California Department of Public Health
Weekly Facility COVID-19 Update Call
July 14, 2020
8:00 am – 9:00 am

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

None provided.

II. **Overview:** **Ngoc Ly Le**

None provided.

III. **Laboratory Update:** **Dr. Deb Wadford**

COVID-19 Testing Priorities:

While the state is doing more COVID-19 testing than ever, this volume of testing has overwhelmed some testing facilities and laboratories. Some people must wait 3 to 5 days for an appointment for specimen collection. Increased testing demand and volume has put excess strain on the supply chain for test reagents and plastics thereby causing a ripple effect on test turnaround times, with the average TAT now at 5 to 7 days or longer. These delays present significant challenges in the ability to care for hospitalized individuals, for whom COVID test results inform appropriate treatment, and challenge our ability to make timely decisions to isolate those who are COVID-19 positive in order to prevent further spread of illness. To ensure that those at highest risk have access to testing with actionable turn-around-times, I'd like to review recently updated testing priorities for California. CDPH recommends first prioritizing hospitalized individuals with signs or symptoms of COVID-19 infection followed by testing of other symptomatic individuals and higher risk asymptomatic individuals (such as first responders and healthcare workers).

It is important to note that not all labs have reached their testing capacity and we have mentioned previously the lists of CLIA-certified laboratories that is maintained by the CA Testing Task Force (TTF) and CDPH Laboratory Field Services (LFS). Some larger health jurisdictions maintain a listing of laboratories that serve their jurisdictions which includes details such as a laboratory's testing capacity, pricing, and expected turnaround times. If your facility needs COVID testing, please reach out to your local health jurisdiction which may be able to help match you with a laboratory that can provide timely test results.

The link to the TTF list is provided in the call notes and is available on the landing page of TTF website. The TTF website now includes a tool where users can find a test site near them by inputting a location and a distance between 0 to 100 miles of that location. The link for this tool is provided in these notes. You may contact the CA TTF by email at testing.taskforce@state.ca.gov with questions or comments.

Laboratory Testing Updates from the FDA:

In case you missed it, last week the FDA alerted laboratories about false positive results with BD SARS-CoV-2 Reagents for the BD Max System. The manufacturer reported a false positivity rate of approximately 3%. The FDA recommends clinical laboratory staff and health care providers:

- Consider any positive result presumptive from tests using the BD SARS-CoV-2 Reagents for the BD Max System and consider confirming with an alternate authorized test.
- Report any issues with using COVID-19 tests to the FDA.

Additional information can be found in the False Positive Results with BD SARS-CoV-2 Reagents for the BD Max System - Letter to Clinical Laboratory Staff and Health Care Providers.

Select Guidance Links:

- Specimen collection: https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html
- The California COVID-19 Testing Task Force (CA TTF): https://testing.covid19.ca.gov
- CA TTF COVID-19 Laboratory list: https://testing.covid19.ca.gov/wp-content/uploads/sites/332/2020/07/COVID-19-Testing-Task-Force-Lab-List-updated-07_09_20.pdf
- CA TTF "Find a Test Site" tool: https://www.arcgis.com/apps/Nearby/index.html?appid=43118dc0d5d348d8ab20a81967a15401

IV. Healthcare-Associated Infections — Dr. Erin Epson

The HAI Program has continued to receive questions about the 14-day observation period for new admissions to skilled nursing facilities (SNF). As we've discussed during previous Q&A sessions on these calls, SNF may consider acute care hospital days as part of the observation period from the date of last potential exposure for new admissions if the following criteria are met:

- SNF is in regular communication with their local health department (LHD) and/or the hospital infection preventionist and occupational health program, and there is no suspected or confirmed COVID-19 transmission among patients or staff at the hospital
- SNF has verified (via the LHD or hospital) that the hospital is testing all patients upon admission and has designated COVID-19 unit(s) with dedicated staff and minimal cross-over

In addition, we'd like to clarify that the tests obtained in the hospital prior to and for the purpose of transferring asymptomatic patients to SNF are *ideally* resulted prior to transfer; but we recognize that given current testing resource constraints and prolonged turnaround time it is often infeasible to have results prior to transfer, and acknowledge that it is reasonable that test results for asymptomatic patients do not necessarily have to be resulted prior to SNF transfer, as these residents will be admitted to an observation area with full PPE use for COVID in the SNF. Despite these considerations, facilities should be aware that their LHD might have additional requirements. Also, hospitals do not need to place asymptomatic patients in isolation with full PPE use for COVID solely because they are being tested for the purpose of SNF discharge.

