



**California Department of Public Health
All LHD Coronavirus Update Call July 23, 2020
1:00 pm – 2:00pm**

Contents

.....	1
Clinical	2
MIS-C Update	2
Cases with Concern for Re-infection	2
Reporting of Pregnant Cases and Pediatric Cases	2
Warmline	3
Epidemiology & Surveillance Update	4
Viral and Rickettsial Disease Laboratory (VRDL).....	5
Antigen Assays to detect SARS-CoV-2	5
CLIA Waived SARS-CoV-2 Point of Care Antigen Tests.....	6
CalREDIE & ELR.....	6
Healthcare-Associated Infections (HAI) Program	7
Occupational Health Branch (OHB).....	9
Contact Tracing	9
Workforce	9
Training	9
Data Management Platform (CalCONNECT).....	10
Isolation and Quarantine	10
Testing Task Force	10
Questions & Answers	13
Mentioned URLs	15
Team Contacts	16

Clinical

MIS-C Update

Thank you again to all those who have continued to work with us to report cases of multisystem inflammatory syndrome in children (MIS-C). Currently we are aware of 23 confirmed cases of MIS-C in the state of California.

As the overall case burden increases across the state, we expect there to be more cases. Reporting this condition is extremely important so that we can continue to track this severe condition.

Hospitals and health care providers should immediately report cases meeting the MIS-C case definition to their respective local health jurisdictions (LHJs). LHJs should then report cases to CDPH.

As a reminder, for reporting MIS-C in CalREDIE, the condition can be found under the title “Multisystem inflammatory syndrome associated with Coronavirus disease”.

Please also send us an email at CoVmis-c@cdph.ca.gov if our team can be of assistance to you as you work on these cases.

Cases with Concern for Re-infection

We have been seeing anecdotal reports in the news [media reporting](#) potential cases of re-infection. While we suspect that these few reports of recurrence are not truly re-infections with SARS-CoV-2. Because people can continue to shed non-viable viral particles for weeks after infection, repeat positive molecular testing in these cases doesn't necessarily represent active infection.

In certain cases, especially when an individual who was known to previously have COVID-19, recovered, and then re-developed symptoms with a repeat positive SARS-CoV-2 PCR and no other diagnosis after an appropriate infectious disease work-up, viral culture may be an appropriate next step. If you know of cases like this in your jurisdiction, CDPH may be able to assist you in pursuing culture. Please email the COVID-19 clinical team at CoronavirusClinical@cdph.ca.gov and we can assist in reviewing the case and discuss if viral culture would be appropriate.

Reporting of Pregnant Cases and Pediatric Cases

Please note that ICU admission in pregnant patients as well as ICU admissions in children under 5 years of age should be reported to CDPH. To report admission to the ICU in either of these populations, please call the warmline during business hours.

Additionally, COVID-19 deaths in cases under the age of 18, COVID-19 deaths in pregnant cases, and cases of stillbirth or fetal demise related to COVID-19 should be reported. To report these cases, please call the warmline if during business hours or the DCDC Duty Officer if after hours.

Warmline

The CDPH warmline operates from 8am to 5pm on Monday through Friday and is only for local health departments to use. Please use the warmline to request assistance for outbreaks if needed; report deaths and ICU admissions among vulnerable populations; and submit requests for consultation. Outside of the warmline hours urgent reports and requests for assistance should be directed to the DCDC Duty Officer. Please note that new outbreaks do not need to be called into the warmline unless assistance is needed.

