California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
December 14, 2022

Weekly Call-in Information:

- Every other Tuesday starting January 3, 2023, 8:00am All Facilities Calls:
  - 844.721.7239; Access code: 7993227
- Every Tuesday, 11:30am NHSN Updates & Office Hours (Hosted by HSAG NHSN Experts)
  - December 20 & 27 registration https://bit.ly/OctNovDecNHSNOfficeHours
  - January-March 2023 registration https://bit.ly/NHSNofficehours2023JanFebMarch
- 2nd & 4th Wednesdays every month, 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/

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 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
CDC's Interim Infection Prevention and Control Recommendations for HCP During COVID-19 (9/23/2022)	https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
HSAG NHSN Website	www.hsag.com/nhsn-help https://www.hsag.com/6-week-booster-sprint
CDC Health Alert Network: Interim Guidance for Clinicians to Prioritize Antiviral Treatment of Influenza in the Setting of Reduced Availability of Oseltamivir	https://emergency.cdc.gov/han/2022/han00482.asp

AFL	Date	Title	Website
22-31	12/12/22	Movement of Patients/Residents in the Healthcare Continuum During Seasonal Surges and the Coronavirus Disease 2019 (COVID-19) Pandemic	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-31.aspx
21-08.9	12/2/22	Guidance on Quarantine and Isolation for Health Care Personnel (HCP) Exposed to SARS-CoV-2 and Return to Work for HCP with COVID-19	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx
CDPH Health Advisory	12/2/22	Reminder to Lower Barriers to Prescribing COVID-19 Therapeutics to Mitigate Impact of COVID-19	https://www.cdph.ca.gov/Programs/OPA/Pages/CAHAN/Reminder-to-Prescribe-COVID-19-Therapeutics-to-Mitigate-Impact-of-Winter-Respiratory-Surge.aspx

CMS QSO	Date	Title	Website
20-38-NH	9/23/22	Long-Term Care Facility Testing Requirements	https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf
20-39-NH	9/23/22	Nursing Home Visitation - COVID-19	https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

New Admissions Questions & Answers

Q-1: Can nursing homes require that hospitals test patients prior to discharge?
A: No. Per AFL 22-31, SNFs may not require a negative test result prior to accepting a new admission. Results for asymptomatic patients tested in the hospital do not have to be available prior to SNF transfer. Nursing homes should work collaboratively with hospital discharge planners and local health departments to facilitate the safe and appropriate placement of nursing home residents, including new and returning residents requiring isolation and transmission-based precautions.

Q-2: Do new admissions need to be tested by the nursing home upon admission?
A: Yes. Per AFL 22-31, new admissions, regardless of vaccination status, should have a series of three viral tests for SARS-COV-2 infection; immediately upon transfer or admission and, if negative, again at 3 days and 5 days after their admission. Testing is not required for new admissions who tested positive for COVID-19 and met criteria for discontinuation of isolation prior to admission and are within 30 days of their infection. Testing of recovered residents within 31-90 days of prior infection should be done using an antigen test, preferably.

Q-3: Is quarantine required for new admissions?
A: No. Quarantine is not required for new admissions.

Q-4: Can nursing homes close to new admissions during an outbreak?
A: Per AFL 22-31, many local health departments require SNFs to close to new admissions during an outbreak until transmission is contained.

- COVID-19: Containment is evidenced by no new cases among residents for 14 days.
- Influenza: Containment is evidenced by no new cases for one week.

During hospital surges, local health departments should consider the following to allow SNFs to admit new residents before containment is demonstrated:

- SNF has implemented outbreak control measures (i.e., post-exposure or response testing, cohorting, transmission-based precautions, and chemoprophylaxis for influenza, assuming adequate availability).
- SNF has no staffing shortages or operational problems.
- SNF has adequate PPE, staff have been fit-tested, and staff have access to adequate hand hygiene and environmental cleaning supplies.

Cohorting Questions & Answers

Q-5: Do nursing homes still need to have a red zone to isolate COVID-19 positive residents?
A: Yes. SNFs need to have a dedicated COVID-19 isolation area (formerly referred to as “red zone”).

- Per AFL 22-13.1, “SNFs should continue to ensure residents identified with confirmed COVID-19 are promptly isolated in a designated COVID-19 isolation area. The COVID-19 isolation area may be a designated floor, unit, or wing, or a group of rooms at the end of a unit that is physically separate and ideally includes ventilation measures to prevent transmission to other residents outside the isolation area. SNFs that do not have any residents with COVID-19 and do not have a current need for an isolation area should remain prepared to quickly reestablish the area and provide care for and accept admission of residents with COVID-19."

