DEPARTMENT OF HEALTH

COVID-19 Testing Recommendations for Long-term Care Facilities

May 14, 2020

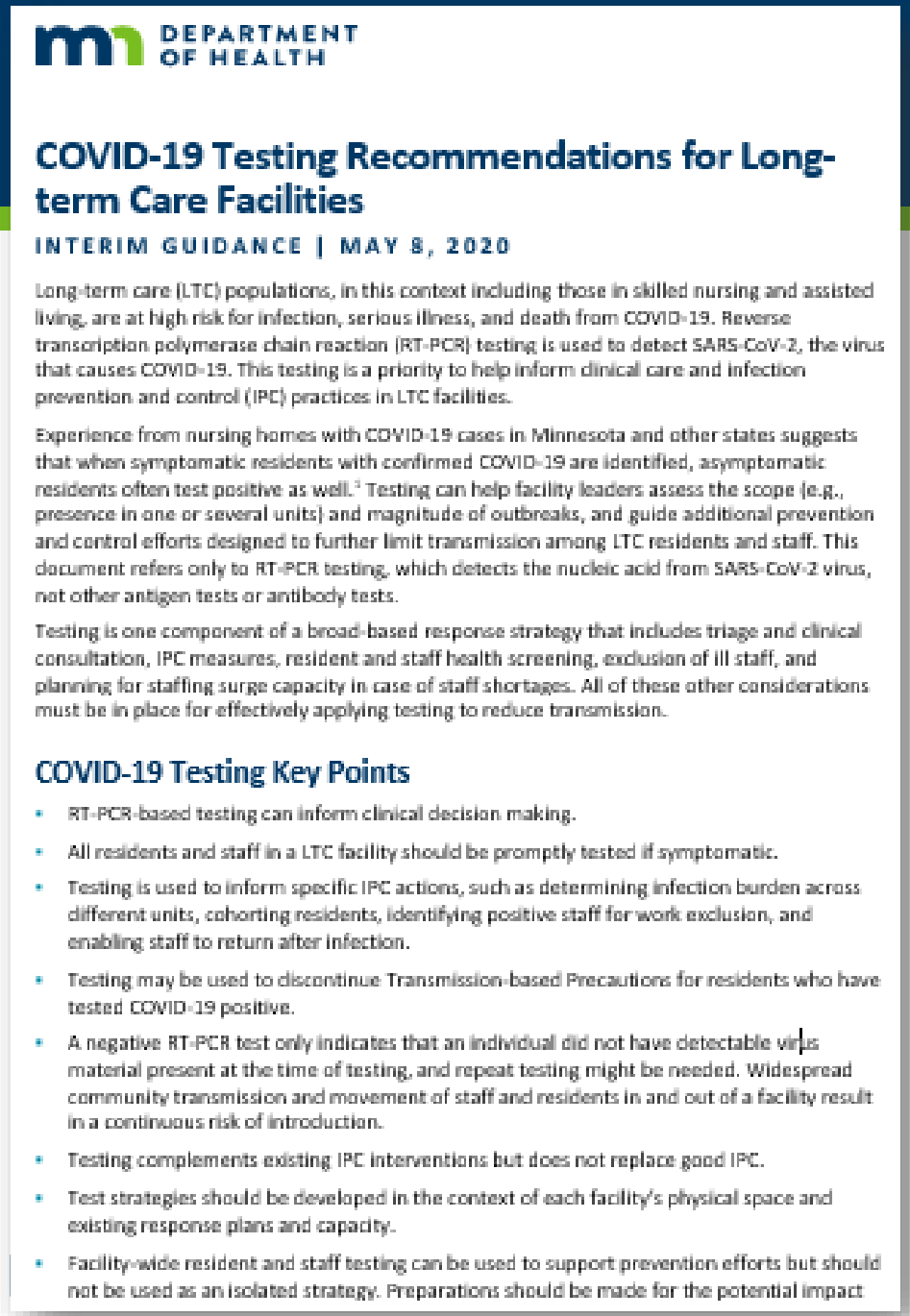
Agenda

- **State approach to testing**
- **Indications for testing**
  - Individual resident and health care worker (HCW) testing
  - Population-based testing (point prevalence survey)
- **Testing strategies**
- **Specimen collection**
- **Implications of testing**
  - Staffing shortages, mental health
- **Cohorting and other infection prevention recommendations**
- **Question and answer session**

