California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
December 2 & 3, 2020

The webinar recording, handouts and notes can be found at the Health Services Advisory Group (HSAG) registration website https://www.hsag.com/cdph-ip-webinars and the CDPH Skilled Nursing Facility Infection Prevention Education website: https://www.cdph.ca.gov/Programs/CHCQ/Pages/SNFeducation.aspx

The presentation covered the following updates:

- Testing Taskforce Updates
- NHSN Reporting Updates
- COVID-19 Vaccine Pharmacy Partnership- Friday, December 4th deadline
- AFL 20-83 IDT Authorized Medical Interventions for Residents Unable to Provide Informed Consent and Without a Health Care Decision Maker
- AFL 20-87 Movement of Patients/Residents in the Healthcare Continuum During Seasonal Surges and the Coronavirus Disease 2019 (COVID-19) pandemic

Questions & Answers

Q: What data source should SNFs use to identify their county positivity rate?
A: Use the CDPH data at Blueprint for a Safer Economy to access and determine your county positivity rates. Do not use the CMS data to determine your county positivity rate. The county data on the CDPH Blueprint website is updated weekly. Check your county's data every week to ensure you are up to date.

- Blueprint for a Safer Economy Home Page https://covid19.ca.gov/safer-economy/
- Blueprint for a Safer Economy county level data chart can be found here. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID19CountyMonitoringOverview.aspx
- Blueprint data from past weeks are archived at this site. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CaliforniaBlueprintDataCharts.aspx

COVID-19 Vaccine Related Questions

On December 1st, AMDA, The Society for Post-Acute and Long-Term Care Medicine issued a frequently asked questions document on vaccine safety and efficacy. Access this resource "Questions and Answers about the COVID-19 Vaccine for PALTC Staff, Patients, Residents and Family Members" at: http://paltc.org/sites/default/files/QA%20about%20the%20COVID-19%20Vaccine%20for%20PALTC%20Patients%20Family%20Member%20and%20Staff%20_%2012_1_20%20FINAL.pdf

Q: Will essential workers with comorbidities working in our facility, that are not healthcare workers, be able to receive the COVID vaccine?
A: Yes, all staff working in the facility will be able to receive the COVID-19 vaccine.

Q: Do previously positive HCP and residents need to get the COVID vaccine?
A: At this point, they would all be recommended for COVID-19 vaccine. Further guidance will be coming about people with prior infections.

Q: Do we need informed consent for the vaccines? Do you have a sample consent?

A: In general, informed consent is not required for immunizations (vaccine information sheets are required). HOWEVER, for COVID-19 vaccine, there are consent and assent forms being developed by pharmacies and will be shared when available.

Q: How do we get the second dose of the COVID-19 vaccine to residents should they be discharged before the second dose is due?
A: There are systems being worked out on this exact issue of second dose coordination. More information will be shared when available.

Q: For the COVID-19 vaccine, in our centers is only the CVS/Walgreens pharmacist administering the vaccine?
A: The CDC-Federal-Long-Term Care Facilities (LTCF) program is only working with CVS and Walgreens in California for Phase 1a vaccine distribution. Other pharmacies will be part of later phase vaccine distribution.

Q: Can a vaccinated individual give blood?
A: There is no specific guidance on this at this point, but it seems most likely yes.

Q: How do you recommend physician orders for vaccination are handled for staff? Our Medical Director wants to write a standing order to cover all staff unless dosing is contraindicated of course. Is it alright for our Medical Director to write a standing order for these vaccines in SNFs?
A: Yes, this is appropriate and that's the practice we are hoping for, but we need to educate the staff so they feel comfortable getting the vaccine.

Q: Can Assisted Living Facilities (ALFs) sign up for COVID-19 Vaccination distribution? Where do they sign up?
A: ALFs can sign up for the CDC-Pharmacy partnership LTCF program.
https://www.cdc.gov/vaccines/covid-19/long-term-care/pharmacy-partnerships.html

Q: Looking into the vaccines' side effect reports, facilities might find that quite a few vaccinated staff have symptoms that would normally exclude them from work (fever, myalgia, significant fatigue). Will there be any guidance about how to manage such side effects to protect staffing and available sick hours? If a lot of staff from the same facility are vaccinated on a particular day, the number of excludable staff could be a significant problem.
A: Guidance is forthcoming.

