

The California Department of State Hospitals COVID-19 Transmission-Based Precautions and Testing August 2020

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Contents

I. Admission Testing	6
II. Quarantine Testing.....	8
III. Isolation Unit Testing	11
IV. Diagnostic Screening Testing.....	13
V. Fully Vaccinated Asymptomatic Patients and HCP COVID-19 Testing	18
VI. Patient Testing Refusal.....	20
VII. Healthcare Personnel (HCP) Screening.....	22
VIII. Vaccination	23
IX. Return to work.....	24
X. Travel Guidance for HCP	26
XI. Visitation During Re-Opening.....	26
XII. Guidelines for Patient Activities During Re-Opening	29
XIII. Influenza During the Pandemic and the COVID-19 Rapid Antigen Test.....	31
XIV. COVID-19 Units/Processes and Personal Protective Equipment (PPE) Summary	34

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. Local Public Health Department collaboration is highly encouraged to further support these State protocols.

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.

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.

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 100.0°F (37.8°C) 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 patient or an HCP (either assigned to the unit or visiting) that is suspected (PUI) or confirmed with COVID-19 infection. A Quarantine Unit is activated when patients are exposed to a confirmed or suspected COVID-19 patient or HCP.

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.

I. Admission Testing

Patients that arrive to a DSH hospital 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 5-7 days after admission.

- Baseline Admission, Day 1 (Antigen or PCR testing)
- 2nd in series, Day 5-7 (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.

While in the AOU, 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.

Patients who are up to date with vaccination and/or has fully recovered from SARS-CoV-2 infection in the prior 90-days **may** proceed to their assigned unit without an observation period.

- [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.

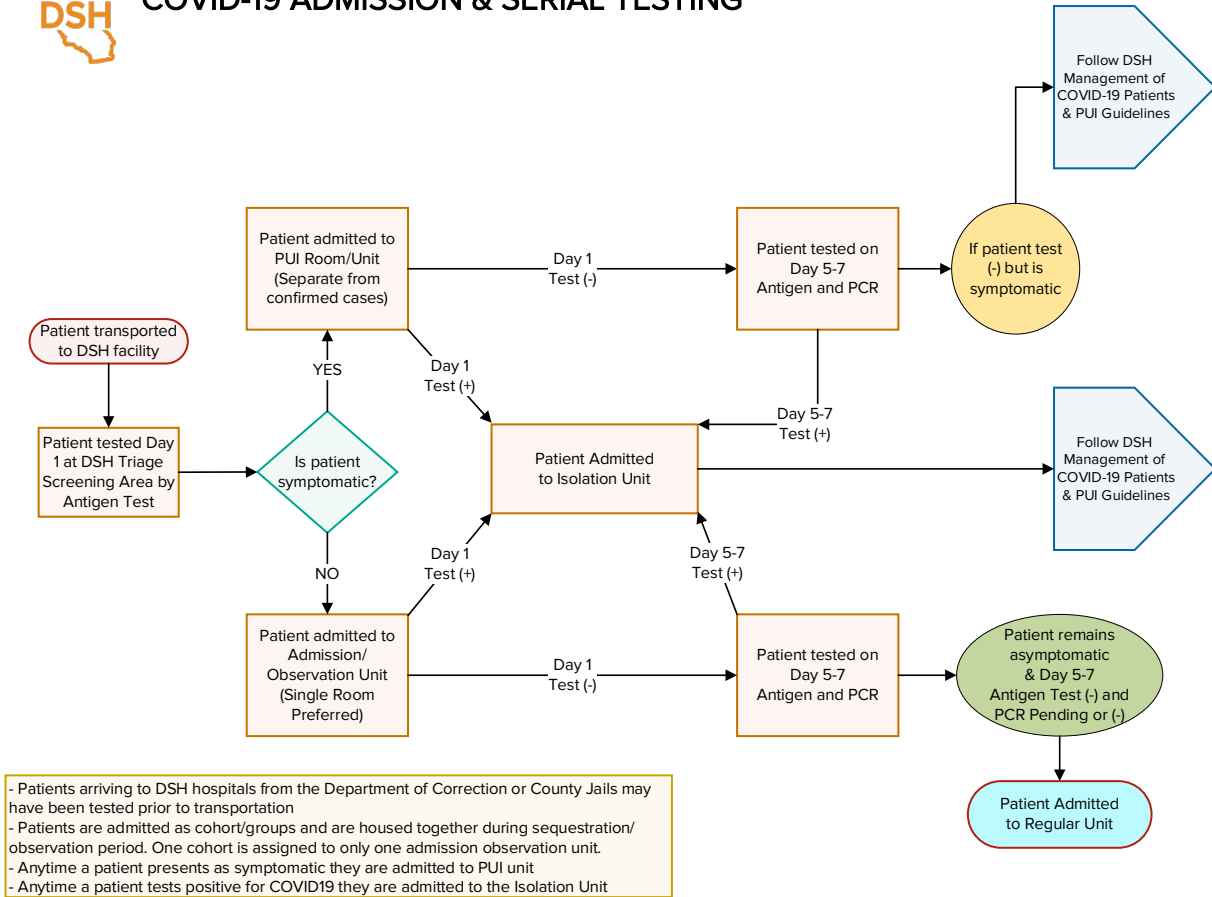
At any time, if any of the two tests returns positive, the patient is immediately moved to an isolation unit and the cohort testing schedule resets to day 1.

- Isolation units house confirmed COVID-19 patients.

Figure 1. COVID-19 Admission & Serial Testing



COVID-19 ADMISSION & SERIAL TESTING



II. Quarantine Testing

A quarantine unit is defined as a unit that houses COVID-19 exposed patients. Upon knowledge of a suspected or confirmed COVID-19 exposure, the hospital unit is immediately placed under quarantine.

For hospitals with SNF units, please refer to AFL 22-13 for more information on quarantine guidance.

The minimum quarantine period is 5 days with approval from the respective county public health departments of each hospital but may be extended to 10 days, as needed, during periods of increased COVID-19 infections conditions at the facility, or during periods of local community high-level alert risks or when recommended by local public health department. For hospitals who have not received approval from the respective county public health department to shorten the quarantine period, the minimum quarantine period is 10 days.

