



Fall 2023 Immunizations: RSV, Influenza and Building Vaccine Confidence

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Nava Yeganeh, MD MPH

Los Angeles County Department of Public Health

Vaccine Preventable Disease Control

Pingting Karen Nie, MD

Los Angeles County Department of Public Health

Acute Communicable Disease Control



Disclosures

There is no commercial support for today's webinar.

Neither the speakers nor planners for today's webinar have disclosed any financial interests related to the content of the meeting.

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Preventing Respiratory Viruses this Winter

Nava Yeganeh, MD MPH

Vaccine Preventable Disease Control





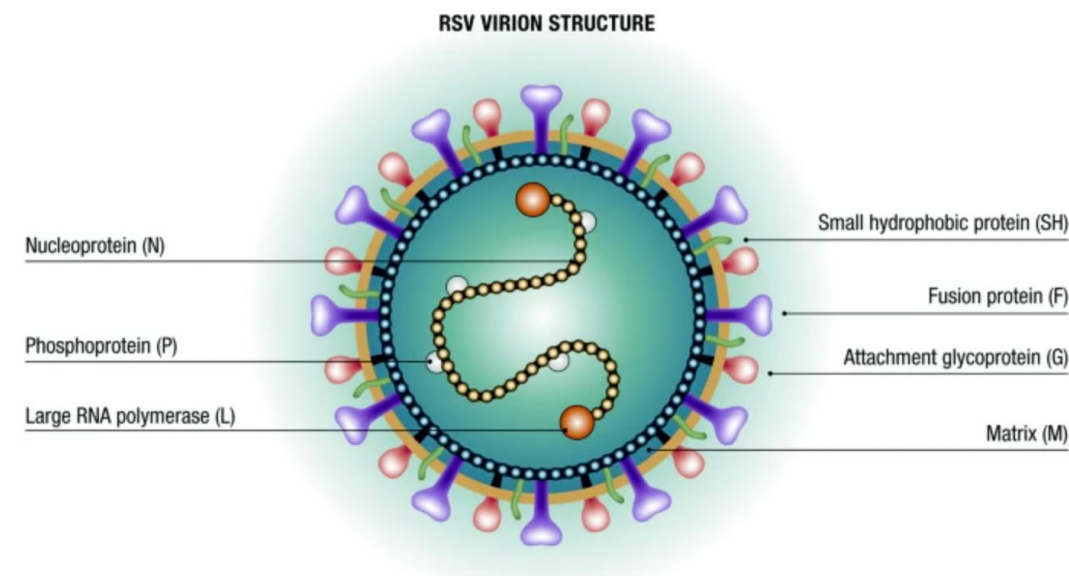
RSV



Respiratory Syncytial Virus (RSV)

- Discovered in 1956
- Member of the pneumovirus genus of the family *Paramyxoviridae*
 - Negative-sense RNA virus
- Two antigenic subgroups (RSV A and B)
 - Subgroups can co-circulate
- RNA codes 11 proteins
 - Nonstructural proteins (NS1, NS2, M2-2)
- 8 Structural Proteins
 - F (fusion) glycoprotein
 - G (attachment) glycoprotein
 - Both crucial for infectivity
 - F is the main neutralizing antigen, highly conserved and essential for virus viability

Fig. 2



Clinical Disease: RSV in children

- Most (68%) infants are infected in the first year of life and nearly all (97%) by age 2 years
- Leading cause of viral lower respiratory tract infection (LRTI) in infants and toddlers
 - Bronchiolitis
 - Pneumonia
- RSV in infancy has been strongly associated with increased wheezing and asthma
 - 1,900 children followed 5 years of life, 54% infected with RSV during infancy
 - 18% developed asthma by the age of 5
 - 21% of those infected by RSV vs 16 % of those who hadn't had RSV.

Hall, C et al. NEJM. 2009.

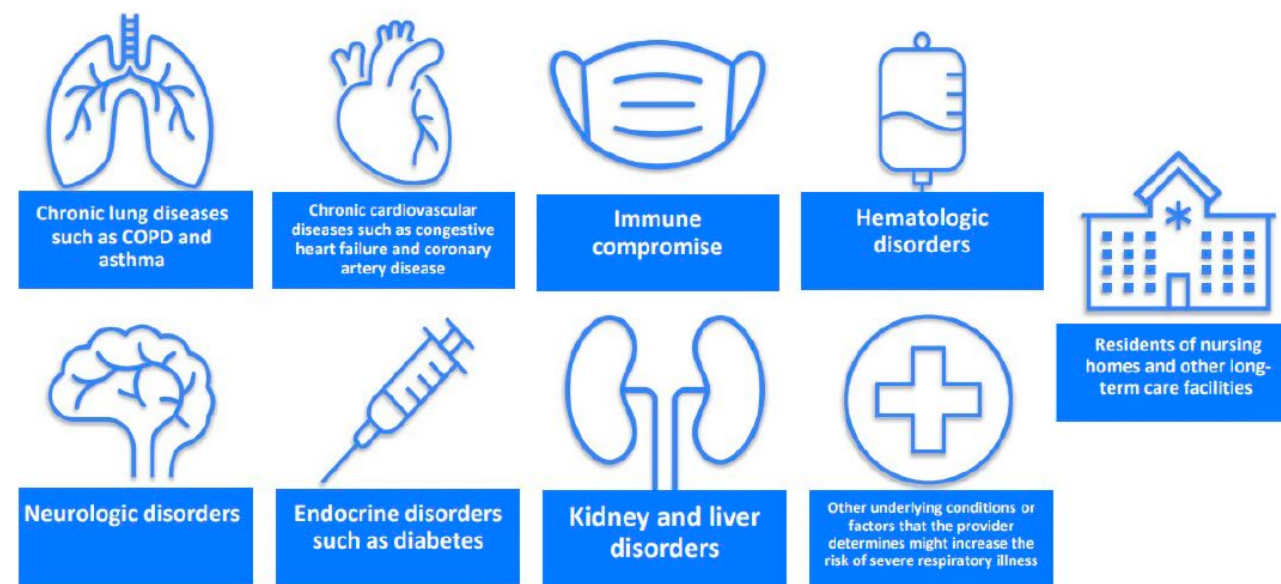
Mejias, A et al. Pediatric Allergy and Immunology. 2019

Rosas-Salazaar, C et al. Lancet. 2023

Clinical Disease : RSV disease in adults

- RSV is responsible for 5%–10% of LRTI, with hospitalization rates of 255 per 100 000
- 60,000–160,000 hospitalizations among adults aged ≥ 65 years each year
- 6,000–10,000 deaths each in year in United States, especially in those with chronic medical conditions

Adults who may be at higher risk of RSV disease include persons with:



<https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2023-06-21-23/07-RSV-Adults-Britton-508.pdf>

Seasonality

- RSV circulation varies by climate
- Tropical climates: RSV circulates year round
 - Infants born in tropical climates are exposed shortly after birth
- Temperate climates: RSV circulates yearly in seasons
 - Typically starts in mid-September to mid-November and ends in mid-April to mid May
 - Infants born in temperate climates are usually exposed to RSV by approximately 7 months of life
 - COVID-19 pandemic disrupted RSV seasonality during 2020–2022

Gaps in data: RSV is not a reportable disease

- Under Title 17, Influenza and SARS-CoV-2 NAAT positive and negative results are reportable to public health.
- Not previously required:
 - RSV positive results
 - RSV hospitalizations
- However, starting this year
 - Voluntary reporting of RSV NAAT and non NAAT diagnostic results
 - Will be required in future



State of California—Health and Human Services Agency
California Department of Public Health



June 14, 2023

Dear Laboratory Partners,

To better align laboratory reporting for SARS-CoV-2, influenza virus, and respiratory syncytial virus (RSV), the California Department of Public Health (CDPH) is issuing updated reporting requirements for the types of results to report for these three pathogens. Please note, SARS-CoV-2 and influenza virus results are currently required to be reported to public health per CCR Title 17 section 2505. CDPH is in the process of adding RSV to section 2505 and asks laboratories to voluntarily report these results until CCR Title 17 section 2505 is officially updated.

SARS-CoV-2, Influenza Virus and RSV Result Reporting

- Report results electronically to the CalREDIE system within 24 hrs



LA County COVID-19 Data

[View Other Data Pages](#)

Data through 12:00pm 7/17/2023
Updated once per week on Thursdays.

Cases

2,034

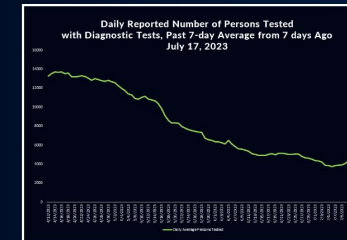
Weekly Cases Reported (07/20/2023)*

3,761,107

Total Cases Reported*

**The weekly case count does not include Long Beach or Pasadena cases. The cumulative case count includes cases reported by Long Beach and Pasadena public health departments through 6/27/23.*

Testing

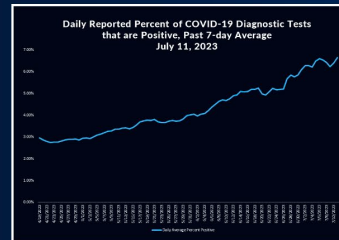


7-Day Daily Average: 4,374
Total Number of People Tested*:
13,099,221

**may include unduplicated negative test results or out of jurisdiction negative test results*

[What This Means](#)

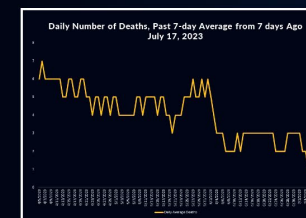
Testing Positivity Rate



7-Day Daily Average: 6.64%

[What This Means](#)

Deaths



Weekly Deaths Reported (07/20/2023)*:
14

Total Deaths Reported*: 36,564

**The weekly and cumulative death counts include*

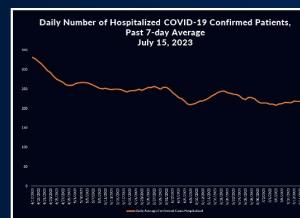
Death Rate

Age-Adjusted Death Rates due to COVID-19 per 100K July 17, 2023		Mortality Rate
Los Angeles County Total		334
Race/Ethnicity	Asian	292
	Black/African American	359
	Hispanic/Latino	494
	White	216
Area Poverty	<10% area poverty	203
	10% to <20% area poverty	346
	20% to <30% area poverty	442
	30% to 100% area poverty	569

by Race, Ethnicity and Poverty Level

[What This Means](#)

Hospitalizations



Current Hospitalizations (07/15/2023):
221

[What This Means](#)

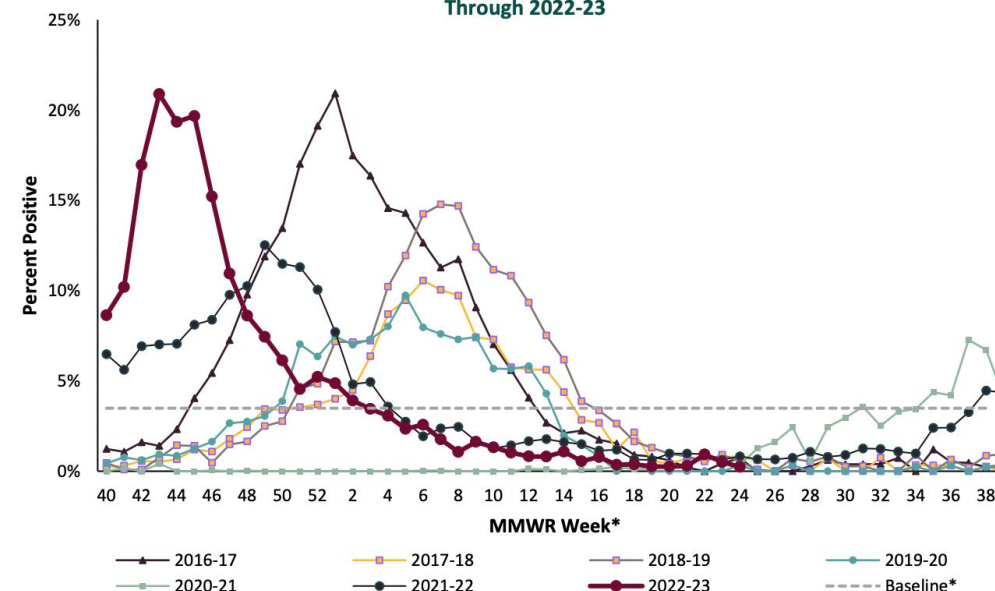
Data sources used to track RSV Cases

- Los Angeles Department of Public Health
 - Influenza Watch: 7 health system-based laboratories serving hospitals and healthcare networks across Los Angeles County.
 - Voluntary
 - Does not collect patient-data or demographic information.
 - Multiple samples may be collected from a single patient
 - Do not necessarily reflect the number of patients tested but shows trends

INFLUENZA WATCH

Summary of Los Angeles County Department of Public Health (LAC DPH)
Influenza and Other Respiratory Disease Surveillance

Figure 4. Percentage of Respiratory Specimens Testing Positive for Respiratory Syncytial Virus (RSV) at LAC Sentinel Surveillance Laboratories by Season, 2016-17 Through 2022-23



* Data have been shifted so that week 1 aligns across all seasons.

