APPENDIX 5: COVID-19 CASE AND CONTACT SHAREPOINT REPORTING TOOL

1. DAILY CASE LINE LIST REPORTING IN SHAREPOINT

During the COVID-19 pandemic, the California Correctional Health Care Services (CCHCS) institutions shall report to the Public Health Outbreak Surveillance COVID-19 SharePoint all cases of COVID-19 among patients (suspected and confirmed). Next business day reporting is required for newly identified cases (suspected or confirmed) and significant updates to existing cases, including false-positive determination and symptom onset. No report is needed if there are no new cases and no significant updates to existing cases.

2. DEFINITIONS TO GUIDE REPORTING

CONFIRMED CASE
A positive laboratory test for the virus that causes COVID-19 in at least one respiratory specimen. A positive antigen test should be reflexively confirmed using a molecular test.

SUSPECTED CASE
Acute illness compatible with COVID-19 of unknown etiology without a conclusive test result for the virus that causes COVID-19.

ACUTE ILLNESS COMPATIBLE WITH COVID-19
At least one of the following symptoms: cough, shortness of breath or difficulty breathing, fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s) (e.g., loss of sense of taste or smell).

RE-POSITIVE TEST
A positive test for the virus that causes COVID-19 in a patient who has previously tested positive.

FALSE POSITIVE TEST
A test which incorrectly indicated that a virus was present. A positive test for the virus that causes COVID-19 may be determined to be a false positive by Quest Diagnostics, the institution Chief Physician and Surgeon (CP&S), or the Chief Medical Executive (CME); see “Concern for COVID-19 False-Positives: What to Do” subsection in the Testing section.

3. SHAREPOINT REPORTING REQUIREMENTS

The following events require same-day reporting to the COVID-19 SharePoint:

- All new suspected and confirmed COVID-19 cases in a new SharePoint record.
  - Note that positive test results from Quest or a positive point of care (POC) test performed at the institution will auto-generate records in SharePoint.
  - Tests performed at outside labs (community hospitals, public health labs) require manual entry into SharePoint.

- For previously reported suspected or confirmed cases, update the existing SharePoint record with first positive lab results, new symptoms, date of first symptom onset, and false-positive determinations.

- Re-positive tests >90 days after the first positive test should be reported in a new SharePoint record. The only required fields, besides identifying information, are test date, result (positive), symptom onset date, and symptoms.

No report is needed if there are no new cases and no significant updates to existing cases.

4. RESOLVING CASES IN SHAREPOINT

Cases are now resolved in the Quality Management (QM) Monitoring Registry based on the date of the first positive test, active isolation orders, and out-to-medical status. Cases no longer need to be resolved in SharePoint.
5. REPORTING FALSE POSITIVES TO SHAREPOINT
False positives (as determined by the institution CME or CP&S or by Quest Diagnostics) must be documented in the medical record by the CME or CP&S or designee and then reported to SharePoint (see the Concern for COVID-19 False Positives: What to Do subsection in the Testing section).

Enter the specimen collection date and test result (positive). Enter the date of release from isolation. Select the **Reason case closed** as “False positive documented by CME or CP&S; not a case.”

CCHCS data systems will then ignore positive tests collected on that date for that patient when determining the patient’s COVID status. The date in the SharePoint report must match the date of the positive test in other CCHCS data (e.g., from Quest or the influenza-like illness (ILI) POC Results PowerForm) for the status to update correctly. The positive result on that date will be listed as “DETECTED (Possible False Positive)” in the patient’s Lab Results Report in the QM COVID monitoring registry historical Lab Results Report. These data systems changes will occur no sooner than 5 days after the collection date to allow time for false positive case determinations and documentation in the medical record.

6. REPORTING RESOLVED CASES IN RETURNING PATIENTS
When a patient with confirmed active COVID-19 is released from CDCR prior to meeting the criteria for release from isolation (e.g., unresolved) and later returns to CDCR, the patient will **no longer** initially show in the COVID-19 monitoring registry with a status of Confirmed Active, because of the new reliance of the QM registry on time since the first positive test, active isolation orders, and out-to-medical status for determining active/resolved status. Therefore, no action is needed in SharePoint.

