HEALTH ALERT NETWORK BROADCAST
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FROM: CO-CDPHE
SUBJECT: HAN Update: COVID-19
RECIPIENTS: Local Public Health Agencies / IPs / Clinical Labs / EDs / ID Physicians / Coroners
RECIPIENT INSTRUCTIONS: Local Public Health Agencies – please forward to healthcare providers
This information is for the public health and health care community. Do not post this document on a public web or social media site

HEALTH UPDATE | COVID-19 | July 31, 2020

Health care providers: Please distribute widely in your office

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Key points

- CDC has released updated guidelines on return to work for health care workers and discontinuation of isolation in hospitalized and non-hospitalized patients.
- CDPHE has developed new guidance for the interpretation of subsequent positive SARS-CoV-2 PCR results in individuals already known to be infected with COVID-19. In general, a person does not need to be re-isolated or re-quarantined if a positive test or exposure occurs within 90 days after developing PCR-confirmed COVID-19 infection (see below for details).
- Except for rare situations, a test-based strategy should not be used to determine when to discontinue transmission-based precautions or release a case from isolation.
- Patients can be discharged when medically appropriate to a facility that provides a lower level of care utilizing a non-test based strategy. The receiving facility should continue transmission-based precautions while caring for the patient until they meet the requirements for release from isolation.
- Protective eye-wear (e.g. goggles or face shields) is recommended for staff providing direct patient care in communities with moderate to substantial COVID-19 transmission due to the risk of exposure to asymptomatic individuals. Eye-wear, including face shields, does not replace the need for other indicated PPE (e.g. respirator, facemask).
- Providers are encouraged to talk to their patients about contact tracing and what to expect, both when collecting samples for testing and when reporting positive results. More information on contact tracing can be found here: https://covid19.colorado.gov/prevent-the-spread-of-covid-19/contact-tracing. A printable graphic on contact tracing is available here in multiple languages: https://covid19.colorado.gov/communication-resources/print-materials
- When testing is ordered due to suspicion of COVID-19, patients should be instructed to self-isolate. Information about isolation can be found here: https://covid19.colorado.gov/how-to-isolate

- CDC has updated and reorganized testing guidance. https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/testing.htm
- The American College of Rheumatology has issued guidelines for the evaluation and management of pediatric patients with suspected MIS-C, found here: https://www.rheumatology.org/Practice-Quality/Clinical-Support/COVID-19-Guidance

Updated Release from Isolation Guidance

All individuals in isolation should be excluded from in-person work settings.

NON-HOSPITALIZED MEMBERS OF THE GENERAL PUBLIC WITH CONFIRMED OR PROBABLE COVID-19	
Category	**Release from isolation**
Symptomatic	**Symptom-based strategy** • At least 10 days have passed since symptom onset **and** • At least 24 hours have passed since resolution of fever without the use of fever-reducing medications **and** • Other symptoms have improved. (A limited number of individuals who are severely immunocompromised may produce replication-competent virus beyond 10 days which may warrant extending the duration of isolation for up to 20 days after symptom onset. Consider consultation with infection control experts.) **Test-based strategy** • Not recommended except for severely immunocompromised* patients in consultation with an infectious disease expert.
Asymptomatic (with positive test)	**Time-based strategy** • At least 10 days have passed since the date of the first positive COVID-19 diagnostic test unless they have subsequently developed symptoms. If symptoms develop during isolation, the isolation period should be restarted based on the symptom onset date as above. **Test-based strategy** • Not recommended except for severely immunocompromised* patients in consultation with an infectious disease expert

Adapted from https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html

HEALTH CARE WORKERS WITH CONFIRMED OR PROBABLE COVID-19	
Category	**Release from isolation**
Symptomatic: mild to moderate illness** who are not severely immunocompromised*	**Symptom-based strategy** • At least 10 days have passed since symptoms first appeared **and**