Background

- Long-term care (LTC) refers here to skilled nursing and assisted living
- Health care worker (HCW) refers to all staff that work in a LTC facility
- This presentation and the guidance document refer only to RT-PCR testing
  - Detection of virus material in nose or nasopharynx
  - Reflects COVID-19 status only at the time of testing
  - Test can indicate active infection and infectiousness
  - After resident is no longer infectious, can still be RT-PCR positive

MDH Recommendations for Testing in LTC Facilities



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COVID-19 Testing Recommendations for Long-term Care Facilities

INTERIM GUIDANCE | MAY 8, 2020

Long-term care (LTC) populations, in this context including those in skilled nursing and assisted living, are at high risk for infection, serious illness, and death from COVID-19. Reverse transcription polymerase chain reaction (RT-PCR) testing is used to detect SARS-CoV-2, the virus that causes COVID-19. This testing is a priority to help inform clinical care and infection prevention and control (IPC) practices in LTC facilities.

Experience from nursing homes with COVID-19 cases in Minnesota and other states suggests that when symptomatic residents with confirmed COVID-19 are identified, asymptomatic residents often test positive as well.[1] Testing can help facility leaders assess the scope (e.g., presence in one or several units) and magnitude of outbreaks, and guide additional prevention and control efforts designed to further limit transmission among LTC residents and staff. This document refers only to RT-PCR testing, which detects the nucleic acid from SARS-CoV-2 virus, not other antigen tests or antibody tests.

Testing is one component of a broad-based response strategy that includes triage and clinical consultation, IPC measures, resident and staff health screening, exclusion of ill staff, and planning for staffing surge capacity in case of staff shortages. All of these other considerations must be in place for effectively applying testing to reduce transmission.

COVID-19 Testing Key Points

- RT-PCR-based testing can inform clinical decision making.
- All residents and staff in a LTC facility should be promptly tested if symptomatic.
- Testing is used to inform specific IPC actions, such as determining infection burden across different units, cohorting residents, identifying positive staff for work exclusion, and enabling staff to return after infection.
- Testing may be used to discontinue Transmission-based Precautions for residents who have tested COVID-19 positive.
- A negative RT-PCR test only indicates that an individual did not have detectable virus material present at the time of testing, and repeat testing might be needed. Widespread community transmission and movement of staff and residents in and out of a facility result in a continuous risk of introduction.
- Testing complements existing IPC interventions but does not replace good IPC.
- Test strategies should be developed in the context of each facility's physical space and existing response plans and capacity.
- Facility-wide resident and staff testing can be used to support prevention efforts but should not be used as an isolated strategy. Preparations should be made for the potential impact

- MDH has posted interim recommendations for testing in LTC facilities
- Available on MDH COVID-19 website

https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html

Point Prevalence Surveys in Literature

- **Point prevalence survey (PPS)**: Facility-level testing to establish a snapshot of COVID-19 status of residents and staff

- Skilled nursing: Testing symptomatic residents, HCW insufficient to identify all cases[1]
  - After 2 serial PPS, 64% residents positive
  - 26% case fatality rate
  - 27 (57%) tested positive while asymptomatic, and 24 (89%) of those later developed symptoms

- Assisted living: Testing symptomatic residents insufficient to identify all cases[2]
  - 4.3% of residents and 3.8% of staff positive
  - 75% of positive residents and 33% of positive staff had no symptoms

