

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

2020 Overarching Jurisdictional SARS-COV-2 Testing Strategy

Jurisdiction:	Washington
Population Size:	7,614,893

1. Describe the overarching testing strategy in your state or jurisdiction.

The State of Washington has approximately 7.6M residents. The priorities for testing are tiered and range from testing persons who are symptomatic, close contacts of persons testing positive, persons in congregate settings where there has been one or more positive cases, testing of asymptomatic groups at highest risk of severe illness (e.g. those in long term care settings), and essential workers, including but not limited to: first responders, health care, food and agricultural workers. It is also a priority for the state to work with stakeholders and community members to effectively outreach to and test traditionally marginalized groups, including but not limited to: people experiencing homelessness, people of color, members of tribal nations, Latinx people and those with disabilities.

To meet a minimum of testing 2% of the population monthly, 5,000 persons need to be tested daily. Testing numbers in Washington have slowly increased as specimen collection supplies and PPE have become more available. For the week of May 12-18, approximately 5,100 persons were tested daily. By the week of June 25- July 1, that number has increased to 11,335 persons tested per day. Ultimately, our state's testing goal targets are to test 50 people for every positive case found and to have a majority of test results available within 24 hours.

Recognizing the need for testing will likely exceed this number as fall approaches, Washington State has developed a near-term model for predicting testing needs that includes the following considerations: estimates of disease prevalence, estimates of symptomatic persons presenting for testing and their contacts, and the number of daily tests needed to proportionally sample asymptomatic populations at high risk of community spread. Included in this model, assuming a sustained and reliable supply of specimen collection and processing supplies become available, is weekly to monthly testing of asymptomatic staff living in nursing facilities and memory care units as well as monthly testing of 10% of the asymptomatic persons who are in groups with a high risk of community spread. Efforts will be made to assure staff who work at multiple facilities are identified and tested regularly. Testing frequency will be determined by local case rates.

The numbers initially put forth in this model reflected our estimated daily capacity needs into August. At the time of this plan's submission, we do not feel we have enough epidemiologic information to estimate with certainty our testing needs as flu season arrives. We are hopeful that information obtained from some of the surveillance testing we have planned, along with the information gained from the testing of asymptomatic persons at high risk of community spread, will improve our ability to more accurately model capacity needs beyond August as we head towards fall. We also recognize that

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

the science around testing is rapidly evolving and that new tests may come on line that will further limit the need for PPE and allow us to rethink our approaches.

Current in-state laboratory capacity to test for COVID-19 is significant. If our federal partners can help assure adequate and ongoing laboratory supply chain needs, including sample preparation, extraction, and reagent, 16 of high throughput labs have analytical capacity of analyzing 37,000 specimens daily. In comparing our testing rates to those of other states, if we were to reach 25,000 tests daily, or 3.5 tests per 1000 people, we would be testing at rates comparable to the highest performing states.

There are 122 sites in Washington that report testing for COVID-19, including the 16 noted above, with either fixed and/or point of care platforms. The daily combined capacity of all sites performing testing is more than 47,000. These numbers do not include the processing capabilities of the national commercial labs (which we understand to be encountering repeated, significant delays in sample processing, significantly reducing the utility of the result). These labs provide the bulk of testing for private business and health care related entities and help augment most of the hospital or clinic based labs also providing and processing testing in Washington. The 16 labs have the ability to increase their throughput and by working with additional labs who have expressed an interest in expanding their capacity, with a federal backstop for the supply chain, we could reach the ability to process between 45,000- 50,000 tests per day by year's end.

Washington State law (RCW 43.20, WAC 246-101) requires laboratories and providers report COVID-19 results to local health jurisdictions (LHJ). Electronic lab reporting, ELR, of notifiable conditions is not mandatory, but strongly encouraged. An estimated 87% of COVID-19 RT-PCR tests are reported electronically to Washington State Department of Health, meeting local reporting requirements. While the majority of results are reported via ELR, only a minority of certified labs testing for COVID, 55 (37%) in the state are reporting via ELR. To promote electronic reporting by other labs, we established an electronic laboratory flat file (ELFF) for labs to submit COVID-19 results to DOH. We are working with 87 labs to onboard them to ELFF. While labs are in the process of onboarding to ELFF, their positive results are reported to the LHJ of the patient by phone or fax. Negative results are faxed to DOH for manual entry onto a "mini-ELFF" form so the results can be ingested into our Washington Electronic Laboratory Reporting System (WELRS) and processed together with the ELR labs. Capacity for manual entry of negative lab results is being outpaced by increased testing numbers and we are working to direct COVID-19 testing to laboratories reporting via ELR or ELFF.

