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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