID-19 Testing Recommendations

Symptomatic Patients

Testing for COVID-19 with nasal or nasopharyngeal PCR is indicated when:

- Clinical symptoms consistent with COVID-19 **OR**
- Discretion of provider based on epidemiologic risk factors, presenting symptoms

Persons Under Investigation (PUI): Any patient displaying symptoms consistent with COVID-19, as determined by treating provider. Epidemiologic exposure risk should be considered in determining a PUI but due to community transmission of the virus, a known exposure risk is not mandatory to determine a patient to be a PUI.

An asymptomatic patient who is being tested for COVID-19 for other screening purposes *is not* a PUI.

See ANMC COVID-19 Clinical Guideline located on the Hub: https://anthcstaff.org/covid-19-updates/

Asymptomatic Patients

ANMC patients may be screened for COVID-19 (asymptomatic testing) in the following situations:

- Pre-operative testing presenting for Labor and Delivery
- Pre-operative testing presenting for surgical and endoscopic interventions per surgical services protocol.
- All inpatient admissions to ANMC
    - All patients admitted to an ANMC inpatient location (with the exception of NICU) will undergo asymptomatic testing for SARS-CoV-2 upon admission.
    - Anyone with a previous positive COVID19 test result will not be tested.
- Additional COVID19 surveillance screening on inpatients during admission as determined by disease epidemiology.
- Patients and escorts prior to return travel to rural Alaska when required
- Close contacts without immunity to persons infected with COVID19

Guidance for COVID-19 Order Selection

The COVID-19 within 24hr turn around order, both asymptomatic and symptomatic, is specifically intended for non-urgent testing. Use this order in cases that do not require an urgent / STAT result. Non-urgent cases should represent the vast majority of cases.

The asymptomatic screening test and standing order are intended ONLY for those persons without symptoms consistent with COVID-19 infection and/or known close contact to a person with COVID19 infection.

All symptomatic persons and/or known close contacts should contact their primary care provider (e.g., Customer-Owners/Patients) or Employee Health (e.g., ANTHC or SCF Employees) to obtain an order for symptomatic COVID-19 testing.

COVID-19 Specimen Priority Ranking
Hundreds of COVID-19 lab specimens are processed 24/7 at the ANMC Laboratory. Each COVID-19 testing platform has a batch capacity. To support clinical decision-making and ensure safe-working conditions and healthy staffing levels, COVID-19 test specimens may be ranked for priority processing.

Priority Processing:

- Orders for Pre-op/pre-procedure
- Employee Health orders for symptomatic ANTHC and SCF Employees - especially front-line healthcare workers
- Orders for symptomatic Customer-Owners/Patients
- Orders for ANTHC and SCF Employees traveling to remote communities for work purposes
- Orders for Customer-Owners/Patients traveling home to remote communities

No Priority: Standing orders for asymptomatic Customer Owners/Patients, asymptomatic Employees, or persons traveling for pleasure

Specimens collected as priority will be marked to indicate to ANMC Laboratory personnel their need to be prioritized for processing.

COVID-19 Contact Investigation

Determining the significance of exposures to COVID-19 includes the nature of the contact and PPE used during the contact. Not all contacts to COVID-19 are significant enough to warrant COVID-19 testing or quarantine.

Close Contact
Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset, or 2 days prior to test specimen collection for asymptomatic patients.

Factors to consider when determining close contact and exposure risk:

Proximity to source patient; closer distance likely increases exposure risk
Duration of exposure; longer exposure time increases risk
PPE worn by source patient and contact
Symptoms of source patient; if patient was symptomatic, this increases the risk. In addition, the period of symptom onset is associated with higher levels of viral load and therefore increases risk.
Generation of respiratory aerosols, i.e. coughing, singing, shouting, or AGPs performed, increases risk.
Environmental factors such as crowding, adequacy of ventilation, whether exposure was indoors or outdoors are additional considerations of risk.
Acquired immunity from COVID19 illness or completion of the vaccine series

If patients are considered a close contact to someone with known COVID-19, contact Infection Control to conduct further contact investigation and testing.

If appropriate PPE is used during the close contact then there was no significant exposure to warrant follow up COVID-19 testing or consideration of quarantine.