7. REQUESTING RECORD DELETION
SharePoint users in the institutions can update but not delete records. To request deletion of a duplicate record or a record entered in error, change the CDCR number to “DELETE”. Send an email to Sharon.Albers@cdcr.ca.gov and cc Amber.JonesHarvel@cdcr.ca.gov.

Subject line: “Requesting deletion of PH SharePoint record, <institution>”

Include the date of report, reporting institution, and the patient’s last name in the email message.
8. REPORTING IN SHAREPOINT
From https://cdcr.sharepoint.com/sites/cchcs_ms_phos, click on your institution.

Each institution has a home page with a navigation panel on the left.

To access the CASES line list, click on **CV19 Cases Suspected & Confirmed**. To access the CONTACTS line list, click on **CV19 Contacts**; reporting contacts is now optional. This guide applies to both the CASES and CONTACTS line lists. To add a new patient to a line list, click on **New**.
A new record (data entry form) will open on the right.

Scroll through the form to enter data. Brief instructions are provided below the form fields. Refer to the Data Definitions section below for detailed instructions for each field in the CASES and CONTACTS line lists. Click on Save at the bottom of the form to add the report to the line list.

Saving the form adds the report to the line list.
To locate a record among many in the line list, use the Search box [1] or click on a column heading (e.g., CDCR number, Patient last name) [2] and select Filter by.

Any column may be custom filtered to subset the line list to records of interest (e.g., released from isolation and ready to close) for editing directly in the line list (refer to the Quick Edit feature instructions below).

To enter updated information after saving the form, click on the row [1] to select the record in the line list, then click on Edit [2] to re-open the form.

Enter your new information (e.g., diagnostic test, isolation dates) and click on Save (as above).
To edit a record directly in the line list, you can also click on **Quick Edit**.

Use the scroll bar [1] to move across the line list. Clicking on any field [2] will highlight it and enable an update to be entered. You can also cut and paste from an Excel spreadsheet into a blank row [3] in SharePoint (e.g., to add a list of CDCR numbers to initiate reports for new patients).

After entering new information into the line list, click on **Exit Quick Edit** to save the update.
To share a link to an individual case report (e.g., to communicate with other health care staff in the institution), select the record by clicking on it [1] and then click on Share [2].

A link to the case or contact report can be sent by entering an email address in the pop-up [1] or by clicking on Copy Link [2] and pasting the generated link into a separate email thread.

Click on Export to Excel [1] to create a copy of your CASES or CONTACTS line lists into a spreadsheet that can be saved for other non-reporting activities. Click on Open or Save [2] to view or save the spreadsheet in Excel.
9. DATA DICTIONARY
COVID-19 CASES SUSPECTED AND CONFIRMED