	• At least 24 hours have passed since last fever without the use of fever-reducing medications **and** • Symptoms (e.g., cough, shortness of breath) have improved. **<u>Test-based strategy</u>** • Not recommended
Symptomatic: severe to critical illness*** or who are severely immunocompromised*	**<u>Symptom-based strategy</u>** • At least 20 days have passed since symptoms first appeared **and** • At least 24 hours have passed since last fever without the use of fever-reducing medications **and** • Symptoms (e.g., cough, shortness of breath) have improved. **<u>Test-based strategy</u>** • Not recommended except for severely immunocompromised patients in consultation with an infectious disease expert
Asymptomatic (with positive test): not severely immunocompromised*	**<u>Time-based strategy</u>** • 10 days have passed since the date of their first positive COVID-19 diagnostic test (assuming they have not subsequently developed symptoms since their positive test). **<u>Test-based strategy</u>** • Not recommended
Asymptomatic (with positive test): severely immunocompromised*	**<u>Time-based strategy</u>** • HCP who are severely immunocompromised* but who were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test. **<u>Test-based strategy</u>** • Not recommended except in consultation with an infectious disease expert

Adapted from https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
After returning to work, HCP should: 1) Continue to wear a facemask for source control at all times while in the healthcare facility following their facility policy regarding universal source control during the pandemic. [A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection.] 2) Self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen.

If using test-based strategy for HCP return-to-work, see CDC guidance at:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

HOSPITALIZED PATIENTS WITH CONFIRMED COVID-19	
Category	**Release from Isolation**
Symptomatic: mild to moderate illness** who are not severely immunocompromised*	**Symptom-based strategy** • At least 10 days have passed since symptoms first appeared **and** • At least 24 hours have passed since last fever without the use of fever-reducing medications **and** • Symptoms (e.g., cough, shortness of breath) have improved. **Test-based strategy** • Not recommended. • Patients can be discharged to a facility that provides a lower level of care (e.g. SNF, ALR) without testing. The receiving facility should continue transmission-based precautions as indicated unless the patient has met criteria to be removed from transmission-based precautions.
Symptomatic: severe to critical illness*** or who are severely immunocompromised*	**Symptom-based strategy** • At least 20 days have passed since symptoms first appeared **and** • At least 24 hours have passed since last fever without the use of fever-reducing medications **and** • Symptoms (e.g., cough, shortness of breath) have improved. **Test-based strategy** • Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens). • Patients can be discharged to a facility that provides a lower level of care (e.g. SNF, ALR) without testing. The receiving facility should continue transmission-based precautions as indicated unless the patient has met criteria to be removed from transmission-based precautions.
Asymptomatic (with positive test): not severely immunocompromised*	**Time-based strategy** • 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. **Test-based strategy** • Not recommended. • Patients can be discharged to a facility that provides a lower level of care (e.g. SNF, ALR) without testing. The receiving facility should continue transmission-based precautions as indicated unless the patient has met criteria to be removed from transmission-based precautions.

Asymptomatic (with positive test): severely immunocompromised*	**Time-based strategy** • Hospitalized patients who are severely immunocompromised* but who were asymptomatic throughout their infection may have transmission-based precautions discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test. **Test-based strategy** • Not recommended except in consultation with an infectious disease expert

Adapted from https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html)

*For the purposes of this guidance, CDC used the following definition of severely immunocompromised: Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of isolation. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of isolation. Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.
Mild Illness: Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

***Severe Illness**: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

The evidence behind these changes has been summarized in the following decision memo:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

CDPHE Updated Guidance for the Interpretation of Subsequent Positive SARS-CoV-2 PCR Results

CDPHE has created new guidance for how to interpret subsequent positive PCR results in patients who already have PCR-confirmed COVID-19 (https://drive.google.com/file/d/1--s4BfQfqk6H_iLtLD2FzvfQz1_ODJ_y/view?usp=sharing).

