



**California Department of Public Health  
Weekly Facility COVID-19 Update Call  
October 27, 2020  
8:00 am – 9:00 am**

**AT&T Meeting Recording: (866) 207-1041**

**Access Code: 9248463**

**Available after 10am 10/27/20**

- |   |                              |
|---|------------------------------|
| I. <b>Welcome / Introduction</b>            | <b>Heidi Steinecker</b>      |
| II. <b>Overview</b>                         | <b>Dr. Kathleen Jacobson</b> |
| None provided.                              |                              |
| III. <b>Laboratory Update</b>               | <b>Dr. Deb Wadford</b>       |
| None provided.                              |                              |
| IV. <b>Healthcare-Associated Infections</b> | <b>Dr. Erin Epton</b>        |

Last week CDPH released updated All Facilities Letters on visitation in SNF and acute care hospitals. AFL 20-22.5 updates CDPH's visitation guidance for SNF to align with CMS QSO-20-39-NH including:

- Required visitation; failure to facilitate visitation without adequate reason related to clinical necessity or resident safety may be subject to citation and enforcement actions.
- Updated previously issued indoor and outdoor visitation guidelines.
- Allowance for visitation for residents in the green zone in a facility with an ongoing COVID-19 outbreak that has not yet achieved two sequential negative rounds of response testing over 14 days.
- Exceptions to visitation restrictions, which include compassionate care visits.

**Indoor In-Room Visitation Requirement for Facilities Meeting Specific Criteria**

Facilities that meet the following conditions shall allow residents indoor facility visitation:

- The county is in Tier 2 (Red), 3 (Orange), or 4 (Yellow) under Blueprint for a Safer Economy.
- Case status in the facility: Absence of any new COVID-19 cases in the facility for 14 days, among either residents or staff.
  - Facilities that had a COVID-19 outbreak and have achieved two sequential negative rounds of response testing over 14 days among residents should allow indoor in-room

visitation, as long as the other conditions are met, while resuming regular screening testing of healthcare personnel (HCP) and targeted response testing of potentially exposed residents as described in AFL 20-53.3. Visits for residents who share a room should preferably be conducted in a separate indoor space or with the roommate not present in the room (if possible).

- For facilities located in counties with substantial or lower levels of community transmission ("red tier" or less restrictive tier as per CDPH's Blueprint for a Safer Economy website) with an ongoing COVID-19 outbreak may allow "green" zone residents indoor in-room visitation even if they have not yet achieved two sequential negative rounds of response testing over 14 days. This visitation is permitted for residents in "green" (unexposed or recovered) areas (wings or buildings) with staffing that do not overlap the "red" or "yellow" status areas.
- Adequate staffing: No staffing shortages
- Access to adequate testing: The facility has a testing plan in place in compliance with AFL 20-53.3 and Title 42 CFR 483.80(h).
- An approved COVID-19 Mitigation Plan: The facility must maintain regulatory compliance with CDPH guidance for safety.

### **Continuing Outdoor and Communal Space Visitation Requirements**

All facilities must continue to allow outdoor and communal space visitation options.

#### Outdoor Visitation

Outdoor visits pose a lower risk of transmission due to increased space and airflow; therefore, outdoor visitation is preferred and should be held whenever practicable. Facilities should allow scheduled visits on the facility premises where there is 6-feet or more physical distancing, and both residents and visitors wear facial coverings with staff monitoring infection control guidelines (e.g., drive-by visits, or visit through a person's window).

#### Visitation in Large Communal Indoor Spaces that Allow for Physical Distancing

If outdoor visitation is not possible (e.g., inclement weather, poor air quality, resident inability to be moved outside, etc.), facilities shall accommodate visitation in large communal indoor spaces such as a lobby, cafeteria, activity room, physical therapy rooms, etc. where six-foot distancing is possible. Facilities may need to rearrange these spaces or add barriers to separate the space to accommodate the need for visitation of multiple residents.

**Communal activities and dining** may occur while adhering to the core principles of COVID-19 infection prevention:

- Residents who are not on isolation precautions or quarantine may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Facilities should consider additional limitations based on status of COVID-19 infections in the facility. Facilities should consider defining groups of residents that consistently participate in communal dining together to minimize the number of people exposed if one or more of the residents is later identified as positive. Facial coverings should be worn when going to the dining area and whenever not eating or drinking.

- Group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation or quarantine) with social distancing among residents, appropriate hand hygiene, and use of a face covering.
- Encourage as many of these activities to occur outdoors when feasible, especially when eating or drinking and face coverings will not be worn.

During last week's update, I reviewed COVID-19 infection prevention core principles and best practices for visitation in SNF; please refer to the AFL or last week's transcript for the highlights.

