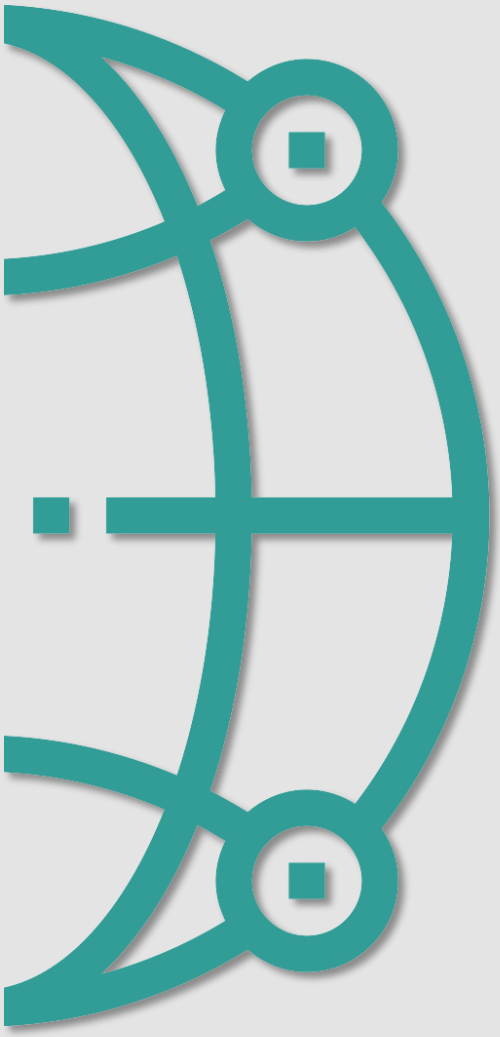
Washington State Testing Strategy for COVID-19

2020



Washington State Department of Health

May 2020

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Problem Statement

To assure the early detection of persons infected with COVID-19 in Washington State we need to substantially increase testing capacity, access, and throughput and speed. This document outlines Washington State's plan to utilize new testing supplies provided through the federal government and state procurement processes to rapidly expand these activities in order to assure equitable access to testing for all communities and populations in our state, particularly for those disproportionately impacted by COVID-19. However, the success of this plan is predicated upon receipt of testing supplies and resolution of current supply chain constraints.

Testing Guidelines for the Period of May-July 2020

1. Rapidly scale physical access to testing and the development of culturally tailored and community-specific information about molecular testing for the following priority populations (highest to lowest):
    a. Persons with COVID-19-like symptoms.
    b. Close contacts of persons with COVID-19-like symptoms (symptomatic and as testing supplies allow, those who are asymptomatic).
    c. Those in congregate settings with one or more active cases, such as nursing homes, assisted living, adult family homes, low-income housing/high risk housing, correctional settings, homeless shelters, farm worker housing, and worksites like meat-packing plants.
        a. Every effort will be made to test all residents and staff in skilled nursing facilities in the next 2 weeks. Systems will be set up to implement and continue testing of staff every 2 weeks. Testing in memory care units will be prioritized for asymptomatic testing subsequent to that.
        b. By the end of July, residents and staff of all Washington State Department of Social and Health Services owned, operated or contracted facilities will be tested.
        c. Repeat testing should be based on the epidemiology of the outbreak and determined by local health officials.
    d. Once a sustained and adequate supply of specimen collection tests are available, consider routinely scheduled testing of asymptomatic persons at high-risk due to employment or living conditions (i.e. health care workers/first responders; residents and staff in nursing homes, assisted living, adult family homes, correctional settings,

farm worker housing, worksites where physical distancing/environmental controls are not feasible.)

e. Routine screening of other populations is not recommended at this time.

f. As testing supplies and capacity allow, stand up a serial, population-based surveillance system that

considers how best to elucidate disease prevalence and activity in historically marginalized communities.

2. Rapidly scale laboratory testing capacity.
    a. By July, support the stated desire of labs in the state to move from a current capacity of 22,000 tests per day to 44,000 tests per day.
    b. Maintain ongoing discussions with labs to assess capacity, monitor turnaround times, and maintain visibility of whether capacity is being dedicated to processing out-of-state specimens
    c. Develop processes to forecast needs, procure, and track the availability of specimen collection supplies, reagents and other laboratory supplies.
    d. The Public Health Lab will contract with regional high-capacity labs to avoid exceeding the capacity of the PHL and creating backlogs.
    e. Work will continue with the Health Care Authority and the Office of the Insurance Commissioner to clarify what tests are the responsibility of insurers' vs. the responsibility of public health.
    f. Work with laboratories to develop a payment and billing mechanism for LHJs and/or the state for persons who are uninsured or underinsured when their tests are sent to a commercial lab, rather than the PHL.
3. Maximize the use of current health system resources to increase access to testing.
    a. Redirect the bulk of testing from hospital to outpatient settings.
    b. Hospitals and ambulatory surgery centers should move from blanket testing of all patients to prioritize testing for persons suspected of having COVID-19, and, for hospitals, to determine placement within the facility.
    c. Routine, blanket testing of all patients receiving care at hospitals or ambulatory surgery centers should be halted until an adequate and sustained supply of specimen collection kits is available to providers across the state.
    d. Outpatient settings that are community-preferred, including Federally Qualified Health Centers and Rural Health Centers should create same day, low-barrier access to testing for all symptomatic patients and those contacts directed to testing according to the criteria above.
    e. Community health workers and promontoras should be used to facilitate testing in historically marginalized communities.
    f. Outpatient settings should coordinate with local area hospitals and/or urgent care clinics to assure regional access to 24-hour specimen collection and analysis.

g. Outpatient or healthcare settings that perform point-of-care molecular tests for COVID-19 need to assure the results are submitted to public health authorities.