Quarantine
See ANTHC Employee Health COVID-19 Procedure: anthcstaff.org/covid-19-updates

Guidance for COVID-19 Vaccinated Healthcare Workers with Potential Exposure to COVID-19
At this time, vaccinated persons should continue to follow current guidance to protect themselves and others, including wearing a mask, staying at least 6 feet away from others, avoiding crowds, washing hands often, following travel guidance, and following any applicable workplace or school guidance, including guidance related to personal protective equipment use or SARS-CoV-2 testing. However, vaccinated persons with an exposure to someone with suspected or confirmed COVID19 are not required to quarantine if they meet all of the following criteria:

- Are fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine)

- Have remained asymptomatic since the current COVID-19 exposure

Persons who do not meet the above criteria should continue to follow current quarantine guidance after exposure to someone with suspected or confirmed COVID-19.

Guidance for Healthcare Workers with Natural Immunity from COVID-19 Infection
If a HCW has a new exposure to someone with suspected or confirmed COVID-19, they are not required to quarantine if the meet all of the following criteria:

- Has recovered from laboratory-confirmed (PCR or antigen) SARS-CoV-2 infection and has already met criteria to end isolation
- Is within the first 3 months following the onset of symptoms of their initial confirmed infection, or within the first 3 months of their first positive viral test if they were asymptomatic during initial infection
- Has remained asymptomatic since the new exposure

Persons who do not meet all three of the above criteria should continue to follow current quarantine guidance after exposure to someone with suspected or confirmed COVID-19.

See Employee Health COVID-19 Procedure: anthcstaff.org/covid-19-updates

See ANMC Infection Control Guideline for High Risk and Aerosolizing Procedures: anthcstaff.org/covid-19-updates

Ancillary Services
Limit who enters the patient's room to essential personnel only. RNs for example will draw blood, check vital signs, perform simple housekeeping, deliver food trays, etc. Discharge care, social workers, pharmacists, customer service, etc. may use the phone or other electronic devices to communicate with the patient.

Food Service
Disposable dishware is used. Designated healthcare workers will deliver meals and assist with meal tray set up, limiting those who enter the room to designated essential personnel only.

Pharmacy
Limit who enters the patient's room. Consider using the phone or other electronic means to communicate with the patient. Nursing to provide medications and education to the patient.

Radiology
Use portable x-ray equipment and dedicate both staff and equipment if possible. Limit tests requiring transport. If testing in the radiology department is required, schedule towards the end of the day when the volume of other patients in the department is most likely to be low. Staff will wear appropriate PPE. Remind the patient to wear their mask. Perform thorough cleaning with hospital approved, EPA registered disinfectants.

Environmental Services
Daily Isolation Room Cleaning: For rooms occupied by patients under investigation (PUI) or patients confirmed to have COVID-19 infection, EVS staff will provide cleaning and disinfecting services using EPA-registered, hospital-grade disinfectants that has qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2 (refer to List N). Nursing staff may be required to clean specialized patient care equipment. Any person entering these rooms will wear all appropriate PPE to protect against COVID-19 infection. PPE should be removed upon leaving the room, immediately followed by performance of hand hygiene. The N95 respirator/PAPR stays on until after leaving the room. Disinfect equipment after use followed by thorough hand hygiene.

Terminal Isolation Room Cleaning: For rooms occupied by PUI or patients confirmed to have COVID-19 infection EVS staff will perform full room turnover clean with disinfection of all surfaces in the patient room (e.g. cabinetry, bed, chair, IV poles, etc.), resupply of room supplies, floor & wall care, curtain change and disinfection of bathroom surfaces. Nursing staff may be required to clean specialized patient care equipment.

- EVS staff will wear appropriate PPE, as indicated by their cleaning procedures, and in accordance with the transmission-based isolation precautions signage posted on the door to protect themselves against transmission of an infectious condition.
- CDC advises routine cleaning procedures to be used in areas where patients under investigation (PUI) or patients confirmed to have COVID-19 receive care.
- Routine cleaning procedures entail using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant that has qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2 (refer to List N) to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label.