Q: Posted with Better Clarification: Does a COVID vaccinated HCP still shed Virus if/when exposed to COVID? So, does a COVID Vaccinated HCP exposed to a COVID positive family member (same household, no masks) have to quarantine from working in a SNF?
A: We don't know the answer just yet. We are proceeding into a new world. We can use the flu vaccine as an analogy. We will need to continue testing for some time even for those who have been vaccinated.

Q: Will the vaccine cause a person to test positive for COVID?
A: This is unlikely. There would need to be a specific timing just when the body was producing the protein and the PCR sequence used would need to target that exact sequence. So unlikely.

Q: Does the vaccine require 2 doses, one month apart before considered fully vaccinated?
A: "Vaccinated" should mean finishing the full 2 dose series with respect to the Pfizer vaccine (21 days between 1st and 2nd doses), and Moderna vaccine (28 days between 1st and 2nd doses).

Questions Related to Testing, PPE, Surge Best Practices

Q: We are having an issue with respect to RCFEs sending their COVID patients to the ED/Hospitals, and then not taking them back. We need to find a good solution for these non-skilled patients that are unable to return to their homes/RCFEs.

A: Sending patients to the ED is the last option and this should be considered after you have exhausted all resources; don't send residents to the ED unless absolute necessary. Need to find other placements to avoid unnecessary ED visits. CDPH doesn't oversee RCFEs. They are regulated by the Department of Social Services (DSS). CDPH will touch base with DSS for more guidance.

Q: Does CDPH have an algorithm on the use of the antigen POC machine on when a confirmation PCR test is required.

A: Yes, the Testing Task Force does have an algorithm that will be uploaded soon. In the interim feel free to reach out to Kathleen Jacobson Kathleen.Jacobson@cdph.ca.gov and she would be happy to forward it to you.

Q: Can hospitals have access to the Valencia lab?

A: Yes, hospitals may have access to the Valencia lab. To get on the list to access the lab, please register on the Testing Taskforce (TTF) website. The registration process on the TTF website should be available in the next few days. It's being finalized now.

Q: The CDC just announced the change in quarantine time. CDC now recommends two additional options for how long quarantine should last. Based on local availability of viral testing, for people without symptoms quarantine can end on day 10 without testing; or on day 7 after receiving a negative test result. Is CDPH recommending following these changes?

A: CDPH is reviewing the updated recommendations in consideration of providing new guidelines. The CDC change of guidelines apply to community and healthcare settings. CDC's guidance doesn't specify if the new recommendations apply to healthcare personnel. It could be an option for healthcare personnel.

Q: If a patient is admitted and placed in yellow/observation area pending test result. Does this patient need to be moved to red zone area once positive COVID test is confirmed?

A: Yes, all confirmed positives should be in the Red Zone.

Q: When are the alternative sites opening? Hospitals are pushing SNFs in the geography of the Sleep Train Arena in Sacramento to take COVID-19 patients.

A: Sleep trains will be opening soon, but the date is not public yet. Plans are in place to reopen alternative care sites that have been in warm shutdown.

Q: Can the facility extend the use of gowns in resident on isolation for c-diff (in the green zone)?

A: Extended use should only be done in a cohort setting where residents have the same condition.

Q: We had a red zone for one COVID-19 positive resident. We had designated staff working on the red zone and followed all PPE and regulatory guidance. After a staff member's last day on the red zone, how many days should he/she wait before working with residents on the yellow or green zone?

A: There is no guidance on this. We cohort to avoid cross-contamination from one zone to another. The staff can work on a different zone on a different day but not on a given shift. The individual should wear clean clothes for the different zone.

