Residential and Long-term Care Facility Call

04.21.21

COLORADO
Department of Public
Health & Environment

The COVID-19 Residential and Long-term Care Facility call is hosted by CDPHE's Infection Prevention Unit and the Residential Care Strike Team. This is a biweekly call to provide updates to our residential care facilities and to mitigate the spread of COVID-19.

Information provided during the call and included in this slide deck is based on currently available information at the time it was drafted and is subject to change as new guidance is made available. To ensure you always have the most current information, go to: https://covid19.colorado.gov/ltcf.

Slides are shared following the call via MailChimp
http://eepurl.com/dKuwjQ

Corresponding links will be included in the slides

The next call is scheduled for May 5, 2021

Please keep your line muted during the call.

Chat Etiquette:

- Keep it positive. Remember, we are all in this together.
- Questions will be answered by subject matter experts and included in the slide decks Q&A portion following the call.
- Individuals using the form will also receive an email response.

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Agenda

- **COVID-19 Vaccine Breakthrough, Variants, & the J&J COVID-19 Vaccine**
  - Isaac Armistead MD MPH, CDPHE Medical Guidance Unit Intern
- **Guidance Updates**
  - April Burdorf, CDPHE Program Manager for SME Teams (Team School, Industry, Clinical SME/IP)
- **PPE Updates and Clarification**
  - Janell Nichols, Infection Prevention Unit Manager

Isaac Armistead MD MPH

Preventive Medicine Resident

Physician, University of Colorado

CDPHE Medical Guidance Unit Intern

COVID-19 Vaccine Breakthrough, Variants, & the J&J COVID-19 Vaccine

Vaccine Breakthrough

Vaccine Breakthrough Definition

In general:	For COVID-19:
• When a fully-vaccinated person develops the disease they were vaccinated against	• Positive PCR or antigen test on a respiratory specimen collected two weeks or more after the final dose of vaccine

Background

- Vaccine breakthrough infections are expected - no vaccine is 100% effective
- Reasons for breakthrough vary
  - Primary - Host factors, vaccine storage & handling
  - Secondary - Waning immunity over time, virus changes
- Symptoms of COVID-19 may or may not be present
  - Some evidence that infection after vaccination may be less severe
- Vaccine breakthrough infections occur in a small proportion of those who are fully vaccinated

Current Data on Vaccine Breakthrough

United States Numbers (*as of 4/13/21*)

- 75 million people fully vaccinated
- 5,814 vaccine breakthrough infections reported
  - 29% were asymptomatic
  - 7% were known to be hospitalized - not necessarily for COVID-19
  - 1% died - not necessarily from COVID-19

Current Data on Vaccine Breakthrough

Colorado Numbers (*as of 4/19/21*)

- 1.5 million people fully vaccinated
- 819 vaccine breakthrough infections reported

Recent CDPHE Analysis

- Case Rate Comparison (Cases per 100,000 people per 14 days)
  - Unvaccinated: 413
  - Vaccinated: 29.6
- Corresponds to ~93% lower likelihood of being reported as a case if fully vaccinated

Limitations of Vaccine Breakthrough Data

Current numbers of vaccine breakthrough infections are likely an undercount

- Voluntary reporting in some jurisdictions
- Not all breakthrough infections identified due to lack of testing
  - Asymptomatic or mild illness
  - Vaccinated and assume other cause of symptoms
- More severe cases might be more likely to be reported
- Requires matching of immunization and case data

> This data is a “snapshot” and is intended to help detect patterns.

Vaccine Breakthrough and Variants

- Based on current data, vaccines authorized in the US afford protection against circulating SARS-CoV-2 variants
  - No evidence currently that vaccine breakthrough infections are occurring because of changes in the virus (variants)
- **Vaccine breakthrough infections occur in a small percentage of vaccinated people**

What is being done?

We are learning more about COVID-19 vaccine breakthrough infections

- Vaccine effectiveness studies: What characteristics (patient, vaccine, virus) are associated with vaccine breakthrough?
  - Emerging Infections Program (which includes Colorado) - comparing COVID-19 cases in vaccinated and unvaccinated individuals
  - CDC MMWR publication - 5 states, including Colorado, to describing early vaccine breakthrough cases
  - Other national studies
- Investigation of vaccine breakthrough cases by CDC and state health departments
  - Particular focus on those that result in hospitalization or death

Key Messages

- As more people are vaccinated we are learning more about COVID-19 vaccine breakthrough infections
- Vaccine breakthrough infections occur in a small percentage of vaccinated people
- COVID-19 vaccines are effective and recommended

Variants

What is a variant?