AFL 20-38.5 updates CDPH's visitation guidance for hospitals, permitting facilities located in counties with medium or low COVID-19 positivity rates to allow one visitor per patient at a time. In addition, the AFL provides visitor guidelines for certain individuals, regardless of the COVID-19 county positivity rate:

- Pediatric patients
- Patients in labor and delivery
- Neonatal intensive care unit (NICU) patients
- Pediatric intensive care unit patients (PICU) patients
- Patients at end-of-life
- Patients with physical, intellectual, and/or developmental disabilities and patients with cognitive impairments
- Students obtaining clinical experience

All visitors and support persons must stay in the patient's room. Visitors and support persons should be screened by the facility upon entry for fever and COVID-19 symptoms, and be asymptomatic for COVID-19 and not be a suspected or recently confirmed case. Visitors and support persons must wear a face covering upon entry and at all times within the facility, and must comply with any health facility instructions on PPE while in the patient's room.

## V. **Remdesivir Update**

**Dr. Philip Peters**

Remdesivir received FDA approval on October 22nd for COVID-19 treatment.

Remdesivir is indicated for adults and pediatric patients (12 years of age and older and weighing at least 40 kg) for the treatment of COVID-19 requiring hospitalization. Remdesivir should only be administered in a hospital or in a healthcare setting capable of providing acute care comparable to inpatient hospital care.

[https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2020/214787Orig1s000lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/214787Orig1s000lbl.pdf)

Pediatric use for patients less than 12 years of age or weighing less than 40 kg is still covered via an updated emergency use authorization.

As stated previously, two companies, Regeneron and Eli Lilly, have submitted emergency use authorization (or EUA) requests to the FDA for their monoclonal antibody products. We don't have any updates at this time whether these EUAs will be approved or not.

We would like to alert you to several resources that can help you to prepare and respond to this unique upcoming influenza season. The links to these resources will be included in the minutes to this call.

CDC has released a comprehensive webpage entitled "[Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic](#)." This webpage includes detailed considerations for influenza immunization in various health care settings, including immunization when COVID-19 is suspected or confirmed. A couple of key points from this guidance:

- Visits to an outpatient healthcare setting for the purpose of receiving routine immunizations should be deferred for individuals who are on COVID-19 isolation or quarantine, due to infection control considerations.
- However, for individuals who are already present in healthcare settings and/or congregate settings such as skilled nursing facilities, providers may immunize individuals who are contacts to a COVID-19 case or who have asymptomatic or presymptomatic COVID-19. For individuals with symptomatic COVID-19 infection, there is latitude regarding whether to immunize, balancing considerations of severity of illness and potential missed opportunities for flu immunization.

A brief word about fever after influenza vaccination.

- While symptoms vary for adults after influenza vaccination, the incidence of fever is low. Adults who receive adjuvanted or high-dose products may be more likely to have fever or systemic symptoms following immunization than after standard dose IIV.
- In the "Interim Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic," CDC notes that influenza vaccine recipients who develop fever after vaccination should stay home until they have been fever-free for 24 hours. The guidance also notes that flu vaccine does not cause respiratory symptoms such as cough or shortness of breath, and that individuals who develop these symptoms after vaccination should contact their provider.
- In healthcare settings and high-risk congregate settings such as SNFs, it makes sense to approach fever, myalgia, malaise and other systemic symptoms after influenza vaccination more conservatively, and to follow your existing institutional guidance regarding the management and follow-up of symptoms that could be due to COVID-19. Dismissing symptoms that could be due to COVID-19 as due to having received influenza immunization may lead to the undetected spread of COVID-19. These considerations would apply to both healthcare workers and patients.

A few additional resources that may be of interest:

- Many of your facilities are conducting mass immunization activities for employees, patients, and/or members of the public. CDPH has created a listing of guidance documents from CDC and other sources regarding conducting mass immunization activities safely during the pandemic.
- CDC's COCA Calls have included several influenza update presentations for clinicians.
- CDC's Influenza Antiviral Medications Guidance has been updated for the pandemic, and includes considerations raised by various influenza and COVID-19 testing scenarios.

- The National Institutes of Health (NIH) have added influenza guidance to their COVID-19 Treatment Guidelines, addressing influenza vaccination, diagnosis, and antiviral treatment.
- On CDPH's influenza webpage, under Surveillance Reports, you can find weekly updates concerning California's influenza surveillance data.
- The #dontwaitvaccinate campaign contains flu season talking points, images, and social media messages that facilities and providers can use to promote flu vaccination for their staff and patients.

