**Criticism mounts as Virginia includes 15,000 antibody results in COVID-19 testing data**

Virginia’s count of COVID-19 tests to date includes results from 15,000 as-yet unreliable antibody tests, skewing the state’s testing capacity and its outlook on the spread of the virus, albeit to a small degree.

The Virginia Department of Health shared the new figures on Thursday, as it faced public criticism for muddying the state’s COVID-19 data by lumping together diagnostic and antibody tests. Many of the antibody tests on the market have not been vetted by federal regulators and do not measure the current spread of the active virus, unlike the diagnostic tests used by health care facilities.

Gov. Ralph Northam, a physician, said Thursday via Twitter that he had not been aware until recently that the two types of tests were being combined.

“[VDH] has been reporting all tests, regardless of the type of test, since the beginning of this health crisis. When I found out recently that data from all types of tests were being combined, I immediately directed that the diagnostic tests be separated out,” Northam said.

Northam became aware Monday that the numbers were conflated and has been pushing to separate data on the different types of tests, spokeswoman Alena Yarmosky said. Virginia will still report antibody tests, but starting Friday it will report different types of tests separately.

The [Richmond Times-Dispatch](https://www.richmond.com/special-report/coronavirus/virginia-misses-key-marks-on-virus-testing-as-leaders-eye-reopening/article_021e12c6-6d20-5030-9068-4caaeda495f7.html) first reported Saturday that the state was combining test data. State officials faced additional pressure on Thursday, when the national news magazine [The Atlantic](https://www.theatlantic.com/health/archive/2020/05/covid-19-tests-combine-virginia/611620/) highlighted the practice, and disputed claims by Virginia officials that many other states were also including antibody tests in their total testing counts.

The inclusion of antibody tests highlighted the state’s ongoing testing woes. As the state begins reopening on Friday — except for Northern Virginia, the city of Richmond and Accomack County on the Eastern Shore — it has yet to meet key testing goals set by its own officials and public health experts, per a Times-Dispatch analysis.

On Monday, Northam’s chief of staff, Clark Mercer, said the state decided to conflate the two types of results to improve Virginia’s testing rankings, suspecting that other states were doing the same.

Antibodies

Antibodies are proteins that help fight off infections, and their presence in a person’s bloodstream can signal a previous infection.

Public health experts have rejected the practice of combining the results of the diagnostic and antibody tests, which they say can skew public understanding of the spread of COVID-19.

For one, antibody tests don’t gauge how many people might currently be infectious.

The tests can also skew the state’s positive rate — the share of positive results among all tests — a key number state officials use to make decisions about restrictions. With a higher number of tests in the state’s log due to antibody tests, Virginia’s positive rate was skewed down by a percentage point, from 15% to 14%.

Jennifer Nuzzo, an epidemiologist and public health expert at Johns Hopkins University, said the two types of tests should be separated for analyzing the spread of COVID-19.

“It is a totally different type of test, and it’s not clear what the validity of those tests are. It’s true that you can use [antibody] testing to understand what portion of the population may have been infected in the past, but you can’t understand that based on looking at the group of people that saw an ad and decided to get tested.”

State official agrees

State epidemiologist Lillian Peake agreed that excluding antibody tests when calculating the rate of positives is the best approach. “We use that metric to make sure we are doing enough testing to identify cases. It’s important to look just at the [diagnostic] test for that metric.”

Peake said that antibody tests are useful to gauge what share of the population has fought off COVID-19, but only as part of a controlled, statewide study of healthy people. Peake said Virginia is planning for a study to be rolled out in the summer.

Peake agreed that antibody tests are not reliable yet, so the state is not logging positive antibody tests as either confirmed or probable cases. Eventually, antibody tests will be used to classify COVID-19 cases as probable.

The U.S. Food and Drug Administration launched a review last week of the validity of dozens of commercial antibody tests in the market after an evaluation by the National Institutes of Health found that “a concerning number” of the tests yielded poor results.

That review is ongoing. Peake said the state is working to compile a list of which specific tests different labs in the state are using, and plans to exclude tests from its count that are not approved by the FDA.

