DEPARTMENT OF HEALTH

COVID-19 Source Control (Masking), PPE, and Testing Grid

The guidance provided in this document follows CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

Masking, Personal Protective Equipment (PPE), and Testing

Status	Resident Masking	Staff PPE	Testing	Notes
Resident with a positive COVID-19 test.	Mask, if able, when staff or visitors enter room.	Full COVID-19 PPE: respirator, eye protection, isolation gown, and gloves.	Repeat testing is not needed to exit isolation unless test-based strategy is being used to determine isolation duration for immunocompromised resident.	**Place resident in transmission-based precautions and isolate to room.** Room door closed (when safe to do so); communal activity and dining are restricted; and therapy or bathing are preferably performed in the resident's room. Designated isolation area in building with dedicated staff is ideal when the number of residents with SARS-CoV-2 infection is high.
Symptomatic resident with COVID-19 test pending.	Should mask, if able, when staff or visitors enter room.	COVID-19 full PPE: respirator, eye protection, isolation gown, and gloves.	If using an antigen test, a negative result should be confirmed by either a negative PCR or second negative antigen test	**Place resident in transmission-based precautions and isolate to room.** Room door closed (when safe to do so); communal activity and dining are restricted; and therapy or

Status	Resident Masking	Staff PPE	Testing	Notes
			taken 48 hours after the first negative test.	bathing are preferably performed in the resident's room. Resident should not be moved to a COVID-19 unit until positive status confirmed.
Facility in outbreak status(1): Refer to link at the top of page 5.	Everyone should mask in communal areas of facility.	Everyone should use source control in communal areas of facility. Facility should consider universal use of N95 and protective eyewear for staff when facility is in an outbreak, especially when residents are unable to use source control or the area is poorly ventilated.	Contact tracing approach can be used when facility is able to clearly identify exposures (e.g., single resident exposure to a visitor). Broad-based (unit-wide) approach is preferred when contacts cannot be identified or additional cases are identified after contact tracing approach. *Outbreak testing is not recommended for asymptomatic persons with SARS-CoV-2 infection in the prior 30 days.	**Initial testing:** Perform a series of three tests, 48 hours apart. This will typically be at day one (exposure day zero), day three, and day five. **Follow-up testing if additional cases identified:** Strong consideration to shift to broad-based approach. Testing should continue on affected unit(s) or facility-wide every three to seven days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every three days), should be considered. **If concerns exist for outbreak containment** (e.g., large number of resident cases, ongoing transmission, etc.) facilities should consider infection prevention and control escalation phase (refer to outbreak table below).

Status	Resident Masking	Staff PPE	Testing	Notes
Facility not in outbreak status. Sample metrics to consider for risk assessment(2): Refer to links at the top of page 5	Broader use of source control per facility policy when needed, based on risk assessment(2): Refer to links at the top of page 5. Perform risk assessment to identify higher levels of COVID-19 or other respiratory illness circulating in the community. (2): Refer to links at the top of page 5. Residents may choose to wear source control even if not otherwise required by the facility.	Broader use of source control per facility policy when needed, based on risk assessment(2): Refer to links at the top of page 5. Perform risk assessment to identify higher levels of COVID-19 or other respiratory illness circulating. Staff may choose to wear source control even if not otherwise required by the facility. Facility should consider universal use of N95 and protective eyewear when	No routine testing. Perform test on anyone with even mild symptoms of COVID-19.	Facility should provide guidance about recommended actions for staff, visitors, and residents that promote core principles of COVID-19 infection prevention: Hand hygiene Face covering or mask, in accordance with CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Use of PPE, per standard precautions. Respiratory hygiene/cough etiquette. Place residents in cohorts, when possible. Cleaning and disinfection of environmental surfaces. Instructional signage at entrance and throughout facility. MDH reminds use of a mask is an important tool.

Status	Resident Masking	Staff PPE	Testing	Notes
		levels of COVID-19 are higher.		
Resident with a close contact.	Resident should wear mask for 10 days following their close contact.	Health care personnel wear source control based on facility outbreak status or facility policy. Staff who have had close contact or a higher-risk exposure with someone with SARS-CoV-2 infection should wear source control for 10 days after their exposure.	Admission testing is at the discretion of the facility. Close contact, if asymptomatic, should have a series of three viral tests, each 48 hours apart (this will typically be at day one, where day of exposure is day zero, and again day three and day five).	In general, asymptomatic residents do not require empiric use of transmission-based precautions (TBP). Examples of when empiric TBP may be considered include: Resident is unable to be tested or to wear source control as recommended for the 10 days. Resident is moderately to severely immunocompromised. Resident is residing on a unit with others who are moderately to severely immunocompromised. Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

(1) Outbreak links:

Situation Update for COVID-19 (www.health.state.mn.us/diseases/coronavirus/stats)

CDC: RESP-NET Interactive Dashboard (www.cdc.gov/surveillance/resp-net/dashboard.html)

CDC: National Emergency Department Visits for COVID-19, Influenza, and Respiratory Syncytial Virus (www.cdc.gov/ncird/surveillance/respiratory-illnesses/index.html)

CDC: Weekly US Map: Influenza Summary Update (www.cdc.gov/flu/weekly/usmap.htm)