- Viruses naturally develop mutations in their genes
- A virus variant has one or more mutations that distinguish it from the original virus
- Mutations may affect variant characteristics (transmission, etc.)
- In most situations, all the virus genes have to be sequenced to detect a variant
  - Different from a standard PCR test
  - More expensive, takes longer, not done routinely

How are variants classified?

Variant of Interest	• Different characteristics compared to the original virus but not yet considered a variant of concern
Variant of Concern	Potentially: • More transmissible • More severe disease • Treatments and/or vaccines less effective • Harder to detect with current tests
Variant of High Consequence [NONE currently]	• CDC: “Clear evidence of significantly reduced effectiveness of prevention measures or medical countermeasures”

What Variants of Concern have been found?

- United States:
  - B.1.1.7 - first seen in the United Kingdom
  - B.1.351 - first seen in South Africa
  - P.1 - first seen in travelers from Brazil to Japan
  - B.1.427 & B.1.429 - first seen in California
- All five have also been detected in Colorado

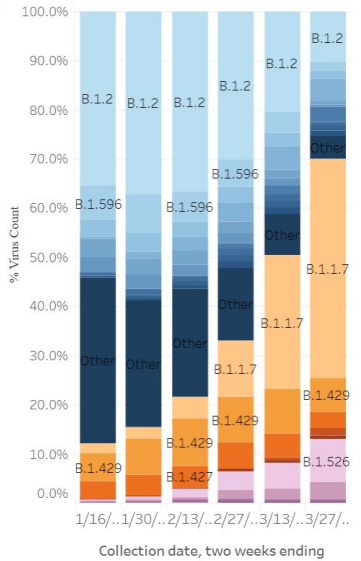
Variants of Concern in Colorado

Proportions of SARS-CoV-2 Variants of Concern by State

State	B.1.1.7	B.1.351	B.1.427/B.1.429	P.1	Other lineages	Total Available Sequences
Arizona	16.4%		36.3%	0.8%	46.5%	482
California	17.8%	0.3%	53.3%	1.9%	26.8%	7,582
Colorado	33.3%	0.6%	28.4%	0.9%	36.9%	1,275

- B.1.1.7 is the most common variant in US and Colorado currently

https://covid.cdc.gov/covid-data-tracker/#variant-proportions



Variants of Concern

What are characteristics of these variants?
Some evidence of:

- Increase in transmissibility
- Increased disease severity
- Reduced effectiveness of some treatment
- *Potential* reduction of vaccine effectiveness
    - Vaccinated people are still less likely to get sick and less likely to be hospitalized than unvaccinated people.

> Not every variant has all these characteristics

What to do about variants?

- What we are still learning:
  - How transmissible?
  - Is disease more severe?
  - How effective are treatments?
  - How well do vaccines work against current variants?
- Continued surveillance sequencing to understand how common variants are and detect new ones

Key Message

Transmission control measures (masks, distancing, etc.) continue to be important

- Overall case numbers are high
- Risk of variants
- Vaccine breakthrough infections can occur

Johnson & Johnson (J&J) COVID-19 Vaccine HAN - April 13th, 2021

- The FDA and CDC have recommended pausing the use of the Johnson & Johnson (Janssen, J&J) vaccine while they investigate reports of a rare and severe type of clotting syndrome in combination with low platelets (thrombotic thrombocytopenia) in six women, each reported between six to 13 days after J&J vaccination.
- Out of an abundance of caution, CDPHE and the Colorado Joint Vaccine Task Force have directed providers to temporarily pause use of the J&J COVID-19 vaccine.
- Similar rare reports of a thrombotic thrombocytopenic clotting syndrome have been reported in Europe with the AstraZeneca (AZ) vaccine, which uses similar adenovirus-vector DNA-based technology but is not authorized for use in the U.S. The rare syndrome appears similar to heparin-induced thrombocytopenia (HIT).

J&J COVID-19 Vaccine HAN

- Health care providers should maintain a high index of suspicion for symptoms that might represent serious thrombotic events or thrombocytopenia in patients who have recently received the J&J COVID-19 vaccine (or the AZ vaccine in travelers from outside the U.S.) and obtain testing when indicated as recommended below. Clinicians should also be aware that these patients should not be treated with heparin.
- This syndrome has not been observed with the mRNA vaccines (Pfizer, Moderna). The recommended pause in administration of the J&J vaccine does not affect administration of these mRNA vaccines.
- Health care providers are required to report adverse events to the Vaccine Adverse Event Reporting System at https://vaers.hhs.gov/reportevent.html.
- In addition to reporting to VAERS, CDPHE also requires that health care provider report blood clot events following COVID-19 vaccination directly to the state using this secure, HIPAA-compliant REDCap form: https://redcap.link/9ytrvg22 Health care providers can contact 303-692-2700 with questions.