Separating the results

Mercer, Northam’s chief of staff, said the state is willing to separate the two types of tests, but will continue to report on antibody tests for the sake of comparisons between testing in Virginia and other states.

In a tally by Johns Hopkins University updated Wednesday, Virginia ranked 47th in cumulative tests per 100,000 people since the pandemic started.

“If we’re going to be compared to all 50 states I want it to be apples to apples,” Mercer said at the Monday briefing. “It became clear other states are including serological testing. If you’re going to be comparing us to other states, and be critical of the volume of tests we are doing, and not comparing apples to apples, I think that’s grossly unfair.”

Virginia Health Secretary Dan Carey said Monday: “Without [federal] guidance, we went for as much testing as represented in the community. Going forward, we’ll look into how to untangle those.”

Northam tweeted Thursday: “I am a doctor, and I have said all along that I will act based on science and data — and the data must be reliable and up-to-date, so we can make informed decisions based on the facts. Going forward, the [VDH] website will break out the number of diagnostic tests.”

Legislators urge change

At least two state lawmakers on Thursday joined calls for Virginia to change course on how it reports testing data.

House Minority Leader Todd Gilbert, R-Shenandoah, said in a statement: “It’s incomprehensible that a doctor would allow the manipulation of testing data to occur.”

“Today’s story in The Atlantic amplifies what the Richmond Times-Dispatch had already reported: Doctor Northam and his team are committing malpractice with Virginia’s testing program. The governor recently stated that ‘Virginia is in a good place.’ The Atlantic’s report contradicts that claim and undermines any faith in what’s been communicated to Virginians about testing in the commonwealth.”

Del. Mark Keam, D-Fairfax, tweeted: “This news reports how [Virginia’s] government officials should have done a better job of reporting accurate COVID-19 data to the public.”

Daily numbers

The number of COVID-19 cases in Virginia climbed by more than 1,000 from Wednesday to Thursday.

The Virginia Department of Health reported 27,813 cases in the state, an increase of 1,067 from the 26,746 reported Wednesday. Nearly 1,000 people have died from the virus, according to the state Health Department, with the total number of deaths rising from 927 to 955.

Of Virginia’s 955 COVID-19 deaths, 927 are confirmed to have been caused by the coronavirus and 28 are probable. Probable cases are people who are symptomatic with a known exposure to COVID-19, but whose cases have not been confirmed with a positive test.

Roughly 1,500 people remain hospitalized by the virus, according to the Virginia Hospital and Healthcare Association, which represents 27 health systems and 110 hospitals. The association reported Thursday that 3,678 people have been hospitalized and discharged.

According to the Virginia Department of Health, here’s what COVID-19 data looks like in the Richmond area:

* Chesterfield County: 909 cases (+47); 68 hospitalizations; 29 deaths
* Hanover County: 198 cases (+15); 41 hospitalizations (+1); 18 deaths (+1)
* Henrico County: 1,174 cases (+28); 168 hospitalizations (+2); 112 deaths
* Richmond: 611 cases (+19); 102 hospitalizations; 18 deaths

# Some Democrats sour on redistricting amendment. Northam says it's not the only solution.

Virginia Democrats, splintered on how to approach political redistricting in 2021, are up against a tight deadline to coalesce, and the number of proposals is only growing.

A proposed constitutional amendment that passed with bipartisan support last year is up for a second and final vote before the General Assembly, but some Democrats are distancing themselves from the measure and proposing alternate ways to secure a bipartisan process. House and Senate Republican leaders have said their caucuses support the amendment.

Even Gov. Ralph Northam, who has said he supports the amendment, shared concerns about it in a recent interview and said it is not the only way to give Virginians non-gerrymandered maps.

The amendment would shift power over the drawing of legislative and congressional districts from the General Assembly to a 16-member commission of legislators and citizens. In the event of an impasse, the Supreme Court of Virginia would have the final say.

If the proposed amendment clears the legislature during this session, it would go to a November referendum in which Virginia voters would have the power to approve it or shut it down.