- In general, as above, repeat testing is not recommended for the first three months (90 days) after disease is first detected (whether by PCR or symptom onset, whichever is earlier), as subsequent positive results are difficult to interpret and likely reflect persistent viral shedding without infectiousness.
- However, if repeat testing is performed within the first 90 days, these results should not be used to make decisions about duration of isolation or quarantine of contacts outside of specific clinical contexts, including severe and critical disease or severe immunocompromised state.
- In rare cases, for individuals who develop new symptoms consistent with COVID-19 during the first three months since the date of symptom onset of the most recent illness episode, retesting may be warranted if alternative etiologies for the illness cannot be identified. If reinfection is suspected, repeat isolation and contact tracing may be needed. The determination of whether a patient with a subsequently positive test is

contagious to others should be made on a case-by-case basis, in consultation with infectious diseases specialists and public health authorities, after review of available information (e.g., medical history, time from initial positive test, RT-PCR Ct values, and presence of COVID-19 signs or symptoms). (https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Patients-with-Persistent-or-Recurrent-Positive-Tests)

- If a person with a PCR- confirmed infection is identified as a contact of a new case within 90 days of symptom onset (or positive test), quarantine is not recommended.
- A positive result >90 days from detection of the initial disease (day 0) should be considered as a possible case of reinfection, and the affected individual treated as potentially infectious. Patients should be re-isolated and contacts should be quarantined. While the time period where COVID-19 reinfection may be possible is not yet known, a persistently positive PCR after 90 days is less likely. Reinfection has been demonstrated with other coronaviruses in various settings.

Updated Testing Guidance from the CDC

The CDC has updated the structure of its pages related to community testing. This collects information on testing different populations in one unified site, including information for schools, corrections facilities, long-term care facilities, and critical infrastructure workers (https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/testing.html)

- The CDC now recommends FDA EUA approved antigen tests as well as PCR tests to assist in the evaluation of symptomatic persons for COVID-19. However, given the low sensitivity of antigen tests, a negative result should not be used to rule out COVID-19, and should be followed by a confirmatory PCR with the patient isolating as appropriate while PCR results are pending.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html
  https://www.fda.gov/consumers/consumer-updates/coronavirus-testing-basics
- The CDC has issued recommendations against pre-admission or pre-enrollment testing in several contexts, including K-12 schools, or institutes of higher education.
- Public health may recommend that all residents and staff in homeless shelters be tested at least once. However, entry testing is not recommended.
  https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/testing.html

Updated Infection Prevention Guidance

- CDC has updated testing guidance specific for nursing home residents and staff; this guidance can be applied to other long-term care facilities (e.g. assisted living residences, intermediate care facilities for individuals with intellectual disabilities, psychiatric residential treatment facilities).
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
- All residents in residential care facilities should continue to be assessed for symptoms of COVID-19 at least daily. Clinicians are encouraged to test residents who have signs and symptoms of COVID-19 even if symptoms are only mild. Clinicians are also encouraged to consider testing for other causes of respiratory illness, such as influenza, in addition to testing for SARS-CoV-2.
- Patients can be discharged from an acute care facility to a facility that provides lower level of care using a non-test based strategy whenever medically appropriate. The receiving facility should continue

transmission-based precautions while caring for the patient until they meet the requirements for release from isolation.

- Protective eye-wear (e.g. goggles or face shields) is recommended for staff providing direct patient care in communities with moderate to substantial COVID-19 transmission due to the risk of exposure to asymptomatic individuals. Eye-wear, including faceshields does not replace the need for other indicated PPE (e.g. respirator, facemask). Facilities can consider using safety glasses (e.g. trauma glasses) that have extensions to cover the side of the eyes. However, protective eyewear (safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.

Guidance on the Evaluation and Management of MIS-C

The American College of Rheumatology has issued guidance regarding diagnostic evaluation and therapeutic options for children with suspected Multisystem Inflammatory Syndrome in Children (MIS-C).
https://www.rheumatology.org/Practice-Quality/Clinical-Support/COVID-19-Guidance

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More information

- CDPHE COVID-19 web page: covid19.colorado.gov
- CDC COVID-19 web page: https://www.cdc.gov/coronavirus/2019-ncov/index.html
- For questions about COVID-19 in Colorado, call the **CDPHE Disease Reporting Line:** 303-692-2700 or 303-370-9395 (after hours)
- Health care provider FAQs from CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html
- CDC Clinician Outreach and Communication Activity (COCA) Calls: https://emergency.cdc.gov/coca/calls/index.asp
- List of updated CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html