HHP/HPH COVID-19 Webinar: August 24, 2020
Q&A: Unanswered Questions

HAWAIʻI PACIFIC HEALTH | HAWAIʻI HEALTH PARTNERS
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As we were not able to answer all your questions during the webinar, we have compiled responses to all unanswered questions. If you have any further questions, comments, or concerns, please email Covid19bulletin@hawaiipacifichealth.org.

CDC Guidelines:

- **Q: How was 15 minutes determined to be the cut off time? Shouldn't 10 minutes be more appropriate as one cannot remember their contact?**
- A: In general on the CDC's website, they say prolonged exposure is any exposure greater than 15 min, but they don't really define how they came up with that. Other countries were using 10 or 20 minutes, but we really don't know if there is any scientific basis about the actual time limit. So one of the messages from this is that while the science is not entirely clear about these questions and answers, we are following the CDC's guidelines so that at least it is a consistent message which hopefully will help.

- **Q: If a provider was in a room wearing a surgical mask (not N95) and eye protection with a positive patient for 25 min (doing H&P and an exam), they don't need to self-quarantine?**
- A: CDC recognizes that healthcare workers know how to wear masks and eye protection/face shields and such, so assuming that you were wearing those correctly and not doing any aerosolizing procedures, you would not need to consider yourself a contact.

- **Q: If the close contact is negative at day 7 (and is still asymptomatic when they get the results), can they break quarantine or should then continue to quarantine for the full 14 days?**
- A: Quarantine must continue. A negative test does not take you out of quarantine. A positive test takes you into a 10-day minimum isolation period.

- **Q: If they are an asymptomatic positive, they have 10 days minimal quarantine? So do we have to test every one contacted in case they are asymptomatic positive?**
- A: If they are asymptomatic positive, they have 10 day ISOLATION and if they remain asymptomatic after those 10 days (and clearly fever free with no symptoms to improve) then therefore their isolation ends.

  No, the testing of a contact is really to help understand how to manage other folks. Any real contact of a positive needs to do a 14 day quarantine; you are only testing to help manage the other people around them.

- **Q: Should household contacts of a positive patient who is in isolation move out?**
- A: It depends on where they can move to. If they can move out without coming in contact with others, then yes. If they would move out to live with others who haven't already been exposed, that might actually increase the risk of spread and would not be a good idea.

- **Q: What if I'm wearing PPE: mask and shield at all times; if my MA is positive, would I still have to quarantine?**
- A: If the coworkers were wearing correct PPE and had no other lunch room or any other close contact that you can identify, then are not considered close contacts and they can stay at work.

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- **Q: What if your positive MA took care of patients in clinic, but both patient and MA were wearing masks?**
- A: With an infected MA, you would want to evaluate the degree of contact with any patients in the 48 hours prior to onset of symptoms, or date of specimen collection for the positive test, until the MA is in isolation. It is not clear how much protection is provided by the mask that the MA was wearing, but it was likely not complete. CDC does not include face coverings worn by non-medical personnel as having any reliable protection, so they are not included in the assessment.

  If the situation was reversed and it was the patient who was positive, and the MA exposed, then assuming the MA is wearing a medical mask and eye protection (and not doing any aerosolizing procedure with the infected patient) the MA would be considered non-exposed.

- **Q: In scenario 6, if the mother is a healthcare worker but a direct contact of a positive patient, does she still need to quarantine? I'm hearing HCW who are contacts but test negative are exempt from needing to quarantine.**
- A: If the mother is a HCW and is caring for a positive patient and wearing the appropriate PPE (meaning eye coverings or face shield and mask or an N95 if doing aerosolizing procedures), then no, they would not need to quarantine because presumably they are protected because they are wearing appropriate PPE. The other part of that might be though that we have had healthcare workers that have had real contact because they weren't wearing their PPE appropriately and because they were critical workers, they were tested on day 7 and brought back to work if they were negative. It's only a critical healthcare worker that can break quarantine and come to work with a negative test (the general public is not allowed to do that). The CDCs recommendation is if you are doing a test date's return to work criteria, then you need two negative tests greater than 24 hours apart (primarily for healthcare workers).