Q: If a patient tests positive from the yellow zone and is then moved to the Red zone, is there testing guidance for other patients who were also in the yellow zone at the same time as the patient who tested positive.
A: Yes, they would be considered exposed as the most recent exposure to the newly positive individual. This would reset the clock on their last known exposure and continue to need to be tested on a minimum of weekly for response testing.

Q: Can dialysis residents be placed in the green zone with a roommate; or do they need to be placed in the yellow zone only?
A: Yes, they can be in the green zone with a roommate. Some facilities are cohorting the dialysis residents together since they continually leave the facility. There is no guidance that they have to be in the yellow zone. It's case-by-case. If they were exposed to a known outbreak, they should go to the yellow zone and tested.

Q: Can you please clarify staffing for the red and yellow zones in GACHs? Can the staff in the red zones also care for those in the yellow? If we cannot accomplish this due to call offs, etc., what is the suggestion for staff assignments?
A: The most important is to have dedicated staffing in the COVID units to prevent cross-contamination. Helps facilitate extended use of respirators and eye wear. It doesn't mean those staff can't work in another zone during another shift. There can be some flexibility. It does not have to be from shift to shift to shift. On a given shift, they should be dedicated to that unit, but on another shift they can work in another unit.

Q: What is your recommendation for newly admitted recovered patients when it comes to staff who should care for them? Is there a special type of precaution or are they considered green zone?
A: Newly recovered residents within 90 days of previous positive test can be admitted to the green zone. If after 90 days, they should be managed as a new admission with unknown status and should be admitted to the yellow zone.

Q: After the initial 21 days in the Red Zone without signs and symptoms, how long before we can move the patient from the red zone? Do they go to a yellow zone for monitoring or do the stay in red zone for the 90 days and rescreening?
A: Not sure why they would be in the red zone for 21 days. The duration in the red zone is for the duration of their isolation period. Stay in the red zone for 10 days from date of positive test/symptoms onset. There are rare instances in immunocompromised patients where they might need to stay for 20 days. Once they are clear, they can head into the green zone. Refer to your local health department as well as they might have different guidance.

Q: When the cleared positive staff work with positive patients, do they still need to wear full PPE (mask, eye protector and gown)?
A: Yes.

Q: If residents cannot be contained in their rooms who are COVID positive in an Alzheimer's unit. Is it okay for the staff to wear full PPE the whole time in the common areas?
A: We would try to avoid that. You'll already be wearing your N-95 and face shield in an extended use manner. Gowns and gloves should not be worn in common areas, halls, or nurses stations. Rather focus on properly donning and doffing when needed for interacting with the residents.

Q: We had an IP survey and they were concerned that a nurse had gel nail polish. She said that hand gel does not work on that surface. Thoughts?
A: Gel nail polish is not allowed because it has an affinity for bacteria. Please refer to CDC hand hygiene guidelines as nail polish and gels are not allowed.

Q: We are running low on PPE, N95s in particular. The shortage is bad enough to where all we have left are expired respirators. Vendors we have contacted (and documented requests with) will not allocate N95s to us. What can we do?
A: Each county has a Medical Health Operational Area Coordinator (MHOAC). Contact information for each MHOAC can be found on the California Emergency Medical Services Authority website at: https://emsa.ca.gov/medical-health-operational-area-coordinator/. What you are describing is an urgent issue, so please contact them immediately. If you have questions, contact Jason Belden at CAHF jbelden@cahf.org and he can help guide you with you how to get support.

Q: A surveyor just pointed out something important ... during rapid response testing, we only have to test staff and residents every 7 days per the QSO and AFL on testing. Once we are clear for two weeks, we go back to routine. Routine testing is based on positivity rate. Does this mean that we do not have to test staff twice a week if we are in rapid response mode and our county positivity rate is above 10%?
A: The response testing in the QSO and CDC guidance is recommended to be done every 3 to 7 days. Ideally we would do it every 3 days for facilities that have the capacity. 7 days is more of a minimum.
If you are a SNF in response testing, do you test all staff/residents once every 7 days for two weeks? Or do you follow the county positivity rate and test staff twice a week and residents once a week? We are getting different guidance in two counties.
A: Test the residents if you have the capability, twice a week as well including your staff.