April Burdorf
CDPHE Program Manager for SME Teams (IP, Team School, Industry, Clinical SME)

EMResource

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Guidance Update

EMResource Information

- The EMResource reporting database is used for situational awareness during the public health emergency and is required per PHO 20-20.

- If you have NOT YET accessed EMResource please see the training/support materials and login information outlined in the EMResource Account Access Document.

EMResource Training Documents by Facility Type:

- Nursing Facilities
- Assisted Living Residences
- Intermediate Care Facilities and Group Homes

Updated Guidance

- Released on Monday
  - All-in-One Mitigation Living Document

- Changes to communal dining, group activities and facility outings.
- Added language regarding vaccinated vs. unvaccinated individuals
- New sections added for new admissions and readmissions, and residents who leave the facility.
- Updated travel guidance for HCP
- Additions to definitions, including the clarification of staff, volunteers, and visitors

Definitions

•**Staff**--Staff are defined as employees, (e.g. nurses, licensed independent practitioners, students and trainees, therapists, environmental services) whether employed, contracted, consulting or volunteer.

•**Visitor-**-A visitor does not meet the criteria of staff. Visitors may include musicians and other performers that provide group activities to more than one resident at a time or a family member or friend visiting one resident. Visitors do not typically participate in orientation or training programs. Visitors are not included in surveillance and outbreak testing nor are they offered vaccination. See visitation section for more information.

•**Volunteer**--Non-paid staff members who provide routine services, generally have a recurrent role within the facility and have received structured training and orientation on resident rights and infection prevention practices. Volunteers generally are 18 and older, have an ongoing relationship with a contract, role and/or schedule. Volunteers are not individuals who are infrequent visitors (e.g. ARE NOT girl scout troops, musicians, individuals seeking community service hours). Volunteers should be treated as staff and should be included in surveillance and outbreak testing and offered vaccination (e.g. influenza, covid).

All Communal Dining, Group Activities & Facility Outings

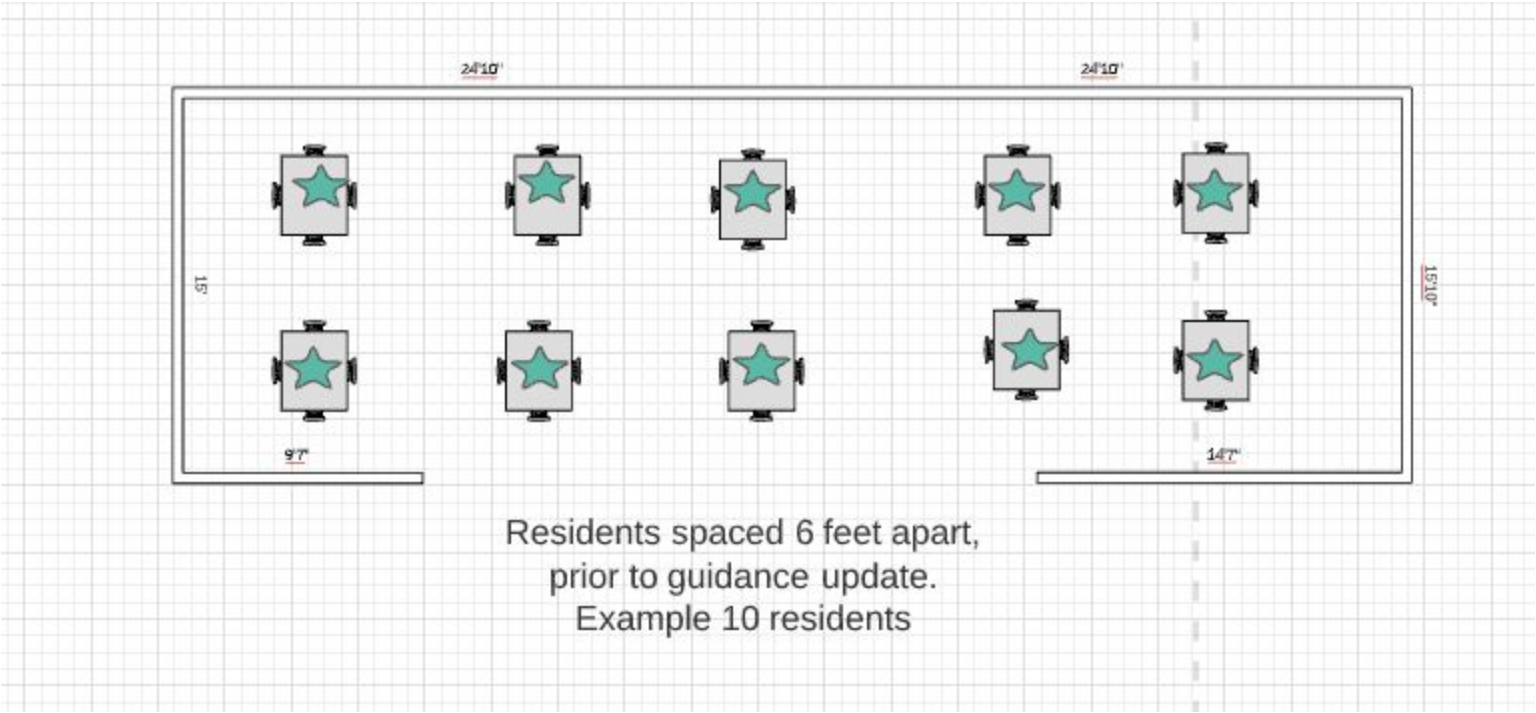
- Hand hygiene should occur before and after all communal dining, group activities and outings.
- Masks should be worn at all times when outside of the resident room
- The social distancing calculator should be used to determine the appropriate number of participants for any room, outdoor space, or vehicle.
- Unvaccinated residents should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated.
- Pets other than ADA service animals should not be included in communal dining or group activities. See visitation for individual pet visits.

