



Health Services
LOS ANGELES COUNTY

May 5, 2020

**Los Angeles County
Board of Supervisors**

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First District

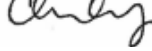
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TO: Supervisor Kathryn Barger, Chair
Supervisor Hilda Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

FROM: Christina R. Ghaly, M.D. 
Director

SUBJECT: **EXPANDING TESTING IN CONGREGATE LIVING ENVIRONMENTS (ITEM NO. 15, AGENDA OF APRIL 28, 2020)**

Christina R. Ghaly, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Deputy Director, Clinical Affairs

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Chief Deputy Director, Population Health

On April 28, 2020, the Board of Supervisors (Board) directed the Director of the Department of Health Services (DHS), in collaboration with the Director of the Department of Public Health (DPH) and any other relevant Departments, to report back to the Board in seven days on a high-level strategic plan for expanding access to appropriate, high-quality testing in congregate living environments, with a specific focus on Skilled Nursing Facilities (SNF) and homeless housing facilities, including consideration of onsite testing and the role that the relevant County Departments will need to play in operationalizing the plan.

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In its new role as the lead County entity for molecular COVID-19 testing, the Departments' overarching goal is to provide widespread access to high-quality testing in a way that supports public health, protects vulnerable populations, and allows the County to safely re-open¹. As a part of this, DHS has placed a high priority on rapidly expanding testing in congregate living settings, both due to the vulnerability of the residents in these settings as well as the speed with which infectious diseases can spread.

While this report, as directed by the Board, focuses specifically on the strategy in SNF and homeless housing facilities, DHS is also adapting this general approach for other congregate living settings, including correctional health (jail and juvenile halls/camps), and other licensed

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¹ See full testing strategy in Appendix I.

congregate health care facilities². While the relevant business lead (e.g., DPH, DMH, DPSS, DCFS) must ultimately work with their contracted or regulated entities on implementing the strategy included here, DHS will take the lead role in assisting with access to the testing supplies needed to implement the plan in these other congregate settings as well. DHS will do this by developing contracts (e.g., for test kits) with laboratories and other service providers or resolving supply shortages (e.g., swabs) that might otherwise hamper a facility's ability to use its own directly contracted commercial laboratory. DHS is also available to advise on proper Personal Protective Equipment (PPE), sampling protocols, staffing models for test sample collection, and facilitating the provider's access to test results as needed. For the jails and juvenile halls and camps where DHS is the primary health provider, DHS will retain full responsibility for implementation of the entire end to end testing process. Post-test activities (e.g., outbreak management, contact tracing, quarantine and isolation) will continue to be led by DPH.

This strategy must emphasize the need to rapidly respond to and manage outbreaks once they are identified and prioritize prevention and/or early identification of potential outbreaks before they escalate to put the lives of staff and residents at risk. Rapid response to identified COVID-19 outbreaks and implementation of effective control measures in any congregate living setting is critical to limiting spread. Simultaneously, active surveillance (i.e., periodic testing among asymptomatic individuals) of all congregate living facilities is necessary to ensure new cases or outbreaks are quickly identified so that measures can be taken to prevent large scale outbreaks and avoid morbidity, potential loss of life, and a potential strain on the County's public and private hospital system.

In the setting of active outbreaks in congregate living settings, all residents and staff should be promptly tested, with isolation of any individuals who are COVID-19 test-positive. All residents and staff should be monitored daily for symptoms with immediate isolation and re-testing of individuals with new symptoms. To prevent further spread and given the prominence of asymptomatic carriers, active ongoing surveillance testing among asymptomatic residents and staff is a critical element of a congregate living test strategy. Such testing permits the cohorting of all infected persons, even if they do not have symptoms, so that they can be separated from persons who are uninfected.

Active surveillance should also extend into all congregate living settings without known positive cases by testing a random sample of residents and staff at regular intervals.

² Per the 4/24/20 Los Angeles County Department of Public Health Health Officer Order, licensed congregate health care facilities include all of the following: Adult Residential Care Facilities, Chronic Dialysis Clinics, Continuing Care Retirement Communities, Hospice Facilities, Intermediate Care Facilities, Psychiatric Health Facilities, Residential Care Facilities for the Elderly, Residential Facility Chronically III, Skilled Nursing Facilities, Social Rehabilitation Facilities, Long-Term Care Facilities, Congregate Living Health Facilities, Nursing Facilities.

