**VDH Partner Call, 10:00, 28 Aug 2020:**

* Case Count Update: Suzi Silverstein:
	+ Cases: 117,592; Hospitalizations: 9,460; Deaths: 2,550
* Nursing Home Infection Control Survey update: Kim
	+ Infection control and emergency preparedness – two separate regulations
	+ Emergency Preparedness regulations:
		- Emergency plan has to be reviewed and updated annually
		- All Hazards approach and community-based risk assessments
		- Continuity of Operations
		- Evacuation and Shelter in place plans
		- Emergency Lighting and power
		- Fires, Floods, water issues, etc.
		- Requirement to work with local emergency preparedness coordinators in planning effort
		- Training on emergency procedures for staff
		- Full-scale or table top, community based exercises required annually
		- A real world emergency or disaster can be used to meet annual requirements for exercise
		- Emergency and standby power systems, generators and fuel
		- The emergency preparedness plan regulations does not specifically address a requirement for a respiratory plan – cannot hold them to specific requirements or make specific recommendations
* Testing Update: Dr. Parham Jaberi:
	+ Slides available at <https://www.vdh.virginia.gov/emergency-preparedness/emergency-preparedness/covid-19-information/>
	+ Testing encounters and number of cases has decreased the past couple of weeks
	+ Percent positivity has stayed very steady statewide
	+ 7-Day testing average about 13,072 per day, but decreasing in recent days – due to turnover of testing team members
	+ Will still meet August testing goals
	+ New testing teams coming on board in September
	+ VDH Testing efforts focused on:
		- Community Testing Vulnerable Populations
		- Congregate Settings Point Prevalence Surveys
		- Outbreak Testing Long term care facilities, places of employment/schools, etc.
	+ Increasing testing capacity:
		- Continue Private Contracts/Turnkey Vendors
		- Partnership with Retail Pharmacies
		- “One Lab” Model
		- Multi state Compact Agreement
		- Partnerships with Federally Qualified Health Centers, Free Clinics, Retail Pharmacies, Primary Care Providers, etc.
		- Virginia National Guard – returning September 2020 (4 testing teams)
	+ Each LHD has been provided a target number for testing based on number of cases and presumed contacts (Cases x 8)
	+ Point Prevalence Survey – Testing of all people working or residing in a facility, including asymptomatic individuals in those facilities
		- Baseline testing for Long Term Care Facilities (one baseline event per facility)
		- Outbreak testing (as often as needed to control outbreaks
	+ Testing Turnaround Times (TATs) – continues to improve:
		- 0.7 Days for Hospitals
		- 2.1 Days for Public Health (DCLS) laboratory testing
		- 2.3 Days for Commercial laboratories
	+ Mulistate Compact Agreement (Non-PCR based antigen testing)
		- Working with other States to develop a contract and purchase large numbers of antigen tests
		- Purpose is to increase buy power and to prime the pump to increase the overall production of testing systems
	+ Next Steps:
		- Continue collaboration with the Governor’s Testing Advisory Council (e.g. determine alternate testing strategies antigen, saliva testing, etc.), testing priorities, community messaging, and information dissemination of new technologies
		- Implement One Lab Model
		- VDH Central Office to Hire Regional Strike Teams that will respond to “hot spots”/serve as surge support across the state.
			* Positions have been advertised but having difficulty filling with qualified applicants
		- Local Health Districts have received some funding to hire additional personnel locally
		- Preparing for school and university outbreaks
	+ Testing remains a cornerstone strategy to our containment efforts. Symptomatic patient testing still has a higher priority than asymptomatic testing, but in the context of contact tracing and outbreak response, testing of asymptomatic testing is still an important tool.
* Antigen Testing Considerations – Dr. Shaina Bernard
	+ Slides available at <https://www.vdh.virginia.gov/emergency-preparedness/emergency-preparedness/covid-19-information/>
	+ Interpreting antigen test results – need to consider:
		- Clinical and epidemiological context of the person who has been tested
			* Why was the test performed?
				+ Diagnostic Testing (symptomatic or known exposure)
				+ Screening Testing (in congregate settings – LTCFs, Correctional, Education, etc.)
				+ Surveillance (To monitor for a community or population wide level of infection – testing of random individuals in a population – results would not be treated like diagnostic results – de-identified data)
		- Performance characteristics of the test (e.g. sensitivity, specificity)
			* What test was performed?
			* Molecular vs Antigen testing:
				+ Molecular tests test for RNA, Antigen tests test for antigens (proteins from the virus)
				+ Molecular tests usually need to be tested in a lab with a 1-2 day turnaround time; Antigen tests take about 15 minutes
				+ Molecular tests are generally more expensive than antigen tests
				+ Both tests have high specificity (low false positive rate), but Molecular tests have higher sensitivity (lower false negative rate) compared to antigen testing
		- Prevalence of COVID-19 in that particular community
			* What is the positivity rate over the previous 7–10 days?
	+ Interpreting Antigen Results:
		- Symptomatic OR Asymptomatic Close Contact:
			* Antigen Positive result: Indicates Current infection
			* Antigen Negative results: Do not rule out infections
* Emergency Preparedness Updates – Suzi Silverstein
	+ Table Top in a Box exercises – available for education institutions (K-12, Higher Ed and residential) to use to assess their COVID-19 response plans. Exercises are designed to be ready to use.
	+ Training resources also available at the same webpage <https://www.vdh.virginia.gov/emergency-preparedness/emergency-preparedness> and select Training from the menu on the left.
	+ Vaccination updates – will be provided on the next call on Sept 11. Budget was submitted for approval this week