The California Department of State Hospitals

COVID-19 Transmission-Based Precautions and Testing

Effective April 3, 2023, and approved by the DSH Executive Team on March 29, 2023

DSH

Contents

Introduction....3
Definitions....4
Section I. Admission Testing to Admission Observation Unit (AOU)....7
Section II: Admission Testing to Home Unit....8
Section III: Testing Exposed Patients and Healthcare Personnel....10
Section IV: Isolation Unit Timeline and Discontinuation....13
Section V: Diagnostic COVID-19 Testing of Symptomatic Patients and HCP....15
Section VI. Patient Testing Refusal....20
Section VII: HCP Screening....21
Section VIII. Vaccinations....22
Section IX. Return to Work....24
Section X: Travel Guidance for HCP....27
Section XI: Visitation During Re-Opening....28
Section XII: Guidelines for Patient Activities During Re-Opening....30
Section XIII: Influenza During the Pandemic and the COVID-19 Rapid Antigen Test....31
Section XIV: COVID-19 Units/Process and Personal Protective Equipment (PPE)....34

Introduction

The guidelines and protocols included in this document were developed in partnership between DSH and the California Department of Public Health, Healthcare Associated Infections (HAI) Program to provide guidelines for COVID-19 transmission-based precautions and testing. These guidelines represent current best practices and may require regular updates. These are the minimum requirements. Each hospital develops local operating procedures to support these protocols based on their resources, staffing and physical plant layout.

These guidelines provide flexibility for the hospitals to put in place more conservative precautions when the community cases or hospital infections are high and relax precautions when low. Hospitals should discuss plans to increase or decrease precautions with their local health department for guidance.

Definitions

Admission Observation Unit (AOU): Houses patients arriving to the hospital for admission and in certain circumstances patients arriving from receiving outside care/services. Patients are isolated and tested for 10 days. CDC defines this prevention measure as Routine Intake Quarantine.

Close Contact: Determined through Proximity & Duration of exposure:

- Proximity- Someone who was < 6 feet away from an infection person (laboratory-confirmed or clinical diagnosis) AND;
- Duration- For a TOTAL of 15 minutes or more over a 24-hour period (Can be 3 separate 5-minute exposure for total of 15 mins)

COVID-19 Illness:

- Mild Illness – Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
- Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
- Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Exposure: Having come into contact with a cause of, or possessing a characteristic that is a determinant of, a particular health problem.

Facemask: OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as 'medical procedure masks." Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Fever: For this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0oF (37.8oC) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti- inflammatory drugs [NSAIDS]).

Fully Vaccinated: Individuals two weeks or more after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or two weeks or more after they have received a single-dose vaccine (Johnson and Johnson [J&J]/Janssen). For staff who did not receive vaccination via DSH, proof of vaccination must be provided before they are considered fully vaccinated.

Healthcare Personnel (HCP): All paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Not Fully Vaccinated: A person who has received at least one dose of COVID-19 vaccine but does not meet the definition of fully vaccinated.

Isolation Area: Separates patients who refuse testing from those that are under serial testing. Isolation areas may be in a home unit or any specified locations within each hospital.

Isolation Unit: Separates confirmed COVID-19 (+) patients from people who are not infected.

Persons Under Investigation (PUI) Unit/Rooms: Separates patients in individual rooms that who are potentially exposed and have symptoms consistent with COVID-19 disease who are not confirmed to be infected.

Personal Protective Equipment (PPE): Refers to protective clothing, helmets, gloves, face shields, goggles, surgical masks and/or respirators or other equipment designed to protect the wearer from injury or the spread of infection or illness, and chemical and biological hazards.

Quarantine Unit: Houses asymptomatic patients that have been exposed to a person(s) with a confirmed COVID-19 infection.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

Transmission-Based Precautions: The second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent

infection transmission. Contact Precautions: Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Examples include COVID-19, MRSA, VRE, diarrheal illnesses, open wounds and RSV.

Unvaccinated: A person who has not received any doses of COVID-19 vaccine or whose status is unknown.

Section I. Admission Testing to Admission Observation Unit (AOU)

Patients that arrive to the hospitals' AOU as a new admission or readmission (left >24 hours) undergo sequential COVID-19 testing and are housed when possible as a cohort in an Admission Observation Unit (AOU) where they are separated from the rest of the hospital.

Patients undergo 2 serial tests for SARS-CoV-2 immediately at day 1, and if negative, again at 3-5 days after admission.

- Baseline Admission, Day 1 (Antigen or PCR testing)
- 2nd In series, Day 3-5 (Antigen and PCR testing) Patient may transfer to assigned unit with negative Antigen test without waiting for PCR confirmation.
    - If both sequential tests are negative and the patient remains asymptomatic, the patient can then be moved and housed in a regular unit at Day 5.

Section II: Admission Testing to Home Unit

Patients who are directly admitted to their home unit as a new admission or readmission (left >24 hours) undergo sequential COVID-19 testing and may proceed to their designated home unit if they have negative infectious disease admission clearance form and negative PCR testing.

Patients undergo 3 serial tests for COVID-19 immediately at Day 1, Day 3, and Day 5.

- Baseline Admission, Day 1 (PCR testing)
- Serial test at Day 3 and Day 5 (Antigen Testing)

If the patient develops symptoms consistent with COVID-19 disease, they are immediately moved to a patient under investigation (PUI) room where the patient is isolated and undergoes testing.

- DSH Management of COVID-19 Patients and PUI contains detailed instructions on what actions to take if a patient is suspected or is confirmed to have COVID-19.

At any time, if any of the two tests returns positive, the patient is immediately moved to an isolation unit and the cohort testing schedule resets to Day 1.

- Isolation units house confirmed COVID-19 patients.