The particular sample size and testing frequency will vary by the risk-level of the facility, taking into account facility and resident characteristics. Given the high rate of asymptomatic individuals with COVID-19, all new admissions to congregate living facilities should either be isolated until they have tested negative or should be quarantined for fourteen days. If testing during active surveillance identifies a positive COVID case, DPH would launch a comprehensive outbreak investigation.

Appendices 2 and 3 provide a more detailed description of the testing strategies for SNFs and homeless housing facilities, respectively. These testing approaches are designed to optimize the use of available testing resources to protect the health of residents in the specified living arrangements. Testing completed on nasopharyngeal (NP) swabs specimens have been shown to date to have the best sensitivity, which means they are best for ruling out COVID infection. However, NP swabs must be collected by trained health care workforce. In some cases, such as SNFs, licensed clinical staff are available to collect the NP specimens, with training provided by DPH. In homeless housing settings, health care workforce are often not available on site to perform NP specimen collection. In this setting, either health care workers can be deployed to perform testing in outbreak and surveillance situations. As an alternative, particularly for asymptomatic surveillance, an acceptable alternative would be to shift to an observed self-collection strategy using either nasal (i.e., anterior nares) or mid-turbinate collection, both of which have been demonstrated to be able to yield a high-quality specimen, though sensitivity is likely lower than NP. The EMS Agency has also received regulatory flexibility to allow Emergency Medical Technicians (EMTs) to assist with specimen collection. These staff can also be used in both locations on an as needed basis if facility-based staff are not available.

To ensure successful implementation of this testing strategy, DHS will work to ensure adequate laboratory test kits and swabs are made available. To implement the above strategy in SNFs and homeless housing facilities, DHS and DPH estimates that approximately 20,000 to 60,000 tests will need to be completed per week. To meet this necessary volume, DHS, in collaboration with Internal Services Department (ISD) and the Office of Emergency Management (OEM), has executed contracts with testing vendors to secure access to 50,000 COVID-19 molecular (Polymerase Chain Reaction) PCR tests per week with planned increase to over 75,000 tests per week in the next two weeks. To be prepared for a potential increasing need, and due to the dynamic changes in supply and test turnaround time that has been experienced in the COVID pandemic to date, DHS will continue to identify additional high-quality laboratories in the coming weeks. Additionally, DHS and DPH will work together with laboratory vendors to deliver the required turnaround time to test result, so that DPH teams can support congregate living facilities in timely response to outbreaks.

Currently, laboratory contractors are meeting demand for swabs, and DPH is working with SNFs to leverage their existing supply of PPE for testing; however, additional supplies are needed to perform the tests, particularly in homeless housing facilities.

Staff performing specimen collection should wear appropriate PPE which includes gown, gloves, and surgical mask. While each facility has primary responsibility for procuring equipment and supplies for the safety of its workforce, DHS, with involvement from the EMS Agency, will work closely with DPH to promptly address any shortages on a facility-specific basis, subject to availability of State stockpile distributions.

The County continues to face challenges seen nationally over testing supplies, reagents, PPE, and turnaround times. Although testing is more available now than it was four weeks ago, a surge in demand could once again severely limit resource availability. Therefore, it is important to have clear plans for what to do if testing becomes more limited. Our plans take these aspects into consideration.

Implementation of these strategies will require substantial coordination with the directors and managers of facilities as well as with a wide range of other partners and organizations, including the private sector laboratory industry. As more information is gathered on the effectiveness of the recommended approaches and as testing capacity continues to evolve, we will update the strategies described in this report.

For questions related to the content of this report, you may contact me or your staff may contact Dr. Clemens Hong at chong@dhs.lacounty.gov.

CRG:amg

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Department of Public Health
Department of Mental Health
Department of Children and Family Services
Department of Public Social Services
Probation
Sheriff's Department

Overarching Goal: Provide widespread access to molecular COVID-19 testing in a way that supports public health, protects vulnerable populations, and allows the County of Los Angeles to safely re-open.

1. Expand overall test capacity to levels needed to serve public health and health system goals.
 - a. Achieve progressive quantitative targets for COVID diagnostic testing over time through high-quality molecular tests.
 - i. Establish progressive targets over time with consideration for evolving role of serology testing.
 - b. Work in partnership with the State and private entities to address current gaps in the supply chain make the COVID-19 PCR molecular test more available across LA County.
 - c. Expand access to COVID testing by leveraging private partners with available capacity and developing mobile and point of care testing options.