Communal Dining

Facilities may resume communal dining, group activities, and facility outings with the following requirements:

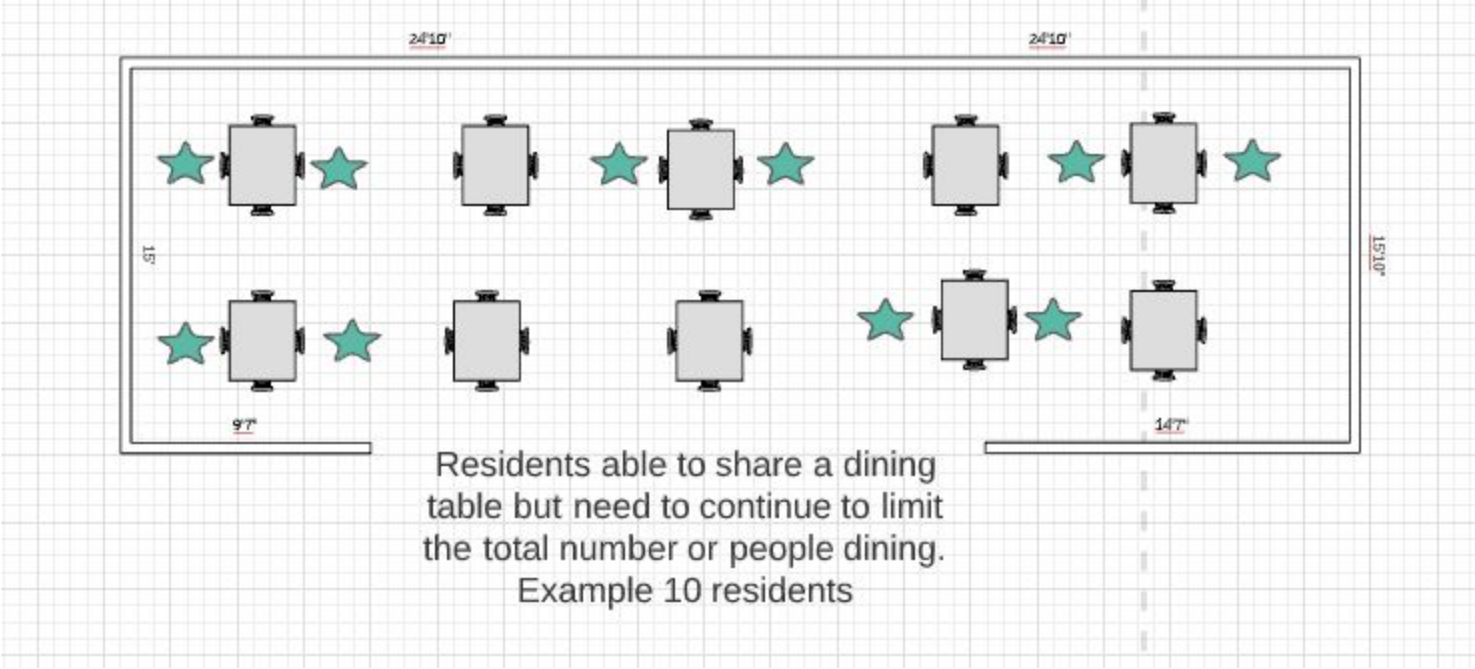
- Masks should be worn at all times when outside of the resident room
  - Can be removed once seated at a table to consume a meal.
- Guests from outside of the facility including staff, visitors, and residents of neighboring facilities should not participate in communal dining activities.
- Residents do not need to follow physical distancing requirements during communal meals if all of the above recommendations are followed.

