California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
May 18, 2022

Weekly Call-in Information:

- Tuesday 8:00am All Facilities Calls: 844.721.7239; Access code: 7993227
- Wednesday 3:00pm SNF Infection Prevention Webinars:
  - Register at: https://www.hsag.com/cdph-ip-webinars
  - Recordings, call notes and slides can be accessed at https://www.hsag.com/en/covid-19/long-term-care-facilities/cdph-ip-webinars-past/
- Friday 11:30 Booster Vaccine Quickinars:
  - Register at: https://bit.ly/FullSpeedAheadBoosterProgram
  - Recordings: https://www.hsag.com/covid-19/vaccine-resources

UPDATED Wednesday Webinar Frequently Asked Questions Document is Posted
https://www.hsag.com/globalassets/covid-19/cdph_faqsipwebinars.pdf
To view the updated FAQ (dated 5/13/2022), you may need to clear your cache to force your browser to download a "fresh" version of the website (click the refresh button or press Ctrl + F5 simultaneously)

Important Links to State and Federal Guidance	
Important Links and FAQs to CDPH State Guidance	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Guidance.aspx
2020 CDPH All Facilities Letters (AFLs)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL20.aspx
2021 CDPH AFLs	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL21.aspx
2022 CDPH AFLs	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL22.aspx
CDC COVID-19 Data Tracker	https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk&null=Risk
CDPH Wednesday Webinar FAQs	https://www.hsag.com/globalassets/covid-19/cdph_faqsipwebinars.pdf
CDPH Vaccine Guidance and Resources	https://eziz.org/resources-for-longterm-care-facilities/
CDPH Long-Term Care COVID-19 Vaccine Toolkit	https://eziz.org/assets/docs/COVID19/LTCFToolkit.pdf

Vaccine Questions & Answers

Q-1: Who is eligible for a second booster?
A: People eligible for the second booster at this time, include:

- People 50+ years old
- People 12+ years old who are moderately or severely immunocompromised (e.g., organ transplant, on chemotherapy, or other conditions)
- People 18-49 years old who got two doses of J&J vaccine

There is no current guidance for a second booster for healthcare workers or long term care facility (LTCF) residents who don't meet the age or clinical criteria. View second booster CDPH FAQs at: https://eziz.org/assets/docs/COVID19/SecondBoosterDoseFAQ.pdf.

Q-2: If an individual just received their second vaccine in the primary series, how long should they wait to get their first booster vaccine?
A: Following the second dose of either the Pfizer or Moderna mRNA primary vaccine series, the recommended interval to obtain the first booster dose is five months after. However, AFL 21-34.3 and the February 22, 2021, State Public Health Officer Order state a 6-month interval before the booster is required after the primary series; therefore, HCP will have up to 6 months to get their first booster to be in compliance. CDPH strongly recommends HCP get their booster as soon as they are eligible. CDPH created a useful document, "COVID-19 Vaccine Timing by Age" which can assist with the timing of the recommended vaccine doses (https://eziz.org/assets/docs/COVID19/IMM-1396.pdf).

Q-3: Do HCP need to have their second booster to be considered up to date with their vaccines?
A: No, not at this time. The first booster is necessary to be considered up to date, but not the second booster. There is no current requirement for a second COVID-19 booster for HCP.

Q-4: How many months does an individual need to wait before they can get their second booster?
A: Following the second dose of either the Pfizer or Moderna mRNA primary vaccine series, the recommended interval to obtain the first booster dose is five months after. However, AFL 21-34.3 and the February 22, 2021, State Public Health Officer Order state a 6-month interval before the booster is required after the primary series; therefore, HCP will have up to 6 months to get their first booster to be in compliance. CDPH strongly recommends HCP get their booster as soon as they are eligible. CDPH created a useful document, "COVID-19 Vaccine Timing by Age" which can assist with the timing of the recommended vaccine doses (https://eziz.org/assets/docs/COVID19/IMM-1396.pdf).

Q-5: Should SNFs stop offering flu vaccines in April and May? Or should flu vaccines continue to be administered given the rise in cases?
A: In line with CDC & CDPH guidance, flu vaccination should continue to be offered as long as influenza viruses are circulating, and unexpired vaccine is available. Recently, flu activity has been increasing: California Influenza and Respiratory Disease Surveillance. Given this, **SNF's should continue to offer flu vaccines** at this time. From a recent CAHAN that was sent out (see attached): "If influenza vaccine is still available, continue to recommend:

- Influenza vaccination, particularly to patients at high risk of severe influenza.
- Coadministration of influenza and COVID-19 vaccine when patients present for either vaccine separately.

