California Department of Public Health
All LHD Coronavirus Update Call August 20, 2020
1:00 pm – 2:00pm

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Clinical

MIS-C Update

Currently we are aware of 41 confirmed cases of multisystem inflammatory syndrome in children (MIS-C) in the state of California.

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.

Thank you again to all those who have continued to work with us to report cases. 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.

Use of Antigen Tests in Clinical Settings

The Clinical Team offers the following guidance for interpretation and management of antigen test results:

- If the test is positive, the individual is infected with SARS CoV-2 and presumed to be contagious. The individual should be isolated per CDC guidance. No further confirmatory testing is required.
    - If the pretest probability of disease is low, and there is concern for a false positive, individuals who receive a positive antigen test can be retested by RT-PCR for confirmation. In these situations, the case should be isolated until the results of the RT-PCR test are available.
- If the test is negative, the interpretation and management depends on the testing platform used and the timing of symptom onset:
    - Negative results for the BD Veritor Antigen test should be treated as presumptive negative.
    - Negative results for the Sofia Antigen test should be treated as presumptive negative if the specimen is collected more than five days from symptom onset.
    - All presumptive negative results should be confirmed with an RT-PCR test.
    - A symptomatic individual with a presumptive negative result should always be isolated while awaiting molecular testing

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.

<table>
<tr><th>Type of Report ↓</th><th>8am-5pm
Mon-Fri</th><th>8am-5pm
Sat-Sun</th><th>5pm-8am (after hours)
7 days/week</th></tr>
<tr><td>Death
<18 years old
Pregnant person
Fetal demise (stillbirth)
Death of special concern (at discretion of LHD)</td><td rowspan="3">Call Warmline
(510) 255-8922</td><td rowspan="3">Call DOD
(916) 328-3605</td><td>Call DOD</td></tr>
<tr><td>Outbreak/ cluster in congregate living, community, or workplace setting
Requests for assistance</td><td>Call DOD only if urgent assistance is required that cannot wait until the morning</td></tr>
<tr><td>Case in vulnerable population and/or case with potential for large transmission
Report cases in:
<5 years old in ICU
Pregnant in ICU
Other cases at LHD’s discretion, e.g.:
People experiencing homelessness in a congregate living facility
Long-term care facility residents and staff</td><td>Call DOD only if urgent assistance is required that cannot wait until the morning</td></tr>
<tr><td>Cases related to flights</td><td colspan="3">Email flight info to CovTravelEpi@cdph.ca.gov</td></tr>
</table>

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

Case counting methodology

There has been some confusion expressed to us on how cases are identified and counted. CDPH counts COVID-19 cases based on confirmatory laboratory testing, NOT Resolution Status. However, approximately 98% of the cases have a Resolution Status of "Confirmed". Both ELR messages and manually entered positive results are considered when determining if an incident should be counted as a case. ELR messages are mined for a positive result, which includes looking beyond the information provided in the SNOMED code/results field. If an incident has multiple test results, positives will be prioritized. Please note that a subsequent negative result will NOT remove the incident from the positive case count. Please email us if you would like for us to go over this in detail with you.

CSTE update: probable case and death addition

Thus far for COVID, we have focused on confirmed cases. However, currently it is imperative to begin to report probable cases as antigen testing methods have become more commonly used. Per the updated CSTE case definition, there are 3 criteria by which an incident should be considered a probable case: (1) If the patient meets the clinical criteria and has an epidemiologic linkage with no confirmatory lab testing performed for SARS-CoV-2; (2) If the patient has tested positive for SARS-CoV-2 by an antigen test of a respiratory secretion; and (3) If the patient meets vital records criteria with no confirmatory laboratory evidence for SARS-Co-V-2.

Importantly, the updated probable case definition does not require clinical criteria to be met for a patient that has tested positive via antigen test; those patients can be counted as probable cases based on laboratory testing alone. CDPH asks that all LHJs begin to use the new probable case definition to report probable cases to CDPH.

CDPH is finalizing the methodology for including probable cases in our surveillance in accordance with the CSTE case definition, and will share the details with LHDs before the process goes live.

Regarding identifying probable deaths, CDPH will implement new code starting on August 24 to identify probable COVID-19 deaths and will notify LHDs of any such incidents within their jurisdictions. CDPH requests that LHDs investigate these incidents, verify that they meet the criteria to be counted as a probable COVID-19 deaths, and enter these incidents into CalREDIE.