Seasonality in Los Angeles County

Before COVID-19

After COVID-19

Figure 4. Percentage of Respiratory Specimens Testing Positive for Respiratory Syncytial Virus (RSV) at LAC Sentinel Surveillance Laboratories by Season

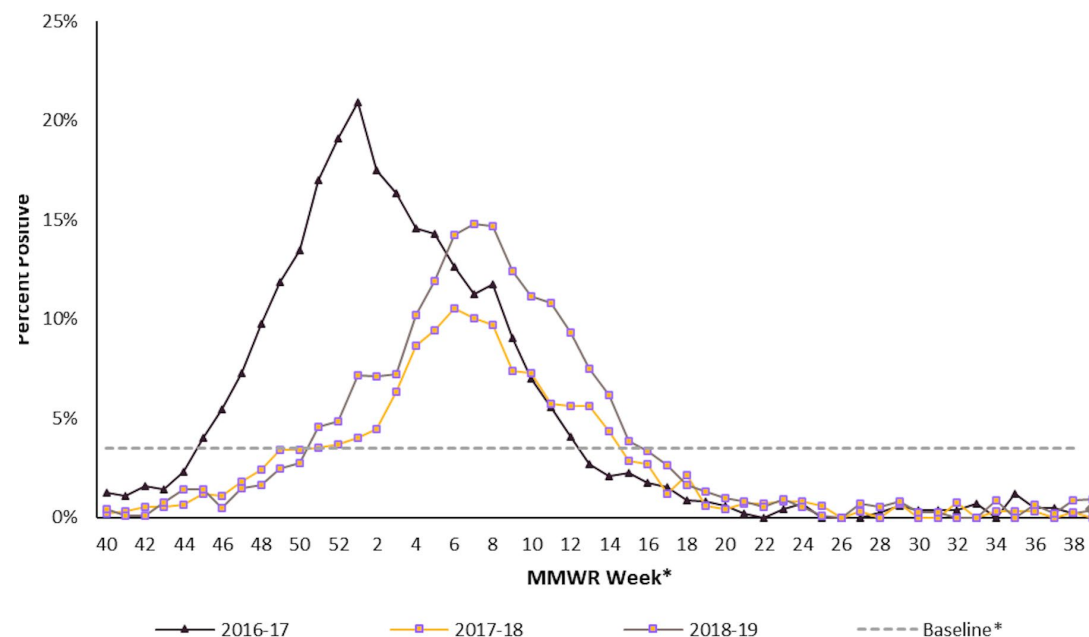
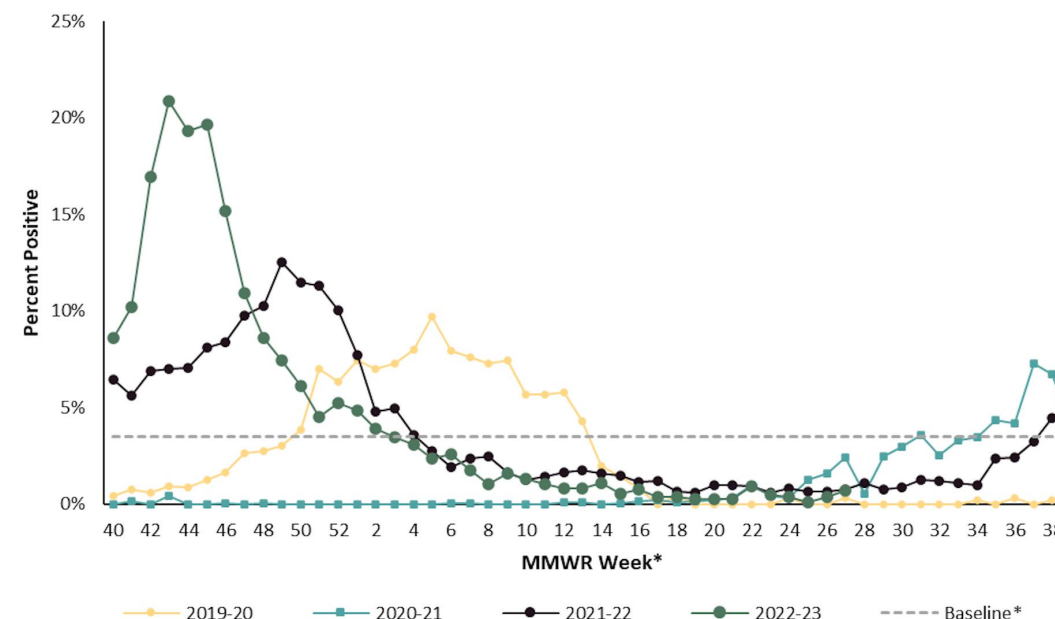


Figure 4. Percentage of Respiratory Specimens Testing Positive for Respiratory Syncytial Virus (RSV) at LAC Sentinel Surveillance Laboratories by Season



https://content.govdelivery.com/attachments/CALACOUNTY/2023/06/23/file_attachments/2535910/Influenza%20Watch%20Los%20Angeles%202022-23%20Week%2024.pdf

Data sources used to track RSV activity

- LACDPH Influenza Watch
- California Department of Public Health sentinel lab report

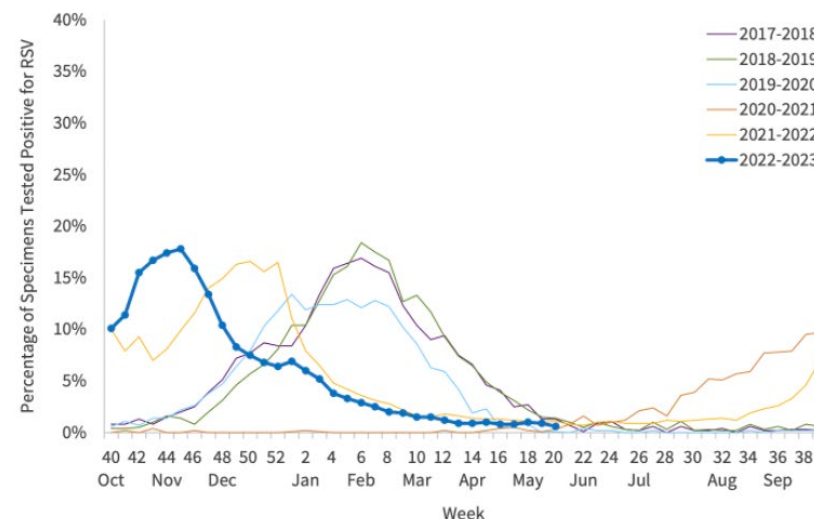


California Weekly Report

Influenza (Flu), RSV, and Other Respiratory Viruses

Week 20: May 14, 2023 – May 20, 2023

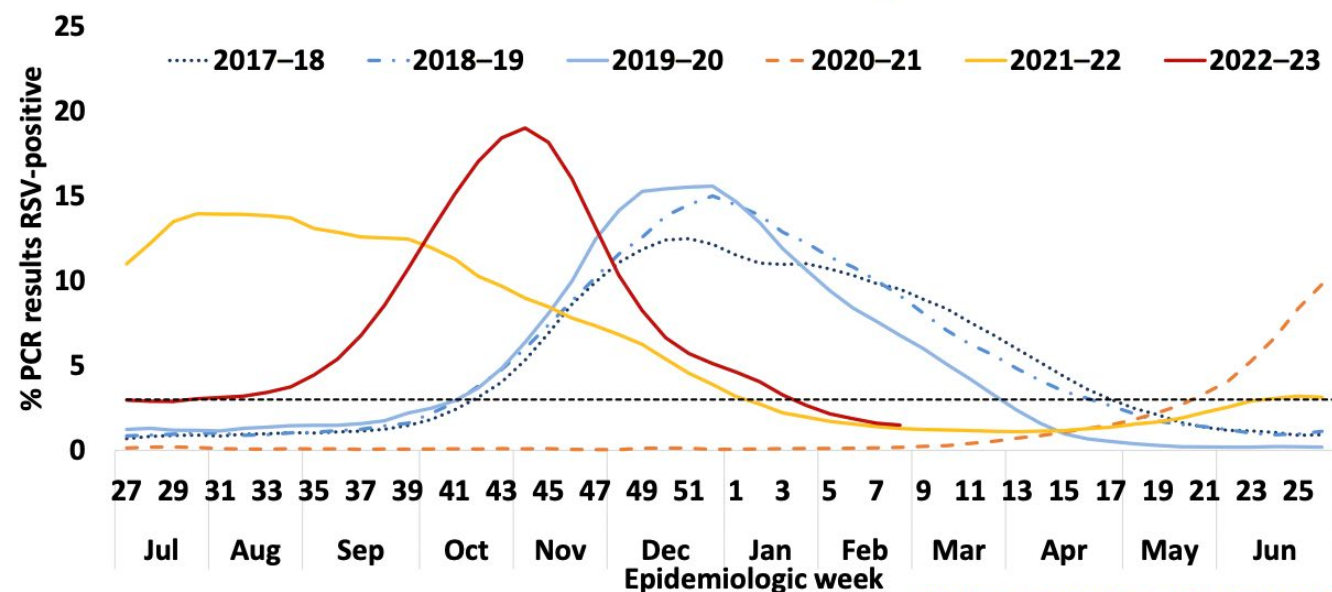
Figure 13. Percentage of RSV Detections at Clinical Sentinel Laboratories, 2017-2023 Season to Date



Data sources used to track RSV activity

- LACDPH Influenza Watch
- CDPH sentinel lab report
- CDC National Respiratory and Enteric Surveillance Systems (NREVSS) (600 labs)

Changes in seasonality of RSV transmission following SARS-CoV2 introduction— NREVSS¹, 2017–2023



Abbreviation: PCR = polymerase chain reaction; RSV = respiratory syncytial virus.

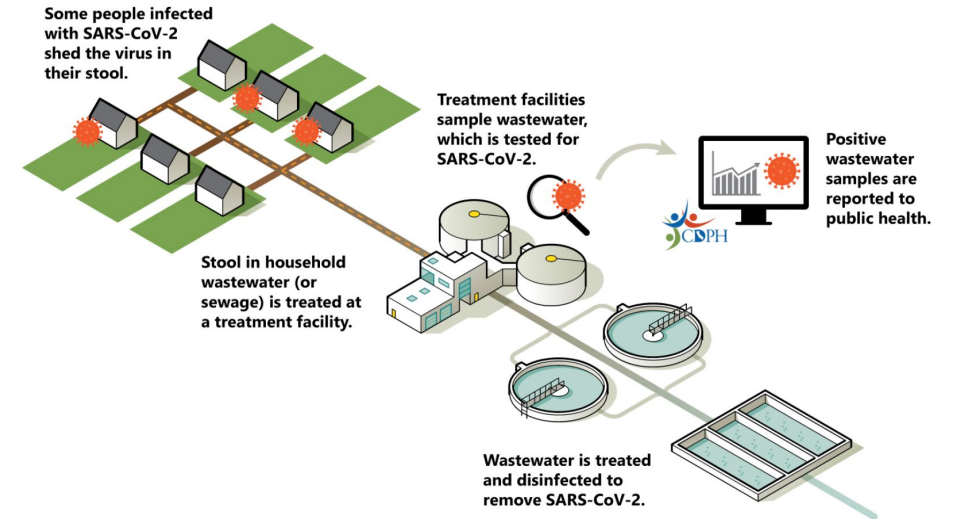
* 3-week centered moving averages of percentage of RSV-positive PCR results nationwide. The black dotted line represents the threshold for a seasonal epidemic (3% RSV-positive laboratory PCR results).