2. Expand access to testing in a way that appropriately prioritizes at risk populations, addresses potential health equity issues, and protects the most vulnerable and marginalized Angelenos.
 - a. Develop strategy to align testing with priority populations, as outlined by State and/or LADPH guidelines.
 - b. Develop and implement strategy to increase testing among clinically and/or socially vulnerable populations, including surveillance testing strategies for asymptomatic individuals in high risk settings, when appropriate; specific target populations include:
 - i. Persons experiencing homelessness ;
 - ii. Individuals in skilled nursing facilities and other congregate living settings;
 - iii. Incarcerated individuals; and
 - iv. Individuals at high-risk for poor COVID outcomes due to age, underlying chronic conditions, race/ethnicity/language, insurance status, etc.
 - c. Track disparities in access to COVID testing and COVID outcomes by geography and among high-risk groups (e.g. at risk racial/ethnic groups) and iteratively improve access to testing and COVID outcomes through targeted outreach, engagement, and treatment approaches.

3. Integrate testing processes with the broader healthcare and public health systems.
 - a. Streamline data workflows and improve test results notification to patients and public health and ensure patient linkage to treatment and timely contact tracing.
 - b. Investigate options for enhancing data sharing between laboratory vendors and health providers (e.g., payers, health information exchange).

- c. Link community-based testing sites to DPH contact tracing and quarantine and isolation efforts.
 - d. Link community-based testing sites to health care providers to support consistent test follow-up and management of positive tests.
 - e. Help to inform state and federal reimbursement mechanisms that provide sustainable funding to private entities to expand access to COVID testing.
4. Deliver on-going communication and transparency.
- a. Develop a proactive communication strategy and provide regular updates to a broad range of stakeholders.
 - b. Develop and maintain a transparent dashboard detailing tests performed by geographic region and high-risk population.
 - c. Develop and disseminate culturally appropriate, public/participant facing education materials to increase COVID knowledge, access to testing and support navigation to treatment.

Overview of COVID Testing Strategy for Residents and Staff of Skilled Nursing Facilities

Revision Date: April 30, 2020

Overview

The ~360 Skilled Nursing Facilities (SNFs) in Los Angeles County (County) house an estimated 35,000-40,000 residents on any given day. Each facility employs an average of 3-4 staff for each resident. SNFs concentrate large numbers of staff with individuals that are at the highest risk of poor outcomes from COVID infection. COVID infections in SNF residents lead to poor outcomes, including hospitalizations and death for residents and, if the infection is not contained, COVID outbreaks have catastrophic consequences for many. Effective testing and isolation strategies can save lives and reduce strain on our health care system during this pandemic. This document provides an overview of the COVID testing strategy for SNFs in County.

Goals

1. To rapidly respond to identified outbreaks in SNFs, in order to limit spread through the implementation of effective control measures; and
2. To perform and maintain active surveillance of all SNFs in the County to ensure new cases or outbreaks are identified quickly so that measures can be taken to prevent large-scale outbreaks.

Plan

1. Comprehensive testing of all residents and staff in all SNF facilities with active outbreaks (defined as facilities with at least one positive case) with an FDA-approved, high-sensitivity Polymerase Chain Reaction (PCR) test (performed on a specimen collected with a nasopharyngeal swab, when possible) with 24-hour turnaround time. The following steps will then be taken based on testing results:
 - Isolate all PCR-positive residents and staff per guidelines;
 - Ensure daily monitoring of all residents and staff for symptoms with immediate isolation and re-testing of individuals with new symptoms; and
 - Serial testing of all residents and staff who were initially PCR-negative no less frequently than every 2 weeks.
2. Ongoing active surveillance in all SNFs without known positive cases with an FDA-approved, high-sensitivity PCR test (performed on a specimen collected with a nasopharyngeal swab, when possible) with 48-hour turnaround. The following surveillance efforts will be ongoing:
 - Test a random sample of residents every 1-2 weeks according to the following sampling approach:
 - Less than 50 residents: 10 samples
 - Between 50 and 200 residents: sample 20% of residents
 - 201 or more residents: 40 samples
 - When feasible, test a random 25% sample of all asymptomatic SNF staff in each facility, with a minimum of 20 staff members, every 1-2 weeks.
 - Test all new admissions to the facility and have the patient remain in isolation until the test result is negative.
 - Isolate all PCR-positive residents and staff, and those with symptoms until a test result is available, per guidelines.

