



**California Department of Public Health
Weekly Facility COVID-19 Update Call
July 28, 2020
8:00 am – 9:00 am**

- I. **Welcome / Introduction:** **Heidi Steinecker**
- II. **Overview:** **Dr. Kathleen Jacobson**
- III. **Laboratory Update:** **Dr. Deb Wadford**

An update of the May 1st COVID-19 Testing Guidance from CDPH was released on July 23rd, link found here: <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Updated-COVID-19-Testing-Guidance.aspx>

CDPH recommends first prioritizing testing of hospitalized individuals with signs or symptoms of COVID-19 infection followed by testing of other symptomatic individuals and higher risk asymptomatic individuals and then other asymptomatic individuals when certain conditions exist. This guidance should be used for prioritization of patient populations as well as for the purposes of guiding laboratories in managing specimen processing.

Tier One Priority

- Hospitalized individuals with COVID-19 symptoms.
- Investigation and management of outbreaks, under direction of state and local public health departments (includes contact tracing).

Tier Two Priority

- All other individuals with COVID-19 symptoms.
- Close contacts of confirmed cases.
- Individuals who are asymptomatic (having no symptoms of COVID 19), who fall into one of the following categories:
 1. **Live in higher risk congregate care facilities** including skilled nursing facilities, residential care facilities for the elderly, correctional facilities, or homeless shelters.
 2. **Work in the health care sector who have frequent interactions with the public** or with people who may have COVID-19 or have been exposed to SARS-CoV-2. The health care sector including: hospitals; skilled nursing facilities; long-term care facilities; ambulatory surgery centers; health care providers' offices; health care clinics; pharmacies; blood banks; dialysis centers; hospices; and, home health providers
 3. **Work in a congregate care facility**, including shelters for people experience homelessness and residential care facilities for the elderly.
 4. **Provide care to an elderly person or a person with a disability in the home**, including a person providing care through California's In-Home Supportive Services Program.

5. **Work in the emergency services sector who have frequent interactions with the public** or with people who may have COVID-19 or have been exposed to SARS-CoV-2. The emergency services sector includes police and public safety departments, fire departments, and emergency service response operations.
6. **Work in a correctional facility.**
7. **Patients requiring pre-operative/pre-hospital admission screening.**
8. **Patients being discharged from hospitals to lower levels of care.**

Tier Three Priority

The following individuals who are asymptomatic (having no symptoms of COVID 19), and fall into one of the following categories:

- **Individuals who work in the retail or manufacturing sectors who have frequent interactions with the public or who works in an environment where it is not practical to maintain at least six feet of space from other workers on a consistent basis.**
- **Individuals who work in the food services sector who have frequent interactions with the public.** The food services sector includes grocery stores, convenience stores, restaurants, and grocery or meal delivery services.
- **Individuals who work in the agricultural or food manufacturing sector who have frequent interactions with the public or who works in an environment where it is not practical to maintain at least six feet of space from other workers on a consistent basis.** The agricultural or food manufacturing sector includes food production and processing facilities, slaughter facilities, harvesting sites or facilities, and food packing facilities.
- **Individuals who work in the public transportation sector who have frequent interactions with the public.** The public transportation sector includes public transit, passenger rail service, passenger ferry service, public airports, and commercial airlines.
- **Individuals who work in the education sector who have frequent interactions with students or the public.** The education sector includes public and private childcare establishments; public and private pre-kindergarten programs; primary and secondary schools; and public and private colleges and universities.

Tier Four Priority

Tier Four would be implemented when the state's testing turnaround time, as monitored by CDPH, is less than 48 hours.

- Other individuals not specified above including those who are asymptomatic but believe they have a risk for being actively infected as well as routine testing by employers.

Other Testing updates

Pooling

On July 23rd, the CDC issued lengthy guidelines on pooling procedures to test for SARS-CoV-2. The link to this guidance is below.

<https://www.cdc.gov/coronavirus/2019-ncov/lab/pooling-procedures.html>

The FDA has also granted EUA status to both Quest (pooling up to 4 specimens) and LabCorp for pooled testing.

<https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-issues-first-emergency-authorization-sample-pooling-diagnostic>

<https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-first-diagnostic-test-screening-people-without-known-or>

Testing of Asymptomatic Individuals

FDA has also issued the first ever EUA to LabCorp to test **asymptomatic individuals** (people who do not have COVID-19 symptoms or who have no reason to suspect COVID-19 infection). See link above.