Interim vaccine effectiveness results from CDC's U.S. Flu Vaccine Effectiveness Network indicate that vaccination did not reduce the risk of mild to moderate illness from these H3N2 viruses. However, it is reasonable to continue to vaccinate as long as influenza viruses are circulating and even when protection against one virus is reduced. Influenza vaccines protect against four different influenza viruses and vaccination may prevent serious outcomes in people who are vaccinated but still get sick. While the results of influenza vaccine effectiveness studies against severe outcomes are still to come, vaccination has been shown in several past studies to reduce severity of influenza in people who get vaccinated but still get sick. Persons who receive a late-season influenza vaccine will still be eligible for a 2022-23 seasonal influenza vaccine at the usual time.

Medical Director Certification Questions & Answers

Overview of June 30th Medical Director Certification Deadline: A SNF medical director must, within 5 years of initial hire, be certified by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM; https://www.abplm.org/home), or an equivalent organization, as a Certified Medical Director. A medical director already employed by SNF as of January 1, 2022, shall have until January 1, 2027, to become a Certified Medical Director. More information about this requirement can be found in:

- AB 749 https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB749
- CDPH AFL 21-46 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-46.aspx

Application Packet Reporting Requirement:
Per **AFL 21-46**, SNFs have until **June 30, 2022** to report the name and certification status of their medical director by submitting the following information to CDPH:

- CDPH HS 215A form or its successor form https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/hs215a.pdf
- Medical Director Resume
- Whether its medical director is certified as a Certified Medical Director according to the requirements established by the American Board of Post-Acute and Long-Term Care Medicine or an equivalent organization as determined by CDPH
- If the medical director is not yet certified, the expected date of certification

SNFs must also submit the information above on their initial licensing applications and must notify CDPH within 10 days of changes in its medical director by submitting the same information.

Q-6: Where do SNFs need to submit their completed application packets?
A: SNFs can submit their completed application packets to the Centralized Applications Branch address below. Please do not wait until the last minute to submit your packet. The earlier you send it in, the more time CDPH will have to verify the information before the deadline.

- California Department of Public Health
  Licensing and Certification Program
  Centralized Applications Branch
  P.O. Box 997377, MS 3207
  Sacramento, CA 95899-7377

Q-7: Is Medical Director certification required for Congregate Living?
A: No, not that we are aware of.

Q-8: Is Medical Director certification required for a Distinct Part (D/P) SNF that has the Chief Medical Officer as the Director of the SNF?
A: No. The medical director certification requirements do not apply to D/P SNFs. However, D/P SNFs shall designate a qualified physician as a medical director who is responsible for standards, coordination, surveillance, and planning for improvement of medical care. Qualified physician means either of the following:

- The physician is certified, or pursuing certification, by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) as a Certified Medical Director.
- The physician is board certified in a medical specialty consistent with the type of care provided in the SNF, including, but not limited to, physical medicine and rehabilitation or pulmonology, and whose role as the medical director of the SNF has been reviewed and approved by the hospital's leadership.

Q-9: If the medical director is already certified at a facility, do they need to be recertified for other facilities?
A: No, if the medical director is certified already, that will work for all facilities that they are the medical director for. They do not need a separate certification for each facility.

Testing Questions & Answers

Q-10: How often should testing for residents and HCP be done during response testing?
A: Per CDPH AFL 20-53.6, as soon as possible after one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility. Serial retesting of all residents and HCP who test negative upon initial testing should be performed at least weekly if NAAT test is used (e.g., PCR test) or twice weekly if an antigen test is used until no new cases are identified in residents in sequential rounds of testing for 14 days.

Q-11: Can the general public order free at-home COVID-19 tests?
A: Yes. Residential households in the U.S. are now eligible for another order of free at-home tests on USPS.com. This is the third round of tests being distributed. Each order now includes eight rapid antigen COVID-19 tests. To order tests, visit: https://www.covid.gov/tests. A best practice shared in the chat box from a nursing home was that they have had success ordering the free at-home tests for each resident by adding the room and bed number to the address on the order form. Also, Medicare beneficiaries qualify for up to eight free over-the-counter COVID-19 tests each calendar month. These tests can be obtained at an eligible pharmacy or health care provider that participates in this initiative. A partial list of participating pharmacies can be found at https://www.medicare.gov/medicare-coronavirus. More information can be found at: CMS Newsroom.

Q-12: Our SNF is receiving a smaller amount of BinaxNOW test kits each week (only 2 boxes compared to 16 boxes delivered every week). Why are we receiving a smaller supply?
A: We are not sure why that is. We recommend contacting your MHOAC to get access to more tests.

