

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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Acting Commissioner




Ned Lamont
Governor
Susan Bysiewicz
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HEALTHCARE QUALITY AND SAFETY BRANCH

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TO: All Nursing Homes and Assisted Living Services Agencies

FROM: Deputy Commissioner Heather Aaron, MPH, LNHA 

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Barbara Cass, RN., Branch Chief, Healthcare Quality and Safety Branch
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DATE: August 14, 2020

SUBJECT: Updated COVID-19 Guidance for Nursing Homes

The attached document is for your attention.



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Updated COVID-19 Guidance for Nursing Homes – August 12, 2020

This updated Nursing Home guidance supplements prior guidance provided by the Connecticut Department of Public Health (DPH) and incorporates updates from the Centers for Disease Control and Prevention (CDC).

CDC recently updated guidance regarding duration of isolation and transmission-based precautions for patients with COVID-19.^{1,2} They also published a Decision Memo citing persistent RNA detection in the absence of live virus, and the lack of confirmed reinfections.³ Please refer to the **DPH Provider Memo dated August 5⁴** for details about CDC's updated guidance, which affect the following infection control/public health decisions:

- Duration of home isolation of individuals diagnosed with COVID-19 or asymptomatic detection of SARS-CoV-2¹
- Duration of transmission-based precautions for healthcare settings²
- Return-to-work criteria for healthcare personnel⁵

Updated Guidance for Cohorting New Admissions with Unknown COVID-19 Status

DPH guidance previously recommended placing new admissions with unknown COVID-19 status in a 14-day quarantine upon admission.⁶ DPH now recommends that new admissions who have not had a COVID-positive test result in the past 90 days undergo a risk assessment upon admission to inform decision-making for the placement of the newly-admitted resident. Quarantine is not recommended for individuals who have recovered from COVID-19 during the 3-month period after symptom onset.⁷

Residents naïve to COVID-19 with a high risk for exposure during the 14 days prior to admission should be placed in a single room for quarantine. Single rooms should be prioritized for residents who require quarantine. If two residents under quarantine must share a room, this is not without risk; one resident might develop infectiousness during the quarantine period, while another remains naïve to COVID-19. Every effort must be made to physically separate individuals under quarantine.

The risk assessment at admission should be similar to assessments conducted for readmissions and residents leaving nursing homes for any reason. Risk assessments should be well documented to include the reasons for a placement decision, and considerations should include (but not be restricted to) evaluation of:

- Level of potential exposure during the 14 days prior to admission.
 - While hospital infection control measures are generally robust, consider discussing risks with the hospital.
 - Consider extent of COVID-19 activity and infection control measures at pre-admission location(s).
- Transportation mode and potential for unprotected (others unmasked) exposures during transportation.
- Level of physical distancing and source control of others who interacted with the resident.
- Degree to which the resident can maintain/adhere to adequate physical distancing and hand hygiene.
- Degree to which the immune system of the resident might be compromised.



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- Risks and benefits of making any room changes.
- Recent COVID-19 testing (e.g. a negative test just before admission).

New admissions whose risk assessment indicates a low risk for COVID-19 may be placed in a “negative/unexposed” unit. Other possible placement outcomes for residents with unknown COVID-19 status could include (but are not limited to):

- Quarantine for a full 14 days (incubation period) before transfer to the “negative/unexposed” unit.
- Quarantine for part of the 14-day incubation period if there is confidence that exposure did not occur for a period of time before admission.

Newly-admitted residents who are quarantined can undergo COVID-19 testing at the end of the quarantine period if there is concern for possible exposure during the quarantine period. If the resident tests COVID-positive at this point, they should remain on isolation precautions until CDC criteria for lifting transmission-based precautions.²

Contact Tracing and Case Investigation in the Nursing Home⁸

Contact Tracers associated with local health departments and DPH do not conduct contact tracing for residents of congregate living settings. Nursing Homes should conduct contact tracing and case investigation as soon as a resident or staff member is diagnosed with COVID-19. Rapid identification of staff and residents who might have been in close contact with someone who tests positive for COVID-19 is important for controlling the spread of COVID-19. Local health departments and DPH can provide technical assistance with contact tracing and case investigation.

- **Contact Tracing** identifies close contacts of individuals who test positive for COVID-19. Someone with a significant exposure to an individual with COVID-19 (e.g. roommates) should quarantine for 14 days. The period of 14 days has been established as the maximum incubation period for COVID-19.
 - The index case’s infectious period sets the time period for which close contacts should be identified. This starts 2 days prior to COVID-19 symptom onset (or 2 days prior to first positive test for index cases without symptoms at time of testing), and ends when the index case meets criteria of lifting isolation precautions.^{1,2}
 - While data to inform the definition of a “significant” exposure is limited, CDC considers a “close contact” as someone who was within 6 feet for ≥ 15 minutes.
 - Non-Healthcare Personnel (HCP) are considered to have had a significant exposure if they had close contact (<6 feet, ≥ 15 min) with someone in their infectious period for COVID-19, irrespective of whether either party was wearing a cloth face covering or whether the contact was wearing respiratory personal protective PPE.⁹
 - HCP are considered to have had a significant unprotected exposure if they had prolonged close contact (<6 feet, ≥ 15 min) with someone in their infectious period for COVID-19 AND:
 - o The HCP was not wearing a respirator or facemask.
 - o The HCP was not wearing eye protection if the person with COVID-19 was not wearing a face covering.
 - o The HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure.^{10,11}
- **Case Investigation** involves identifying where someone diagnosed with COVID-19 might have been exposed. A case investigation for each case of nursing home-onset COVID-19 should be conducted to identify potential breaches in infection control. Exposure may have occurred up to 14 days prior to symptom onset or time of first positive specimen collection; median time from exposure to symptom onset is 4–5 days.
 - During case investigation, look for adherence to infection control guidance such as hand hygiene, source control (face covering over nose and mouth), and physical distancing.
 - Indoor gatherings, particularly where adherence to face covering is low, should be identified as potential sources of exposure.

