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SPECIAL COMMITTEE ON PANDEMIC EMERGENCY RESPONSE

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Informational Hearing

Senate Special Committee on Pandemic Emergency Response Testing and Contact Tracing during the COVID-19 Pandemic: Present and Future

Wednesday, May 6, 2020 at 1:30pm
State Capitol, Room 4203

BACKGROUND

Coronavirus Disease 2019 (COVID-19) is a respiratory illness that can spread from person to person and it has been impacting countries around the world, starting at least as early as December 2019. With the number of cases of COVID-19 growing rapidly in the United States and around the world, the World Health Organization declared it a pandemic on March 11, 2020. On March 13, 2020, President Trump proclaimed that the COVID-19 outbreak in the United States constitutes a national emergency.

According to tracking by the New York Times, as of May 3, 2020, the coronavirus pandemic has sickened more than 3,421,100 people worldwide. At least 243,884 people have died, and the virus has been detected in at least 177 countries. More than 1,153,300 people in the United States have been infected with the coronavirus and at least 67,365 of them have died. The United States has the highest number of known cases in the world. More than 1,000 additional deaths have been announced in the United States every day since April 2nd.

Due to the severity of the COVID-19 crisis, on March 4, 2020, Governor Newsom issued an Executive Order declaring a state of emergency and on March 19, 2020, he issued a statewide stay-at-home order. As of May 2nd, the California Department of Public Health (CDPH) had recorded 53,616 total cases of COVID-19 in California, with 2,215 deaths reported, 1229 of which were in Los Angeles County. As of May 2nd, there were 3318 patients who tested positive for COVID-19 who were hospitalized in California and another 1,169 in the hospital who are suspected to have COVID-19. The state intensive care unit (ICU) figures as of May 2nd were 1,169 who have tested positive in ICUs and another 299 in ICUs who are suspected to have COVID-19. As of May 1st, local health departments reported 5,743 confirmed positive cases in health care workers and 31 deaths statewide.

Adequate testing, contact tracing and self-isolation are precursors to loosening stay-at-home orders. In April, Governor Newsom announced six indicators that would drive California’s decision to gradually modify portions of the state’s stay-at-home order. The first of those six is the subject of this hearing. Those indicators include:

- Expanding testing and contact tracing to be able to identify and isolate those with the virus;
- Preventing infection in people who are most at risk;
- Being able to handle surges in hospitals and the health care delivery system;
- Developing therapeutics to meet demand;
- Ensuring businesses, schools and child care facilities can support physical distancing; and
- Determining when to reinstate certain measures like the stay-at-home order if need be.

Diagnostic Testing for COVID-19. Broad access to polymerase chain reaction (PCR) diagnostic testing for COVID-19 and rapid results are vital for disease monitoring, rapid public health response, and disease control. At the start of the COVID-19 outbreak, widespread access to testing in the United States was hampered by supply shortages, technical flaws and regulatory hurdles. Only limited testing was available. For instance, demand for the specialized 6-inch swabs required for the nasopharyngeal procedure far outpaced supply. The Center for Disease Control and Prevention (CDC) currently calls nasopharyngeal swabs the “preferred choice” for coronavirus testing, but drive thru testing sites often offer an oral self-swab.

California responded by developing a mix of public and private testing options. The state and local public health laboratories developed testing capacity. Individual health systems such as the University of California (UC) Davis Medical Center and UC San Diego Health followed suit. In addition, a number of private entities have entered the testing marketplace. Samples are collected at collection sites and sent to centralized laboratories for the actual testing. The amount of time it takes to obtain results has varied widely, from 24 hours to two weeks.

On April 4th, Governor Gavin Newsom announced the launch of California’s COVID-19 Testing Task Force, with the mission of coordinating public and private sector efforts to significantly increase access to testing across California. The goals of the Testing Task Force include:

- Ensuring California has lab capacity to rapidly turn around test results and increase capacity strategically to meet demand;
- Improving the supply chain to ensure that California can both collect samples and evaluate results without delay;
- Enabling new, high-quality tests to launch in California as soon as possible;
- Improving our ability to accurately track and evaluate COVID-19 testing capacity, results and reporting; and,
- Building the workforce necessary to meet our testing goals.

As of May 1st, more than 685,048 tests have been conducted in California with results reported to CDPH. These numbers include data from commercial, private and academic labs, including Quest, LabCorp, Kaiser, University of California and Stanford, and the 25 state or county health

labs currently testing. There are over 600 testing sites in California, with approximately 250 of those sites being described as core sites. In recognition that many rural and lower-income urban areas lacked testing sites, the Newsom Administration is working with Verily and OptumServe to expand the number of testing sites. Approximately 42 of the 86 anticipated new testing sites intended to serve rural and underserved communities were stood up in April 2020, with more scheduled to become operational this week.