Type of Report ↓	8am-5pm Mon-Fri	8am-5pm Sat-Sun	5pm-8am (after hours) 7 days/week
Death <ul style="list-style-type: none"> • <18 years old • Pregnant person • Fetal demise (stillbirth) • Death of special concern (at discretion of LHD) 			Call DOD
Outbreak/ cluster in congregate living, community, or workplace setting <ul style="list-style-type: none"> • Requests for assistance 			Call DOD only if urgent assistance is required that cannot wait until the morning
Case in vulnerable population and/or case with potential for large transmission Report cases in: <ul style="list-style-type: none"> • <5 years old in ICU • Pregnant in ICU Other cases at LHD’s discretion, e.g.: <ul style="list-style-type: none"> • People experiencing homelessness in a congregate living facility • Long-term care facility residents and staff 	Call Warmline (510) 255-8922	Call DOD (916) 328-3605	Call DOD only if urgent assistance is required that cannot wait until the morning
Cases related to flights	Email flight info to CovTravelEpi@cdph.ca.gov		

NOTE: ALL cases should be reported to CDPH by entry into CalREDIE by the following day, or by LHJ's usual method of reporting.

Epidemiology & Surveillance Update

As of July 22, 425,616 cases of COVID-19 were reported in California, including 8,027 deaths.

At this time, CDPH continues to report only confirmed cases. The CSTE position statement and CDC definition for a confirmed case of COVID-19 does not include a timeframe for re-infection. This means there should be only one positive confirmed COVID-19 incident for each individual person.

To prevent double-counting of patients, the Epi Team continues to review for duplicate positive incidents. When a duplicate is identified, the Epi Team will change the 'Resolution Status' of the duplicate to 'Previously Reported,' and record the change in the 'Notes' section, including the CalREDIE ID for the duplicate incident. The Epi Team will not perform incident merges. To determine which duplicate incident should be retained or counted, the Epi Team will prioritize records that contain: positive laboratory results, a link to CalCONNECT, completed data elements for demographic, lab and clinical information, and files uploaded to the electronic filing cabinet.

Laboratories that are unable to submit results to CalREDIE electronically (by ELR) have been providing .csv files that CalREDIE routes to the Epi Team for review. We identify positive tests results and confirm that these have not been reported in CalREDIE. We use patient address, or and if unavailable, provider address, to identify the appropriate jurisdiction to send these results. We are sending LHJs a secure email with the subject line: COVID non-ELR Positive Results [secure]. In this email, we are asking LHJs to please enter these cases into CalREDIE, otherwise they cannot be counted. We recognize that the volume is increasing and are currently working with CalREDIE on methods for importation that will not interfere with your workflow and reduce burden of hand entry—we appreciate your patience with this process.

Finally, CDPH continues to assist LHJs with notification to CDC when a confirmed case of COVID-19 has traveled on an airplane while infectious. CDC will then contact the airline, identify exposed passengers using a flight manifest and send notifications to state and local health jurisdictions via EpiX notification. As a reminder, if an investigation reveals that a case was on a domestic or international flight while infectious, please call the CDPH warmline or send an email to CoVTravelEpi@cdph.ca.gov. CDPH will need the following information to send to CDC. These flight details should also be completed in the CalREDIE incident:

- Patient info (name, DOB)
- Flight dates and details
- Date of symptom onset

- Symptoms on day of travel
- Lab results

Viral and Rickettsial Disease Laboratory (VRDL)

Considering news that CMS (Centers for Medicare & Medicaid Services) plans to provide these tests to SNFs, I will briefly discuss COVID-19 antigen tests and their use as CLIA waived assays.

Antigen Assays to detect SARS-CoV-2

Antigen tests can provide relatively rapid results; however, they are not as sensitive as molecular nucleic acid amplification assays, such as PCR. Thus, although positive results tend to be accurate, a negative result should be interpreted with caution.

A negative result from an antigen assay may be a false negative. Indeed, one antigen test (BD Veritor) advised that negative results should be considered presumptive, while the other approved Ag test says that negative results from patients with symptom onset beyond five days should be treated as presumptive.

- To quote the package insert from the BD Veritor antigen test: “Negative results should be treated as presumptive, do not rule out SARS-CoV-2 infection and should not be used as the sole basis for treatment or patient management decisions, including infection control decisions. Negative results should be considered in the context of a patient’s recent exposures, history and the presence of clinical signs and symptoms consistent with COVID-19, and confirmed with an FDA authorized molecular assay if necessary for patient management.”

