VDH COVID Partner Call

Friday, April 9, 2021

- **Introduction: Suzi Silverstein, VDH Office of Emergency Preparedness**
    - https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/
    - Our case count, 632,625 cases, and we're at 10,451 deaths reported so far. We have given over 4.5 million doses of vaccine so far, 34.9% have received one dose and 19.7% are fully vaccinated. We have a very full agenda for today.
    - We're going to begin with our vaccine updates. We have two presenters and then we're going to open it up to Q&A for them, because they have to get off for a 10:30 call. And then we will move on for three additional presentations.

- **Monoclonal Antibodies & Medically Fragile/Homebound Community Outreach-Chris G, Professor of Emergency Medicine, University of Virginia:**
    - I do have two topics to present back to back. They're a little bit unrelated, but we'll run through those together. So, since my time began at VDH about a year ago, I became involved in the novel therapeutics for COVID-19. And as many of you know, monoclonal antibodies are a therapy that have been given emergency use authorization for high-risk individuals who are not yet admitted to the hospital but have tested positive for COVID-19.
    - The federal government has supported the purchase and distribution of these antibody therapies since roughly December. And so, each state agency, VDH, of course, included, needed to set up a program to get these out to our Virginia residents. So, in a nutshell, monoclonal antibodies actually prevent the replication of the virus and prevent the severity of illness from increasing in patients who have been infected in the early stages of Coronavirus infection.
    - So, a EUA was granted for any patient who has high-risk criteria, who test positive within the first ten days of symptoms onset. And this high-risk criteria is actually very broad. If you are following along at home with the slides, you'll see that in adult patients, anyone who is obese or over age 65, has cardiovascular disease, diabetes, or other common medical illness actually qualify for this drug. And so, we've been working with Dr. Jaberi at the health department to create the opportunity to get this out to people in Virginia. The treatment effect of this drug is if you treat one of these high-risk individuals early on in the disease, it will decrease their need for admission by up to 70%. So this helps not only the patient, but it helps our health care system.
    - As you know, in various surges that we've had, including the winter surge, hospital utilization, hospital capacity had been major concerns that we've had to consider, and this is truly the one intervention that's very direct, that fits the medical model, that we can apply to patients and help that hospital capacity. As I mentioned, the cost is covered, actually, by the federal government.
    - There are minimal administrative fees that are charged, and these are not charged to the patients directly. So, just to get you an idea of where we are now. We have worked with all of our health systems in the commonwealth. Almost all of them have been

participating well, and we actually have 66 unique facilities that are either hospital-based or health system associated, a couple of independent infusion centers along the way. We've been able to deliver just under 13,000 courses of therapy over the last few months, and we've seen some novel problem-solving and some great outreach efforts to patients in all of the areas where these operations are occurring.