Figure 1. COVID-19 Admission to AOU

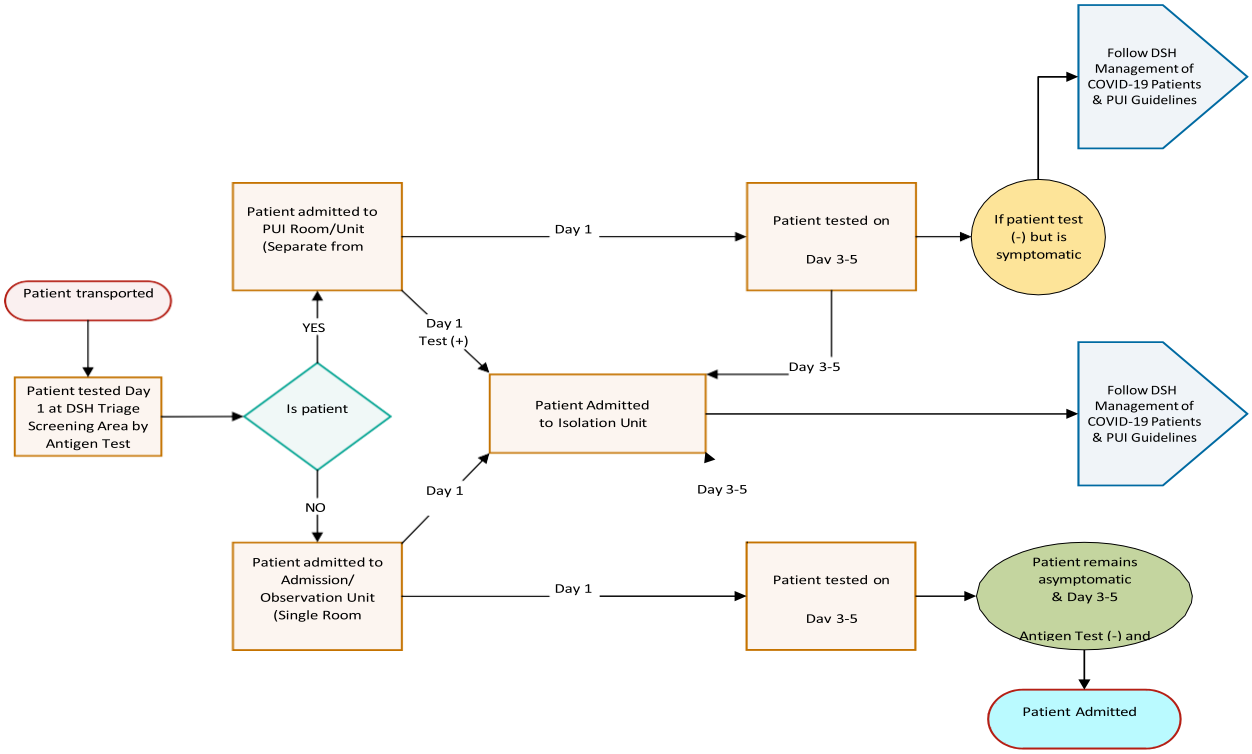
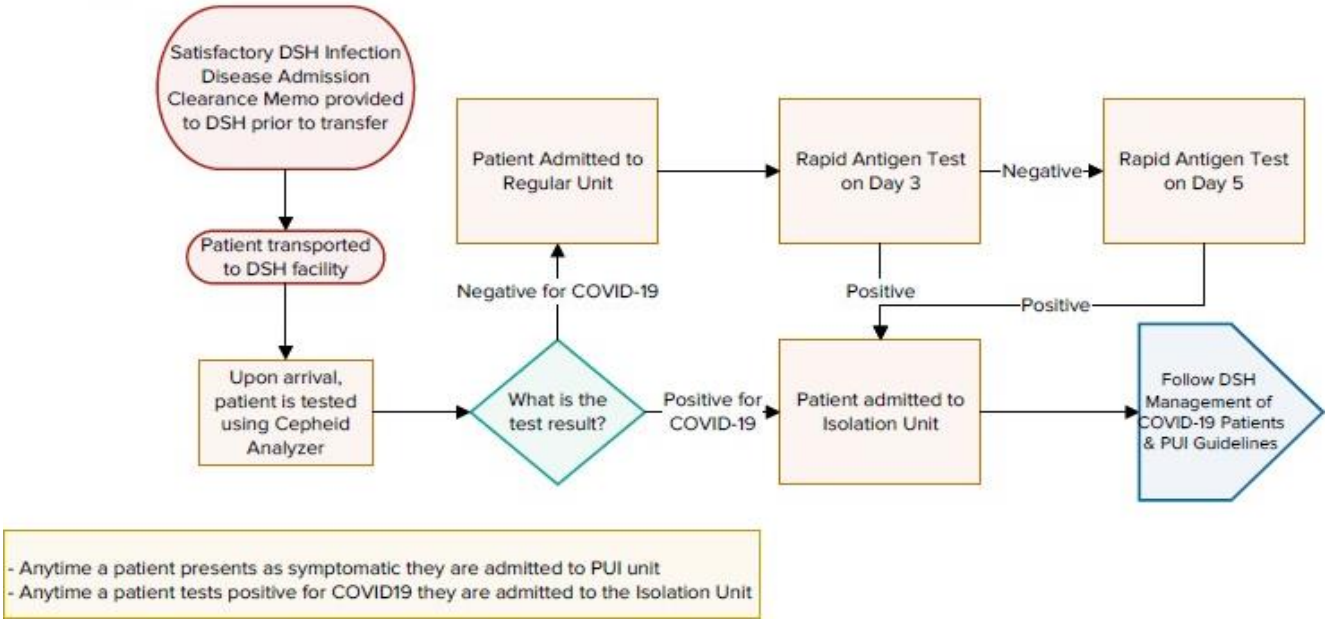


Figure 2. COVID-19 Admission to Home Unit



Section III: Testing Exposed Patients and Healthcare Personnel

Patient(s) with known exposure to a suspected or confirmed COVID-19 infection undergo serial testing and may be placed under quarantine. Whole units may be quarantined when indicated. HCP working in or around quarantined units may be required to test daily.

1. Close Contact (Exposure Duration):
    a. An exposure of 15 minutes or more is considered prolonged. (This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period.)
    b. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. (For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.)

2. Close Contact (Exposure Proximity):
    a. Being within 6 feet of a person with confirmed COVID-19 infection or
    b. Having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19 infection.
    c. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 infection could have been infectious:
    a. For Symptomatic individuals with confirmed COVID-19, consider the exposure window to be **2 days before symptom onset** through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.
    b. For Asymptomatic individuals with confirmed COVID-19 infection, if the date of exposure cannot be determined, consider using a starting point of **2 days prior to the positive test** through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.