1 Arons MM, et al. N Engl J Med. https://www.nejm.org/doi/full/10.1056/NEJMoa2008457

2 Roxby AC, et al. MMWR Morb Mortal Wkly Rep 2020;69:416–418. https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e2.htm

Minnesota Data as of May 13, 2020

- **26% of assisted living and 10% of skilled nursing facilities in Minnesota are impacted**
- **523 LTC facilities have had cases** (487 lab reports received to date)
  - 218 (42%)—1 case
  - 72 (14%)—2 cases
  - 197 (38%)—more than 2 cases
- **3,015 cases in people associated with LTC**
  - 2,009 (67%) confirmed resident cases; 1,006 (33%) confirmed HCW cases
  - 95 (18%) facilities—resident cases only
  - 206 (39%) facilities—HCW cases only
  - 186 (36%) facilities—resident and HCW cases

Testing Individual Residents and Staff

- **Residents and staff:** Test immediately when symptomatic
- **Residents:** Test to guide release from Transmission-based Precautions
  - Symptom- and time-based approaches can also be used
- **Staff:** Consider testing individual staff when:
  - Worked at another facility with COVID-19 in residents and/or staff
  - Experienced high-risk PPE breach while working with COVID-19-positive resident
  - Have a household member or intimate contact with confirmed or suspected COVID-19
  - Unprotected exposure to coworker with confirmed COVID-19

Point Prevalence Survey

- **Point prevalence survey (PPS)**: Facility-level testing to establish a snapshot of COVID-19 status of residents and staff

- Consider PPS when:
  - One or more residents are confirmed to have COVID-19
  - ≥2 residents and/or staff develop symptoms consistent with COVID-19
  - HCW tests positive for COVID-19 and worked while ill, worked in the 48 hours before symptoms started, or worked in the 48 hours before the date of a positive test
  - No known COVID-19-positive residents or HCW but facility located in high-risk area (e.g., close to other LTC facilities experiencing outbreaks, share staff with positive facilities)

Testing in Individual Units and High-risk Residents

- **Testing of units or wards**
  - If unable to conduct facility-wide PPS, can conduct PPS in smaller part(s) of facility
  - Consider expanding to additional units if positive resident(s) and/or staff found
  - Consult with MDH if testing capacity is a concern