A. PATIENTS:

For hospitals with local public health department approval to shorten the quarantine period:

-All exposed patients are monitored, quarantined, and undergo testing at Day 5.

- Test at Day 5 (PCR)

-The unit may be released from quarantine after Day 5 if test results are negative.

-The unit continues to quarantine if any patients chose not to test and may be released after Day 10 if cohort remains asymptomatic.

For hospitals without local public health department approval to shorten quarantine period:

All patients in the quarantine unit undergo serial response testing.

- Baseline (Antigen or PCR testing) not earlier than 24 hours after exposure
- Round 1, Day 4-5 (Antigen or PCR testing)
- Round 2, Day 7 or 8 (PCR testing) performed within 48 hours prior to day 10

-Before the unit is released from quarantine after Day 10, besides the baseline test, all serial testing must be negative for two consecutive rounds

-Any patients that test (+) by antigen or PCR are immediately moved to an Isolation Unit.

- Quarantined cohort testing schedule resets to Day 1.

- Testing within 90-days post infection- use the antigen test instead of the nucleic acid amplification test (NAAT)-PCR.

-Any patients that develop symptoms regardless of testing (-) are moved to the PUI room.

- Follow PUI testing protocol

B. STAFF:

-All quarantined unit HCP undergo daily Antigen Testing.

- HCP to wear full PPE in quarantined units.
- Any HCP that tests positive on daily antigen testing isolates and follows return to work protocol.

-Hospital Police Officers (HPO) and Correctional Officers are tested when applicable.

Figure 2A. Unit Workflow for Shorten Quarantine with Local Public Health Department Approval

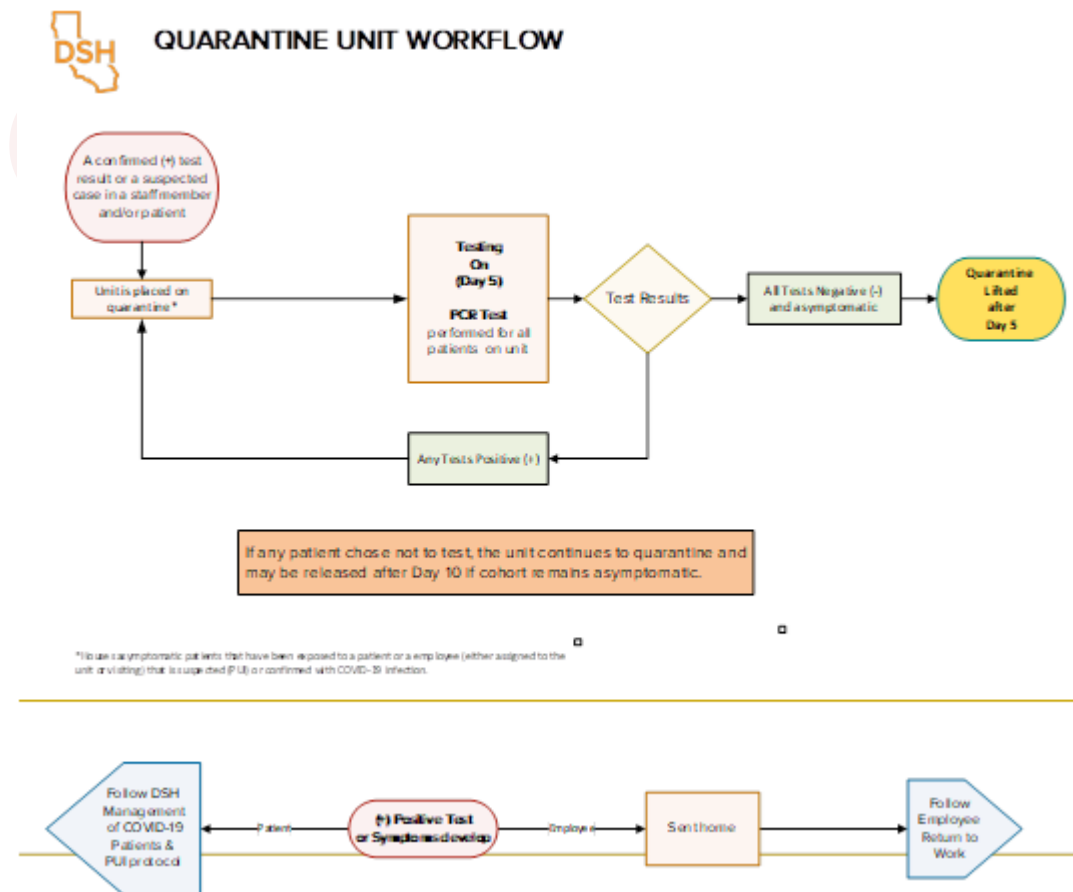
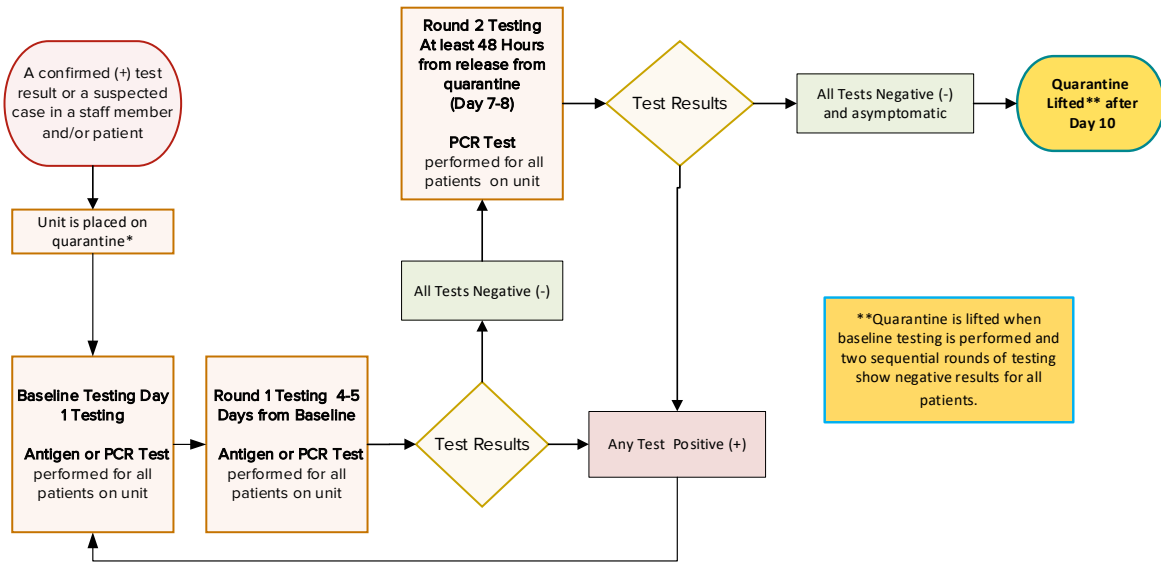