Q-6: Do nursing homes need to have dedicated staffing for caring for residents in the red zone?
A: Dedicated staffing for the COVID-19 isolation area is no longer required.

- Dedicated staffing might be preferable during a large outbreak.
- Sequencing care for uninfected residents before positive residents is not required, but is a best practice.
- Ensure all HCP perform hand hygiene and change gloves and gowns between residents and when leaving the resident's room, or area of care (i.e., treatment or therapy room)
- Ensure all HCP strictly adhere to masking for source control (to prevent an infected HCP from inadvertently exposing the residents they are caring for).

Q-7: Do nursing homes need to have a yellow zone to quarantine residents?
A: The "yellow zone" is no longer applicable because quarantine and empiric transmission-based precautions are no longer required for exposed and newly admitted residents. Per AFL 22-13.1, "A facility-wide or group-level approach with quarantine for exposed groups should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission." If a contact tracing approach does not successfully prevent transmission, in consultation with the local health department, the facility may need to revert back to the unit-based quarantine approach wherein all residents would be considered exposed. In this scenario, the facility would essentially have a yellow zone.

PPE Questions & Answers

Q-8: When do HCP need to wear eye protection (face shields, goggles)?
A: HCP need to wear eye protection when caring for symptomatic or confirmed COVID-19 positive residents in isolation. Eye protection should also be worn when performing tasks that could generate splashes or sprays of blood, body fluids, secretions, and excretions per Standard Precautions.

- Universal eye protection is no longer required during care of residents who do not have COVID-19 or for recently exposed residents, regardless of community transmission rates.
- Universal eye protection and N95 respirators for AGPs can be considered:
  - During a surge or periods of high community transmission
  - During a COVID-19 outbreak in the facility.
  - If recommended by the local health department.
- Eye protection is not necessary in non-patient care areas (i.e., kitchen, hallways, nurses' station).

Isolation and Quarantine Questions & Answers

Q-9: Do HCP need to quarantine if they are exposed?
A: No. Per AFL 21-08.9, "Guidance on Quarantine and Isolation for Health Care Personnel (HCP) Exposed to SARS-CoV-2 and Return to Work for HCP with COVID-19" (12/2/2022), quarantine and work restriction are not required for exposed asymptomatic HCP, regardless of vaccination status. Following an exposure, HCP must be tested immediately (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and if negative, again at 5 days after the exposure. To provide an additional layer of safety, exposed HCP should wear a fit-tested N95 for source control for 5 days at all times while in the facility until they have a negative test result on day 5.

Management of Asymptomatic HCP with Exposures

Vaccination Status	Routine	Critical Staffing Shortage
All HCP, regardless of vaccination status	No work restriction with **negative** diagnostic test† upon identification (but not earlier than 24 hours after exposure) and if negative, test at days 3 and 5	No work restriction with diagnostic test† upon identification (but not earlier than 24 hours after exposure) and at days 3 and 5

Q-10: When can HCP with COVID-19 return to work?
A: Recognizing that staffing shortages continue to persist, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours and symptoms improving). To provide an additional layer of safety, these HCP should wear a fit-tested N95 for source control through day 10. If there is a critical staffing shortage, per the table below from AFL 21-08.9, positive HCP may return to work immediately with a fit-tested N95 for source control and work with COVID-19 positive residents only, wherever feasible. HCP who aren't already fit-tested for their role do not need to become newly fit-tested solely for the purpose of being able to return to work; these workers should wear a well-fitting N95. COVID-19 positive staff should take meal breaks outdoors, or in a well-ventilated area, away from other staff or residents when removing their mask.

Work Restrictions for HCP with SARS-CoV-2 Infection (Isolation)

Vaccination Status	Routine	Critical Staffing Shortage
All HCP, regardless of vaccination status	5 days* with at least one negative diagnostic test† same day or within 24 hours prior to return OR 10 days without a viral test	<5 days with most recent diagnostic test† result to prioritize staff placement‡

Q-11: If HCP are isolating at home after testing positive, can they do an at-home rapid test to return to work or does the antigen test need to be done at the facility in front of staff?
A: The test should be observed or validated 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 (i.e., telehealth, time-stamped picture of the test).

Vaccine Questions & Answers

Q-12: When can people get the bivalent booster if they recently recovered from COVID-19?
A: People with known current SARS-CoV-2 infection should defer vaccination at least until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html).

Q-13: When can a resident receive the influenza vaccine if they have previously been positive for influenza?
A: In general, "The presence of a moderate or severe acute illness with or without a fever is a precaution to administration of all vaccines…After they are screened for contraindications, persons with moderate or severe acute illness should be vaccinated as soon as the acute illness has improved." https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
Additionally, recommendations for prevention and control of Influenza and outbreaks in SNF include to "Vaccinate residents; mild illness is not a contraindication to flu vaccination, and residents may receive influenza vaccination regardless of COVID-19 status as long as clinically stable" Table 2: https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/RecsForPreventionControl_Flu_inCA_SNFsDuringCOVID_FINAL_100120.pdf

Q-14: A new admission received the bivalent booster, but did not receive the primary series. There is no record of the primary series in CAIR2. Should we administer the primary series now?
A: Providers should only accept written, dated records as evidence of vaccination; an attempt should be made to locate records and if records cannot be located within a reasonable time, these persons should be considered susceptible and started on the age-appropriate vaccination schedule. Consider alternate options for locating and verifying if the patient has received the vaccines https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Record-Guidelines-Standards.aspx. Additionally, healthcare providers may enter it as historical data into CAIR https://cair.cdph.ca.gov/CAIRHelp/webhelp/immunizations/Record_Historical_Immunizations.htm. More information can be found at: CDC Timing and Spacing of Immunobiologics https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.

Q-15: A staff member is up to date on their vaccines per the vaccine white card, however, CAIR2 has no record of the vaccines? Can our SNF enter in staff vaccine information into CAIR2?
A: No. The uses of CAIR2/immunization registries are limited by law to protect confidentiality. Employers can use CAIR2 to verify vaccine records for patients/residents, but cannot look up vaccine records for employees or visitors. With regard to vaccination verification, please refer to this guidance: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Record-Guidelines-Standards.aspx. Details on the legal language can be found on this website: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=120440. To troubleshoot CAIR2 discrepancies, contact the CDPH Virtual Vaccination Support website: https://chat.myturn.ca.gov/?id=17 or email DCVRRemediation.Requests@cdph.ca.gov.

Q-16: If the resident stated that he had Flu vaccination recently, but has no proof and no record found in CAIR, is it OK to have another flu vaccine?
A: Self-reported doses of influenza vaccine are acceptable, and the provider would not need to repeat the flu vaccine dose. However, providers can assess this on a case-by-case basis to ensure the resident is able to appropriately recall the information of when they last received the flu vaccination. A suggestion would be to check with the insurance company or pharmacy to see if there are records that can be found to confirm the flu vaccination was administered. More information can be found at: CDC Timing and Spacing of Immunobiologics https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.

COVID-19 Therapeutic Treatment

Q-17: Is Paxlovid and Remdesivir recommended to treat COVID-19 positive residents?
A: Yes. Per the 12/2/2022, CDPH Health Advisory, "Reminder to Prescribe COVID-19 Therapeutics to Mitigate Impact of COVID-19" https://www.cdph.ca.gov/Programs/OPA/Pages/CAHAN/Reminder-to-Prescribe-COVID-19-Therapeutics-to-Mitigate-Impact-of-Winter-Respiratory-Surge.aspx, there is ample supply of COVID-19 therapeutic agents, but they have been underused – especially among long-term care residents. COVID-19 treatments may decrease the risk of developing long COVID and reduce the risk for hospitalization and death by 50-88% among unvaccinated people; 45-50% among vaccinated or previously infected people. Providers, including nursing homes, must have a low threshold to prescribe COVID-19 therapeutics:

- Any patient with suspected COVID-19 should be tested for SARS-CoV-2 infection, and
- All symptomatic patients with a positive COVID-19 test should be evaluated for treatment (i.e., nirmatrelvir/ritonavir (Paxlovid) and remdesivir).
- **The decision to not prescribe COVID-19 treatment should be reserved for situations in which the risk of prescribing clearly outweighs the benefits of treatment in preventing hospitalization, death, and the potential for reduced risk of long COVID.**

Q-18: What is the latest guidance regarding the ability to take Paxlovid multiple times?
A: Paxlovid can and has been used multiple times in people who have been infected multiple times with different COVID variants and it appears to continue to be just as effective. However, CDC guidance in cases of COVID-19 rebound after treatment with Paxlovid is to NOT treat again. https://emergency.cdc.gov/han/2022/pdf/CDC_HAN_467.pdf

- "There is currently no evidence that additional treatment for COVID-19 is needed for COVID-19 rebound. Based on data available at this time, patient monitoring continues to be the most appropriate management for patients with recurrence of symptoms after completion of a treatment course of Paxlovid."

