California Department of Public Health
Weekly Facility COVID-19 Update Call
September 22, 2020
8:00 am – 9:00 am

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

II. **Overview:** **Dr. Kathleen Jacobson**

None provided.

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

Influenza Season and co-circulation of SARS-CoV-2 – Clinical Outreach and Communication Activity (COCA) webinar held on September 17, 2020

- CDC held a COCA call last week entitled: Testing and Treatment of 2020-2021 Seasonal Influenza During the COVID-19 Pandemic– please see link below for the recorded presentation and slides. Continuing educational units are available for medical professionals. https://emergency.cdc.gov/coca/calls/2020/callinfo_091720.asp

Viral Testing – Overview from CDC updated September 18, 2020

https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

Clarifications made on September 18, 2020

Due to the significance of asymptomatic and pre-symptomatic transmission, this guidance further reinforces the need to test asymptomatic persons, including close contacts of a person with documented SARS-CoV-2 infection.

Authorized assays for viral testing include those that detect SARS-CoV-2 nucleic acid or antigen. Viral (nucleic acid or antigen) tests check samples from the respiratory system (such as nasal or oral swabs or saliva) to determine whether an infection with SARS-CoV-2, the virus that causes COVID-19, is present. Viral tests are recommended to diagnose acute infection of both symptomatic and asymptomatic individuals, to guide contact tracing treatment options, and isolation requirements Some tests are point-of-care tests, meaning results may be available at the testing site in less than an hour. Other tests must be sent to a laboratory, a process that may take at least 1-2 days.

Antigen Assays to detect SARS-CoV-2

- There are 4 SARS-CoV-2 Antigen (Ag) Assays available through FDA Emergency Use Authorization (EUA) and all 4 assays are approved as CLIA-waived tests (point of care).
- These antigen tests are lateral flow assays designed to detect the nucleocapsid of SARS-CoV-2 virus, if present, from a patient's nasal swab and can provide results in about 15 minutes.
    - All 4 tests require dry swab collection with NO transport media
    - All 4 tests recommend testing as soon as possible once the specimen is collected

Antigen tests are not as sensitive as nucleic acid amplification assays such as PCR. Thus, positive results tend to be accurate, but a negative result should be interpreted with caution, and should be considered in the context of clinical suspicion of disease and risk status of the patient.

CDC Interim guidance on use of antigen tests for SARS-CoV-2 (September 4, 2020):
https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html

Uses of antigen testing nursing homes (CDC Guidance released on September 27, 2020)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html

- Considerations for Interpreting Antigen testing at SNFs:

https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf

IV. **Healthcare-Associated Infections** **Dr. Erin Epson**

CDC's guidance on testing asymptomatic individuals and the role of airborne transmission has been changing recently; this morning I'd like to reiterate our CDPH guidance in these areas, which hasn't changed.

CDPH guidance on the role of testing asymptomatic individuals for HCP screening, and response testing of potentially exposed HCP and residents or patients in SNF (as per AFL 20-53.3) and other healthcare settings, has not changed. We do continue to receive many questions on the testing guidance in recently updated AFL 20-53.3; there are now updated flow charts linked from the AFL depicting the different categories of testing, and specifically the use of antigen testing and whether antigen results need to be confirmed with RT-PCR testing depending on the testing scenario and antigen test result.

Regarding the role of airborne transmission of SARS-CoV-2, CDPH has since the beginning of this pandemic recommended use of respiratory protection with an N95 or higher-level respirator by HCP caring for patients or residents with suspected or confirmed COVID-19; respiratory protection is also required by Cal/OSHA under the Aerosol Transmissible Diseases (ATD) standard. HCP respiratory protection is supported by current data, as cited by CDC's Infection Control FAQ, that suggest close-range aerosol transmission of SARS-CoV-2 by inhalation. Long-range (> 6ft) aerosol transmission, such as is seen with airborne transmitted viruses such as measles, is the area of controversy. CDC did signal that the updated guidance would acknowledge opportunistic airborne (long-range aerosol) SARS-CoV-2 transmission in settings with poor ventilation, but it's unclear whether, and if so, how this will impact infection control measures in healthcare settings. We continue to recommend prioritizing negative-pressure airborne isolation rooms for patients with suspected or confirmed COVID-19 who are undergoing or will likely require aerosol generating procedures, and are continuing to follow the updates to CDC, NIOSH and professional society guidance to better understand the science and what we can recommend to mitigate any potential risk for opportunistic long-range aerosol transmission in healthcare settings.