Old Recommendations



Residents spaced 6 feet apart,
prior to guidance update.
Example 10 residents

New Communal Dining



Residents able to share a dining table but need to continue to limit the total number or people dining. Example 10 residents

Group Activities

- Group activities should be facilitated by facility staff; group activities are not open to visitors at this time. As community transmission decreases this will be reevaluated and guidance updated.
- The consumption of food and drink should not occur during group activities or facility outings unless these activities occur outdoors while participants are spaced at least 6 feet apart.

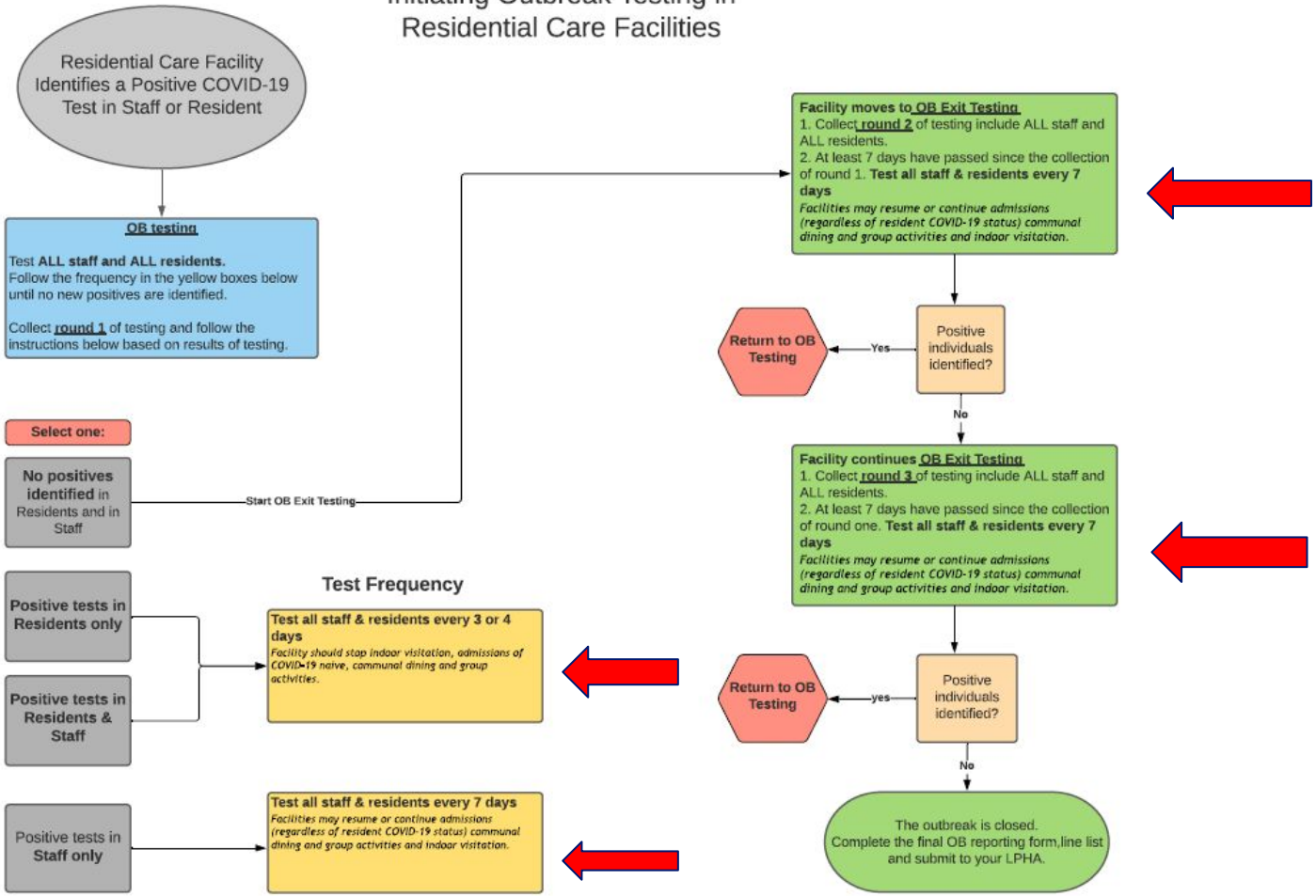
Communal Meal vs. Group Activities

Communal Meal vs. Group Activities

Outbreaks, Illness and Communal Dining/Group Activities

- Residents with symptoms of illness, including signs and symptoms of COVID-19 or those that require isolation or quarantine (regardless of the reason) should be excluded from participating.
- Facilities that are conducting outbreak testing related to the identification of one or more positive COVID-19 cases should follow the OB testing guidance and decision tree document to determine when communal dining, group activities or outings may continue or resume.

