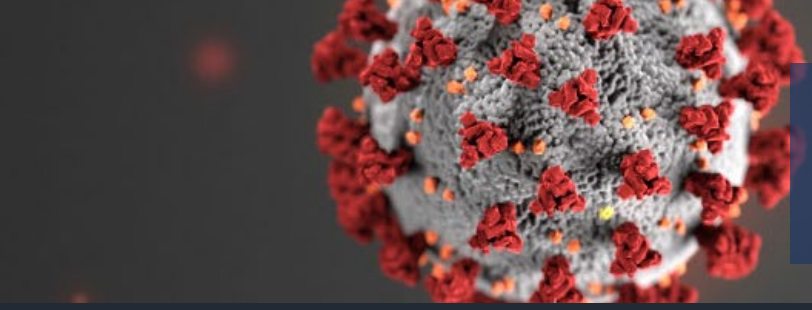

GUIDANCE TO PROTECT RESIDENTS OF LONG-TERM CARE FACILITIES

Quarantine and Testing Protocols

Michigan.gov/Coronavirus

April 2, 2021

This document is to assist Michigan's residential care facilities with how to determine when residents should be placed into quarantine or tested when returning to the facility. Residential care facilities include including nursing homes, homes for the aged, adult foster care facilities, hospice facilities, substance use disorder residential facilities, or assisted living facilities. The guidance in this document also applies to independent living facilities.

These recommendations are from the Centers of Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html; published March 29, 2021). Though intended for nursing homes, the guidance applies to other long-term care and residential settings.

The guidance is displayed by a resident's vaccination or COVID-recovered status, time away from the facility, and activity.

How to Determine Quarantine Status After Returning to the Facility

	Known Exposure	Symptomatic	Medical appointments, dialysis, hospital stay, family or community outing		New admissions
			Leave is **Less** than 24 hours - with no known exposure or symptoms	Leave is **More** than 24 hours - with no known exposure or symptoms	
Resident Fully Vaccinated[1]	Quarantine[2]	Quarantine	No quarantine	No quarantine	No quarantine
Resident Not Fully Vaccinated[1]	Quarantine[3]	Quarantine	No quarantine	a. Quarantine for hospital stay; b. For all others, assess risk of exposure[4] (e.g., Activity, Time, Precautions Taken, Resources Available)	Quarantine
Resident COVID-recovered within 90 days	No quarantine[5]	Quarantine[6]	No quarantine	No quarantine	No quarantine

MDHHS Michigan Department of Health & Human Services

How to Determine Testing After Returning to the Facility*

***Applicable to SNF, HFA, and AFCs licensed for 13 or more beds**

	Known Exposure	Symptomatic	Returning from medical appointment/dialysis or family or community outing	Returning from hospital stay (>24 hours)	New admissions
Resident - Regardless of vaccinatio	Test[7]	Test[8]	No - unless known exposure or symptomatic and testing is indicated[5,6]	Yes - during intake unless tested in the 72 hours prior to intake	Yes - during intake unless tested in the 72 hours prior to intake
Resident COVID-recovered within 90 days	Testing may be indicated[5]	Testing may be indicated[6]	No - unless known exposure or symptomatic and testing is indicated[5,6]	No - unless known exposure or symptomatic and testing is indicated[5,6]	No - unless known exposure or symptomatic and testing is indicated[5,6]

1 A fully vaccinated resident is an individual who is ≥2 weeks post receipt of the second dose in a 2-dose series, or ≥2 weeks post receipt of one dose of a single-dose vaccine.

2 Fully vaccinated inpatients and residents in healthcare settings should continue to quarantine following prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with SARS-CoV-2 infection; outpatients should be cared for using recommended Transmission-Based Precautions. This is due to limited information about vaccine effectiveness in this population, the higher risk of severe disease and death, and challenges with physical distancing in healthcare settings. Although not preferred, healthcare facilities could consider waiving quarantine for fully vaccinated patients and residents following prolonged close contact with someone with SARS-CoV-2 infection as a strategy to address critical issues (e.g., lack of space, staff, or PPE to safely care for exposed patients or residents) when other options are unsuccessful or unavailable. These decisions could be made in consultation with public health officials and infection control experts.

3 Alternatives to the 14-day quarantine period are described in the Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing. Healthcare facilities could consider these alternatives as a measure to mitigate staffing shortages, space limitations, or PPE supply shortages. However, these alternatives are not a preferred option because of the special nature of healthcare settings (e.g., patients at risk for severe illness, critical nature of healthcare personnel, challenges with social distancing).

4 These decisions should be made on a case-by-case basis (activity, social distancing, # of people, vaccine-status, mask-wearing, etc.) - situation dependent. Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission.

5 CDC currently recommends that asymptomatic patients and residents who have recovered and are within 3 months of a positive test for SARS-CoV-2 infection may not need to be quarantined or tested following re-exposure to SARS-CoV-2. However, there might be clinical scenarios in which the certainty about a prior infection or the durability of the immune

response exist, for which providers could consider testing for SARS-CoV-2 and recommending quarantine following an exposure that occurs less than 3 months after their initial infection. Examples could include:

- Patients or residents with underlying immunocompromising conditions (e.g., patient after organ transplantation) or who become immune compromised (e.g., receive chemotherapy) in the 3 months following SARS-CoV-2 infection and who might have an increased risk for reinfection. However, data on which specific conditions may lead to higher risk and the magnitude of risk are not available.
- Patients or residents for whom there is concern that their initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result (e.g., resident was asymptomatic, antigen test positive, and a confirmatory nucleic acid amplification test (NAAT) was not performed).
- Patients or residents for whom there is evidence that they were exposed to a novel SARS-CoV-2 variant (e.g., exposed to a person known to be infected with a novel variant) for which the risk of reinfection might be higher.

6 For persons who have recovered from laboratory-confirmed SARS-CoV-2 infection and who experience new symptoms consistent with COVID-19 within 3 months since the date of symptom onset of the previous illness episode (or date of last positive viral diagnostic test if the person never experienced symptoms), repeating viral diagnostic testing may be warranted if alternative etiologies for the illness cannot be identified. If reinfection is suspected and retesting is undertaken, the person should follow isolation recommendations for cases of COVID-19 pending clinical evaluation and testing results. Results of repeat testing should also be interpreted in consultation with an infectious disease specialist with consideration of cycle threshold values (if available) and clinical presentations. The determination of whether a patient with a subsequently positive test is contagious to others should be made on a case-by-case basis, in consultation with infectious diseases specialists and/or public health authorities, after review of available information (e.g., medical history, time from initial positive test, RT-PCR Ct values, and presence of COVID-19 signs or symptoms).

7 Residents who are known close contacts should be considered for testing initially, and, if negative, again about 5-7 days after exposure.

8 Current recommendations for SARS-CoV-2 testing for HCP and residents remain unchanged, regardless of vaccination status. Clinicians should use their judgment to determine if a resident has signs or symptoms consistent with COVID-19 and whether the resident should be tested. Individuals with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Some may present with only mild symptoms or other less common symptoms.

Clinicians are encouraged to consider testing for other causes of respiratory illness, such as influenza, in addition to testing for SARS-CoV-2. See Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating.