All Physician Call with RUHS Public Health

April 30, 2020

The RCMA all physician call with Riverside County Department of Public Health was cancelled due to unforeseen circumstances. RCMA posed the following questions which were answered in writing by Public Health Officer Cameron Kaiser, M.D.

1) When and how do you suggest reopening for non-emergent outpatient care? We remain closed to all but telehealth and emergent cases. Thank you!

   There is no specific guidance from us or the state. If you are able to maintain appropriate social distancing and precautions, assuming that any of your patients may have the disease, then there is no specific restriction on opening. Nothing says that you couldn't do a phased-in approach either where you have a limited number of routine in-person visits in addition to urgents/same days and then fill in the rest with telemedicine.

2) What guidelines will be available for opening up ambulatory care in regards to patient and physician office protection? Do we assume all patients are COVID positive and PPEs for all or?. It would be very helpful if there were uniform guidelines for both medical offices as well as hospitals.

   Regardless of what happens with face coverings as a mandate (at any level), they will almost certainly be a recommendation. Many offices are requiring patients cover their faces and staff use at minimum surgical masks. Providers may also wish to consider staggered appointments and reducing overbook percentages to make sure waiting rooms aren't filled, block off seats, do more frequent cleaning of high-touch surfaces and reserve particular exam rooms for symptomatic patients. There is no all-or-nothing necessary to dealing with scheduling; as in the question above a phased-in approach may actually be advantageous to many offices. Providers may wish to also consider symptom screens at entry and at scheduling, and to limit walk-ins to certain hours, so that unscreened patients are less likely to mix with screened ones.

3) Are there new updates or guidelines as to which patients we can start to seeing in person. Often times as physician we user our judgement, for example treating Otitis media on Telehealth, but some patients call insurance directly and they are instructed to go in person to their own clinics thereby redirecting patients away from their PCP. Mixed message are causing massive confusion.

   The highest risk patients would be those with respiratory symptoms, but given that any patient could potentially have COVID-19, there is no way to reduce the risk completely. I think physician judgment is clearly the best option when you have it. While we have been trying to message that people call ahead, and we continue to do so, it is unfortunate the insurers are not echoing the message as well.

4) For patients going to the hospital during this Pandemic period and then follow up with PCP, it has been very difficult to obtain records from hospitals in absence of physical HIPPA signature release from the patient. Can hospitals be instructed to relax their HIPPA rules regarding that?

Unfortunately, probably not. While the federal government has relaxed some documentary requirements of HIPAA, they have not shown any motion on changing rules on clinical documentation access itself. We can try to advocate for it with our congressional delegation but I do not expect there will be much change.

5) HCW, essential workers, first-line responders requiring clearance to go back to work. The newly updated documents are still not clear. What does "modified non-testing criteria" and "re-testing is not generally recommended" mean? What if the employer insists on two negative tests before patient can go back to work despite Riv. Co. PH guidelines?

It is not clear if it is even legal to demand a negative test before returning to work, though we are aware of many employers (even non-HCWs) who are demanding at least one and sometimes two. We have been trying to accommodate these people in our testing units to the extent we have the resources. The CDC has recently changed their guidance for non-test clearance of ambulatory individuals to 10 days since symptom onset and 72 hours since resolution of fever (without antipyretics) and improvement in respiratory symptoms. The local modification we use is 10 days since test date, since this gives us wiggle room and also covers asymptomatic individuals. At some point retesting will be a concept primarily for disease-naïve individuals in whom we are trying to see if they have contracted it, but for those recovering we don't generally recommend testing again because of the amount of junk RNA they'll shed. If they must be tested again, doing so after they have met clinical criteria for clearance first seems more considerate of testing capacity.

6) Which antibody test for COVID-19 is most accurate and is it readily available?

Rather than give an immediately inaccurate answer given the gold rush of antibody testing and the constantly changing landscape, I'll just mention a few things about it and requirements for performing it. Please bear in mind above all else that herd immunity to SARS-CoV-2 is at best speculative. No one knows to what level people ordinarily produce antibodies, nor to what level they function or how long. Similarly, the sensitivity for most assays may not become optimal for many days; for some it may be as long as 10, substantially longer than RT-PCR assays. If someone gets a positive antibody result (especially IgM, but even IgG or IgA), we may require them to also have a PCR assay so that their potential communicability can be assessed.

If you choose to offer antibody testing, you must make sure you have a CLIA certificate of sufficient complexity. If the test you select does not have an FDA emergency use authorization (EUA) – and be warned many do not! -- then you must have a high complexity CLIA certificate to use that test. As of this writing, no test, even those that have FDA EUA, may be done with a simple CLIA waiver. Additionally, per emergency amendments to CCR 2500 and my own local order, you must report not only the positive results (using a CMR as always) but also a total denominator through Manifest MedEx so that we can accurately assess county testing capacity. Vikram Kumar, MD, is

the RUHS CHIO responsible for tallying this data; contact v.kumar@ruhealth.org for info.

The FDA lists all tests that have EUA on their website:

https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations

Each test has documents associated with it and these contain the performance characteristics of the test. As I mentioned, be particularly mindful of how long it takes the test to achieve maximum sensitivity, and if you are trying to do an unofficial prevalence assessment of your patients or community, watch out for selection bias and false positivity rates. The type of CLIA certificate required ("H", "M" for high and medium respectively) are also shown. If a waiver-authorized assay is available, it would appear tagged with "W".

7) If a surgical patient, such as an acute displaced ankle fracture tests positive for COVID-19, but asymptomatic now and thinks might have been exposed and had mild case 4 weeks ago, is it best to delay surgery for 10-14 days or would you require a repeat negative COVID-19 test

Emergent and highly urgent surgeries should not be delayed, even if the patient actually is positive, but surgery on a known case may require the use of additional PPE in the OR suite (such as an N95), the suite in question may need to be distant from other operating theatres and the suite should be cleaned thoroughly. If the surgery is important but still elective, testing and acting on that test may be prudent (including delaying while the results are pending). Note that this particular person would probably meet non-test criteria already, even our stricter local standards, so the decision to test them additionally wouldn't be mandated by us (you are of course free to do so).

8) Nursing home patients diagnosed with COVID-19:
   a. When can isolation be discontinued? CDPH recommends two weeks isolation from onset of symptoms and no fever for > 72 hrs. Based on disease course, some pts might need to be isolated a total of 3-4 weeks total depending on if you count two weeks from onset of low grade fever vs onset of respiratory symptoms. Some pts exhibit no severe symptoms until after several weeks of initial onset of fever and are even hospitalized at 2 weeks from onset of symptoms.

   b. As for the test-based isolation protocol, pts have been testing positive for many many days after the two week isolation period. However, testing positive doesn't mean one actually carries live virus and should be regarded as unknown. Given that some pts are asymptomatic and some might display respiratory symptoms a week or two after they first have a low grade fever, what is the most prudent time based isolation protocol?

Part of this question actually boils down to what constitutes a fever for the purposes of clearance, and I haven't seen anything to suggest anything lower than the standard 100.4 F is prudent even in vulnerable populations. However, in patients with significant pulmonary disease to begin with, it may not be possible to confidently clear them without a test-based strategy due to their baseline symptoms. It should also be pointed out that in a high-burden locale such as a nursing home with an outbreak, multiple exposures could lengthen the apparent

incubation time considerably. I have not seen anything currently to suggest that the two weeks should be extended for every patient, but I certainly concur with proceeding cautiously in this population.

9) As the eventual stay at home order becomes phased out and various businesses etc opening, what would be the plan for asymptomatic COVID positive patients with and without serology results? Can these individuals be allowed to circulate in the community?

Without a clear understanding of what serology actually means even in the short term, I don't think it changes a great deal. If we detect a patient with a positive PCR, they would be required to isolate, even if asymptomatic, at least for the 10 minimum days since test date (assuming they stay that way).

10) Do you expect the 125-bed temporary hospital in Indio to be used soon based on the current trend COVID-19 cases here in Riverside County? And if so, when?

While we still have plans in place to activate it if necessary, the current situation does not seem to indicate either of the half federal medical stations will be activated in the near term. The larger question is whether they may be needed in the fall and winter, and if so, whether they should stay or be shipped back. We have some input on this but it is ultimately an HHS asset.

11) We have a pharmacy in our building and over the last two weeks, two service employees and one pharmacist tested positive, yet the remaining employees did not self-quarantine after the first employee was diagnosed positive for covid-19. Two reports were made to the Riverside County Health Dept. Yet pharmacy remained open with exposed non-symptomatic employees still filling prescriptions and working. My question: Can our local County Health Dept override the CDC recommendations of employees exposed to a known covid-19 diagnosed person to self-quarantine?

I believe this was a question from an earlier session, but I'll still answer it generally: under the Governor's Executive Order, health care workers (these people would qualify) may continue to work while asymptomatic. Locally we additionally require a mask, but we cannot prevent them from working as long as they are not ill.

12) Do we have any Covid-19 obstetrics cases? If so, what was the outcome? Can County help our physicians to get tested?

I am not aware of any obstetric cases, though it is possible for that to have occurred after the county evaluated the case, of course. If there were an exposure related to an OB case that was COVID-19 positive, physicians (and in particular those involved in the patient's care) would of course be very high priority.

13) Can we get an update on unemployment in Riverside County and actions to address that?

This is better posed to the Supervisors' offices, but it is believed that unemployment in Riverside County is at least as severe as anywhere else. Although our logistics-based economy has enabled some sectors to weather this better than others, it is likely that

the level of unemployment here and in the IE is substantial. This is almost certainly to be addressed in whatever guidance the Board-level economics impact committee determines, as well as through expanded aid and assistance through DPSS and related programs as state and federal funding permit.

14) As the Apple-Google Tracing API is released formally next week or so, will RivCoPH
    a. Develop an app;
    b. If they do will they be the code issuing coordinating authority for the opt-in by individuals etc ? or
    c. Delegate this Condition of Participation to another competent authority eg CDPH

It would be determined by the level of infrastructure necessary to support the app and its component API. Depending on the complexity and the staffing requirements to serve it, it's possible we may delegate this to CDPH, and then CDPH would make the usual pushdown reports to individual counties through the existing notification systems. However, I'm just speculating, as we have not received any formal description of the ask of us from either company or other interested parties.