Long Term Care Facility Testing Plan

June 12, 2020

Oregon Health Authority

Background

Nursing, residential care, and assisted living facilities, collectively referred to as long-term care facilities (LTCF) are at high risk for severe COVID-19 outbreaks due to their congregate nature and vulnerable population (e.g., older adults with multiple co-morbidities). A primary strategy for reducing the likelihood and severity of outbreaks in LTCFs is mass testing of both residents and staff.[1]

Oregon currently has 685 LTCFs licensed by the Aging and People with Disabilities program (APD) in the Oregon Department of Human Services (DHS). These facilities house about 31,000 residents and employ about 29,000 staff—about 60,000 people in all.[2] To date, a vast majority of these facilities have not had a staff or resident test positive for COVID-19.

Plan Objectives

1. By September 30th, 2020, ensure that all residents and staff at all 685 nursing, residential care, and assisted living facilities licensed by the Aging and People with Disabilities (APD) program in the Oregon Department of Human Services have been offered testing for the COVID-19 virus at least once. For the purposes of this plan, these facilities are collectively referred to as long-term care facilities (LTCF).
2. Within 30 days of completion of baseline testing outlined in Plan Objective 1, Initiate an on-going testing strategy that includes mandatory testing of 25% of staff every seven days so that 100% are tested each month throughout the duration of the pandemic.

Plan Assumptions

- Given the on-going challenges in acquiring testing supplies, OHA estimates that the testing entities currently serving the state could collectively maintain a reliable rate of 17,000 tests per week (see Testing Capacity section below).
- Per the Oregon Health Authority's (OHA) COVID-19 Strategic Testing Plan for Oregon[3], Oregon will need to conduct about 12,500 tests per week to meet the state's non-LTCF testing needs.
- The initial round of comprehensive testing will begin on June 24th, 2020 and be complete by September 30th, 2020.
- The 685 facilities are comprised of about 31,000 residents and 29,000 staff. While some of these people have already been tested, the initial round of comprehensive testing will require 60,000 tests.
- Most facilities either have or will have the capacity to conduct the tests and will be responsible for conducting and paying for the tests, with assistance from OHA as necessary to obtain supplies and fill capacity gaps.

Based on these assumptions, baseline testing of all LTCFs will be complete in September 2020. Assuming that the amount of available testing supplies does not change, any effort to complete this testing strategy in a shorter time period will result in fewer tests being available for Oregon's other testing priorities, including increased testing for other populations being disproportionately impacted by the pandemic. These populations include all of Oregon's Hispanic and non-white communities, as well as people with disabilities and frontline service workers.

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1 Adult foster homes house a similarly vulnerable population. However, they are typically small, family-like settings with a maximum resident capacity of five and have not experienced many of the infection prevention and control challenges faced by LTCFs. Currently, only 7 of the approximately 1,400 (.5%) adult foster homes have a COVID-19 positive resident or staff. Due to this low occurrence, APD does not recommend a testing strategy for adult foster homes at this time. Scarce resources should be focused on other areas experiencing outbreaks.

2 In addition to licensed facilities, Oregon also has many other unlicensed senior living communities that house a seniors and adults with disabilities and face similar challenges related to infection prevention and control. An example includes senior apartment complexes, commonly referred to as independent living communities. No state agency currently licenses or otherwise tracks these facilities.