With continued resumption of economic and social activity over the ensuing months we expect an increase in the number of contacts an infected person will have, which combined with the onset of cold and flu season, will require further increases in our testing capacity. Over the next several months we plan to increase the number of high risk groups who will be added to routine asymptomatic testing efforts. Working towards this increase through year's end, assuming that supply chain issues for both specimen collection kits and test processing supplies will continue to improve, we will be better able to

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

limit and control community spread. . Without the assistance of our Federal partners in assuring that these supply chains remain steady and that states are supported through continued delivery of Federal supplies to augment state purchasing, to include processing extraction kits and reagents, it will not be possible to perform the necessary number of tests. Most of the labs mentioned above are using high throughput instruments/processes like the TaqPath assay, Cobas 6800/8800, Abbott m2000, Panther Fusion or other lab developed tests. These laboratories have increased their own capacity using existing instrumentation and have added testing capability based on their institution's or business needs. This has led to a diverse set of testing capabilities which will be helpful as supply chain issues may persist for some time. We also anticipate that additional testing capabilities will emerge over the course of the response. We will continue to evaluate the performance characteristics of newly developed lab tests as they become available. While these testing methods/sites may provide additional testing capacity, it is unclear how reliable new test methods are or will prove to be. Antigen testing for instance currently requires confirmatory testing for any negative result. Currently, any test that requires confirmation is difficult to support due to additional labor and PPE required for subsequent sampling. As such, Washington's testing strategy relies on testing performed by established laboratories running more robust and sensitive/specific tests.

In response to the increased need for testing as a result of outbreaks among agricultural and other essential workers who may be uninsured, the State Public Health Lab has added capacity. There has also been capacity added to a mobile Community Supported Testing site run by the National Guard and several mobile response teams from Medical Teams International have been engaged to aid in outbreak response. In addition, strike teams supported by personnel from the State Department of Health have been deployed to help assist local health jurisdictions in responding to outbreaks. The testing supplies needed for these outbreaks have been provided by the state and the bulk of processing has been performed at the State Public Health Lab. As the size of outbreaks have expanded with the seasonal increase in agricultural workers, some of the specimens are being directed to additional labs. To assure there are not barriers to testing for persons who are uninsured, the state is assuming the costs of providing and processing these tests when other payment options are not available. We would like to facilitate the development of additional community-based testing sites in counties experiencing significant outbreaks and inadequate testing levels.

In terms of added testing capability, there are several pharmacies and private businesses, some of which are employing point of care testing platforms that currently offer or are planning to offer onsite testing services through their clinics or as part of a drive through operation. To date, drive through testing sites have been set up and supported with the help of FEMA, individual cities, counties, local health jurisdictions, healthcare centers and first responders. As the availability of PPE and specimen collection supplies increase, outpatient health care providers will be able to incorporate testing for COVID-19 into their routine work flows, adding substantially to current access points for testing.

Currently, Washington State is considering ways in which to broaden its strategy for the use of serological testing for COVID-19. While its utility as a clinical tool is not fully understood given the

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

uncertainty around the degree of immunity conferred through past infection, understanding regional differences in estimated seroprevalence rates can provide actionable information. The results of the Commercial Laboratory Seroprevalence Survey Data posted by the CDC on June 26, 2020 highlights the degree of undetected infections in Western Washington. If regional seroprevalence estimates of past infection are available, this knowledge can be used to inform the size and scale of future outbreaks and the extent of mitigation strategies needed in response to new outbreaks.

Current capacity within the State to perform serologic testing as referenced is presented in the table below. In addition, the State Public Health lab plans to run up to 250 serological tests per day for diagnostic/surveillance purposes. We will serve as a reference lab to support verification of serology testing within clinical labs throughout Washington State to increase capacity. In addition, we will provide serological testing as needed to investigate children with symptoms consistent with Multisystem Inflammatory Syndrome. Additional information obtained from 3 statewide seroprevalence surveys currently planned in partnership with the University of Washington and Vulcan Inc, in which oversampling of vulnerable populations will be carried out, a 7 –state Survey from Emory University and data provided from the Red Cross on seroprevalence among blood, platelet, and plasma donors will add to our understanding .