Del. Mark Levine, D-Alexandria, has become a leading voice against the amendment, and particularly opposes the Supreme Court’s role. He says that court, controlled by conservatives, could yield gerrymandered maps that favor the GOP.

Del. Lamont Bagby, D-Henrico, the chair of the legislature’s black caucus, also has long expressed concerns with the amendment, arguing that it doesn’t guarantee representation for minorities on the commission.

Meanwhile, Sens. Louise Lucas of Portsmouth and Mamie Locke of Hampton, both in the chamber’s Democratic leadership, filed legislation to enact the amendment they say addresses those concerns. It calls for diversity in the commission, and gives the Supreme Court parameters within which to operate in the event that the maps come before it.

Asked in an interview if she supports a path forward that doesn’t include the constitutional amendment, Lucas said flatly, “No.”

Lawmakers in each chamber will have until Feb. 20 to make up their minds on the measure after House Democrats sought unsuccessfully to nix the deadline for considering constitutional amendments. Related legislation should be finalized by the last day of session in mid-March.

It’s all part of a strict redistricting timeline.

The counting of the population by the U.S. Census Bureau will take place April 1.

Virginia will get its results by the end of 2020, an expedited schedule to accommodate redistricting ahead of the elections for the House of Delegates in November 2021.

Absentee voting for state primaries could start as early as January 2021.

\*\*\*

**Levine describes** the proposed constitutional amendment as “recipe for severe gerrymandering.”

He said all it would take for the maps to wind up in the hands of the state Supreme Court, controlled by Republicans, is two of the four GOP legislators on the redistricting commission parting with the rest of the membership.

Once in the hands of the Supreme Court, he believes no guidelines from the General Assembly would be able to trump its decision.

Levine said the amendment calls on the court to “establish” maps.

“The constitution trumps other law,” he said.

Northam shared concerns about the state Supreme Court’s purview.

“I’m not sure that’s the best way to go,” he said in a recent interview. “I mean, just look at the makeup of the Supreme Court, whether it be at the state level or the national level. I think not everybody would feel comfortable with that approach.”

Northam said unequivocally that if the amendment passes, he will support it.

“If it doesn’t, I will continue to advocate for nonpartisan redistricting and that will need to be a piece of legislation that I will pass,” he said. “So I’m committed to making sure that in Virginia, if I have anything to do with that process, it’s nonpartisan redistricting.”

Levine was among the lawmakers who voted for the proposed amendment last year. Asked about that vote, he said he went with the only measure available to his party at the time.

“It’s not like we had a choice of several delicious apples and we chose a rotten one. We had no choice and we were hungry, so we ate the rotten apple,” Levine said. “Now, with power, we can have a full apple orchard of the very best apples in the country. Why would we go back to that rotten apple?”

He said in an interview that he was in the process of retooling his redistricting proposals with the aid of experts from different states. Levine expects his new approach to be finalized Monday.

The crux of his plan, he said, is that the maps should yield representation in the General Assembly that mirrors the statewide popular vote. For example, he said that if 55% of voters statewide support one party, then roughly 55% of the seats in each chamber should belong to that party.

He said his method would call for the use of the past two statewide elections for lieutenant governor and attorney general as a guide.

“I chose the two where I felt people were least likely to know who’s running, purposely, as a party barometer. My goal is to get a generic party makeup,” Levine said. He excluded presidential and gubernatorial races because personality preferences, rather than party, influence voter choice in those races.

“People have unique views on Trump and Hillary Clinton,” he said. “That wasn’t my goal.”

\*\*\*

**In the Senate**, Lucas said she was optimistic most concerns with the amendment would be quelled by the legislation she filed.

One bill specifies guidelines for how maps will be drawn that calls for “contiguity, compactness, racial and ethnic fairness, respect for existing political boundaries, and respect for existing communities of interest,” and bans political party considerations. The other calls on the state Supreme Court to abide by those parameters if the decision is left to the court.

Her bills would go into effect if voters approve the constitutional amendment.