CORHA: Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings (www.corha.org/wp-content/uploads/2024/01/COVID-19-HC-Outbreak-Definition-Guidance_January-2024.pdf)

(2) Sample metrics:

Situation Update for COVID-19 (www.health.state.mn.us/diseases/coronavirus/stats)

CDC COVID Data Tracker: hospitalizations sub landing (covid.cdc.gov/covid-data-tracker/#hospitalizations-landing)

CDC: RESP-NET Interactive Dashboard (www.cdc.gov/surveillance/resp-net/dashboard.html)

CDC: National Emergency Department Visits for COVID-19, Influenza, and Respiratory Syncytial Virus (www.cdc.gov/ncird/surveillance/respiratory-illnesses/index.html)

CDC: Weekly US Map: Influenza Summary Update (www.cdc.gov/flu/weekly/usmap.htm)

CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

Social vulnerability index (SVI)

Health care facilities should consider the social vulnerability index (SVI) score when making decisions about their COVID-19 infection control policy. Areas with higher social vulnerability (lower SVI quartile) have been shown to be at increased risk for COVID-19 outbreaks, in-hospital death, and major cardiovascular events while experiencing decreased vaccination rates and uptake of antiviral treatments. More about Minnesota's use of SVI in the COVID-19 pandemic response and a list of Minnesota ZIP codes with their SVI score and quartile is at: COVID-19 Vaccine Equity in Minnesota (www.health.state.mn.us/diseases/coronavirus/vaccine/mnsvi.html).

Considerations for infection prevention and control escalation phases for facilities in outbreak status

Transmission-based precaution measures should be implemented in the event of ongoing COVID-19 transmission within the facility that is not controlled with initial interventions. Facilities should consider shifting to uncontrolled COVID-19 outbreak phases when there are concerns related to outbreak containment (e.g., large number of resident cases or ongoing transmission, such as new resident COVID-19 cases being identified in rounds of testing seven days or more after the first residents(s) identified as COVID-19 positive).

Infection prevention and control escalation does not need to be considered if the facility has only staff positive cases identified during outbreak testing.

Uncontrolled COVID-19 Outbreak

Phase	Staff PPE Use	Additional Transmission-Based Precautions Recommended
Phase 1	Universal staff use of N95 and eye protection.	Resident wears mask when outside of room. Restrict communal dining. Small group activities may continue with mask and physical distancing.
Phase 2	Universal staff use of N95 and eye protection.	Resident wears mask when outside of room. Restrict dining and group activities.
Phase 3	COVID-19 full PPE: respirator, eye protection, isolation gown, and gloves.	Residents mostly limited to their rooms. Keep resident doors closed (when safe to do so). Restrict dining and group activities. Facility may devise a plan for a small number of residents to be outside of their rooms at any given time, with a mask. Facility should ensure physical distancing and could prioritize outdoor visits, dependent on weather.

Note: Facility may choose to initiate infection prevention and control escalation with any of the three phases listed above, depending on their assessment of outbreak (e.g., nature of exposure, ability of residents to follow instructions, ventilation in the building, number of staff and resident cases, etc.). However, if facility continues to see resident cases seven days after implementing a lower-level phase, then proceed to a higher-level phase. If already in Phase 3 and still seeing new cases seven days later, reassess infection control practices and consider contacting MDH Infection Control Assessment and Response to discuss additional infection control measures.

Adapted from Nebraska Infection Control Assessment and Promotion Program.

Guidance

Follow applicable PPE guidance:

CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

CDC: Types of Masks and Respirators (www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html)

OSHA: 1910.134 - Respiratory protection (www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134)

OSHA Fact Sheet: Voluntary use of filtering facepiece respirators (N95) for COVID-19 (www.dli.mn.gov/sites/default/files/pdf/fact_voluntry_use_filtering_facepiece_respirators_for_COVID-19.pdf)

CMS Ref: QSO-20-39-NH REVISED 05/08/2023 (www.cms.gov/files/document/qso-20-39-nh-revised.pdf)

CDC: Infection Control Basics (www.cdc.gov/infectioncontrol/basics/index.html)

Definitions

Isolation: when people who are infected with a contagious disease are separated from others.

Transmission-based precautions: infection prevention and control measures used when clients/residents with known or suspected infection are separated from others. Transmission-based precautions are used in both isolation and quarantine. Refer to CDC: Transmission-Based Precautions (www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html).

Eye protection: goggles or a face shield that covers the front and sides of the face.

Face mask: OSHA defines face masks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA emergency use authorization, or offered or distributed as described in an FDA enforcement policy.” Face masks may also be referred to as "medical procedure masks.” Face masks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other face masks, such as some procedure masks that are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: 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 CDC/National Institute for Occupational Safety and Health (NIOSH), including those intended for use in health care.

Source control options for health care workers include any of the following:

A National Institute for Occupational Safety and Health (NIOSH)-approved particulate respirator with N95 filters or higher.

A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated).

A barrier face covering that meets American Society for Testing and Materials (ASTM) F3502-21 requirements, including Workplace Performance and Workplace Performance Plus Masks. Refer to CDC: Barrier Face Coverings and Workplace Performance/Performance Plus Masks (wwwn.cdc.gov/PPEInfo/RG/FaceCoverings).

A well-fitting face mask.

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To obtain this information in a different format, call: 651-201-5414.