- So, our program goal had been to maximize utilization of drugs and to ensure access across the commonwealth. There's a map in the slide deck that shows that we're basically in every region of the state at this point and that patients have the opportunity to receive these drugs. We are currently working on optimization, working on removing barriers and trying to reach the other underserved populations right now.
- So working with Dr. Jaberi, folks at VDH, to continue with educational efforts, continue with outreach. And we are still onboarding new sites, if there are those that are interested. So, why am I talking about this now that the winter surge is over? Because there are projections that we could have another bump here in the summer, particularly with the variants.
- We have to think about therapeutics as a way to treat public health. So, you'll see there is a projection in the slide deck that if the variants really take off, we could be dealing with another surge that's not quite as bad as what we saw in the winter but significant and greater than earlier surges. So, these drugs are effective versus almost all variants, including the UK variant. So, we are working on education to increase utilization. So that was part one of the presentation. And part two, I'd just like to give an overview of our approach through the unified command to vaccinate the medically fragile and homebound residents of Virginia. I'm working with VDH, but we've been reaching out to several state agencies.
- We've had help from VDEM, we've had help from DARS, from DHH, DSS, and many others, including private agencies like Meals on Wheels. And what we're looking at here is the vaccination program is up and running, right? We are able to reach people. We've gotten our 1A and 1B individuals and people who are highly motivated and mobile, who can get to a vaccination site or a hospital.
- Now we're thinking about how do we get to those hard-to-reach places? And the analogy I like to use is, you know, in the beginning of oil drilling, in 1859, we had the first oil well in Titusville, Pennsylvania. That well started the oil industry in the U.S. and the world. It was 69 feet deep, all right? This was easy-to-get oil. Where we are now, much like in oil, is we're trying to reach harder-to-reach patients. This is more like deep sea drilling. By comparison to 69 feet, by the time we came along in 2010 and had the deep oil horizon well, that was 35,000 feet deep, 50 miles offshore, under 4,000 feet of water. So, I use this comparison because we're trying to get to people who can't get to us.
- We're trying to get to people who maybe can't even communicate with us. So this is the challenge, and it's going to take a little more time and a lot more coordination. So, our problem statement here was really to get access for these homebound, medically fragile and medically complex Virginians.
- We have coordinated with, as I said, many state agencies. And what we've done just over the last three to four weeks is worked to identify who these people are, how we can get to them, but also, what are the resources that we can leverage to get to these patients. It turns out that the DMAS population is probably our core group. In Virginia right now, we have 1.1 million patients who are DMAS or Medicaid beneficiaries. But out of that group, 233,000 are in programs for significantly disabled or disadvantaged people who in

other circumstances would actually be in skilled nursing facilities, but they are at home. So that 233,000 is really our target group. And within that, it turns out that there are only actually a small number, a little bit less than 2,000 patients, who are truly homebound. Most of the others can actually, with assistance and coordination, get to a vaccination site. So, we have two prongs to our approach. We have the truly homebound and then the folks who can actually get to a site.

- We've been working with DMAS very closely and other agencies to use a network of care coordinators, where we will reach out to patients who are familiar to them and who have relationships, see if they still need to have a vaccine scheduled, schedule that vaccine, and then arrange transportation. In the case where they cannot actually leave the home, we are using another one of our great assets, which is the local health districts. The local health districts have been setting up mechanisms over the last couple of months, independently, to get to homebound patients. And what we're now doing is feeding that system.
- We're getting lists of patients with names, addresses, phone numbers to them, and the local health district staff are actually either getting in a car, taking a dose out to the home, or what's very exciting, partnering with local fire and EMS groups to get out into the community.
- So, this is ramping up. We've seen 100% increase in the vaccination rate of these homebound patients over the last two weeks, but we still have a lot of way to go. This group was very far behind when we started. Only 7% of the homebound patients had received vaccination, and so, we're now up to 17%, but we're really picking up speed and we hope to accomplish the majority of the homebound vaccinations within the next three to four weeks. So, we hope to have a great impact here and get to this vulnerable population.

- **Vaccination Update, Bob Mauskapf, VDH Office of Emergency Preparedness**

  - This week, the big news is that the Johnson & Johnson, the one-dose vaccine, we were expecting a very large bolus of that vaccine. We only will be receiving 10% of that projection next week. This really impacts our ability in other initiatives that we've been undertaking. One of them is with the Institutes of Higher Education, trying to get the students as well as the faculty vaccinated before break so they don't go out into the communities and become spreaders. So trying to get that as much as possible. The other one is an initiative that we've been working on, is mobile vaccination.
  - We've been going through vendors, trying to identify vendors that can go out into the communities, in partnership with the local health districts, and vaccinating folks that might not be able to get to the vaccination centers, perhaps because of distance or some other issue. But we see that as a necessary move, and we are working on that contract. We developed operations to do that.
  - The equity lens I think is moving quite, quite well. As we've stated before, the vest has hired Elite and Green Street to help with the outreach, and that seems to be working well with them. We expand that outreach into rural communities. That's happening right now. The medical reserve corps now is at 36,000. Remember it was 9,000 when COVID was first recognized. We have over 3,000 MRC vaccinators actually in place, trained and checked, doing skills tests already, and they're ready to go. Suzi will post the link to the Virginia volunteer vaccination registry. That's the registry created as a result of general

assembly initiative this year, which is already in place. We've got a website and we've already, in fact, brought aboard 82, as of today, volunteer vaccinators, and they are given the choice in the website to go either to MRC or to VVVR https://www.vdh.virginia.gov/covid-19-community-vaccinator/

