Recent Changes to Document (5-18-20) Revised facility type from “Long Term Care Facility” to “Skilled Nursing Facility”.

A. Background: Infection control, universal source control, and physical distancing are the mainstays of COVID-19 mitigation strategies in skilled nursing facilities (SNFs). Improved COVID-19 testing capacity in Los Angeles County (LAC) provides us with an additional tool to intervene earlier in outbreaks. In our limited experience with COVID-19 in congregate settings, Los Angeles County Department of Public Health (LAC DPH) has found through mass testing (or facility-based testing) that when a single or small number of symptomatic cases are identified, there are many additional asymptomatic or mild cases other residents and staff. Identification of these additional asymptomatic cases and targeted infection control guidance based on testing may help reduce the risk of transmission of COVID-19. We have identified the following benefits of facility-based testing:

- We can make better-informed decisions about cohorting. For example, for facilities with a large number of asymptomatic COVID positive residents, DPH may recommend either to “reverse isolate” the negative patients or may recommend sending the COVID positive residents to a dedicated COVID facility.
- We can make more informed decisions on selecting patients for isolation and quarantine. With limited testing, we may be unintentionally exposing uninfected patients by isolating them together with infectious asymptomatic and pre-symptomatic COVID-19 patients.
- Asymptomatic staff who test positive will be excluded from work until no longer infectious, thus preventing unintentional spread of COVID-19 to other patients and staff.

B. Facility-Based Testing Strategies: We have identified 2 strategies for mass testing that we will be implementing in parallel:

1. **Strategy 1: Facilities with COVID-19 infected staff or residents.** Facilities experiencing single cases or outbreaks of patients with confirmed or suspect COVID-19. This strategy includes the following steps:
   a. Test of all SNF residents and healthcare workers.
   b. Cohort all COVID-positive residents and staff as outlined in Section D or consider transferring COVID-positive staff and residents to a designated COVID receiving facility, after approval by LAC DPH.
   c. Collaborate with LAC DPH on a virtual or in-person Infection Control Assessment and Response (ICAR).
   d. Consider re-testing all COVID-negative residents and staff weekly until no new cases are identified. However, retesting strategies may differ based on the specific outbreak situation and circumstances at each facility and should be tailored in consultation with LAC DPH.

2. **Strategy 2: Pre-emptive intervention.** Prospective surveillance of facilities not currently experiencing outbreaks. Testing facilities in this category will allow DPH to monitor facilities pro-actively to ensure that interventions can be made as early as possible.
   a. Choose a sample of asymptomatic residents and staff within the facility (at least 20% of residents and staff, or a larger percentage for small facilities).
   b. Continue sampling of residents weekly if testing is negative.
   c. If sampling identifies any positive staff or residents, confirm result with additional test.
   d. If repeat test is positive, initiate strategy 1.
C. Testing Logistics: Successfully executing these plans requires close coordination between the facility leadership and the public health investigators.

1. Test types.
   a. Direct viral detection testing (e.g. PCR, etc) is useful during outbreaks when patients are shedding virus in the days and weeks after initial infection.
      i. Direct viral detection tests should be used for facility-wide testing of staff and residents as described in this document.
      ii. Direct viral detection tests are not 100% sensitive, so if individuals have negative tests, they still may have COVID-19.
   b. Serologic/antibody testing may become useful in determining past infection that may no longer be identified through direct detection. Until there is better data on how to use these tests, they are not recommended for patient care or cohorting decisions.

2. Individual facilities should make plans to initiate testing themselves.
   a. While governmental help with facility-based testing is available for facilities that have no readily accessible alternative, the large scope of the pandemic will require facilities to use their own resources to obtain testing results more rapidly.
   b. Facilities should develop relationships with commercial laboratories.
   c. Facilities that have current or past cases of COVID-19 are likely to have asymptomatic transmission and should test all residents and staff in their facility as soon as testing is available.
   d. In facilities that do not have known cases of COVID-19, they should plan to test ~10% of residents (or 10 residents, whichever is larger) weekly to identify early transmission. If any testing from the sample population is positive, the facility should plan to do facility-wide testing.
   e. Facilities do not require prior approval to perform testing on their own. All laboratory confirmed COVID-19 cases results must be reported by the facility to LAC DPH within one day (see Reporting). Facilities are encouraged to contact LAC DPH to answer testing questions or for guidance about interpretation of results by calling the LAC DPH provider consult line (213) 240-7941 during business hours (Monday to Friday 8 am-5 pm)

3. For facilities unable to test on their own, LAC DPH can facilitate testing of the facility. LAC DPH requires the following to initiate testing:
   a. All sites to be tested should identify a person who can coordinate testing
   b. All sites must furnish staff to perform the testing (if this is not possible, alternative options may be available). The following information is required:
      i. Name of Facility
      ii. Address of Facility
      iii. Contact name at the Facility
      iv. Phone number at facility
      v. Name of Facility Medical Director (he/she must be the ordering MD for the facility, so they get results directly)
      vi. NPI of Facility Medical Director.
vii. Number of swab kits to be used
viii. Date of proposed testing
ix. List of residents and staff to be tested (Excel spreadsheet will be provided by LAC DPH)

4. The results of testing will be forwarded to the Facility Medical Director and must be copied to LAC DPH. The specific details of result notification will be worked out by the laboratory prior to initiating testing.