- After discharge, terminal cleaning will be performed by EVS staff. If the patient was on airborne isolation precautions the EVS staff will continue to wear a respiratory mask or PAPR when in the room to perform services. Allowing sufficient air changes per hour (ACH) and delaying housekeeping services is not needed, as long as all appropriate PPE is worn during the cleaning process. See Appendix A, Cleaning and Disinfection of Patient Care Equipment and the Environment of Care Procedure.

Transfer Room Cleaning: On occasion, patients' will be diagnosed with a new condition requiring transmission-based isolation precautions after they have already been admitted to a semi-private room with a roommate.

- In these instances, transmission based isolation precautions will be initiated in the semi-private room and signage posted until such time as the affected patient can be transferred to a private room.
- Transmission-based isolation precautions will be maintained until EVS staff can safely perform a terminal isolation discharge clean on the affected side of the semi-private room and in the bathroom, and an additional daily clean in un-affected side of the room with attention to high-touch surfaces.
- A terminal isolation discharge clean will also be performed upon the discharge/transfer of the patient from the un-affected side of the room.

See Cleaning and Disinfection of Patient Care Equipment and the Environmental of Care for more information on cleaning and disinfection duties and responsibilities.

Waste Disposal

Follow routine disposal practices following the Waste Stream Diagram. Use appropriate PPE when handling soiled linen and waste. Keep linen hampers close to the point of use to prevent carrying dirty linens long distances.

Discontinuation of Transmission-Based Isolation Precautions for patients with COVID-19

Hospitalized patients with previous diagnosis of COVID-19:

The safety of our patients and our healthcare workers is our highest priority. As patients with COVID-19 are hospitalized, they may require continued hospitalization for other medical or care needs after resolution of their COVID-19 infection. We are continuing to learn more about the duration of shedding of the virus (SARS-CoV-2) that causes COVID-19 once symptoms resolve. Based on current recommendations, the following conditions must be met prior to consideration of discontinuing precautions for a hospitalized patient with confirmed COVID-19.

Discontinuation of Transmission-Based Precautions for patients suspected of having COVID-19:

The decision to discontinue Transmission-Based Precautions for patients with confirmed SARS-CoV-2 infection should be made using a symptom-based strategy as described below. The time period used depends on the patient's severity of illness and if they are immunocompromised. **Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge from a healthcare facility.**

A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

In addition, retesting a patient who previously tested positive within the last 3 months is not recommended. Patients may continue to shed detectable SARS-CoV-2 RNA while no longer contagious. Providers may retest patients with new onset of COVID-19 symptoms but are encouraged to avoid testing within the first 3 months of confirmed COVID-19 unless the clinical suspicion is high and without alternative explanation of symptoms.

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions/Isolation

Inpatients 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: 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.

Inpatients with severe to critical illness or who are severely immunocompromised[1]:

- At least 10-20 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.

Outpatients with mild to moderate illness who are not severely immunocompromised:

- At least 5 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

In the event someone tests positive for COVID-19 and is asymptomatic at the time of their test, but later develop symptoms, the isolation period resets, “since symptoms first appeared”.

Patient Isolation Table Reference
This table references the minimal isolation time contingent upon resolution of fever for 24 hours and significant improvement in symptoms.

	Clinical Scenario	Minimum isolation period (days)	Notes
Inpatient	Asymptomatic, Mild – Moderate Illness	10 days	If discharged to outpatient, isolation period may end after 5 days
	Severe Illness	10-20 days	May review with ID before discontinuing isolation
	Moderate-Severely Immunocompromised	20+ days	May review with ID before discontinuing isolation
Outpatient	Clinic visit, No AGP expected, infusion, procedure NOT involving airways	5 days	Patient required to wear well-fitting mask at all times
	Performing AGP (Intubation for scheduled surgery, or ENT procedure, etc.)	10 days	Reschedule elective procedure after at least 10 days of isolation
	Procedure or visit that cannot be delayed due to potential loss of limb or urgent medical condition	0 days	Work with nursing/healthcare provider. Consider scheduling end of day. Take patient to private room (not in waiting area or with other patients) Follow Isolation Precautions/PPE protocols
	Moderate-Severely Immunocompromised	20 days	

Moderate and severe immunocompromising conditions and treatments include but are not limited to:
•Active treatment for solid tumor and hematologic malignancies
•Receipt of solid-organ transplant and taking immunosuppressive therapy
•Receipt of CAR-T-cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppression therapy)
•Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
•Advanced or untreated HIV infection (people with HIV and CD4 cell counts <200/mm3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV)
•Active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

