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

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

All General Acute Care Hospitals and Skilled Nursing Facilities must report their data to CDPH by noon each day online.

Skilled Nursing Facilities Infection Prevention All Facility Calls will start next Thursday at noon-1 p.m.- AFL/ CAHAN (All Facilities Letter/ California Health Alert Network) will be sent out.

II. **Overview:** **Dr. Charity Dean**

None provided.

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

Utility of COVID-19 Serology Testing

COVID-19 serological assays are intended to detect antibodies against SARS-CoV-2 in blood samples. It may take at least 1 week or longer, following onset of symptoms, for antibodies against SARS-CoV-2 to be detectable. Thus, unfortunately, antibody tests for SARS-CoV-2 currently have limited clinical utility, and none are approved for diagnosing cases of COVID-19. This is true even for serologic assays that have been granted an FDA Emergency Use Authorization (EUA) status. Thus, any serologic test should be used only in conjunction with molecular methods when evaluating a suspect case of COVID-19. Healthcare Providers using FDA EUA assays are advised to read their accompanying fact sheet.

Within the past week, additional serologic assays have been granted Emergency Use Authorization status by the FDA. Several of these are high throughput enzyme immunoassays. Most detect IgG only and some also detect IgM. Potential uses for these assays include public health surveillance and research.

For more information, visit the California Testing Task Force information pages: https://testing.covid19.ca.gov/ and the FDA website: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations.

Swab specifications for COVID testing

Please check with your laboratory or testing facility to ensure that the swabs and viral transport media used to collect samples for

COVID PCR meet the sample requirements in your testing facility. The size of the swab does make a difference, so if the swab is acceptable but too large for NP collection, then OP or nasal collection should be considered. https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html.

As per the FDA (https://www.fda.gov/media/134922/download), "swab specimens for COVID testing should be collected using only swabs with a synthetic tip, such as nylon or Dacron®, and an aluminum or plastic shaft. Calcium alginate swabs are unacceptable and cotton swabs with wooden shafts are not recommended."

Result Reporting to the State

We request that all test results, both PCR and serology, as well as all positive and all negative results for SARS-CoV-2, be reported electronically. Please contact CalREDIEhelp@cdph.ca.gov for help in transmitting data.

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

1. During their weekly update call yesterday, CDC discussed plans for updating their non-test-based clinical criteria for discontinuation of isolation (including return to work for infected healthcare personnel) to be a minimum of 10 days instead of 7 days from symptoms onset (the time period must still include 72 hours afebrile without antipyretics and improving symptoms). CDC indicated this is based on evidence of culturable up to but not beyond 9 days from symptoms onset. They will continue to include the test-based strategy as an option, but it will no longer be a "preferred" strategy and will be listed after the non-test-based strategy. The new guidance should be out soon.

2. CDC updated their guidance on Decontamination and Reuse of Filtering Facepiece Respirators with just minor revisions to wording for clarity such as for individual facilities to use their discretion when determining what decontamination methods to use; Emergency Use Authorization statements; bleach decontamination, and ethylene oxide.

3. CDC released an updated COVID-19 Outpatient Dialysis Facility Preparedness Assessment Tool (Checklist) , which includes elements such as identifying an isolation room (not being used for hepatitis B surface antigen positive patient) to dialyze patients with suspected or confirmed COVID-19, or if an appropriate isolation room is unavailable, a designated dialysis station(s) at a corner or end-of-row, away from the main flow of traffic, separated by at least 6 feet from nearest patient (in all directions), to dialyze a masked symptomatic patient; and also developing plans for cohorting patients and HCP if they are dialyzing multiple patients with suspected or confirmed COVID-19 [e.g., in the same section of the unit and/or on the same shift - consider the last shift of the day].

V. **Sample Collection Supplies:** **Robin Christensen**

One of the goals of the Testing Taskforce is to improve the supply chain to ensure that California can both collect samples and evaluate results without delay. Scarce sample collection supplies have been a major barrier to increasing testing in our state. We are forecasting that we will be receiving more reliable shipments of nasopharyngeal swabs and viral transport media over the coming weeks. If your facility cannot procure sample collection supplies through the usual channels, we ask that you submit a request through your Medical Health Operational Area Coordinator (MHOAC). By leveraging the existing infrastructure of the Medical and Health Coordination Center (MHCC), the state can streamline ordering and distribution, ensure equitable availability, and track ongoing and changing demand for supplies over time.

While the state expects to significantly increase available supplies, specimen collection supplies may remain insufficient to fully address all requests at all times. When supplies fall short of demand, we will work with our partners at the regional and local levels to allocate based on the current CDPH testing prioritization guidance.

VI. **Decontamination System for PPE:** **Lt. Marvin Green**

The state of California has been working tirelessly to address PPE shortages in light of the COVID-19 pandemic.

One line of effort has been PPE decontamination. California has established an N95 respirator decontamination program with Battelle systems that is available free of cost to healthcare facilities. The process uses vaporous hydrogen peroxide to decontaminate each compatible N95 up to 20 times. It is easy for facilities to participate. You just need to sign, label, collect, and ship.

SIGN:
Each healthcare facility that would like to participate in the program must sign a service agreement with Battelle Systems. This is simply a requirement set forth by the FDA EUA, and the service is available free of cost to all healthcare facilities across the state.

LABEL:
Once the signed service agreement is received, Battelle will assign your facility a unique 3-digit identifier that personnel can use to label their N95s.
N95s that are sent for decontamination should not be visibly soiled (free of blood, cosmetics, dirt, etc.) and labeled with the 3-digit code using a permanent marker.