Travel Epi Reminders

CDPH continues to assist LHJs with notifying the CDC Division of Global Migration and Quarantine (DGMQ) when a confirmed case of Covid-19 has traveled on an airplane while infectious. If an investigation reveals a case was a passenger on a domestic or international flight while infectious in the last 14 days, please call the CDPH warmline at (510) 255-8922 8-5pm Monday through Friday, or email CovTravelEpi@cdph.ca.gov . Please note that if the flight was more than 14 days ago, the flight does not need to be reported, as all of the passengers on the flight will have passed the incubation period of this exposure incident. To avoid duplication of efforts, please ONLY notify CDPH if you have NOT already reported the passenger and flight to the CDC DGMQ. As a reminder, all flight notifications for the CDC will require, at minimum, the following information: patient name, date of birth, symptom onset date, symptoms on last day of travel, lab results, and flight dates and details. The same information will need to be entered into the patient's CalREDIE incident.

VRDL

This past week several testing guidance were released.

CDPH released an updated guidance on the types of tests – molecular, antigen, and serology – that are available for COVID-19 testing

A new CDPH guidance document that specifically addresses antigen tests is forthcoming.

This past weekend the **CDC** released its much-anticipated guidance on the use of antigen tests to diagnose COVID-19. This can be found under the **Using Antigen Tests** tab on the CDC COVID-19 Testing webpage. As part of this guidance, they have defined 3 categories of testing and their intent for use: ***Diagnostic, Screening*, and *Surveillance***. The CDC guidance is quite descriptive, but basically they consider *Surveillance* testing as a public health tool to be used across a population. Surveillance testing does not require use of a CLIA compliant lab or an EUA granted test, and surveillance results are **not** to be returned to the individual or to be used for patient management. Conversely, both *Diagnostic* and *Screening* testing, as defined by the CDC, are intended to detect COVID-19, whether in someone who is symptomatic or asymptomatic. Diagnostic and screening test results *are* to be reported to both the individual and to public health, and they must be performed with an FDA approved test in a CLIA regulated environment. This CDC Antigen testing guidance also provides information on advantages, uses, and limitations of antigen testing.

The **US FDA** has provided a new question and answer response, directed at healthcare providers, on the use of testing of asymptomatic persons (what the FDA refers to as "screening"). Visit the FAQs page under the "General FAQs" heading. Essentially, if a healthcare

provider suspects COVID-19 in an asymptomatic individual, any FDA-approved test can be used. *However*, if the health care provider is ordering an off-label use (i.e., outside the EUA) of an authorized SARS CoV2 diagnostic test to *screen asymptomatic* individuals NOT suspected of COVID-19, the FDA recommends that these three factors be considered:

1. Data are limited on the viral loads in symptomatic vs asymptomatic people across demographics, different settings, and specimen types. Therefore, consider using a highly sensitive test, which is more likely to provide more accurate results, especially when results can be provided in a timely or rapid fashion.
2. If less sensitive tests, such as some POC tests are used, be aware of the performance of the test. You may want to consider serial testing when POC results are negative, such as repeat testing with a different test or with new samples collected on a different day.
3. Negative results in asymptomatic persons should be considered as *presumptive negative* and you should consider them in the context of clinical observations, patient history, and epidemiological information.

There are still only 2 Ag tests approved for diagnostic use, and CDPH continues to caution that there are limited data to guide the use of rapid Ag tests as screening tests on asymptomatic persons to detect or exclude COVID-19. The manufacturers have stated that when samples are collected with 5 days of symptom onset, these tests are reported to have positive percent agreement of 97% (Quidel) and 84% (BD Veritor) compared to RT-PCR. Since these tests are generally less sensitive than PCR tests, they may return a negative result when a more sensitive test such as PCR may be positive. Positive results are likely to be reflect an active infection, but negative results may not rule out infection. Note that the 2 Ag tests are intended for use on swabs that are not placed into viral transport media; the use of VTM may cause a falsely positive result in these tests.

CalREDIE & ELR

The CalREDIE Team continues providing assistance to LHJs with Disease Incident Staging Area (DISA). If LHJs need assistance with importing positive ELRs from the DISA, please contact CalREDIE Help.

The CalREDIE Team continues active follow-up and reconciliation of data with LHJs and laboratories. We are working on following up with laboratories based on feedback from LHJs. Please continue to send any issues to CalREDIE Help.

As approved by the California Communicable Disease Controllers Association (CACDC), we've updated CalREDIE so that non-positive COVID-19 ELR results are auto-closed. This means that when non-positive incidents are auto-imported into CalREDIE, the Process Status will be set as

'Closed by LHD – ELR'. The auto-closing will apply to all NEW non-positive incidents auto-imported on or after 8/20/2020.