Initiating Outbreak Testing in Residential Care Facilities



New Admissions

- Residents with confirmed SARS-CoV-2 infection who have not met criteria for discontinuation of Transmission-Based Precautions should be placed in the designated COVID-19 care area.
- In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.
    - Exceptions include residents within 3 months of a SARS-CoV-2 infection (confirmed by a positive test) and fully vaccinated residents.

Residents Who Leave the Facility

- Residents who leave the facility should be reminded to follow all recommended IPC practices including source control, physical distancing, and hand hygiene and to encourage those around them to do the same.

- In most circumstances, quarantine is not recommended for residents who leave the facility for day visits (e.g., for medical appointments, community outings with family or friends) **and do not have close contact with someone with SARS-CoV-2 infection.** However they should be included in surveillance testing as outlined in the PHO.

    - Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.

- Facilities might consider quarantining residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended IPC measures.

- Residents who leave the facility for an overnight visit should generally be managed as described in the New Admission and Readmission section.

Janell Nichols
CDPHE Infection Prevention Unit Manager

PPE Supply Availability & Use

PPE Supply

CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency and then crisis capacity strategies augment conventional capacity measures and are meant to be considered and implemented sequentially.

PPE supplies and availability, including respirators, have been returning back to normal. Facilities should promptly resume conventional practices when PPE supply returns to normal.

Updates To PPE Use

Reuse

- Reuse of N95s is considered a crisis standard of care and should only be considered when other strategies have been exhausted. Facilities should resume conventional practices given that the supply availability has returned to normal.

Extended Use

- Extended use of respirators is a contingency capacity strategy and as PPE supplies and availability have been returning back to normal, facilities should promptly resume conventional respirator practices.
- Respirators should be disposed of when doffed/removed. Respirators should no longer be reused.

Disinfection of N95s

- Disinfection of N95s is no longer an option as there are no manufacturer authorized methods for N95 respirator decontamination.

Exhalation Valves

- NIOSH-Approved N95s with exhalation valves will protect your staff and provide source control to protect others. These can be worn without having to cover the valve with another mask. However, they are not fluid resistant. In situations where a fluid resistant respirator is indicated (e.g., in surgical settings), individuals should wear a surgical N95.

More about Extended Use

Extended Use

- Extended use of respirators should only be used as a contingency capacity strategy as PPE supplies and availability, including respirators, have been returning back to normal and facilities should promptly resume conventional respirator practices.
- If extended use of N95 respirators is permitted, HCP should dispose of respirators when:
  - Performing aerosol generating procedures
  - Contaminated with blood, respiratory or nasal secretions, or other bodily fluids
  - Caring for patients co-infected with an infectious disease requiring contact precautions (e.g., methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococci, *Clostridium difficil*e, norovirus, etc.)
  - Any respirator that is obviously damaged or becomes hard to breathe through
- Consider use of a cleanable face shield over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls) to reduce surface contamination.
- Staff must take care not to touch their respirator. If they touch or adjust their respiratory they must immediately perform hand hygiene, before and after. Avoid touching the inside of the respirator.
- If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene.

More about N95s with Exhalation Valves

- **Exhalation Valves**
  - N95s with exhalation valves will protect you and provide source control to protect others.
  - As source control, findings from **NIOSH** research suggest that N95 respirators with exhalation valves provide the same or better source control than surgical masks, procedure maks, cloth masks, or fabric coverings.
  - N95s with exhalation valves can be used and individuals wearing a **NIOSH-approved** N95 with an exhalation valve does not need to cover it with a face covering or mask.
- **However,**
  - NIOSH-approved N95 respirators with an exhalation valve are not fluid resistant. Therefore, in situations where a fluid resistant respirator is indicated (e.g., in surgical settings), individuals should wear a surgical N95 or, if a surgical N95 is not available, cover their respirator with a surgical mask or a face shield. Be careful not to compromise the fit of the respirator when placing a facemask over the respirator. https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/n95list1.html

Fit Testing and Seal Check

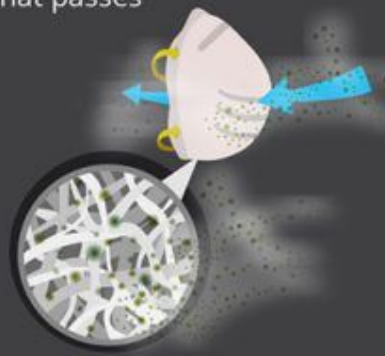
- During times of extreme supply constraints, when there may be limited availability of respirators or fit test kits, employers may face challenges in fit testing staff.
  - Although this is not ideal, in this scenario, ensure staff choose the respirator that fits them best. Even without fit testing, a respirator would provide better protection than a facemask or using no respirator at all.
- With PPE supply availability returning to normal, including fit testing kits, employers should make every effort to ensure that staff who need to use tight-fitting respirators are fit tested to identify the right respirator for each staff member.
  - OSHA requires an initial respirator fit test to identify the right model, style, and size respirator for each person and annually thereafter.
- Regardless, always perform a seal check when donning a respirator.
  - Without an adequate seal, air and small particles leak around the edges of the respirator and into the wearer's breathing zone.