- **Q: As explained in Scenario 6: if an employee does not know mother's test result, he/she will continue to work, right? Although it is a contact of a contact, the 1st contact does not need the test?**
- A: The contact of a contact does not need to be tested and can go to work, but the 1st person contact of the positive, needs to quarantine for 14 days and test them if it impacts others and if their test comes back positive then there will need to be contact tracing on who individual came into contact with. If their test comes back negative, it doesn't do anything for their 14-day quarantine. The time that you would test the contact of the positive would be if a positive results impacts others in terms of their contact tracing.

- **Q: What is the difference between quarantine and isolated?**
- A: Quarantine is keeping someone who was in close contacts with a COVID+ person away from other people. Isolation is keeping someone who is ill or tested positive for COVID-19, away from others, even if that is within their own home. They are similar concepts but isolation is actually someone who is sick or tested positive with COVID-19, even if they are asymptomatic.

- **Q: Why doesn't CDC consider mask wearing when determining close contact?**
- A: CDC considers healthcare workers as knowing how to wear a mask properly (over the nose and the mouth), but does not consider the general public as always knowing how to wear it properly.

- **Q: The rule is "6 feet for 15 minutes". What about less than 6 feet for 2 minutes 8 times?**
- A: This is where the difficulty comes in - it is a judgement call. In these discussions we are having with people in these scenarios (are variations of real calls), it is a discussion about how much contact has occurred and is that enough to be a concern. There is no guideline for less than 6 feet for 2 min 8 times or variations thereof… it could be 15 sec but you were sneezed on…Really you're discussing your discussing the kind of interaction and over what period of time and masks or no masks (although CDC does not take masks into account).

- **Q: When can a COVID-19 positive employee safely return to work? What if they have prolonged symptoms?**
- A: The CDC advises 10 days after onset or positive test if they were asymptomatic. If they have symptoms, they need to be fever free for at least 24 hours without antipyretics and they have to be improving (they do not need to be completely well). If they have prolonged symptoms (as we do know some people have COVID-19 symptoms for months), they are not passing the virus any longer, but they would return to work when they are capable of managing their job.

- **Q: Why do people with COVID-19 need to isolate for only 10 days, whereas people who are close contacts have to quarantine for longer 14?**
- A: The difference between "knowing" and "waiting for". If you don't know if you are COVID+ and you are waiting for symptoms or results, you need to go on a 14 day quarantine for the incubation period. But if you do know you are COVID+, then we do know the clinical course of the virus from the time you are infected to the time where you're relatively cleared from viral transmission is about 10 days.

  It is worth mentioning that if someone is in a household with a COVID+ and cannot isolate or quarantine from that, then the household contact has to be cleared (so they have to do that 10-day isolation and be cleared AND THEN the 14-day quarantine starts).

  BUT there is a way to make it better too. Say you just got sent home because you were put on a 14-day quarantine, and you tested positive the next day, then you would only have to isolate for 10 days (assuming you do not have symptoms) - if you have symptoms then the duration would need to be symptom criteria based.

<u>Contact Tracing:</u>

- **Q: Does anyone know if DOH is adequately staffed to do this contact tracing now?**
- A: This is still unclear at this time.

- **Q: Are there any training resources on how to do contact tracing when we get a patient who is positive?** Seems like we need all the help we can get to get the word out to folks who have been exposed.
  A: That is why we set up the employer line so if you don't want to deal with these sort of questions, we are there for you. So you can refer people in to talk to us. We prefer to talk to people with specific scenarios because it is a bit more difficult with those that are "maybe this" or "maybe that", but we are here to try to help. But if you are motivated or you know someone interested, there is a contact tracing, there is a Johns Hopkins course online that you can do because there will continue to be a great need for that.

On that note, if you would like to get involved, there is an Ambulatory call that is starting to occur with regulatory on Wednesdays at noon and out of that conversation, we hope that things like an approach to address the knowledge gap with the public, a way to define work flows so that upper respiratory influenza and COVID-19 have a smooth way of being handled by PCPs, the Virtual Care Clinic and the Respiratory Evaluation Clinic in a nice, coordinated manner, and I encourage you to all be part of that.

