Maine MDA policy Recommendations for COVID19 in Long Term Care Setting

1. Diagnostic Testing of *possible* COVID cases among staff and residents, not just probable cases

Obtain nasal swab (**deep nasopharyngeal swab**) for any symptoms of:

-Temp of 99 or higher for **residents** (consider working up for other causes as well, as appropriate)
-Temp of 100 or higher, or two degrees higher than normal for **staff**
-Any URI, common cold, or flu like symptoms
-New onset Cough or SOB
-Sudden onset of muscle aches or chills
-Sudden onset of acute GI symptoms (happens in 15% of COVID cases)
-Sudden loss of sense of smell or taste
-"COVID Toes" or other unusual/unexplained vascular type symptoms
*-Consult medical Director about any sudden nonspecific, or unexplained, changes in cognition or function, or symptoms reported by the CDC as manifestations of COVID***.*

**Mid-turbinate swabs have never been evaluated in nursing home or assisted livings, and user inexperience and technique may reduce the sensitivity of the PCR test.

Dual Testing during Flu season: When testing Residents and staff for COVID during Flu season, facilities need to test for both the FLU and COVID19.
If test capacity is limited due to limited testing supplies or lab capability, facilities could consider narrowing the Flu testing to those with typical Flu symptoms and exclude common cold symptoms, unless otherwise advised by the CDC.

2. Surveillance testing of staff based on risk stratification*:

Tier 1 risk group (once a week surveillance testing):
-Healthcare providers serving multiple units and or multiple buildings
-COVID unit staff. Testing should continue two weeks after the cessation of high-risk work
-Staff working in multiple facilities
-New hires (weekly test for two weeks after pre-employment negative test, then back to normal risk classification)
-Staff returning from vacation (weekly test, after pre-return to work negative test, for two weeks then back to normal risk classification). Exceptions can be made by medical director based on length of vacation and extent or lack of exposure risk and prevalence of the virus in the population. When in doubt always err on the side of caution.

If tests or testing supplies are unavailable to the facility in quantity needed or general supply is critically short then consider applying tier 2 testing standards until shortage resolves.

Tier 2 risk group (Every other week surveillance testing):

-Nursing staff working on multiple units
-Housekeeping working on multiple units
-Therapy staff working on multiple units
-Dietary or ancillary staff working in multiple facilities

-Hairdresser
-Activities staff

Tier 3 risk group:
ALL REMAINING STAFF

Tier 3 surveillance testing should be initiated only when state has sufficient test capacity and testing supplies to accommodate the volume.
This can be the first to be halted for test shortage reasons or decrease in virus prevalence in the community as reported by the CDC.
The testing interval of tier 3 should be monthly unless otherwise recommended by the CDC.

*****The surveillance testing outlined above is based on high prevalence situation and can be scaled back when the CDC data, and local data, shows the prevalence and community transmission to be low.
In such situations, facilities could consider scaling back surveillance testing to only include their Tier 1 risk group and reduce the interval to every other week. Such reduction in surveillance testing should not impact the need for active diagnostic testing of mildly symptomatic residents in Long Term Care setting during the pandemic-this testing should continue for the duration of the pandemic.

3. Surveillance testing of Residents

-**Pre-admission Testing** of asymptomatic **new admissions within 48 hours of admission**, and **post-admission** day 5 (being the average incubation period) then again on day 10 (the average time for symptom onset-goal is to catch cases in the Asymptomatic phase of the disease). This measure does not alleviate the need for 14-day quarantine of new admissions and use of PPEs.

-**Residents returning from ER visits** to be tested on day 5 and 10 and remain in quarantine for 14 days.

-**Surveillance Testing of asymptomatic discharges** from nursing homes and assisted living facilities where there are COVID19 cases in their building. This is to establish a useful baseline in case of post-discharge exposure and positive testing. Positive test does not preclude discharge so long as appropriate care plans are in place, and full disclosures are made.

4. Exposure testing of staff and residents

-All asymptomatic staff and residents exposed to a COVID case should be tested at baseline and if negative they should be retested every week x 2 to cover the full 14-day incubation period.
-The extent of exposure testing can vary from targeted exposure testing in the section of the building where exposure occurred, to a full scale facility wide **universal testing** when staff or resident interaction with other residents in other units or is deemed significant by the CDC and or the Medical Director.
-With positive cases, further weekly staff and resident exposure testing x2 to cover incubation period.
-Testing of secondary exposure of staff and residents interacting with a high-risk exposure staff or residents who have not yet tested positive.

5. Point of care testing
There are point of care PCR tests and Antigen tests.

Based on current data, the Antigen test is not to be considered diagnostic on its own and both negative and positive tests need confirmatory PCR tests.
The point of care PCR tests are yet to be FDA approved. Many have emergency use authorization EUA from the FDA and have variable sensitivity and positivity that is yet to be evaluated by the FDA. At present we can only recommend commercial PCR tests as reliable and dependable COVID tests.
Verifiable Data on Point of care antibody tests data is scarce at this time.

