Wyoming Department of Health

Proactive Testing Protocol for COVID-19 in Long-Term Care Facilities

A. Background: Improved COVID-19 testing capacity in Wyoming provides us with a powerful tool to intervene earlier in outbreaks in long-term care facilities (LTCF). In our limited experience with COVID-19 in congregate settings, the Wyoming Department of Health (WDH) has found through increased testing that when a single or small number of symptomatic cases are identified, there may be many additional asymptomatic or mild cases in residents and staff. There is substantial evidence that asymptomatic and persons with mild illness contribute to transmission within these facilities. Without testing to identify and act on these additional cases, we cannot effectively control the outbreak. We have identified the following benefits of increased testing:

- We can make better-informed decisions about cohorting.
- We can make more informed decisions on selecting patients for isolation and quarantine.
- Asymptomatic staff who test positive can be excluded from work until no longer infectious, thus preventing unintentional spread of COVID-19 to other patients and staff.
- Infection control can be assessed and modified as necessary.

B. Increased Testing Strategies: We have identified two strategies for increased testing that we will implement in parallel:

1) **Strategy 1: Pre-emptive intervention**. This strategy involves prospective surveillance of facilities not currently experiencing outbreaks. Testing facilities in this category will allow WDH 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 (20% sample, or larger for small facilities). Each staff sample should include representation from the range of staff roles across your facility (ideally nurses, CNAs, rehabilitation, and environmental services staff at a minimum) and representation from multiple units.

b) Continue sampling of residents and staff bi-weekly if testing is negative as long as directed by the WDH.

c) If sampling identifies any positive staff or residents, then initiate strategy two.

1) **Strategy 2: Facilities with COVID-19 infected staff or residents.** This includes facilities experiencing single cases or outbreaks of patients with confirmed or suspect COVID-19. This strategy may include the following steps:

a) Test all LTCF residents and staff.

b) Cohort all COVID-positive residents and staff as outlined in Section D.

c) If one has not been conducted, collaborate with WDH on a virtual or in-person infection control assessment and response (ICAR).

d) Re-test all COVID-negative residents and staff weekly until their tests are negative for 1 incubation period (14 days), and then do one additional round of tests on COVID-negative individuals after 28 days.

C. Testing Logistics: Successfully executing these plans requires close coordination between the facility leadership and the WDH.

1) Test type.

a) Direct viral detection testing (i.e. 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.

2) Individual facilities may make plans to initiate testing themselves.

a) Facilities with existing relationships with commercial laboratories, or are part of a hospital system that conducts testing for SARS-CoV-2, are strongly encouraged to utilize commercial testing to accomplish surveillance goals.

3) WDH can assist with testing of the facility through the Wyoming Public Health Laboratory (WPHL). WDH requires the following to initiate testing:

a) All facilities should identify a person who can coordinate testing.

b) All facilities will be required to submit a very brief survey to the WDH to gain staff and resident census information, number of staff and residents to be tested, request for testing supplies, and potential needs for help with sample collection. The survey can be completed by following this link: https://docs.google.com/forms/d/e/1FAIpQLSdd8z7nphbcXfEWrkH26MVXnok9EEG8DPGtQBiFrvFYbHYeRw/viewform?usp=sf_link

C Testing must be scheduled with WDH prior to sampling. After your facility completes the survey, WDH will reach out to the testing point of contact to schedule testing. To allow for faster turn-around time, and ease of sample accessioning and resulting, each facility must sample the 20% on the same day,

and the samples must be shipped together. The WPHL will be scheduling a webinar to help facilities with the requirements for specimen shipping and handling.

b) All facilities must furnish staff to perform the testing (if this is not possible, alternative options may be available).

c) The facility must follow sample collection and shipping guidelines in the latest WDH COVID-19 HAN, which can be found here: https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/novel-coronavirus/covid-19-information-for-healthcare-providers/

D. Potential Public Health Responses to Testing: Based on testing results, WDH 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 respiratory symptoms, regardless of test result, should be excluded from work and isolated until they meet CDC's return to work criteria for healthcare personnel.

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) Consider having pregnant or immunocompromised staff without COVID-19 assigned to non-COVID areas in the facility.

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 work with WDH to 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.

iii) COVID positive staff must wear appropriate PPE

2) Residents

a) General infection control recommendations:

i) Dedicate equipment to COVID-19 positive residents and disinfect between each use.

ii) A log should be kept of all staff going in and out of the room. Include family if end-of-life visits were to occur.

iii) Increase monitoring for worsening of symptoms.

b) 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.

c) Completion of cohorting. Viral shedding is still not clearly defined for COVID-19 for all patient groups. Because patients in LTCFs are at particular risk for poor outcomes, these guidelines are more stringent than for the general population or for home-dwelling individuals. Cohorting should be used until transmission-based precautions may be discontinued. **Facilities should work with WDH to determine whether a symptom-based strategy or a test-based strategy is most appropriate for determining when to discontinue transmission-based precautions.**

i) Test-Based Strategy - transmission-based precautions and cohorting may be discontinued after:

(1) *Symptomatic residents with COVID-19:* resolution of fever AND improvement of respiratory symptoms AND the resident has had two

negative SARS-CoV-2 PCR tests from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens).

(2) *Asymptomatic residents with COVID-19:* two negative SARS-CoV-2 PCR tests from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens).

ii) Symptom-Based Strategy - transmission-based precautions and cohorting may be discontinued after:

(1) *Symptomatic residents with COVID-19:* At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications AND improvement in respiratory symptoms AND at least 10 days have passed since symptoms first appeared.

(2) *Asymptomatic residents with COVID-19:* 10 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.