- **Q: I think part of the problem is that employers are not saying who the positive person is and the co-worker is not really able to determine close contact.**
- A: I think this is the whole challenge of contact tracing. Contact tracing, even in places that are fully staffed and running hard, are still only catching about 50% of the people that are potentially coming clean and saying "Yea I'll tell you who I've come into contact with", but half of them won't even offer that. But the silver lining is that any one you get is taking one less out of the circulation of the virus. And even if you do not know what the contact was at work, you can know your behavior at work; you can know if you were sitting in a protected space or if you ate in a shared lunchroom, or those sorts of things. So you can have a better idea if you were maybe in contact with someone or not.

COVID-19 & Hawaii:

- **Q: Do the local positive cases include false positives?**
- A: There should be only a small number of false-positives.

- **Q: Hasn't Mayor Caldwell closed all lunchrooms? Should all HPH lunchrooms close?**
- A: We recognize that our HCWs need a place to eat lunch or take breaks, and we are exempt as essential workers. That said, we have had concerns about exposures in such areas so we want to make sure that all recognize the risk if we fail to have appropriate distancing while eating or taking breaks.

- **Q: The models often say that "We are still in good shape" and yet there has been a significant rise in COVID+ patients in the adult hospitals. Further models seem to talk about ICU Bed space, not necessarily actual staffed beds, taking into account the high acuity of COVID-19 patients.**
- A: I think this is expressing a discomfort around the models and I think that is fair to say that when you start, you don't really know. Your model is the best guess based on what you know at that time and the experience you have in living it, informs the way we adjust the models. And the models have been adjusted to reflect our lived experiences - the expected rate of hospitalization and use of ICUs is lower than we thought it would be and the reason why we thought it still makes sense to look at ICU beds and rather than all beds is that we have, in each of our hospitals, a much larger capacity to absorb med surg or tele patients than we do ICU. All of the questions have been discussed and the models have been adjusted and we feel reasonably comfortable that they have helped to inform us. We now have a daily call among all of the hospitals in Hawaii and are keeping each other up to date on the capacity of the hospitals and we do still have capacity. Not each hospital, every day has capacity, but among all of us we are able to load shift a little bit and manage, but the models have been adjusted as we learn more. I think everyone wants transparency, and that is what we are shooting for, but we also want to be realistic. Things definitely change; the use of ventilators has changed dramatically over a short period of time, the advent of certain medications has changed, the severity levels of the average patient.

I think there was a hidden comment in there about hospital beds and physical space vs. staffing and that is a problem. We learned a couple weeks ago that several of the hospitals, particularly on Oahu, have a much larger number of licensed beds than they are able to staff. When we were talking about how to respond to a surge and as hospitals get close to capacity and beyond - do we need tents for example? The answer is we don't need tents - we need staff. So an exercise is going on right now to identify how many staff we need and what kind of staff that would be so we can use those empty hospital beds to best of their capacity.

Flu:

- **Q: Can we remind folks that flu season is around the corner and to order flu test along with COVID-19 if symptoms match (fever, chills etc.).**
- A: Everyone is concerned about the flu season and [Dr. Ashton] would like to mention that flu season in the southern hemisphere has been muted. Dr. Sarah Park has mentioned that we have not received our flu season in Hawaii as we normally would because of our lack of southern hemisphere travel. So please don't dismiss something as the flu, please think they could be COVID-19 positive.

- **Q: Is any planning being done in anticipation of the upcoming flu season and the additional pressure that will put on healthcare deliver and capacity?**
- A: Yes, we are very concerned about it and we are promoting flu vaccines and keeping our eye on flu testing. We will be able to do flu tests as well as COVID-19 tests together. But right now, if you have someone with flu symptoms, think it is COVID-19 and not the flu.

- **Q: When will the flu shots be available?**
- A: Vaccine is already available.

HPH:

- **Q: Is Kapiolani testing all patients (even kids) who are being admitted? If so, any positives?**
- A: Yes, at all HPH facilities we do testing on admission. This includes Kapiʻolani, where we have identified obstetric patients on admission screening. I believe that our positive pediatric patients have been identified as part of their pre-admission evaluation (rather than from screening).

- **Q: What can we do as HPH to help address the Pacific Islander and Filipino community which are the #1 and #2 hardest hit with COVID-19 in our community?**
- A: This is very challenging. Providing correct information about exposure, what a negative test result may mean (for a contact), etc is really important. We (and HDOH) have educational materials translated into appropriate languages to help. A major challenge is to help infected people isolate in small, heavily occupied, homes. For that, knowing about the Hawaiʻi CARES line (832-3100) to request help with accommodations may be beneficial.