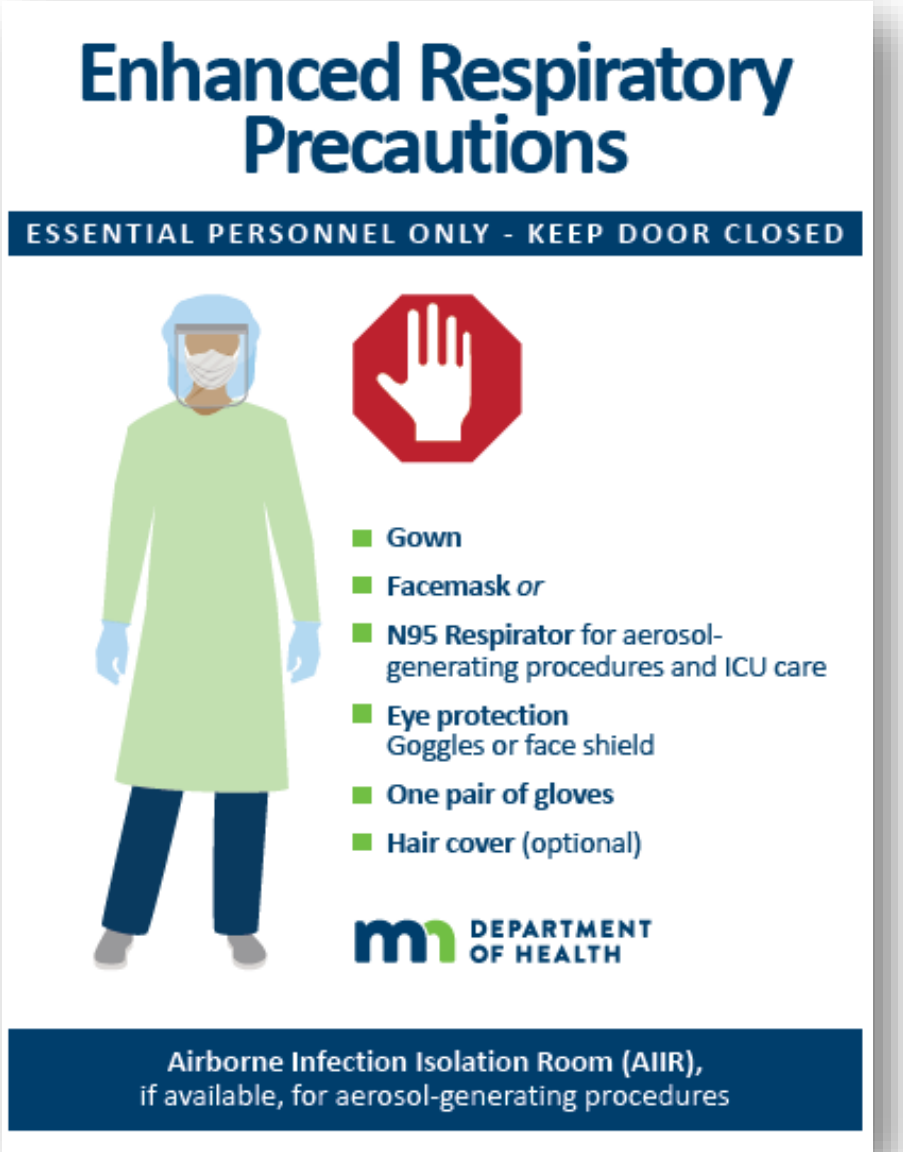
- **Routine testing of high-risk residents**
  - Maintain a very low threshold for testing these residents if change in condition
  - New admissions from hospital or other facility, regardless of referring facility COVID-19 status
  - Roommates of symptomatic residents, regardless of COVID-19 status
  - Residents who leave regularly for dialysis or other essential medical services

Essential Considerations for Expanding Testing and PPS

- Resident placement (chorting)
- Infection prevention and control (IPC)
- Personal protective equipment (PPE) supplies
- Staffing shortages
- Mental health and wellbeing of HCW and residents
- Communication with residents, families, and staff

Cohorting Strategies

- **Why cohort?**
  - Positive residents separated
  - Universal PPE can be used
- **Plan:** What will you do if 10, 20, or 50 cases are detected?
- **Select a location for the COVID-19 Unit:**
  - Look at floor plans
  - Pick a unit or wing
  - **Dedicate staff to this area**
- **Post:** "Restricted Area" signs at entry to COVID-19 Unit



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Sign available at:
https://www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf

Infection Prevention and Control

- Designate donning area with a sign “Donning Area”
  - Hang a donning poster aid
  - Shelving with gowns, gloves, alcohol-based hand rub (ABHR)
- Designate doffing area with a sign “Doffing Area”
  - Hang a doffing poster aid
  - Large enough waste baskets, ABHR
- ABHR should be inside and outside of rooms and at desk
- Cleaning and disinfection with appropriate disinfectant
  - Cleaning equipment & environment
  - High-touch cleaning
- Establish process for staff to don, doff, and store PPE when on break

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Poster available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

Personal Protective Equipment

- Ensure adequate PPE supplies
- Track PPE supplies daily
  - Use the CDC Personal Protective Equipment (PPE) Burn Rate Calculator[1]
  - Get support from your health care coalition (HCC)[2]
- Initiate measures to optimize current supply
- Extended use and reuse of PPE
- If supplies become critically low (0–3 days left), complete PPE Request Form through HCC
- Educate staff who provide direct care, including contractors, on PPE donning and doffing