Noted limitations for the Quidel Sofia Antigen assay include:

- The use of viral transport media may result in decreased test sensitivity, and directly testing specimens is recommended.
- Some lots of M4 and M4RT have been shown to cause false positive results when used with the Sofia SARS Antigen FIA Assay and therefore should not be used with this system.

There have been recent anecdotal reports of false positives with antigen assays.

Antigen tests are NOT recommended for screening of asymptomatic individuals or screening of healthcare workers, first responders and other essential personnel.

Overall, it is difficult to assess the performance characteristics of antigen assays until we have more clinical test data. So we will have to wait to see what the data tell us going forward.

The Association of Public Health Laboratories (APHL) has published a [guidance](#) document on the use of antigen tests.

CLIA Waived SARS-CoV-2 Point of Care Antigen Tests

CLIA waived tests may be performed at sites that possess a CLIA Certificate of Waiver. These sites are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Facilities performing only waived tests have no routine oversight and no personnel requirements. These sites are only required to obtain a CLIA Certificate of Waiver, pay biennial certificate fees, and follow manufacturers' test instructions.

The two antigen tests currently with FDA EUA status are both considered CLIA waived assays meaning that, as defined by CLIA, these waived tests are simple with a low risk for an incorrect result, but they are not error-proof.

Despite being a CLIA waived test, erroneous results may have serious health consequences. To decrease the risk of erroneous results, the test must be performed correctly, by trained personnel, and in an environment where good laboratory practices are followed.

Links:

CDC guidance on CLIA [Waived tests](#)

FDA EUA [list of approved COVID-19 tests](#)

[Specimen collection](#)

[The California COVID-19 Testing Task Force](#) (CA TTF)

CA TTF ["Find a Test Site"](#) tool

CalREDIE & ELR

Update on CalREDIE and ELR.

We have a total of **313** labs reporting ELR, an increase of 7, including **22** Public Health Labs. The CalREDIE ELR team continues to onboard new laboratories for reporting, and work with our existing submitters to improve data quality and timeliness.

CalREDIE received an extraordinarily high volume of incoming ELR data late last week (nearly 3x our new normal daily volume), which resulted in some delays in processing incoming ELR data. The CalREDIE Team and our ITSD partners worked through the weekend to increase infrastructure, conduct monitoring, and ensure the data was processed as quickly as possible. This is a continued area of focus for the CalREDIE and ITSD teams. Additional work is on-going to decrease the time from when the lab results the test to when it is reported.

Recently, CDPH, in consultation with the California Conference of Local Health Officers, updated Title 17 sections 2500 and 2505 to improve our ability to accurately assess disparities in reportable conditions related to race, ethnicity, sexual orientation and gender identity. We've also shortened the laboratory reporting timeframe for SARS-CoV-2.

2500 (Provider reporting to public health) Changes

- Requirement to report sexual orientation and gender identity data elements:
 - Current gender identity
 - Sex assigned at birth
 - Sexual orientation
- Clean-up of Race/Ethnic Group to separate data elements:
 - Race
 - Ethnicity

2505 (Laboratory reporting to public health) Changes

- Requirement to include Race and Ethnicity on test requisition and lab report
- Change in SARS-CoV-2 reporting timeframe
 - No longer required to be reported immediately by telephone
 - Must be reported to public health within eight hours

Additionally, we have increased the frequency of transmission of cases from CalREDIE to CalCONNECT from once per day to three times per day (at 6:00a; 10:00a and 2:00p). The CalREDIE system is updated once per day (in the morning) with cases that have been closed in CalCONNECT.