3 https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2346.pdf

Table 1. Roles and Responsibilities for LTCF Testing	
Partner	**Roles and Responsibilities**
LTC Facilities	• Order tests if possible • Report test results to LPHAs and APD • Develop and implement plan for on-going monitoring of staff and residents, including mandatory testing all staff every 7 days so that 100% are tested every month. This includes staff at all facilities and all shifts. • Assist with contact tracing and ensuring appropriate return to work and isolation practices in response to positive test • Provide testing and infection control protocol education to facility staff, residents, and families • Maintain agreements with laboratories to conduct on-going surveillance testing of HCP. • Ensure use of culturally appropriate, trauma-informed testing practices • Share information about the testing with residents, staff, and stakeholders • Cover costs for on-going testing after initial first round of comprehensive testing is complete
Regional clinical, academic, and commercial laboratories	• Maintain CLIA-certification and employ an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA • Provide the necessary specimen collection supplies • Turn around test results within 48 hours of receipt
Local Public Health Authorities (LPHA)	• Support facility testing efforts • Report facility test results to OHA • Lead case investigation and contract tracing for positive tests • Support use of culturally appropriate, trauma-informed testing practices • Order tests for facilities unable to do so
Oregon Health Authority (OHA)	• Work with LPHAs to coordinate testing supplies • Work with DHS to cover all unreimburasble testing costs for initial round of comprehensive testing • Fill gaps in facility testing capacity • Coordinate facility testing efforts to align with plan objectives • Track and monitor facility testing efforts • Work with LPHAs to provide testing and infection control protocol guidance to facilities • Support use of culturally appropriate, trauma-informed testing practices • Work with SOQ and facilities to develop a testing schedule for all facilities based on risk of COVID outbreaks

Table 1. Roles and Responsibilities for LTCF Testing	
Partner	**Roles and Responsibilities**
Department of Human Services (DHS) – Office of Safety, Oversight and Quality (SOQ)	• Ensure appropriate communication and guidance is shared with all facilities prior to testing. • Throughout testing, maintain ongoing communication with facilities as needed • Work with OHA and facilities to develop a testing schedule for all facilities based on risk of COVID outbreaks • Support use of culturally appropriate, trauma-informed testing practices • Survey facilities to determine current testing capacity and needs • Work with OHA to cover all unreimburasble testing costs for initial round of comprehensive testing
LTC Ombudsman (LTCO)	• Ensure that the testing plan and protocols are understood and assist with questions or concerns raised by constituents. • Help assure residents and families that the testing, though strongly encouraged, is voluntary. • Provide timely feedback to SOQ on any known situations where residents' rights are potentially impacted.
Associations (Oregon Health Care Coalition, Leading Age)	• Support education and communication to facilities around the testing process and the rationale for the project. Partner with SOQ to provide ongoing education to member facilities on the high level of danger COVID-19 still presents to LTC facilities, and the importance of staying ahead of any new outbreaks; including the role of comprehensive testing in accomplishing this.
Unions	• Work with SOQ to establish minimum standards so all buildings are meeting the same requirements, regardless of union status.

Ensuring Equity, Trauma-Informed Testing and Cultural Responsiveness

Understanding Oregon's history and medical testing on marginalized communities is the foundation needed to ensure equity for COVID-19 testing in LTCFs. There is inherent distrust and fear among marginalized communities who have unwillingly and unknowingly found themselves the subjects of medical experiments. From the early foundations in the study of gynecology, to Tuskegee and forced sterilization of Native American, African American, Latina women, and people who experience disabilities. We must recognize these traumas, some as recent as the 1970's, and provide concrete steps to building relationships, restoring trust and lessening fears that will allow us to truly protect the health and well-being of all of our most vulnerable and marginalized residents in LTCFs.

The following steps will be taken to ensure that testing is trauma-informed and culturally responsive:

- Every person administering testing undergoes a session on the history of medical testing on marginalized communities.
- All communications will be in plain language, ADA compliant, and provided in languages other than English, including methods for signed language. Where possible and feasible, the communications will come two weeks prior to testing to allow for one on one follow ups and understanding for folks who need assistance with cognition and decision-making.
- To the extent possible, testing staff will be multilingual/multicultural to build connections and reassure residents who are undergoing testing.
- Resident rights and protected health information will be protected in the process. Culturally appropriate mediation and decision-making support will be available to allow residents time and space to understand their rights and keep their identities protected. The only released information will be aggregate case counts, deaths, and demographic information for facilities that experience outbreaks.
- Mediation processes and personnel should be identified and available using the communication methods to all residents who are administered a test.
- Culturally appropriate mental health and spiritual services should be provided at the time of testing so that residents can process their feelings and fears in a manner that will be respected and allow them to process their trauma.
- Each facility will communicate the process protocols if a resident is found to be positive, using the steps above regarding, ADA compliance, language access and culturally appropriate mental health services. They shall too include methods for human connection while a resident is in isolation. This can include iPads for virtual meetings, visitation through windows or setting up spiritual services via phone or other means.
- There will be non-discrimination policies in place for staff and residents to ensure that harassment and bullying is not taking place against residents who are from marginalized communities. This will include a hotline and immediate redress for residents who experience these incidents. In particular, Asian and Asian Americans are facing increased racism in the era of COVID-19 as the virus has been dubbed the "Chinese virus". This is also true for LGBTQ residents where the virus is reminiscent of the HIV pandemic where the virus was labeled the "gay virus" leaving many without proper medical care or support for a decade.
- Regardless of the test results, health staff will follow-up with all residents, using the communication methods and resources above to answer follow-up questions and reassure the residents their rights remain intact and protected. This is the key to continued cooperation.

These steps will take time and resources to enact, however it is imperative that we as a state, recognize the impacts of this process and seek to reduce the harm this will cause. Healthcare has not always been a right for many of these folks, nor has it been equitable.

Plan Timeline and Facility Prioritization

This plan has two components. The first component is focused on ensuring that all residents and staff at all LTCFs in Oregon have been tested at least once between June 1st, 2020 and September 30th, 2020. The second component is ensuring that all LTCFs develop and implement a rigorous plan for on-going monitoring and testing for residents and staff.

The proposed timelines below are dependent on the availability of testing supplies which continue to be severely limited and highly variable from week to week. In addition, as outlined in OHAs COVID-19 Strategic Testing Plan for Oregon[4], priority will continue to be given to responding to all outbreaks and meeting the other testing priorities identified in the plan.

Component 1: Comprehensive Testing of all Staff and Residents

The first component consists of four phases.

1. Phase 1: Facility engagement (6/14-6/23)
    a. Communicate plan details to facilities and other partners listed in Table 1.
    b. Survey facilities to determine testing capacity and current testing practices, identify specific resource, staffing and other needs for completing comprehensive testing.
    c. Develop testing schedule, prioritizing higher-risk facilities based on licensing type and location, and on the results of the OHA prevalence study.
    d. Work with the Coalition of Local Health Officials to ensure coordination with local contact tracing efforts.
2. Phase 2: Complete testing of Priority 1 and Priority 2 facilities by July 29th, 2020
3. Phase 3: Complete testing of Priority 3 and Priority 4 facilities by September 2nd, 2020
4. Phase 4: Complete testing of Priority 5 and Priority 6 facilities by September 30th, 2020

Facility Prioritization

Facilities that are able to arrange their own testing will be able to complete their testing at any time. Given existing constraints on testing supplies, however, there will likely be a need to prioritize the order of testing. APD recommends an approach that prioritizes the facilities at highest risk of an outbreak.

APD has been collecting data on licensed LTCFs with COVID-19 positive residents and staff since early March. APD licenses three types of larger (more than 5 residents), congregate LTCFs: nursing facilities, residential care facilities, and assisted living facilities. Nursing facilities provide the highest levels of care and house the most medically fragile people. Residential care facilities and assisted living facilities provide lower levels of care. Many Nursing and Residential Care Facilities have Memory Care endorsements, allowing them to provide dementia care in secure environments. Facilities with people who need memory care can face additional challenges to infection prevention and control due to their behaviors, care needs, and capacity for adhering to infection control guidelines.

Thus far, the data is showing that the greatest risk of an outbreak is tied to nursing facilities. As of May 20th, 25 licensed LTCFs have at least one resident or staff who has tested positive for COVID-19. Of this number, 12 (48%) are nursing facilities. Both the number of facilities with active outbreaks and the ratio of nursing facilities with outbreaks to other licensed facilities with outbreaks has stayed relatively stable over time, with nursing facilities accounting for about

4 https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2346.pdf

50% of the outbreaks at licensed LTCFs despite accounting for less than 20% of the total number of facilities.[5]

Regarding location, facilities in Multnomah, Washington, Clackamas, Yamhill, Marion and Polk counties account for the vast majority of LTCF outbreaks, indicating that facilities in these counties are currently at the highest risk of experiencing outbreaks.

