

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

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Acting Commissioner



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Updated COVID-19 Guidance for Healthcare Providers- May 20, 2020

We continue to learn more about COVID-19 and the SARS-CoV-2 virus every day. As the state moves to the first phase of reopening, the Department of Public Health (DPH) continues to request the assistance of healthcare providers in furthering our understanding of COVID-19.

Healthcare Provider Reporting for Laboratory-Confirmed COVID-19

In accordance with reportable disease requirements, healthcare providers must complete a COVID-19 Case Report Form (CRF) for all patients with a positive laboratory finding of SARS-CoV-2, the virus that causes COVID-19; this includes patients that test positive on either a virus-based test or serologic (antibody) test. If a patient tests positive multiple times, a new CRF should be submitted for any positive test ≥ 30 days since the last positive test.

The CRF should be completed via the online portal here: <https://dphsubmissions.ct.gov/Covid/InitiateCovidReport>

Healthcare providers are asked to complete all fields on the CRF, including race and ethnicity field. The CRF was recently updated to collect additional information including expanded symptoms and underlying medical conditions.

CRFs for patients diagnosed in the hospital are typically completed by the infection control team. For hospitalized patients with two positive tests >30 days apart, a new CRF should be completed **only** if there was a period of complete recovery to the patient's baseline health status between the two tests. Nursing homes can also provide CRF data through the line lists being submitted to DPH on a daily basis. Please check with your facility regarding internal protocols for submitting CRFs to DPH.

Clarification on Provider Order Required for COVID-19 Testing

On May 14, 2020, Acting Commissioner Deidre S. Gifford, MD, MPH, reinstated the requirement that SARS-CoV-2 testing be ordered by a licensed provider (e.g., a physician, physician assistant, advanced practice registered nurse, and pharmacist), and reinstated the obligation to report COVID-19 results to the licensed provider who ordered testing.¹

DPH requests that organizations that manage COVID-19 sample collection sites (e.g. Federally Qualified Healthcare Facilities, CVS or other rapid test facilities, etc.) provide a way for persons who have not gotten an order in advance to be given an order for SARS-CoV-2 testing at COVID-19 sample collection sites by a licensed provider.

It is important that testing for COVID-19 be easy to obtain quickly and by as many people as possible. How the test is ordered should not be an impediment to testing.



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Multisystem Inflammatory Syndrome in Children (MIS-C)

On May 14th, the Centers for Disease Control and Prevention (CDC) released a Health Advisory about severe illnesses among children associated with COVID-19 which has been named Multisystem Inflammatory Syndrome in Children (MIS-C).² Cases of children presenting with severe inflammatory illnesses with Kawasaki-like features were first reported in the United Kingdom (UK) on April 26th. Similar illnesses were also reported among 102 children in New York City and New York (NY) state, including 3 deaths, as of May 12th. Among the cases reported from the UK and NY, children tested positive for COVID-19 by either RT-PCR or serologic testing.

CT DPH is asking healthcare providers to report suspected cases of MIS-C to DPH to better characterize and understand these illnesses. Cases that meet the case definition below should be reported to the DPH Epidemiology Program at (860) 509-7994.

Case Definition for MIS-C

- An individual aged <21 years presenting with feverⁱ, laboratory evidence of inflammationⁱⁱ, and evidence of clinically severe illness requiring hospitalization, with multisystem (≥ 2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological); **AND**
- No alternative plausible diagnoses; **AND**
- Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test; or COVID-19 exposure within the 4 weeks prior to the onset of symptoms

ⁱFever $\geq 38.0^{\circ}\text{C}$ for ≥ 24 hours, or report of subjective fever lasting ≥ 24 hours

ⁱⁱIncluding, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, d-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes and low albumin

Additional comments

- Some individuals may fulfill full or partial criteria for Kawasaki disease but should be reported if they meet the case definition for MIS-C
- Consider MIS-C in any pediatric death with evidence of SARS-CoV-2 infection

COVID-19 Serologic Testing

There continues to be a high level of interest in the use of serologic testing to detect persons who might have antibodies against the SARS-CoV-2 virus. While there are now tests with Emergency Use Approval from the Food and Drug Administration (FDA)³, it is still not clear how to interpret results from these tests. It is not yet known if detection of antibodies on a serologic test for the SARS-CoV-2 virus means the person is immune to the virus, how protective those antibodies are, or how long any immunity might last. While we await more data on how to best use these tests, it is important to understand that serologic tests should not be used to diagnose a patient with active SARS-CoV-2 infection.

Additional information about COVID-19 serologic testing is available from the CDC⁴, the Council of State and Territorial Epidemiologists (CSTE) and the Association of Public Health Laboratories (APHL)⁵ and the Infectious Diseases Society of America⁶ in the references at the end of this document.

Release from Isolation Guidance

CDC recently updated their guidance for when persons diagnosed with COVID-19 can be released from isolation precautions and be allowed to return to work and other activities.⁷ This update aligns the release from isolation guidance for all groups diagnosed with COVID-19 including healthcare workers, persons residing in healthcare settings, and persons living in the community.

As part of this update, CDC also described the evidence that is the basis for this updated guidance, which includes the finding that live virus has not been isolated from patients 10 days after symptom onset.⁸

Before pursuing test-based strategies, it is important to note that there can be prolonged detection of RNA fragments beyond 10 days after symptom onset that may not reflect transmissibility of live virus.

For persons with symptoms of COVID-19 that test positive, there are two strategies for release from isolation. It is recommended that only one strategy be chosen for determining when a patient can be released from isolation.

Symptom-based strategy

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications; **and**,
- improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed *since symptoms first appeared*.

Test-based strategy

- Resolution of fever **without** the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- 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). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

For persons that test positive for COVID-19 but are asymptomatic, there are two strategies for release from isolation:

Time-based strategy

- At least 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.
- If they develop symptoms, then the symptom-based or test-based strategy should be used.

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).

References

¹DPH Order modifying the May 6, 2020 order on the reporting of COVID-19 testing: <https://portal.ct.gov/-/media/Coronavirus/20200514-DPH-Order-modifying-the-May-6-2020-order-on-the-reporting-of-COVID19-testing.pdf?la=en>

²CDC Health Advisory: Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 2019 (COVID-19): <https://emergency.cdc.gov/han/2020/han00432.asp>

³Food and Drug Administration, Emergency Authorization Approvals for COVID-19 Serologic Testing: <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#sarscov2antibody>

⁴CDC, Serology Testing for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/lab/serology-testing.html>

⁵APHL and CSTE, Public Health Considerations: Serologic Testing for COVID-19: <https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/Serologic-Testing-for-COVID-19.pdf>

⁶IDSA, COVID-19 Antibody Testing Primer: <https://www.idsociety.org/globalassets/idsa/public-health/covid-19/idsa-covid-19-antibody-testing-primer.pdf>

⁷CDC, Discontinuation of Isolation Persons with COVID-19 Not in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>

⁸CDC, Symptom-Based Strategy to Discontinue Isolation for Persons with COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html>