This weekend is a CDPH IT Maintenance Weekend and the CalREDIE servers have been prioritized. The CalREDIE system will be unavailable starting at 10 PM Friday night, and will be available by 12 PM on Saturday July 25th. The Help Desk will send out a notification on Saturday, when the system is available.

REMINDER: When emailing the CalREDIE Help Desk, please remember to NOT include protected health information (PHI), unless the email is sent securely.

Healthcare-Associated Infections (HAI) Program

CDC has updated their guidance on the [duration of isolation and precautions](#) and the role of testing strategies for their discontinuation and return to work for infected healthcare personnel.

Essentially, CDC no longer recommends the test-based strategy except for persons who are severely immunocompromised (e.g., currently receiving chemotherapy, or recent organ

transplant), and they are recommending a symptoms-based approach of 10 days after symptoms onset (or date of positive test for asymptomatic individuals) with lack of fever and improving symptoms for 24 hours (instead of 72 hours) for most individuals; extending the duration to 20 days can be considered for persons with severe illness.

To inform these changes CDC cites available data that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset, and that persons with more severe to critical illness or severe immunocompromised likely remain infectious no longer than 20 days after symptom onset. Whereas recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, replication-competent virus has not been reliably recovered in these individuals and studies have not found evidence that clinically recovered persons with persistence of viral RNA have transmitted SARS-CoV-2 to others. As such, CDC is recommending a symptom based, rather than test-based strategy for ending isolation of these patients, so that persons who are by current evidence no longer infectious are not kept unnecessarily isolated and excluded from work or other responsibilities.

In addition, CDC acknowledges that reinfection with SARS-CoV-2 has not yet been definitively confirmed in any recovered persons to date, and that if, and if so when, persons can be reinfected with SARS-CoV-2 remains unknown and is a subject of investigation. Persons infected with related endemic human betacoronavirus appear to become susceptible again at around 90 days after onset of infection. Thus, for persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection. In addition, quarantine is not recommended in the event of close contact with an infected person.

Importantly, this 3 month timeframe also now applies to [retesting of residents and healthcare personnel in skilled nursing facilities](#), where previously the recommendation was to retest as part of facility-wide testing after 8 weeks. Residents and HCP who had their initial positive viral test in the past 3 months and are now asymptomatic do not need to be retested as part of facility-wide testing; testing should be considered again (e.g., in response to an exposure) only if it is 3 months after the date of onset of the prior infection.

For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset, if an alternative etiology cannot be identified, then the person may warrant retesting in consultation with infectious disease or infection control experts. Quarantine, isolation and transmission based precautions, may also be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.

Occupational Health Branch (OHB)

In June, the Occupational Health Branch posted guidance documents to assist local health departments and employers managing workplace outbreaks of COVID-19. These guidance documents include a table with return-to-work criteria listed by the employee's status, such as "symptomatic, laboratory confirmed infection" or "asymptomatic, exposed but not tested." We are now updating the guidance documents to reflect CDC's recent changes to the discontinuation of isolation criteria. Specifically, we are changing the requirement that a worker be fever-free for 72 hours to 24 hours to be consistent with CDC.

We will continue to emphasize the symptom- or time-based strategy for discontinuation of isolation, rather than the test-based strategy. CDC no longer recommends the test-based strategy in most cases. This recommendation to stop using the test-based strategy was made on the basis of recently published studies. These studies have found that virus detected 10 days following symptom onset is not replication-competent and that contacts exposed 6 days or later following symptom onset do not become infected.

Contact Tracing

We would like to provide you a few updates from the CA COVID-19 Contact Tracing workgroup.

Workforce

Our workforce team is continuing to deploy redirected staff to LHDs throughout the State. In the past we were only training and deploying redirected state staff as contact tracers. However, we understand the current urgent need for case investigators and are identifying and pre-screening state staff that could be trained to perform this more advanced role. Our pool of potential case investigator trainees is currently very small but we are working to identify and train additional staff. Deployment is made through MHOAC requests -- if your LHD is in need for contact tracers or case investigators, please submit your request through your MHOAC coordinator. LHDs may also choose to train redirected state staff contact tracers to become case investigators but it is required that this is done in consultation with CDPH prior to training.