Test-Based Strategy for Discontinuing Transmission-Based Precautions/Isolation

In some instances, a test-based strategy could be considered for discontinuing Transmission-based Precautions earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some patients (e.g., those who are severely immunocompromised[1]) in consultation with local infectious diseases experts if concerns exist for the patient being infectious for more than 20 days.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- 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 molecular viral assay 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 molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions. Consult with ANMC Infectious Disease when considering discontinuing Transmission-Based Precautions inpatient with higher level of clinical suspicion of COVID-19 despite negative COVID-19 testing

Consult with infection control with questions regarding removal of COVID-19 isolation. Consult with an Infectious Disease physician when considering removal of COVID-19 isolation on patient with COVID-19 who remains on the ventilator beyond 20 days of illness.

Disposition of Patients with COVID-19

Patients can 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. 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.

If discharged to a nursing home or other long-term care facility (e.g., assisted living facility), AND

- Transmission-Based Precautions have been discontinued, but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline.
- Transmission-Based Precautions have been discontinued and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.

Removal of COVID-19 quarantine of newborns of COVID-19 positive mothers

The quarantine of the newborn will last at least as long as the isolation period of mother recovering from COVID-19. The mother will be wearing a mask when with newborn. Quarantine of newborn can be removed after either criteria is satisfied below:

- Test-based criteria: infant tests between 5-7 days after initial direct exposure with mother during her isolation period; if asymptomatic and test is negative, infant's quarantine ends at day 7 after initial exposure

- Time-based criteria: infant's quarantine ends 14 days after initial direct exposure with mother during her isolation period, as long as infant remains asymptomatic

Visitors
Visitor restrictions in place.
See **ANMC Visitor's Guide during COVID-19 Policy** at anthcstaff.org/covid-19-updates/

- Visitors who have symptoms of COVID-19, have a positive viral test for SARS-CoV-2, or who meet criteria for quarantine or exclusion from work are restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively.
- Visitors who are unvaccinated should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.
- For parents/caretakers of pediatric and maternity patients please see the visitation policy specific to Maternal and Child Health.
- All visitors will follow masking requirements, respiratory hygiene and cough etiquette. Visitors are not allowed to visit if they are not feeling well. Visitors need to practice physical distancing. Visitors will be required to wear a mask and will be encouraged to perform hand hygiene.
- Restrict visitors from entering patient rooms with known or suspected COVID-19. Exceptions may be made on a case by case basis with consultation from Infection Control. An example might be an end of life situation. Consider alternatives such as Zoom, Skype, or other electronic means for communication. Visitors will not be present during aerosol-generating procedures.
- Exposed visitors or those exhibiting respiratory signs and symptoms of illness will be advised to contact their provider and will not visit other patients while ill.
- Visitors will not be present during aerosol-generating procedures.

Follow the State DHSS alerts, mandates, and health advisories as the situation evolves.
http://dhss.alaska.gov/dph/Epi/id/Pages/COVID-19/default.aspx

Healthcare Worker Restrictions and Testing
Follow current CDC recommendations for risk stratification and follow up.

See Employee Health COVID-19 Procedure: anthcstaff.org/covid-19-updates

Employees that are sick will not report for duty and will notify their supervisor. Employees with signs/symptoms of COVID19 will contact Employee Health for a referral for testing and further instruction. Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test as soon as possible.

Asymptomatic HCP with a higher-risk exposure 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. In these situations, testing is recommended immediately (but not earlier than 2 days

after the exposure) and, if negative, again 5–7 days after the exposure. However, testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic; this is because some people may have detectable virus from their prior infection during this period.

