Letters

Editor’s Note

The Uncertain Effects of Surveillance Screening for COVID-19 for Individuals Entering Health Care Facilities

Entrance surveillance screenings have been widely implemented in health care settings during the COVID-19 pandemic. These measures, which are required by the US Department of Labor, rely on self-reported factors such as symptoms or exposure history and are intended to reduce risk to patients and health care workers. In this issue of JAMA Internal Medicine, Roberts and colleagues examine the usefulness of entrance surveillance screenings at a single academic medical center. They find that during the first wave of the pandemic, about 1 in every 38 people screened positive. However, during later periods, the catch rate was considerably lower, closer to 1 in every 3000 people. This lower rate was constant regardless of community incidence of disease. It cannot be known from their findings if the screening requirement itself acted as a deterrent to those who might have otherwise sought entry to the health care center. Awareness of the screening procedure or of the nature of COVID-19 symptoms may have increased over the course of time.

Surveillance screening is expensive for health care systems and a daily annoyance for those who work there. The authors suggest that screening may have maximum utility during the early phase of a public health crisis. Nonetheless, self-reported symptoms have a low sensitivity for true infection with COVID-19, so it remains unclear the degree to which screening measures are truly effective in reducing the spread of COVID-19.

Certainly there is value in keeping all symptomatically ill workers and visitors out of the hospital—not merely those who are infected with COVID-19. It is known that some health care workers come to work under virtually any personal health circumstance due to tacit pressure. COVID-19 surveillance screening has enabled workers to appropriately stay home when they are ill.

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