Training

In partnership with UCSF and UCLA, we continue to provide subject-matter training courses for case investigators and contact tracers. This training, called the Virtual Training Academy, or VTA, runs weekly. In response to the need for additional case investigators around the state, the VTA is launching a new track for previously trained contact tracers who need additional case investigator training. This track will include approximately 1.5 hours of webinar and two 90-minute skills labs. The first session will begin August 3 and will continue through the end of the month. Local health departments (LHD) staff can register for the VTA by visiting the [training registration portal](#).

Data Management Platform (CalCONNECT)

To date, we have on-boarded 40 LHD to CalCONNECT (California CONFidential NETWORK for Contact Tracing), the state's contact tracing data management platform. We have recently implemented significant enhancements and new functionality to the data platform which include: 1. Increasing data transfers from CalREDIE to CalCONNECT from once a day to three times a day, 2. Inbound calling, 3. Sending outbound emails, 4 Allowing data capture for monitoring during isolation and quarantine, and 5. Enhanced referral capabilities. We are also piloting new functionality that facilitates contact tracing of outbreaks via exposure location.

Isolation and Quarantine

Finally, on July 17, CDPH released [Guidance on Isolation and Quarantine for COVID-19 Contact Tracing](#). This guidance provides a framework for local public health departments and the contact tracing workforce related to both isolation and quarantine. Of note, this document was released just as the CDC updated their guidance on the duration of isolation, and thus we are working to align with the CDC on these updated changes in this CDPH document as soon as possible.

For additional questions, please email our team at CALHJ_COVIDCT@cdph.ca.gov. Note, this e-mail address is for LHD use only -- please do not share it outside of LHD staff.

Testing Task Force

As you are all aware there are increases in COVID-19 cases nationwide. Simultaneously states throughout the country have scaled testing. This has caused new constraints for testing in California. Prior to the 4th of July weekend California was consistently performing 80-90,000 test per day. Then over the holiday weekend California hit an all-time high of 127,000 tests in a single day and now are consistently doing over 120,000 tests daily. This increase in testing in California and nationally has resulted in increased number of specimens that are going to labs, increasing the time for a patient to get an appointment to have a test, and markedly increased turnaround time to get test results back.

All of this impacts timely clinical care, implementation of contact tracing and ultimately inhibits our ability to control the COVID-19 epidemic here in California. The way this has been experience on the ground is that testing supplies that are delivered to testing sites for collection have been limited –sometimes substantially. This has resulted in some testing sites having to close. Yet we know in California that we have over 400 high and medium throughput labs resulting in a potential capacity of 190-200 thousand tests per day if the sites ran 24/7. Or about 66,000 cumulative tests across all labs in an 8 hour shift.

So initially the TTF thought if we matched the organizations needing testing to the labs that still had capacity we could resolve the issues. In fact the TTF has a [lab list](#) that identifies over 50 of

these labs which meet CDPH lab readiness criteria for COVID 19 testing for licensure, FDA Emergency Use Authorization, reporting to CalREDIE (which is what allows us to implement contact tracing) and are registered with Lab Field Services and willing to contract to do more testing.

However we quickly learned that there were barriers to organizations matching with new labs. Many organizations had longstanding hardwired contracts with just a few of the major labs. Those labs are national labs and organizations have long term commitments to those labs. Additionally, some of the major labs were all using the similar testing platforms and those platforms were now starting to have reagent, and plastics (pipette tips, pipettes, and trays) shortages. As well those labs were being overwhelmed with specimens beyond their current capacity—as you can see with CA alone we increased our testing by 40-50,000 tests a day. So the next question that surfaced was whether the larger labs could subcontract with some of the other labs that had capacity to run the tests.