1. <https://www.cdc.gov/mmwr/volumes/72/wr/mm7214a1.htm>

Data sources used to track RSV Cases

- LACDPH Influenza watch
- CDPH sentinel lab report
- CDC NREVSS
- **Wastewater surveillance**
 - Presence and concentration of pathogens that are passively shed into wastewater provide information about disease
 - Correlation between wastewater testing and trends in RSV, COVID, mpox, Influenza A levels and subtypes in the community

Looking for SARS-CoV-2 in wastewater can help public health track the burden of COVID-19 in certain areas



(click image to enlarge)





Wastewater surveillance



[Home](#) [About](#)

Add your wastewater plant for free. [Learn More](#)

Viruses
RSV ×

Locations
Los Angeles County, CA ×

Duration
All time

Raw Data PMMoV Normalized

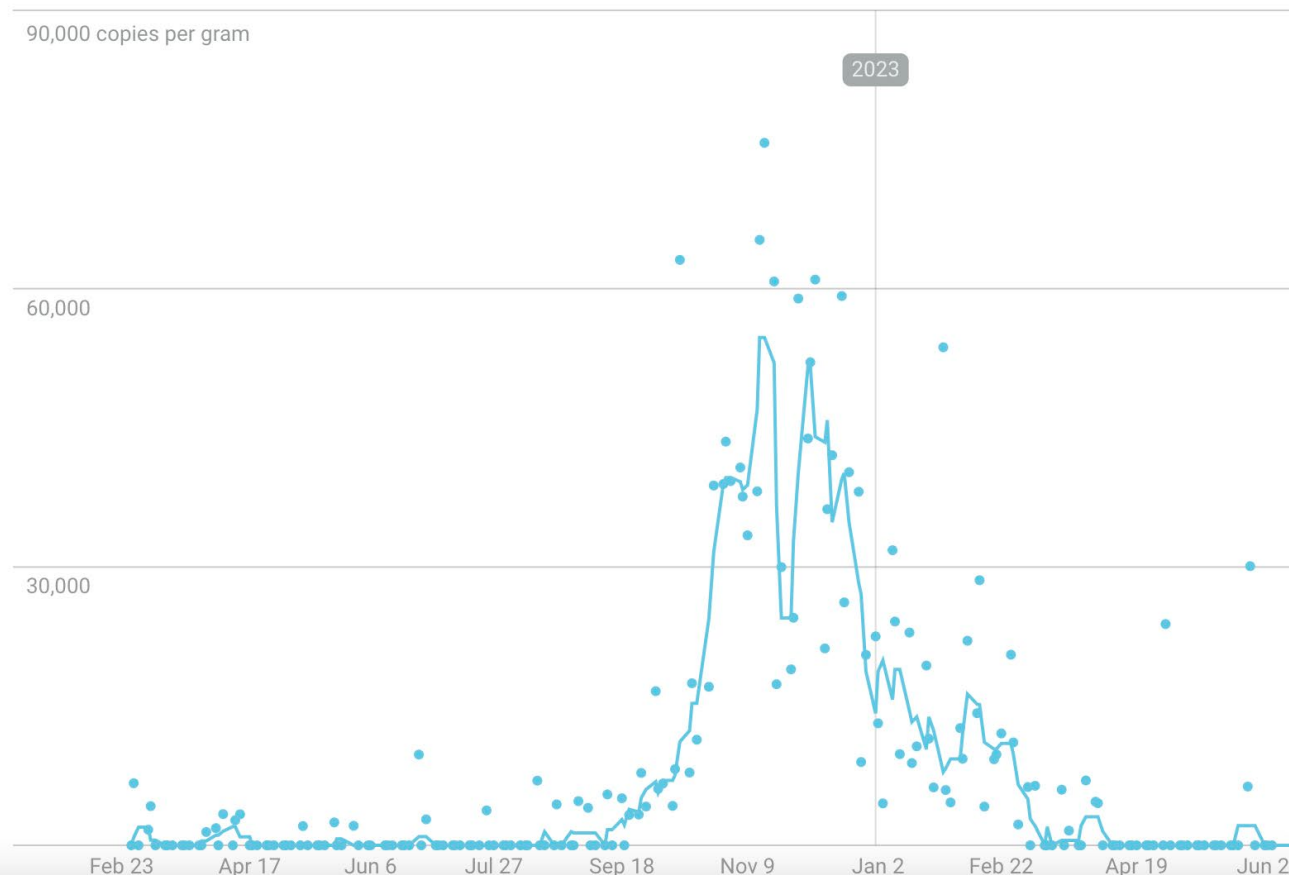
☐ Show Outliers

● Nodes represent **raw** sample values on collection dates, which are not always at regular intervals.

— Trend lines have been **smoothed**.

[Download raw data \(CSV\).](#)

[Download data dictionary \(PDF\).](#)



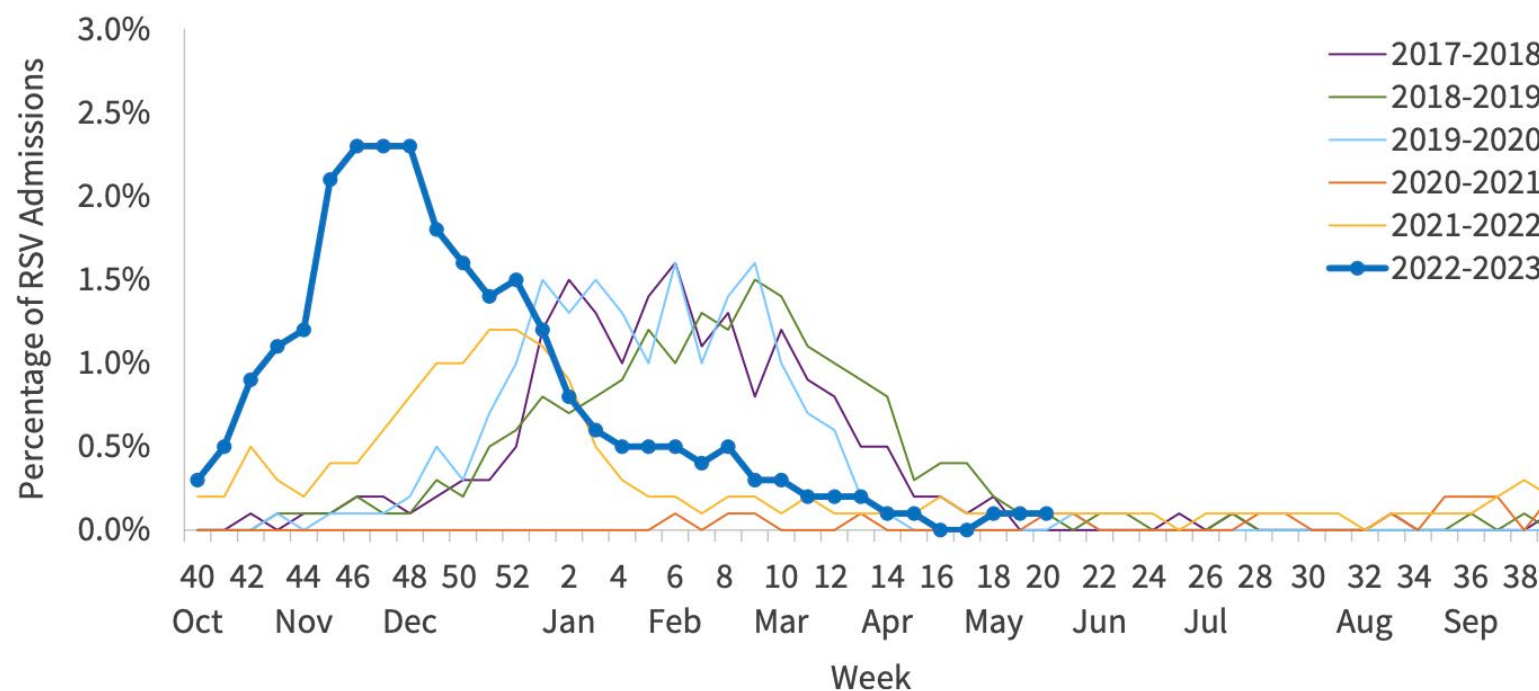
https://publichealth.verily.com/?v=SC2_N&l=Coeur+d%27Alene%2C+ID

Data sources used to track RSV Hospitalizations and Deaths--California

- Kaiser Northern California
 - Inpatients with admission diagnosis “RSV”, “syncytial”, “bronchiolitis” divided by total number of hospital admissions
 - delivery, birth, and outpatient procedures are excluded from the denominator
 - Southern California Kaiser will be hopefully joining this contract shortly

Hospitalizations at Kaiser Northern California

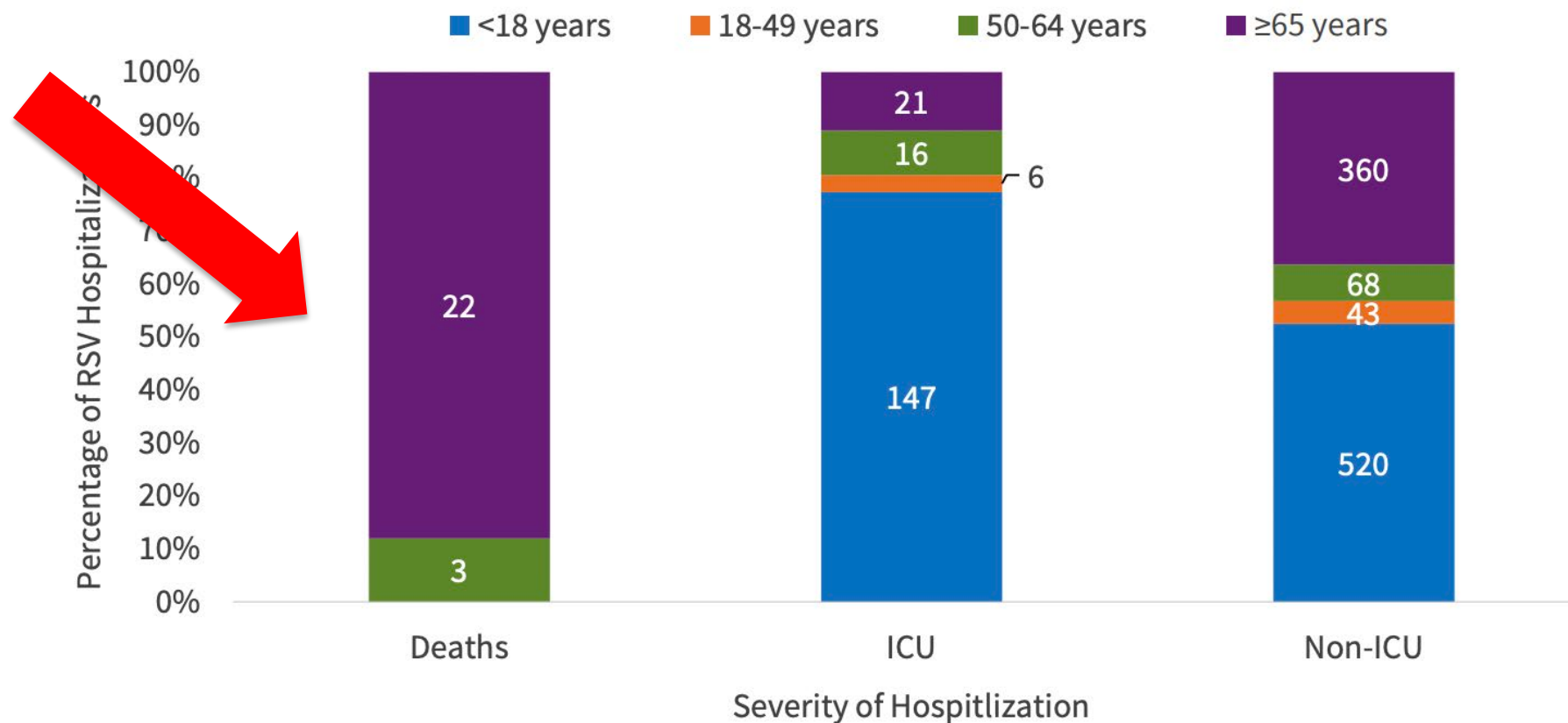
Figure 14. Percentage of RSV Admissions in Kaiser Permanente Northern California Facilities, 2017–2023 Season to Date



Note: Data have been shifted so that Week 1 aligns across seasons.

https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/Week2022-2320_FINALReport.pdf

Figure 15. Age Group Distribution of Non-ICU, ICU, and Deaths Associated with RSV Admissions in Kaiser Permanente Northern California Facilities, 2022–2023 Season to Date





RSV Vaccines



Pre vs Post F Trimer

- 2006 discovery that certain antigenic sites only present in preF form, and can be potent neutralizing epitopes
- Lead to structure-based vaccine and monoclonal antibodies targeting the RSV preF antigen