- This initiative was done for folks that didn't want to go through all of the wickets of becoming an MRC vaccinator. It also expanded the eligibility to those who have not had licenses for up to 20 years. The requirement for background checks has not been required in the VVVR, and that's happening. And as I said, we've already got about 82 folks on that and we'll do a public information push on that probably next week and see where that's garnered. Most of the health districts have already finished 1A and 1B, as Chris said. We're into 1C.
- We expect to be into phase two by the 18th of April. A fifth community vaccination center -- these vaccination centers are federally funded. They're state-managed, and they are vendor-operated. And the fifth one opened this week in Suffolk. So, they seem to be going along well. In some cases, the uptake hasn't been as much as we had expected, but we are, through the outreach, we are going out and bringing folks in to get their vaccinations through the CVC.
- We also have the Federal Safe site in Norfolk at Military Circle, and that safe site is working in the communities in and around Southampton Rhodes. They are also looking at a hub-and-spoke methodology that they will be doing some outreach beyond their vaccination center, which is at the Macy's in Military Circle.

- **Lizzie Gasteiger, CDC Cleaning and Disinfection Guidance**

  - I'm a COVID-19 guidance writer with the health communication. And today I'll be providing an overview of CDC's updated guidance on cleaning and disinfection. So, first I'm going to differentiate between cleaning and disinfection.
  - Cleaning physically removes but does not kill microorganisms like viruses and bacteria. It is accomplished using water and soap or detergent. Disinfection, on the other hand, actually inactivates or kills microorganisms.
  - EPA maintains a list of disinfectants, what they call List-N that are effective at inactivating or killing the source of the CoV-2 virus. There was a brief that emphasized the risk of spreading the SARS-CoV-2 virus through contact with contaminated surfaces is generally low in indoor community settings. Most of the time, cleaning surfaces with soap or detergent, not disinfectant, is enough to lower the risk of spreading SARS-CoV-2 through contaminated surfaces.
  - Disinfection is recommended in indoor community settings when someone with confirmed or suspected COVID-19 was in the space in the past 24 hours. Other important prevention measures include washing hands often and wearing masks consistently and correctly. So, based on this science brief, CDC updated guidance on cleaning and disinfection in homes and community facilities, and it's important to note that the updates do not apply to health care settings or facilities where specific regulations or practices for cleaning and disinfection may apply, such as food and agriculture production or processing workplace settings, manufacturing workplace settings, or food preparation and food service areas.
  - So, for homes and community facilities, CDC had previously recommended that they regularly clean using soap and water and then disinfected. Revised guidance now

recommends regular cleaning in homes and once daily cleaning in community facilities if no one is sick or diagnosed with COVID-19. The routine disinfection is no longer recommended. Some facility operators may decide to clean more frequently or disinfect the space in certain circumstances.

