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California Department of Public Health

GAVIN NEWSOM
Governor

January 18, 2023

AFL 23-09

TO: All Facilities

SUBJECT: Coronavirus Disease 2019 (COVID-19) Outbreak Investigation and Reporting Thresholds (This AFL supersedes AFL 20-75.1)

AUTHORITY: Title 17 California Code of Regulations (CCR) sections 2500, 2501, and 2502; Title 22 CCR sections 70737, 70739, 72523, 72539, and 72541

All Facilities Letter (AFL) Summary

- This AFL reminds licensed health facilities of requirements to report outbreaks and unusual infectious disease occurrences to their local health department (LHD) and Licensing and Certification District Office and provides investigation and reporting thresholds for reporting for COVID-19.
- This AFL revision incorporates updated joint Council for Outbreak Response – Healthcare-Associated Infections and Antimicrobial Resistance (CORHA) and Council of Territorial Epidemiologists (CSTE) outbreak investigation and reporting thresholds for hospitals and long-term care facilities.

This AFL reminds licensed health facilities of requirements to report outbreaks and unusual infectious disease occurrences to their local health department (LHD) pursuant to Title 17 CCR sections 2500, 2501, and 2502, and to their Licensing and Certification District Office pursuant to Title 22 CCR sections 70737, 70739, 72523, 72539, and 72541.

The national CORHA and CSTE Proposed Investigation/Reporting Thresholds and Outbreak Definition for COVID-19 in Healthcare Settings (PDF) are intended to expedite facilities' investigation of COVID-19 cases and reporting to public health authorities, to help ensure early detection of possible outbreaks and timely intervention to prevent the virus' spread. When the recommended reporting threshold is reached and reported, LHDs will determine if the cases constitute an outbreak.

The CORHA/CSTE recommendations were updated in August 2022 to acknowledge that LHDs may adjust the reporting thresholds and outbreak definitions to reflect current conditions and to the local epidemiology of COVID-19, with recognition that limitations in resources such as staffing may impact capacity for investigation, reporting, and response. During periods of high community transmission or surge, specific reporting thresholds for cases among healthcare personnel (HCP) may be adjusted because of challenges identifying whether transmission occurred within or outside the facility. In these situations, healthcare facilities should shift efforts to strengthening and monitoring HCP adherence to source control and distancing in common areas and prioritize investigation and reporting of potentially hospital-acquired cases in patients. Similarly, public health jurisdiction capacity to respond to reported cases may be limited during periods of high community transmission and surge, and public health staff may need to triage the reports for which they are able to provide consultation or support. However, when the

reporting threshold for HCP cases is adjusted, facilities must still report suspected or confirmed outbreaks. In addition, reporting of outbreaks and unusual infectious disease occurrences does not replace reporting of individual COVID-19 cases as part of state and local COVID-19 surveillance.

Updates to the CORHA/CSTE recommendations also include adding suspect and probable case definitions to account for increased use of point-of-care antigen testing to identify cases and shortening the interval between admission and a potentially hospital-acquired case in patients from 7 to 4 days to account for the shorter incubation period of recent SARS-CoV-2 variants.

Acute Care Hospitals:

Threshold for Additional Investigation by Facility

- ≥1 case of probable[1] or confirmed COVID-19 in a patient 4 or more days after admission for a non-COVID condition;
- ≥1 case of suspect[2], probable or confirmed COVID-19 in HCP

Threshold for Reporting to Local Public Health

- ≥2 cases of probable or confirmed COVID-19 in a patient 4 or more days after admission for a non-COVID condition, with epi-linkage[3];
- ≥3 cases of suspect, probable or confirmed COVID-19 in HCP with epi-linkage[4] in counties where the level of SARS-CoV-2 transmission in the community is low to moderate, or
- Any identified cluster of suspect, probable or confirmed COVID-19 in HCP with epi-linkage in counties where the level of SARS-CoV-2 transmission in the community is substantial or high (or ≥100/100,000 for 7 days)

Outbreak Definition

- ≥2 cases of probable or confirmed COVID-19 in a patient 4 or more days after admission for a non-COVID condition, with epi-linkage[3];
- ≥3 cases of suspect, probable or confirmed COVID-19 in HCP with epi-linkage[4] and no other more likely sources of exposure for at least 2 of the cases

Long-Term Care Facilities and Long-Term Acute Care Hospitals:

Threshold for Additional Investigation by Facility

- ≥1 suspect, probable or confirmed COVID-19 case in a resident or HCP;
- ≥3 cases of acute illness compatible with COVID-19 in residents with onset within a 72-hour period;
- ≥1 suspect, probable or confirmed COVID-19 case in HCP

Threshold for Reporting to Local Public Health

- ≥1 probable or confirmed COVID-19 case in a resident or HCP;
- ≥3 cases of acute illness compatible with COVID-19 in residents with onset within a 72-hour period;
- ≥1 probable or confirmed COVID-19 case in HCP

Outbreak Definition

- ≥1 facility-acquired[5] COVID-19 case in a resident;
- ≥3 suspect, probable or confirmed COVID-19 cases in HCP with epi-linkage and no other more likely sources of exposure for at least 2 of the cases

For additional information on the identification and response to COVID-19 cases please refer to Investigation of COVID-19 Outbreaks in Acute Care Hospitals (PDF). This document was developed by CDPH Healthcare Associated Infections (HAI) Program in accordance with CDC guidance on Responding to SARS-CoV-2 Infections in Acute Care Facilities.

If you have any questions about this AFL, please contact the CDPH Healthcare-Associated Infections Program via email at CovHAI@cdph.ca.gov.

Sincerely,

Original signed by Cassie Dunham

Cassie Dunham

Deputy Director

Resources:

- Proposed Investigation/Reporting Thresholds and Outbreak Definition for COVID-19 in Healthcare Settings (PDF)
- Investigation of COVID-19 Outbreaks in Acute Care Hospitals (PDF)

[1] Probable case is defined as a person meeting presumptive laboratory evidence. Presumptive laboratory evidence includes the detection of SARS-CoV2 specific antigen in a clinical or post-mortem specimen using a diagnostic test performed by a Clinical Laboratory Standards Institute (CLIA)-certified provider.

[2] Suspect case is defined as a person meeting supportive laboratory evidence OR meeting vital records criteria with no confirmatory or presumptive laboratory evidence for SARS-CoV-2. Supportive laboratory evidence includes the detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight.

[3] Epi-linkage among patients is defined as overlap on the same unit or ward, or other patient care location (e.g., radiology suite), or having the potential to have been cared for by common HCP within a 7-day time period of each other. Determining epi-linkages requires judgment and may include weighing evidence whether or not patients had a common source of exposure.

[4] Epi-linkage among HCP is defined as having the potential for close contact while working in the facility during the 7 days prior to the onset of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility. Determining epi-linkages requires judgment and may include weighing evidence whether or not transmission took place in the facility, accounting for likely sources of exposure outside the facility.

[5] Facility-acquired COVID-19 infection in a long-term care resident refers to SARS-CoV-2 infections that originated in the facility. It does not refer to the following:
• Residents who were known to have SARS-CoV-2 infection on admission to the facility
• Residents who tested positive on day 1, 3 or 5 after new admission.

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