HAI

This past weekend the CDC released guidance on the use of antigen tests to diagnose COVID-19, which defines 3 categories of testing and their intent for use: Diagnostic, Screening, and Surveillance. The CDC defines Surveillance testing as a public health tool to be used across a population and for which results are not to be returned to the individual or to be used for patient management. Conversely, CDC defines Screening testing as testing to detect COVID-19 in someone who is asymptomatic and without known or suspected exposure to SARS-CoV-2, and its purpose is to identify persons who may be contagious so that measures can be taken to prevent further transmission.

The CDPH All Facilities Letter 20-53.2, which was originally released several months ago, recommends regular "Surveillance" testing of skilled nursing facility healthcare personnel, which is more aligned with the category of testing that CDC is now defining "Screening" testing. As such, AFL 20-53.2 will be updated to align its terminology with CDC, and also to incorporate forthcoming CDPH guidance about the use of antigen tests that specifically addresses their use in SNF, as well as other clarifications that I have discussed on recent previous healthcare facilities calls.

CDC also posted a note to their guidance on the duration of isolation and precautions for adults with COVID-19. The note seems intended to clarify misinterpretation of their guidance to not re-test asymptomatic individuals within 3 months of a prior positive test to mean definitively that individuals were immune to reinfection for 3 months, and concerns that this misinterpretation would potentially lead people to not follow physical distancing and source control measures if they had (or thought they had) COVID-19. Rather, CDC is saying that we don't know for sure about immunity, but that because PCR tests can continue to be positive for prolonged periods without infectiousness, testing asymptomatic individuals is not recommended for 3 months. If a previously positive individual develops COVID-19 symptoms without another apparent cause, even if within 3 months of their prior positive test, CDC recommends considering re-testing for COVID-19. CDC recommends that all people, whether or not they have had COVID-19, continue to take safety measures to avoid becoming infected with COVID-19 (wash hands regularly, stay at least 6 feet away from others whenever possible, and wear masks).

Contact Tracing

A few updates from the CA COVID-19 Contact Tracing workgroup.

Workforce

Our workforce team is continuing to deploy redirected state staff to local health departments (LHDs) throughout the State. We continue to deploy contact tracers and case investigators -- our first set of case investigators were deployed on August 10. If you have not placed a formal MHOAC request for case investigators or contact tracers, please do so while we have state staff available. We ask that for case investigators, LHDs provide some mentorship for these case investigators as written in the MOU signed by your LHD and the State. 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.

We also have created a new strike team of 37 communicable disease investigators and team leads hired through the CDC Foundation. After their initial 4-6 week training deployments, these staff will provide short-term assistance to LHDs to increase surge capacity, mentor local communicable disease investigators, and assist with outbreak management. The first set of these case investigators were deployed on Monday, August 17, with additional teams being deployed over the next few weeks. We will communicate how requests for outbreak management assistance should be made over the next couple of weeks, but determinations for deployments will be made in collaboration with the Science Branch.

Training

In partnership with UCSF and UCLA, we continue to provide subject-matter training courses, which include both formal presentations and interactive skills labs, for case investigators and contact tracers. This training, called the Virtual Training Academy, or VTA, runs weekly. LHD staff can register for the VTA by visiting the training registration portal. The VTA now also offers an optional skills lab in Spanish for Spanish-speaking case investigators and contact tracers. Additionally, UCSF is developing a new 8-hour Outbreak Investigation & Management course that will focus on case investigation in various types of congregate settings, including prisons, workplaces, schools, and long-term care facilities. A pilot of the course is scheduled for the week of August 24, with plans to offer the full course in September. This course will include both didactic training components as well as hands-on case studies. We will share registration information as soon as it is available for the Outbreak course.