- These circumstances could include significant spread of COVID-19 in the area, low use of masks or handwashing or if the facility serves individuals at higher risk of severe illness from COVID-19. CDC's guidance for cleaning and disinfection when someone is sick or diagnosed with COVID-19 has also changed. Previously, the facility guidance recommended closing off the areas used by the person who's sick and waiting 24 hours to clean and disinfect those spaces. If waiting 24 hours is not feasible, they had said wait as long as possible. And if more than seven days had passed since the person who was sick occupied the space, additional cleaning and disinfection were not necessary outside of routine cleaning and disinfection.
- And CDC now recommends that when a person who is sick or diagnosed with COVID-19 had been in a home or facility, you should close off the areas they occupied and wait as long as possible, or at least several hours to clean and disinfect. If less than 24 hours have passed, the space should be cleaned and then disinfected. If more than 24 hours have passed, the space should be cleaned but does not need to be disinfected. In this situation, though, some facility operators may still decide to disinfect the space, given the circumstances I provided earlier.
- And finally, if more than three days have passed since the person who was sick or diagnosed with COVID-19 was in the space, no additional cleaning is necessary outside of routine cleaning. For high-touch outdoor surfaces, made of metal or plastic, such as playgrounds or railings, CDC recommends regular cleaning, disinfection of these surfaces is no longer recommended. So again, the recent updates to CDC's cleaning and disinfection guidance in homes and facilities now recommend that regular cleaning is sufficient in most cases to prevent the spread of COVID-19 through contact with surfaces in indoor settings.
- You may still decide to clean more frequently or disinfect based on certain conditions in your facility. If a person who is sick or diagnosed with COVID-19 has been in the space in the past 24 hours, you should clean and disinfect.

- **<u>Ambassador Program, Kelly Vance</u>**

  - We've been working with VDH for the past year to lead a comprehensive statewide media effort to inform the public and inspire behavior change. One of the biggest communications challenges throughout the pandemic has been misinformation. So, whether it's been about wearing masks or getting your vaccine, misinformation campaigns are designed to fuel sentiments of distrust amongst Virginia's most disproportionately impacted communities. Some of this can be countered through mass advertising, but trust is built on relationships, so we built a platform to make it easy for anyone to champion the message. I'd like to introduce you to our Director of Strategic Innovation on this project.
  - If you spent any time on the COVID Communications Hub, which I suspect some of you have not, but it's an internal platform to help kind of motivate our own folks to help champion the message. But Brandon built that as well. He has also built similar programs

for the likes of Red Bull, Adidas, "The New York Times", and many others. I'll turn it over to him now to share the vision for this project and how you can help.

- Thank you, everyone, for letting us give a little spotlight on the Community Ambassador program. I'm really excited to tell you about it. So, ambassador programs, as Kelly mentioned, they're used as part of the communications and outreach mix to bring a level of authenticity, relevance, and trust, that we don't generally assign to maybe an advertisement that we see on TV or when we're scrolling through social networks. When we see a peer share a message, it lands with us a little bit differently, and so, that's part of what we're doing here, is that it's about peer-to-peer and person-to-person.
- So, in the case of COVID-19 vaccination in Virginia, we're helping reach people who might otherwise miss out on important and accurate information, or they're not sure what to trust, but they might trust that friend, family member, pastor, or someone closer to them. So, we help also address misinformation and disinformation, as Kelly noted. The World Health Organization and CDC listed this as the first true infodemic, as we've all spent more time at home and online.
- So, I want to tell you a little bit about what our ambassadors are up to. We have over 3,500 ambassadors across Virginia, and they're sharing trusted information with friends, family, neighbors, workplaces, faith communities, volunteer groups, leadership organizations, and so many more.
- When we zoom in, this is where we see the power, because this is foster parent networks, this is pastor groups, public library networks, homeowner associations, businesses with thousands of people signed up to their newsletters, and food banks. It's also important to note that ambassadors, they can be connected to two people or thousands. It doesn't matter.
- This is about anyone in Virginia who wants to sign up to help keep the people around them safe. And I would encourage all of you, if you would like to join us at www.COVIDcommunityambassadors.com
- And there you can learn more about the program. Again, that's www.COVIDcommunityambassadors.com. As soon as you land on the page, you can see a sign-up form where you'll be placed in our newsletter. But the website will also show the five actions anyone can take right now to support. You'll also see a virtual library and classroom to hear from the likes of Dr. Fauci and local experts. We have featured content for pressing topics, like who's included in Phase 1C, to an overview of vaccine safety, how was it created, vaccine rollout, and so many other resources. That's everything I have. Thank you so much for listening. Again, that's www.COVIDcommunityambassadors.com