We'd also like to highlight that CDC recently released new Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2. Testing of HCP can be considered in four situations:

- Testing HCP with signs or symptoms consistent with COVID-19
- Testing asymptomatic HCP with known or suspected exposure to SARS-CoV-2
- Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 for early identification in special settings (e.g., nursing homes)
- Testing HCP who have been diagnosed with SARS-CoV-2 infection to determine when they are no longer infectious (although, CDC signaled on a recent call that they would be moving away from the test-based strategy for those with mild-moderate symptoms)

Regarding testing of asymptomatic HCP with higher risk exposures: CDC generally recommends these HCP be excluded from work for 14 days following the exposure; however, where exclusion would lead to staffing shortages, HCP with higher risk exposures may be allowed to continue to work during their 14-day post-exposure period. When testing is readily available, performing testing during the 14-day post-exposure period can be considered to more quickly identify pre-symptomatic or asymptomatic positive HCP who could then be isolated and excluded from work. As we've discussed, there's no specific recommendation on the timing or frequency of that testing, but a reasonable approach would be to initiate testing at 3 days post exposure and repeat every 3-5 days (depending on the turnaround time and test availability in your institution).

Finally, we reached out to CDC for clarifications on their interim infection control guidance for universal use of personal protective equipment (PPE) for healthcare personnel (HCP) working in facilities located in areas with moderate to substantial community transmission. CDC confirmed the recommendation for universal eye protection does apply to all healthcare settings (including hospitals, skilled nursing facilities and outpatient clinics) in areas where there's moderate to substantial community transmission, but that the eye protection is only for HCP during direct close care encounters with patients to ensure HCP eyes, nose, and mouth are all protected during patient care, i.e., it is not intended for HCP to wear eye protection throughout the facility (in hallways, etc.) as is recommended with facemask use for source control. CDC also acknowledged that eye protection might not necessarily have as much incremental protective benefit in settings where patients are reliably source controlled (e.g., an outpatient clinic where the patient wears a facemask throughout visit).

V. **Remdesivir Update** **Dr. Philip Peters**

Remdesivir Distribution Update for all Healthcare Facility Call

This is the first week that we have transitioned to the commercial distribution model for Remdesivir. California has been allocated 354 cases (or 14,160 doses) of Remdesivir. The federal government has provided California this allotment and based on feedback from county health departments and the CHA, we will continue to allocate Remdesivir by county based on number of hospitalized patients with COVID-19 infection. The county MHOACs will then determine how much Remdesivir to allocate per hospital. CDPH will send that information to Amerisource Bergen who will contact each hospital with the amount of Remdesivir that they can order. Hospitals will place their order and be billed for the Remdesivir that is ordered. We are encouraging hospitals to order all the Remdesivir that they are allocated as we have been allocated a limited amount of medication and the number of patients being hospitalized in California continues to increase. If a hospital does not want all the Remdesivir allocated, we ask that you to let your MHOAC and CDPH know as soon as possible so that medication

can be reallocated to another hospital that needs Remdesivir. If we do not do this, the medication gets put back into the national supply and can't be used in California.

The first hospital allocations for this new process were sent to CDPH last night by the MHOACs and CDPH is sending the full California hospital allocation to Amerisource Bergen today and we will also post that distribution to the web later today with a link provided in the meeting notes.

Note that hospitals must have an account with Amerisource Bergen. To set up an account, a hospital can email accountsetup@asdhealthcare.com and information on how to set-up an account will also be included in the meeting notes as an additional attachment called "Questionnaire from ABC".

One other topic to mention, the Remdesivir patient information sheets that were translated into Spanish, Arabic, Armenian, Chinese, Korean, Tagalog, and Vietnamese are now posted on the CDPH website on the guidance page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Guidance.aspx) under Remdesivir.

VI. **Question and Answer**

Q: Question pertains to mitigation plans related to sick leave policy. Should this be in our policies? How should this information be displayed?
A: Please continuing working with your county in terms of getting clarity on this issue and we (the State) can follow up on this issue. Please send me the exact issue and we can assist.

Q: I have a question about employee screening and temperature checks. Are their AFLs that clarify expectations for long-term care facilities? We have been hearing conflicting information
A: This is the second question on this topic we received this week, thus there is clearly a need for improved clarity for facilities. We will review our current guidance and provide updates.

Q: Does CDPH have a stance of people using face shields but not masks in the workplace?
A: Using face shields without face masks does not provide the same level of source control as using both. We would not recommend not using both, unless there is a severe shortage of PPE resources that prevents this from happening.

Q: Question on testing. There has been much confusion regarding what tests are being used, especially amidst antibody tests. Are there now two Antigone tests available?
A: We now have two Antigone tests. The data is not complete for Antigone tests and we recommend cross-referencing the test results against PCRs.

Q: Issue over gowns. To clarify, can cohorting new admissions on varying days be housed in the same space? Is this practice allowed?
A: We strongly encourage any facility that is experiencing a shortage of gowns to contact their MHOAC about immediate supply needs. In terms of interacting with cohorts, please follow guidance related to individuals in these new cohort areas. We caution against extended use of gowns and only under emergency situations. Always consider room placement. We generally recommend against moving around amidst different cohorting groups; however, we understand operational challenges. Once again, we encourage you to reach out to your MHOACs for supply needs

Q: Question for FQHCs. We are having trouble getting diagnostic testing materials. Do you have any other information?

A: Quest is unfortunately very backlogged. To control this backlog, they are reducing collection kits to manage the inflow of testing samples coming in. This is an issue that needs to be brought to the Testing Task Force to address this issue of lab capacity that can test this level of samples. In the meantime, we encourage you to pursue other testing options.