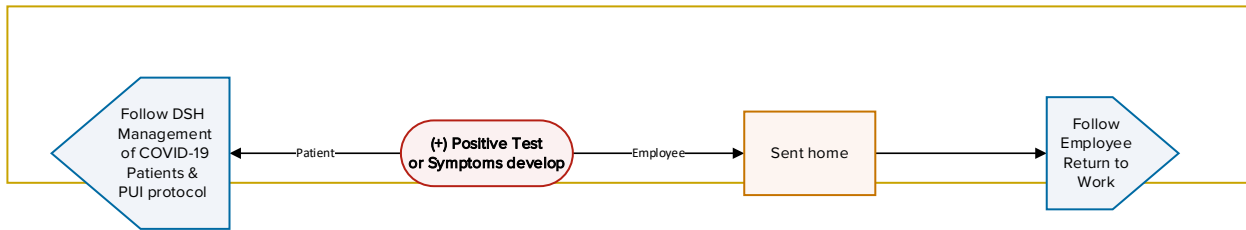
Figure 2B. Unit Workflow 10-Day Quarantine



QUARANTINE UNIT WORKFLOW



*Houses asymptomatic patients that have been exposed to a patient or a employee (either assigned to the unit or visiting) that is suspected (PUI) or confirmed with COVID-19 infection.



III. Isolation Unit Testing

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.

- *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 Physician& Surgeon, the Medical Director or an ID specialist. In this situation a negative “Test-based Strategy” may also be used.*

- *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 Physician& Surgeon, the Medical Director or an ID specialist. In this situation a negative “Test-based Strategy” may also be used.*

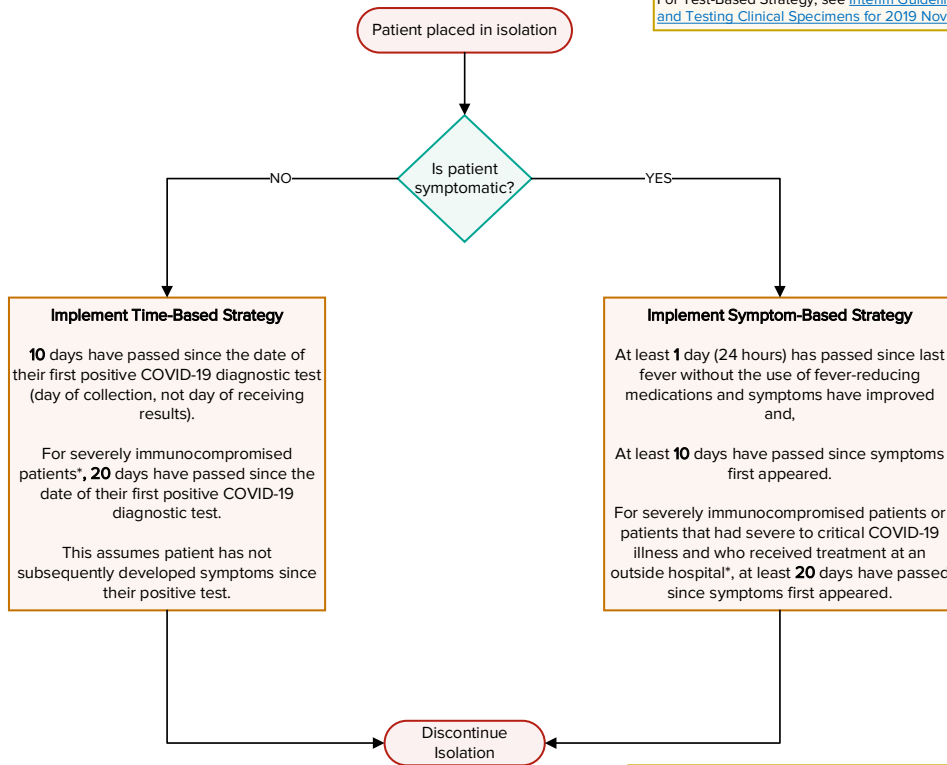
Figure 3. Discontinuation of Isolation



DISCONTINUATION OF ISOLATION

See [DSH Management of COVID-19 Patients & PUI protocol](#) for additional information

For Test-Based Strategy, see [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).



*For severely immunocompromised patients, a Test-Based Strategy may also be used. See [DSH Management of COVID-19 Patients & PUI protocol](#) for Test-Based Strategy Protocol.

IV. Diagnostic Screening Testing

The purpose of a diagnostic screening testing is to detect new cases, prevent exposure, and mitigate outbreaks. Congregate living has the potential for rapid and widespread transmission of COVID-19. A broader testing strategy is recommended to reduce the chance of a large outbreak when contact tracing is difficult to perform. This is especially relevant with COVID-19 since there is a high proportion of asymptomatic cases. DSH in consultation with the California COVID-19 Testing Task Force and the California Department of Public Health (CDPH), Healthcare Associated Infection Program, has adopted diagnostic screening testing. HCP testing is mandatory. If an HCP refuses to be tested, disciplinary action may be taken.

DSH performs diagnostic screening testing of HCP, regardless of vaccination status, who provide direct patient care or who work in patient care areas using the Abbott BinaxNOW Antigen Card. This also includes but is not limited to HCP providing transportation, environmental services, culinary/dietary services to the unit, Hospital Police Officers (HPO) and Correctional Officers (CO) that provide transportation and escort patients to outside community services. All DSH staff, regardless of vaccination status, working in non-patient care areas must be tested at least twice weekly with either PCR testing or antigen testing.