- For residents who refuse testing, isolate for 14 days if they remain asymptomatic or for 7 days¹ after symptoms develop with least 72 hours symptom free.
- Staff who refuse testing must not be allowed to work at the facility.
- Follow State/CDC guidance on management of symptomatic SNF personnel (e.g. perform COVID testing, stay at home for a minimum of 10 days after symptoms develop with least 72 hours symptom free).

¹ Seven days as per current guidance; to be revised as needed based on evolving CDC recommendations.

Overview of COVID Testing Strategy for Residents and Staff of Congregate Living Facilities for Persons Experiencing Homelessness

Revision Date: May 3, 2020

Overview

Los Angeles County (County) has a large network of congregate living facilities that provide interim and permanent housing to persons experiencing homelessness (PEH). Facilities include shelters, recuperative care centers, other project-based interim and permanent housing sites, Project Room Key hotels/motels, COVID isolation and quarantine sites, and Single Room Occupancies (SRO's). Facilities have a range of staff and many residents that would have poor outcomes, including hospitalizations and death, in the event of a COVID infection. COVID outbreaks would have catastrophic consequences for many. Effective testing and isolation strategies can save lives and reduce strain on our health care system during this pandemic. This document provides an overview of the COVID testing strategy for Congregate Living Facilities for PEH. Test strategies for encampments for unsheltered PEH are described separately.

Goals

1. To rapidly respond to identified outbreaks in congregate living facilities for PEH, in order to limit spread through the implementation of effective control measures; and
2. To perform and maintain active surveillance of all congregate living facilities for PEH in the County to ensure new cases or outbreaks are identified quickly so that measures can be taken to prevent large-scale outbreaks.

Plan for PEH Testing in Sheltered Settings

1. Comprehensive testing of all residents and staff in all congregate living facilities with active outbreaks (defined as facilities with at least one positive case, or 2 persons under investigation (PUI) for COVID-19 infection) with an FDA-approved, high-sensitivity Polymerase Chain Reaction (PCR) test (performed on a specimen collected with a nasopharyngeal swab, when possible) with 24-hour turnaround time. The following steps will then be taken based on testing results:
 - Isolate all PCR-positive residents and staff per guidelines;
 - Ensure twice daily monitoring of all residents and staff for symptoms with immediate isolation and re-testing of individuals with new symptoms; and
 - Weekly serial testing of all residents and staff who were initially PCR-negative.
2. Ongoing active surveillance in all congregate living facilities without known positive cases with an FDA-approved, high-sensitivity PCR test (performed on a specimen collected with a nasopharyngeal swab, when possible) with 48-hour turnaround. The following surveillance efforts will be ongoing:
 - Test a random sample of residents according to the following schedule, every 1-2 weeks:
 - Less than 50 residents: 10 samples
 - Between 50 and 200 residents: sample 20% of residents; and
 - 201 or more residents; 40 samples.
 - Test a random 25% sample of all asymptomatic Homeless Housing Facilities staff in each facility every 1-2 weeks.
 - Test all residents to establish baseline, screen and test all new admissions to the facility and have the resident remain in isolation until the test result is negative.
 - Subsequently, screen symptoms twice daily and test, if symptomatic

- Isolate all PCR-positive residents and staff, and those with symptoms until a test result is available, per guidelines.
- For residents who refuse testing, isolate for 14 days if they remain asymptomatic or for 10 days¹ after symptoms develop with at least 72 hours symptom free.
- Staff who refuse testing must not be allowed to work at the facility.
- Follow State/CDC guidance on management of symptomatic congregate living facility personnel (e.g. perform COVID testing, stay at home for a minimum of 10 days after symptoms develop with least 72 hours symptom free).

Modifications to testing strategy in the event of limited testing capacity

In the event of limited testing capacity, we will prioritize facility types in the following order:

1. Large shelters
2. Recuperative care centers
3. Other interim housing sites (e.g. bridge, stabilization, smaller shelters)
4. Project Room Key hotels/motels (Tier 1)
5. Isolation & Quarantine sites
6. SROs

Testing modifications for outbreak investigations when test capacity is limited would include:

- Only testing residents and staff with symptoms; and
- Testing select contacts based on location of confirmed cases, facility layout and immediate close contacts.

Testing modifications for active surveillance when test capacity is limited would include:

- Only testing individuals with symptoms at admission to facility and cohort new asymptomatic residents for 14 days.

¹ Seven days as per current guidance; to be revised as needed based on evolving CDC recommendations.