**Questions Regarding MDH's Recommended Point Prevalence Testing**

**Current as of May 21, 2020**

We welcome the opportunity to do more widespread testing in long term care settings and understand that this needs to be part of a broader plan to mitigate the introduction and spread of COVID-19 in our settings. Refer to MDH testing guidance document:

1. How does a LTC facility get consent from residents with dementia?
   MDH is working on a template consent form that facilities may choose to use but have not published anything yet. Facilities should follow their normal protocol for obtaining consent.

2. Can health care workers of a LTC facility refuse a test, and if they refuse, may the facility, or must the facility, require the health care worker to self-quarantine for 14 days?
   Health care workers may refuse testing. MDH would encourage facility leadership to positively engage and educate staff on the importance of testing, even when asymptomatic. MDH is seeking additional legal guidance on this and will share when they receive.

3. Can residents of a LTC facility refuse a test, and if they refuse, must the facility require the resident to move to the observation/admission unit to self-quarantine for 14 days?
   Yes, they can refuse a test. Residents may refuse testing. Residents should be monitored for COVID-19 according to CDC and MDH guidance.

4. If a LTC facility has already conducted partial tests, do they need to test all residents and health care workers again or just those not tested before?
   This decision could depend on the timing of the previous testing, but in general, yes it would be appropriate to test all non-positive residents and staff again. The goal of point prevalence surveys is to have a snapshot in time of the infection status of an entire group of individuals – in this case, a LTC facility. Previous negative tests only indicate that the individual did not have detectable virus at the time of that test.

5. If a LTC facility has staff in asymptomatic quarantine (due to risk exposure), or on a leave of absence, or not scheduled during their testing day, how should the facility handle getting them tested?
   Prior to performing testing, facilities should consider and creatively plan how they will test all staff at the same time or as close to the same time as possible. For example, if staff are on leave because of potential exposure, the facility could offer them testing on the day of the PPS using a drive-thru system to avoid having them enter the facility. Staff who are off-shift could be encouraged to come in for testing. Communities can be flexible within a short period of time. Another option, staff could be tested by their own health care provider at or close to the time of the PPS. For those employees that weren't available on the day of testing, the facility could have additional specimen collection kits to test employees on their next shift. Just keep in mind, the goal is to test as close to the same time as possible.

6. Who pays for the lab testing and/or testing kits if the facility is doing the coordination of the testing themselves?
   If the site is using their own health system or has a relationship with a lab, it will be billed to insurance. The State is looking at funding availability for costs over and above insurance

payments. No decisions are made at this time. The intent is for sites to have no expense incurred as a result of testing.

7. In the past only the positive cases were identified when tested by the LTC facility—shouldn't the testing results include both negative /inconclusive and positive for purposes of data collection?
   Testing results should include positive, negative and inconclusive for point prevalence testing.

8. For health care workers working in multiple facilities - do they need to be tested at each place of employment or just once? If just one employer, how will the test results be shared?
   It would be in the best interest of organizations to share results with another site where the employee works. Facilities could consider including this in the consent process for staff testing. This is not required. If the HCW tells MDH they work at a second location, MDH has been notifying that community too.

9. Given the vast increase in testing volume using Point Prevalence Testing, does the state expect longer delays in LTC facilities getting test results? Will tests for symptomatic residents or staff be prioritized?
   At this time, MDH does not expect any delays in receiving test results. Each laboratory has a different turn-around-time for test results, and lab capacity may vary as the situation progresses.

10. Will Point Prevalence Testing be geographically scheduled in a manner that to avoid depleting the SNSA agency staff in a geographic area at any one point in time?
    The State is trying to balance the needs of staffing, outbreaks, willingness of facilities to test, and schedule efficiency with the National Guard teams.

11. Will SNSA staff be tested under this plan? How about other contract staff coming into the buildings on a regular basis such as therapists/NPs, etc?
    If there is a SNSA staff in the building at the time of the test, they should be eligible for testing in the building. Otherwise, no further information is available at this time.

12. Is MDH committing to Point Prevalence Testing in LTC facilities every seven days until two consecutive testing weeks at a facility result in all negative results?
    Yes, the intention is to test every 7 days. At this time, there is not a fully built system to ensure this, but the State is working toward that goal.

13. As increased testing could have a significant impact on staffing and exacerbate shortages we will likely need to lean on SHCC bridge-staffing resources, will these staff be tested?
    There is not a system in place to test these staff right now, but it will continue to be evaluated as the process is more fully developed.

14. Who gets test results for healthcare workers?
    This will vary depending on who the ordering provider is for the tests and who conducts the testing. This question should be asked during the scheduling and coordination process.

15. Many Assisted Living Communities have no relationships with laboratories (labs were traditionally ordered through the physician office). How will this affect Point Prevalence Testing?
    The site does not need an existing lab contract if the State performs the specimen collection and testing. The State has a testing coordination center who will guide that process. Various labs across the state are being used for this purpose.

16. Increased Point Prevalence Testing will increase PPE usage, do we anticipate any additional issues with PPE supply chain?
    At this point in time, MDH is not aware any PPE supply chain issues as a result of increased testing. PPE availability is subject to change.

17. Understanding that prioritization for PPS will be sites with confirmed or suspected COVID cases, when might we anticipate PPS being available for other sites wishing to establish a baseline?
    We are prioritizing those with a confirmed case and also working to meet the Governor's goal of testing ten facilities per day. As we get further into the testing process and capacity continues to expand, sites wishing to establish a baseline may be considered. There is no specific timeline for this.

18. Is the attached Testing Registration Form what MDH considers a resident consent form?
    Facilities should use their standard consent process i.e. verbal, opt-out, mass communication. MDH is working on an optional template form but they don't have a final resident or staff consent form.

19. Has MDH developed a Staff consent form yet (including one for staff under the age of 18)?
    No. MDH is working on an optional template form but they don't have a final resident or staff consent form. Facilities should use their standard consent process i.e. verbal, opt-out, mass communication.

20. The COVID Testing Checklist directs the facility to have the "Medical Director" write orders for facility testing. Is this testing of residents, staff, or both? Note that most assisted living facilities do not have medical directors - what are you advising ALs to do?
    MDH still working on a response

21. Can asymptomatic staff who test positive be scheduled to work in a Covid-19 positive resident cohorted unit (separate entrance, separate staff area, appropriate PPE, etc.)?

    This is not recommended by MDH. While the CDC has this as the last option before facility evacuation, MDH urges facilities to exhaust all possible staffing options prior to considering this as a last resort. The potential exposures to staff and residents from an asymptomatic positive staff member are very high and these staff are potentially shedding large amounts of virus. The State is in the process of defining when, and with what documentation, "crisis capacity strategies" including asking confirmed positive staff back to work, would be acceptable.

22. How to handle the REDCAP survey if a facility is doing their own testing as the survey "makes them" include a survey date?

If able, facilities can “back date” to when the testing was completed.  MDH will look into the questionnaire and provide further feedback.