COVID-19: Frequently Asked Questions for Infusion Providers

What should we tell patients asking if they should continue to receive their infusions in light of COVID-19 community outbreaks?

Many of the therapies administered at infusion therapy centers have immunomodulatory effects—they change the way the immune system works. Immunomodulators can act at different levels of the immune system, resulting in varying degrees of immunosuppression. This means that each therapy, combined with each individual patient’s medical history, results in a different level of risk for each patient. This information, combined with COVID-19 activity data and guidance from local and state public health officials, should inform plan of care decisions made by healthcare providers for particular patients.

Our distributors haven’t been able to fill out orders for PPE. What are our options if this shortage continues?

The global outbreak of COVID-19 has caused disruptions to overseas manufacturing, supply chains and delivery schedules. Additionally, public concern about transmission of COVID-19 has resulted in an unusually high volume of consumer purchases. Healthcare facilities are also increasing purchase volumes in preparing to care for large numbers of infected patients. The decrease in supply coupled with a tenfold increase in demand has resulted in supply shortages which are estimated to last several months. Strategies to combat this shortage are underway, including plans for global surge manufacturing, and releasing stockpiles of N95 respirators. The following actions are recommended during the PPE supply shortage:

- Review CDC guidance regarding conventional, contingency and crisis alternative strategies for optimizing the supply of PPE.
- Conserve available supplies and maximize efficacy by providing ongoing staff training regarding when PPE is needed, what type of PPE is needed, and how to properly put on and take off PPE.
- Monitor facility inventory of PPE closely, and employ strategies to prevent losses by theft, damage, or accidental loss.

If you are experiencing difficulty obtaining critical supplies needed to continue providing patient care, please contact NICA right away.

Should the infusion center staff wear N95 respirators when caring for all patients during this outbreak, just in case?

No, PPE should only be worn by healthcare personnel caring for patients with a known or suspected SARS-CoV-2 infection. Healthcare workers who are caring for patients with known
or suspected SARS-CoV-2 infections should follow transmission-based precautions, wearing eye protection, masks, gowns, and gloves. Patients with suspected or confirmed SARS-CoV-2 should wear a facemask while being evaluated. Due to the shortage of respirators (N95 masks), their use should be prioritized for settings where aerosol-generating procedures are performed\(^1\). Knowledge of COVID-19 transmission evolves very frequently, as does the regional supply chain for PPE; consult the [CDC Infection Prevention and Control Recommendations](https://www.cdc.gov/infectioncontrol/) for the latest updates.

**Do we need to buy a special disinfectant to kill the SARS-CoV-2 virus?**

Review the [EPA’s list of Registered Antimicrobial Products for Use Against Novel Coronavirus SARS-CoV-2, the Cause of COVID-19](https://www.epa.gov/ registration/registered-products-use-against-novel-coronavirus-sars-cov-2) to determine if the product(s) used in your facility are effective against SARS-CoV-2. In addition to choosing an effective product, it is very important to follow the manufacturer’s instructions on the product label; **allow the product to stay on surfaces for the full recommended contact time** (the amount of time the disinfectant is in direct contact with the surface/item to be disinfected). If the disinfectant air dries or is wiped dry before the contact time is reached, it may not provide the required level of disinfection.

**What should we do if we identify a patient who may meet criteria for COVID-19 testing?**

As community transmission is now confirmed in 18 states in the U.S., clinicians should use their judgement to determine if a patient has signs and symptoms of COVID-19 and should be considered a **person under investigation**. Factors may include:

- Presence of fever and/or symptoms of a respiratory illness (cough, shortness of breath);
- Recent history of travel to areas with known community transmission. (As of April 1, 2020, nearly all states in the U.S. are experiencing community transmission in either widespread or defined areas. Refer to the [CDC website](https://www.cdc.gov/) for the most up-to-date information);
- Close contact\(^2\) with:
  - A person with a known or suspected case of COVID-19;
  - A person experiencing COVID-19 symptoms (e.g., fever, cough, shortness of breath);
  - A person who has been instructed to self-monitor/isolate/quarantine at home due to potential exposure; or,

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\(^1\) Aerosol generating procedures include intubation, administration of nebulizer treatments, and airway suctioning.

\(^2\) Close contact is defined as: a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case; OR b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)
 Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. In outpatient settings, this includes providing the patient with a mask, and escorting them to a private room to separate them from other patients while conducting a risk assessment, and disinfecting the affected area(s) according to CDC guidance. Healthcare providers should then contact internal infection control personnel as well as their local or state health departments to discuss patients they suspect meet criteria for testing.

How should we proceed if we are notified that a patient has been diagnosed with COVID-19 after spending time in our facility?

The CDC has developed comprehensive, specific guidance for risk assessment following possible exposure. Those recommendations, which should be read in their entirety, are summarized here:

- Employees who had no direct contact with a confirmed case (i.e. in the office but did not contact the patient or enter the patient examination room) are defined as having no risk and may continue to work.
- Employees who had brief interactions with a confirmed case (i.e. check-in, checkout, escorting patient into a room but not spending time in the room with the patient) are considered low risk and they can continue to come to work but must self-monitor for 14 days (i.e. taking temperature twice daily and reporting fever or concerning symptoms to a supervisor).
- Employees who had prolonged close contact with a confirmed case, which would include a physician spending time in an exam room with the patient or an infusion nurse administering an infusion, must self-isolate at home for 14 days.

The area(s) within the facility, including environmental surfaces and patient care equipment, should also be cleaned and disinfected in accordance with CDC guidance.

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3 Adapted from the guidance issued by the American Rheumatology Network