Based on this data, DHS and OHA recommend prioritizing testing based on facility type and location, starting with nursing facilities in Multnomah, Washington, Clackamas, Yamhill, Marion and Polk counties, and ending with residential care and assisted living facilities in other parts of the state.

Consistent with this recommendation, Table 3 below prioritizes LTCFs for testing by facility type and location and provides a timeframe for completing testing of all staff and residents within a 3-month time period.

Table 2. Prioritized list LTCFs for testing by facility type and location and schedule for 3-month completion of comprehensive testing

Priority	Description	Number of Buildings	Resident Estimate	Staff Estimate	Total Estimate	Schedule (4,286 tests/week)
1	Nursing facilities in Multnomah, Washington, Clackamas, Yamhill, Marion and Polk counties.	71	4,708	7,075	11,783	Weeks 1-3
2	Assisted living and residential care facilities with memory care endorsements in Multnomah, Washington, Clackamas, Yamhill, Marion and Polk counties.	122	4,516	3,163	7,679	Weeks 4-5
3	Assisted living and residential care facilities without memory care endorsements in Multnomah, Washington, Clackamas, Yamhill, Marion and Polk counties.	169	8,377	5,869	14,246	Weeks 6-8
4	All remaining nursing facilities in Oregon.	58	3,807	5,721	9,528	Weeks 9-10
5	All remaining assisted living and residential care facilities with memory care endorsements in Oregon.	92	2,958	2,072	5,030	Week 11
6	All remaining assisted living and residential care facilities without memory care endorsements in Oregon.	173	7,215	5,056	12,271	Weeks 12-14
	Totals	**685**	**31,581**	**28,956**	**60,537**	

5 Oregon's robust community-based care infrastructure (i.e., residential and assisted living) is paying major dividends during the COVID-19 emergency. We currently have 556 facilities licensed as assisted living or residential care. Of this number, only 13 (2.3%) are associated with a COVID-19 positive resident or staff. This statistic is driven by the ability of these settings to appropriately isolate residents that may not always be possible in nursing facilities.

Component 2: Ongoing Monitoring for Long-Term Care Facilities

The second component of the plan is ensuring ongoing monitoring for COVID-19 at all LTCFs. Ongoing monitoring is critical to avoid outbreaks and protect residents of LTCFs. Each facility will be required by rule to establish a plan for COVID-19 testing of residents and health care personnel (HCP)[6] necessary to protect this vulnerable population. The plan should be developed in partnership with OHA, DHS and their local health department within one month of completing comprehensive testing and must include:

- Active screening of all residents and HCP for fever and COVID-19 symptoms daily and offer testing to any resident with a fever or shows even mild symptoms consistent with COVID-19. HCP who have a fever or even mild symptoms consistent with COVID-19 must be tested and excluded from work pending results pending the results of their test. Symptoms include:
  - Fever or chills
  - Cough
  - Shortness of breath or difficulty breathing
  - Fatigue
  - Muscle or body aches
  - Headache
  - New loss of taste or smell
  - Sore throat
  - Congestion or runny nose
  - Nausea or vomiting
  - Diarrhea
- Residents who test positive and are symptomatic should be isolated until test-based criteria met or:
  - At least 3 days have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement of respiratory symptoms (e.g., cough, shortness of breath), AND
  - At least 10 days have passed since symptoms first appeared
- Residents who test positive and are asymptomatic should be isolated until test-based criteria met or for 10 days from the date of their positive test, as long as they have not subsequently developed symptoms, in which case the symptom-based criteria for isolation should be followed.

6 HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual HCP not employed by the facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the LTCF setting (e.g., clerical, dietary, environmental, laundry, security, administrative, etc.)