Three Key Factors Required for a Respirator to be Effective

① The respirator must be put on correctly and worn during the exposure.

② The respirator must fit snugly against the user's face to ensure that there are no gaps between the user's skin and respirator seal.

③ The respirator filter must capture more than 95% of the particles from the air that passes through it.



CDC NIOSH

*If your respirator has a metal bar or a molded nose cushion, it should rest over the nose and not the chin area.

https://blogs.cdc.gov/niosh-science-blog/files/2020/02/KeyFactorsRequiredRespLG-768x514.jpg

When to use an N95

N95

- When performing an aerosol-generating procedure
- When caring for a resident on Transmission-Based Precautions
  - Symptomatic and/or testing positive for COVID-19
  - When caring for a resident on quarantine
- N95 respirators should be prioritized for HCP who are using them as PPE over those HCP who are using them for source control

PPE FAQ - PPE Table

COVID-19 PPE Requirements per CDC Guidelines

COLORADO
Department of Public Health & Environment

	PPE Required for Staff Entering Resident Rooms or w/ Direct Contact (includes ancillary)*				
	GOWN	PROCEDURAL /SURGICAL MASK	RESPIRATOR (PAPR/N95/P100)	EYE PROTECTION	GLOVES
When caring for a resident without signs or symptoms of COVID-19 **	⊘	✓	⊘	>10% positivity rate*	✓
When caring for a resident on a 14-day observation after admission (new residents and/or readmissions) **	✓	⊘	✓	✓	✓
When caring for a resident on a 14-day quarantine after an exposure to COVID-19 **	✓	⊘	✓	✓	✓
When caring for a resident suspected or confirmed to have COVID-19 **	✓	⊘	✓	✓	✓
While working in non-patient care areas or common areas (e.g., hallways, charting, breakrooms) **	⊘	✓	⊘	⊘	⊘
When transporting a resident out of their room **	⊘	✓	⊘	>10% positivity rate*	⊘
When obtaining a respiratory specimen (nasal swab/NP) on an asymptomatic patients/staff (e.g., surveillance or outbreak testing).	✓	✓ OR	✓	✓	✓
While performing aerosol generating procedures (AGP) ***	✓	⊘	✓	✓	✓

Lasted updated: 03/17/2021 Reference: www.cdc.gov/coronavirus/2019-ncov/downloads/summary-of-IPC-guidance-P.pdf

*Staff working in facilities located in counties with >10% two-week average test positivity rate ("Colorado Covid Dial"), should wear eye protection (e.g. face shields, goggles) during all resident care activities to protect against viral spread from asymptomatic individuals.
**Remind residents to don (put on) a mask prior to staff or visitors entering their room, keeping the mask on for the duration of the visit (if tolerated). Residents should also wear a mask when leaving their rooms (if tolerated).

***If an N95 is not available, use a surgical mask. A face sheild can be used in addition to the surgical mask for added protection.

Thank you!

From our team to yours, thank you for all you do and for your ongoing collaboration.

COLORADO
Department of Public Health & Environment

Additional Resources for Residential Settings

CDPHE Supplemental Resources

Prevention Checklists (Temporarily removed for updating)

- LTC Checklist_COVID-19 Preparation and Response
- Small Facility Checklist_COVID-19 Preparation and Response

COVID-19 Screening Forms

- Employee health screening form | Español (PDF)
- Visitor health screening tool (PDF) | Español (PDF)

Outbreak Forms

- COVID-19 outbreak report form (PDF)
- COVID-19 line list template | Español (Excel)

Personal Protective Equipment

- CDPHE FAQs for Personal Protective Equipment (PPE)

Q&A

Visitation

Can we use volunteers to help with the screening, escorting, and/or monitoring of visitation?

- Yes, volunteers can be used to assist facilities in maintaining visitation requirements.
    - Volunteers are defined as: Unpaid staff members who provide routine services, generally have a recurrent role within the facility and have received structured training and orientation on resident rights and infection prevention practices. Volunteers generally are 18 and older, have an ongoing relationship with a contract, role and/or schedule. Volunteers are not individuals who are infrequent visitors (e.g. girl scout troops, musicians, individuals seeking community service hours). Volunteers should be treated as staff and should be included in surveillance and outbreak testing and offered vaccination (e.g. influenza, covid).