Influenza Questions & Answers

Q-19: What if there is an oseltamivir (Tamiflu) shortage?
A: Prioritize **treatment** of residents with lab-confirmed influenza (either antigen or molecular test may be used). If there are sufficient oseltamivir supplies, consider empiric antiviral treatment for symptomatic exposed residents (e.g., roommates and other close contacts) while awaiting test results if results will not be available within 48 hours. As oseltamivir supplies allow, prioritize post-exposure prophylaxis for residents with the highest degree of exposure (e.g., roommates and other close contacts). Information and guidance will be updated as the situation evolves. Please see CDC Health Alert Network: Interim Guidance for Clinicians to Prioritize Antiviral Treatment of Influenza in the Setting of Reduced Availability of Oseltamivir (https://emergency.cdc.gov/han/2022/han00482.asp).

Q-20: What test method should be used for testing of symptomatic individuals for influenza?
A: Either molecular assays or rapid influenza diagnostic tests (RIDTs) may be used to test for influenza. RIDTs are most useful during periods of high influenza activity (www.cdc.gov/flu/professionals/diagnosis/overview-testing-methods.htm).

- Reduced sensitivity of RIDTs may produce false negative results
- For symptomatic residents with a negative RIDT, obtain a molecular test to confirm diagnosis
- Multiplex influenza/COVID-19 rapid antigen tests allow for simultaneous flu/COVID testing of symptomatic individuals
    - Available to SNF via the Medical Health Operational Area Coordinator (MHOAC) or the local health department (LHD)

Q-21: Should we continue to test residents for influenza and for COVID-19 once an outbreak of either virus has been established?
A: Yes. Pre-pandemic, we recommended not testing once an outbreak of influenza was established. Now with co-circulation of influenza and SARS-CoV-2, identifying the infecting agent is important to determine antiviral treatment and cohorting. Test only symptomatic individuals for influenza.

Q-22: How should we place residents who are symptomatic before test results are available?
A: Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for care of a resident with suspected COVID-19. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or **remain in current room, pending results of viral testing**. They should not be placed in a room with new roommates, nor should they be moved to a COVID-19 care unit (if one exists) unless they are confirmed to have COVID-19 by SARS-CoV-2 testing.

Q-23: What if the resident tests positive for flu and the roommate remains asymptomatic?
A: A private room is **preferred** for the resident with influenza. If private room is unavailable:

- Treat the resident with influenza with oseltamivir and have them mask for source control.

- Optimize distancing measures including curtain and spacing.
- Oseltamivir prophylaxis for the roommate if sufficient supplies.

Q-24: Where should a resident who is returning to the SNF from a hospitalization for influenza be placed?
A: Isolation period is 7 days after illness onset or until 24 hours after resolution of fever and respiratory symptoms, whichever is longer. If resident is still in their isolation period, ideally, resident would return to a private room to complete their isolation. If no private room is available, return the resident to the original room and follow guidance in the response to Q-23 above.

Q-25: Can residents with influenza A be cohorted with residents with influenza B?
A: No, ideally. Factors to consider:
- At this time, there is very little influenza B circulating.
- If there are no other options, use source control for the residents in the room with both influenza A and influenza B and maintain as much distance as possible between residents, keep privacy curtains drawn.

Q-26: When should testing be considered for respiratory viruses other than flu and COVID?
A: When there is a cluster of residents with viral respiratory illness in a facility and all tests for influenza and SARS-CoV-2 are negative, obtain broader respiratory viral testing

Q-27: What Transmission-Based Precautions should be used for residents with influenza?
A: Standard plus Droplet Precautions for 7 days after symptom onset or until 24 hours after fever and respiratory symptoms have resolved, whichever is longer. Factors to consider:
- If there will be very close contact with a resident's respiratory secretions, use gowns and gloves per Standard Precautions
- Use N95 or higher respirator if providing aerosol-producing procedures (AGP).

Q-28: Are RSV antigen tests available?
A: Yes. Please see FDA news release (5/16/2022) "COVID-19 Update: FDA Authorizes First COVID-19 Test Available without a Prescription That Also Detects Flu and RSV" https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-first-covid-19-test-available-without-prescription-also