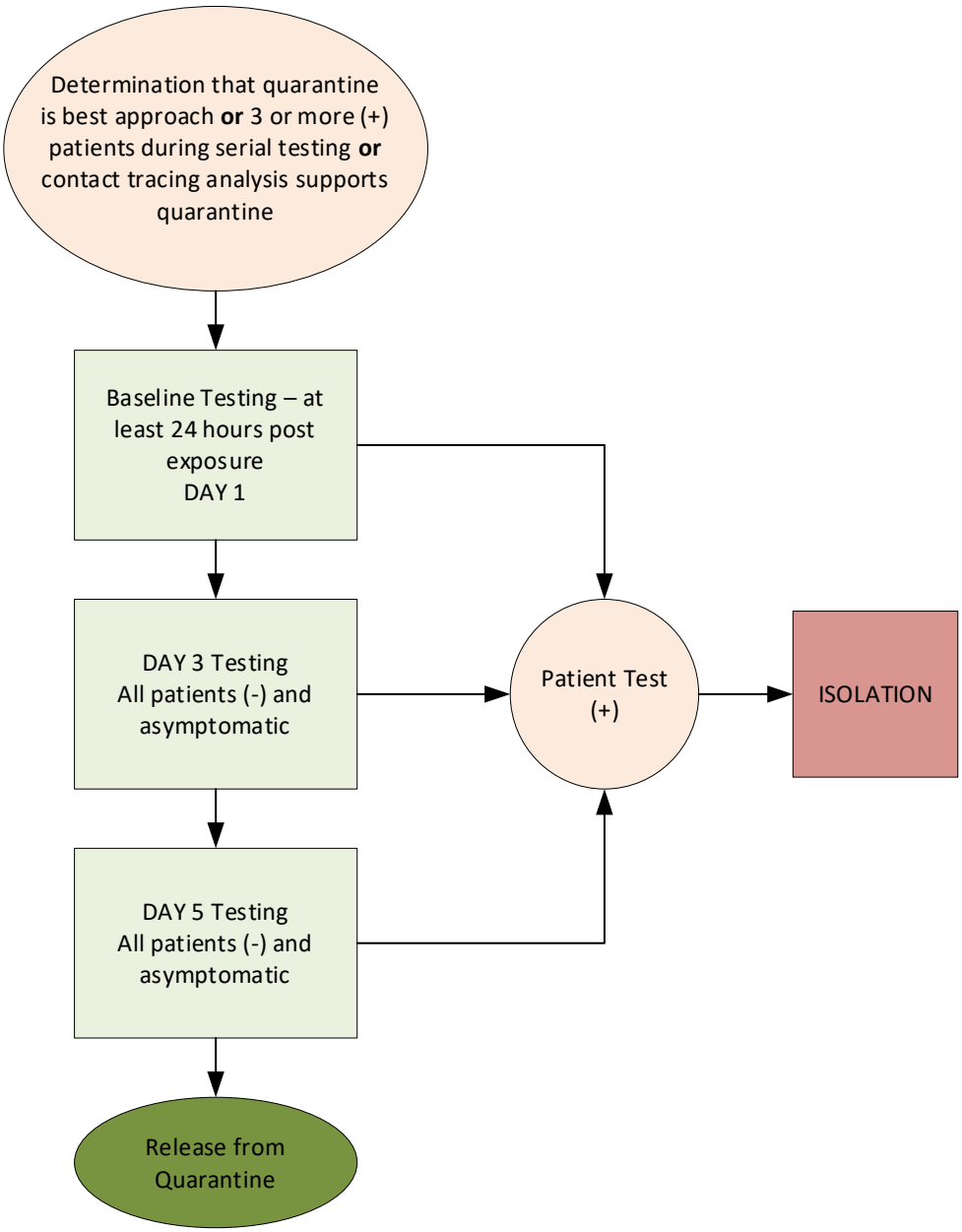
A. Patient Close Contact or Exposure:

1. All close contact or exposed patients undergo serial testing.
    a. Baseline – **DAY 1** (Antigen or PCR testing) **not earlier than 24 hours after exposure**
2. Test at **DAY 3** (Antigen or PCR testing) and **DAY 5** (PCR preferably). Consider unit quarantine if testing of patients reveals (+) case(s). Quarantine is required if 3 or more (+) cases are revealed from serial testing.
3. Consider quarantine based on contact tracing analysis.
4. If any patient chose not to test, consider quarantine and release after Day 10. Perform serial testing on patients who agree to test.
5. Any asymptomatic patient that is (+) by RAT or PCR is immediately placed in isolation. Positive RAT does not need confirmatory PCR testing.
6. Any patients that develop symptoms are placed in an area of no contact with other patients and tested by antigen or PCR. If antigen tested first and antigen is negative, then test using PCR. If PCR (-), the patient is allowed to reintegrate to the unit. If antigen or PCR (+), the patient is placed in isolation and the unit undergoes serial testing. Consider unit quarantine. Some facilities may choose to place the patient in isolation upon an antigen positive test result.
7. If influenza or another contagious disease is highly suspected after a negative COVID test, the patient should remain in area upon physician request with no contact with other patients until the diagnosis is established.
8. Testing is not recommended for asymptomatic patients who have recovered in the prior 30 days.
9. Testing for those recovered in prior 31-90 days should use the antigen test instead of the nucleic acid amplification test (NAAT)-PCR.

B. Unit Exposure from Positive (+) Staff

1. If an HCP tests positive, contact tracing is initiated and serial testing of patients should be considered.
2. If staff are identified through contact tracing as having higher risk exposures, serial testing should be considered for those staff.
3. Any HCP that tests positive on antigen or PCR follows return to work protocol.
4. Consider unit quarantine if testing of patients reveals (+) case(s) or if contact tracing analysis support immediate quarantine of the unit. Quarantine is required if more than 3 or more (+) cases are revealed from serial testing.