A. Diagnostic Screening Testing for Staff working Patient Care Areas:

- Effective 08/02/2021 DSH will return to daily antigen testing of staff who provide direct patient care or who work in patient care areas, regardless of their vaccination status.
 - If a staff's antigen test result is presumptive positive for COVID-19 infection, the supervisor arranges for the staff to immediately leave the patient care area and the staff is tested by PCR. Employees will receive ATO for their entire shift on the day they are sent home due to positive screening
 - If the results of the PCR test are positive, the supervisor instructs the staff to isolate in the community (fully vaccinated HCP with positive test results and Ct values of greater than 33 may be asked to retest, see Section V. Fully Vaccinated Asymptomatic Patients and HCP). Employees will receive ATO for their entire shift on the day they are sent home due to positive screening.
 - The staff follows the Return-To-Work protocol included in this document and returns to work using a time-based or symptom-based strategy as discussed in Section VIII.

B. Diagnostic Screening Testing for Staff working in Non-Patient Care Areas:

- Effective 08/02/2021 DSH staff working in non-patient care areas must be tested at least twice weekly with either PCR testing or antigen testing, regardless of their vaccination status.
 - If a staff's antigen test result is presumptive positive for COVID-19 infection, the supervisor arranges for the staff to be immediately tested by PCR. Employees will receive ATO for their entire shift on the day they are sent home due to positive screening.
 - If the results of a staff's PCR test are positive, the supervisor instructs the staff to isolate in the community (fully vaccinated HCP with positive test results and Ct values of greater than 33 may be asked to retest, see Section V. Fully Vaccinated Asymptomatic Patients and HCP). Employees will receive ATO for their entire shift on the day they are sent home due to positive screening
 - The staff follows the Return-To-Work protocol included in this document and returns to work using a time-based or symptom-base strategy as discussed in Section VIII.

C. Skilled Nursing Facilities Surveillance/Screening Staff testing

- DSH follows all CDPH AFLs for surveillance/screening testing in SNF units.
- SNF units follow DSH's Diagnostic Screening/Routine testing of staff as above.
- SNF units test, at a minimum, a random sample of 10% of all patients weekly, or as required by local public health department.

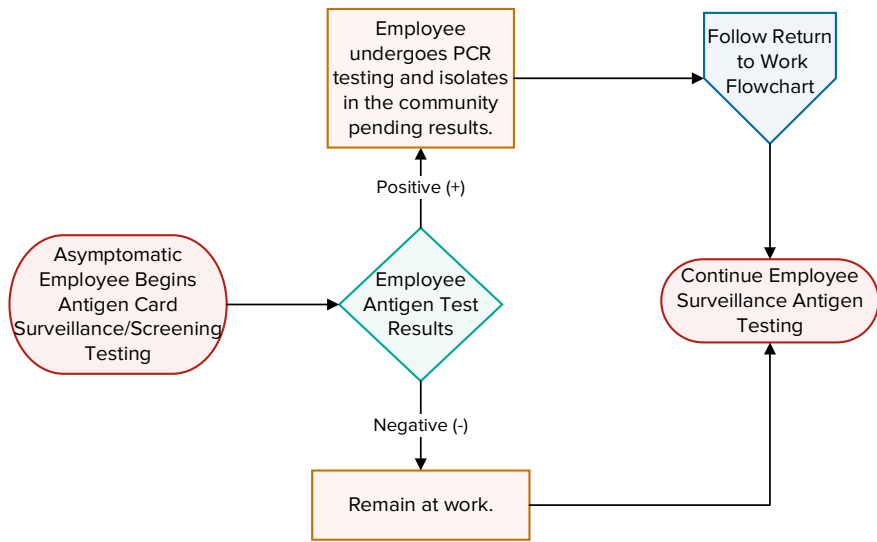
D. Testing for HCP recovered from COVID-19 Disease

- If the HCP has recovered from COVID-19 disease and remain asymptomatic throughout the 90 days from release of isolation, they do not participate in Diagnostic Screening or response testing during this period.
- If the HCP at any time have new onset of symptoms during the 90-day period, they follow isolation and testing in Section VII. Healthcare Personnel (HCP) Screening for positive symptoms.
- After the 90-day period, the HCP will resume current surveillance/ screening testing protocols.

Figure 4. COVID-19 Employee Daily Antigen Surveillance/Screening Testing



COVID-19 EMPLOYEE DAILY ANTIGEN SURVEILLANCE / SCREENING TESTING



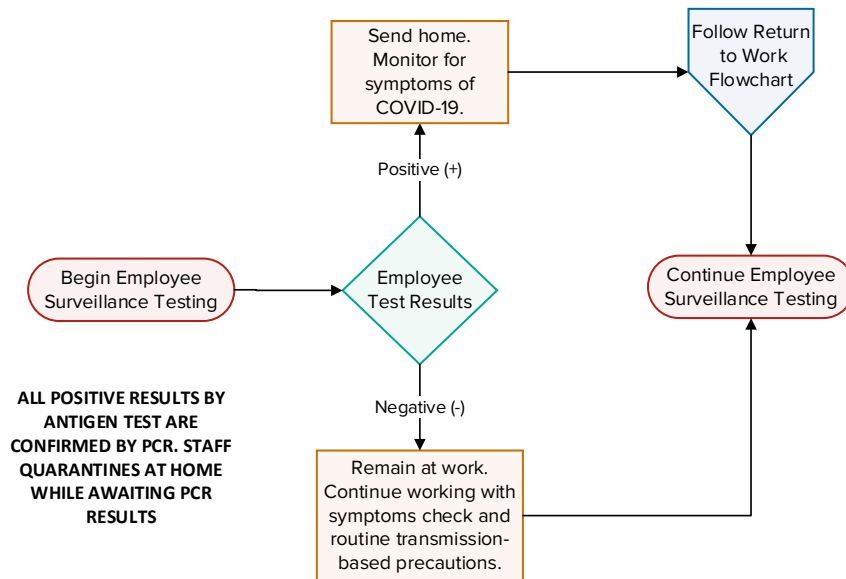
*For SNF units please see DSH SNF Testing and Surveillance

- References:
- AFL-20-53 Corona Virus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF)
 - California Department of Public Health (CDPH) Hospital Acquired Infections (HAI) Team consultation.