A key component of Washington’s approach to testing is the development of a statewide testing network across laboratories. Unlike other outbreaks, the scale and need for testing far outstrips the ability of the Public Health Lab to manage all specimens collected outside of the health care system. The network will provide increased testing capacity, manage samples unable to be processed by the Public Health Lab and will accept universal requisition forms. The labs will bill patient insurance whenever possible and seek reimbursement from the State when a patient doesn’t have insurance or is otherwise ineligible. The State will develop an electronic test ordering portal that will collect all required demographic information to facilitate rapid contact tracing. The labs will be required to report results electronically to the State Department of Health. Each laboratory will provide daily updates on available capacity such that the ordering portal can route samples to labs that can accept samples. This will maximize testing efficiency, minimize sample TAT and reduce specimen backlog. We will hold regular conversations with a variety of institutions involved in sample collection, including healthcare systems, clinics, local health jurisdictions and community-based testing sites, as well as with labs.

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

Table #1a: Number of individuals planned to be tested, by month

BY MONTH:	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
Diagnostics*	434,000	600,000	930,000	1,364,000	1,320,000	1,364,000	1,364,000	1,364,000	8,740,000
Serology	0	0	0	0	0	0	0	0	0
TOTAL	434,000	600,000	930,000	1,364,000	1,320,000	1,364,000	1,364,000	1,364,000	

*Each jurisdiction is expected to expand testing to reach a minimum of 2% of the jurisdictional population.

Table #1b: Planned expansion of testing jurisdiction-wide

Name of testing entity	Testing venue (select from drop down)	Performing Lab (if different from testing entity)	Daily diagnostic through-put	Daily serologic through-put	Specific at-risk populations targeted (list all)
Northwest Pathology & Northwest Laboratory	Commercial or private lab		8,000		Nursing homes and long term care facilities (Patients and staff)
UW Lab Medicine Virology (UW) MOLECULAR	Hospitals or clinical facility		8,000		Nursing homes and long term care facilities (Patients and staff)
Polyclinic Madison Center	Hospitals or clinical facility		0	3,000	Nursing homes and long term care facilities (Patients and staff)

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

Name of testing entity	Testing venue (select from drop down)	Performing Lab (if different from testing entity)	Daily diagnostic through-put	Daily serologic through-put	Specific at-risk populations targeted (list all)
2nd Floor Lab SEROLOGY					
UW Lab Medicine Virology (UW) SEROLOGY	Hospitals or clinical facility		0	3,000	Nursing homes and long term care facilities (Patients and staff)
Altius Institute for biomedical science	Commercial or private lab		1,700		Nursing homes and long term care facilities (Patients and staff)
Pacific Northwest National Laboratory - already live but wish to be underwater	Other		1,300		Nursing homes and long term care facilities (Patients and staff)
Molecular Epidemiology Inc	Commercial or private lab		800		Nursing homes and long term care facilities (Patients and staff)
WA PHL	Public health lab		1,000	250	Nursing homes and long term care facilities (Patients and staff)

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

Name of testing entity	Testing venue (select from drop down)	Performing Lab (if different from testing entity)	Daily diagnostic through-put	Daily serologic through-put	Specific at-risk populations targeted (list all)
FIDA lab	Commercial or private lab		750		Nursing homes and long term care facilities (Patients and staff)
Everett Clinic	Hospitals or clinical facility		450		Nursing homes and long term care facilities (Patients and staff)
The Brotman Baty Institute at the University of Washington (aka, Seattle Flu Study Lab)	Hospitals or clinical facility		600		Nursing homes and long term care facilities (Patients and staff)
Molecular Testing Labs	Commercial or private lab		3,000		Nursing homes and long term care facilities (Patients and staff)
US Biotek Laboratories LLC	Commercial or private lab		500		Nursing homes and long term care facilities (Patients and staff)
InCyte Diagnostics	Commercial or private lab		700		Nursing homes and long term care facilities (Patients and staff)
Atlas Genomics LLC.	Commercial or private lab		3,000		Nursing homes and long term care facilities (Patients and staff)
Washington State University	Other		500		Nursing homes and long term care facilities (Patients and staff)