- **Testing Update, Brooke Rossheim, MD, VDH**

  - I want to provide an overview of where we are with testing. And if you have the slide deck in front of you, you're going to notice that the numbers on the bottom left-hand corner of the slides are not correct, so, sorry about that, but somehow, we had a little issue with the numbering.
  - So, basically, I want to go over the three areas -- the agenda, an overview of COVID-19 testing in Virginia, an update on at-home COVID-19 testing, and then, third, to talk about K-12 school testing in the state. So, if we go to the next slide, the overview of COVID-19 testing. Since the beginning of 2021, one of the things that we've noticed is that the

amount of COVID-19 testing in Virginia has declined really notably, and this is not unique to Virginia. This has happened in the U.S. as well. So, in January 2021, we were doing about 50,000 COVID tests each day, and now we're down to less than 30,000 tests each day. And the reason this is concerning is because COVID testing is our window into how the pandemic is going in Virginia. Testing is essentially our eyes and ears about how we're doing.

- The reason that testing is -- or one of the reasons that testing is so important is because 40% to 50% of cases of COVID-19 are asymptomatic. And when you have an illness like that I that's asymptomatic, you know, people, as opposed to an illness where people, where most everybody has symptoms, you can't identify people just based on the presence or absence of symptoms alone. So, that's where testing comes in. The benefits of testing. I've listed three of them.
- First, it provides very important data about the status of the pandemic, and that's certainly one of the most crucial things. Second, it allows for both individual-level actions and public health actions to be taken quickly. So, for example, if you can do a test on somebody, and we have antigen tests that take 10 or 15 minutes, and if you have a person who tests positive, we know to go ahead and isolate that person. And if they need further testing, we can get further testing done, but that's all facilitated by the fact that we have testing available and that we're doing testing.
- The third reason is that it allows us to track and identify variant viruses, and this is becoming a very important thing, because without testing, you can't do whole genome sequencing, so you can't -- and that's what you need to do to find a variant virus. So, really, the main message is that even though vaccinations are available and other measures are available to stop the spread or help stop the spread of COVID-19, testing continues to have a very important role.
- VDH's response to declining testing. One of the things we're doing is working with the advertising firms to create messages to increase testing. So, these will be on different platforms, such as online, TV, radio. And the other thing we're doing is we're reaching out to groups directly to try to increase testing. So, I've given a few examples. So, the State Health Commissioner, Dr. Oliver, sent out a letter earlier this week that went to all medical providers in the state, encouraging them to consider testing people who are in higher risk groups for COVID-19. So, for higher risk groups, just to name a few, first of all, those would be racial and ethnic minority groups that have been disproportionately impacted by COVID.
- Another group would be people who have jobs where they work a lot with the public, so they're coming into contact with a lot of people. Another example of a higher risk group would be people who live or work in congregate care settings. Again, they're coming into contact with more people, and this is how COVID is mainly transmitted. So, the testing team, we've been working directly with a whole variety of groups, homeless service providers, operators of long-term care facilities, and you know, medical groups. And basically, the message is to encourage them to either continue the testing that they're doing, or if they're not really doing much testing, to consider starting testing. And we have developed documents so that people can sort of go through step by step to start doing testing. And then the testing team, we can provide supplies for them. We have the Abbott BinaxNOW antigen cards.
- We have a lot of those. We can provide guidance and support and helping them, if they want to set up their own testing service, we can help them with that. Moving to the next

slide, I wanted to talk about an update on at-home COVID testing. So, last week, the FDA on two days, March 31 and April 1st, FDA granted six emergency use authorizations for serial antigen testing.

