Health Advisory

KITSAP PUBLIC HEALTH DISTRICT

March 3, 2021

Free BinaxNOW COVID-19 Rapid Antigen Cards Available

Actions Requested

- **Contact KPHD to obtain** BinaxNOW COVID-19 rapid antigen cards for use at your facility.
  - Contact Anna Gonzalez at anna.gonzalez@kitsappublichealth.org or (360) 633-9693.
  - Availability is on a first come, first serve basis.
  - Expiration dates for the tests available are 4/8/2021, 4/13/2021, and 5/2/2021.
- **Utilize** BinaxNOW COVID-19 rapid antigen cards according to manufacturer instructions and in accordance with CDC recommendations.
  - Review CDC Interim Guidance for Antigen Testing for SARS-CoV-2 (link below).
  - Testers need to review BinaxNOW training materials prior to administering the tests (link below).
- **Interpret and confirm results** of BinaxNOW COVID-19 rapid antigen tests according to manufacturer instructions and CDC guidelines.
  - Consider community positivity rate and clinical and epidemiological context of the individual being tested.
  - KPHD COVID-19 antigen interpretation flowsheet is attached to aid in interpretation, including when to perform confirmatory PCR.
- **Understand reporting requirements** for COVID-19 rapid antigen tests (point of care testing). Reporting to WA DOH and KPHD is required.
  - All point of care (POC) test results (positive & negative) must be reported to WA DOH. See link below for reporting options.
  - Report positive test results to KPHD by faxing the completed KPHD WA COVID-19 POC result form to (360) 813-1168.

Background

Kitsap Public Health District (KPHD) has free BinaxNOW rapid antigen cards available to distribute to community partners for use at their facilities. Please contact Anna Gonzalez at KPHD if you are interested in receiving BinaxNOW rapid antigen cards. Availability is on a first come, first serve basis.

The U.S. Food and Drug Administration (FDA) has granted emergency use authorization (EUA) for antigen tests that can identify SARS-CoV-2. The high specificity and rapid BinaxNOW antigen test turnaround time facilitate earlier isolation of infectious persons. Antigen tests can be an important tool in an overall community testing strategy to reduce transmission.

Resources

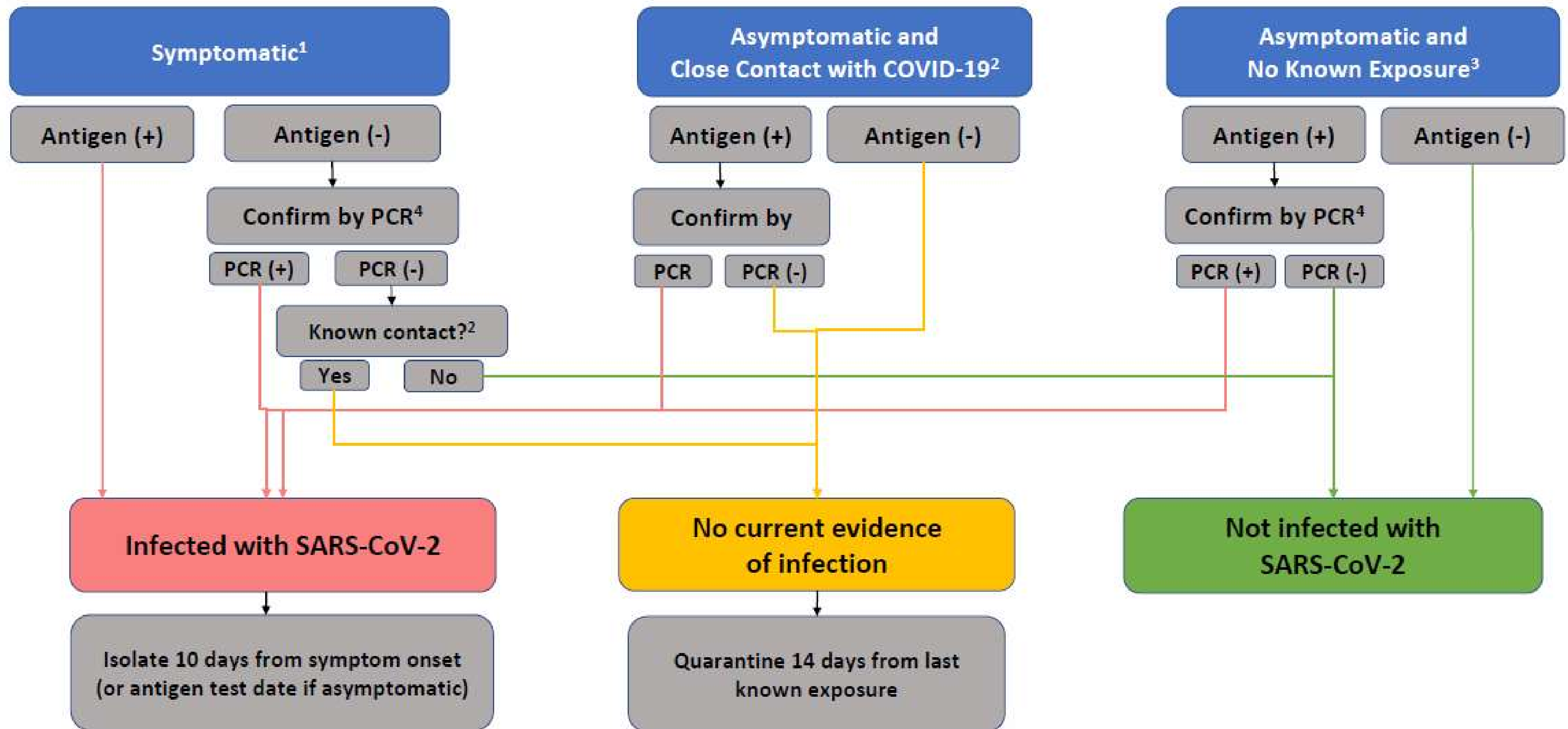
Attachments:

(1) KPHD COVID-19 Antigen Interpretation Flowsheet
(2) KPHD WA COVID-19 POC Result Form

Resources:

1) CDC Interim Guidance for Antigen Testing for SARS-CoV-2 - https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html#general-guidance
2) Abbott BinaxNOW Ag training materials - https://www.globalpointofcare.abbott/en/support/product-installation-training/navica-brand/navica-binaxnow-ag-training.html
3) WA DOH Reporting COVID-19 Test Results for Point-of-Care Testing Facilities - https://www.doh.wa.gov/Emergencies/COVID19/HealthcareProviders/ReportingTestResults/ReportingCOVID19TestResultsforPointofCareTestingFacilities

KPHD COVID-19 ANTIGEN INTERPRETATION FLOWSHEET*



1 - Symptoms of COVID-19 can include:
- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

2 - Definition of close contact of someone with COVID-19: Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.

3 - Within past 14 days

4 - Confirm result with a PCR test within 48 hours. Patient should isolate while awaiting PCR test results.

*Guidelines adapted from the CDC Antigen Test Algorithm flowchart: https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html

WASHINGTON STATE COVID-19 POINT OF CARE TEST RESULT REPORT FORM*

Instructions: Complete and submit one form per result. Submit completed form by fax to the Washington State Department of Health at (206) 512-2126.

Submitter name:	Submitted date (MM/DD/YYYY):____/_____/ _______

Section 1: Testing Facility and Ordering Provider Information

Facility name:	License number (if applicable):

Facility address:			City:
State: WA	Zip code:	County:	Phone:

Type of facility:
- ☐ Airport/Transit station
- ☐ Assisted Living/Adult Family Home
- ☐ Childcare or daycare
- ☐ College/University
- ☐ Congregate housing (e.g., dorm, military)
- ☐ Correctional setting
- ☐ Drive-/walk-through testing site
- ☐ Homeless shelter
- ☐ Hospital
- ☐ Inpatient behavioral health care
- ☐ Nursing Home
- ☐ Outpatient care (including freestanding emergency department, urgent care)
- ☐ Pharmacy
- ☐ K-12 School
- ☐ Supported living
- ☐ Other (specify): ___________________

Ordering provider name (first and last):	Phone:	NPI (if applicable):

Ordering provider street address:

Ordering provider city:	Zip code:	County:

Section 2: Patient Information

Last name:	First name:	Middle name:

Sex at birth: ☐ Female ☐ Neither/Other ☐ Male ☐ Unknown

Is the patient: ☐ Pregnant ☐ Postpartum ☐ Unknown ☐ Neither pregnant nor postpartum

What is the patient's affiliation to the facility?
☐ Resident ☐ Staff ☐ Visitor ☐ Patient ☐ Student ☐ Client ☐Inmate

Date of birth (MM/DD/YYYY):_______/_______/ ________	Age:______years

Patient's address:			City:
State: WA	Zip code:	County:	Phone:

Did the patient die? ☐ Yes ☐ No ☐ Unknown	Date of death (MM/DD/YYYY):_____/_____/ _____

Race (select all that apply): ☐ Unknown ☐ Black or African American ☐ Other race (specify): ___________________________________ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Did the patient have symptoms at time of testing? ☐ Yes-Symptom onset ____/____/_____ ☐ No ☐ Unknown