Figure 3. Unit Workflow for Quarantine



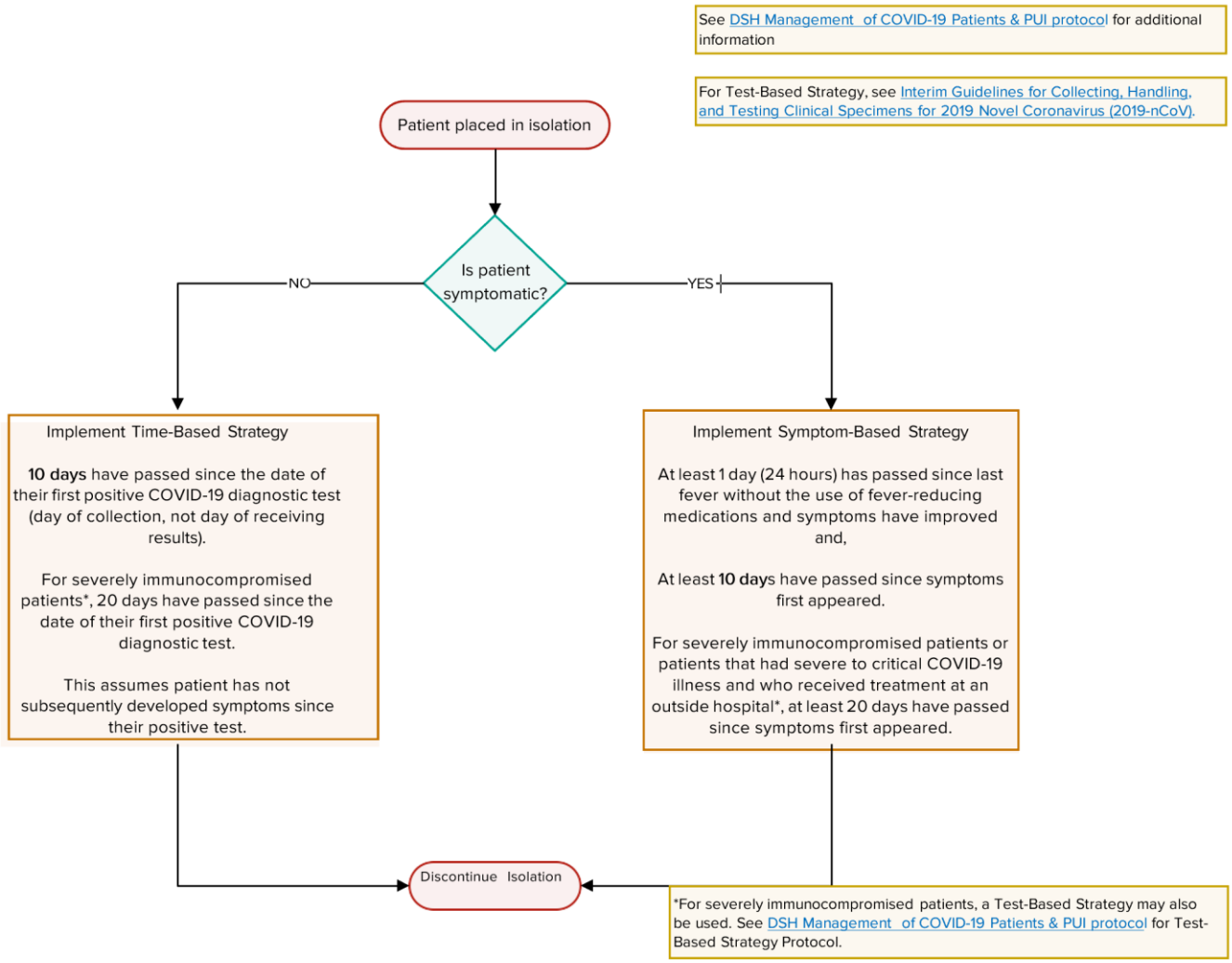
Section IV: Isolation Unit Timeline and Discontinuation

Isolation units house patients confirmed to have COVID-19 disease. All patients have had a positive test result. Patient's transmission-based precautions are discontinued using a symptom-based or time-base strategy.

1. Symptom-based strategy:
    - At least 1 day (24 hours) have passed **since last** fever without the use of fever-reducing medications and;
    - Symptoms consistent with COVID-19 disease (e.g. cough, shortness of breath, etc.) have improved, and;
    - At least 10 days have passed **since symptoms first appeared**.
        - For severely immunocompromised patients or severely symptomatic patients, a time frame of 20 days since symptoms first appeared is recommended after consultation with either the Chief of Primary Care, Chief Physician & Surgeon, Medical Director, or an ID specialist. In this situation a negative "Test-based Strategy" may also be used.

2. Time-based strategy:
    - 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test.
        - For severely immunocompromised patients, a time frame of 20 days since the date of their first positive test is recommended after consultation with either the Chief of Primary Care, Chief Physician & Surgeon, Medical Director, or an ID specialist. In this situation a negative "Test-based Strategy" may also be used.

Figure 4. Discontinuation of Isolation



Section V: Diagnostic COVID-19 Testing of Symptomatic Patients and HCP

Considerations for reactivating daily rapid-antigen testing:

COVID-19 Outbreak Definition for Non-Healthcare Settings:

For large settings (residential congregate facilities with >100 persons present in the setting), particularly during high levels of community transmission, local health departments may determine that a higher proportion (at least 5%) of cases within a 14–day period may be appropriate for defining an outbreak, even in the absence of identifiable epidemiological linkages.

Long-Term Care Facilities and Long-Term Acute Care Hospitals:

≥3 suspect, probable or confirmed COVID-19 cases in HCP with epi-linkage and no other more likely sources of exposure for at least 2 of the cases

Community case rate increase?

A. Symptomatic Patient:

- Patients with signs/symptoms consistent with COVID-19 should be tested immediately by RAT or Cepheid PCR, regardless of vaccination status.
- For Initial Rapid Antigen Testing:
    - If initial RAT is negative (-) but symptoms remain:
        - Place patient in area with no patient contact and perform confirmatory PCR (Cepheid).
        - May consider Multiplex Cepheid testing to r/o other pathogens causing symptoms (Influenza A, B, or RSV).
    - If initial RAT is positive (+):
        - No confirmatory COVID-19 test is needed.
        - Patient is transferred to an isolation unit.
        - The patient's unit will undergo serial testing and may be placed in quarantine.
    - If 2nd PCR result is negative (-):
        - Patient is integrated back to the unit and should follow all non-pharmaceutical interventions (NPI).
    - If 2nd PCR result is positive (+):

        - Patient is transferred to an isolation unit.
        - Patient's unit will undergo serial testing and may be placed on quarantine.
- For Initial PCR Testing (Cepheid):
    - If initial PCR is negative (-) for COVID-19 but symptoms remain:
        - If influenza or another contagious disease is highly suspected after a negative COVID test, the patient should remain in area upon physician request, with no contact with other patients until the diagnosis is established.
    - If initial PCR is positive (+):
        - Patient is transferred to an isolation unit.
        - Patient's unit will undergo serial testing and may be placed on quarantine.

Those with prior positive test who develop new symptoms should be tested if within 31-90 days from prior infection with RAT.

B. Symptomatic HCP:

1. HCP with signs/symptoms consistent with COVID-19 should be tested immediately by either a RAT or PCR, regardless of vaccination status.
2. For Initial Rapid Antigen Testing:
    - If initial RAT is negative (-) but symptoms remain:
        - HCP quarantines at home and needs to be retested by either RAT or PCR 48 hours after first negative test for total of at least 2 tests.
        - If after 24 hours, HCP has improved symptoms they may be retested by RAT and return to work if negative (-).
    - If 2nd RAT or PCR is negative (-), but symptoms remain:
        - HCP may return to work if screening shows no fever in the last 24 hours (<100 degrees without fever reducing medications) with improving symptoms.
        - Otherwise, the HCP may use available leave credits until symptoms improve per the guidance of their own primary care provider.
    - If 2nd RAT or PCR is positive (+):
        - HCP to follow their local return to work policy and table. HCP may use available leave credits or other

benefit options as available.