COLLECT:
Healthcare facilities should collect all N95s for decontamination in a single plastic bag.
Once the plastic bag is filled, tie the bag, and place it into another bag.

SHIP:
Clean the outside bag with disinfectant and place it in an appropriately labeled shipping box, along with the chain of custody form, and contact UPS for pickup.

UPS will return cleaned N95 to your facility, with a turnaround time of ~24 hours.

FAQ:
What are "compatible" N95s?

N95s that do NOT contain cellulose or cellulose components are compatible. Information regarding the cellulose content of N95s should be directed towards the manufacturer or Battelle.

Where should N95s be shipped to?

Please ship N95s to your local Battelle site. Currently, two sites are able to receive shipments, serving the Bay Area and greater Los Angeles area. More details can be found in the information packet.

My facility has already been assigned a 3-digit site code; do we still need to sign a service agreement?

Having a 3-digit site code assigned does not imply that a service agreement is in place. You may begin collecting and labeling respirators using the 3-digit code. However, please reach out to hospital administration, Battelle, or us to verify that a service agreement is in place prior to shipping the N95s for decontamination.

Do we have to pay for shipping?

No, the costs of decontamination as well as shipping are covered. Facilities only need to supply the plastic bags for collection and cardboard box for shipping.

The labeling image in the infographic shows N95s labeled with employee names. Is that required?
No. The N95 only needs to be labeled with the 3-digit site code and 2-digit location code. Any additional labeling (names, initials, departments, etc.) is entirely up to the healthcare facility.

Who can I contact for further guidance or questions about the process?

Jaskiranjeet.k.sodhi.mil@mail.mil
battlesupport@soc.caloes.ca.gov
833-998-2381

VII. **Question and Answer**

Q: Can you provide some guidance around housing students in single dorm rooms versus multiple people in dorm rooms?
A: We have six indicator workgroups on this matter, indicator one is working on pieces like congregate care settings for education. Therefore, I will relay this information on to them.

Q: There is some information going around that if you are 65 years of age or older you can get tested right now. However, I believe that the only way to get a test is to go through the public health department, and it is only for symptomatic people. Is that correct?
A: As testing becomes more available across all the counties, testing will become more available. We have been limiting testing supplies due to supplies being limited, but now we are at the point that we have enough testing supplies to expand upon that.

Q: This question is about virtual destruction of controlled substances, what is the status of whether facilities can participate in this? Is a program flex waiver required?
A: Go ahead and submit a program flex waiver to CHCQDutyOfficer@cdph.ca.gov. CHCQ will get that reviewed and back to you quickly. You can submit one application and detail each location.

Q: Is there still the provision to retain video evidence of destruction for three years for virtual destruction of controlled substances?
A: Currently, yes, but you can go ahead and write in your rationale in your program flex request of how you wish to do an alternate means of safety with it.

Q: Has CMS guidance about patient and family notification requirements for positive COVID been finalized?
A: It has not yet been finalized; however, I expect it should be released soon.

Q: For the new calls for infection prevention, do we have those calls already scheduled for next week? If so, where is that information going to be distributed?
A: These calls will most likely be scheduled last this week or early next week. And when we do have those scheduled, those will be weekly reoccurring with the same time and date. These calls will be announced in AFLs and via CAHAN.

Q: What is the decontamination system called?
A: The system is called the Battelle Critical Care Decontamination System.

Q: What is the turnaround time for decontaminating N95 masks with Battelle?
A: We can turn them around within 24 hours at the site; however, to ship them back it will likely be 2-3 days. This will vary depending on how far from the site you are.

Q: Do you expect that the skilled nursing facilities will accept the non-test-based strategy for discontinuation of transmission-based precautions and transferring hospital patients to skilled nursing facilities and not require two negative tests?
A: Although the test-based strategy for discontinuation of transition precaution is still an option, it is not necessarily going to be preferred over the non-test-based strategy. Additionally, now instead of seven days it is 10 days from symptom onset with at least 72 hours without fever and improving symptoms. The second issue you raised is regarding transferring or discharging patients from hospitals to skilled nursing facilities. To reiterate, such transfers or discharges are to be made based on the patient's clinical or medical status and readiness for discharge from the acute care setting and not necessarily based on any ongoing need for transmission-based precautions. We are recommending that hospitals that are discharging someone with COVID-19 infection to the skilled nursing facility

notify and consult with their local health department before making that discharge to ensure that the facility can implement the necessary precautions.

Q: Can you comment on the interpretation of results for antibody testing?
A: A previous infection with a different coronavirus could potentially give a positive IGG in someone that has not been infected with COVID-19. That is one of the challenges with interpreting serology. It is also possible that a person is still infectious if they are IGG positive. We just do not know enough about the antibody test currently to use those results to evaluate a patient.

Q: For the crisis guidelines that were sent out on April 20th, are these guidelines, requirements, or just a framework for hospitals to use? And are these final?
A: At this point, these are still a draft. They were meant to create framework for discussion, and we are discussing at many levels in our government.

Q: Can I get the contact information for the MHOAC to order supplies?
A: The information for the MHOAC is different for each county, so please reach out to your local public health department for that contact information.

Q: How often are we expected to test asymptomatic healthcare workers? And are we going to make positive healthcare workers wait 10 days now without any repeat testing?
A: When testing anyone, there needs to be a plan for what they are going to do with the results. At this point, we are not recommending broadly testing of all asymptomatic healthcare personnel. For the change from seven to 10 days for isolation forthcoming from CDC, we anticipate links to the literature that describes those recommendations.