



**California Department of Public Health
Weekly Facility COVID-19 Update Call
September 29, 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

- COVID-19 and Influenza: <https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm>.
- Similarities
 - For both COVID-19 and flu, there are several similar symptoms and 1 or more days can pass between when a person becomes infected and when he or she starts to experience symptoms.
- Differences
 - Typically, a person develops COVID-19 symptoms 5 days after being infected, but symptoms can appear as early as 2 days after infection or as late as 14 days after infection, and the time range can vary. In contrast, a person with flu may develop symptoms anywhere from 1 to 4 days after infection.
 - It's possible for people to spread the SARS-CoV-2 for about 2 days before experiencing signs or symptoms and remain contagious for at least 10 days after signs or symptoms first appeared. If someone is asymptomatic or their symptoms go away, it's possible for them to remain contagious for at least 10 days after testing positive for COVID-19.
 - Most people with flu are contagious for about 1 day before they show symptoms. Older children and adults with flu appear to be most contagious during the initial 3-4 days of their illness but many remain contagious for about 7 days. Infants and people with weakened immune systems can be contagious for even longer.

- It is possible to have flu, as well as other respiratory illnesses, and COVID-19 at the same time. It is still unclear at this time how common such co-infections are.
- Because some of the symptoms of flu and COVID-19 are similar, it may be hard to differentiate between the two based on symptoms alone, and testing may be needed to help confirm a diagnosis, especially for vulnerable and high-risk populations.

Viral Testing to distinguish SARS-CoV-2 from Influenza Virus

- Antigen tests for SARS-CoV-2 and influenza virus
 - Separate assays available for each virus (lower sensitivity in general than molecular assays).
- Molecular assays for both viruses (rapid or real-time RT-PCR) – based on nucleic acid amplification
 - Several FDA Emergency Use Authorization (EUA) assays available.
- Multiplex molecular assays that can test for both viruses in one test
 - Several EUA assays available: <https://www.cdc.gov/flu/professionals/diagnosis/table-flu-covid19-detection.html> (not a complete list).
 - FDA EUA List of Assays for COVID-19: <https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/vitro-diagnostics-euas>.

IV. Healthcare-Associated Infections:

Dr. Erin Epon

Last week, CDPH released several new AFLs, including [AFL 20-74 Coronavirus Disease 2019 \(COVID-19\) Recommendations for Personal Protective Equipment \(PPE\), Resident Placement/Movement, and Staffing in Skilled Nursing Facilities](#) and [AFL 20-75 Coronavirus Disease 2019 \(COVID-19\) Outbreak Investigation and Reporting Thresholds](#). This AFL reminds licensed health facilities of requirements to report outbreaks and unusual infectious disease occurrences to their local health department (LHD) as required under Title 17 and Licensing and Certification District Office as required under Title 22, and provides separate sets of investigation and reporting thresholds for COVID-19 in acute care hospitals and in long-term care facilities including long-term acute care 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. Reporting of outbreaks and unusual infectious disease occurrences does not replace reporting of individual COVID-19 cases as part of state and local COVID-19 surveillance nor daily reporting for upload on their behalf to the National Healthcare Safety Network (NHSN). When the reporting threshold is reached and reported, LHDs will determine if the cases constitute an outbreak.

Several weeks ago I reviewed the investigation and reporting thresholds posted by the Council for State and Territorial Epidemiologists and upon which these thresholds are based, but there are a few local adaptations for the hospital healthcare personnel thresholds in this AFL, which I'll go over now.

Acute Care 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 Local 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, where epi-linkage is defined as overlap on the same unit or ward for any duration or having the potential to have been cared for by common HCP within a 14-day time period of each other.
- ≥ 2 cases of confirmed COVID-19 in HCP with epi-linkage, where 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 the onset of symptoms or positive test (for example, worked on the same unit during the same shift), in counties with < 4 daily new cases per 100k population or $< 5\%$ test positivity based on the county positivity rate reported in the past week^[4], or
- ≥ 3 cases of confirmed COVID-19 in HCP with epi-linkage in counties with ≥ 4 daily new cases per 100k population or $\geq 5\%$ test positivity based on the county positivity rate reported in the past week.
- Facilities and LHDs should refer to the California Blueprint for a Safer Economy website for their county's daily new cases per 100k population and percent test positivity. The reason for the tiered threshold for HCP based on community transmission is to account for the greater likelihood that HCP cases in settings with substantial or widespread community transmission could be associated with community exposures and not transmission within the hospital.
- The determination of epi-linkage should generally be made irrespective of whether HCP were wearing a respirator or facemask. Although respirator or facemask use mitigates the risk of exposures, a cluster of cases meeting the investigation and reporting thresholds suggests a breach or lapse in practice (for example, HCP not using appropriate personal protective equipment while caring for a patient with unrecognized COVID-19, or HCP not physically distancing and wearing facemasks in breakrooms) that should be further investigated and reported.