3. For Initial PCR Testing (Cepheid/Personal Provider)
    - If initial PCR is negative (-) but symptoms remain:
        - HCP may return to work if screening shows no fever in the last 24 hours (<100 degrees without fever reducing medications) with improving symptoms.
        - Otherwise, the HCP may take their own sick time until symptoms improve per the guidance of their own primary care provider.
    - If initial PCR is positive (+):
        - HCP to follow return to work policy and table.

Those with prior positive test who develop new symptoms should be tested if within 31-90 days from prior infection with RAT.

Figure 5. Diagnostic COVID-19 Testing of Symptomatic Patients

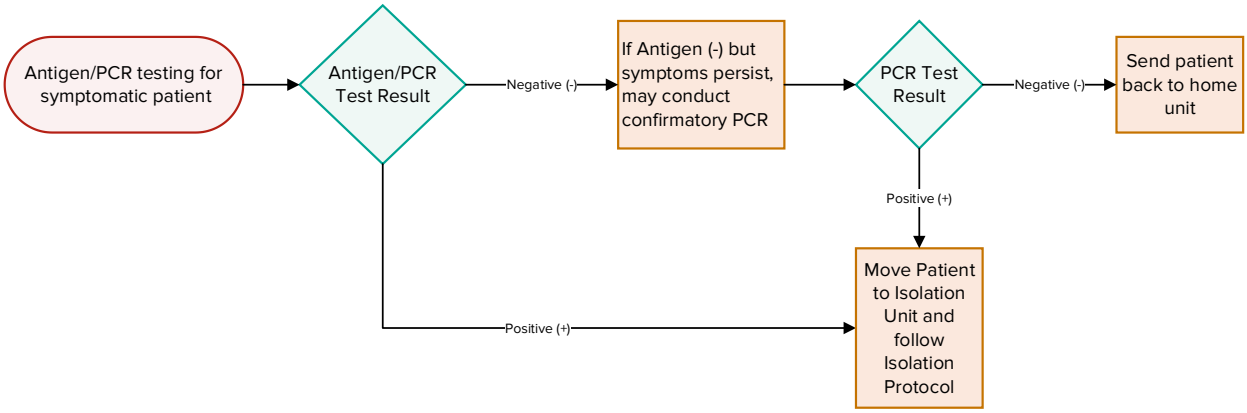
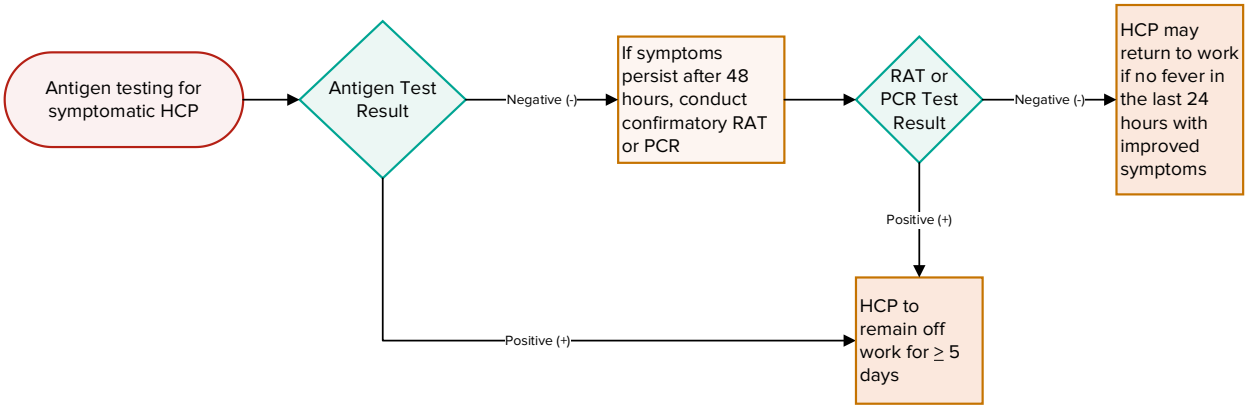


Figure 6. Diagnostic COVID-19 Testing of Symptomatic HCP



Note: Those with prior positive (+) test who develop new symptoms should be RAT tested if within 31 – 90 days from prior infection

Section VI. Diagnostic Screening Testing During a COVID-19 Outbreak

AFL 23-09 defines an outbreak at a Long-Term Care Facility and Long-Term Acute Care Hospitals as having either ≥1 facility-acquired COVID-19 case in a resident or ≥3 suspect, probable or confirmed COVID-19 cases in HCP with epi-linkage and no other more likely sources of exposure for at least 2 of the cases.

CDPH recommendations for masking are currently tied to the CDC's COVID-19 Community Levels based on hospitalization rates, hospital bed occupancy, and COVID-19 incidence to determine the impact of COVID-19 on communities and to take action.

Section VI. Patient Testing Refusal

A. Refusal of testing during admission:
    - Patient refusing to test when initially admitted to the hospital will be housed separated from other patients for a minimum of 7 days.
    - If patient agrees to test, follow serial testing protocol before releasing to regular unit.
    - HCP to provide patient education.
    - Treatment team members to develop an incentivization plan for patient participation.
    - Continue to offer testing at least daily and perform testing as soon as patient agrees.

B. Refusal of testing after close contact exposure:
    - Consider placing unit in quarantine if refusing patient(s) can't be house separately.
    - If able to house separately, release the refusing patient(s) after 10 days or earlier if they agree to test.
    - HCP to provide patient education
    - Treatment team members to develop an incentivization plan for patient participation
    - Continue to offer testing at least daily and perform testing as soon as patient agrees

Patients refusing to test poses a challenging situation for other patients and staff. Reasonings for refusal may be multifactorial and dependent on different situations. The hospital administration in consultation with clinical staff may address patient testing refusal on an individualized approach to maintain transmission-based precautions and safety.

Section VII: HCP Screening

All HCP undergoes daily COVID-19 screening. This process may include in-person screening, or the HCP may self-attest that they do not have reportable symptoms, elevated temperature, or recent exposure to an individual diagnosed with COVID-19 in the last 10 days. This self-attestation can be documented in-person at sign-in or electronically and is monitored daily by a hospital administrator or designee for any reportable symptoms or findings. Reportable symptoms or findings include:

- Fever or chills
- Cough, dry or productive
- Dyspnea or difficulty breathing
- Fatigue
- Myalgia/muscle aches or body aches
- Headaches
- New loss of taste or smell
- Sore throat
- Nasal congestion or runny nose
- Nausea, vomiting and diarrhea

HCP exhibiting a reportable symptom or exposure risk should immediately contact their supervisor for further instructions to follow Section V. Diagnostic COVID-19 Testing for Exposed and Symptomatic HCP. Any personnel with known symptoms, elevated temperature, or exposure risk should not come to work.