“I’m very hopeful that this bill is going to pass because for the longest time, people have been interested in having some bipartisan participation with redistricting,” she said. She rebuffed concerns that the Supreme Court could ignore those parameters.

“At the end of the day, everybody has got to abide by the law. That’s what it is,” Lucas said. “Even the Supreme Court has to follow the laws that are written by the legislators.”

Sen. Jennifer McClellan, D-Richmond, echoed that view.

McClellan filed her own bill stipulating guidelines for how to draw the redistricting maps, whether it’s done through the constitutional amendment or by the legislature.

The bill calls for maps that protect the rights of racial and language minorities, takes into account municipal boundaries and communities, and calls for racial and ethnic fairness. No political data can be used to create the maps.

She believes that legislation setting clear criteria — similar to the federal Voting Rights Act — will hold the Supreme Court to standards that will yield fairness for voters. If the amendment doesn’t pass, then lawmakers have parameters with which to work.

Still, McClellan would prefer it happen through the amendment to empower people outside the legislature to have the final say. Without it, the constitution requires the legislature to have the final approval, and any group or expert tasked with creating the maps would simply have an advisory role.

“At the end of the day, we would have to vote for the lines,” she said, arguing that a bill giving final say to a commission would bind future legislatures unconstitutionally. “You can’t bind the General Assembly.”

# Strain on hospitals intensifies in Virginia; VCU Health deploys surge capacity plans

A swamped ICU and escalating COVID-19 crisis forced a turning point at VCU Health last week: The Richmond area’s anchor hospital formally deployed the next level of its surge capacity plan, signaling the end of normal operations to prepare for significant strain on its resources.

In Virginia’s hard-hit Southwest, a front-line physician at Ballad Health said weeks and weeks of escalating numbers are threatening a “second pandemic”: the physical and mental exhaustion of its workforce.

At hospitals across the state, a workforce firm is helping backfill 926 health care jobs, three-fourths of which are for the care of the state’s sickest patients.

A relentless surge in COVID-19 cases is threatening to overwhelm Virginia’s hospitals and health care resources — the front lines of the fight against the coronavirus — before new vaccines can change the course of the pandemic.

“There’s a cost to be paid for the continued rise of this virus, and we’re starting to see that cost in our health care systems,” said Virginia Health Secretary Dan Carey in an interview.

“This isn’t theoretical. This is real. The message to Virginians is that if this rise continues, it’s going to be harder for the health system to take care of them if they or a family member or a friend were to get sick.”

\*\*\*

**The trend line** for COVID-19 hospitalizations in Virginia for the past two months looks like a steep hill towering over the two bumps that represent the state’s spring and summer surges. Never have so many Virginians faced hospitalization for COVID-19 at one time.

In the past week, roughly 2,300 Virginians were in the hospital every day for COVID-19, far more than the 1,300 people hospitalized at the peak of the summer surge that followed Memorial Day and 1,600 during the spring peak near the beginning of the pandemic.

The numbers align with the skyrocketing number of infections reported every day in the state. Over the past week, the Virginia Department of Health reported about 3,600 new cases per day, slightly down from a peak of 4,200 last week, but still far above trends in October, when the state was reporting 800 new cases per day. When hospitalizations increase, a surge in deaths typically follows weeks later.

A look at the number of people hospitalized compared to the state’s total capacity and surge capacity doesn’t suggest panic: Of the state’s 16,500 hospital beds, 13,400 were occupied Friday. But health experts in Virginia and elsewhere say that if the virus continues unmitigated, that untapped capacity could quickly dwindle.

On the ground, health care workers interviewed by the Richmond Times-Dispatch say weariness and staffing shortages made worse by growing spread of the virus are not always captured by the number of open hospital beds.

“What you see and hear is a lot of monitors beeping and nurses FaceTiming families. I see a second pandemic coming from the immense mental and emotional toll of the pandemic on those who are fighting bravely,” said Dr. Amit Vashist, an internal medicine physician and psychiatrist out of Johnston Memorial in Abingdon, part of the Ballad Health network.