Governor Newsom announced a goal of running 10,000 COVID-19 tests daily by mid-April and 25,000 tests per day by the end of the month. At the end of the week of April 27th, the Governor reported that testing levels had reached an average of 25,000 daily, with close to 30,000 tests per day by the end of that month. The Governor has stated that 60,000-80,000 tests per day is a longer-term goal. During the month of April, despite a significant increase in testing swabs being delivered to California, a lack of sufficient testing swabs and viral transport medium in some areas of the state continued to be an issue that kept the number of tests performed lower than they would otherwise be.

Health insurers, health plans, Medi-Cal and Medicare cover COVID-19 testing without co-pays or other out-of-pocket costs, but there have been some issues with coverage when someone needs re-testing. Those who are undocumented can get free testing for COVID-19 through Medi-Cal emergency services. COVID-19 Presumptive Eligibility (through Medi-Cal) provides no cost diagnostic testing to those who otherwise lack coverage.

Prioritization for Testing. As access has increased, the criteria for testing eligibility has also expanded. On April 30, 2020, the CDPH issued new guidance on prioritization to expand access to COVID-19 testing.

Tier 1

Testing Modality: PCR with or without Serology

- Hospitalized patients
- Symptomatic and asymptomatic healthcare workers, first responders, and other social service employees
- Symptomatic and asymptomatic persons >65 years of age OR any age with chronic medical conditions that increase the risk of severe COVID 19 illness
- Persons identified for testing by public health contact investigations and disease control activities in high risk settings
- Screening of asymptomatic residents or employees of congregate living facilities including:
 - After positive cases have been identified in a facility
 - Prior to resident admission or re-admission to a facility
- Symptomatic and asymptomatic persons in essential occupations

- E.g., utility workers, grocery store workers, food supply workers, other public employees
- Lower risk symptomatic persons

Tier 2

Testing Modality: PCR with or without Serology

- Lower risk asymptomatic persons

Serology Testing (anti-body testing). Antibody testing can help identify who has been infected with COVID-19 and has developed antibodies that may protect them from future infection, as well as identify those still at higher risk. Initial research shows that some individuals have higher concentrations of antibodies than others, which could mean that some individuals will have a stronger immune response than others if re-exposed to the virus.

The U.S. Food and Drug Administration (FDA) has issued at least nine Emergency Use Authorizations (EUAs) for serological tests, and that number is expected to grow. Other serology tests without specific FDA authorization are also in use. Additionally, on April 17th, the state's Testing Task Force provided guidance on serology testing options to public health labs currently testing for COVID-19, as well as to stakeholders.

In mid-April, the University of Southern California (USC) and the Los Angeles County Department of Public Health released preliminary results from a study of antibody tests which suggest infections from COVID-19 are more widespread than diagnostic testing and other indicators had previously demonstrated. Most diagnostic testing had been conducted on patients with symptoms, and even some people with symptoms did not have access to testing.

In talking about the USC/Los Angeles Department of Public Health antibody testing study, Barbara Ferrer, Director of the Los Angeles County Department of Public Health explained, "These results indicate that many persons may have been unknowingly infected and at risk of transmitting the virus to others. These findings underscore the importance of expanded polymerase chain reaction (PCR) testing to diagnose those with infection so they can be isolated and quarantined while also maintaining the broad social distancing interventions."

Convalescent plasma is the liquid part of blood that is collected from patients who have recovered from the novel coronavirus disease, COVID-19. Convalescent plasma is being investigated for the treatment of COVID-19 because there is no approved treatment for this disease and there is some information that suggests it might help some patients recover from COVID-19.

People who have fully recovered from COVID-19 for at least two weeks are being encouraged to consider donating plasma, which may help save the lives of other patients. COVID-19 convalescent plasma can only be collected from recovered individuals if they are eligible to donate blood. Individuals must have had a prior diagnosis of COVID-19 documented by a

laboratory test and meet other donor criteria. Individuals must have complete resolution of symptoms for at least 14 days prior to donation. A negative lab test for active COVID-19 disease is not necessary to qualify for donation.

Contact Tracing. Contact tracing is an essential tool to help contain the virus. Contact tracing will be particularly important as stay-at-home orders are loosened, especially since many infected people can be asymptomatic carriers of the disease and expose others without knowing it. Contact tracing involves public health staff talking with a patient to help them recall everyone with whom they have had close contact during the timeframe during which they may have been infectious. Public health staff then warn these exposed individuals (contacts) of their potential exposure as rapidly and sensitively as possible. Under guidelines from the CDC, in order to protect patient privacy, contacts are only informed that they may have been exposed to a patient with the infection. They are not told the identity of the patient who may have exposed them. Those contacted about potential exposure are asked about any symptoms they might have, are offered COVID-19 tests, and isolation is recommended until they receive their test results.