Section VIII. Vaccinations

Table 1. CDC Guidelines of SARS-CoV-2 Vaccination & Booster

	MODERNA (Spikevax)	PFIZER-BioNTech (Comirnaty)	J&J JANSSEN
VACCINATION:			
(*) Primary Series (**) Males (12-39 years old)	18 years & older 2 doses given 3 weeks (28 days) apart 2nd shot at 8 weeks interval	5+ years old 2 doses given 4 weeks (21 days) apart 2nd shot at 8 weeks interval	18 years & older 1 dose
BOOSTER:			
1st Booster Time from Primary Series	18 years & older 5 months after last dose in primary series	18 years & older Teens 12-17 years old 5 months after last dose in primary series	18 years & older Either Moderna or Pfizer 2 months after first dose of J&J
2nd Booster Time from 1st Booster/ 3rd Shot	50 years & older > 4 months after 1st booster	50 years & older > 4 months after 1st booster	18 years & older > 4 months after 1st booster (Either Moderna or Pfizer)
(***) History of COVID infection	5 months after last dose in primary series AND 90-days post clinical diagnosis or first (+) test	5 months after last dose in primary series AND 90-days post clinical diagnosis or first (+) test	2 months after first J&J dose in Primary series AND 90-days post clinical diagnosis or first (+) test (Either Moderna or Pfizer)
IMMUNOCOMPROMISED			
Time from primary series (3rd dose)	4 weeks after last dose in primary series	4 weeks after last dose in primary series	4 weeks after first dose of J&J (Either Moderna or Pfizer)
(#) (4th dose)	3 months after 3rd dose	3 months after 3rd dose	3 months after 3rd dose

(*) <u>Definition of "fully vaccinated"</u>: 2 weeks after their 2nd dose of Pfizer or Moderna OR single dose of J&J vaccine.

(**) <u>CDC/ CDPH Vaccine update (2/22/22)</u>: Recommends males (12-39 years old) to consider getting the 2nd vaccine shot at 8 weeks interval due to a potential increased risk for myocarditis.

(***) Refer to OP 8311 (AFLs: 21-27.3 General Acute Care Hospitals, 21-28.3 Skilled Nursing Facilities, 21-29.3 Health Care Facilities, 21-30.3 Intermediate Care Facilities, 21-34.3 Health Care Personnel": AFL revision notifies all facilities of the February 22, 2022 Public Health Order and requires HCP be up to date with vaccinations and receive boosters by March 1, 2022, unless exempt. The revision also allows HCP who have completed their primary vaccination series and provide proof of subsequent COVID-19 infection may defer booster administration for up to 90 days from the date of clinical diagnosis or first positive test, which in some situations, may extend the booster dose requirement beyond March 1st."

(#) Immunocompromised Individuals: Please consult with your primary care doctor on eligibility and appropriateness of vaccination & booster dosing timeline. Individuals 12 years and older who are moderately or severely immunocompromised may receive the 2nd Pfizer booster after > 4 months from their 1st booster.

Section IX. Return to Work

For HCP who were initially suspected of having COVID-19 but following evaluation another diagnosis is suspected or confirmed, return to work decisions should be based on their other suspected or confirmed diagnoses.

Hospitals always have the option to implement more protective procedures and follow prior guidance for a longer (10-day) isolation period for infected or a longer (10-day) quarantine for exposed HCP.

A. Exposure Risk Assessment for HCP

Hospitals use the CDC's updated risk assessment framework to determine exposure risk for HCP with potential exposure to patients, residents, visitors, and other HCP with confirmed COVID-19 in a health care setting.

Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing COVID-19, particularly if these HCP were present in the room for an aerosol-generating procedure.

Other exposures not classified as high-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth.

When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission.

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with COVID-19 infection was not wearing a cloth mask or facemask)
- HCP was not wearing eye protection if the person with COVID-19 infection was not wearing a cloth mask or facemask

- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, **any duration** should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.

CDC guidance for assessing travel and community-related exposures apply to HCP with potential exposures outside of work (e.g., household,) and among HCP exposed to each other while working in non-patient care areas (e.g., administrative offices).

For the purpose of contact tracing to identify exposed HCP, the exposure period for the source case begins from two days before the onset of symptoms or, if asymptomatic, two days before test specimen collection for the individual with confirmed COVID-19.

B. Isolation and Work Restriction for HCP

Hospitals use the table, below, to guide work restrictions for HCP with SARS-CoV-2 infection and for asymptomatic HCP with exposures based upon HCP vaccination status and facility staffing level.

Table 2. Work Restrictions for HCP with COVID-19 Infection (Isolation)

Clinical 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‡

Table 3. Management of Asymptomatic HCP with Higher Risk Exposures

Clinical 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

* Asymptomatic or mildly symptomatic with improving symptoms and meeting negative test criteria; facilities should refer to CDC guidance for HCP with severe to critical illness or moderately to severely immunocompromised.

t Either an antigen test or nucleic acid amplification test (NAAT) can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for discontinuation of isolation and return-to-work for SARS-CoV-2 infected HCP and for HCP who have recovered from SARS-CoV-2 infection in the prior 90 days; NAAT is also acceptable if done and negative within 48h of return.

+ If most recent test is positive, then HCP may provide direct care only for patients/residents with confirmed SARS CoV-2 infection, preferably in a cohort setting. This may not apply for staff types or in settings where practically infeasible (e.g., Emergency Departments where patient COVID status is unknown) or where doing so would disrupt safe nurse to patient ratios, and for staff who do not have direct patient/resident care roles.

§ In general, asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days do not require work restriction following a higher-risk exposure.

HCP whose most recent test is positive and are working before meeting routine return-to-work criteria must maintain separation from other HCP as much as possible (for example, use a separate breakroom and restroom) and wear a N95 respirator for source control at all times while in the facility. Similarly, exposed unvaccinated and vaccinated HCP who are booster-eligible but have not yet received their booster dose who are working during their quarantine period should also wear a N95 respirator for source control at all times while in the facility until they meet routine return-to-work criteria. In addition, healthcare facilities should make N95 respirators available to any HCP who wishes to wear one when not otherwise required for the care of patients or residents with suspected or confirmed COVID-19.

Section X: Travel Guidance for HCP

DSH follows CDC and CDPH guidelines for within the US/territories and international travel.

