	# Health Alert Network Message 20-32: Update: Testing for COVID-19 in Nursing Homes, Long-Term Care Facilities, and Other Congregate Settings
Origination Date: *May 8, 2020*	**Revision Dates (list all revision dates):**

Update 05/08/2020: Testing for Coronavirus (COVID-19) in Nursing Homes, Long-Term Care Facilities, and Other Congregate Settings

Considerations for Use of Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes, Long-Term Care Facilities, and other Congregate Settings

Nursing homes, long-term care facilities, and other congregate settings (referred to as congregate settings moving forward) populations are at high risk for infection, serious illness, and death from COVID-19. Reverse transcription polymerase chain reaction (RT-PCR) testing (referred to here as testing or test) for SARS-CoV-2 infection among residents and healthcare personnel (HCP) in these facilities has become a priority to help inform prevention and control. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Increased SARS-CoV-2 testing in congregate settings has the potential to not only describe the scope and magnitude of outbreaks, but also to help inform additional prevention and control efforts designed to further limit transmission among residents and HCP. See CDC guidance on RT-PCR testing and specimen collection. The following testing strategy should be implemented as resources allow.

Consider the following four key principles when using testing in congregate settings:

1. Testing should not supersede existing infection prevention and control (IPC) interventions.

Testing conducted at congregate settings should be implemented *in addition to* existing infection prevention and control measures recommended by CDC, including visitor restriction, cessation of communal dining and group activities, monitoring all HCP and residents for signs and symptoms of COVID-19, and universal masking as source control. See CDC

guidance on Preparing for COVID-19: Long-Term Care Facilities and Nursing Homes and the Interim Guidance on Management of Coronavirus Disease 2019 in Correctional and Detention Facilities for more details.

2. Testing should be used when results will lead to specific IPC actions.
For example, testing can lead to IPC actions such as:

- Cohorting residents to separate those with SARS-CoV-2 infection from those without detectable SARS-CoV-2 infection at the time of testing to reduce the opportunity for further transmission.
- Discontinuing transmission-based precautions for residents diagnosed with SARS-CoV-2 infection.
- Identifying HCP with SARS-CoV-2 infection for work exclusion.
- Enabling HCP to return to work after being excluded for SARS-CoV-2 infection.
- Determining the SARS-CoV-2 burden across different units or facilities and allocating resources.

3. The first step of a test-based prevention strategy should ideally be a point prevalence survey (PPS) of all residents and all HCP in the facility.

Testing of residents in congregate settings:

- If testing capacity allows, **facility-wide PPS of all residents** should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience from nursing homes with COVID-19 cases suggests that when residents with COVID-19 are identified, there are often asymptomatic residents with SARS-CoV-2 present as well. PPS of all residents in the facility can identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility. If undertaking facility-wide PPS, facility leadership should be prepared for the potential to identify multiple asymptomatic residents with SARS-CoV-2 infection and make plans to cohort them.
- If testing capacity is not sufficient for facility-wide PPS, performing PPS on **units with symptomatic residents** should be prioritized.
- If testing capacity is not sufficient for unit-wide PPS, testing should be prioritized for **symptomatic residents and other high-risk residents**, such as those who are admitted from a hospital or other facility, roommates of symptomatic residents, or those who leave the facility regularly for dialysis or other services.

Testing of congregate setting employees:

- If testing capacity allows, PPS of **all HCP/employees** should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well. HCP likely contribute to introduction and further spread of SARS-CoV-2 within nursing homes.
- CDC recommends **HCP/employees with COVID-19 be excluded from work**. Facility leadership and local and state health departments should have a plan for meeting staffing needs to provide safe care to residents while infected HCP/employees are excluded from work. If the facility is in Crisis Capacity and facing staffing shortages, see CDC guidance on Strategies to Mitigate Healthcare Personnel Staffing Shortages for additional considerations.

4. Repeat testing may be warranted in certain circumstances.

After initial PPS has been performed for residents and HCP/employees (baseline) and the results have been used to implement resident cohorting and HCP/employee work exclusions, congregate settings may consider retesting under the following circumstances:

Retesting of residents

- Retest any resident who develops symptoms consistent with COVID-19.
- Retest all residents who previously tested negative 3-days after the initial PPS, and then weekly to detect those with newly developed infection. Facilities may consult with the Louisiana Office of Public Health (LOPH) to determine if more frequent retesting is indicated.
- Consider continuing retesting until PPSs do not identify new cases. LOPH should be consulted prior to discontinuation of weekly testing.
- If testing capacity is not sufficient for retesting all residents, retest those who frequently leave the facility for dialysis or other services and those with known exposure to infected residents (such as roommates) or HCP.
- Use retesting to inform decisions about when residents with COVID-19 can be moved out of COVID-19 wards.

Retesting of congregate setting employees including HCP

- Retest any HCP/employee who develops symptoms consistent with COVID-19.
- Retest to inform decisions about when HCP/employee with COVID-19 can return to work.
- Consider retesting HCP/employees at some frequency based on community prevalence of infections (e.g., once a week).

If testing capacity is not sufficient for retesting all HCP/employees, consider retesting HCP/employees who are known to work at other healthcare facilities with cases of COVID-19.

Congregate setting criteria to determine discontinuation of transmission-based precautions for patients with COVID-19 and return-to-work for employees with COVOD-19

A test-based strategy (if feasible) should be applied to the following recovered persons:

1. Persons who could pose a risk of transmitting infection to:
    1. Vulnerable individuals at high risk for morbidity or mortality from SARS-CoV-2 infection, or
    2. Persons who support critical infrastructure
2. Persons normally residing in congregate living facilities (e.g., correctional/detention facilities, retirement communities, ships) where there might be increased risk of rapid spread and morbidity or mortality if spread were to occur.
3. Persons who because they are immunocompromised may have prolonged viral shedding.

Test-based strategy

- Resolution of fever without the use of fever-reducing medications and
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two

negative specimens) [1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

Symptom-based strategy

- At least 14 days have passed since recovery(defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath)

Time-based strategy

- At least 14 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *test-based strategy* or *symptom-based* should be used.

More Resources

- Responding to COVID-19 in Nursing Homes
- Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings
- Additional Infection Control Guidance for Nursing Homes and Long-Term Care Settings
- Nursing Home and Long-Term Care Facility Checklist