Symptoms include:

1. Fever
2. New cough that is not attributable to another medical condition
3. New muscle aches not attributable to another medical condition or specific activity
4. Throat pain not attributable to another medical condition
5. New shortness of breath not attributable to another condition
6. New congestion, runny nose not attributable to another condition
7. New loss of sense of taste or smell

Outpatient Clinics

All efforts will be made to reduce the likelihood of unexpected exposures to patients infected with COVID-19 in the outpatient clinics. Strategies for preventing exposure include:

- Screen patients for infection with COVID-19 and isolate as indicated
- Instruct visitors to not enter if feeling unwell
- Instruct all patients/visitors to wear a mask covering both mouth and nose for the entire visit.
- Space visitors at least 6 feet apart in waiting areas.
- Physically distance patients from front desk staff by 6 feet.
- Use barrier/screen shields where able
- Follow appropriate hand hygiene.
- Staff will wear **eye protection** and a **N95 respirator (PAPR preferred)** for patients suspected or confirmed to have COVID-19. Other PPE will be worn as appropriate following Standard Precautions. Isolate the patient and close contacts in a private room.
- If the decision is made to test the patient, staff will follow precautions for isolation and wear a **respirator (PAPR preferred), gown, gloves**, and **eye protection**. If testing the patient in another location, clinic staff will notify the receiving department ahead of time.
    - It is not recommended to send outpatients to the emergency department for the sole reason of COVID-19 testing, but rather utilize the designated COVID-19 testing site on the ANMC campus if testing cannot be provided at current clinic location.
- Limit staff who enter the room to essential personnel only. Restrict visitors.
- If the patient requires admission, coordinate with the House Supervisor. Clinic staff will call ahead to the receiving facility prior to transport.
- If the patient does not require admission, follow the discharge process. Ensure the patient continues to wear a mask and directly leaves the building. Do not allow the patient to visit others or other buildings on campus. Consider an escort or Security Officer if needed.
- Frequently clean and disinfect surfaces in the waiting areas.
- Consider utilizing VTC, Telehealth, or phone calls for outpatient visits
- Remind patients to call ahead and reschedule their appointment if symptomatic.

COVID19 Vaccines

COVID19 vaccines are now currently available in the US. Vaccination began at ANMC on December 15th, 2020. COVID19 vaccination is a required vaccine at ANMC.
See the COVID-19 Vaccination Policy, #HR-517.

Vaccination with currently available mRNA vaccines is a two dose series separated by approximately 3 or 4 weeks, depending on vaccine manufacturer. Other vaccine options include single dose vaccines. Vaccines are dependent upon current authorization, recommendations, and availability. ANMC encourages all eligible persons to get vaccinated as soon as possible. Research indicates that waning immunity occurs following the primary vaccine series. All staff are highly encouraged to get a booster vaccine as soon as they are eligible.

All staff will continue to wear appropriate PPE regardless of vaccination status. All staff is asked to report any signs/symptoms following vaccination to Employee Health. Common side effects include pain or swelling at the injection site, fever, chills, lethargy, and headache. Severe adverse events are reported in the Vaccine Adverse Event Reporting System (VAERS).

Signs and symptoms unlikely to be from COVID-19 vaccination include any systemic signs and symptoms consistent with SARS-CoV-2 infection: cough, sore throat, loss of taste or smell, or another infectious etiology (i.e. influenza). Staff will not report to work if sick. Staff with mild symptoms that are not unexpected to occur within 2 days after COVID-19 vaccination (malaise, headache, arthralgias) may continue work if they are able, but should not work if they have a fever (>100 F) or develop symptoms more specific to an upper respiratory infection (new cough, sore throat, or congestion).

We continue to learn more about COVID-19 and prevention. For more information visit www.cdc.gov.

References

CDC https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html
CDC https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
CDC https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
CDC https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html
CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
ANTHC Employee Health Worker Restrictions Guideline
ANMC PPE Conservation Policy
https://anthcstaff.org/covid-19-updates/

Responsibility	Infection Control Committee
Written	7/21/20
Approval ICC	1/28/22
Approval IC	2/1/22
Date of last review	1/26/22
Date of last revision	1/26/22
Supersede:	7/21/21

Attachment 1: CDC Reference for Signs and Symptoms of COVID19

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Symptoms of Coronavirus (COVID-19)

Know the symptoms of COVID-19, which can include the following:

Symptoms can range from mild to severe illness, and appear 2–14 days after you are exposed to the virus that causes COVID-19.

Seek medical care immediately if someone has Emergency Warning Signs of COVID-19

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone

This list is not all possible symptoms. Please call your healthcare provider for any other symptoms that are severe or concerning to you.

CDC Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases

cdc.gov/coronavirus

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