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

2020 Direct Expansion of SARS-COV-2 Testing by Health Departments

2. Describe your public health department's direct impact on testing expansion in your jurisdiction.

The State of Washington currently has high throughput labs with the capacity to assess close to 37,000 specimens per day, if they are kept fully supplied, or 9% of the State's population every month. As we are able to establish a secure and continuing supply chain of specimen collection and test processing materials, and expand testing to asymptomatic persons at high risk of community spread, we hope to increase our testing capacity to 45,000-50,000 by year's end.

As described in our overarching testing strategy, this expansion will build upon the capabilities of current high throughput labs and their expressed plans to further expand their capacity. A portion of the current capacity has been achieved by redirecting staff in our State's Public Health Lab. As of this writing, 80-90% of the work performed within the Lab's Microbiology Office is COVID-19 related. To meet this need, we have curtailed or eliminated many routine functions such as foodborne disease surveillance, flu surveillance, TB and STD testing. Part of our strategy is to leverage the use of additional funds to support and expand the ongoing COVID-19 testing at the Public Health Lab and allow all routine functions to resume. Our plans include the purchase of the Cobas 6800, 2 KingFisher Flex extraction platforms, one Thermo Fisher Q5 Real-Time PCR platform, one Panther Fusion platform and 1 Abbott Alinity serology platform. These platforms will improve labor efficiency and maintain rapid turnaround time (TAT). To further increase capacity, the PHL will evaluate pooling on the COBAS 6800. Our intent is to perform a validation/verification study and determine how many samples can be pooled without excessive loss of sensitivity. If needed, and prevalence remains relatively low, this approach may serve to increase throughput and/or preserve limited reagents. The WAPHL will also evaluate multiplex assays that allow for simultaneous detection of influenza and COVID-19. To achieve this increase in capacity for the near term and what is likely to be a need for additional capacity come fall and winter, efficient use of the current laboratory system in Washington State and the creation of a laboratory network, will be needed.

To support an increase in efficiency, funds will also be used to improve or replace the Public Health Lab's LIMS system. Because there is not at present a state-wide laboratory network, we recognize the need to develop an infrastructure that will allow a real-time look at lab capacity across the network. This will assure samples can be routed to labs that have current capacity and not overwhelm them or slow down their TAT. We also plan to provide real time information that allows persons submitting specimens a view of a lab's current supplies of testing and processing materials to assure that capacity exists to meet their needs. As of this writing the Washington Department of Health has developed a contract with four of the largest COVID-19 testing labs in Washington with plans to add more.

All labs participating in the network are required to report results electronically to state and local stakeholders. The Public Health Lab is using an electronic portal for submissions. We have expanded this

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

portal for use by all network labs. The enhancement will add the ability to capture information for billing insurance, contact tracing and support QR code generation. This will facilitate the transfer of information from the requisition into the receiving lab's LIMS. The system will have an interface for network labs to update their testing capacity on a daily basis. This will allow the system to route samples to labs with capacity. We expect that this system will ensure specimens are submitted and tested in an efficient manner. Submitters will only need to interface with one portal and by using a universal requisition form, specimens can be re-directed without the need for additional paperwork. The State will also establish a courier to pick up and deliver specimens as appropriate. The state will continue to procure specimen collection that will be provided at no charge to local health jurisdictions.