RSV Vaccine and mAb Snapshot

TARGET INDICATION: P=PEDIATRIC M=MATERNAL E=ELDERLY

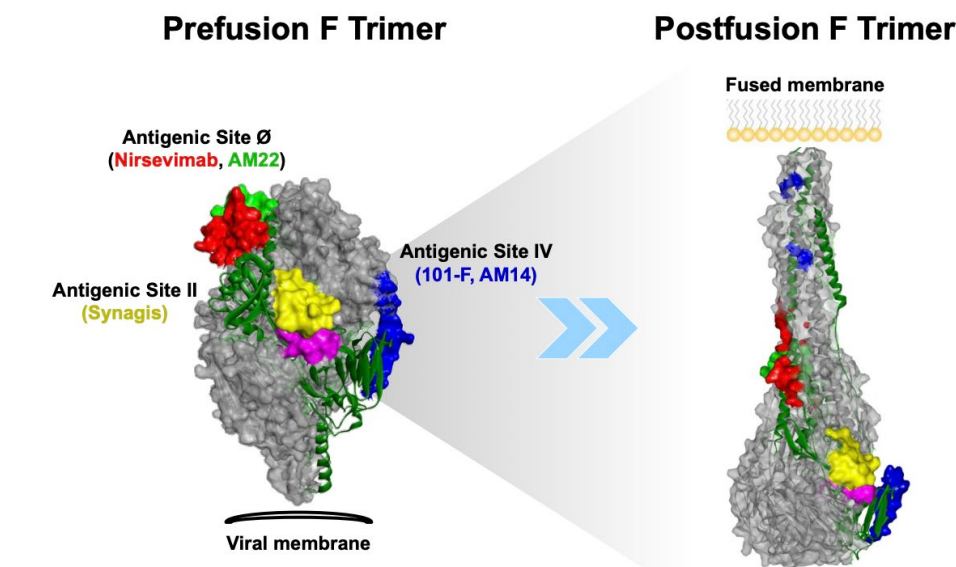
	PHASE 1	PHASE 2	PHASE 3	MARKET APPROVED
LIVE-ATTENUATED/CHIMERIC	Blue Lake PIVS/RSV Pontificia Universidad Catolica de Chile BCG/RSV	Codagenix, LID/NIAID/NIH RSV SIPL, St. Jude Hospital SeV/RSV	Intravacc RSV-ΔG	
PROTEIN-BASED • PARTICLE • SUBUNIT	Icosavax RSV/hMPV VLP Virovetix VLP	Immunovaccine, VIB RSV SH Protein NIH/NIAID/VRC RSV F Protein	Advaccine Biotechnology RSV G Protein Daichi Sankyo Protein ? Pfizer RSV F Protein	GlaxoSmithKline RSV F Protein Pfizer RSV F Protein
NUCLEIC ACID	Moderna RNA Sanofi RNA		Moderna RNA	
RECOMBINANT VECTORS		Janssen Pharmaceutical Adenovirus	Bavarian Nordic MVA	
IMMUNO-PROPHYLAXIS	Gates MRI Anti-F mAb Trinomab Biotechnology Anti-F mAb		Merck Anti-F mAb	Astra Zeneca, Sanofi Nirsevimab Astra Zeneca Palivizumab

UPDATED: June 2, 2023

Indicates Change

<https://www.path.org/resources/rsv-vaccine-and-mab-snapshot/>

PATH
P O A O H Z Q



For children—new products that may be available

- Maternal immunization with Pfizer Abrysvo (32-36 weeks of gestation)—FDA Approved
 - Advantages over immunizing infants
 - Newborns representing the greatest proportion of RSV-associated hospitalizations
 - Inability of immune system to mount an effective antibody response against RSV
 - Maternal immunization is an attractive, established strategy, with proven efficacy for prevention of tetanus, pertussis, and influenza in young infants
- Long-acting monoclonal antibody: “vaccine-like” product
 - Nirsevimab—FDA approved
 - [CDC](#) and the [American Academy of Pediatrics \(AAP\)](#) recommended:
 - a single dose of nirsevimab be administered to all infants under 8 months of age entering their first RSV season.
 - Additionally, infants and children 8-19 months of age who are at increased risk for severe RSV disease and entering their second RSV season should receive nirsevimab.

RSV vaccine for adults

2 FDA approved products:

- Pfizer bivalent RSVpreF (Abrysvo)
- GSK adjuvanted RSVPreF3 (Arexvy)

CDC recommends that adults 60 and older may receive RSV vaccination, using shared clinical decision-making.

“The decision to vaccinate an individual patient should be based on a discussion between the healthcare provider and the patient, and may be informed by the patient’s risk of severe RSV disease and their characteristics, values, and preferences; the healthcare provider’s clinical discretion; and the characteristics of the vaccine.”

CDC Recommends RSV Vaccine For Older Adults

[Print](#)

Media Statement

For Immediate Release: Thursday, June 29, 2023

Contact: [Media Relations](#)
(404) 639-3286

CDC Director Rochelle P. Walensky, M.D., M.P.H., endorsed the CDC Advisory Committee on Immunization Practices’ (ACIP) recommendations for use of new Respiratory Syncytial Virus (RSV) vaccines from GSK and Pfizer for people ages 60 years and older, using [shared clinical decision-making](#). This means these individuals may receive a single dose of the vaccine based on discussions with their healthcare provider about whether RSV vaccination is right for them.

Adults at the highest risk for severe RSV illness include older adults, adults with chronic heart or lung disease, adults with weakened immune systems, and adults living in nursing homes or long-term care facilities. CDC estimates that every year, RSV causes approximately 60,000–160,000 hospitalizations and 6,000–10,000 deaths among older adults.

[Morbidity and Mortality Weekly Report](#)

Use of Respiratory Syncytial Virus Vaccines in Older Adults: Recommendations of the Advisory Committee on Immunization Practices — United States, 2023

Michael Melgar, MD¹; Amadea Britton, MD¹; Lauren E. Roper, MPH¹; H. Keipp Talbot, MD²; Sarah S. Long, MD³; Camille N. Kotton, MD⁴; Fiona P. Havers, MD¹

[Abstract](#)

long-term care facilities (14), and persons who are frail* or

RSV vaccine for adults--GSK

- Double-blind, placebo-controlled phase 3 clinical trial
 - 17 countries
- 24,973 immunocompetent participants aged ≥60 years
 - Randomized 1:1 to receive 1 dose of vaccine (intervention group, 120 µg preF protein with AS01E adjuvant) or saline placebo (control group)
- Weakness: Few enrollees/events in high risk groups

TABLE 1. Efficacy of 1 dose of GSK respiratory syncytial virus RSVpreF3 vaccine against respiratory syncytial virus–associated disease among adults aged ≥60 years — multiple countries, 2021–2023

Efficacy evaluation period	Vaccine efficacy against outcome*	
	RSV-associated LRTD [†]	RSV-associated medically attended LRTD [§]
Season 1[¶]	82.6 (57.9–94.1)**	87.5 (58.9–97.6) ^{††}
Season 2^{§§}	56.1 (28.2–74.4) ^{††}	— ^{¶¶}
Combined seasons 1 and 2 (interim)^{***}	74.5 (60.0–84.5) ^{†††}	77.5 (57.9–89.0) ^{††}

Abbreviations: LRTD = lower respiratory tract disease; RSV = respiratory syncytial virus.

* Manufacturer-calculated efficacy. Includes events >14 days after injection

GSK, Harms: relative risk

Outcome	Importance	Data sources	Relative risk estimate ^a (95% confidence interval)	Concerns in certainty assessment
Harms				
Serious adverse events (SAEs)	Critical	One phase 3 RCT ^b , one phase 1/2 RCT ^c	1.02 (0.91, 1.15) N=25,174 total participants	None serious
Inflammatory neurologic events	Important	One phase 3 RCT ^d one phase 1/2 RCT ^d	Vaccine: n=0/12,570 participants Placebo: n=0/12,604 participants	Unable to evaluate
Reactogenicity (grade ≥3)	Important	One phase 3 RCT ^f one phase 1/2 RCT ^g	4.06 (1.97, 8.36) N=1,955 total participants	None serious

RCT: Randomized control trial

^a Pooled relative risk estimates were independently calculated using counts of events and participants in the GSK pivotal phase 3 trial (Papi A, et al. NEJM 2023 <https://doi.org/10.1056/nejmoa2209604>), as well as from a placebo-controlled phase 1/2 dosing selection study (Leroux-Roels I, et al. J Infect Dis. 2022 <https://doi.org/10.1093/infdis/jiac327>). Data provided by manufacturer.

^b Up to 6 months after injection

^c After dose 1, but before dose 2 (day 61)

^d Within 42 days after

^e No events recorded in the investigational vaccine or comparator. Two events were reported after the first dose of seasonal influenza vaccine administration compared with 1 event in the comparator.

^f Within 7 days after

^g Within 4 days after vaccination

Total of 3 inflammatory neurologic events reported within 42 days of vaccination with RSVpreF3 among 17,922 older adults across all clinical trials

recipient of the
vaccinated
with standard
vaccines

RSV-Pfizer

- Double-blind, placebo-controlled phase 3 clinical trial
- 7 countries
- 36,862 immunocompetent participants aged ≥60 years
- Randomized 1:1 to receive 1 dose of vaccine or placebo containing the same buffer ingredients as the vaccine

TABLE 3. Efficacy of 1 dose of Pfizer respiratory syncytial virus RSVpreF vaccine against respiratory syncytial virus–associated disease among adults aged ≥60 years — multiple countries, 2021–2023

Efficacy evaluation period	Vaccine efficacy against outcome, % (95% CI)*	
	RSV-associated LRTD [†]	RSV-associated medically attended LRTD [§]
Season 1 [¶]	88.9 (53.6–98.7)	84.6 (32.0–98.3)
Season 2 (interim)**	78.6 (23.2–96.1)	— ^{††}
Combined seasons 1 and 2 (interim) ^{§§}	84.4 (59.6–95.2)	81.0 (43.5–95.2)

Abbreviations: LRTD = lower respiratory tract disease; LRTI = lower respiratory

Pfizer, Harms: relative risk

Outcome	Importance	Data sources	Relative risk estimate ^a (95% confidence interval)	Concerns in certainty assessment
Harms				
Serious adverse events (SAEs)	Critical	One phase 3 RCT, one phase 1/2 RCT ^b	1.04 (0.94, 1.15) N=36,953 total participants	None serious
Inflammatory neurologic events	Important	One phase 3 RCT ^c one phase 1/2 RCT ^c	Vaccine: n=3/18,622 participants ^d Placebo: n=0/18,335 participants ^e	Imprecision (very serious) ^{f,g}
Reactogenicity (grade ≥3)	Important	One phase 3 RCT ^h one phase 1/2 RCT ^h	1.43 (0.85, 2.39) N=7,164 total participants	Imprecision (serious) ^f

^a Pooled relative risk estimates were independently calculated using counts of events and participants in the Pfizer pivotal phase 3 trial (Walsh EE et al. NEJM 2023 <https://doi.org/10.1056/nejmoa2213836>), as well as from a placebo-controlled phase 1/2 dosing selection study (Falsey AR, et al. J Infect Dis. 2022 <https://doi.org/10.1093/infdis/jiab611>). Data provided by manufacturer.

^b After dose 1, but before dose 2 (day 61). RCT = randomized controlled trial.

^c Within 42 days after injection. RCT = randomized controlled trial.

^d In the Pfizer pivotal phase 3 trial, 3 events of Guillain-Barre syndrome (GBS) and 1 event of myelitis were reported within 42 days after vaccination with RSVpreF among 18,622 participants in the phase 3 trial. No events were reported within 42 days after vaccination with the placebo formulation selected for phase 3.

^e Measures of relative risk.

^f 95% confidence interval.

^g Fragility of estimate.

^h Within 7 days after vaccination. RCT = randomized controlled trial.

Total of 3 inflammatory neurologic events reported within 42 days of vaccination with RSVpreF among 20,255 older adults across all clinical trials

Clinical consideration: Timing of RSV vaccination for the 2023–2024 RSV season

Given this variability the ideal time to start vaccinating cannot be predicted in advance of the 2023-2024 RSV season.

Providers **should therefore offer RSV vaccination as soon as vaccine supply becomes available.**

Providers should continue to offer RSV vaccination throughout the RSV season to eligible adults who remain unvaccinated.