So on Friday July 10th we invited the lab directors from over 200 labs to a meeting to discuss these issues and try to trouble shoot solutions. What we learned is that some of the larger labs were actually willing to subcontract with the smaller labs but they were running into a few challenges. Even if a lab does subcontract with another lab to do their tests, there is an initial processing of specimens (accessioning) that has to happen in the first lab. This process is timely and takes a significant amount of manpower. Yet there is a “no mark-up” clause that prevents labs from billing insurances for this initial process if they are preparing the specimen to go to another lab. So this is something the TTF is looking into to find solutions. Additional laboratory challenges were also brought to our attention.

This initial processing for labs (accessioning) as mentioned above takes a lot of time and manpower. But the time it takes can substantially decreased if the ordering and registering of specimens is done via online electronic registration process instead of a paper process that requires significant more time to accession which adds to turn around time and therefore delays results getting to patients and CalREDIE further delaying contact tracing and epidemic control. So laboratory directors across CA requested the TTF to urge all facilities to please register and order tests via the labs online registering platform. When labs are getting tens of thousands of specimens a day this can have a substantial impact on speeding turn-around time if all facilities use these electronic registration and ordering processes.

We also learned that some labs could actually run more specimens but they are facing workforce shortages. They actually have capable staff who could help process additional specimens but their personnel level is too low to allow them to do so. However the lab directors believe with appropriate supervision they could process the specimens. This would require executive order to do so. TTF has looked into this and have learned that there was a

previous executive order placed in April to waive CA regulatory personnel requirements for the duration of the emergency based on federal CMS CLIA personnel requirements. To date the federal government has not yet lowered their requirements. The CDPH Lab Field Services is having weekly conversations with CMS CLIA to try to address this. Additionally the TTF is working on a solution to this personnel requirement issue.

Additionally, TTF ultimate goal is to have all tests turnaround time down to 24-48 hours, however given the current constraints and in efforts to prioritize currently which specimens need absolute 24-48 hour turnaround time (hospitalized and under public health department outbreak investigations), the TTF wrote new Testing Prioritization Guidance for healthcare providers and public health departments. In order to ensure these Tier 1 specimens get prioritized the laboratory directors have asked the TTF to also get the message out to all facilities asking them to ensure that those priority specimens are appropriately identified based on your labs requirements which may be a card, or a sticker or some other way to mark and identify these priority specimens.

The TTF has also shared with the laboratory directors that by law they are required to transmit COVID-19 results to CALREDIE within 24 hours. For those labs not doing so TTF implored them to do so every 24 hours or if possible even more frequently. For those already transmitting once every 24 hours TTF asked labs to increase their frequency of transmission to multiple times a day since that transmission from the lab to CalREDIE is transmitted to CalCONNECT and this triggers contact tracing. Ultimately this helps with in epidemic control.

The TTF has also looked into additional strategies to address the testing constraints including the possibility of the state of CA actually developing our own reagents and supplies such as pipette tips, pipettes and other plastics to ensure long term sustainability. However what we learned is that the testing platforms used by some of the major labs have received their FDA Emergency Use Authorization using proprietary equipment and thus different supplies could not be used on these platforms as they are not open platforms. So TTF considered whether CA should develop its own testing platform and supplies. Simultaneously we learned of a company that had developed a new platform including reagents and supplies. Uniquely, when this testing platform and supplies applied for its EUA with the FDA it also applied for an EUA on another 20+ "open" testing platforms that would allow its supplies to be used on these additional platforms without having to go back for an additional FDA EUA approval. The TTF solidified a contract with this company last Friday July 17th. We are in the processing of first implementing this with the PHL in CA to expand their testing capacity since PHL are the first line of testing in outbreak investigations. Once PHL are adequately outfitted then it may be possible to expand beyond the PHL. Currently, the TTF is also working to solidify a deal with a transport media manufacturer since this has also been a challenging supply to obtain.