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

Regarding remdesivir distribution, we have now received our eleventh commercial distribution and for the fourth week in a row, the supply has exceeded the demand for remdesivir. We were allocated 1,500 cases and we ordered about 295 cases (or 11,804 doses) which is about 17% of what was available.

A weblink is posted on the CDPH guidance page in the "other" section with the distribution details.

Link:
https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/CaliforniaRemdesivirAllocationCommercial-9-14-20.xlsx

We have received questions about the use of remdesivir in non-hospitalized settings such as skilled nursing facilities or assisted living facilities that are capable of infusing remdesivir and can conduct the monitoring specified in the emergency use authorization (EUA). Currently, the EUA limits use to inpatients only so under the current EUA it is not authorized for use in a non-hospitalized setting. CDPH has been told that FDA is reviewing the data on the use of remdesivir in a non-hospitalized setting and will update the EUA if their guidance changes.

The only additional update is a reminder that the California Medical Association in collaboration with CDPH will be hosting a virtual grand rounds on October 13th at noon. The topic will be COVID-19 treatment and will feature an excellent speaker who will discuss cutting edge issues relevant to clinical providers. You can find more information on the CMA website and I've included a link in the notes as well: https://www.cmadocs.org/event-info/sessionaltcd/CME20_1013_GRCOVID/t/Virtual_Grand_Rounds_COVID-19_Updates_in_Theapeutics

VI. **Question and Answer**

Q: Is it appropriate to use antigen testing for surveillance for athletes?
A: Antigen testing does not specifically capture any testing for asymptomatic individuals. None of the antigens on the market have been validated for asymptomatic use. The idea with antigen testing is that if it's less specific but the idea that you get to test everyday makes up for that. I believe quidel is performing a study on athletes to release a rapid antigen testing for athletes.

Q: How do you feel about the possibility of airborne transmission?
A: CDC signals in their updated guidance they would acknowledge the possibility of what they're calling opportunistic airborne or long-range aerosol transmission. By opportunistic that referring to settings where there is poor ventilation. We'll continue to monitor data, science, and studies in order to mitigate any potential risks. Currently we have not seen any evidence of airborne transmission through an HVAC system.

Q: What is the state's plan on how to distribute the vaccine?
A: Efforts are underway to plan and process for the implementation of the vaccine. We need to do the planning for the implementation, prioritization, and operationalizing the vaccine roll out. We hope that you please answer the survey to the best of your ability, so that we can understand how many vaccines you will need and the capacity and what ways can hospitals operate like this.

Q: Can you speak on the freezing and storage of the vaccine?
A: I've heard that the moderna vaccine needs to be stored at -70 degrees and I understand that there are not a lot of those around. There have been talks that you can store it at a warmer temperature and

that it lives for 24 to 48 hours but that's all I've heard. It does add some complexity because you will start to have to calculate how many vaccines will be used in that time frame where there's no waste.

Q: I thought I heard that no copays or deductibles for surveillance testing, so I wanted to hear a comment because I'm hearing differently from insurance carrier.
A: I would urge to go to the Department of Managed Care Site, where we have FAQ on what their new emergency regulations this summer. I would recommend reviewing their FAQ site and if you are still struggling with the instructions to reach out to them and go through the regulations.

Q: Are registered dental hygienist allowed to collect the nasopharyngeal specimen?
A: No, that requires an RN, LVN, RT, EMT and recently pharmacists are the only authorized licensed professional to collect nasopharyngeal specimen collection.

Q: What is the optimal testing period?
A: In reference testing after an exposure, HCP who have a known exposure and are being tested early and serially in the incubation period. We've recommended that in that situation that the HCP could be tested serially at three days after exposure or tested every three to five days during the 14 days after their exposure. The purpose of doing this is that if they test positive that they be excluded from work earlier rather than later.

Q: Regarding communal dining and activities, I'm wondering if you have any guidance on that?
A: We will be covering that in our revision of our visitation AFL. On June 26, we did reissue a revised revision that did allow for facilities to maintain social distance. We will be revising this.

Q: I'm wondering if there's anything on the requirements that have changed on how much PPE you need to have for a certain amount of days. I've heard anything from 30 to 90 days of available PPE.
A: We can get more clarity on that for you and follow up. There are more folks who have been asking for more specifics on this.