V. Remdesivir Update

Dr. Philip Peters

Remdesivir Distribution and General Therapeutic Update for all Healthcare Facility Call

- Regarding remdesivir distribution, we have now received our twelfth commercial distribution. There continues to be more supply than demand both nationally and in California. For this week, we have ordered about 315 cases (or 12,610 doses) which is a similar amount as the prior two weeks.

- Next week will be the final week of directed allocation of remdesivir at which time the distribution will revert to a commercial model with Amerisource Bergen continuing to directly ship medication to hospitals based on the direct request of those hospitals.
- A weblink is posted on the CDPH guidance page in the “other” section with the distribution details.
<https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/CaliforniaRemdesivirAllocationCommercial-9.21.20.xlsx>.
- As 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.cmadoes.org/event-info/sessionaltcd/CME20_1013_GRCOVID/t/Virtual_Grand_Rounds_COVID-19_Updates_in_Theapeutics.

VI. Questions and Answers

Q: On a CDC call last week, they mentioned the recommendation of FLOW testing for high rescue groups, not everyone. However we test anyone with respiratory symptoms for COVID. In this case, can I test for COVID and not FLOW at the same time? For my second question, can we use remdesivir for patients that are not intubated?

A: One of the reason influenza testing is recommended is because you need to completely rule out Sars-COV-2. We definitely recommend testing for influenza and COVID. As for your second question, remdesivir can be used on anyone who is considered at risk and who may benefit from treatment. Patients do not need to finish the complete treatment if they are showing signs of improvement. We recommend that if your facility has had one COVID patient, that you should have at least 1 complete treatment on hand because you might see more COVID patients. Insurance should reimburse the cost of the treatment.

Q: My question is related to antigen test results and a clinician’s comfort with that. We have a lot of clinicians that are uncomfortable, especially surgeons and anesthesiologists. Say an antigen test was done two days before admission, are they supposed to be able to accept that or do we retest that person?

A: If a clinician has concerns about an antigen test, it wouldn’t be unreasonable to request a molecular test within 24 hours of the antigen test.

Q: With concerns about discharging and accepting patients from an acute care hospital. We are seeing Skilled Nursing Facilities (SNFs) in our area state that they will not take a COVID positive patient. They are saying that are requiring a negative test result before they will accept the patient back. According to CDC guidance, if the patient is 20 days or more out from the positive and if transmission based isolation is ruled to be discontinued, that the patient can be “gone out”. Also that the recommendation for repeating COVID test that are positive, it’s not recommended that you are retesting within 90 days. Is that accurate and is anyone else seeing pushback from SNFs?

A: Facilities should not be refusing to admit an individual for whom they can implement transmission based precautions. The maximum duration of the transmission based precautions using the time or

symptom based strategy is up to 20 days. However, this is for your most immune compromised individual. In general, the recommendation is for 10 days based on the time since the positive test for asymptomatic individuals or 10 days from the onset of symptoms. CDC no longer recommends and we do not recommend using a test based strategy for discontinuing of transmission based precautions. There should not be requirements for a negative test before accepting an individual.

Q: The responses that we are getting back from SNFs is that their policy is that they will not accept the COVID positive patient if they have not had a negative test result within 30 days of admission. We are left with patients that no longer require acute care level of care who could effectively and safely go to a SNF for their next level of care. The SNF is just not comfortable with accepting the patient without a negative test result.

A: Everyone has the same goal of trying to keep everyone safe. We have very specific guidelines out there does state that they need to be tested but does not need to be negative because if they are tested then they know where to cohort them appropriately. If you are still struggling after reaching out to the SNFs, I would suggest reaching out to your local CDPH district office as well as your county Public Health Office and have those local leaders reach out to the facility and work this out. We need to make sure that everyone is following guidelines. We are going to be working very closely to put together a Transfer AFL. Hopefully we will have an AFL and also a webinar about this by the end of October.

Q: There have been questions coming from SNFs regarding contradictory PCR results after a PLC antigen results. Regarding the AFL regarding testing and the algorithm that goes along with your recommendations for the use of PLC antigen in the setting of an asymptomatic individual, routine screening and response driven testing, we have had 2 instances at the SNF last week. They did proceed with confirmatory PCR testing in the same day as the antigen, which were positive, and the PCR came back negative. What is your opinion as to which test we should believe?

A: There is always going to be the possibility of false positives and I think that depends somewhat on some of the user practices. We do not recommend a confirmatory PCR test for symptomatic individuals. There are going to be individual circumstances that might merit additional investigation. It was mentioned on the CDC call yesterday that they test were several false positive test results and it turns out that the person doing the tests was doing something wrong. That person was retrained and they were able to mitigate that. We seem to put more confidence in a PCR test than an antigen but from a lab scientist perspective, it all hinges on how well the sample was collected.

Q: You said with a positive result in routine screening, it is optional to do confirmatory PCR in an area of low transmission. What do you consider low transmission?

A: I think that you can follow the transmission metrics that are a part of the blueprint to guide those considerations. I think that the algorithm is the recommended framework for addressing the situation.