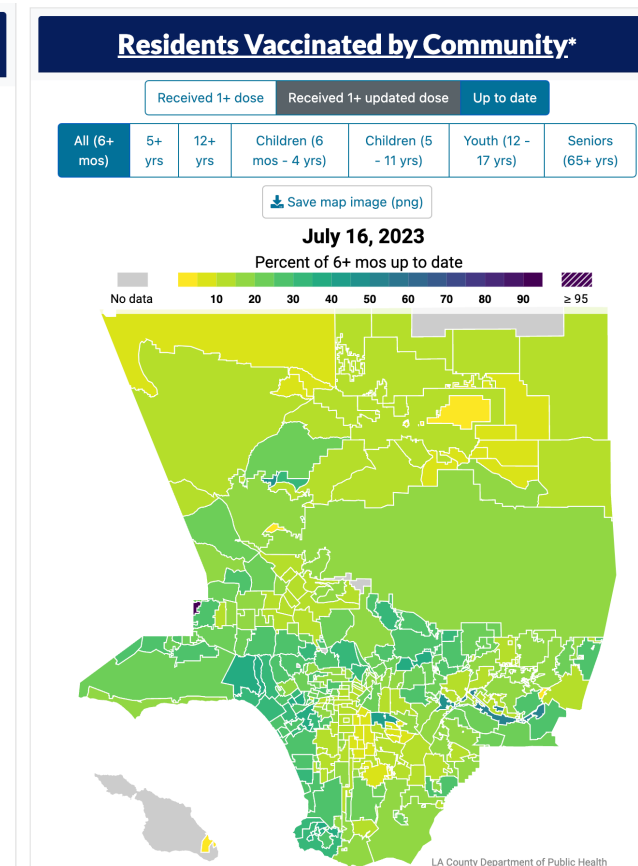
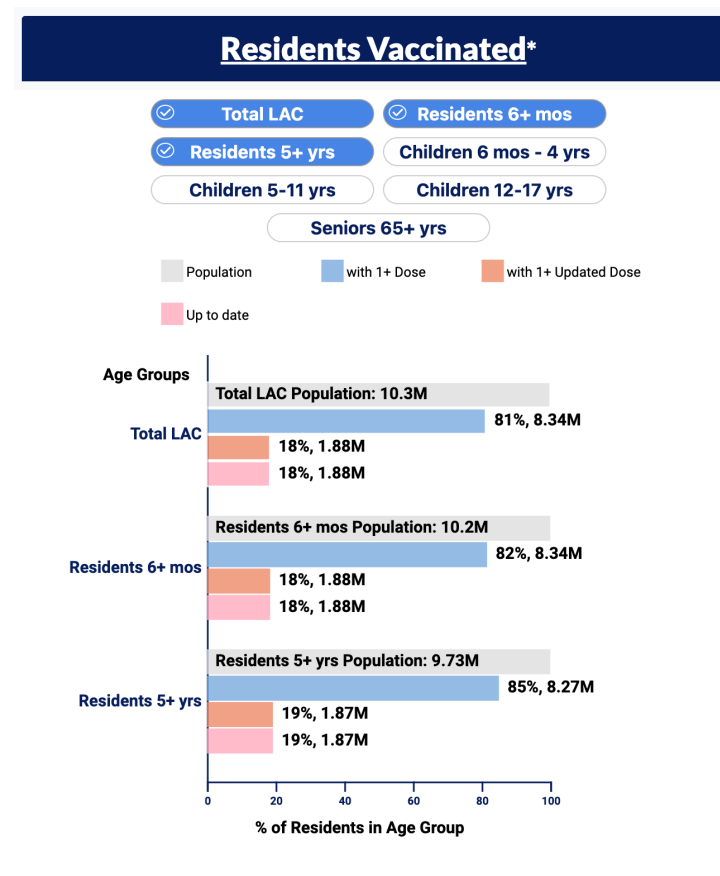
There are insufficient data at this time to determine the need for revaccination.

Co-administration

- Coadministration of RSV vaccines with other adult vaccines during the same visit is acceptable
 - Giving RSV vaccines simultaneously with seasonal influenza vaccines, COVID-19 vaccines, pneumococcal vaccines, Td/Tdap, and recombinant zoster vaccine (Shingrix).
- There are currently limited data available on immunogenicity of coadministration of RSV vaccines and other vaccines.
 - Coadministration of RSV and seasonal influenza vaccines met non-inferiority criteria for immunogenicity.
 - RSV and influenza antibody titers were generally somewhat lower with coadministration.
- Additional studies on immunogenicity of coadministration of RSV with other adult vaccines are in process.

California Immunization Registry

- Effective January 1st, 2023, **requires** providers to enter immunizations they administer as well as a patient's race and ethnicity into a California immunization registry



for Notes: Changes are being implemented in the California Immunization Registry (CAIR). Data on doses administered and people vaccinated may fluctuate.

Summary

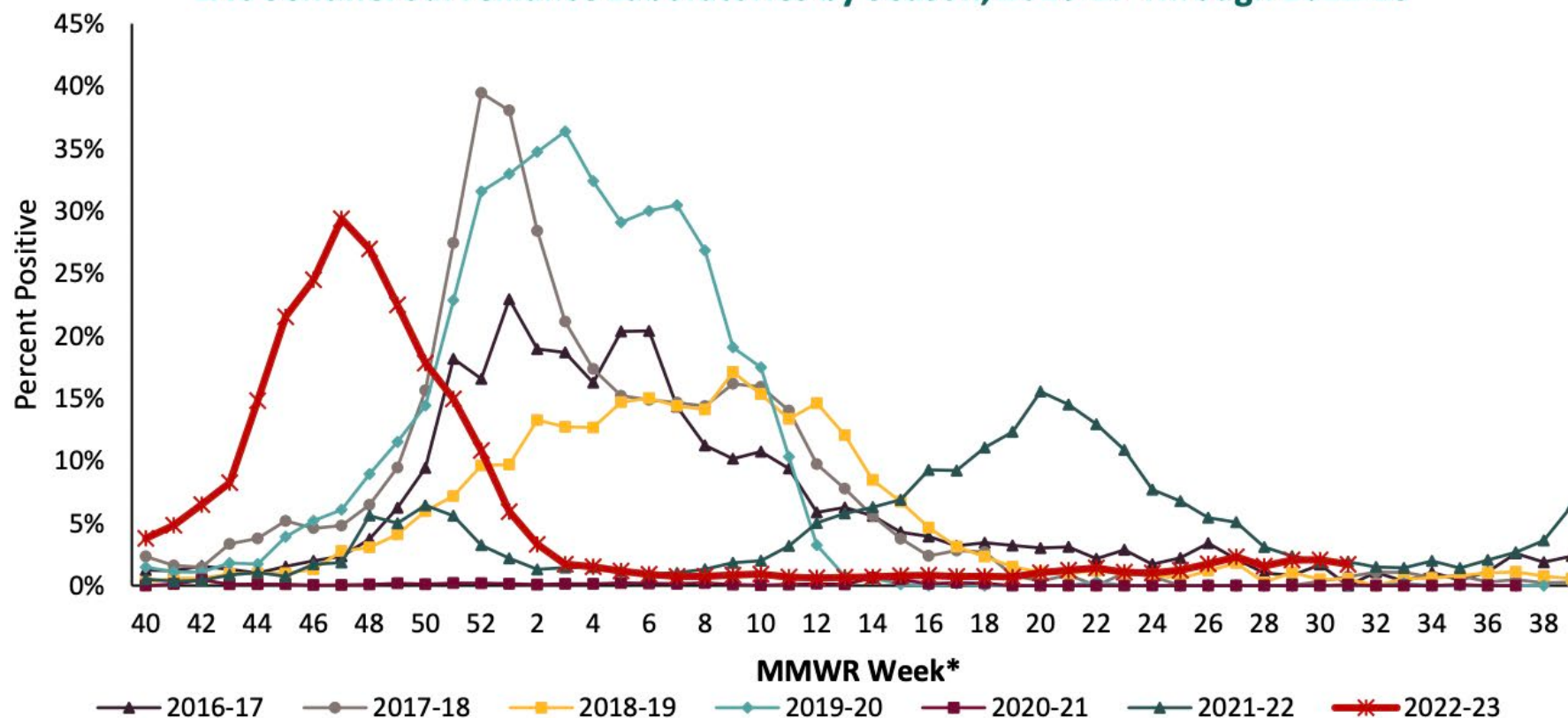
- RSV is an important cause of illness, hospitalizations, and death in infants and older adults
- Public Health is aiming to strengthen surveillance systems to better characterize RSV's impact on health and health systems
- Two vaccines are available to prevent severe illness are now available and recommended for those 60 years of age and above
 - Co-administration of RSV and Flu vaccines showed acceptable immunogenicity
- A long-acting monoclonal antibody is recommended for all infants <8 months to prevent RSV disease
- A vaccine for pregnant women is FDA approved for pregnant women 32-36 weeks GA
- Ongoing safety monitoring to evaluate for rare serious adverse effects



Flu and COVID-19 updates



Figure 2. Percentage of Respiratory Specimens Testing Positive for Influenza at LAC Sentinel Surveillance Laboratories by Season, 2016-17 Through 2022-23



**Data have been shifted so that week 1 aligns across all seasons.*

Quadrivalent vaccine provides protection against 4 different strains of Influenza

Egg-based vaccines

- an A/Victoria/4897/2022 (H1N1)pdm09-like virus; **(Updated)**
- an A/Darwin/9/2021 (H3N2)-like virus;
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

Cell- or recombinant-based vaccines

- an A/Wisconsin/67/2022 (H1N1)pdm09-like virus; **(Updated)**
- an A/Darwin/6/2021 (H3N2)-like virus;
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus; and
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

These recommendations include **one update** compared to the 2022-2023 U.S. flu vaccine composition. The influenza A(H1N1)pdm09 vaccine virus component was updated for egg-based and cell- or recombinant-based flu vaccines.

Vaccine Recommendations—Influenza Vaccine

- Recommended for all persons 6 months of age and older starting in September and October
 - For adults (especially those 65 years old and older), avoid vaccinating in July and August
- Anyone can get sick with flu, but certain people are at higher risk including:
 - people 65 years and older
 - Fluzone High-Dose Quadrivalent vaccine (approved for 65+)
 - Flublok Quadrivalent recombinant flu vaccine (approved for 18+)
 - Fluad Quadrivalent adjuvanted flu vaccine (approved for 65+)
 - pregnant women
 - children younger than 5 years (some children will need to get 2 doses of vaccine)
 - people with chronic medical conditions (such as asthma, diabetes, heart disease, or HIV)
- Last season, people who were vaccinated against flu were about 40% to 70% less likely to be hospitalized because of flu illness or related complications



Vaccine Recommendations: COVID-19

- All persons 6 months of age and older should remain up to date with COVID vaccine
 - Number of doses and interval between doses will depend on patient's age, immune system and the number and types of vaccine products received previously
- Anyone can get sick with COVID, but certain people are at higher risk including:
 - people 65 years and older
 - pregnant women
 - infants
 - people with chronic medical conditions (such as asthma, diabetes, heart disease, or HIV)
- Available from medical providers offices, pharmacies and DPH health centers and mobile vaccine teams
- New monovalent vaccine targeting XBB variants will be assessed by FDA and CDC in September and may be available in fall.



CAIR2 Reporting Reminders

CAIR2 (California Immunization Registry): Reporting of all immunization doses administered is required for all healthcare providers in California, including skilled nursing facilities*, [effective Jan 1, 2023](#).

Enroll in [CAIR2](#) to report vaccines administered at your site. For more information or for technical support, please contact

- Your [local CAIR representative](#) (scroll down to CAIR2 Los Angeles Region); or
- The [CAIR Helpdesk](#)

Include your facility name, full address, and CAIR org ID (if available) when reaching out.

Please also see our **Aug 4, 2023 webinar** on this topic: [slides](#) & [recording](#)

Fall 2023 COVID-19 Vaccine Transition Timeline

High Level

Week of July 31, 2023

- CDC set vaccine thresholds to -0- in anticipation of decreased vaccine demand
- Providers were asked to order a 2-month vaccine supply to last until new products are approved by FDA
- Vaccine doses can still be ordered by States, but the processes, timing, and cadence for ordering processing will change. Based on doses ordered, we ask CDC for allocations, wait 1-3 days for doses, then transmit orders to CDC.