Critical to achieving the capacity needed to effectively control the outbreak will be our ability to do two things. The first is to increase demand for the tests. We plan to work with our medical associations and our media partners to help encourage people to actively seek out testing. Due to initial supply limitations, we have previously recommended testing be prioritized for persons with moderate or severe symptoms or persons associated with an outbreak. Through additional state procurement efforts and with the supplies received from our Federal partners, our testing guidance has expanded to include testing all persons, regardless of symptom severity, who present with symptoms consistent with COVID-19 and their close contacts. This has led to an increase in demand but continued efforts are needed to increase demand even further. The second critical requirement will be to maintain an adequate supply of specimen collection and processing materials. As everyone in the world is competing for the same resources, we have been challenged in obtaining adequate supplies. In addition to shortages and delays, we have received large numbers of swabs and viral transport media that have failed quality control checks, some from international but also U.S. companies. This has led to our inability to adequately provide tests to all those who request them. More recently we have heard from a number of labs that they are unable to obtain the extraction kits and reagents they need to process specimens. While our Federal partners have helped to address our specimen collection needs in the last two months, we are concerned that unless their plans to support states in procuring adequate swabs and VTM continue through the end of the year, we will not be able to keep up with our testing goals or have any chance of meeting surge needs come fall. We would also like to request assistance with processing supplies. We can collect all of the tests we have available, but if the labs are unable to process them in a very timely manner, we will miss our opportunity to effectively control community spread. We respectfully request our Federal partners' assistance in assuring states are able to maintain adequate supplies of specimen collection and laboratory processing materials.

Vulnerable populations are part of our third tier of testing after persons with symptoms and their contacts. Our plans include rapidly scaling physical access to testing and the development of culturally tailored and community-specific information about molecular testing for those in congregate settings with one or more active cases, such as nursing homes, assisted living, adult family homes, low-income housing/high risk housing, correctional settings, homeless shelters, farm worker housing, and worksites like meat-packing plants. To assure adequate testing and surveillance of our long term care facilities, we performed and have completed a point prevalence survey in nursing facilities and memory care units. Reassuringly the rate of asymptomatic infection was low, 0.8%, with 144 out of 18,607 persons testing

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

positive. Systems will be set up to continue routine testing of the staff in these facilities. By the end of August, all residents and staff in assisted living facilities across the state will be tested. Targeted testing of staff and residents of adult family homes and of facilities owned, operated or contracted by the Washington Department of Social and Health Services (DSHS) will also occur. In response to an outbreak in a nursing facility or congregate setting, repeat testing will be based on the epidemiology of the outbreak and determined by local health officials. The state testing program includes staff whose focus is on equity. Dashboards are being developed that will reflect the rates of testing across the state. This dashboard will overlay variables associated with the social determinants of health to assure groups that may be under-represented in terms of access to testing are identified. The equity support team will also work with our tribal partners and the local health jurisdictions to help support their community outreach efforts to vulnerable and disproportionately affected populations, including efforts to address language barriers. We will work with our partners to help provide access points for testing that are low barrier and culturally appropriate to these less served communities. We will also look at how home testing can be used to support persons who are not able or who should not travel.

The state is continuing to look for ways to support local health jurisdictions and tribal nations to expand testing sites. Several local health jurisdictions have developed drive through testing sites with health care providers in their communities and some of the larger cities, Seattle and Tacoma, have developed drive through testing sites as part of public/private partnerships. Companies like Walmart, CVS and Bartell's have reached out to partner in these efforts and have been directed to the local health jurisdictions to determine how best to support their communities in terms of locating collection sites that are most accessible to the local population. More recently we have been in communication with Kroger, Safeway, Walgreen's, Rite Aid, UPS, Optum Serve and first responder units to add specimen collection capacity across the state. The Department of Health will also continue to procure specimen collection kits to ensure local health jurisdictions are able to respond to outbreaks and to act as a backup source of supplies for health care systems and providers.

Currently, Washington State is working with epidemiologists and infectious disease specialists from academia and the private sector to determine how best to use the results of seroprevalence studies to inform the need for regional resources. Current capacity within the State to perform these tests is referenced in the table below.

The Public Health Lab's plan for serologic testing, including to serve as a reference lab as noted in the previous section. For sentinel surveillance, the State of Washington will work with academic and philanthropic partners. Ongoing surveillance will occur through existing systems. As well results of molecular testing obtained from the Greater Seattle Coronavirus Assessment Network (SCAN), an outgrowth of the Seattle Flu Study, will continue to be used to aid in these efforts.

The Washington Department of Health has no current limitations regarding hiring of staff or purchasing of equipment in support of the COVID-19 response. All HR and procurement processes have been streamlined as the result of the activation of our State's Incident Response Framework. Our plan for hiring staff will be to simultaneously recruit for management positions and bench staff. We will shift current staffing to a 24 hour operation to accommodate additional staff and maintain appropriate social distancing. Procurement of equipment and supplies will continue to occur through established relationships with vendors.