<table>
<thead>
<tr>
<th>Field</th>
<th>Definition / Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of report</td>
<td>The date that the suspect or confirmed case-patient was initially reported. This field is auto-populated and should not be edited.</td>
</tr>
<tr>
<td>Reporting institution</td>
<td>The default value (auto-populated) is the hub institution. If the patient is at a Community Correctional Facility (CCF), select the CCF from the drop-down menu.</td>
</tr>
<tr>
<td>CDCR number</td>
<td>In addition to the CDCR number, enter the patient’s last name and date of birth. These identifiers are needed to identify the patient correctly and link to other CCHCS data and the Quality Management (QM) COVID-19 Monitoring tool. Enter the birth date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Patient last name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Housing assignment yard</td>
<td>Enter the patient’s housing location (optional, for institutional use). Usually, the cell bed or number is a 3-digit number. In some cases, it may be followed by a single letter representing an upper or lower bunk (U or L).</td>
</tr>
<tr>
<td>Housing assignment building</td>
<td></td>
</tr>
<tr>
<td>Housing assignment tier</td>
<td>Select an option from the drop-down list to record the result or status of the COVID-19 test used for diagnosis. Sometimes nasopharyngeal (NP) and oropharyngeal (OP) swabs may be collected and tested separately. If ANY specimens tested positive, select Positive. If ALL specimens tested negative, select Negative. Other options include Pending, Refused, Not tested-Probable case within outbreak, or Not tested-Other. Do not update this value later as a patient with a confirmed case is re-tested as part of a strategy to release from isolation.</td>
</tr>
<tr>
<td>Housing assignment cell bed bunk</td>
<td></td>
</tr>
<tr>
<td>COVID-19 test for diagnosis</td>
<td>Select an option from the drop-down list to record where the test for diagnosis of COVID-19 is or was performed. The options are Quest Diagnostics, Outside hospital lab, Local public health lab, State public health lab, Point of Care, Other.</td>
</tr>
<tr>
<td>COVID-19 test laboratory</td>
<td>Select an option from the drop-down list to record the type of test. The options are PCR (NAAT), Antigen test, Viral culture, Antibody test, or Other test.</td>
</tr>
<tr>
<td>COVID test type</td>
<td>Enter the date that the specimen was collected for the tested used for the diagnosis of COVID-19. Do not update this value later as a patient with a confirmed case is re-tested as part of a strategy to release from isolation.</td>
</tr>
<tr>
<td>COVID-19 collection date</td>
<td>Select any respiratory pathogens, confirmed by laboratory testing, present while the patient was infected with the virus that causes COVID-19. The options are: No co-infection, Influenza A, Influenza B, RSV, Other co-infection.</td>
</tr>
<tr>
<td>Respiratory pathogen co-infection</td>
<td>Select all symptoms that apply at any time during this illness from the drop-down list. The options are: Cough (new onset or worsening of chronic cough), Shortness of breath (dyspnea), Fever &gt;100.4F (38C), Subjective fever (felt feverish), Other symptoms not listed above, Asymptomatic, Unknown. Only select Asymptomatic if the patient has not had any symptoms of COVID-19 at any time during their infection.</td>
</tr>
<tr>
<td>Symptoms</td>
<td>Enter the first date that the patient had any of the symptoms associated with COVID-19. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Date of symptom onset</td>
<td>Enter the last date that the patient had any of the symptoms checked above. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Date of symptom resolution</td>
<td>In the 14 days prior to symptom onset, did the patient have close contact with a confirmed case of COVID-19? Refer to the current COVID-19 guidance for definitions of close contact. Select an option from the drop-down list.</td>
</tr>
<tr>
<td>Close contact</td>
<td>Cluster of influenza-like illness (ILI) Is the patient linked to a cluster of ILI? Select a response from the drop-down list.</td>
</tr>
<tr>
<td>Patient hospitalized (outside hospital)</td>
<td>Has the patient been hospitalized at an outside hospital for this illness? Select an option from the drop-down list.</td>
</tr>
<tr>
<td>Field</td>
<td>Definition / Instruction</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hospital name</td>
<td>If the patient was admitted to an outside hospital or seen in the emergency room (ER), enter the hospital’s name.</td>
</tr>
<tr>
<td>Hospital level of care</td>
<td>Select the current level of care (LOC) for the patient at an outside hospital from the drop-down menu (e.g., intensive care unit – ICU, ICU/Vent, Telemetry, Med/Surg, ER).</td>
</tr>
<tr>
<td>Hospital admission date</td>
<td>Enter the date the patient was admitted to the hospital. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Hospital discharge date</td>
<td>Enter the date the patient was discharged from the hospital. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Return placement LOC</td>
<td>Select the level of care of the patient when they returned to the institution from the hospital (e.g., correctional treatment center - CTC, outpatient housing unit - OHU, skilled nursing facility - SNF, Housing Unit) from the drop-down menu.</td>
</tr>
<tr>
<td>Isolation status</td>
<td>Select the patient’s current isolation status (e.g., alone in Airborne Infection Isolation Room - AIIR, at an outside hospital, released from isolation) from the drop-down list.</td>
</tr>
<tr>
<td>Date isolation began</td>
<td>Enter the date the patient was isolated. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Date released from isolation</td>
<td>Enter the date the patient was released from isolation (M/D/YYYY). Enter the date in M/D/YYYY format.</td>
</tr>
</tbody>
</table>
| Reason for closing case       | If the case has been closed, select the reason from the drop-down menu. The options are:  
  • COVID-19 ruled out through testing or an alternative diagnosis  
  • Confirmed case, the patient recovered and was released from isolation  
  • Confirmed case, the patient died  
  • Patient transferred to another CDCR institution  
  • Transferred to another agency (e.g., Bureau of Prisons - BOP, Immigration and Customs Enforcement - ICE, Department of State Hospitals - DSH)  
  • Released from CDCR (e.g., parole, discharge)  
  • False positive documented by CME or CP&S; not a case  
  • Patient returned to CDCR >21 days from positive test; case resolved  
  • Other                                                                                                                                                                                                                                                                                                                                                  |  |
| Transfer institution          | If the patient was transferred to another institution or CCF before COVID-19 was ruled out or, if confirmed, before recovery, select the institution or CCF from the drop-down list.                                                                                                                                                                                                                                                                                   |  |
| Date case closed              | Enter the date that the case was closed in M/D/YYYY format. This is the date that the closure was entered into SharePoint.                                                                                                                                                                                                                                                                                                                                  |  |
| Modified                      | The auto-populated date and time of the most recent edit/update to the report. This date/time cannot be edited by the user.                                                                                                                                                                                                                                                                                                                                   |  |
| Modified by                   | The auto-populated user who last edited the report. This entry cannot be edited by the user.                                                                                                                                                                                                                                                                                                                                                                     |  |
## COVID-19 CONTACTS – NO LONGER REQUIRED

