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

I. **Welcome / Introduction:** **Dr. Erin Epson**

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

Improved lab turn-around time. Testing TAT as of 8/22/20 the 80% of labs had TAT < 2 days, and 57% had TAT< 1 day.

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

None provided.

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

The Healthcare-Associated Infections (HAI) Program is updating our *Recommendations for the Prevention and Control of Influenza in California Skilled Nursing Facilities (SNF) During the COVID-19 Pandemic*. This year, it is likely that SARS-CoV-2 will be co-circulating with influenza viruses and could increase the severity of illness in the presence of influenza co-infection. Key messages from this guidance include:

1. SNF must optimize all available influenza prevention interventions, including vaccination of healthcare personnel (HCP) and residents and chemoprophylaxis of residents as soon an influenza outbreak is suspected.
2. Influenza vaccine will not prevent SARS-CoV-2 infection but is expected to prevent severe disease and complications associated with co-infection with influenza and SARS-CoV-2. In one report of preliminary data from Brazil, there was a significant reduction in mortality from COVID-19 in those who received influenza vaccine.
3. Since signs and symptoms of influenza and COVID-19 are similar, facilities must be vigilant for the possibility of concurrent outbreaks and develop plans for prompt diagnostic testing of all symptomatic individuals for both influenza and SARS-CoV-2 throughout the season, and even when an outbreak with either pathogen has been confirmed.
4. Many COVID-19 prevention and control strategies will contribute to influenza prevention in SNF, including:
    a. Universal masking for source control, spatial distancing and avoidance of group gatherings both within the SNF and the outside community.
    b. Implementation of systematic surveillance including recommended screening and response testing, and prompt cohorting of residents and HCP.
    c. Rigorous implementation of all recommended infection control practices.

The HAI Program will provide an updated guidance document and webinars for SNF and local health departments during the coming weeks.

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

Regarding remdesivir distribution, we have now received our ninth commercial distribution and for the second week in a row, the supply has exceeded the demand for remdesivir. We were allocated 1,000 cases and we ordered about 515 cases (or 20,584 doses) which is about 51% of what was available.

A weblink is posted on the CDPH guidance page with the distribution details.

Link:
https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/CaliforniaRemdesivirAllocationCommercial-8.31.20.xlsx

There is a clinical update on therapeutics that I wanted to note.

A series of manuscripts were published in JAMA on September 2nd evaluating the impact of corticosteroids on COVID-19 mortality in critical illness. One of the studies was a meta-analysis from World Health Organization who pooled data from 7 trials (including the RECOVERY trial which showed the survival benefit of Dexamethasone and 6 additional trials) totaling 1703 patients (678 had been randomized to corticosteroids and 1025 to usual care or placebo). The 28-day mortality was lower in patients randomized to corticosteroids compared to usual care or placebo (~33% vs. ~41%, odds ratio 0.66). Notably, although the RECOVERY study dominated the results, the meta-analysis included studies that used dexamethasone (1282 patients), hydrocortisone (374 patients), and methylprednisolone (47 patients). “These trials and the meta-analysis have strengthened confidence, further defined the benefit, and shifted usual care of COVID-19–related ARDS to include corticosteroids.”

As a reminder the NIH treatment guidelines recommends using dexamethasone 6 mg per day for up to 10 days or until hospital discharge, whichever comes first, for the treatment of COVID-19 in hospitalized patients who are mechanically ventilated (AI) and in hospitalized patients who require supplemental oxygen but who are not mechanically ventilated (BI).

The Panel recommends against using dexamethasone for the treatment of COVID-19 in patients who do not require supplemental oxygen (AI).

If dexamethasone is not available, the Panel recommends using alternative glucocorticoids such as prednisone, methylprednisolone, or hydrocortisone (AIII).

Link to the meta-analysis:
https://jamanetwork.com/journals/jama/fullarticle/2770279

Link to the NIH treatment guidelines (immunomodulatory section):
https://www.covid19treatmentguidelines.nih.gov/immune-based-therapy/immunomodulators/

Finally, I'd like to highlight that the California Medical Association in collaboration with CDPH will be hosting a virtual grand rounds next week on September 8th at noon. The topic is Transmission, Testing and Masks: creating a culture to curb COVID-19 and will feature some excellent speakers to 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_0908_GRCOVID

VI. **Question and Answer**

Q: For SNFs, if moving to weekly testing would there be a criterion that would need to be met to make the change to weekly testing?
A: We are looking at doing weekly testing for surveillance purposes due to the CMS guidance.

Q: The inaccuracy in doing temperature checks is becoming an issue due to the heat wave and other causes. Could CDPH argue to get rid of the CDC guidance for temperature checks?
A: It is important that the temperature is one symptom of COVID, but symptoms are important to monitor as well. This is something we continue to explore.

Q: Do you have any updates regarding healthcare personnel quarantining as we move into the cold and flu season?
A: We are thinking very much about the upcoming cold and influenza season. In this context, due to overlapping signs and symptoms, testing for both COVID and influenza will be critical. A negative influenza test will not rule out a test for COVID-19.

Q: If a resident in a nursing home is having symptoms that are both flu and COVID symptoms, should we be testing for both?
A: Yes, as we move into cold and influenza season along with COVID, it is important to test those symptomatic individuals for both influenza and COVID throughout the season. Right now, facilities should we working to get influenza vaccinations for as much of their population as possible.

Q: The weekly testing of healthcare personnel will not make it any easier for streamlining this process. Cost aside, it is a huge burden to test staff weekly. Not to mention, this would also include our external partners. So, what documentation will we need to use for that kind of personnel, and will we be able to use point of care testing?
A: There is modeling that illustrates that this is the best strategy for surveillance. The use of the antigen testing for weekly surveillance testing, they are not necessarily required to do a PCR confirmatory test if they receive a negative test with the antigen test. For the documentation part of your question, this will be addressed in the AFL. It will be required that they are reported to CDPH, but the duration of time for reporting is not clear yet.

Q: Is the SNF responsible for testing lab technicians or is the lab responsible?
A: These are typically contracted staff, so the requirement is that they be tested. However, since they are not the employees of the facility, you should not be responsible for their testing.

Q: Can you clarify if employees at facilities getting tested for surveillance purposes is covered by insurance?

A: Yes, in California asymptomatic employees are covered by insurance for the costs of surveillance testing.