Figure 5. COVID-19 Twice Weekly Employee Surveillance/Screening Testing



COVID-19 TWICE WEEKLY EMPLOYEE SURVEILLANCE / SCREENING TESTING



*For SNF units please see DSH SNF Testing and Surveillance

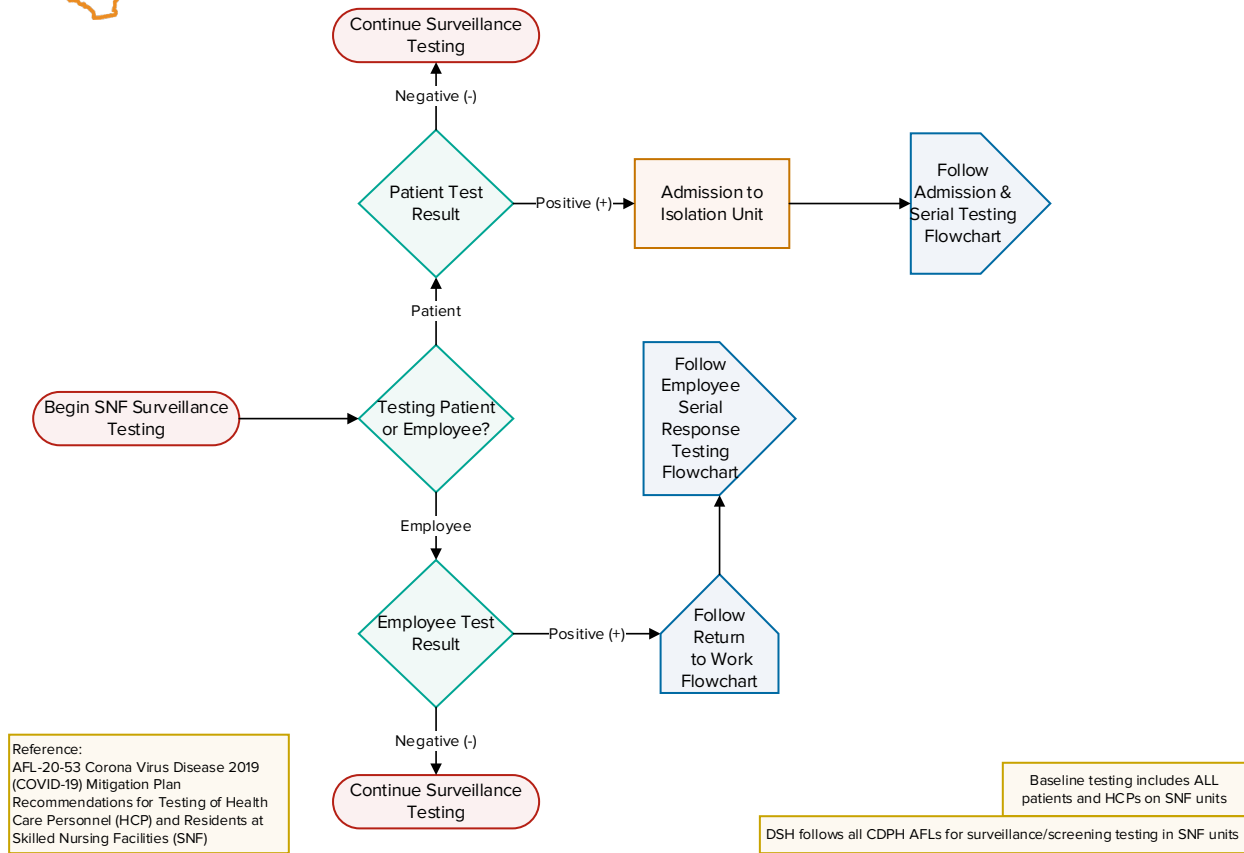
References:

- AFL-20-53 Corona Virus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF)
- California Department of Public Health (CDPH) Hospital Acquired Infections (HAI) Team consultation.

Figure 6. Skilled Nursing Facility COVID-19 Testing and Surveillance



SKILLED NURSING FACILITY COVID-19 TESTING AND SURVEILLANCE



V. COVID-19 Testing of Fully Vaccinated Patients and HCP

Fully vaccinated patients who are exposed or develop COVID-like symptoms are tested by PCR and placed in a PUI room until the results return and their home unit is quarantined. If the PCR result is negative, the patient is released from PUI and the home unit is released from quarantine. If the result is positive and the patient's PCR Ct value is less than or equal to 33, the patient is transferred to an isolation unit. The patient's home unit remains on quarantine and participates in serial testing. If the PCR Ct value is greater than 33, the PCR test is repeated within 48 hours. The patient remains in a PUI room awaiting the results of the second PCR and the home unit remains on quarantine. If the patient's second PCR result is negative, the patient is released from PUI and the home unit quarantine ends.

Fully vaccinated HCP who test positive during antigen screening testing or have COVID-like symptoms, are tested by PCR and quarantine at home while awaiting confirmatory