Q-13: Is there an emergency supply of reagent for the BinaxNOW PRO test kits? We almost always end up running out before utilizing all 40 tests in the kits and end up having to borrow from other kits?
A: No, there is not an emergency supply of reagent and it cannot be bought separate from the test.

PPE Questions & Answers

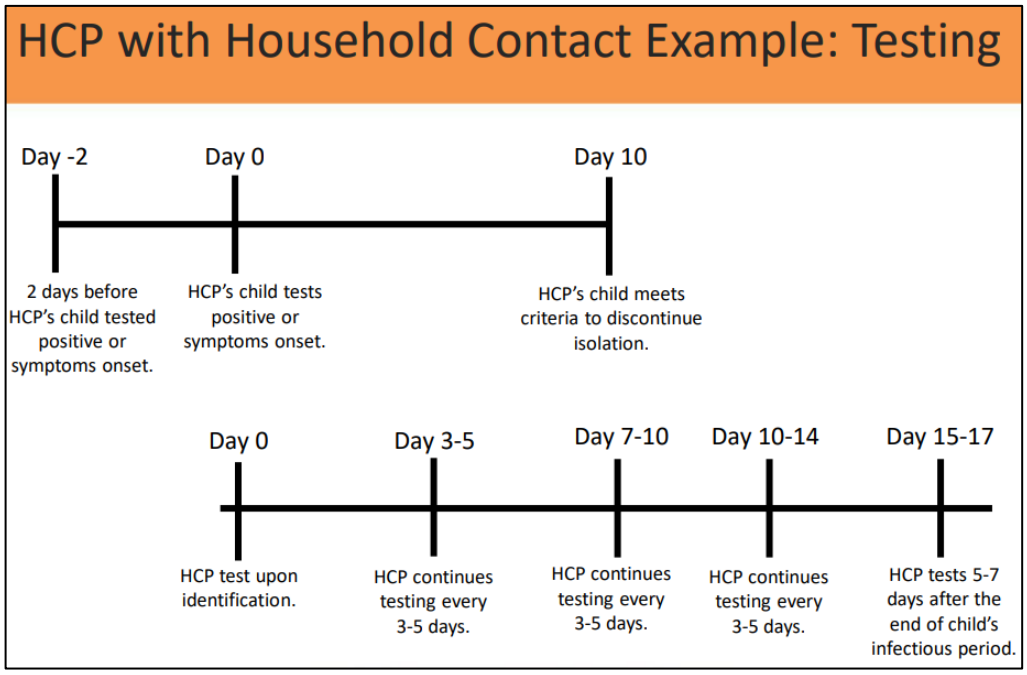
Q-14: Do HCP have to wear eye protection in the green zone?
A: Eye protection (face shields, goggles) is required as PPE during all resident care, including green zones during an outbreak, and during care of residents in the green zone in counties with substantial or high COVID-19 transmission per CDC's COVID-19 Data Tracker.

- Eye protection in the green zone is NOT required in counties with low to moderate county transmission, unless otherwise indicated as part of standard precautions.
- Eye protection is NOT necessary in non-patient care areas—such as the kitchen, hallways, nurses' station—regardless of county transmission.
- Check with your local health department to see if they have more stringent requirements.

Q-15: How do we determine the exposure period for testing and quarantine for HCP with a household contact (e.g., exposed to positive child)?
A: If the HCP cannot isolate from their infected household member, the HCP would be considered exposed throughout the infected household member's infectious period. The HCP should test as follows, regardless of vaccination status (see diagram below):

- Test upon identification of the exposure, which starts 2 days prior to the infected person's symptoms onset or positive test, if asymptomatic.
- Continue testing every 3–5 days through 7 days after the end of the infected household member's infectious period (generally at least 5 days if testing negative on day 5 or later, or 10 days if no negative test, and improving symptoms if symptomatic).

Unvaccinated or booster-eligible HCP that are not boosted should quarantine in addition to testing. HCP that are up to date with their vaccinations do not need to quarantine, but still need to test.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control



Q-16: When does quarantine end for the HCP in the above household contact timeline example?
A: The quarantine period for HCP not up to date with their vaccines would end during the day 15-17 mark on the timeline, as long as the HCP tests negative with an antigen test.

Q-17: What test does an HCP need to use to return to work after a family member tested positive?
A: Either a PCR or antigen test is acceptable. If using an antigen test, the test needs to be observed by the facility to verify the identity of the HCP being tested, the date of the test, and that the test is negative. This proctoring does not need to happen physically in person with the HCP. There are options for telehealth or other ways to allow for observation of the HCP testing themselves.