- So, this is something that is new. So, what is serial antigen testing? What that is its two antigen tests that are done over two to three days with a 24 to 36-hour interval between the tests. So, to give you an example, the BinaxNOW cards that we have that HHS provided to the state, those are single-use cards. Those are prescription items. Those are meant for, you know, one test at one point in time. And what serial testing does is it throws in a second test.
- So now you're not just testing once, but what you're doing is you're testing a second time at some point in the future, but not really in the too distant future. And what that does is, that way, if you are in the, for example, let's say you've been exposed to COVID-19 and it's sort of percolating in your system, the first test may not come up positive, but by the time of the second test, as the virus continues to replicate and the virus continues, you know, to spread in the body, that second test may be positive. And so, that's the idea of the thinking behind doing serial testing.
- Now, the next bullet is pretty important. Of these six EUAs that we're given, four of these are now for nonprescription products, and then two of them were prescription products that basically got relabeled, so they were given -- you know, not only could they be done as a single point-in-time test, but they could also be done as a serial test. The main thing is that these nonprescription products, this is a trend that we are seeing in terms of moving testing from being a prescription item to being a nonprescription item where people will be able to test themselves.
- What this does is it really opens up the testing market, because when you take the prescription out of it, then people can just go into a store, buy a test kit, test themselves at home, and we're going to talk about that little bit more. Another important thing about these six EUAs that were granted last week is that in the package labelling for these six products, what it said is that you could test people with symptoms or without symptoms. And also, you could test people who had a reason to suspect COVID-19 or those who did not have a reason to suspect COVID-19.
- This also is another big change for FDA. So, for example, the BinaxNOW cards that we got from HHS, which are the quote -- as I like to call them, these are the quote/unquote original BinaxNOW cards. Those cards, if you look at the instructions, they are for people -- meant to be used for people who have symptoms of COVID-19 or they have some reason that you would suspect them, perhaps, of having COVID-19. These new, these six tests, now we have expanded greatly the number of people who these can be used for. So, now we can use them for people, for anybody. So, even if you have no symptoms of anything and you have no exposure history, you can still, you can use these products to be tested.
- That falls right in line with the idea of the reason for asymptomatic testing. So, there's a strategy behind all of this. So, if you're wondering, what is an epidemiologic reason to test somebody for COVID-19, well, one of the most obvious would be if you had an exposure.
- So, let's say, you know, you spent a bunch of time with a friend or something like that, that person turns out to be diagnosed with COVID two days later, then, well, that's an epidemiologic reason to suspect COVID. So, moving on to the next slide, the new Abbott BinaxNOW COVID-19 antigen card test. I apologize. I know this is a lot of information

on one slide, so I'm going to -- I won't, obviously, go through everything. I'll hit the high points. You can see that now Abbott has five different BinaxNOW COVID-19 antigen cards, so this gets a little confusing. The first one, number one, is the original. This is the Abbott BinaxNOW COVID-19 antigen card. This is the one that we have at VDH. We got them from HHS. HHS also sent these out to nursing homes and to lots of other facilities around, you know, directly, just, you know, by themselves.