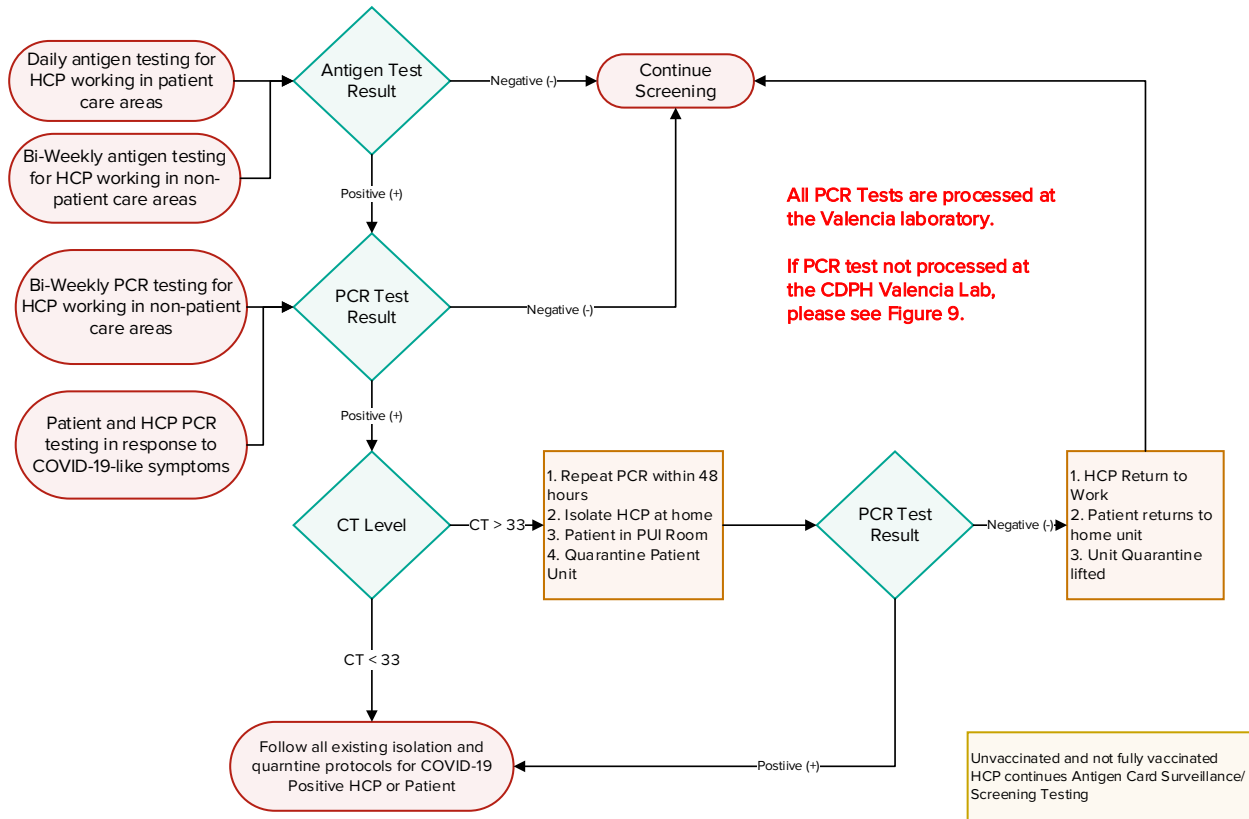
PCR results. If the PCR test is negative, but symptoms remain, HCP may return to work if screening shows no fever in the last 24 hours (<100 degrees without fever reducing medications) with improving symptoms. Otherwise, the HCP may take his/her own sick time until symptoms improve per the guidance of their own primary care provider. If the PCR is positive and the HCP's PCR Ct value is less than or equal to 33 the HCP will remain off work for 10 days either from the positive test date or date of the onset of symptoms. If the PCR Ct value is greater than 33, the PCR test is repeated within 48 hours. The HCP remains at home to quarantine until the results of the second PCR. If the HCP second PCR result is negative the staff may return to work. If the second PCR test is positive, the HCP isolates at home for 10 days.

DSH uses the State of California Department of Public Health - Valencia Branch Laboratory to process PCR samples. The assay in this lab is more sensitive than other PCR assays that are used in community-based laboratories, for this reason a Ct value of 33 is recommended by CDPH as the cut off for clinically relevant cases.

Figure 7. Fully Vaccinated Patients and HCP COVID-19 Testing



FULLY VACCINATED PATIENT AND HCP COVID-19 TESTING



VI. Patient Testing Refusal

A. Refusal of Surveillance Testing:

- Testing is voluntary for patients
- HCP to provide patient education
- Treatment team members to develop an incentivization plan for patient participation
- Continue to offer testing at regular testing cycle

B. Refusal of testing during Admission Observation:

- Patient refusing to test when initially admitted to the hospital will be placed in PUI room/unit for 10 days.
- Place patient in PUI room/unit for the remainder of the AOU observation period if patient refuses testing after the initial admission 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

C. Refusal of Response/Quarantine testing

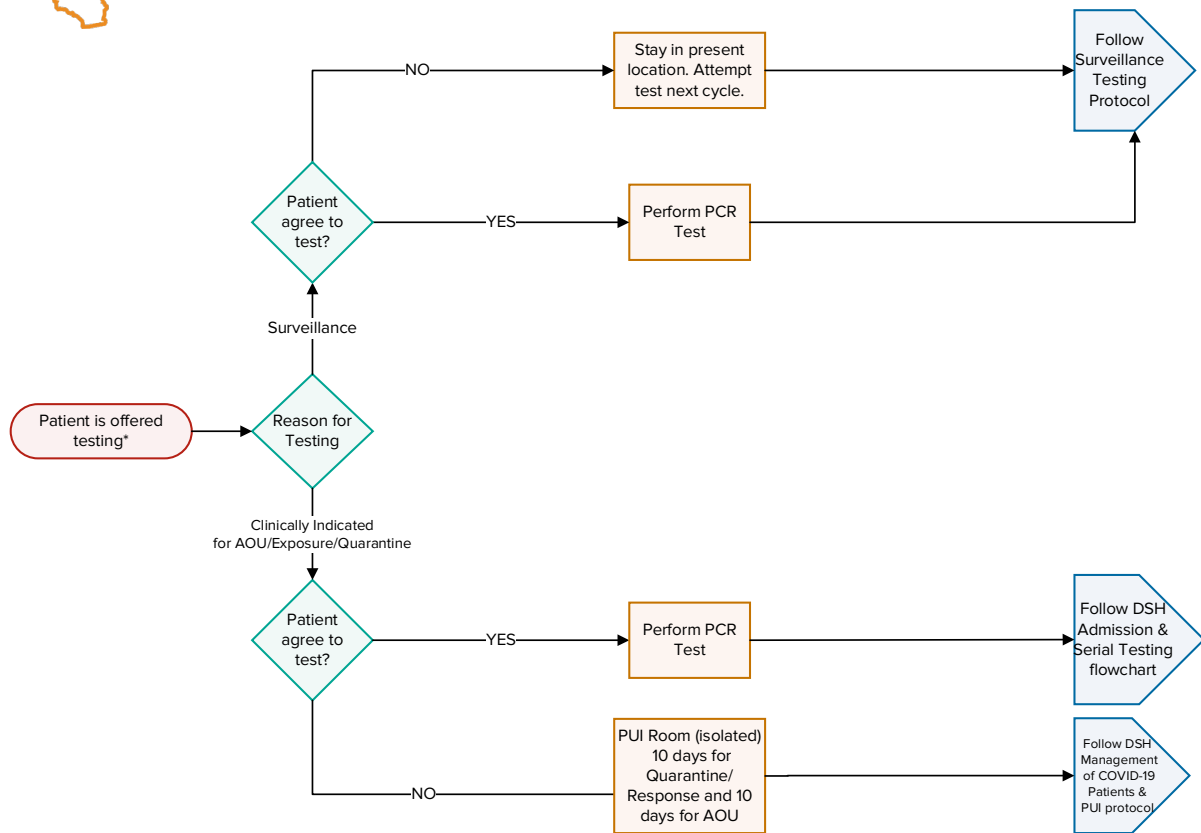
- Place patient in PUI room/unit for 10 days
- HCP to provide patient education
- Treatment team members to develop an incentivization plan for patient participation
- Continue to offer testing at least daily and perform testing as soon as patient agrees