IV. Healthcare-Associated Infections

Dr. Erin Epton

Last week, the Council of State and Territorial Epidemiologists (CSTE) posted [Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Acute Care Hospitals, Critical Access Hospitals, Long-Term Care Facilities \(LTCFs\) and Long-Term Care Acute Hospitals](#). These thresholds are intended to expedite facilities' investigation of COVID-19 cases and reporting to public health authorities, to help ensure early detection of possible outbreaks and timely intervention to prevent the virus' spread. The thresholds and outbreak definitions are based on available scientific resources and expert opinion and intended as guidance; states and localities may have their own outbreak definitions and reporting requirements, and this reporting does not replace reporting of COVID-19 as part of state and local COVID-19 surveillance.

FOR ACUTE CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS

Threshold for Additional Investigation by Facility

- ≥ 1 case of confirmed COVID-19 in a patient 7 or more days after admission for a non-COVID condition;
- ≥ 1 case of confirmed COVID-19 in Healthcare Personnel (HCP)

Threshold for Reporting to Public Health

- ≥ 2 cases of confirmed COVID-19 in a patient 7 or more days after admission for a non-COVID condition, with epi-linkage[†];
- ≥ 2 cases of confirmed COVID-19 in HCP with epi-linkage[‡]

[†]Epi-linkage among patients is defined as overlap on the same unit or ward, or having the potential to have been cared for by common HCP within a 14-day time period of each other. [‡]Epi-linkage among HCP is defined as having the potential to have been within 6 feet for 15 minutes or longer while working in the facility during the 14 days prior to prior to the onset of symptoms; for example, worked on the same unit during the same shift.

Outbreak Definition

- ≥ 2 cases of confirmed COVID-19 in a patient 7 or more days after admission for a non-COVID condition, with epi-linkage[†] ;
- ≥ 2 cases of confirmed COVID-19 in HCP with epi-linkage[‡] who do not share a household, and are not listed as a close contact of each other outside of the workplace during standard case investigation or contact tracing.

FOR LONG-TERM CARE FACILITIES (LTCF) AND LONG-TERM ACUTE CARE HOSPITALS (LTACH)

Threshold for Additional Investigation by Facility

- ≥ 1 probable[§] or confirmed COVID-19 case in a resident or HCP;
- ≥ 3 cases of acute illness compatible with COVID-19 in residents with onset within a 72h period

§ Probable case is defined as a person meeting clinical criteria AND epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19; A person meeting presumptive laboratory evidence AND either clinical criteria OR epidemiologic evidence; A person meeting vital records criteria with no confirmatory laboratory testing performed for COVID-19.

Threshold for Reporting to Public Health

- ≥ 1 probable or confirmed COVID-19 case in a resident or HCP;
- ≥ 3 cases of acute illness compatible with COVID-19 in residents with onset within a 72h period

Outbreak Definition

- ≥ 1 facility-acquired** COVID-19 case in a resident

**Facility-acquired COVID-19 infection in a long-term care resident is defined as a confirmed diagnosis 14 days or more after admission for a non-COVID condition, without an exposure during the previous 14 days to another setting where an outbreak was known or suspected to be occurring.

V. Remdesivir Update

Dr. Philip Peters

We have now received our third commercial distribution of remdesivir which was 300 cases (or 12,000 doses). This third shipment brings the total remdesivir allocated to California in the last three weeks to a little over 1,000 cases (1,014) and over 40,000 doses (40,560).

We've requested to have the full three weeks of allocations posted to our website and anticipate that should happen soon.

Now that allocations of remdesivir are weekly, the Medical Health Operational Area Coordinator (or MHOAC) for each county determines individual hospital allocations, and relays this information to the State. The State sends hospital allocations to AmerisourceBergen 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 still encouraging hospitals to order all of the remdesivir that they are allocated until the supply starts to truly exceed the number of patients with clinical indications 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 of the remdesivir allocated, there is no longer the option to reallocate to another hospital in California. Any remdesivir that a hospital declines to purchase will revert back to HHS/ASPR for reallocation.