- This requires a prescription. It's a single antigen test. Abbott then introduced the Abbott BinaxNOW COVID-19 antigen card home test. And this, basically, is just the home version of number one. It's a prescription-only test. It's done at home. It does use a smartphone, so you have what they call a telehealth proctor who goes through the test with you via the video on the smartphone, and so, they help you with the test. So, now, the items in bold purple are new.
- We have the first new item that we have is the Abbott BinaxNOW COVID-19 Antigen 2 card, okay? This is a new test. You can see when it got its EUA approval. So, this is a nonprescription serial test for people with or without symptoms of COVID, people with or without an epi reason to suspect it. This particular test is really meant for use by medical professionals or trained personnel. It's not really meant for home use. But again, it is an over-the-counter item, so it can be obtained by anybody.
- So, number four is, basically, the Abbott BinaxNOW COVID-19 Antigen Card 2 Home Test. So, this is just the over-the-counter version of the prescription version of the home test. Again, this is new, so new packaging, new labelling. You know, this is a nonprescription at-home test. Same thing as before. You can either be symptomatic or asymptomatic, have a reason to suspect COVID or no reason. This test does use a telehealth proctor.
- This test is really meant for those people who need an official, basically, lab report of having a COVID test done, but they really want to do it at home. They don't want to go to their doctor's office. They don't want to go to an urgent care center. So this service is provided by doing this, and so the telehealth proctor is there as the, basically, the person who's monitoring the whole process. And then the fifth test is what's called the Abbott BinaxNOW COVID-19 Antigen Self-Test. This, again, new test. And basically, the same thing as above.
- You can either have symptoms, no symptoms, have a reason, a specific epi reason or no reason. This is just simply for the person who wants to test themselves at home. There's no proctor involved. It just comes with instructions on how to do the test. And then the next slide is, there has been an additional -- so, the fourth over-the-counter test is the Quidel Quickview at-home over-the-counter test. This, again, nonprescription, serial test, so done -- it's a two-pack. Same instructions -- similar instructions to what Abbott has. The main thing is that this is, you know, two tests over a period of two to three days. By the way, all of these use an anterior nasal swab.
- None of these use saliva or anything else. Last thing I want to talk about briefly is K-12 school testing in Virginia. Obviously, we know there's a strong interest to return children to classrooms for in-person school. Overall, while there certainly have been cases of COVID-19 and outbreaks of COVID-19 in K-12 schools, K-12 schools are really not considered a major league mode of COVID transmission. Now, there is one caveat, and you're seeing that play out in states that are getting hit really hard by COVID now, which is that, if there's a lot of COVID in the community, then it's going to be seen everywhere, including the schools, so that's the caveat. So, the federal government is going to be

providing funding for K-12 school testing. And in the next slide, I just wanted to let everybody know that VDH, the testing team is currently working with the Virginia Department of Education, school districts, school superintendents, school nurses, and others about how to address this issue.

- The goal here is to come up with a testing program that is both diagnostic -- so for people who get sick at school -- that could be children, that could be teachers, that could be staff. So you know, for diagnostic testing. So, do we have a way of getting those people who are ill tested quickly so that we can then make decisions about what needs to happen for both them and then any possible close contacts? And the other thing is screening testing, and that's a new term that I want to add in.
- The idea of screening testing is, basically, testing everybody in the school once a week. And these are asymptomatic people, so these are people that have no signs or symptoms of illness. Testing them once a week to see if they have COVID. Again, the reason that this is important, it goes back to the earlier slide, because so many people with this illness are asymptomatic.
- The benefit is, if you can pick up those infections early, you can make those individual decisions and public health decisions so that you don't have somebody that is infected but asymptomatic who can transmit illness around the school. So, what we have done is VDOH, the Virginia Department of Education and VDH, have recently launched two pilot programs in K-12 schools.
- One is for diagnosing COVID-19 in, you know, students, teachers, staff who are ill, who have symptoms of the illness, or who are close contacts. They have an epi reason to test. The other pilot program is weekly screening testing of asymptomatic students, staff, and faculty. This pilot program will run until June 30, 2021. And what we're doing now is we are in the process of formulating a testing plan for the 2021-2022 school year.

- **Question & Answer Session**

  - No Questions

- **Closing, Suzi Silverstein, VDH Office of Emergency Preparedness**

  - I know we've shared a lot of information today. Hopefully, all of our presenters were very thorough. So, if you do have additional questions, you can always email me and I can see what I can do about getting an answer.
  - I've already gotten a few emails with suggestions for topics for next week, so I appreciate that. We'll be working on those. Our next call will be next Friday, April 16th, at 10:00 a.m. Thank you all very much for your participation in today's call, and we will see you next week.
  - This concludes our call.