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.

Figure 8. COVID-19 Patient Testing and Refusal



COVID-19 PATIENT TESTING AND REFUSAL



VII. Healthcare Personnel (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 14 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 positive findings. Reportable symptoms 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. Any personnel with known symptoms, elevated temperature, or exposure risk should not come to work.

VIII. VACCINATIONS

CDC GUIDELINES ON SARS-CoV-2 VACCINATION & BOOSTER

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

(*) **Definition of “fully vaccinated”:** 2 weeks after their 2nd dose of Pfizer or Moderna OR single dose of J&J vaccine.

(**) **CDC/ CDPH Vaccine update (2/22/22):** 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.

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.

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.

CDC's updated definition of higher-risk exposure includes use of a facemask by HCP (instead of a respirator) while caring for an infected patient who is not also wearing a facemask or cloth mask.

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.

Isolation, Quarantine 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.

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

Vaccination Status	Routine	Critical Staffing Shortage
Boosted, OR Vaccinated but not booster-eligible	5 days* with 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+
Vaccination Status	Routine	Critical Staffing Shortage
Unvaccinated, OR Those that are vaccinated and booster-eligible but have not yet received their booster dose	7 days* with 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 results to prioritize staff placement+

Work Restrictions for Asymptomatic HCP with Exposures (Quarantine)

Vaccination Status	Routine	Critical Staffing Shortage
Boosted, OR Vaccinated but not booster-eligible	No work restriction with negative diagnostic test upon identification and at 5-7 days	No work restriction with diagnostic test upon identification and at 5-7 days
Unvaccinated, OR Those that are vaccinated and booster-eligible but have not yet received their booster dose§	7 days with diagnostic test upon identification and negative diagnostic test within 48 hours prior to return	No work restriction with diagnostic test upon identification and at 5-7 days

* 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.

† 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.

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.

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.

Visitors are screened for COVID-19 signs and symptoms and close contact with individuals with COVID-19 in the prior 14 days. Visitors will have their temperature taken.

Visitors who are screened out will be asked to leave the hospital immediately and reschedule the in person visit or will be provided with an opportunity to schedule a video 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.

All visitors are required to provide proof of vaccination or a negative COVID-19 test (PCR or Antigen collected within 72 hours of the visit) at the time of the scheduled visitation to be allowed to participate in an in-person visit. Hospitals reserve the right to deny visitation based on infection prevention measures not included in these guidelines.

CDPH Guidance for Vaccine Records Guidelines & Standards states that only the following modes may be used as proof of vaccination:

1. COVID-19 Vaccination Record Card (issued by the Department of Health and Human Services Centers for Disease Control & Prevention or WHO Yellow Card) which includes name of person vaccinated, type of vaccine provided, and date last dose administered); OR
2. a photo of a Vaccination Record Card as a separate document; OR
3. a photo of the client's Vaccination Record Card stored on a phone or electronic device; OR
4. documentation of COVID-19 vaccination from a health care provider; OR
5. digital record that includes a QR code that when scanned by a SMART Health Card reader displays to the reader client name, date of birth, vaccine dates and vaccine type. The QR code must also confirm the vaccine record as an official record of the state of California, OR
6. documentation of vaccination from other contracted employers who follow these vaccination records guidelines and standards.

In the absence of knowledge to the contrary, a facility may accept the documentation presented as valid.

Antigen Testing of visitors age 4 or older will be offered at the time of the visit for in-person visitation if negative PCR, negative antigen test results or if proof of vaccination is not provided. Visitors without proof of vaccination or negative COVID-19 test will not be allowed to visit.

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.

No food or drink is allowed during visitation.

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-foot 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 XI. Guidelines for Patient Activities During Re-Opening for additional information.

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. All off-unit activities should be conducted with source control (cloth covering/masks) and maintaining 6-feet of distance at all tiers. **Hospitals may be more restrictive based on their current COVID-19 conditions or as recommended by CDC, CDPH and local Health Departments guidance.**

These guidelines for opening activities and services in DSH have been developed with the intent to provide the hospitals a thoughtful and safe road map to full operations. More rapid progression to Phase 3 is allowed if resources and safety permits. Each Hospital's Executive Team can modify this plan to account for local conditions and transmission patterns or based on guidance by the local Health Department.