He is also the chief clinical officer for the system, which announced last month that it was halting elective non-emergency surgeries to help mitigate the strain on its system.

Johnston Memorial has an ICU at 90% capacity, while nearby Norton Community Hospital in Norton is at full capacity, according to data from the federal Department of Health and Human Services updated Dec. 14. Both are Ballad hospitals with more than 100 beds.

“We are on the front lines waging a lonely battle,” said Vashist, explaining that he has watched with frustration as the virus spreads in the community, along with misinformation about hygiene and masking.

Nationwide, around 112,000 people are hospitalized with COVID-19, a dramatic spike from the 30,000 people hospitalized at the start of October. It’s also far above the spring and summer peaks that each saw roughly 60,000 people in the hospital at one time, according to data from the Atlantic’s COVID Tracking Project.

By the number of ICU beds currently occupied, Virginia is better off than many other states, including hot spots like Texas, where several large hospitals have more than 95% of their ICU beds occupied. Nearby Tennessee, Georgia and Alabama are also seeing intense ICU strain.

In Virginia and elsewhere, the COVID-19 vaccine offers a glimmer of hope. The first 70,000 doses of the vaccine to arrive in Virginia are reserved for health care workers, with priority given to workers treating patients with COVID-19. The first doses were distributed on Tuesday.

Virginia expected to be able to vaccinate nearly all health care workers by the end of the year, but state officials were informed by the federal government last week that it should expect 110,000 fewer doses than it was originally promised by the end of the year. The state expected to receive 480,000 doses, enough to give a first dose to every health care worker and nursing home resident in the state — about 500,000 people.

Disappointing news of the delays compound worries about the months ahead, when health care experts warn of a Christmastime surge directly related to holiday socializing and exacerbated by winter weather.

\*\*\*

**By the end** of January, all of Virginia’s hospital regions could face hospitalizations far above their bed capacity, according to projections published last week by the University of Virginia’s Biocomplexity Institute.

Virginia Commonwealth University Health System has begun preparations for worsening COVID-19 trends that could strain its operations, the largest in the state’s central region. VCU Health is elevating its medical surge status, triggering a surge plan that will shift operations to prepare for bed capacity and staffing shortages, the health system and state officials confirmed to The Times-Dispatch.

“In the wake of the Thanksgiving holiday, we are responding to a sharp increase in COVID-19-related admissions and expect a growing surge in the days and weeks to come. That is why we will implement the next level of our surge plan next week and will announce details in the coming days,” said VCU Health spokeswoman Laura Rossacher.

Broadly, Rossacher said, VCU Health will increase the number of outpatient appointments held virtually to reduce the number of people in the hospital and reduce the likelihood of staff being exposed to COVID-19. The health system will also work to staff up in areas where it expects to see growing demand, like its ICU.

The ICU at VCU Health’s flagship hospital in Richmond is at 93% of its capacity, far higher than the state’s other ICUs with at least 100 staffed beds in Charlottesville and Northern Virginia where about two-thirds of ICU beds are taken, according to data from the federal Department of Health and Human Services updated Dec. 14.

According to new data published by the VDH on Friday, VCU’s hospital has the second-highest number of ongoing outbreaks among medical facilities in the state, with at least 16 cases associated with the outbreak. Vaccination of health care workers should help mitigate outbreaks of this kind.

Carey and Virginia Hospital and Healthcare Association spokesman Julian Walker said government health officials and hospital leaders are using a three-number scale to quickly assess the strain on individual Virginia hospitals and regions.

The medical surge level is based on local COVID-19 seven-day trends, ICU occupancy by COVID-19 and non-COVID-19 patients, whether the hospital is diverting any patients and whether it’s facing staff or supply shortages, Walker said.

The state and hospital association declined to publish the levels for each of the state’s hospitals, but said all of the state’s regions remained at a level one. Carey said Ballad Health and VCU Health were the only hospital systems reporting a level two.