Can we host group activities and invite musicians or other entertainers IF we socially distance and hold these activities outdoors?

- No, group activities should be facilitated by **facility staff only**; group activities are **not** open to visitors (e.g., musicians, performers, family members, or friends) at this time. As community transmission decreases this will be reevaluated and guidance updated. See the Comprehensive Mitigation Guidance (pages 9 & 24) for more information.
- Musicians and other entertainers are considered visitors. Visitors are restricted to only a single resident and should follow the visitation guidelines (starting on page 25).

Visitation

Can family members bring in a pet for the visit?

- With pre-notice, and facility permission, pets may accompany a visitor for a visit with a single resident. Pets can aid in the transmission of COVID-19 and therefore the pet must be kept away from other staff and residents during the visit (inside or outside). The facility should have policies and procedures regarding the safety and parameters for pet visitation, including criteria for vaccinations and infection control. This is found on page 30 of the RCF Mitigation Guidance.

Can we hold group mass in our facility?

- No, group mass would be considered a group activity and for now is restricted.
- However, religious exercise cannot be restricted for an individual resident. Clergy are classified as visitors and therefore should restrict their visit to a single resident, follow the visitation guidelines (page 28).

Dining and Activities

Can residents share a table during meals without social distancing?

- Residents can share a table during meals (breakfast, lunch and dinner) that are consumed in the dining room. This exception is allowed if the following is in place:
  - The number of participants in the dining room is limited to 50% of the occupancy AND those that are sharing a table are generally the same individuals at each meal.
  - This is an exception to allow for increased socialization during mealtimes with a small group of people, this exception does not apply outside of mealtimes.
  - Since group activities may include a larger number of people, mask use and social distancing are still recommended to prevent exposures to larger groups at one time. The consumption of food and drink should not occur during group activities or facility outings unless these activities occur outdoors while participants are spaced at least 6 feet apart.

Can visitors eat with the residents?

- No, guests from outside of the facility including staff, visitors, and residents of neighboring facilities should not participate in communal dining activities regardless of indoors or outdoors.

Can we have food and/or drink (including snacks) during activities?

- The consumption of food and drink should not occur during group activities or facility outings unless these activities occur outdoors while participants are spaced at least 6 feet apart. In general residents will be sharing meals with the same small group of residents during communal dining, whereas the number of residents and which residents might participate in activities is likely to be greater.

PPE

Is eye protection still needed when providing resident care?

- Staff working in facilities located in counties with >10% two-week average test positivity rate ("Colorado Covid Dial"), should wear eye protection (e.g. face shields, goggles) during **ALL** resident care activities to protect against viral spread from asymptomatic individuals.
- In addition, when a positive resident has been identified in the facility, HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown." This is found on page 10 of the RCF Mitigation Guidance

Do facilities still need to implement universal masking?

- Yes, HCP should wear a well-fitting medical grade face mask or respirator at all times while they are in the healthcare facility, including in break rooms or other spaces where they might encounter co-workers.
- To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same mask throughout their entire work shift when the face mask or respirator is used for source control. In other words, HCP can wear the same face mask for multiple residential encounters. Staff should take caution not to touch the mask and perform hand hygiene immediately if the mask is touched, adjusted, and doffed.
- With PPE supply availability, including respirators, returning to normal, reuse is now considered a crisis strategy. Facilities should prioritize the use of N95s/respirators for staff providing care to residents on transmission-based precautions (on isolation for COVID-19 or on quarantine following a possible exposure) and for those performing aerosol generating procedures. Facilities should ensure that respirators are disposed of when doffed and not stored for reuse.

What is the difference between a respirator and a N95?

- 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. An N95 is a type of respirator.

Miscellaneous

Do residents who leave the facility for day trips need to quarantine if they are not vaccinated?

- In most circumstances, quarantine is not recommended for residents who leave the facility for day visits (e.g., for medical appointments, community outings with family or friends) and do not have close contact with someone with SARS-CoV-2 infection.
- However they should be included in surveillance testing as outlined in the PHO. You can find this information currently on pg 25 of our guidance.

CDC and CMS recently updated their guidance, will CDPHE be updating their guidance to align?

- CDPHE does anticipate that guidance will be updated to better align with CDC and CMS but this will take time, especially given the number of outbreaks in Colorado (in both the community and in residential settings). CDPHE will notify partners promptly when guidance has been updated. **Until then, facilities should continue to use existing guidance.**
- It is important that facilities maintain infection control measures as outlined in the guidance. The more infection control measures consistently maintained, the more successful your facility will be and preventing transmission.