1 CDC: Personal Protective Equipment (PPE) Burn Rate Calculator (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html)
2 MDH: Health Care Coalitions (https://www.health.state.mn.us/communities/ep/coalitions/index.html)

Preparation for Staffing Shortage

- Prepare to address staffing shortage as soon as testing results are back
  - Know when results are expected from laboratory
  - Expect 5–30% of staff to be positive in PPS, with higher rates in facilities with multiple resident cases
- First explore normal means to fill shifts, including:
  - Bonuses
  - Leadership providing care
  - Short shifts
  - Hazard pay
- Plan for short-term and longer-term staffing
  - When PPS is repeated, additional staff will likely test positive

Staff Cannot Work if:

- Signs or symptoms of illness
- Tested positive with symptoms
- Tested positive without symptoms

Follow CDC's return to work guidance for these staff.[1]

1 Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance) https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

After Normal Staffing Options are Exhausted

1. **Quarantined staff:** Identify staff with **no signs or symptoms and who did not test positive** who could be asked to return
2. **Related facilities:** Contact health system, hospital partners to find out number, type of available staff
3. **Supplemental nurse staffing agencies:** Ask about last-minute coverage, longer-term planning
4. **Local public health:** Discuss staffing support
5. **Regional Health Care Preparedness Coordinator (RHPC):** Advise about expected need, learn about available support (https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html)
6. **Statewide Healthcare Coordination Center (SHCC) Minnesota Healthcare Resource Call Center (MHRCC)**
   - Staffing needs ≤48 hours; 1-833-454-0149 (toll free) or 651-201-3970 (local)
   - Be ready with: open shifts vs. filled crisis-level shifts for positions (RN, LPN, NA) over next 48 hours
7. **County Medical Reserve Corps:** Contact with specific request
8. **County emergency management**

If all attempts to use these options are exhausted, call the SHCC MHRCC for crisis management.

Mental Health and Wellbeing

- Facility leaders must prepare for impacts of testing on staff
  - Concerns of staff receiving positive test, including health and income impacts
  - Stress of short staffing on remaining staff
  - Fears among staff while working in facility with COVID-19-positive cases
  - Emotional response to learning that they could not protect residents from becoming positive
- Residents will also be impacted by testing results
  - Fear of COVID-19 outcome on positive residents
  - Stresses associated with resident movement to COVID-19 unit

Resources for Leaders

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COVID-19 Considerations for Health Care Leaders

SEVEN THINGS YOU AS A LEADER CAN DO RIGHT NOW

1. **Talk with your staff … and listen**

   Tell staff you care about their safety and well-being. Name someone who staff can talk to a
   their concerns, and explain how leadership will answer their concerns.

2. **Walk the floors**

   Walk the floors weekly show that you support your staff. Consider developing symbols of
   appreciation for employees. Minnesota Veterans Home created small "Hero" pins for staff
   working on the COVID-19 unit.

3. **Show safe PPE use**

   Name a leader to show staff the right way to put on and take off personal protective equip
   (PPE). Have that person check with staff every week to be sure they are still using PPE the r
   way.

4. **Start a buddy system**

   Set up a buddy system for staff to support each other. Buddies should: check that they eac
   PPE the right way; share their concerns; talk about stress; and look out for each other's saf
   and well-being.

5. **Share information**

   Post well-being resources and positive messages, so staff know they are heard and seen.

6. **Connect staff to support services**

   Do as much as possible to protect staff from physical and mental stress, so they can fulfill t
   roles. Be aware of how staff is affected by high workloads, grief, and stigma or fear in their
   families or communities.

   Treat staff to a pizza lunch, snacks, or care packages (e.g., hand lotion, laundry soap pods).

   Offer mental health and psychosocial support, and psychological first aid training. COVID
   Support Services offers 20-minute support sessions. See the Minnesota Psychiatric Society
   (https://www.mnpsychsoc.org) website.

