California Department of Public Health
Weekly Facility COVID-19 Update Call
March 31, 2020
8:00 am – 9:00 am

I. **Welcome / Introduction:** **Heidi Steinecker**

II. **Overview:** **Director's Office**

To treat the rising number of patients with COVID-19, our state needs more workers in the health care field to join the fight. Governor Newsom today launched a major new initiative to expand California's health care workforce and recruit health care professionals to address the COVID-19 surge. Health care professionals with an active license, public health professionals, medical retirees, medical and nursing students, or members of medical disaster response teams in California are all encouraged to join the new California Health Corps.

Interested medical and health care professionals are encouraged to visit healthcorps.ca.gov for more information and to register for the California Health Corps. Medical doctors, nurses, respiratory therapists, behavioral health scientists, pharmacists, EMTs, medical and administrative assistants, as well as certified nursing assistants are encouraged to step up and meet this moment to help California respond to the outbreak.

The Governor also signed an executive order that will temporarily expand the health care workforce and allow health care facilities to staff at least an additional 50,000 hospital beds the state needs to treat COVID-19 patients.

This is an evolving situation that we are actively monitoring and we are prepared should the situation change. For more information please visit the California Department of Public Health's website: www.cdph.ca.gov/covid19 and follow @CAPublicHealth for updates.

III. **Disease Update:** **Dr. James Watt**

IV. **Laboratory Update:** **Dr. Jill Hacker**

Diagnostic testing for COVID-19 must be done in a CLIA-licensed laboratory. Testing for COVID-19 is available in 22 public health labs in California, as well as a number of clinical and commercial labs throughout the state. The FDA maintains a list of the tests that have been granted EUA status; there are now 20 tests listed. Several of these tests are suitable for high throughput testing. The FDA[a] EUA-

approved **CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel** is the test used in most public health labs.

Testing Prioritization

- **Testing at a public health laboratory still requires prior testing approval** from your local health jurisdiction.
- **Due to a critical shortage of tests and testing reagents, CDPH recommends prioritizing testing.** CDPH Guidance for Prioritization of Patients for Laboratory Testing for COVID-19 was released on March 20th.
- **As companies market test kits and new laboratories begin offering COVID-19 testing, it is difficult to know if a given lab or assay has been certified or approved.**
    - Any laboratory performing COVID-19 testing must be a CLIA-certified laboratory. If there are any concerns about a testing laboratory, CDPH Laboratory Field Services (LFS) can be contacted (LFSCOVID@cdph.ca.gov).
    - The FDA has not authorized any test that is available to purchase for testing at home for COVID-19.
    - **Serology:** At this time, the FDA list does not include serologic tests to identify antibodies to SARS-CoV-2. FDA does not intend to object to the development and distribution by commercial manufacturers or the development and use by laboratories of serologic tests, provided the test has been validated, notification has been provided to the FDA, and appropriate disclaimers are included in the test report. The FDA states that antibody testing should not be used as the sole basis to diagnose or exclude SARS-CoV-2 infection or to inform infection status.

Specimen Type and Priority

- **For the CDC assay, guidance[b] for respiratory swab collection was updated on March 24, 2020, to allow for increased flexibility when collecting specimens for PCR.** A single nasopharyngeal (NP) swab is still the preferred specimen type; however, when collecting an NP swab is not possible, the following are acceptable alternatives:
- An anterior nares specimen collected by a healthcare professional or by onsite self-collection (using a round foam swab), OR
- A nasal mid-turbinate swab collected by a healthcare professional or by onsite self-collection (using a flocked tapered swab), OR
- An oropharyngeal (OP) specimen collected by a healthcare professional.

In updating this guidance, the CDC has cited studies that show that the less invasive nasal swab is comparable to an NP swab and that self-collection of a nasal swab is equivalent to a HC provider collected swab in symptomatic patients. It was remarked that some studies have reported reduced sensitivity with OP swabs alone.

- If both NP and OP swabs are collected, they should be combined in the same tube. Respiratory specimens such as sputum and bronchoalveolar lavage or tracheal aspirate are also acceptable.
- **For laboratory and jurisdiction-specific testing and specimen submission requirements,** please contact your local laboratory for their specific guidance documents and policies.
- **The CDC has also issued guidance for postmortem specimen collection.[c]**

Please see this link for more details on who to test and specimen collection guidance: https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html

Footnotes:

[1] Wherever testing will be done, be sure to use only synthetic fiber swabs with plastic shafts. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inhibit PCR testing.

[2]A lower respiratory specimen (sputum) can be tested from patients with a productive cough; however, i**nduction of sputum is not recommended.**

[3]Standard Precautions: includes hand hygiene and the use of personal protective equipment (i.e., laboratory coats or gowns, gloves, and eye protection). All laboratories should perform site-specific and activity-specific risk assessment to identify and mitigate risks. Routine diagnostic testing of specimens can be handled in a BSL-2 laboratory using standard precautions**[3]**. Virus isolation in cell culture and initial characterization of viral agents recovered in cultures of SARS-CoV-2 specimens are NOT recommended, except in a Biosafety Level 3 (BSL-3) laboratory using BSL-3 work practices.