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Date of report</td>
<td>Date that the contact to a confirmed case of COVID-19 was initially reported. This field is auto-populated and should not be edited.</td>
</tr>
<tr>
<td>Reporting institution</td>
<td>The default value (auto-populated) is the hub institution. If the patient is at a CCF, select the CCF from the drop-down menu.</td>
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<td></td>
</tr>
<tr>
<td>Housing assignment cell bed bunk</td>
<td></td>
</tr>
<tr>
<td>Type of contact</td>
<td>Select all reasons that apply to the current quarantine from the drop-down list. Use “close contact” as defined by the current COVID-19 guidance. The options are:</td>
</tr>
<tr>
<td>date of last exposure</td>
<td>This date is used to calculate the end of the quarantine period. This value must be updated if the patient is re-exposed to COVID-19. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Quarantine start date</td>
<td>Enter the earliest date that the patient was placed on quarantine. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Quarantine end date</td>
<td>Enter the anticipated (future) or actual (past) end date of the quarantine for this patient. Enter the date in M/D/YYYY format.</td>
</tr>
<tr>
<td>Type of quarantine</td>
<td>How is (or was) the patient being quarantined. Select an option from the drop-down list. Select all options that apply for the reason(s) the patient’s quarantine ended from the drop-down list. The options are:</td>
</tr>
<tr>
<td>Reason quarantine ended</td>
<td>If the patient transferred to another CDCR institution or CCF before completing quarantine, select the institution or CCF from the drop-down list.</td>
</tr>
<tr>
<td>Transfer institution</td>
<td>The auto-populated date and time of the most recent edit/update to the report. This date/time cannot be edited by the user.</td>
</tr>
<tr>
<td>Modified</td>
<td>The auto-populated user who last edited the report. This entry cannot be edited by the user.</td>
</tr>
</tbody>
</table>
10. REQUESTING ACCESS TO THE COVID-19 SHAREPOINT

   a. If you do not have access, an error message will display.
   b. Click on Request access.

2. After you submit your access request, you may be contacted by a member of the SharePoint administration team asking what type of access you need. Respond that you need read-write access, and specify which institution.