- In May 2022, Cal/OSHA updated testing verification requirements in their Emergency Temporary Standards (ETS). Their FAQs state "To comply with the testing requirements of the ETS, an over-the-counter (OTC) COVID-19 test may be both self-administered and self-read if verification of the results, such as a time and date stamped photograph of the result or an OTC test that uses digital reporting with time and date stamped results, is provided.
https://www.dir.ca.gov/dosh/coronavirus/COVID19FAQs.html#testing

Q-18: When can a COVID positive HCP that is boosted return to work?
A: Per AFL 21-08, under routine staffing (not critical staffing shortage), an HCP that tested positive that is up to date with their vaccinations, and asymptomatic or mildly symptomatic with improving symptoms, can return to work on day 5 with a negative diagnostic test administered the same day or within 24 hours prior to return; or they can return to work after 10 days without a viral test. Either an antigen or PCR test can be used. Antigen testing is preferred for discontinuation of isolation and return-to-work for SARS-CoV-2 infected HCP. HCP who are unvaccinated or not up to date with their vaccinations cannot return to work until day 7 with a negative diagnostic test administered the same day or within 24 hours prior to return.

Q-19: Can an HCP return to work after 10 days of isolation even if they have signs and symptoms?
A: If an individual continues to have signs and symptoms after 10 days of isolation, and their symptoms are not improving, they may need to stay in isolation for a longer period of time. If the individual had a severe or critical illness (e.g., intubation, ICU stay), or is moderately to severely immunocompromised, the isolation period may be extended to ≥ 20 days per CDC guidance. Consider consulting with an infectious disease physician to see if a test-based strategy should be followed when an isolation period of ≥ 20 days is indicated.

Cohorting Questions & Answers

Q-20: Can staff working in the yellow zone also work in the red zone?
A: AFL 20-74 addresses cohorting and dedicated staff for the red zone by saying, "The COVID-19 positive cohort should be housed in a separate 'red area' (building, unit, or wing) of the facility and have dedicated HCP who do not provide care for residents in other cohorts and should have separate break rooms and restrooms if possible." Generally, staff in the red zone should be dedicated to the red zone, but for operational purposes and staffing ratios there may be situations where staff need to move between zones, especially in situations when you only have a few residents in the red zone. The facility's full-time infection preventionist should assist with adherence monitoring of hand hygiene and PPE donning/doffing between residents. IP protocols need to be monitored to ensure there are no breaches if staff are moving between zones.

Q-21: Can staff working in the yellow zone also work in the green zone?
A: Generally, staff in the yellow zone should be dedicated to the yellow zone, but for operational purposes and staffing ratios there may be situations where staff need to move between zones. The facility's full-time infection preventionist should assist with adherence monitoring of hand hygiene and PPE donning/doffing between residents. IP protocols need to be monitored to ensure there are no breaches if staff are moving between zones. View CDPH AFL 20-74 for more information on cohorting.

Q-22: What should we do if there is no private room available for a COVID positive resident?
A: If there is not a separate established red zone, then leaving the resident in their current room would be the next best alternative. If there is a roommate, they would be considered exposed and should quarantine in place; we would not recommend moving the exposed roommate (for example, to a separate yellow zone) to avoid new exposures to other residents in the facility.

Q-23: Following a high number of visitors over Mother's Day weekend, our facility now unfortunately has an outbreak, but most residents are asymptomatic. Since our booster vaccination rate is high, do we need to physically move residents to the yellow and red zones, or can they shelter in place as a more reasonable approach?
A: AFL 20-53.6 (which will be updated soon) has considerations for a contact tracing approach to response testing for facilities with staff and resident booster rates exceeding 90%. If the local health department agrees that a contact tracing approach would be feasible for your facility, then response testing may not be necessary for the entire facility. However, regardless of vaccination status, if a resident tests positive, they do need to be isolated and managed in the red zone. They would not be able to shelter in place with a roommate that is not COVID positive.

Other Questions & Answers

Q-24: Do we need to keep version history of our mitigation plans?
A: Saving copies of prior versions of mitigation plans would be considered a best practice, but we are unsure if this is a licensing and certification requirement. We will follow up.

Q-25: Is there a way to get previous versions of the CDPH AFLs?
A: Yes, past AFL versions, as well as other federal and state guidance, can be found at Clear Pol, which is a free search engine designed to make compliance easier for long term care professionals (https://app.clearpol.com/).