August 3-Early September

- Providers may begin ordering locally

Aug 3-Early September (NOW): ALL healthcare providers should begin planning, prebooking, submitting orders, or procuring the fall 2023 COVID-19 vaccine doses for insured individuals (**this applies to all SNFs!**)

These are fulfilled

vaccine doses for

er Bridge Access

- State Program, and

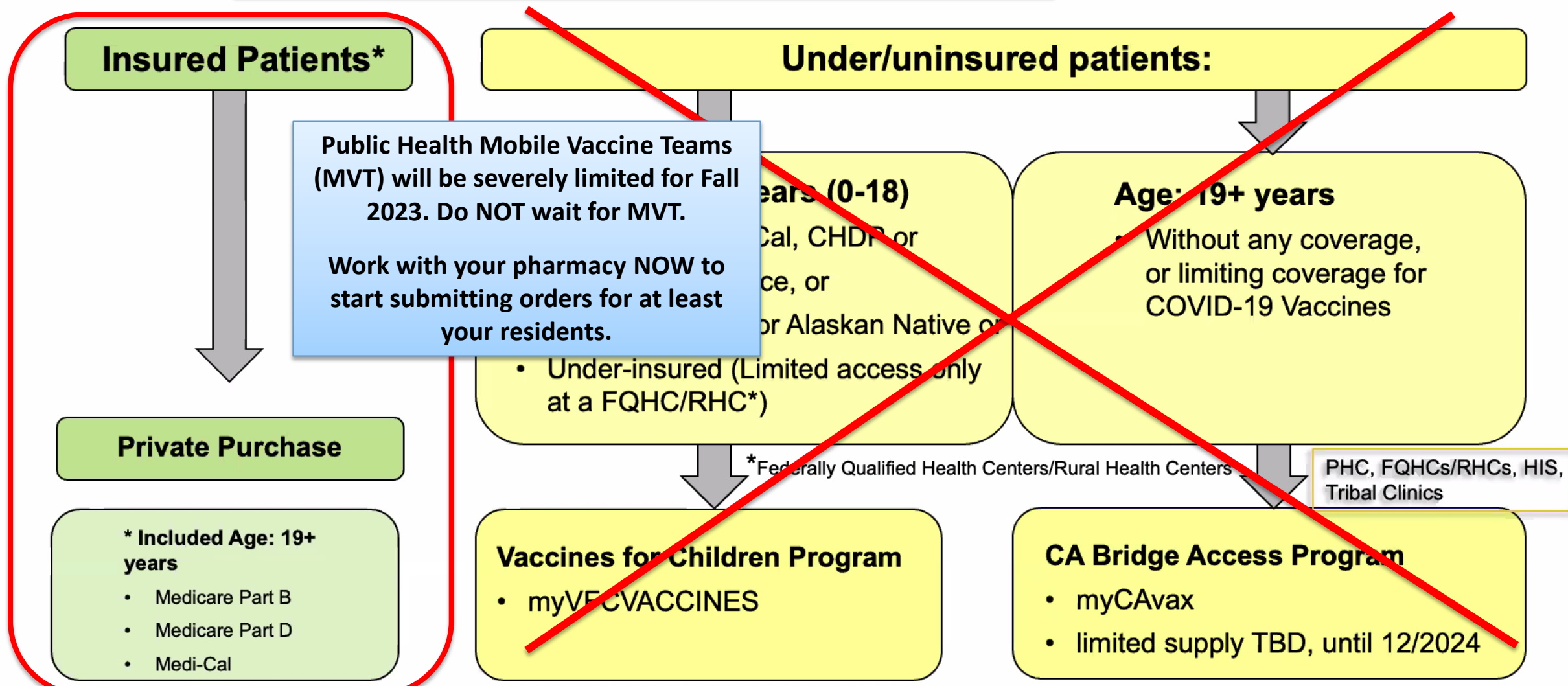
TBD (expected **early to mid-September**)

- FDA decisions and amendments to Emergency Use Authorizations (EUAs) / Biologics License Applications (BLAs). Approve new products, and de-authorized current products.
- Concurrently, USG WILL discontinue distribution of current COVID-19 vaccine composition.
- Advisory Committee on Immunization Practices (ACIP) discussion on COVID-19 epidemiology and vaccine effectiveness and CDC recommendation.
- CDPH and LHDs work on BAP provider enrollment, and prepare for COVID-19 ordering for BAP Provider and VFC Providers

TBD (ACIP Recommendation + 2 weeks=**Late September/Early October**)

- Fall vaccine availability for administration begins across all eligible age groups, with corresponding vaccine supply based on insurance coverage, and eligibility (for providers participating in VFC or CA's Bridge Access Program)
- Providers will dispose of any remaining supply of de-authorized COVID-19 vaccines

Post Sunset of the Federal COVID-19 Vaccination Program: Vaccine ordering will follow more traditional pathways for purchasing vaccines





California COVID-19 Vaccination Program

ENHANCED BY

Program Updates

Program Enrollment

My Turn

Vaccine Management

Vaccine Administration

Reporting Requirements

Archived Communications

Provider Webinars

California COVID-19 Vaccination Program Updates and Q&A

COVID-19 Provider Webinar

- Every Friday from 9 AM - 10:30 AM
- [Register here](#)
- [Archived recordings and slides](#)

Successful Strategies for COVID-19 Vaccine Management Quickinars

- [Archived recordings and slides](#)

<https://eziz.org/covid/education/>



Building Vaccine Confidence for All Vaccines



State of Vaccine Confidence: Routine Immunizations (CDC)

Figure 1. Changes in Claims for All ACIP-Recommended Adolescent and Adult Vaccines Across Markets January 2020–July 2021 Compared to the Same Months in 2019



- After widespread COVID vaccine availability in 2021-2022 seasons, adult influenza vaccine uptake **decreased** from 43.7% to 39.2% in states with lowest COVID-19 vaccine uptake
- Medicare FFS claims study: monthly claims for non-COVID vaccines **decreased** on average by 32% (adults) and 36% (adolescents) in Jan-2020-July 2021 compared to same months in 2019

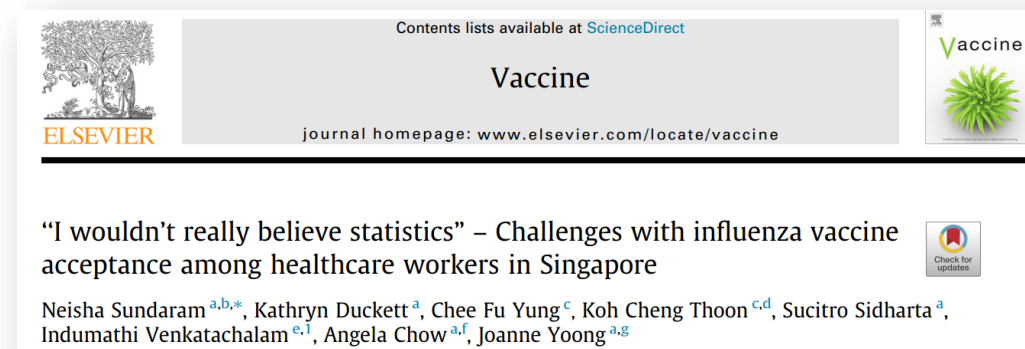
CDC's State of Vaccine Confidence Insights Report. Nov 10, 2022

Leuchter, R.K., et al. NEJM. June 30, 2022.

Avalere. "Declines in Routine Adult and Teen Vaccinations Continued in 2021." Jan 10, 2022.

“I wouldn’t really believe statistics” – Singapore, 2018

- Qualitative, focus group discussions
- 73 hospital HCW (doctors, nurses, PT/OT, dietary, pharm, med tech, SW)
- Challenges identified (**person** and **institutional** level):
 - Fear of contracting influenza from vaccine
 - Concern over vaccine safety
 - Distrust of published data
 - Uncertainty over relevance to their population
 - Low perceived risk for getting infected
 - Limited awareness of flu transmission
 - Lack of overt promotion by hospital leadership
 - Perceived low vaccine confidence among doctors



“I think there are other ways to protect myself... **other natural ways** you know—exercise, eat well, sleep well—instead of getting the jab”

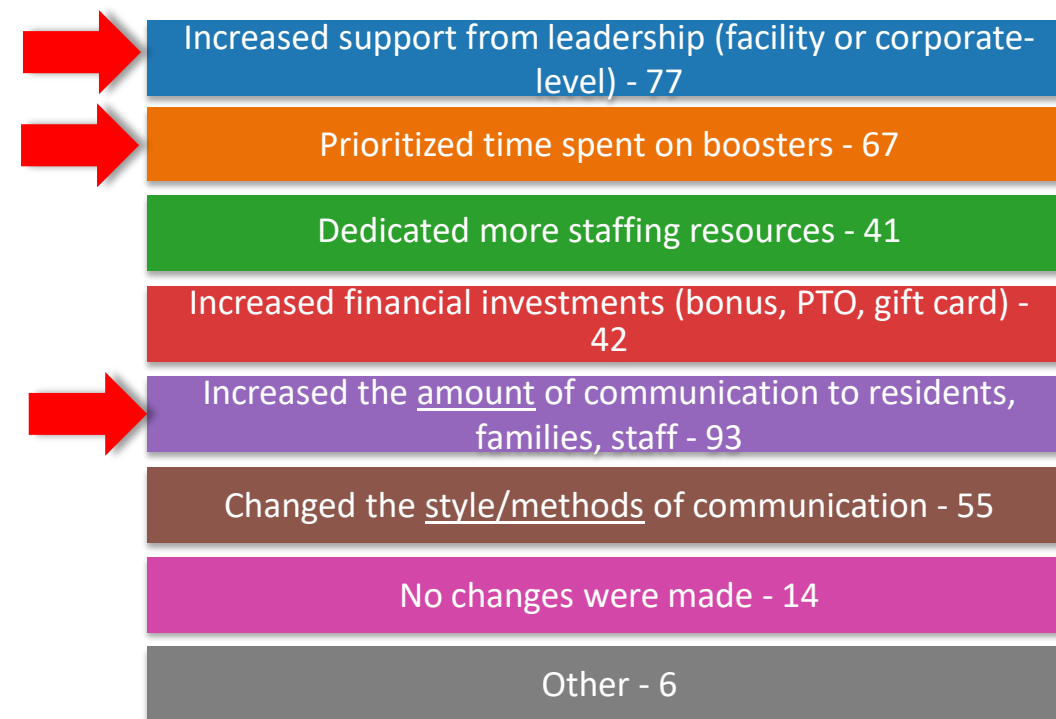
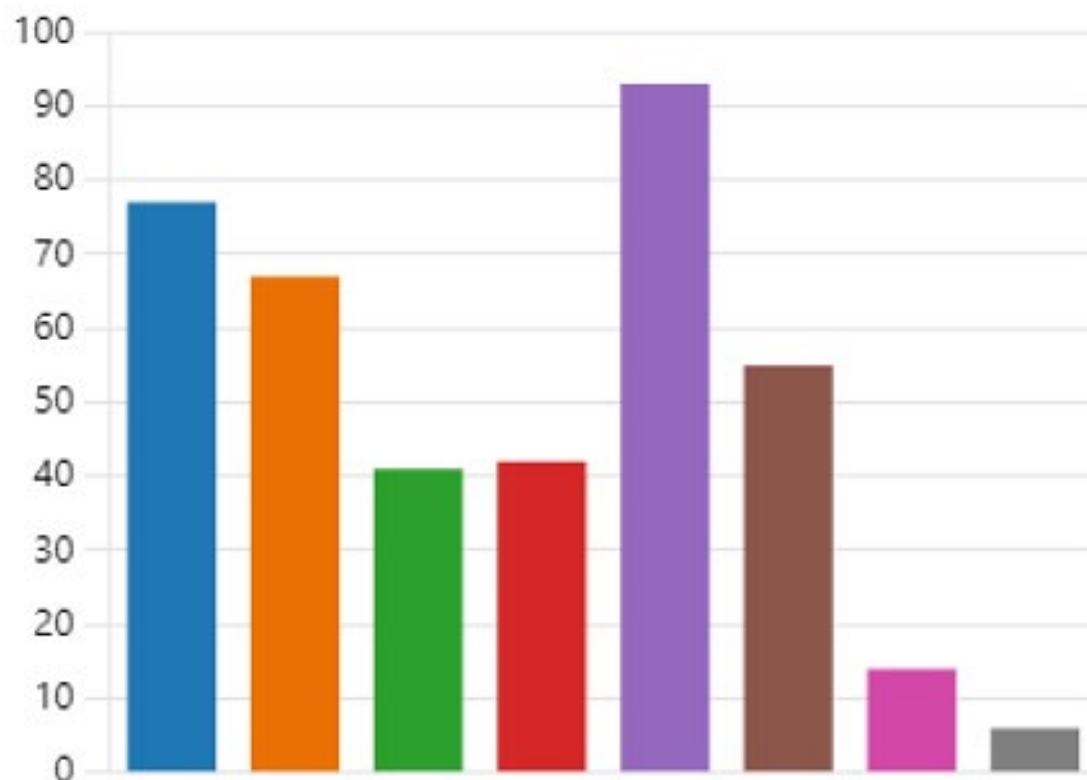
“I don’t really buy into the benefits of this because **I still fall sick after taking the jab**. I don’t see any value that is added to me except it has brought me pain and I still fall sick you know.”