D. Potential Public Health Responses to Testing: Based on testing results, investigators may recommend a number of interventions, depending upon how many residents are affected and where they are located within the facility.

1. Staff
   a. Staff with acute lower respiratory symptoms (i.e. cough or shortness of breath) or fever should be excluded from work and isolated until they meet return to work criteria.
   b. Asymptomatic staff who test positive should be excluded from work and isolated for 10 days from the date of their first positive test (assuming they have not developed symptoms). See exception for critical staffing needs below.
   c. We do not recommend serial testing or test-of-cure for staff testing positive, instead the CDC symptom-based or time-based return to work criteria should be followed.
   d. Exception for critical staffing needs  Asymptomatic staff may potentially be able to work with only COVID-19 positive patients in a setting of critical staffing, but facilities must ensure the following conditions exist prior to letting these staff work:
      i. Asymptomatic COVID positive staff must work only with COVID positive residents and staff.
      ii. Work areas for COVID positive and negative staff must be kept separate, including break rooms, workstations and bathrooms.

2. Residents
   a. Residents testing positive for COVID should be separated from all residents who test negative (cohorting). Cohorting should be organized as follows:
      i. All residents who test positive for COVID should be located in a single area within the facility.
      ii. Cohorted patients can be roomed together strictly by cohort (i.e. Only COVID negative with other COVID negative residents and COVID positive with other COVID positive residents).
      iii. COVID positive and COVID negative groups should not share common areas or bathrooms.
      iv. The cohorting areas should be physically separate from other patient care areas within the facility. If there is no way to separate cohorting areas, then temporary physical barriers (screens, etc.) with clear signage posted should be used.
      v. Cohorting should be done with as much separation as possible (minimum 6 feet separation). If separate floors or buildings are available for separate cohorts, this is ideal.
vi. Staff, equipment, etc. should be dedicated to a cohort (positive or negative) and should not be shared.

b. Residents who have symptoms consistent with COVID-19, but test negative should still be presumed to have COVID-19 given that the sensitivity of the COVID-19 PCR may be around 70%. These residents should be placed on contact and droplet precautions, and isolated away from both COVID-positive and COVID-negative residents if possible. At the discretion of the Facility Medical Director, re-testing can be performed at least 24 hours after the initial test if testing is available. The resident’s disposition can be chosen based upon the retesting results.

c. Residents who test positive but remain asymptomatic should be considered infectious for 14 days after the date of the initial positive test.

d. If after mass testing there is only a small number of individuals identified in one category, consider relocating this minority to another facility. Given the risk of spreading infections to other facilities, transfers must first be cleared by DPH.

i. Residents testing negative:

1) When relocating this group to another facility, they should be placed into quarantine at the receiving facility for 14 days.

2) If DPH recommends moving these COVID-19 negative patients, but a patient refuses, the Facility Medical Director should explain the risks of developing COVID-19 with continued exposure in the current facility. If the resident still refuses transfer, the discussion should be documented and the patient will not be compelled to move. The patient should be put in “reverse-isolation” to be protected from the COVID-19 infected patients.

ii. Residents testing positive:

1) When relocating this group to another facility, the receiving facility should be either a dedicated COVID-19 facility or have a dedicated COVID-19 unit.

2) If DPH recommends moving these COVID-19 positive patients, but a patient refuses, the Facility Medical Director should explain the risk of transmission to other residents/patients. If the patient still refuses, DPH may consider issuing a Health Officer Order to isolate the patient in an appropriate facility.

3. Completion of cohorting. Viral shedding is still not clearly defined for COVID-19 for all patient groups, therefore the recommended duration of cohorting may be vary between different public health authorities. Because patients in SNFs are at particular risk for poor outcomes, these guidelines are more stringent than for the general population or for home-dwelling individuals. Residents who test positive for COVID-19 can be removed from COVID-19 designated cohort area after they are considered no longer infectious:

a. Asymptomatic COVID-19 residents who remain asymptomatic: 14 days from testing date. If residents develop symptoms, the 14 day isolation period should restart from the date of symptom onset.
b. Symptomatic COVID-19 patients that were originally hospitalized: 14 days from the date of hospitalization or 72 hours after last fever, whichever is longer.

c. Symptomatic COVID-19 patients that were never hospitalized: 14 days from symptom onset or 72 hours after last fever, whichever is longer.

d. Once the outbreak has been declared over, residents who were transferred to other facilities may return to their facility of origin, but must comply with any additional quarantine periods as recommended.