7. **Hold COVID-19 exercises**

   Host a planning and training session called, "A Day in our COVID-19 Life." Get your team
   thinking about how their roles and realities change when residents in their communities ha
   COVID-19.

COMMON FEARS AND CONCERNS

Not enough information
- We do not have access to current information and communication.
- We do not always know if we can trust what we see or read.

Not being heard
- Leadership may not know our biggest concerns or how to handle them.

Using personal protective equipment (PPE)
- Why is leadership wearing different PPE than us, or not using the PPE we are expected to use?
- How can we be expected to work in settings with COVID-19 when we do not have the right PPE and/or training?

Staff shortages/extra pay/job security
- What is our organization doing, or planning to do, to make sure enough staff are working during an outbreak? Will I be told I have to come into work?
- Will we be paid more if we work with community members who have confirmed or suspected COVID-19 disease?
- We worry about not getting paid, retaliation for speaking up about concerns, and being pressured to work when sick.

Support for our families
- We worry about being exposed to COVID-19 at work and bringing it home to our families.
- We need access to childcare when we work longer hours and when schools are closed.
- Who will support our families if we are infected? We need support for other personal and family needs, as work hours and demands increase.

Access to testing
- We worry about not being able to get tested fast if we develop COVID-19 symptoms. We worry that infection can spread at work because we cannot get tested fast.

What to expect
- No one has prepared us for what to expect when an outbreak occurs.
- What will happen if coworkers get seriously ill or die from COVID-19?
- How will we handle the grief and loss? What resources are available if we

COVID Cares Support Services from Minnesota Psychiatric Society offers 20-minute support sessions.
https://www.mnpsychsoc.org

MDH has posted this resource for leaders on the LTC COVID-19 webpage:
https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html

Health Care Worker Monitoring

- MDH and facilities work together to identify and monitor HCW with workplace exposure to a person (resident or staff member) with confirmed COVID-19

- **When a facility has <10 known COVID-19 cases in residents and/or staff:**
  - Facility conducts risk assessment for each HCW exposed to specific infected residents and/or staff
  - MDH calls HCW and provides recommendations for health monitoring and quarantine (if appropriate)

- **When a facility has >10 cases:**
  - Facility provides MDH with list of HCW working in the facility (or affected area) with positive people
  - MDH calls HCW and conducts risk assessment based on interactions with all residents and staff

Practical Tips: Prepare

- **Address laboratory needs:** Understand all specimen collection, storage, and transport needs by discussing with your laboratory ahead of time.
- **Complete tasks ahead of time:** Pre-fill all laboratory forms, pre-label tubes, and organize printed resident lists. This will reduce errors during sampling and the chance of running out of supplies.
- **Make laboratory arrangements:** Find out from the laboratory if they require batches of samples to be delivered every hour and the best time frame for sample submission.
- **Prepare for PPE:** Ensure that you have enough PPE (especially gloves), hand sanitizer, alcohol wipes, disposal bags, medical carts.

Practical Tips: Assemble a Team

The team should consist of:

- **Pair of specimen collectors:** one pair for each 20 residents that will be tested
  - One person will swab, and one person will observe, record, and handle specimens
  - For example, if there are 100 residents to test, there should be 10 people identified for specimen collection
  - **If your staff will not collect specimens, someone must accompany the collectors who is familiar with the residents and familiar to the residents.**
- **"Runner"** who will be available to assist teams as needed,
  - Ideally, there should be one for each floor, depending on the size of the facility
- **Specimen transporter:** someone to run samples to the laboratory in batches, if needed
- **Infection preventionist** or someone knowledgeable in IPC should oversee the operation
  - IPC should be the cornerstone of any facility-wide investigation, as testing only supplements IPC

Collecting specimens from residents will take longer than you think!

Question and Answer Session

Thank you.

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