LAC DPH Best Practices for HCW Influenza Vaccination (Jan 2020)

- Support from **leadership**: CEO, Facility Administrator, DON, Medical Director, etc.
- Policy & procedures that **make it hard to say no, easy to say yes**
 - Removal of personal beliefs exemption, only allow medical contraindications
 - Hold staff accountable
- **Educate**
- Offer vaccinations in the workplace at convenient locations & times (**make it easy to get vaccinated**)
- Offer **incentives** for vaccinating
- Track/monitor HCP vaccination

Best Practices for Improving Influenza Immunization Coverage Amongst Healthcare Personnel	
High Impact Best Practices	★ Make the influenza immunization a condition of employment by revising your facility's internal policy, meeting with union counterparts, etc. ★ Revise the declination form to only include options such as medical contraindications and removing the personal beliefs exemption (i.e. implement a medical exemption review process for staff who are requesting exemptions) ★ Develop an influenza management committee to include the Administrator, Nurse Educator/Director of Nursing, Infection Preventionist and Medical Director to meet monthly during the influenza season
Possible Barriers	Strategies to Address Barriers
Hiring freezes or lack of staffing and resources	• Include the healthcare personnel (HCP) influenza immunization as a Quality Improvement measure for the facility • Inform unit managers to hold staff accountable on each unit by submitting weekly updates to assist with data collection • Infection Preventionists or Employee Health can create a spreadsheet with deadlines for follow up
Lack of follow up with staff who did not meet the facility's influenza immunization target	• Consider implementing consequences for staff who are non-compliant with submitting their influenza immunization documentation or with wearing a mask, if required (i.e. verbal/written warnings, badge suspension, etc.) • Encourage discussion about the influenza campaign in staff meetings • Assign influenza immunization champions to increase rates (e.g. staff such as CNAs, RNs, LVNs, Environmental Services, PT/OT, etc., can encourage their colleagues to become immunized)
Difficulty with obtaining documentation from licensed independent practitioners (i.e., some Skilled Nursing Facilities (SNFs) may not require influenza immunization as a condition of employment)	• Encourage staff to submit documentation for the immunization and offer an attestation form for staff who were unable to obtain documentation • Obtain accurate denominator of physical staff in the SNF during the influenza season reporting period
Staff declining the immunization due to personal reasons (e.g., getting sick, not trusting the immunization, etc.)	• Implement mandatory in-services for staff who are declining the immunization to dispel myths
Lack of leadership involvement	• Obtain Medical Director/Administrator buy in to encourage the influenza immunization amongst staff (i.e. issuing a directive to all HCP of the requirement to be immunized, dates the immunization will become available (on-site if possible), and the immunization provided at no cost)
Lack of key messages or incentives provided by facilities	• Encourage the development of a slogan for your influenza campaign • Consider providing flu stickers for staff who become immunized • Encourage staff to provide incentives such as lunch for the unit with the most immunizations, raffle prizes, etc.

What changes (if any) did your facility leadership make to your vaccination strategy or policies after learning about the COVID-19 bivalent booster reward program?



Priority setting

- BEFORE the financial reward announcement
 - **11% disagreed** that the bivalent booster was a priority at their facilities (NOT a priority)
 - **50% strongly agreed** the bivalent booster was already a priority at their facilities (YES priority)
- AFTER the financial reward announcement
 - **8% disagreed** the bivalent booster was a priority at their facilities (NOT a priority)
 - **58% strongly agreed** the bivalent booster was a priority at their facilities (YES priority)



LAC DPH COVID-19 Vaccine Healthcare Worker Survey

Preliminary Results – Dec 13, 2020

Do you plan to **refuse** a recommended COVID-19 vaccine?

	Yes, I will submit a documented exemption	No	Total
Nursing (RN/LVN)	431	1459	1890
	22.8% (*)	77.2% (*)	
Physician/Mid-level	49	1114	1163
	4.21% (*)	95.79% (*)	
Pharmacist	21	136	157
	13.38% (*)	86.62% (*)	
EMT/Paramedic	63	188	251
	25.1% (*)	74.9% (*)	
Certified nursing assistant/medical assistant	66	147	213
	30.99% (*)	69.01% (*)	

Cognitive biases that affect vaccine decision making

Cognitive Bias	Definition	Using it to build vaccine confidence
Default effect	Tendency to go with the default choice when choosing between several options	Make vaccination the default choice (supported by evidence) Importance of language: “vaccine confidence” vs “vaccine hesitancy”
Omission bias	Tendency to consider the consequences of omission (declining vaccination) as less severe than doing it (getting vaccinated) even if the result of omission is more severe. “Don’t fix what’s not broken.”	Reframe the choice to vaccinate is a choice between: - Continuing current health status & avoiding infections/additional rx (align with resident values) - Increased risk for infections and additional rx

CDC: “Promoting COVID-19 Bivalent Vaccinations: Long-term Care Provider Perspectives” Feb 9, 2023

You are viewing Joanna Levine, PHF's screen

View Options

View

Communication

Talking: Patrick Cote

- Communicated with:
 - Providers
 - Residents and families
 - Staff
- Resources provided:
 - Talking points for leaders
 - Talking points for caregivers
 - 1:1 support when:
 - Skeptical physicians
 - Skeptical residents & families
 - Challenges accessing vaccine



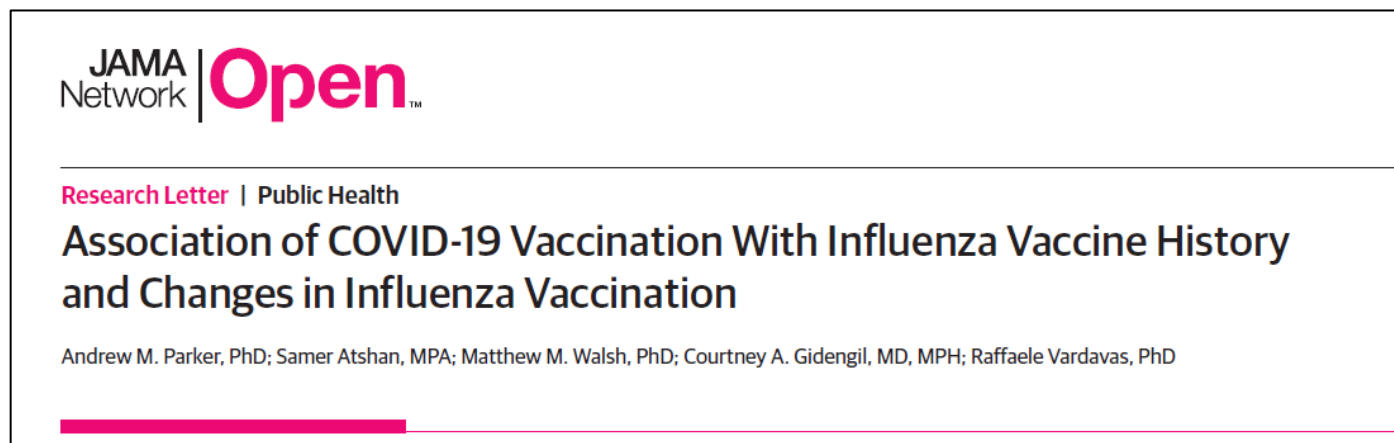
Opt-in vs opt-out consent processes



- **Opt-in:** “Do you want the vaccine?”
- **Opt-out:**
 - Do you want your vaccine this week or next week?
 - Since this vaccine is recommended for you, we will be giving it to you unless you decline by ____ (date).
 - All staff should get this vaccine unless they decline.

- Are both these methods **valid ways to obtain consent** for vaccines? Yes
- **What is legally required?** Provision of the EUA fact sheet or VIS (vaccine information statements) to the recipient and/or their medical decision maker.
- **Is a wet signature (written consent) legally required?** No. However, this is different from documenting consent which depends on facility policy.

Building vaccine confidence in 1 vaccine is beneficial for all vaccines



- Study confirmed high correlation between influenza and COVID-19 vaccination seen in other studies.
- “Most strikingly, among individuals who historically never got the influenza vaccine, those receiving COVID-19 vaccine were **substantially more likely to switch toward getting the influenza vaccine. This suggests that investing in vaccine acceptance has payoffs beyond the vaccine itself.**”

Lessons Learned: **LEAD** with Vaccine Confidence

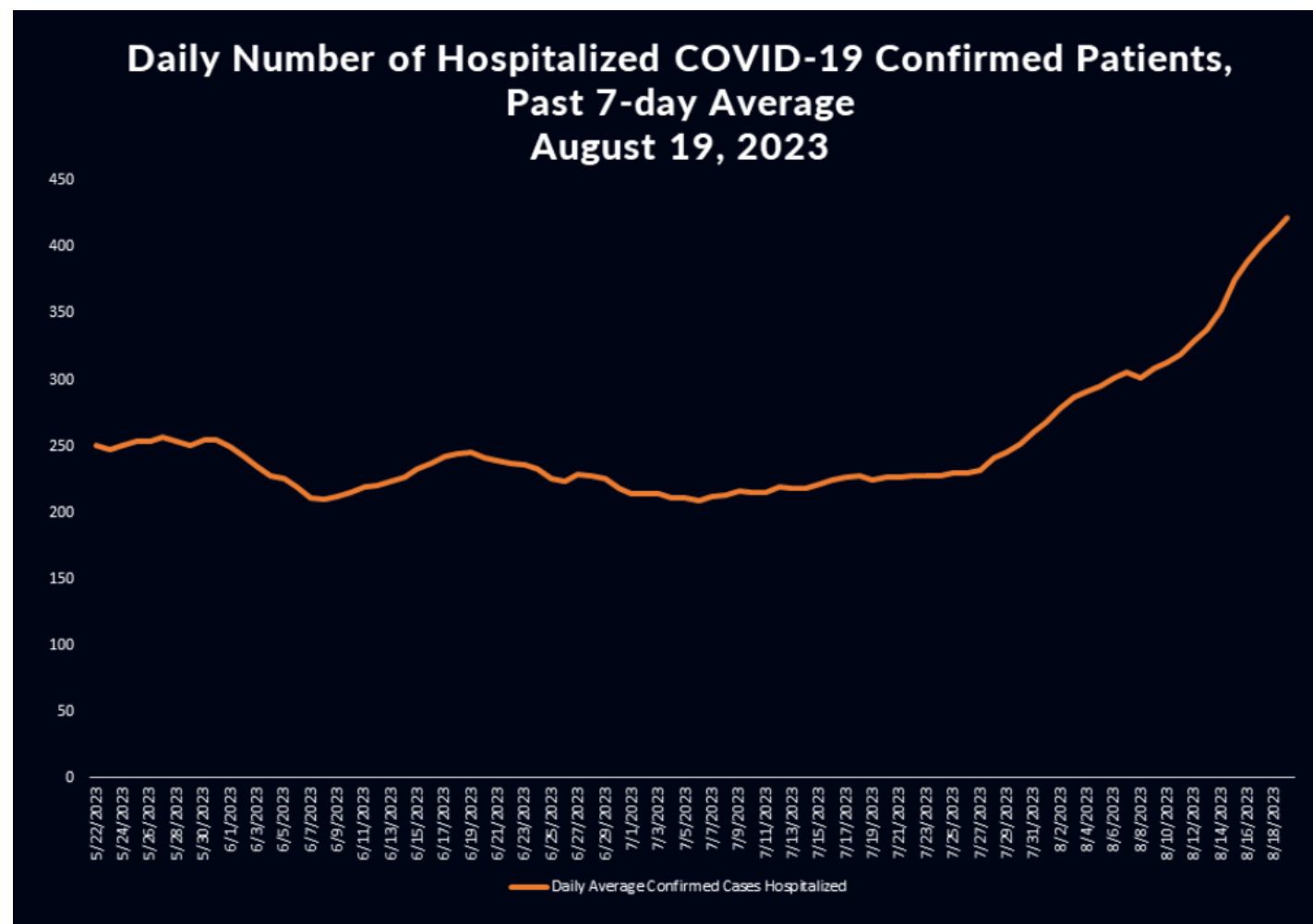
- **Multi-component**
- **L**eadership sets priority
- **E**mpower champions & **E**ngage **E**veryone (including doctors!)
- **A**ncedotes: include alongside data & focus on positive stories
- **D**ecrease barriers





COVID-19 Measures





<http://publichealth.lacounty.gov/media/Coronavirus/data/index.htm#>

Reporting Requirements

- Outbreak reporting **within 24 hours** of knowledge is **mandated** per Title 17, CCR, § 2500 and the [County Health Officer Order on COVID-19 Reporting Requirements](#) to **both**

1. **Public Health (LAC DPH)**

- Phone (888-397-3993 or 213-240-7821)

OR

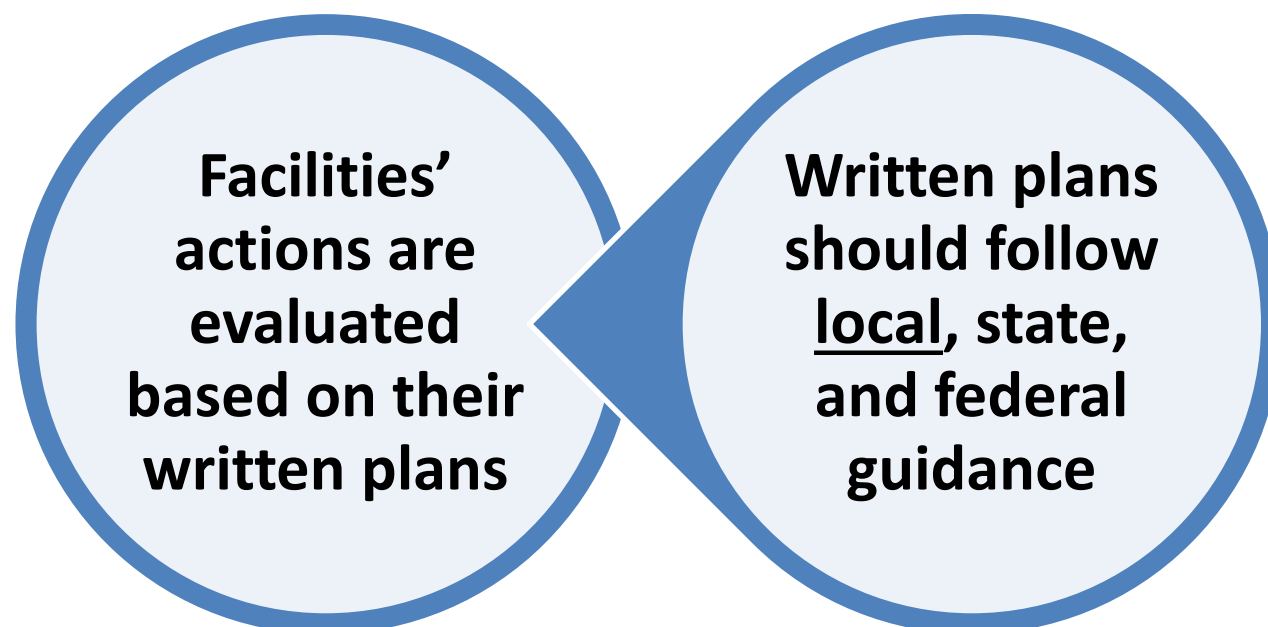
- Submitting via the online form: <https://redcap.link/lac-covid>

AND

2. **Licensing (HFID):** to the local licensing district office for your facility.