Stay informed of CDC Destination Travel Alerts that will warn you about high transmission rates in an area.

Wear a mask, regardless of vaccination status, on public transportation (including airports, planes, trains, buses, stations, etc.) into, within, or out of the U.S.

Section XI: Visitation During Re-Opening

In-person visitation may be modified or suspended based on the hospital's current COVID- 19 conditions or as recommended by CDC, CDPH and local Public Health Department guidance.

Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. Staff should provide monitoring for those who may have difficulty adhering to core principles, such as children.

Infection prevention measures are performed by hospital staff before and after each visit.

The patient and visitor(s) wear surgical masks during the entire visit. The facility will provide surgical masks for visitors.

Facilities may limit the number of visits per patient and limit the number of visitors in the facility at one time.

Video visitations will continue during reopening.

Risks associated with visitation shall be explained to patients and visitors.

We strongly encourage all visitors to be vaccinated, but we do not provide vaccine for visitors.

Vaccinated and unvaccinated patients with active COVID-19 disease or in quarantine are not permitted to have visitors until release criteria from isolation or quarantine are met.

Admission Observation Units are not permitted to have in-person visits.

Facilities should consider scheduling visits for a specified length of time to help ensure as many patients as possible are able to receive visitors. Visits should be scheduled for no less than 30 minutes. Longer visits should be supported.

Facilities shall have a plan to manage visitations and visitor flow with clear directions posted for all visitors.

Hand hygiene should be performed by both parties before and after the visit and source control (masks) be worn regardless of the COVID-19 vaccination status.

All visitors, regardless of their vaccination status, must wear a well-fitting face mask and perform hand hygiene upon entry and in all common areas in the facility.

Visitors and patients must wear masks for source control during visitation. The only exception is children under the age of 2. Surgical masks will be provided and required to be worn by visitors at the hospital.

Visitors and patients maintain 6-feet distance during the visit. Visitors shall maintain distance from other visitors, patients, and staff.

All other facility policies related to visiting regulations, attire, and allowable items remain in effect.

See Section XII. Guidelines for Patient Activities During Re-Opening for additional information.

Section XII: Guidelines for Patient Activities During Re-Opening

Guidelines are based on recommendations by the CDPH and public health departments where the hospital is located. When possible, all unit activities should be conducted with source control (cloth covering/masks) and maintaining safe distance.

Hospitals may be more restrictive based on their current COVID-19 conditions or as recommended by CDC, CDPH and local Health Departments guidance. Each Hospital's Executive Team should modify a plan to account for local conditions and transmission patterns or based on guidance by the local Health Department.

Section XIII: Influenza During the Pandemic and the COVID-19 Rapid Antigen Test

This guidance is developed based on CDC recommendations to address the combined risk faced by patients and staff during the upcoming flu season and ongoing COVID-19 pandemic. While more is learned daily, there is still a lot that is unknown about COVID-19 disease and the virus that causes it. CDC recommendations and this Guidance may change in the future as more information about COVID-19 becomes available.

Please refer to the DSH CLINICAL GUIDANCE INFLUENZA PREVENTION AND CONTROL DURING THE COVID-19 PANDEMIC for more detailed information.

The following recommendations are also applicable to other respiratory infections besides COVID-19 and Flu such as Respiratory Syncytial Virus (RSV), Strep Throat and others.

Influenza (Flu) and COVID-19 are contagious respiratory illnesses caused by different viruses. COVID-19 is caused by infection with a new coronavirus (SARS-CoV-2) and flu is caused by infection with influenza viruses.

It is possible to be infected with the flu, as well as other respiratory illnesses and COVID-19 at the same time. Health experts are studying how common this can be. Flu and COVID- 19 share many characteristics including similar symptoms; it may be hard to tell the difference between both infections based on symptoms alone, and TESTING MAY BE NEEDED TO HELP CONFIRM A DIAGNOSIS. Diagnostic testing can help Health Care Providers (HCP) to determine if a patient is sick with flu or similar respiratory infections, and/or COVID-19. More information about clinical similarities and the differences between Flu and COVID-19 are provided in the following Weblinks:

https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm#
https://www.cdc.gov/flu/symptoms/testing.htm

Utilize the laboratories available in your hospital to perform the necessary COVID-19, Influenza A/B and Respiratory Syncytial Virus (RSV) tests in compliance with CDC guidance.

Patients who present with symptoms consistent with COVID-19 disease and other respiratory infections require isolation until COVID-19 diagnostic testing is performed and COVID-19 is confirmed or ruled out. Patient can be infected with COVID-19 and other respiratory viruses such as Influenza and RSV at the same time.

California Department of Public Health (CDPH) recommends that congregate living setting develop plans to quickly diagnosis, isolate and treat Influenza considering the current SARs CoV2 Pandemic. In high risk setting as in the DSH-Hospitals, once influenz is circulating in the community, it will be important to rapidly test for both flu and SARS-CoV-2 whenever anyone presents with respiratory tract signs and probably G.I. tract symptoms/signs.

The symptoms of influenza and Covid-19 overlap. An individual infected with either Influenza viruses or SARS CoV2 virus can present with fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and/or fatigue. Viral assays are important to aid the diagnostic process because it is very difficult to determine the source of the infection by only clinical symptoms.