Contact tracing is not new in the world of infectious diseases. Contact tracing has been performed in California for decades to help track and contain the spread of tuberculosis, measles, HIV/AIDS and some other sexually transmitted infections or contagious diseases.

Contact testing is performed by local and now state public health workers. In mid-April, Politico reported that twenty-two counties have robust contact tracing programs in place, but these programs vary widely and many counties focus on contacting those who could put vulnerable populations at risk if they have COVID-19, such as health care workers or the elderly.

California has begun efforts to “build an army of tracers”, which will necessitate significant recruitment and training efforts. On April 22nd, the Governor announced that California is establishing a contact tracing workforce by surveying counties about their capacity; developing a statewide training academy; and training 10,000 public health connectors to conduct contact tracing. The need for this expanded tracing capacity is expected to continue beyond 2020.

On May 4th, the Governor announced a partnership with the University of California, San Francisco and University of California, Los Angeles that will substantially increase California’s capacity to conduct contact tracing. UCSF and UCLA will be providing a “virtual academy” to train contact tracers who will support the existing contact tracing workforce that operates through sixty-one local health programs (each county has one, plus Long Beach, Pasadena and Berkeley). The training academy, which begins May 6th, will consist of twelve hours of online training and eight hours of in-person instruction. The capacity is such that it is currently estimated that we can train up to 3000 contact tracers per week through this program, with cultural competency a part of the focus, as well as tracers who can speak more than one language. In the first phase of this effort, 10,000 people are expected to be trained, with the number increasing to 20,000 in the second phase. Though the state is playing a coordinating role, the contact tracing will be led by existing local public health tracing programs. All the

tracing information is expected to be fed into one database. Increasing contact tracing capabilities is described as foundational to modifying stay-at-home orders. In the coming days, CDPH is expected to release guidelines for counties whose public health officers and County Supervisors believe they are well positioned from a public health standpoint to reopen some businesses and public spaces more quickly than will happen statewide. The state guidelines will include a requirement that counties self-certify that their testing and contact tracing capabilities meet state readiness criteria if the county intends to move more quickly to reopen businesses and public spaces beyond what the state's modified stay-at-home orders will provide statewide.

The state is also developing isolation protocols and supports by identifying regional alternate isolation sites and building private-public partnerships to support those who are isolated. Finally, the state is deploying a data management system and tools by publishing a symptom-check app; deploying a data management platform; and establishing a data dashboard for the public. On April 27th, the Governor announced that a contact tracing portal is under development.

The County of San Francisco is partnering with UC San Francisco and Dimagi, a Massachusetts-based software company to pilot a tracing program that may become a model for others. The San Francisco contact tracing pilot program is using an online and phone-based app developed by Dimagi to digitally support contact tracing and monitor people who are potentially infected with COVID-19. The app will allow those being monitored to receive texts to help track and report their symptoms, and to alert public health officials if they need follow-up or care. The program is staffed by health professionals and newly trained volunteers. Approximately 250 tracers completed the twenty-hour online training program by the end of April.

Also, Google and Apple are working together to develop a phone to phone contact tracing system. Digital information gathering and contact tracing is in use in a number of other countries. While less labor intensive than existing contact tracing programs, any of the new technology driven systems will come under scrutiny for how they handle sensitive information. Transparency about what data is being collected, what protections are in place to ensure that only data that is necessary for serving public health needs is being collected and what restrictions for use of the data are put in place are among the issues that privacy advocates have raised.

Health Disparities. Among those who are most vulnerable to the ravages of COVID-19, are those with certain pre-existing health conditions such as those with heart disease, diabetes, and asthma, which are conditions where we have long seen health disparities along racial, ethnic and income-levels.

Those health disparities that exist generally impact health outcomes for those who contract COVID-19, and we see this play out particularly in the death figures. Overall, for adults 18 and older, Latinos, African Americans and Native Hawaiians and Pacific Islanders are dying at disproportionately higher levels than others. The proportion of COVID-19 deaths in African

Americans is about double their population representation in California across all adult age categories. Additionally, the lack of widespread testing availability, particularly at the outset of the pandemic has had a disproportionate impact on communities where we typically already see health disparities.

Data on infection rates, hospitalizations and deaths is being collected and reported in California by race and ethnicity. However, there are other demographic categories who are believed to be impacted by health disparities, such as the LGBTQ community and for whom, we are not currently collecting and reporting data.