Finally, a clinical update, the NIH revised its COVID-19 Treatment Guidelines on July 24th (link: <https://www.covid19treatmentguidelines.nih.gov/whats-new/>).

In this revision, patients hospitalized with COVID-19 who require supplemental oxygen are divided into two groups: 1. Those who require supplemental oxygen but not high-flow oxygen, noninvasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO); and 2. Those who require high-flow oxygen, noninvasive or invasive mechanical ventilation, or ECMO.

The revision contains a new recommendation for Prioritizing Limited Supplies of Remdesivir that states:

Because remdesivir supplies are limited, the Panel recommends that remdesivir be prioritized for use in hospitalized patients with COVID-19 who require supplemental oxygen but who are not on high-flow oxygen, noninvasive ventilation, mechanical ventilation, or ECMO (BI).

This recommendation was made due to the limited supply of remdesivir and the uncertainty regarding whether starting remdesivir confers clinical benefit in patients who have already progressed to need high-flow oxygen, mechanical ventilation, or ECMO

VI. **Question and Answer**

Q: Is the investigation reporting threshold applicable in outpatient setting?

A: An investigation reporting threshold is being developed for outpatient settings, dialysis, and other healthcare settings. Your LHD will have their own thresholds and prioritization strategies.

Q: Does a hospital have any options for recourse when a SNF continues to refuse COVID positive patients due to a lack of observation period? What enforcement is done?

A: CDPH will enforce all AFLs released. Sometimes a SNF may not have the most updated guidance. When provided with the most recent AFL, sometimes their practices shift.

Q: Is there any standard guidance for behavioral health facilities taking patients from a hospital's emergency department that are a PUI/potentially positive that don't meet admission requirements for psychiatric care at the hospital?

A: There is not currently a lot of guidance specific to Acute Psychiatric Hospitals. We should talk offline to address your specific concerns.

Q: Regarding outbreak investigation, if a patient is admitted for non-COVID reasons, but has a sporadic fever or atypical pneumonia, how do we factor these patients into the equation upon admission?

A: We recommend enhanced surveillance and implementing transmission-based protocols for those that test positive. If someone has a clinical syndrome compatible with COVID, even if you have one negative test result, that must be taken in context with all other aspects of clinical presentation. If you have a patient with a negative test result but compatible clinical syndrome, err on side of caution and continue to look for an alternate type of diagnosis.

Q: AFL 20-53 did not address vendors or volunteers entering a healthcare facility. We have limited entrance into building and are doing screening. There have been some various interpretations of AFL 20-53 we want to get clarification. If someone is intermittently coming to the facility, do we need to require evidence they have been tested? If for example a vendor does not have proof of testing, are they not allowed to enter the building?

A: None of our AFLs cover maintenance workers or vendors. That is up to the facility. Our AFLs only have jurisdiction over the healthcare facility. We have no legal authority to mandate test results from anyone outside of the sector. We recommend using proper PPE, requiring face masks for universal source control, and performing screening and risk assessments. AFL 20-53 also does not require hard copy proof or state you must keep a test result on hand for intermittent healthcare personnel, but you do have to report to your local district office. There are no specifics about how long you have to keep each record.

Q: Are there any recommendations for quarantining healthcare personnel that travel domestically other than monitoring their symptoms?

A: Travel within the US presents risk of exposure, but you must consider that we are still mitigating staffing shortages. For healthcare personnel that have had potential exposure through travel or in the community, the current recommendation is the same – a stringent implementation of symptom monitoring, screening, and universal source control at all times within the facility. Some facilities implement work exclusions and potentially serial testing during the incubation period following a known high-risk exposure, and this remains an option for facilities if they want to do this.

Q: I work in an outpatient healthcare setting and we are having “Sofia” testing issues. Do you have guidance? Could we use this for screening of asymptomatic patients?

A: This machine has a lower sensitivity than PCR assays, but if you do have a detection from an antigen test you can typically rely on that being a true positive. The precaution would be with a negative result because of lower sensitivity and then you may want to use a molecular test. It is contrary to use an antigen assay for asymptomatic testing.

Q: I work at UCSF Benioff Children's Hospital and we have a big construction project underway to meet a seismic requirement deadline. This deadline has not been extended, and we are extremely burdened with this in addition to COVID. We have not been able to reach our local district office at all.

A: CDPH will reach out to the Richmond District Office for your hospital.