Table 7. Guideline for Patient Activities During Re-Opening

PHASE 1	GOALS
Off Unit Courtyard Meals Groups Religious services Patient workers	Up to 45% of total hospital units
Barbershop/Beauty Salon	Individual at the site or on the unit
Patient Gym/Sports	Up to 50% capacity
Visitation	In-person visitation in the visitation area is available for fully, partially, or non-vaccinated patients. Testing for unvaccinated and partially vaccinated patients before and after the visit is recommended.
PHASE 2	GOALS
Off Unit Courtyard Meals Groups Religious services Patient workers	Up to 75% of total hospital units
Barbershop/Beauty Salon	Individual at the site or on the unit
Patient Gym/Sports	Up to 50%-75% capacity
Visitation	In-person visitation in the visitation area is available for fully, partially, or non-vaccinated patients. Testing for unvaccinated and partially vaccinated patients before and after the visit is recommended.
PHASE 3	GOAL
	Hospital at full operations

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 detail 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 influenza

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.

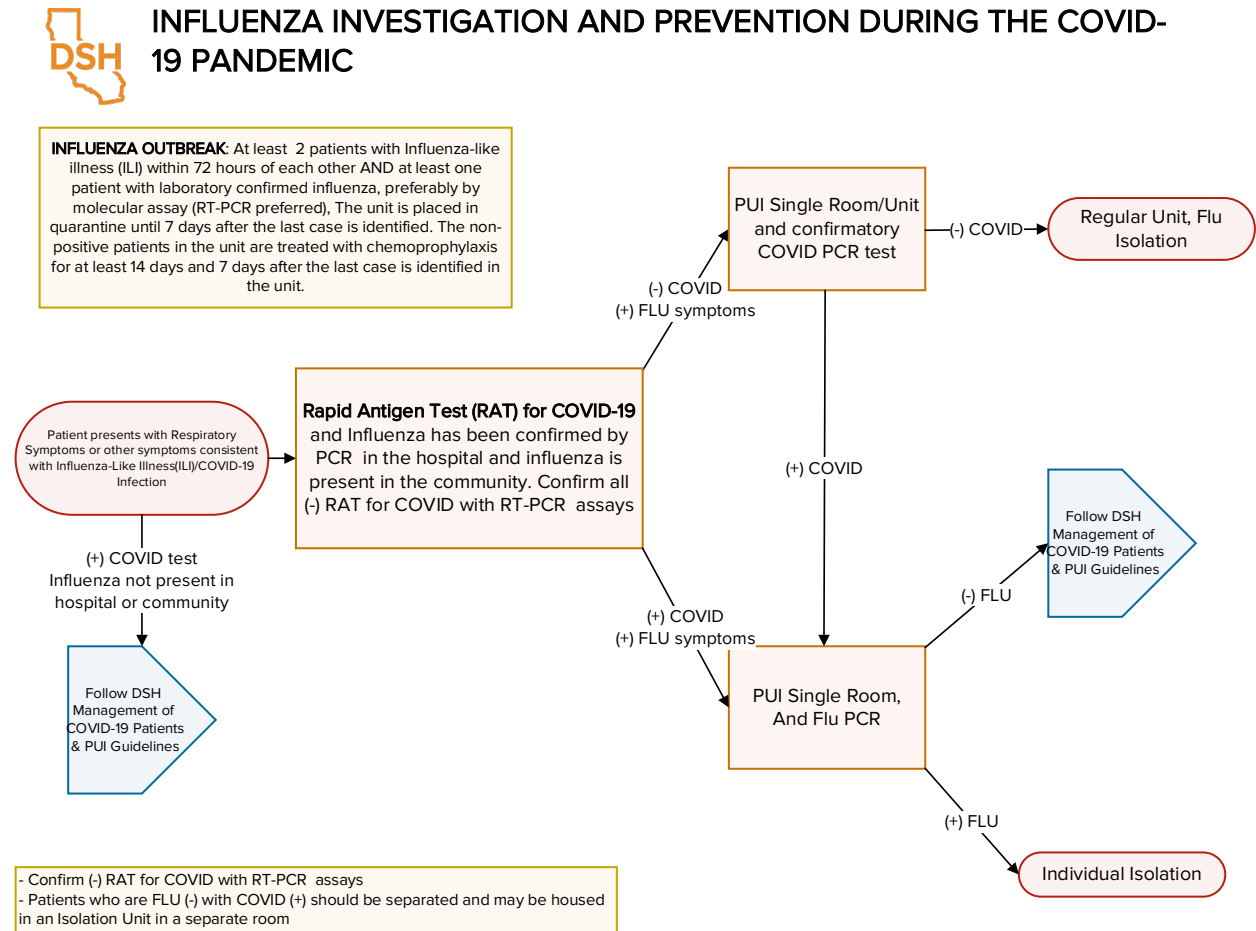
The symptoms of influenza and Covid-19 overlap. An individual infected with either Influenza viruses or SARS CoV2 virus can present with fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and/or fatigue. Viral assays are important to aid the diagnostic process because it is 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. All negative rapid antigen tests should be confirmed by RT-PCR test results.

Figure 11. Influenza Investigation and Prevention During the COVID-19 Pandemic



XIV. COVID-19 Units/Processes and Personal Protective Equipment (PPE) Summary

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.

Table 8. COVID-19 Units/Processes and Personal Protective Equipment (PPE) Summary

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Isolation Unit:	<ul style="list-style-type: none">• N-95 Respirator• Face Shield (when providing direct patient care)• Gloves (when providing direct patient care)	<ul style="list-style-type: none">• Gown

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
PUI Room(s)	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Gown

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Admissions Observation Unit	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Gown

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Quarantine Unit	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Gown
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.	<ul style="list-style-type: none"> • Surgical Mask • N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff 	<ul style="list-style-type: none"> • Face Shield • Gloves
HCP Screening Process	<ul style="list-style-type: none"> • Surgical Mask • N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff • Face Shield • Gloves 	<ul style="list-style-type: none"> • N-95 • Gown

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
CPR/ACLS	<ul style="list-style-type: none"> • N-95 Respirator • Face Shield • Gloves • Gown 	
High Risk Procedures: COVID testing, blood draw	<ul style="list-style-type: none"> • 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).	<ul style="list-style-type: none"> • N-95 Respirator • Face Shield • Gloves 	
Administrative or Non-Treatment Areas Located Outside the STA With No Patient Contact: Staff or visitors to offices and departments on grounds but outside secured treatment area.	<ul style="list-style-type: none"> • Surgical mask • N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff 	