“Normal operations is a level one. Two is contingency. And that is the middle ground where you know that you’re starting to either feel the stress, so you have to alter operations, or you’re anticipating that you could in the very near future. And VCU is a good example of that, whereas Ballad Health would be an example of where they definitely have altered their normal operations,” Carey said.

“Then you have the third level, which is crisis standards of care, and that means there is a true crisis where all of the need cannot be met,” he added. “We pray and we’re working very hard to not get there, where you can’t care for everyone the way you want to.”

Carey was briefed by VCU Health officials on the decision Wednesday. Asked about his reaction, he said: “I would recommend that this is clear evidence that Virginia’s health care system is strained, and it’s not just in far Southwest Virginia.”

\*\*\*

**One way** hospitals are managing staffing challenges is by turning to temporary, contracted staff, like traveling nurses.

Qualivis, a South Carolina-based workforce firm that contracts with the Virginia Hospital and Healthcare Association, is working to fill 926 vacancies across Virginia hospitals, said Sherry Kolb, the firm’s president.

Three-quarters of those jobs are for “high-acuity” positions, meaning they work with the sickest patients. That includes ICU nurses, surgical nurses and telemetry nurses.

Kolb said Virginia’s numbers match nationwide trends. The need for temporary hospital staff to help with shortages has spiked. Before the pandemic, Qualivis was working to fill 10,000 health care jobs nationwide; that number is now 29,000. Most of those are “high-acuity” jobs.

Shortages can be chalked up to, at least in part, the two-week quarantining period to which health care workers are subjected if they become exposed to the virus. While there is some flexibility on that quarantine, for the average hospital it means the loss of critical staff.

That reality is exacerbated by the staffing demands of COVID-19 patients, who tend to require additional staff, often in separate wards within the hospital.

Qualivis has dispatched 529 workers to Virginia — mostly nurses — with an additional 216 in the pipeline. Kolb highlighted the extraordinary demands faced by these workers. They generally enjoy the travel involved for the job, one attractive aspect dimmed by the restrictions of the pandemic.

“All people fighting the pandemic are heroes, but these are workers who are moving from hospital to hospital, at the end of the day returning home to an empty hotel, an RV or an Airbnb,” Kolb said.

Virginia health officials are also working to stave off shortages by seeking out health care workers who until recently held licenses to practice, but may have since retired or switched careers.

“We’re looking at anyone who had a license in 2017, and we’re emailing them and calling them. We’re giving that list to each of the [HR] directors to go through and start calling people like, ‘Hey can you come work?” said Megan Healy, chief workforce adviser to Gov. Ralph Northam.

Healy said the workers must have left the field in good standing. She said that in some cases, their licenses will be reinstated as they return to the hospital setting. In others, the workers could use their skills to fill shortages in unlicensed positions.

The hospitals’ association last week sought to speed up that effort and [launched a form on its website](https://www.vhha.com/resources/covid-19-hospital-staffing-opportunities-for-health-care-professionals/) that allows people who meet the criteria to signal willingness to work on the front lines.

Also last week, the Virginia Department of Health issued guidance to hospitals that reduces the time health care workers exposed to COVID-19 must quarantine before returning to work, if the hospital is facing staffing shortages.

While the recommended period is still 14 days, exposed workers can return to work after 10 days if they don’t develop any symptoms, and after only seven days if they test negative for the virus after day five. That guidance is in line with new guidance from the federal Centers for Disease Control and Prevention.

The VDH said hospitals that opt for shorter quarantines should also be working to mitigate their staffing shortages so as to not need this flexibility.

The state also urged health care workers to take precautions during their lives outside of work, including social distancing and wearing masks.

“VDH has learned through outbreak response that [COVID-19] is often brought into hospitals and long-term care facilities by staff exposed in the community,” reads the guidance, published Dec. 15.

It’s another burden levied disproportionately on the shoulders of health care workers in the pandemic. And it’s one exacerbated by the decisions of the broader community they’re caring for: the more community spread, the higher the risk of exposure for workers.

“The Thanksgiving surge is just starting, the Christmas surge is coming and because of the weather, people are gathering inside more,” Vashist said. “At some point, people have to take responsibility.”