Surveillance Strategies for COVID-19 In Long Term Care Facilities

1. **Active Surveillance for COVID-like illness:** LTCF staff and residents should be actively assessed for symptoms and exposures on a daily basis and tested by nasopharyngeal swab for SARS-CoV-2 PCR if certain criteria are met.
   a. Staff should be screened for symptoms and exposures on entry to the LTCF at the start of each shift. Staff meeting ANY of the following criteria should be excluded from work while awaiting testing for COVID-19 as well as other respiratory pathogens as indicated.
      i. One or more of the following Symptoms: Cough, shortness of breath, or difficulty breathing, fever (measured or subjective), chills, rigors, myalgia, sore throat, new olfactory and taste disorder(s).
         a. *Older adults may NOT have fever, cough, chest discomfort or sputum. They MAY present with Delirium, elevated RR, HR, or low BP.*
         b. *The definition of fever in Older Adults: temperature of > 100.0 F, or temperature > 99.0 F on two consecutive measurements, or temperature > 2.0 F above patient’s baseline temperature*
      ii. Anyone with close contact within 14 days of a suspect or confirmed COVID-19 patient.
   b. Residents should be assessed for symptoms and potential new exposures at least 3x daily. In older adults, persons suspected of having COVID-19 might include:
      i. Fever OR symptoms/signs of LOWER respiratory infection (e.g. new dry cough, dyspnea, or new/worsening hypoxia) OR change in clinical status with no immediate explanation for infection/sepsis (e.g. UTI, bacteremia, skin/soft tissue infection)
      ii. Anyone with close contact within 14 days of a suspect or confirmed COVID-19 patient.
   c. HDOH outreach to LTCF through the infection control assessment and response (ICAR) program (see #4 below) will include sharing of tools for active surveillance:
      i. Line list templates for documentation of symptomatic residents or staff
      ii. Cluster tracking sheets
      iii. Testing flowchart
      iv. Instructions for accessing Swab Team support

2. **Provider Reporting:** COVID-19 is an urgently notifiable condition in Hawaii. Providers are required to report any persons suspected or confirmed to have COVID-19 or any test result positive for COVID-19.
   a. To report confirmed cases of COVID-19 or clusters of COVID-like illness (2 or more persons who reside or work on the same unit or floor, presenting with new onset acute respiratory illness within the same 2 week period), call (808)-586-4586 immediately.
   b. If there is strong clinical suspicion of COVID-19 in a resident or staff member, this should also be reported even if testing has not yet been completed.
c. In addition to telephone notification of confirmed or suspected COVID-19 cases and clusters, line lists of any staff or residents meeting screening criteria should be sent to the HDOH Tele-ICAR point of contact weekly. Line lists should include documentation of symptoms and results of testing.

3. **Laboratory Reporting:** HDOH receives electronic laboratory reports from all clinical laboratories for all COVID-19 test results. HDOH will reach out to facility infection control points of contact to follow up any reports of cases with any history of being in a LTCF, whether as a resident, staff, or visitor.

4. **Case and Cluster Investigation:** A confirmed or suspected case or cluster of COVID-19 in a LTCF will prompt an investigation by HDOH.
   a. HDOH response may include infection control recommendations, quarantine and/or isolation of residents and staff, requests for updated line lists and other additional information, on-site assessment, and additional testing of residents and staff. The extent of testing will depend on investigation findings but may be recommended for affected units, floors, or in some cases throughout the entire facility.
   b. Implementation of prevention measures, such as universal masking and limitation of resident and staff movement within “home” units, PRIOR to any outbreak may limit the need to test the entire facility in response to an initial case or cluster.

5. **Infection Prevention and Control Assessments (“ICARs”)**
   a. DOCD HAI team is engaging all Skilled Nursing Facilities with ICAR telephone calls. These are in-depth conversations intended to identify and close infection control gaps. For COVID-19 focused ICARs, a major priority is prompt identification of any suspected COVID-19 cases
      i. One section is devoted to the education, monitoring and screening of healthcare personnel, with an emphasis on actively screening all personnel for fever and symptoms of COVID-19 prior to their shift
      ii. Another section is devoted to active case finding among residents which includes ensuring residents are monitored at least 3x/daily for symptoms and vital signs, and encouraging providers to have a very low threshold for testing a resident for COVID-19

6. **National Healthcare Safety Network (NHSN)**
   a. CMS issued a requirement that all nursing homes report to the COVID-19 module of NHSN at least weekly, with the first data due on May 17, 2020.
   b. The Hawaii Department of Health has access to the NHSN data per HRS §325-2.5
   c. There are four separate reporting pathways for LTCF’s in NHSN:
      i. Resident Impact and Facility Capacity: Includes information on residents admitted who were previously treated for COVID-19, number of confirmed cases in the facility, number of suspected cases in the facility, total deaths in the facility, and COVID-19 deaths in the facility
      ii. Staff and Personnel Impact: Includes information on confirmed and suspected COVID-19 in staff, as well as if the facility is facing a critical staffing shortage
iii. Supplies and Personal Protective Equipment: Includes information about PPE supplies such as N95, surgical masks, eye protection, gowns, gloves, and hand sanitizer

iv. Ventilator Capacity and Supplies: Includes the number of ventilators in use and available in the facility.

7. **Educational Efforts** to increase quantity and quality of test-based surveillance in Hawaii:
   a. DOCD has released 12 [Medical Advisories](#) related to COVID-19 as of May 14, 2020. The Medical Advisories include information for clinical providers of when to suspect COVID-19, how to access testing, and how to report test results to HDOH and serve as timely reminders for our clinical community to have a high degree of suspicion for COVID-19 and a low threshold for testing.
   b. State Epidemiologist Dr. Sarah Park presented Grand Rounds on Wednesday, April 29th.
   c. HDOH Healthcare Associated Infections Team is a partner and active participant in the ECHO Webinars (held twice weekly) for long term care facilities.

8. **Point Prevalence Surveys**
   a. In response to a single case in a healthcare worker or resident of a long term care facility, a point prevalence survey (testing of all residents and staff regardless of symptoms) on an affected unit, floor, or in an entire facility, might help define the scope of transmission by identifying asymptomatic residents. Repeated surveys over time can assist with decisions around cohorting of residents and staff. However, public health interventions such as implementation of droplet precautions for all residents, strict cohorting of residents and staff, and closure of affected units to new admissions, should be instituted in affected facilities (i.e., any facility with at least one identified case) for both symptomatic and asymptomatic residents, regardless of whether a point prevalence survey is performed. (Negative test results do not ensure a lack of transmission. COVID-19 exposed residents should continue to be monitored for symptoms with use of PPE for all resident care for 14 days after the interventions were implemented).
   b. In the absence of any identified cases in a facility, in geographic areas where there is limited community transmission, a point-prevalence survey would be not be considered a public health investigation and hence may require Institutional Review Board approval and informed consent of participants. While there is a possibility of identifying a previously unknown asymptomatic COVID-19 case, the yield will likely be low and resources should be prioritized for active surveillance and building infection control infrastructure.