Patient identifier (if applicable):____________________________ ☐ N/A
☐ Medical Record Number ☐ Patient Internal ID ☐ Public Health Case ID
☐ Specimen Identifier ☐ Patient External ID ☐ Other (specify): ________________________

Section 3: Test Information

Test name:
- ☐ Abbott BinaxNOW COVID-19 Ag CARD
- ☐ Abbott ID Now COVID-19
- ☐ Access Bio CareStart COVID-19 Antigen Test
- ☐ BD Veritor System for Rapid Detection of SARS-CoV-2
- ☐ LumiraDx SARS-CoV-2 Ag Test
- ☐ Quidel Sofia SARS Antigen FIA
- ☐ Quidel Sofia 2 SARS Antigen FIA
- ☐ Other (specify): ________________________

Specimen type: Nasal swab NP (nasopharyngeal swab) Other (specify): ___________________	Test result: ☐ Detected/Positive ☐ Not detected/Negative ☐ Inconclusive/Undetermined/Invalid/Equivocal	Specimen collection date (MM/DD/YYYY): ____ /____/ ________

Device identifier:	Specimen ID:

Has patient been in contact with someone with confirmed COVID-19? ☐ Yes – Date last exposed _____ /_____/ _____ ☐ No ☐ Unknown

Washington State Department of Health

POC Report Form Field Descriptions

A description for each field in the Report Form is provided below. These explanations are intended to help you fill out the form completely. Please read them before contacting doh-surv@doh.wa.gov with questions on how to fill out the Report Form.

WASHINGTON STATE COVID-19 POINT OF CARE TEST RESULT REPORT FORM

Field	Description
Submitter name	The name of the person filling out the form
Submitted date	The date this form was sent to the Washington State Department of Health
Section 1: Testing Facility and Ordering Provider Information	
Facility name	The facility's name
License number (if applicable)	The facility's state license number. If the facility doesn't have one, put "N/A".
Facility address (including city, state, and zip code)	The facility's physical address
County	The county where the facility is located
Phone	The facility's phone number that DOH can call if there are questions about results
Type of facility	Check only one. Check the best option that describes the facility. If the facility type isn't listed, check "Other" and provide additional details.
Ordering provider name (first and last)	For health care providers or facilities, the full name of the medical provider who ordered the POC test. Other facilities can put "N/A".
Phone	The ordering provider's phone number. If there is not an ordering provider, put "N/A".
NPI (if applicable)	The order providers or health care facility's National Provider Identifier (NPI). If there is not an NPI, put "N/A".
Ordering provider street address (includes city and zip code)	The ordering provider's physical address where they work. If there is not an ordering provider, put "N/A".
Section 2: Patient Information	
Last name, First name, and Middle name	Provide the full name of the patient
Sex at birth	Check the option that best describes the patient
Is the patient pregnant?	Check the option that best describes the patient
What is the patient's affiliation to the facility?	How the patient is related to the facility where he or she was tested
Date of birth	The patient's date of birth
Age	The patient's age in years at time of testing. If the patient is a child under 1 year of age, enter 0.
Patient's address (includes city, state, and zip code)	The patient's physical address
County	The county where the patient lives
Phone	The best phone number to reach the patient
Did the patient die?	Check the option that best describes the patient
Date of death	If the patient died, indicate the date the patient died
Race	Check the option(s) with which the patient identifies
Ethnicity	Check only one. Check the option with which the patient identifies
Did the patient have symptoms at the time of testing?	Indicate if the patient had symptoms of COVID-19 disease. This includes cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, and new loss of taste or smell. Other less common symptoms include nausea, vomiting, or diarrhea.

Patient identifier	Check only one. If your facility uses or assigns identifiers to patients, check the option used and provider the identifier of the patient. If your facility does not use or assign identifies, check "N/A".
Section 3: Test Information	
Test name	Check only one. Indicate the brand and name of the test the facility used to test this patient.
Specimen type	Check only one. Indicate the type of specimen used for this test. A nasal swab specimen is obtained by inserting an absorbent tip into both nostrils, just around the inside of the nostrils (also referred to as "nares"). A NP (nasopharyngeal swab) specimen is obtained from "deep" in the nose. If the specimen type isn't listed, check "Other" and provide additional details.
Test result	Check only one. Indicate the option that identifies the patient's test result.
Specimen collection date	The date the patient's specimen was collected and tested
Device identifier (DI)	The DI for some tests can be found in the National Institute of Health's *Access GUDID Database*. The Device Model is also acceptable here, or the full human readable form of the barcode. If the DI is unknown, put "Unknown."
Specimen ID	If the facility uses or assigns unique identifiers to specimens, provide that ID. Many facilities using POC testing may not use specimen IDs because specimens are not stored. In that case, put "N/A".