When/Who to Test: Screening Asymptomatic Residents and Staff in Nursing Homes

When a new SARS-CoV-2 infection in any HCP or any *nursing home-onset* SARS-CoV-2 infection in a resident is detected, asymptomatic residents and staff should be tested weekly to detect possible asymptomatic transmission of COVID-19 within the facility. Nursing home-onset SARS-CoV-2 infections originated in the nursing facility. If a resident was placed into transmission-based precautions on admission and developed SARS-CoV-2 infection within 14 days after admission, weekly testing of residents and staff does not necessarily need to (re)start, given the risk of that individual causing an outbreak in the facility has been controlled and there is not an indication to test for asymptomatic spread.¹²

All staff and residents who have not tested positive within the past 90 days should be included in weekly testing. Testing should continue weekly until it has been at least 14 days since the most recent positive result.^{12,13}

Antigen Testing in Nursing Homes

Antigen testing is most useful when the person being tested is *symptomatic* and testing occurs in the first five days after the onset of symptoms. Due to potentially lower sensitivities with antigen testing, negative results from an antigen test should be confirmed with a PCR test prior to making treatment or infection control decisions in a nursing home setting.¹⁴

DPH continues to recommend the use of PCR testing for mass testing of asymptomatic individuals, such as the mandatory weekly testing required by the Governor's Executive Order 7AAA for three reasons. First, PCR testing is more sensitive and does not require a second test to confirm a negative result, which enables mass testing of asymptomatic populations and conservation of testing supplies. Second, all nursing homes in Connecticut currently have access to PCR testing for asymptomatic staff and residents with testing turnaround times generally between 24 and 48 hours. Third, in Connecticut, the current prevalence of COVID-19 is low. This means that the probability of an asymptomatic person having COVID-19 is low, increasing the risk for false positives and also the need to test another specimen for confirmation.¹⁵ For someone with a significant exposure, the probability that they will be infected may be higher, however we do not know the best time after exposure to test an asymptomatic individual using an antigen test to optimize sensitivity.

DPH continues to recommend that antigen testing be reserved for testing *symptomatic* individuals only. Although antigen testing may be a less sensitive for testing asymptomatic individuals, DPH recognizes that antigen testing could offer a more timely way to help control outbreaks when PCR testing is unavailable or the incidence of community spread is growing. Should nursing homes lose access to PCR testing with reasonable turn-around-times or should the incidence of COVID-19 increase in Connecticut, DPH will review these recommendations regarding the use of antigen testing.

All Positive Results Require Action: A Note about False Positives

All positive COVID-19 results should be considered true positives unless otherwise indicated by the testing laboratory. Recently, a few laboratories across the U.S. have reported false positive results for SARS-CoV-2 PCR tests due to testing instrument errors, contamination, or other reasons. CLIA-certified laboratories must adhere to strict laboratory protocols to ensure reporting of accurate results, and they are responsible for notifications of erroneous results. Clinicians suspicious of a false positive result should discuss their suspicion with the laboratory that provided the result. Clinicians should not rely on additional testing performed within 10 days of an initial positive result to identify potential false positive results or to eliminate the need for public health action, including enhanced infection control.

References

- ¹CDC. Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>
- ²CDC. Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>
- ³CDC. Decision Memo: Duration of Isolation and Precautions for Adults with COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>
- ⁴CT DPH. Updated COVID-19 Guidance for Healthcare Providers – August 5, 2020: https://portal.ct.gov/-/media/DPH/HAI/COVID19-ProviderMemo_08052020.pdf
- ⁵CDC. Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>
- ⁶CT DPH. COVID-19 Infection Control Guidance for Nursing Homes Updated Jun 22, 2020: https://portal.ct.gov/-/media/DPH/HAI/COVID19-NH-guidance_06222020.pdf
- ⁷CDC. Clinical Questions about COVID-19: “If an infected person has clinically recovered and then later is identified as a contact of a new case, do they need to be quarantined?” <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Patients-with-Persistent-or-Recurrent-Positive-Tests>
- ⁸CDC. Investigating a COVID-19 Case: <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/investigating-covid-19-case.html>
- ⁹CDC. Public Health Guidance for Community-Related Exposure: <https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html>
- ¹⁰CDC. Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
- ¹¹CDC. Clinical Questions about COVID-19: “Which procedures are considered aerosol generating procedures in healthcare settings?” <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control>
- ¹²CDC. Testing Guidelines for Nursing Homes: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>
- ¹³CDC. Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html>
- ¹⁴OASH. Guidance – Proposed Use of Point-of-Care (POC) Testing Platforms for SARS-CoV-2 (COVID-19): <https://www.cdc.gov/coronavirus/2019-ncov/downloads/OASH-COVID-19-guidance-testing-platforms.pdf>
- ¹⁵APHL. Considerations for Implementation of SARS-CoV-2 Rapid Antigen Testing: <https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-SARSCov2-Antigen-Testing-Considerations.pdf>