HealthCap
RISK MANAGEMENT SERVICES

CDC - Testing and Management Considerations

Nursing Home Residents with Acute Respiratory Illness Symptoms

SARS-CoV-2 and Influenza Viruses are Co-circulating

The following practices should be considered when SARS-CoV-2 and influenza viruses are found to be co-circulating based upon local public health surveillance data and testing at local healthcare facilities. While these considerations are specific to care of residents residing in nursing homes, some practices could be adapted for use in other long-term care settings (i.e., assisted living centers).

1. **Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for care of a resident with suspected SARS-CoV-2 infection.**

   Because some of the symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two infections based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in current room, pending results of viral testing. They should not be placed in a room with new roommates nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by SARS-CoV-2 testing.

   Nursing home residents, including older adults, those who are medically fragile and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms of influenza virus infection and may not have fever.

   Older adults with COVID-19 may not always manifest fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache or new dizziness, nausea, vomiting, diarrhea and loss of taste or smell.

2. **Test any resident with symptoms of COVID-19 or influenza <u>for both viruses</u>.**

   Because SARS-CoV-2 and influenza virus co-infection can occur, a positive influenza test result without SARS-CoV-2 testing does not exclude SARS-CoV-2 infection and a positive SARS-CoV-2 test result without influenza testing does not exclude influenza virus infection.

   Facilities should promptly notify the health department for consultation and further investigation for any of the following:

   - A suspected or confirmed case of either SARS-CoV-2 or influenza in a resident or healthcare personnel (HCP).
   - A resident with severe respiratory infection resulting in hospitalization or death; or
   - ≥3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

A) Obtain respiratory specimens for influenza and SARS-CoV-2 testing.

Check the manufacturer's package insert for approved respiratory specimens. There are no FDA-cleared influenza diagnostic assays that utilize saliva specimens.

If available, multiplex nucleic acid detection assay for SARS-CoV-2, influenza A and B Viruses can be performed onsite, or at an offsite clinical laboratory.

Two different specimens may need to be collected if a multiplex nucleic acid detection assay including both influenza viruses and SARS-CoV-2 is unavailable.

B) Test for SARS-CoV-2 by nucleic acid detection4 OR by SARS-CoV-2 antigen detection assay.

Because antigen detection assays have lower sensitivity than nucleic acid detection assays, a negative SARS-CoV-2 antigen detection assay result *in a symptomatic person* does not exclude SARS-CoV-2 infection and should be confirmed by SARS-CoV-2 nucleic acid detection assay.

New SARS-CoV-2 infection identified in HCP or nursing home-onset infection in a resident should prompt additional testing in the facility.

C) Test for influenza by rapid influenza nucleic acid detection assay.

If a rapid nucleic acid detection assay is not available, perform rapid influenza antigen detection assay. Because of lower sensitivities to detect influenza viruses, confirm negative rapid influenza antigen detection test results in a symptomatic person by influenza nucleic acid detection assay.

D) Test for other respiratory pathogens.

If residents with acute respiratory illness test negative for both influenza and SARS-CoV-2, consider additional viral or bacterial testing based on respiratory pathogens known or suspected of circulating in the community.

3. Placement Decisions

A) Residents confirmed to have SARS-CoV-2 infection should be moved to a dedicated COVID-19 care unit

Residents found to have SARS-CoV-2 and influenza virus co-infection should be placed in a single room on the dedicated COVID-19 unit or housed with other co-infected residents on that unit. These residents should continue to be cared for using all recommended PPE for the care of a resident with SARS-CoV-2 infection.

If a single room isolation or cohorting of residents with SARS-CoV-2 and influenza virus co-infection is not possible, consult with public health authorities for guidance on other management options (i.e., transferring the resident; placing physical barriers between beds in shared rooms and initiating antiviral chemoprophylaxis for roommates to reduce their risk of acquiring influenza).

B) Residents confirmed with influenza only should be placed in a single room, if available, or housed with other residents with only influenza. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (i.e., physical barriers, antiviral chemoprophylaxis).

Residents with only influenza should be placed in Droplet Precautions with eye protection, in addition to Standard Precautions.

C) Residents with symptoms of acute respiratory illness who are determined to have neither SARS-CoV-2 infection nor influenza should be cared for using Standard Precautions and any additional Transmission-Based Precautions based on their suspected or confirmed diagnosis.

4. Clinical management

A) Prescribe antiviral treatment if influenza testing is positive OR prescribe empiric antiviral treatment based upon a clinical suspicion of influenza while test results are pending for symptomatic residents.

Antiviral treatment for influenza should be administered as soon as possible following clinical diagnosis.

B) Properly manage residents with SARS-CoV-2 infection.

Recommendations for treatment of persons with COVID-19 are available from the National Institutes of Health COVID-19 Treatment Guidelines (below). Remdesivir is the only FDA-approved treatment for patients with COVID-19 who are hospitalized. There are currently no FDA-approved therapies for persons with COVID-19 who are not hospitalized. Clinicians may wish to consult clinicaltrials.gov for clinical trials of remdesivir in outpatients that are open for enrollment (https://cllinicaltrials.gov/ct2/show/NCT04501952)

On November 9, 2020, FDA issued an Emergency Use Authorization (EUA) for the monoclonal antibody product bamlanivimab for single-dose (700 mg) intravenous treatment of outpatients with mild to moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing and within 10 days of symptom onset who are 12 years of age and older weighing at least 40 kg, and who are at high risk for progressing into severe COVID-19 and/or hospitalization: https://www.fda.gov/media/143603/download Medicare Monoclonal Antibody COVID-19 infusion program instruction is available at: https://www.cms.gov/files/document/covid-medicare-monoclonal-antibody0infusion-program-instruction.pdf

https://www.covid19treatmentguidelines.nih.gov/

Clinicians may wish to consult clinicaltrials.gov for clinical trials of bamlanivimab in outpatients that are open for enrollment (https://clinicaltrial.gov/ct2/show/NCT04427501 Once clinical trial of bamlanivimab for prevention of SARS-CoV-2 infection in skilled nursing and assisted living facility residents and staff is enrolling: https://clinicaltrials.gov/ct2/show/NCT04497987

On November 21, 2020, FDA issued an EUA for the combination monoclonal antibody product carsirivimab and imdevimab to be administered as a single intravenous infusion (1200 mg of each monoclonal antibody given together) for the treatment of mild to moderate COVID-19 in adults and pediatric patients (12 years of age or older weighing at least 40 kilograms (about 88 pounds) who are NOT hospitalized or receiving supplemental oxygen or who require an increase in chronic oxygen therapy, and who test positive for SARS-CoV-2 by a direct viral test and who are at high risk for progressing to severe COFID-19 and/or hospitalization:
https://www.fda.gov/media/143892/download

C) For adult patients with suspected community-acquired pneumonia who do not require hospitalization, see antibiotic treatment recommendations from the American Thoracic Society-Infectious Diseases Society of America Adult Community-acquired Pneumonia Guidelines.

D) Influenza antiviral chemoprophylaxis considerations.

The facility should promptly initiate antiviral chemoprophylaxis with oral oseltamivir to all exposed individuals (i.e., roommates) of residents with confirmed influenza. When at least 2 residents are ill within 72 hours of each other with laboratory-confirmed influenza the facility should expand antiviral chemoprophylaxis to non-ill residents living on the same unit as the residents with influenza (outbreak affected units), regardless of influenza vaccination status.

Persons receiving antiviral chemoprophylaxis who develop signs or symptoms should be tested (see above) and switched to antiviral treatment doses pending results.

E) Encourage influenza vaccination for unvaccinated residents and HCP.

For newly vaccinated individuals with exposure, antiviral chemoprophylaxis can be considered for up to 2 weeks following inactivated influenza vaccination until vaccine-induced immunity is acquired.

https://www.cdc.gov/flu/professionals/diagnosis/testing-management-considerations-nursinghomes.htm
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