Websites:

[a]FDA EUA COVID-19 Website: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations

[b]CDC Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html

[c]CDC Collection and Submission of Postmortem Specimens from Deceased Persons with Known or Suspected COVID-19, March 2020 (Interim Guidance) https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html

[d] CDC Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-biosafety-guidelines.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Flab-biosafety-guidelines.html

CDC Information for laboratories: https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html

V. Healthcare-Associated Infections: Dr. Erin Epson

California is experiencing increasing numbers of COVID-19 cases and hospitalizations, and there is an urgent need to ensure hospital capacity to be able to meet the demand for patients with COVID-19 requiring acute care. Patients hospitalized with COVID-19 can be discharged to a SNF when clinically indicated. Meeting criteria for discontinuation of transmission-based precautions is not a prerequisite for discharge from the hospital.

All California SNFs should be implementing the guidance outlined in AFL 20-25.1 Preparing for Coronavirus Disease 2019 (COVID-19) in California Skilled Nursing Facilities, including preparations to be able to safely:

- Receive residents with suspected or confirmed COVID-19 infection;
- Care for residents with suspected or confirmed COVID-19 infection; and
- Prevent spread of COVID-19 within their facility.

Considerations for Transfer of Patients from Hospitals to SNFs

SNFs should prepare to receive patients that are clinically stable for discharge from hospitals in the following scenarios:

- **Patients with no clinical concern for COVID-19** may be transferred from hospitals to SNF following usual procedures.
    - SNFs may not require a negative test result for COVID-19 as criteria for admission or readmission of residents hospitalized with no clinical concern for COVID-19.
    - Hospitals are NOT required to perform COVID-19 testing on patients solely for discharge considerations unless they develop new respiratory infection symptoms, in which case the patient is not likely to be ready for discharge.
- **Patients investigated for possible COVID-19**, with negative test results may be transferred from hospitals to SNFs following usual procedures.
    - Hospitals should conduct influenza testing as appropriate, and communicate results and any indication for continued transmission-based precautions upon transfer.
- **Patients with confirmed or suspected COVID-19** should not be sent to a SNF via hospital discharge, inter-facility transfer, or readmission after hospitalization without first consulting the local health department (LHD).
    - SNFs can be expected to accept a resident diagnosed with COVID-19 and who is still requiring transmission-based precautions for COVID-19 as long as the facility can follow Centers for Disease Control and Prevention (CDC) infection prevention and control recommendations for the care of COVID-19 patients, including adequate supplies of personal protective equipment (PPE).
        - LHD may direct placement of the patient at a facility that has already cared for COVID-19 cases, or that has a specific unit designated to care for COVID-19 residents.
    - Hospital discharge planners should provide advanced notice to the SNF for any transfer of a patient with COVID-19. If transmission-based precautions have been discontinued AND patients' symptoms have resolved, patients can be discharged back to the facility they came from, regardless of the facility's PPE supply and ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients.
- **Patients under investigation (PUI) for COVID-19, but test results pending**: At this time, PUIs should NOT be transferred to SNFs until test results are available.

Considerations for care for residents with suspected or confirmed COVID-19 infection who do not clinically require hospital transfer

SNFs should only transfer residents with suspected or confirmed COVID-19 infection to higher acuity healthcare settings when clinically indicated. Prior to transfer, SNFs must notify transport personnel and receiving facility about the suspected diagnosis. If clinically stable, residents with suspected or confirmed COVID-19 should remain at the SNF with appropriate infection prevention and control measures. SNFs should review CDPH guidance on facility preparations, and management of suspect or confirmed COVID-19 resident care outlined in AFL 20-25.1.

Last week, the National Emerging Special Pathogen Training and Education Center (NETEC) presented a webinar on extended use, reuse, and decontamination strategies for COVID-19 personal protective equipment, including decontamination and reuse of N95 respirators using a ultraviolet germicidal irradiation (UVGI) process.

On behalf of my epidemiologist colleagues, please ensure your facility is using ICD-10 codes for hospitalization and deaths, to enable tracking of these critical metrics.

VI. **Question and Answer**

Q: For the decontamination of PPE, the 3M manufacturers stated that some of these practices damage the PPE, is there any guidance to address this?
A: CDPH is anticipating CDC guidance to address this, but based on the information already provided, the process of decontamination is a last resort. It appears that respirators can go through three decontaminations until the elastic is no longer working properly.

Q: Is there enough data to address how comprehensive screening is, such as if the questions are sensitive enough to detect the virus?
A: Cases can be asymptomatic and not have any of the symptoms during screening, so it is possible that the screening may not detect a case. However, as we learn more about the virus the screening can be improved.

Q: Is there a waiver pending with regards to healthcare workers with licensing issues?
A: Yes, an executive order is being drafted that will address this.

Q: Is it acceptable to use homemade masks in a skilled nursing facility in order to preserve PPE for suspected or confirmed cases?
A: The use of PPE for resident care is ideally for anyone coming into the skilled nursing facility. In order to maximize PPE, please follow CDC guidance.

Q: Is there any recommendations on doing two screenings a day for skilled nursing facilities, as directed by some local public health departments?
A: CDPH can address this on the LHD call. This guidance may have come from earlier precautions when the directive was much more stringent.

Q: Can you review the negatives of self-collective initiatives? It seems like a good way to reduce PPE.
A: Not sure there are negatives in regard to reducing PPE. It will need to be done in the presence of a healthcare worker and the current data demonstrates that it is comparable in accuracy to healthcare collected samples.

Q: Is the application process for the CNA training course process still stringent or is it being fast-tracked?
A: CDPH is looking at all options to get CNAs fast-tracked as much as possible.