Finally the TTF has already been looking into alternative testing including test pooling which could allow more specimens to be processed simultaneously. TTF previously wrote pooling guidance and had a few small labs studying pooling. As of last week a few of these labs had gone in for FDA approval and were awaiting its outcome, one of these labs (Westpak) shared their FDA pooling approval application packet with the TTF to share with other labs to assist them in writing their own approval applications and finally we learned yesterday that Quest received the first FDA approval for pooling and anticipate seeing more of the pooling applications approval packets to move through the FDA soon.

So in conclusion the TTF will continue to work on supplies, personnel requirements, insurance no mark up, alternative testing and supply strategies. What we ask all of you to do is- if possible contract with additional labs that have capacity to level load the volume throughout labs in CA, when registering patients for test orders and registration—use electronic registering to decrease the initial processing time for labs, and ensure that those individuals who are in Tier 1- hospitalized or under PHD investigation are marked according to your labs requirements to prioritize the specimens.

Questions & Answers

Question: Regarding the supplies that can be used on 20 “open” testing platforms that TTF is contracting with, what are the compatible platforms?

Answer: depends on the platform and the number of the particular device, panther isn't one of them, if you want you can reach out to Kathy Jacobson (Kathleen.Jacobson@cdph.ca.gov) to be connected with someone about your particular platform.

Question: Regarding the test base strategy for severely immunocompromised people, when do we start the retesting and do they defined what qualifies as severe immunocompromise?

Answer: CDC wasn't explicit in written guidance in defining severe compromise, the example presented to quantify severe immunocompromise is an individual who is actively receiving chemotherapy or someone who has received an organ transplant, there isn't guidance on when you would start to test for clearance and there is not guidance for when to discontinue isolation if persistently positive.

Question: Our local access hospital is still using Abbot ID Now, are they to interpret negative results as presumptive negative? What guidance can I provide them?

Answer: Patients hospitalized with symptoms consistent with COVID are considered Tier 1 patients. If they have a negative Abbot ID Now result but there is still suspicion for COVID-19 then they should be retested with a lab-based PCR test. Info on testing tiers is [here](#).

Question: When we open schools and there is a case or cases in schools, there will be a need to conduct contact tracing in the schools. Has a contract module been developed that is specific to schools?

Answer: Contact Tracing is actively working on creating a module related to schools, we will get back to you when we have updates

Mentioned URLs

Title of Articles	Article URLs
CA Coronavirus Testing Task Force	https://testing.covid19.ca.gov/ click <i>Labs with Testing Capacity</i> for latest list
Considerations for Implementation of SARS-Cov-2 Rapid Antigen Testing	https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-SARSCov2-Antigen-Testing-Considerations.pdf
CDC Waived Tests Guidance	https://www.cdc.gov/labquality/waived-tests.html
FDA EUA list of approved COVID-19 tests	https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#covidinvitrodev
Interim Guidelines for Collecting, Handling and Testing Clinical Specimens for COVID-19	https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html
Finding a Testing Site	https://www.arcgis.com/apps/Nearby/index.html?appid=43118dc0d5d348d8ab20a81967a15401
Duration of Isolation and Precautions for Adults with COVID-19	https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
Clinical Questions about COVID-19: Questions and Answers	https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html
NY Times: Can you get COVID-19 Again? It's very Unlikely, experts say	https://www.nytimes.com/2020/07/22/health/covid-antibodies-herd-immunity.html
VTA Training Portal	http://www.uclaextension.edu/ca-vta
Guidance on Isolation and Quarantine for COVID-19 Contact Tracing	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx

Team Contacts

Team	Email
CovMIS-C	CoVmis-c@cdph.ca.gov
CovClinical Team	CoronavirusClinical@cdph.ca.gov
CovTravel	CovTravelEpi@cdph.ca.gov
Contact Tracing for LHD use only	CALHJ_COVIDCT@cdph.ca.gov