Q: Hello, if we are testing HCP 2x a week, how frequent do we need to test residents in response to a positive case? Once a week or twice a week?
A: We'll discuss more to see if we need to make an edit on the AFL.

Q: If antigen testing is used for weekly staff testing, how does the every-three-days model work when staff shifts include a great variety of schedule variations? Would it be, for example, every 3rd shift, or perhaps the next shift that occurs after 3 days from the last test?
A: That is a reasonable strategy.

Q: Are GACH required to retest a known negative COVID patient prior to transferring to LTCFs?
A: One thing to ask is "How do we know the patient is COVID negative and not recently exposed?" That's part of the reason for testing and quarantine. If the individual had a negative test within 48 hours of discharge from hospital to SNF, then the test doesn't need to be repeated. Regardless of the test result, they still need to be in quarantine in the yellow zone under observation for 14 days because they could become positive.

Q: Do BinaxNow rapid test need to be reported as a POC test? Where do we report the POC test results?
A: Yes, they should be reported to CDPH through the CalREDIE module.
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/CalREDIE-Provider-Portal.aspx
Positive tests should be included among the aggregate reported results on the daily CDPH 123 survey.
https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/SNF-COVID-19-Daily-Reporting.aspx

Q: We require all vendors entering our facility to have a negative COVID test within a week of their visit. Can we accept point of care test results or does it have to be a PCR test result?
A: We haven't said one way or another. As long as antigen tests are being done regularly, then a negative test doesn't need to be confirmed through PCR.

Q: An employee and her husband tested positive over 90 days ago. Nine days ago, her husband tested positive again. Do we need to place our employee off work for another 10 days despite she tested negative on Monday 11/30?
A: Since it has been more than 90 days, then she would be considered newly exposed to her husband who is positive. Even if she tested negative, there should still be a quarantine period. Depending on their home

situation, if she is in the same household and they are in contact with one another, she would need to stay in isolation for 14 days from the date that the husband completes his isolation period. There is still a lot we don't know about reinfection beyond 90 days. It could be that people are persistently positive but are not shedding the virus, but we don't know for sure.

Q: A patient tested negative on Monday (PCR), went to Emergency on Tuesday (tested positive). Facility did a rapid test this morning tested negative. Resident was positive in July and subsequent negative test since October after the 90 days. So what results should I follow?
A: There are a number of considerations for evaluating concerns for false positives, which do occur but are not common. You should consider the time interval when the subsequent test was done. If more than 24-48 hours between test results, they are considered separate tests. When in doubt, isolate.

Q: Where can we get written guidelines as reference indicating how frequent residents' vital signs from the red zone should be monitored? Is it q4? Q8? Q shift? Please advise.
A: Guidance can be found on AFL 20-25.2 Preparing for COVID-19 in California SNFs https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-25.aspx. Documents with more information include:

- Preparing for COVID-19 in California Skilled Nursing Facilities (PDF) – guidance for SNFs on how to prevent, detect, and prepare for COVID-19
- Assessment of California Skilled Nursing Facilities to Receive Patients with Confirmed COVID-19 Infection (PDF) – guidance for SNFs planning to designate a specific wing/unit to care for residents with suspected or confirmed COVID-19
- Detection and Management of COVID-19 Cases in Skilled Nursing Facilities (PDF)
- Infection Control Guidance for Local Public Health Response to Congregate Living Facilities with Suspected or Confirmed COVID-19 Cases (PDF)*
- Detection and Management of COVID-19 Cases in Congregate Living Facilities (PDF)*

Q: What are the IP hour requirements and where can IP's get their training requirements?
A: Full-time IP is considered 40 hours. Two people can split it, but it needs to be demonstrated in the mitigation plan and detailed on how the two individuals are splitting the role specifically so there's no overlap. CDPH has a free course that will be online soon. There is also a CDC and APIC course.