Data Management Platform (CalCONNECT)

The state's contact tracing data management platform, CalCONNECT (California CONfidential NEtwork for Contact Tracing), continues to implement significant enhancements and new functionality through new releases that are rolled out every two weeks. Recently launched functions include linking cases and contacts to exposure events and locations to help with outbreak response. LHJs that are documenting outbreaks in CalCONNECT no longer have to also report these outbreaks to CalREDIE. CalCONNECT will provide a weekly report of confirmed outbreaks to the Science Branch Epi team for this purpose. Please utilize the Outbreak

Resolution Status in CalCONNECT to classify exposure events/outbreaks as "confirmed". If the same outbreak/exposure event has been entered in CalREDIE and CalCONNECT, please add the CalREDIE Outbreak ID in the 'CalREDIE Outbreak ID' field in CalCONNECT so we can identify duplicates in reporting. In addition, we have developed a brief electronic survey using a virtual agent that can be sent via text message to cases in CalCONNECT. The survey is now available in both English and Spanish. It is designed to expand LHD outreach capacity by providing self-isolation instructions and collecting key information to prioritize additional outreach for further investigation based on survey responses. Current data collected in the survey include basic demographic information as well as if the case has symptoms (and if so, symptom onset date), if they are able to safely self-isolate, and if during their infectious period have been in a place in which they could have potentially spread the virus to a large number of people, such as congregate settings, workplaces, schools, and others. The release for next week will also include the ability to collect information on close contacts. LHDs will be able to sort and filter responses to prioritize additional telephone outreach. We hope this can help increase efficiencies and allow for prioritization of case investigation and contact tracing for LHDs.

Close Contact definition

Finally, we wanted to give clarification on the definition of close contact. As many of you know, CDC and CDPH have stated that anyone who has been within 6 feet of someone infected with COVID-19 for at least 15 minutes should be considered a close contact and "exposed". The 15 minutes of exposure does NOT need to be consecutive, but rather cumulative over time. Thus, it is the contact's total time of exposure to the infectious case. For example, someone who was exposed 3 separate times to an infectious case for 5 minutes each time (or 15 minutes total) would be considered "exposed" and would be considered a close contact.

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.

Questions & Answers

Q: Hospital administrator, asking about the 90 day retesting, HCW still testing positive and the virus still be detected and does that mean they're infectious or not?
A: These individuals can continue to test positive with PCR without being infectious, we don't recommend retesting these individuals within the 90 day period in response to an exposure or if they're asymptomatic, moreover we haven't seen documentation reinfection.

Q: In reference to the saliva testing, when counties try to get teachers and students tested we have seen issues, will there be anything in the future for contact tracing similar to a home pregnancy testing that there could be saliva testing?
A: LabCorp pixel has a home test that is an oral test, there is more word about testing facilities that are starting to see oral test and do them

Q: Is there any progress and/or recommendation for treatment for mild testing, what to do with all these patients that have tested positive but don't have to be hospitalized, how to treat those outpatients?
A: Will get back to you on what is available

Q: There is a surgeon that tested positive and is now on isolation, he is wondering if there is an antibody tests available that he can take to see if he can travel within a month
A: Antibody shouldn't be used for immunity, reference testing for COVID-19: PCR, Antigen and Serology

Q: Are there any recommendations to not retest within 90 days, if there is a positive person who is beyond isolation and is a close contact to a positive case within those 90 days do they need to quarantine.
A: CDC guidance state they do not have to quarantine

Q:Definition of close contact for CDC, seen that on August 3rd FAQ CDPH stated that close contact is close to 6 ft for longer than 15 minutes without a mask
A: We are aware of the discrepancy and will be following CDC guidance

Q: A positive case doesn't need to quarantine within 90 days, so does that mean everyone that tested positive they're considered "immune."
A: There is an implication, but that is not being said, that people are immune for 90 days. The difference is that they are unlikely to be reinfected and asked to quarantine for 14days

Q: For school nurses that are caring for symptomatic students, should they use N95s when they can't socially distance, is there a guidance that has been posted doesn't state it is indicated for schools
A: Recommendations aren't available for anyone outside of healthcare for a N95

Q: Close contact definition, 15 minutes that does not need to be consecutive, is that in a guidance document since that's not what has been done
A: This came directly from CDC not yet written anywhere yet but they will be releasing clarification on that

Mentioned URLS	
Title of Articles	**Article URLs**
Testing for COVID-19: PCR, Antigen, and Serology 8-6-20	https://testing.covid19.ca.gov/wp-content/uploads/sites/332/2020/08/COVID-testing-8.6.2020-FINAL-letterhead.pdf
Interim Guidance for Rapid Antigen Testing for SARS-CoV-2	https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html
FAQs on Testing for SARS-CoV-2	https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2
Coronavirus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx
Duration of Isolation and Precautions for Adults with COVID-19	https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
VTA Registration Portal	http://www.uclaextension.edu/ca-vta

Team Contacts	
Team	**Email**
CovMisC	CoVmis-c@cdph.ca.gov
CovTravel	CovTravelEpi@cdph.ca.gov
CovContact Tracing	CALHJ_COVIDCT@cdph.ca.gov