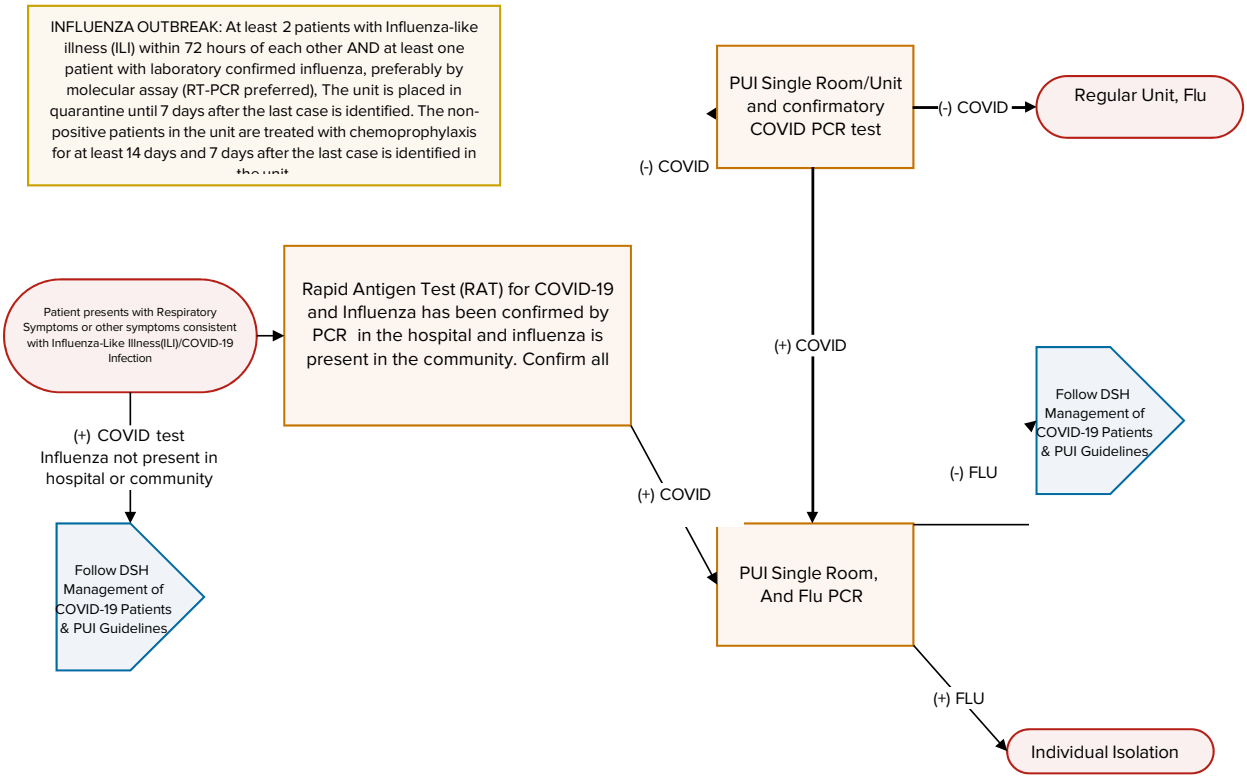
Infections with Influenza and SARS- CoV2 are important to diagnose quickly because:

1. Both infectious diseases can spread rapidly in congregate living settings,
2. The decision to isolate a patient with both Covid-19 and Influenza is very important and patients with one illness should not be isolated in the same location as patients with the other illness.
3. Patients co-infected with Influenza (A or B) virus AND SARSCoV2 should be isolated separate from patient infected with either SARS CoV2 virus OR Influenza virus to decrease risk of co infection to the whole population.
4. A co-infection with both Covid-19 and Influenza viruses leads to 5.92 times the mortality than in a patient without either viral infection.
5. Influenza A and B viral infections have several pharmacological treatment options, all of which work best if initiated within 48 hours of diagnosis.
6. While there is no definitive prophylaxis to prevent Covid-19 infection, the CDC recommends chemoprophylaxis for any patient who has contact with an individual known to have been infected with Influenza regardless of Influenza vaccination status.
7. While Influenza viral testing is not required to make a clinical diagnosis of Influenza in the setting of an Influenza outbreak, the distinction between Influenza and SARS- CoV2 in the time of a Corona virus pandemic is critical.
8. Multiple commercial molecular assays are available for the diagnosis of both Influenza and SARS-Cov2, and the faster a positive test can be returned, the faster the response to an outbreak in a high-risk clinical setting.
9. Rapid antigen tests can return results in a fast as 15 minutes and can be done at the point of care, while Rt-PCR assays require a CLIA approved laboratory and typically return in 24-48 hours (if available test reagents and lab support are available). A 24-48 hour TAT cannot be guaranteed

specially during time of increasing wide spread of C-19 or influenza and increasing the demands for testing and reporting of results.

10. The use of a rapid antigen testing for both Influenza and SARS CoV2 is not meant to replace the use of RT-PCR as gold standard diagnosis of SARs-CoV2 but can be additive in the clinical decision tree of diagnosis and treatment. When the rapid antigen testing is inconclusive, the multiplex PCR analyzer may be considered for confirmatory results.

Figure 7. Influenza Investigation and Prevention During the COVID-19 Pandemic



Section XIV: COVID-19 Units/Process and Personal Protective Equipment (PPE)

The PPE guidelines included for PPE usage in the table below can be modified to comply with local health departments. N-95 respirators are highly encouraged for all staff during a hospital surge in COVID-19 cases.

Masking is required in all patient care areas and where HCP may encounter patients within 6 feet indoors or outdoors. Staff who are not in patient care areas or are not providing care are encouraged to mask at their discretion.

Masking or a higher level of masking may be reinstituted at any time based on COVID-19 cases and outbreak status in any area of the hospital or the hospital as a whole.

Table 4. COVID-19 Units/Process and Personal Protective Equipment (PPE)

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Isolation Unit:	• N-95 Respirator • Face Shield (when providing direct patient care) • Gloves (when providing direct patient care)	• Gown
PUI Room(s)	• Surgical mask in all areas when not providing direct patient care • N-95 Respirator (when providing direct patient care) • Face Shield (when providing direct patient care) • Gloves (when providing direct patient care) N-95 Respirator strongly encouraged to be always worn by unvaccinated and not fully vaccinated staff.	• Gown

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Admissions Observation Unit	• Surgical mask in all areas when not providing direct patient care • N-95 Respirator (when providing direct patient care) • Gloves (when providing direct patient care) • N-95 Respirator strongly encouraged to be always worn by unvaccinated and not fully vaccinated staff.	• Gown Face Shield (encouraged and available upon request)
Quarantine Unit	• Surgical mask in all areas when not providing direct patient care • N-95 Respirator (when providing direct patient care) • Gloves (when providing direct patient care) N-95 Respirator strongly encouraged to be always worn by unvaccinated and not fully vaccinated staff.	• Gown • Face Shield
Regular Unit: • Unit that has not been placed on quarantine and does not have patients being treated, under investigation, or being observed for COVID-19.	• Surgical mask is required in all patient care areas and where HCP may encounter patients within 6 feet indoors or outdoors.	• N-95 Respirator • Face Shield • Gloves
HCP Screening Process	• Surgical Mask • Gloves	• N-95 Respirator • Gown • Face Shield

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
CPR/ACLS	• N-95 Respirator • Face Shield • Gloves • Gown	
High Risk & Aerosol Generating Procedures	• N-95 Respirator • Face Shield • Gloves • Gown	
Transportation Staff: • Any staff assigned to transport or escort a COVID+ patient or PUI in a vehicle (Example: To OMF appointments or on bus between compounds).	• N-95 Respirator • Face Shield • Gloves	
Administrative or Non-Treatment Areas With No Patient Contact	• Masking with a surgical mask or N-95 is strongly encouraged. • Masking may be required	• Surgical mask • N-95 Respirator

-END OF REPORT-