4. For persons who do not or are not able to seek regular health care, home, mobile, walk-up and drive-through specimen collection sites will be identified and or developed in areas with higher prevalence of limited English-proficient populations, communities of color, immigrant and refugee communities, low income populations, etc.
    a. Create a statewide database of community-based testing (CBT) sites that accept persons with or without insurance, including sites associated with hospitals, health systems, local governments, tribal nations, community-based organizations, and those established by private entities.
    b. Assure that information about how to access CBT sites is linguistically and culturally appropriate and is accessible to persons with disabilities.
    c. Support LHJs in providing access to testing for populations who are disproportionately affected by COVID-19 and do not have access to testing through the healthcare system or other means.
    d. Continue work to support private entities (including hospitals, private health care providers, pharmacies, community-based organizations, etc.) in standing up walk-up and/or drive-through access to testing for the public.
    e. Work in partnership with trusted community-based organizations and leaders to co-create messaging and testing strategies in ways that are most effective at reaching the community.
    f. Specimen collection using home-based methods should be based on the recommendations of a health care provider in line with guidance from regulatory authorities.
    g. Determine what subset of symptomatic or asymptomatic priority populations are best served by home testing.
5. Facilitate testing in congregate settings such as nursing homes, assisted living, adult family homes, low-income housing, correctional settings, shelters for persons living homeless, farm worker housing, and worksites like meat-packing plants.
    a. Skilled nursing facilities will have supplies on site for specimen collection for residents or staff suspected of having COVID-19 or as part of an outbreak investigation.
    b. Standing orders should be in place at all skilled nursing facilities to allow testing for COVID-19 at the onset of symptoms suggestive of infection.
    c. Establish contracts with a local or regional labs with the capability of a 24-48 hour turnaround time.

6. Coordinate and improve information flow.
    a. Information gathered by any provider, facility, testing site or private business for specimen collection will be standardized and include information regarding race/ethnicity, language, occupation, disability status, sexual orientation, gender identity, income status, and contact information. Collection and submission of this information will follow privacy and security rules.
    b. All presumptive cases and contacts should receive information on self-isolation/self-quarantine at the time of testing or when identified as a contact.
    c. All submissions to labs testing for COVID-19 should be electronic to assure accurate transfer of information and timely turnaround.
    d. All high-capacity CLIA-certified labs processing molecular tests for COVID-19 will report results electronically to submitting providers and public health entities.
    e. For tests not ordered as part of a clinical visit, pathways to transmit test results to a person's healthcare provider in addition to the PH reporting systems should be developed.
    f. Improve state visibility into turnaround times from specimen collection to the time results are received by public health authorities
7. Success will be tracked through the following dashboards:
    a. Testing supplies ordered, received, and distributed for both purchased and Federal assets.
    b. LHJ requests for specimen collection kits, their distribution, and delivery.
    c. Statewide testing rates by zip code, including social determinants of health-related variables, to better monitor inequities in testing.
    d. Capacity, turnaround time, and days of supply materials for regional labs performing high volumes of tests.
    e. Cycle time from symptom onset to contact by public health (currently being discussed.)

Current FDA Approved Test and their Uses

Type (example)	Recommended Use	Specimen type	Public Health Uses	Issues	Accuracy*
PCR (molecular) testing	CLIA moderate/high complexity health system laboratories and commercial laboratories	Nasopharyngeal Nasal swab Oral swab Bronchial	Identify presence of viral RNA suggesting active or recent infection	Supply chain for collection supplies and reagents for these instruments continues to be a challenge	Low rates of false positives, potential for false negatives
Rapid PCR (molecular) testing (Cepheid, Biofire)	CLIA moderate/high complexity health system laboratories	Nasopharyngeal Nasal swab Oral swab Bronchial	Identify presence of viral RNA suggesting active or recent infection	Collection supplies and COVID-19 test cartridges for these instruments continue to be highly limited, with smaller laboratories and hospitals unable to access.	Low rates of both false positives and false negatives
Point of Care Rapid PCR (molecular) testing (Abbott ID NOW)	CLIA-waived clinics, emergency medical services and hospitals with the primary application being testing for health care providers and first responders; areas of the state with limited or no access to health system or commercial laboratory testing	Nasopharyngeal Nasal swab Oral swab	Identify presence of viral RNA suggesting active or recent infection	HHS has supplied DOH with instruments and cartridges. Some laboratories already have the Abbott ID NOW instrument. Cartridge supplies are limited, DOH can provide cartridges to instruments when cartridges are received. Collection supplies may also be limited.	Increased concerns for false negatives

Serology testing Antibody tests	Conduct population disease surveillance	Blood draw Finger stick	Suggests past exposure to COVID-19 May be useful for population level surveillance of prevalence of past infection	Utility for serology to determine active infection may be limited; evidence is currently very limited as to strength and durability of immunity.	Concerns for false positives and false negatives
Antigen testing (Quidel Sofia Rapid Test) Rapid test	CLIA moderate/high complexity health system laboratories and commercial laboratories	Nasal swab	Test for the presence of infection	Machine is currently available in some doctors' offices	Positives are reliable; High rate of false negatives

*Accuracy is also influenced by the quality of the specimen collected and the time since symptom onset.


Washington State Department of
Health