THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

amda

# Policy Statement: COVID-19 Testing Strategies Should Be Tailored to the Clinical Situation

*May 18, 2020*

**Issue**

There is a clear understanding that protecting our vulnerable post-acute and long-term care (PALTC) population is dependent on adequate access to testing. Testing must be readily accessible, completed in a timely manner by those with appropriate training, have low false negative or false positive rates, impose a low physical or emotional burden on the person being tested, and be appropriately reimbursed.

Many states, local health departments, facilities, and consumers are calling for "universal testing" of PALTC residents and staff. The underlying premises behind these calls are that tests would be available for all, would meet the criteria set forth above, result in better care being delivered to our PALTC residents, and save lives.

A number of considerations must be addressed before implementing universal testing.

1. **What is meant by universal testing?** To some, universal testing involves all residents and staff in a facility, whether or not any individual has symptoms. Here the goal is early identification and assessment of baseline infection rates. In other cases, facility-wide testing is only done once a case occurs. The goal of this approach is to limit spread and assist with management.
2. **How often must universal testing be done?** Universal testing provides a point prevalence estimate. The information obtained is only meaningful for that point in time. Anyone exposed but negative at the time of the point prevalence study may turn positive over the next couple of days or weeks, contributing to spread. Repeat testing should be done, though there is no consensus on how frequently. Recent data suggest an average incubation period of roughly 5 days. [ANNALS 172(9)]. If repeat tests were performed every five days, the entire facility would have to be sampled 6 times in a month. This may not possible given limited availability of test materials, laboratory capacity, and costs of testing.
3. **What is the turnaround time for testing?** A basic tenet of effective testing is the rapid turnaround time necessary to take prompt action. Many areas of the country have experienced turnaround times of up to a week for polymerase chain reaction (PCR) tests. If results take more that 24-48 hours to return, the value of such testing is reduced considerably. In addition, laboratory capacity may be quickly overwhelmed when large numbers of tests are ordered, for example, through a state or federal order.
4. **Should healthcare personnel, residents, or both be tested?** – While the focus of testing is to protect residents, healthcare personnel (HCP) should also be considered for testing. HCP enter and exit the building and enter the larger community each day, increasing risk of acquiring COVID-19 and asymptomatic infections are well documented for this disease. Focusing on just residents will likely miss detecting infected staff who can introduce the virus to the facility.
5. **What tests should be used?** While the most common test is the reverse transcriptase polymerase chain reaction (RT-PCR) test on a nasopharyngeal swab, there are other test

modalities available, and more coming on the market every week. These include rapid point-of-care PCR tests; serology (blood) tests to detect the presence of antibodies; and now a point-of-care antigen test. Each test type has unique characteristics, qualities, and limitations, which must be considered when any testing strategy is developed. Cost, availability, reliability (sensitivity and specificity), collection and transport, and other considerations all need to be taken into account in the specific context of each facility and community.

6. **Can facilities cover the costs of testing?** Average costs currently range from $50-110 or more per test. For residents on Part A coverage, this cost is borne entirely by the facility, many of which are already under financial stress. Directives in some states, such as New York, shift the entire cost of testing to facilities. The monthly cost for a facility with 200 staff members in New York, where twice weekly testing of staff is required, could amount to $80,000. Facilities simply do not have the financial ability to cover such directives.
7. **Are HCP tests covered by private healthcare insurance?** HCP testing costs may not be covered or only partially covered by healthcare insurance. Moreover, some HCP cannot afford healthcare insurance. This presents an inappropriate financial burden to HCP, particularly the direct care workforce in nursing facilities, in whom 30-46% are reported to receive some form of public assistance.
8. **Is there coverage for more than one test?** If a point-of-care test is done and is inconclusive, the individual would need to have a definitive molecular (PCR) test. In such cases, insurers will frequently cover only the first test, leaving the facility or individual responsible for the full cost.
9. **Do we have enough tests?** Many areas of the country do not have access to readily available tests as of the time of publication of this document. Universal screening of residents and staff can deplete regional testing supplies and put symptomatic individuals at risk due to shortages.
10. **What happens if large numbers of staff must suddenly be furloughed?** Facilities need to be prepared for the possibility of having a large percentage of their staff furloughed because of positive results and the probable need for isolation for at least 10-14 days. This negatively impacts staffing levels and the quality of care that can be provided. Staff shortages also have the potential to worsen infection control practices, such as reducing the capability to separate exposed and unexposed staff. Facilities may need to evacuate residents in the event of severe staffing shortages.
11. **Is there a plan in place to deal with the test results?** Facilities need to have a plan in place to address issues such as cohorting, ensuring adequate supplies of personal protective equipment (PPE) and staff shortages.
12. **What if HCP or residents are resistant to testing?** Some HCP or residents may refuse testing, leaving facilities to decide what to do with such individuals. It is not clear whether states or facilities can mandate repeated testing of HCP.
13. **What is the emotional impact of repeated testing of residents with dementia, anxiety, post-traumatic stress disorders or other psychological health conditions?** Nasopharyngeal testing is uncomfortable. Residents, especially those with impaired cognition, may suffer physical and emotional distress from testing, particularly if repeated.

14. **Prevalence matters.** COVID-19 prevalence varies county-to-county and state-to-state. Facilities with lower rates of COVID-19 in their communities may have little to gain from frequent testing. In such circumstances, random screening coupled with strict adherence to clinical screening may be a more appropriate option.
15. **Should nursing facilities and assisted living communities be treated similarly?** State mandates for universal testing differ in terms of the population specified for universal testing. Some include only nursing homes while others include assisted living communities. However, both populations are vulnerable, and this is an important concern for multilevel campuses where spread can occur from one level of care to another.
16. **Testing alone is not enough.** Testing is only a technology and any technology used incorrectly or without a broad strategy will fail. We cannot test our way out of COVID-19. Testing must be done in conjunction with strict attention to clinical case-finding, screening of staff for symptoms, and visitor restrictions, in addition to prevention of transmission with universal masking, appropriate use of PPE, and environmental cleaning.

Increasingly, states are issuing orders for nursing homes and assisted living communities to conduct universal testing of all staff and/or residents. While such mandates are well-intentioned, they do not account for all, if any, of the considerations outlined above. Generally, this is because PALTC expertise and situational understanding have not been included when such policies are being developed. Testing decisions must be individualized to the facility with a clear understanding of the regional prevalence of disease, local testing accessibility and capacity, and well-defined goals of testing.

Without making sure that all complexities related to testing are addressed, in consultation with PALTC medical and clinical specialists, such mandates are likely to be counterproductive and will not produce the results they were intended to deliver.

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Approved by the AMDA Executive Committee