- Active monitoring of HCP: CDC recommends weekly screening of HCP as a state reopens, but recognizes local prevalence should be taken into consideration. Given Oregon's low prevalence, every LTCF will be required to test 25% of all HCP every 7 days so that 100% are tested every month. This includes HCP from multiple shifts and facility locations.
  - HCP who are positive and symptomatic should be excluded from work. They may return to work after[7]:
    - At least 3 days have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement of respiratory symptoms (e.g., cough, difficulty breathing), AND
    - At least 10 days have passed since symptoms first appeared.
  - HCP who are positive and asymptomatic should be excluded from work. They may return to work after:
    - At least 10 days have passed since symptoms first appeared.
- Test all facility HCP and offer testing to all facility residents if there is a new confirmed[8] or presumptive[9] case of COVID-19 among any resident or HCP, then retest weekly to safely cohort residents. Continue weekly retesting until at least 14 days since the most recent positive result.
  - Residents who test positive and are asymptomatic and residents who refuse testing and are symptomatic should be isolated for 10 days from the date of their positive test, as long as they have not subsequently developed symptoms, in which case the symptom-based criteria for isolation should be followed
- Offer testing to all new residents prior to admission or readmission. If they test negative or are asymptomatic, the resident should be isolated for 14 days and then offered retesting. If negative at retest, or if they refuse testing and are asymptomatic, isolation will no longer be necessary.
  - LTCFs should also have the following in place:
    - If an infection control assessment has not been performed, include an evaluation of infection control practices while conducting facility-wide testing.
    - Available, trained HCP to administer the tests without requiring that residents travel to a health care facility.
    - A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., a symptomatic resident or HCP who declines a test should be treated as positive)

7 Test-based strategy may be preferable when making return to work decisions for individuals who might remain infectious longer than 10 days (e.g., severely immunocompromised). Consider consultation with public health in these situations.

8 A case with COVID-19 laboratory-confirmed by NAAT (e.g. polymerase chain reaction [PCR] test) at any laboratory that has successfully verified the CDC testing panel; or by a Laboratory Developed Test under the FDA Emergency Use Authorization.

9 A presumptive case is a person without a positive COVID-19 test result, with an acute illness featuring at least two of the following: shortness of breath, cough, fever, new olfactory or taste disorder, radiographic evidence of viral pneumonia; and no more likely alternative diagnosis; and within the 14 days before illness onset, lived in the same household or congregate setting, or had close contact with a confirmed case.

If, in the course of an outbreak, a LTCF is unable to conduct recommended testing of residents and staff, they should request assistance through their Local Public Health Authority for assistance in any of the following areas:

- Laboratory support at OSPHL for initial facility-wide screen.
- PPE to collect specimens and maintain appropriate transmission-based precautions.
- Licensed clinical personnel to collect specimens. Note that it is the preference that facility staff obtain specimens from residents as it will increase resident comfort during specimen collection and increase willingness to test. HCP who are familiar to residents can most effectively navigate complex consent issues for residents who are unable to consent to testing themselves, and it lowers the risk of additional introduction of COVID-19 from those coming in from outside the facility.
- Education of staff and residents to facilitate testing.
- Infection control support to facilitate safe testing procedures.

In the event that a LTCF resident tests positive for COVID-19 in the course of routine surveillance or from the testing of a symptomatic individual, a case investigation, led by the Local Public Health Authority in collaboration with OHA and DHS, will follow to ensure:

- Testing strategy will be implemented as discussed above.
- Residents with suspect or confirmed COVID-19 are isolated and cared for with full personal protective equipment (gown, gloves, mask, eye protection [goggles or face shield]) until the resident meets criteria for discontinuation of transmission-based precautions.
- Any roommate of a COVID-19 resident and any other residents with a significant exposure to this resident (<6 feet apart for at least 15 minutes) will need to be isolated for 14 days
- If multiple residents with COVID-19 are identified, cohorting is implemented appropriately with designated staff.
- If the need for isolation and quarantine exceeds the capacity of the facility, residents will need to be housed at an alternate care site.