6. Antibody Testing
While not used to diagnose COVID-19, antibody testing can serve an epidemiological purpose within facilities if applied to staff. If more data emerges in the future that positive antibodies equate with immunity to future infections, this would be administratively helpful to facilities as they make decisions about staff testing and quarantine.
In light of that, it would be useful for facilities to test their staff now before the surge of the state reopening and the fall surge.
Facilities can do a one-time test for IgM and IgG, with or without a repeat test in 16 days based on test availability and cost issues. The second test is intended to capture the peak of IgG and has increased sensitivity in those with more recent infections.

5. Barriers to testing
-Tracking and replenishing testing supplies on a regular basis is currently not happening. Each facility is fending for itself which is leading to wide variability in testing capacity.
-State lab request that ONLY swabs supplied by the state be used when sending specimen to the state lab. Facilities have in the past used approved viral swabs interchangeably between labs and they followed manufacturer guidelines in specimen collection and transportation with no reported issues. This barrier to testing should be removed especially considering swab shortage.
-Cost of tests.
While the state lab is doing COVID-19 tests for free for facilities, this does not cover all testing. We encourage the state to use the federal COVID funds to allow for direct billing by the commercial labs in cases when other payment sources are not available. Facilities have reduced revenue and increased cost during the pandemic and the cost of testing can serve as a major barrier.

6. Treatment options for Covid Positive residents
-Remdesivir
The antiviral treatment with Remdesivir is currently reserved for the very ill hospitalized patients, even though the drug is likely most useful during the earlier phase of the disease during the viral load buildup.
Since the elderly are most at risk for negative outcomes and are currently being treated on site in nursing homes, provisions should be made for use of Remdesivir early in COVID patients in nursing homes who have comorbidities that put them at higher risk of negative outcome. The criteria for use of this antiviral drug should be based on exclusions criteria, which can include residents with less than 6 months life expectancy or clear expressed desire to not extend life.
IV capabilities and logistics are a prerequisite for use of Remdesivir in facilities.

-Tocilizumab (IL6 inhibitor)
IL6 inhibitors have been used to combat cytokine storm in some COVID patients. Since most nursing home residents are being treated on site, those residents should be considered for such therapies if clinically indicated, and not limit treatment to only those who are hospitalized. Facilities can develop protocols with their pharmacy around the drug use, exclusion criteria, and surveillance labs needed, based on existing standards (Ask us about are current criteria).

How about standalone Universal Testing?
Unlike Universal Testing as part of an exposure situation, Routine Universal Testing of all residents and staff, or a random sample of residents and staff, should not be considered an adequate replacement for the proactive diagnostic and surveillance testing outlined above.
Here are some of the reasons why this simple solution does not work as intended:

1. Prevalence in different areas of the state vary by time and geographic location, as a result, the usefulness of mass testing will also vary as well. Mass testing in Long Term Care in low prevalence areas will result in a larger number of false positive cases and declarations of non-existent outbreaks with all the associated consequences for the facilities.

2. Mass testing on regular intervals may be seen by facilities as an alternative and simple solution to continued monitoring of staff and residents for high risk exposure. Facilities may even defer to the universal testing instead of testing residents and staff with new symptoms. For instance, if a resident or staff is due to be tested in a couple of days and develops new symptoms, he or she should be tested right away and not wait for the scheduled universal test-this may not happen due to all resources and efforts at the facility being poured into universal testing.

3. Repeat testing of residents on a regular intervals will be traumatic to many dementia residents, and the mid-turbinate option is not a solution to this issue, since, if properly done, the mid turbinate test will take longer to do and has never been studied in Long Term Care setting. This may also inadvertently lead to an increase in false negative tests and a false sense of security during silent transmission.

4. Repeat, non-selective, weekly or biweekly testing of all staff and residents for a time period during the pandemic, diverts testing resources from the active diagnostic testing and targeted surveillance testing needed to identify new cases on a daily basis for the duration of the pandemic.

5. The physical effort and time needed to perform ongoing mass testing is not to be underestimated. Based on our experience, the facilities that had outbreaks and needed ongoing testing of a large number of staff and residents for weeks have shown signs of increased staff burnout and COVID fatigue.

6. Last but not least, there is no clinical or epidemiological value to a “baseline” test in Long Term Care, since a negative baseline test does NOT impact the need for, and the interpretation of, future tests. Having a negative baseline test in low risk residents has no proven clinical value in any of the available data and does in fact increase the statistical chances of false positives results.

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Content is advisory only. Medical Directors should utilize latest available information to guide their decisions.
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