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Quarantine:

- **Q: Could you clarify what neighbor island patients need to do upon return from a visit for ongoing treatment on O'ahu? The treatment is not related to COVID-19. My understanding is that they can get a waiver in order to work but otherwise are supposed to stay at home.**
- A: The quarantine restrictions are now managed by each county. Kauai has a different quarantine approach then does Maui then does the Big Island, and so there is no blanket your patient can come for healthcare and go back and not quarantine. You/your patient need to contact the county involved and find out what the restrictions are. [Dr. Ashton] received an email right before the meeting started that the Big Island has restrictions such that even newborns are not allowed to go in for their checkups because of the quarantine restrictions - so please do not assume anything and make sure to check the restrictions.

- **Q: What are the consequences of breaking quarantine? A fine, jail?**
- A: There are arrests that have occurred with fines being paid to be released.

Transmissibility:

- **Q: Do I understand it correctly that our transmutability rates dependent on our antigen rates?**
- A: It is based on the viral load - and the viral load can be detected in either of those two ways.

- **Q: How are transmissibility rates being tracked currently?**
- A: That seems like the reproduction number at a big level. On a population level, you are looking to see how many cases and how rapidly it is spreading across a given number of susceptible patients. But it moves too, just like the fatality rates move (it looks much worse at the beginning), and then as things start to play out, it starts to look a little bit better and we end up with something less than what we started with. But that's looking at it as a big population level, you could also try to answer that question on "What makes for an effective transmission?" Yea, you are right and if you are asking the question based on "What makes for an effective transmission?" It goes back to your discussion in regards to the laboratory testing. We are using very powerful, very expensive, time-consuming, PCR tests, which are actually designed to be diagnostic tests, as a screening test, (they are not designed to be a screening test). A screening test does not need to necessarily detect my new particles of rNA, a screening test, more in our case, just needs to be able to detect those that transmit virus, and when you try to compare a screening test sensitivity to a PCR test, that is when you are kind of mixing apples and oranges. A screening test would be sensitive enough to pick up somebody who is able to transmit virus because by the time they are able to transmit virus, like you said, you have viral copies in the millions/billions that you are shedding and you can certainly detect that in one of those fast rapid screening tests. And so, with regards to transmissibility, if we are trying to prevent transmission of the virus in the community, ideally, your testing is identifying those that can transmit infection, not necessarily those that have positive rNA viral particles on a PCR test.

  And that actually relates to the above question, what exactly are we getting with the antigen testing? It's a lateral flow of the specimen across embedded antibodies in a strip that's looking for a spike in protein that an antibody can capture and turn the color of the strip. It's not exactly looking for the attack virus—it's a marker, and if you have a lot of it, then the odds are good that you have millions/billions of these copies floating around. So transmissibility, I think, is reasonably reflected by these kind of tests.

***Frustrations & What You Can Do*:**

- **Q: I get calls from patients who have limited information such as "My boss told me that someone at work tested positive. They told me the date of the positive test. They won't tell me if or when I was in close contact."**
- A: I imagine that is a very frustrating situation and I think it might be helpful to figure out if the patient is worried that actually had true contact with someone or if they are developing symptoms. It might also be an opportunity to educate the patient on social distancing, wearing masks, and hand hygiene, and give them resources and have them call you back if they do start to develop symptoms. But with that sort of vague information, it is hard to give any specific recommendations.

- **Q: I must live on a different planet. When I call with the results, they are often at a store or some such.**
- A: Yes, that is a real problem in that people are not necessarily following the directions that they are given "you must stay home until the results come back" and so forth and so on and that is part of the reason why it is still spreading in our community. I think that is also in part why we set up the hotline for employers because we want to make sure they have the right information so that it can be shared correctly. Hitting the messaging is going to be so important, I think we need to look carefully at what we can hit at to help change public behavior.

- **Q: In regards to messaging; the general public undergoes temperature screening throughout the course of their daily life. I have had many patients and parents tell me that they thought if you don't have a fever, you don't have COVID-19.**
- A: I think this speaks to the information gap, and how much work is needed to close some these gaps. It might also be an opportunity to educate the patient on social distancing, wearing masks, and hand hygiene, and give them resources if they do start to develop symptoms.