## VII. Questions and Answers

**Q:** Re-infection: Issues with patients returning to office after 90-days of positive. What resources do you recommend if reinfection issues come up or do you have any suggestions on how to re-validate re-infection.

**A:** Dr Epsom: From an infection control standpoint, it might not be clear whether there is a true re-infection. I would still recommend that you re-isolate these individuals as if they were re-infectious and HC would need to take precaution to prevent infection.

**A:** Dr. Hacker: It is a very challenging question to interpret and determine who is shedding viral material for a prolonged period or if they were re-infected. Guidance to be released soon on re-infection. If the person is symptomatic, we recommend that you treat the person as potentially infectious. If the person is asymptomatic, we would recommend another molecular test. Some assays are more sensitive than others and there are many assays out there. Unfortunately, currently we don't have a clearly defined answer for you.

**Q:** Mitigation Plan for SNF and requirement for full time Infection preventionist

**A:** It's not clear if we need to have a 40 hour a week full time infection preventionist. Smaller facilities, under 60 beds, and the requirement for full time IP

**A:** Heidi Steinecker: We do require a full-time infection preventionist. We do have some OAs that are splitting the duty of the IP working 20 hours.

**A:** Dr. Epsom: We are happy to point you to various training resources and are creating a two-day infection prevention modular class

**Q:** When we define 32 hours as full time are you going to require full time as 40 hours?

**A:** Heidi Steinecker: The AFL does not specify an hour requirement; however, I can tell you that we are thinking full time as 40 hours.

**Q:** When you say shared, if I have a 16 hour a week nurse on the floor, those 16 hours can't be shared towards the 40 hours can it?

**A:** Heidi Steinecker: No, we need the hours dedicated to that time only.

**Q:** San Diego county has issued Public Health order that prohibits the visitation in Skilled Nursing Facilities for non-essential person. I am asking if the public health order in San Diego County takes precedence over the state mandate.

**A:** Heidi Steinecker: Local public health orders do take precedence over state and federal laws.

**Q:** For hospitals that are in counties that are in the widespread category, I understand that for the special population we are to allow 1 visitor, but for the patients who are not in the category what should we adopt?

**A:** Heidi Steinecker: AFL does state if the facility is in widespread purple tier, that you should continue to allow the 1 visitation for special population (end-of-life, pediatric, etc) , but you need the spread rate in the county to be lower than the purple tier when you have one patient per person for the patients in then non-special population.

**Q:** Are patients in the ICU included in that?

**A:** Heidi Steinecker: There are ICU patients that we would consider part of the special population and you need to refer to the AFL to obtain the language.

**Q:** Since we do not have access to an on-site physician, can we submit a program flex application to enable standing orders in our setting and if so, is it possible to submit one application?

**A:** Heidi Steinecker: The Point of Care tests are federal resources that were given to the public. The restrictions are federally in place and program flexes are at the state level. You would need to refer to CMS.

**Q:** CMS responded that the standing order would be a title-22 requirement and they did confirm we would be required to submit a program flex to obtain those orders for each person. We would request program flex for the standing orders. What is your recommendation.

**A:** Heidi Steinecker and Dr. Jacobson: We can talk with lab field services and understand this from their end and get back to you.

**Q:** We have some healthcare workers that cannot wear masks and we have those workers wearing the WHO approved cloth mask.

**A:** Dr. Epton: Those are not considered appropriate or adequate PPE for the healthcare worker if dealing with someone with confirmed COVID. Perhaps what you considered as an alternative would be acceptable as source control, but not as PPE and this sounds like it would be a case by case circumstance.

**Q:** Can we get clarification on AFL 28-35 (updated visitation guidance) does this apply to ambulatory or clinic spaces? The outpatient spaces.

**A:** Heidi Steinecker: We are asking that it applies to non-long-term care settings so yes Ambulatory and clinic can use this as guidance.

**Q:** Can Dr. Epton comment on the CAL OSHA findings on Santa Clara Kaiser for not treating COVID as an airborne illness?

**A:** Heidi Steinecker: We can't answer any information on a specific facility.

**Q:** Can you provide any update on CAL OSHA having findings against any CA hospitals when the state itself do not acknowledge respiratory as the primary route of transmission?

**A:** Heidi Steinecker: Cal OSAH does have title 8 they must regulate and the ATP standard that they must regulate and it's very strict in the state of CA. CDPH is trying to work closely with CAL OSHA to find out what would align with public health, but there's not much more information available on that.

**Wednesday Webinar, 3–4 p.m., October 21, Attendee Information:**

Register at: <https://www.hsag.com/cdph-ip-webinars>

Call-In Number: 415.655.0003 Access Code: 133 788 3426