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

Despite our progress since submitting the first version of this plan, significant barriers remain. Many employers who engage employees for seasonal work are reluctant to allow testing of their workers due to concerns of work stoppage. Similarly employees, many of whom are here on worker visas, are reluctant to test as their wages depend on their presence at work and they are concerned they will not be able to provide for their families. This is also true of many lower paid health care staff working in long term care facilities. In addition, lack of clarity around who bears the responsibility to pay for surveillance testing in nursing facilities impedes facilities willingness to test. For facilities with 100 staff that are required to test weekly at \$100/test, paying \$40,000 per month for testing alone is not sustainable. Without adequate and sustained access to testing collection and processing supplies, employers, educational institutions and the public will seek 'clearance' testing to return to their normal routines, potentially reducing testing capacity for those most in need. Clear guidance as to who should pay for non-illness, non- contact related testing or a dedicated funding source to help support this demand for testing would be welcome.

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

Table #2: Planned expansion of testing driven by public health departments

BY MONTH:	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
Number of additional* staff to meet planned testing levels	50	0	0	0	0	0	0	0	50
FOR DIAGNOSTIC TESTING									
How many additional* testing equipment/ devices are needed to meet planned testing levels? (provide an estimated number, and include platform details in narrative above)	3	0	0	0	0	0	0	0	3

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

BY MONTH:	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
Volume of additional swabs needed to meet planned testing levels ⁺⁺	150,000	150,000	660,000	660,000	660,000	660,000	660,000	660,000	4,260,000
Volume of additional media (VTM, MTM, saline, etc.) needed to meet planned testing levels ⁺⁺	250,000	250,000	660,000	660,000	660,000	660,000	660,000	660,000	4,460,000

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

BY MONTH:	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
Volume of additional reagents needed to meet planned testing levels, by testing unit and platform (i.e. 100K/day - Hologic panther; 100k/day - Thermofisher)	TaqPath; 10700/day, Cobas; 6800/day, Unknown LDT; 3628/day, Abbott m2000; 450/day	TaqPath; 10700/day, Cobas; 6800/day, Unknown LDT; 3628/day, Abbott m2000; 450/day	TaqPath; 11550/day, Cobas; 8800/day, Unknown LDT; 3600/day, Abbott m2000; 450/day, Panther Fusion; 700/day	TaqPath; 11550/day, Cobas; 8800/day, Unknown LDT; 3600/day, Abbott m2000; 450/day, Panther Fusion; 700/day	TaqPath; 10750/day, Cobas; 9800/day, Unknown LDT; 3600/day, Abbott m2000; 450/day, Panther Fusion; 700/day	TaqPath; 10750/day, Cobas; 9800/day, Unknown LDT; 3600/day, Abbott m2000; 450/day, Panther Fusion; 700/day	TaqPath; 10750/day, Cobas; 9800/day, Unknown LDT; 3600/day, Abbott m2000; 450/day, Panther Fusion; 700/day	TaqPath; 10750/day, Cobas; 9800/day, Unknown LDT; 3600/day, Abbott m2000; 450/day, Panther Fusion; 700/day	
FOR SEROLOGIC TESTING									
Number of additional* equipment and devices to meet planned testing levels	0	1 Alinity	0	0	0	0	0	0	0

ELC ENHANCING DETECTION: WASHINGTON TESTING PLAN

BY MONTH:	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
Volume of additional reagents needed to meet planned testing levels, by testing unit and platform (i.e. 100K/day - Hologic panther; 100k/day - Thermofisher)	Abbott; 3000/day, Unknown LDT; 3000/day	Abbott; 3000/day, Unknown LDT; 3000/day	Abbott; 3000/day, Unknown LDT; 3000/day	Abbott; 3000/day, Unknown LDT; 3000/day	Abbott; 3250/day, Unknown LDT; 3000/day	Abbott; 3250/day, Unknown LDT; 3000/day	Abbott; 3250/day, Unknown LDT; 3000/day	Abbott; 3250/day, Unknown LDT; 3000/day	

* Report new monthly additions only, not cumulative levels

++ For May and June, only include needs beyond the supplies provided by FEMA. Report new monthly additions only, not cumulative levels.