Appendix A: Testing Capacity and Costs

Testing Capacity

On May 1, the Oregon Health Authority (OHA) released its COVID-19 Strategic Testing Plan for Oregon. The Testing Plan estimates that 15,000 tests per week will need to be conducted to meet Oregon's goals for tracking and mitigating the spread of the disease while also supporting the re-opening of Oregon's economy. Oregon has achieved this testing rate in the first two weeks of May (Table 1) and anticipates being able to maintain this rate through June. This estimate includes 2,500 tests per week for responding to outbreaks at LTCFs as they occur but was not developed with the intent to proactively test all residents and staff at all licensed LTCFs.

There are three primary types of testing entities in Oregon: the Oregon State Public Health Laboratory (OSPHL), hospitals, and commercial labs. While these entities possess ample testing infrastructure (labs, testing machines, staff, etc.) they are currently severely constrained by the availability of testing supplies (swabs and transport media). All states are facing the same issue.

Testing entities get their testing supplies from two sources—the federal government (FEMA) and the private market. Both sources are similarly constrained by limited production capacity. FEMA distributes supplies to each state upon request, and then the state determines how to distribute the supplies they receive. OSPHL receives all its testing supplies from the state. Hospitals receive some supplies from the state, but also purchase supplies from the private market. Commercial labs purchase all of their supplies from the private market.

While the state knows the amount of testing supplies it has requested from FEMA, it does not know how much it will actually receive from FEMA at any given time. For the past few weeks, the state has been requesting enough supplies for 15,000-25,000 tests per week. However, the state has consistently received less than half of the amounts requested, receiving enough supplies from the federal government to cover tests for about 5,000-10,000 people per week. While the state is not able to track the amount of supplies acquired by testing entities from the private market, the state does track the total number of tests performed for people in Oregon, which gives an indication of testing capacity in Oregon (see Table 1 below). Over this period, the total number of tests conducted in Oregon has been about 9,000-16,000 tests per week since early April (see Table 1 below). While the number of tests per week has increased, indicating improvements in supply chain issues, it is difficult to anticipate whether we will continue to see an increase in the coming weeks.

Given the on-going challenges in acquiring testing supplies, OHA feels that the testing entities currently serving the state could collectively maintain a reliable rate of 17,000 test per week. If additional supplies come available, then the timeframe proposed below for testing all residents and staff at all LTCFs in Oregon could possibly be accelerated, depending on other priority testing needs.

Table A-1. Number of COVID-19 tests per week in Oregon, pre-2/28 – 5/15/2020*

	Pre-2/28	2/29-3/6	3/7-3/13	3/14-3/20	3/21-3/28	3/28-4/3	4/4-4/10	4/11-4/17	4/18-4/24	4/25-5/1	5/2-5/8	5/9-5/15	Total
Tests/week	4	134	501	1,526	7,398	7,871	9,790	9,097	9,171	12,684	14,481	16,787	89,444

*Oregon Health Authority COVID-19 Weekly Testing Summary

Testing Costs

Costs for the actual testing of residents and staff should be primarily covered by insurance coverage, either Medicaid, Medicare or private coverage. However, there is not clarity that private insurance would cover asymptomatic testing. If there are uninsured staff, those costs also may not be covered despite other resources available from CMS to cover testing costs for those uninsured. DHS received $3m to establish a reimbursement fund for LTC facilities to pay facilities back for testing costs associated with testing uninsured staff.

Based on the Oregon Public Health Lab expenses and an estimate from private sector testing, each test will cost approximately $100. The total costs to test all residents and staff at long-term care facilities statewide is approximately $6 million. The estimated cost of tests for uninsured individuals and those not paid by private insurance could be nearly 40%, or $2.4m.

Oregon Health Authority

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Contact Mavel Morales at 1-844-882-7889, 711 TTY or OHA.ADAModifications@dhsoha.state.or.us.

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