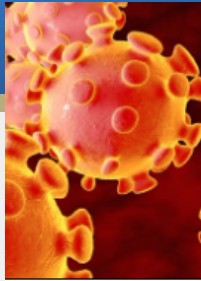
This applies to COVID outbreaks as it does to outbreaks of any other disease.

Why do “recommendations” still matter if PHE “requirements” have ended?



Applies to COVID-19 along with other communicable diseases
(MDROs, group A strep, Legionella, scabies, norovirus, influenza, etc....)

- **Emergency preparedness plans** should include plans in case of hospital overload, staffing shortage, outbreak mitigation measures.



Coronavirus Disease 2019

Guidelines for Preventing & Managing COVID-19 in Skilled Nursing Facilities



This webpage is specifically intended for the medical community.
Click [here](#) to visit DPH's COVID-19 webpage for the general public.

On this page

Updated 8-11-23

- [Summary of Recent Changes](#)
- [Introduction](#)
- [Definitions](#)
- [COVID-19 Vaccination Guidance](#)
- [Outpatient COVID-19 Treatment and Pre-exposure Prophylaxis](#)
- [Infection Prevention and Control Guidance](#)
- [COVID-19 Prevention - General and Administrative Practices](#)
- [Communal Dining, Group Activities, and Visitation](#)
- [COVID-19 Testing](#)
- [Isolation and Quarantine](#)
- [Healthcare Personnel Monitoring and Return](#)

Quick links

Print Version

Other COVID-19 Related Guidelines, Protocols, and Best Practices

- [Infection Prevention Guidance for Healthcare Personnel](#)
- [Best Practices for Improving Vaccination in SNFs](#)
- [Protocol for Oral COVID-19 Antivirals Assessment and Prescription](#)
- [Preventing & Managing Influenza in the Context of COVID-19](#)
- [COVID-19 Case Reporting Protocol for SNFs \(flowchart\)](#)
- [EPA List N: disinfectants active against COVID-19](#)

AFL 22-20 on COVID-19 Outpatient Treatments

September 12, 2022

AFL 22-20

TO: Skilled Nursing Facilities

SUBJECT: Coronavirus Disease 2019 (COVID-19) Treatment Resources for Skilled Nursing Facilities (SNFs)

All Facilities Letter (AFL) Summary

- This AFL provides guidance recommending that all SNF residents with symptomatic COVID-19 be evaluated by a prescribing clinician to be considered for COVID-19 therapeutics.
- In addition, SNFs should evaluate all residents for any oral COVID-19 therapeutics drug-drug interaction risk, renal and hepatic impairment in advance of a COVID-19 diagnosis and indicate such information in charts to facilitate access to appropriate therapeutics when a COVID-19 diagnosis is made.
- This AFL also provides information regarding available guidance and resources for evaluating, prescribing, and obtaining COVID-19 therapeutics for SNF residents.
- This AFL encourages SNFs to provide information for healthcare personnel (HCP) who test positive for COVID-19 to obtain treatment with appropriate therapeutics.

“All SNF residents should be considered eligible to receive treatment for mild-to-moderate COVID-19 and should be evaluated by a prescribing clinician for consideration of COVID-19 therapeutics.”

LAC DPH Outpatient COVID-19 Treatment (Therapeutics) Webpage

Who should receive outpatient therapy for COVID-19?

Clinicians should prescribe COVID-19 treatment to the extent possible to outpatients who meet all of the following:

- Have [mild or moderate COVID-19](#)
- Are within 5 days of symptoms onset for Paxlovid and molnupiravir or 7 days of symptom onset for IV remdesivir
- Have one or more risk factors for severe COVID-19 including:
 - Age over 50 years, especially those 65 and older, regardless of the presence of a medical condition
 - [Being unvaccinated](#) or not being up to date on [COVID-19 vaccinations](#)
 - Being in a racial or ethnic minority group
 - Having common underlying health conditions and behaviors such as physical inactivity, obesity, depression, smoking (former or present), and disabilities. See [CDC comprehensive discussion](#).

For more information, see the CDC webpage [Interim Clinical Considerations for COVID-19 Treatment in Outpatients](#).

To view the IDSA COVID-19 Risk Continuum graphic see [Understanding Risk for Severe COVID-19](#) webpage.

The following factors should NOT be reasons to withhold COVID-19 treatment:

- Being fully or partially vaccinated
- Having a history of prior SARS-CoV-2 infection
- Presence of only mild disease. Patients with **mild** symptoms are included in criteria for outpatient treatment according to the FDA approved label, authorized Fact Sheet for Healthcare Providers for the EUA, and NIH recommendations.
- A lack of recent renal or liver function tests. The FDA does not require assessment of laboratory results.

Clinicians should have a low threshold to prescribe COVID-19 therapeutics given the broad range of individuals who are at higher risk for severe COVID-19 and can benefit from COVID-19 treatment.

Contents

- [Updates](#)
- [Who should receive outpatient therapy](#)
- [Currently recommended treatments](#)
 - [Paxlovid](#)
 - [Remdesivir](#)
 - [Molnupiravir](#)
- [Procuring medication for your patients](#)
- [Medical coverage](#)
- [Resources and contact information](#)

Quick Links

Updated 5-25-23

- [NIH COVID-19 Treatment Guidelines: Nonhospitalized Adults](#)
- [CDC Interim Clinical Considerations for COVID-19 Treatment in Outpatients](#)
- [COVID-19 Drug Interactions Checker- University of Liverpool](#)
- [CDPH Test to Treat !\[\]\(f1e7953d2e6e218818d0040dffb242be_img.jpg\) playbook](#)
- [Therapeutics Locator](#) (for providers)
- [Medicine locator](#) (for the public - oral meds only)
- [Medicine for COVID-19](#) (webpage for the public)

Share with medical director and clinical providers:

<http://publichealth.lacounty.gov/acd/ncorona2019/Therapeutics/>

Fact Sheets

COVID-19 Medications Questions & Answers

We have new, effective tools to take good care of ourselves if we get COVID-19.

COVID-19 medications are safe, free, widely available, and highly effective at preventing COVID-19 illness from becoming serious. They can stop the virus from multiplying in your body, may help you test negative sooner, and may reduce the risk of developing long COVID symptoms.

WHAT are COVID-19 treatments?

Medications that can stop COVID-19 illness from getting serious.

They are free, widely available, and highly effective.

WHO should take COVID-19 treatments?

All Californians 12 years and older who test positive for COVID-19 and have symptoms should seek evaluation for COVID-19 treatments, which are free regardless of insurance or citizenship status. COVID-19 treatments are recommended for those who have certain experiences and conditions that put them at higher risk for worse COVID-19 illness, such as being 50 years and older, not being up-to-date with COVID-19 vaccinations, obesity, physical inactivity, smoking, asthma, diabetes, mental health conditions like depression, being of a racial/ethnic minority, and more.

In fact, most adults and some teens are eligible and should take COVID-19 treatment.

WHEN should I take COVID-19 treatments?

Treatments must be taken within 5-7 days of when symptoms begin. So if you start to feel sick, act fast to get a COVID-19 test and free medication.

Get medications while your illness is mild – don't wait until your illness gets worse.

WHY should I take COVID-19 treatments?

COVID-19 treatments are effective for stopping COVID-19 illness from getting serious. Scientific evidence shows they can cut the risk of serious symptoms, hospitalization, and death in half or more.

Early evidence also suggests they may lower the risk of developing long COVID symptoms.

COVID-19 treatments can also prevent the virus from multiplying in your body and infecting more of your cells, which can help you test negative sooner.



January 2023 • © 2023, California Department of Public Health

COVID-19 Medications Questions & Answers (PDF)

English, Spanish, Chinese (Simplified), Chinese (Traditional), Tagalog, Korean and Vietnamese

Who should take COVID-19 treatments?

Everyone who has symptoms and tests positive for COVID-19 should seek evaluation for medications to treat COVID-19

Safe, highly effective, free, widely available, and recommended for:

Anyone 12 years old and older who:

- Has COVID-19 symptoms, AND
- Has tested positive for COVID-19, AND
- Has certain experiences and conditions that put them at higher risk for worse COVID-19 illness. That's most adults and some teens! The list is broad and includes:
 - Being 50 years of age and older
 - Having common experiences and conditions like obesity, being physical inactive, smoking (either past or present), asthma, diabetes, mental health conditions like depression, being of a racial/ethnic minority, and many more. See here for a comprehensive list: bit.ly/EligibleConditions
 - Being unvaccinated or not up-to-date with COVID-19 vaccination

Call your health care provider or urgent care center or call the statewide COVID-19 hotline at 833-422-4755 to find free COVID-19 treatment.

Learn more about COVID-19 treatments at covid19.ca.gov/treatment

January 2023 • © 2023, California Department of Public Health



As soon as you start to feel sick, act quickly to take a COVID-19 test and get free COVID-19 treatment.

COVID-19 treatments must be taken early, within 5-7 days of when symptoms begin! Do not wait until your illness gets worse.

Why should you take COVID-19 treatment when your illness is still mild?

- COVID-19 treatments are highly effective at preventing COVID illness from getting serious. Scientific evidence shows that they can prevent serious illness, hospitalization, and death from COVID-19 by 50-88%.
- Treatments like the Paxlovid pill can also stop the virus from multiplying in your body and infecting more of your cells, so they can help you test negative sooner.
- Early evidence also suggests COVID-19 treatment may lower the risk of developing long COVID – which are symptoms and medical issues that can last for weeks, months, or years after a COVID-19 infection.

Who should take COVID-19 Treatments (PDF) English, Spanish

Share with residents and families:

<https://www.cdph.ca.gov/Programs/OPA/Pages/Communications-Toolkits/COVID-19-Treatments.aspx>



Well-fitting Mask Recommendations

	“Routine”: None of the criteria to the right are met	Facility has active outbreak ; OR CDC hospitalization level is medium/high ; OR When otherwise directed by LAC DPH
Residents	Yes for the following: - Suspect for COVID - Confirmed with COVID - Close contacts (asymptomatic)	← still applies AND Strongly recommended for <u>all other residents</u>
Staff	Strong recommendation for <u>all</u> . N95 also acceptable.	Yes for <u>all</u> . N95 also accepted.
Visitors	Strongly recommended when visiting residents at high risk (immunocompromised)	← still applies AND Strong recommendation for <u>all other visitors</u> Based on Per CMS QSO 20-39-NH-Revised

Public Health Directives During Outbreak Investigations

Public Health authority during outbreak investigations is not tied to any public health emergencies or health officer orders.

COVID-19 OUTBREAK NOTIFICATION

Please see the attached Health Officer Order.

Site Name: [SITE NAME]

Outbreak Number: [# from IRIS]

Dear [ADMINISTRATOR'S NAME],

The Los Angeles County Department of Public Health (LAC DPH) has received notification of a COVID-19 outbreak at the site specified in this letter among [Choose an item].

The following Public Health staff person will be working with you to investigate this outbreak and to put control measures in place: [OUTBREAK INVESTIGATOR NAME AND TITLE].

Attached to this letter is the Order of the Health Officer for Control of COVID-19: Prevention of COVID-19 Transmission in Skilled Nursing Facilities. You are required by law to comply with this Order in accordance with California Health and Safety Code sections 120175, and 120220.

Based on the preliminary investigation, LAC DPH requires the following control measures and actions:

D. Additional actions may be necessary for outbreak control and management, at the discretion of LAC DPH.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH ORDER OF THE HEALTH OFFICER

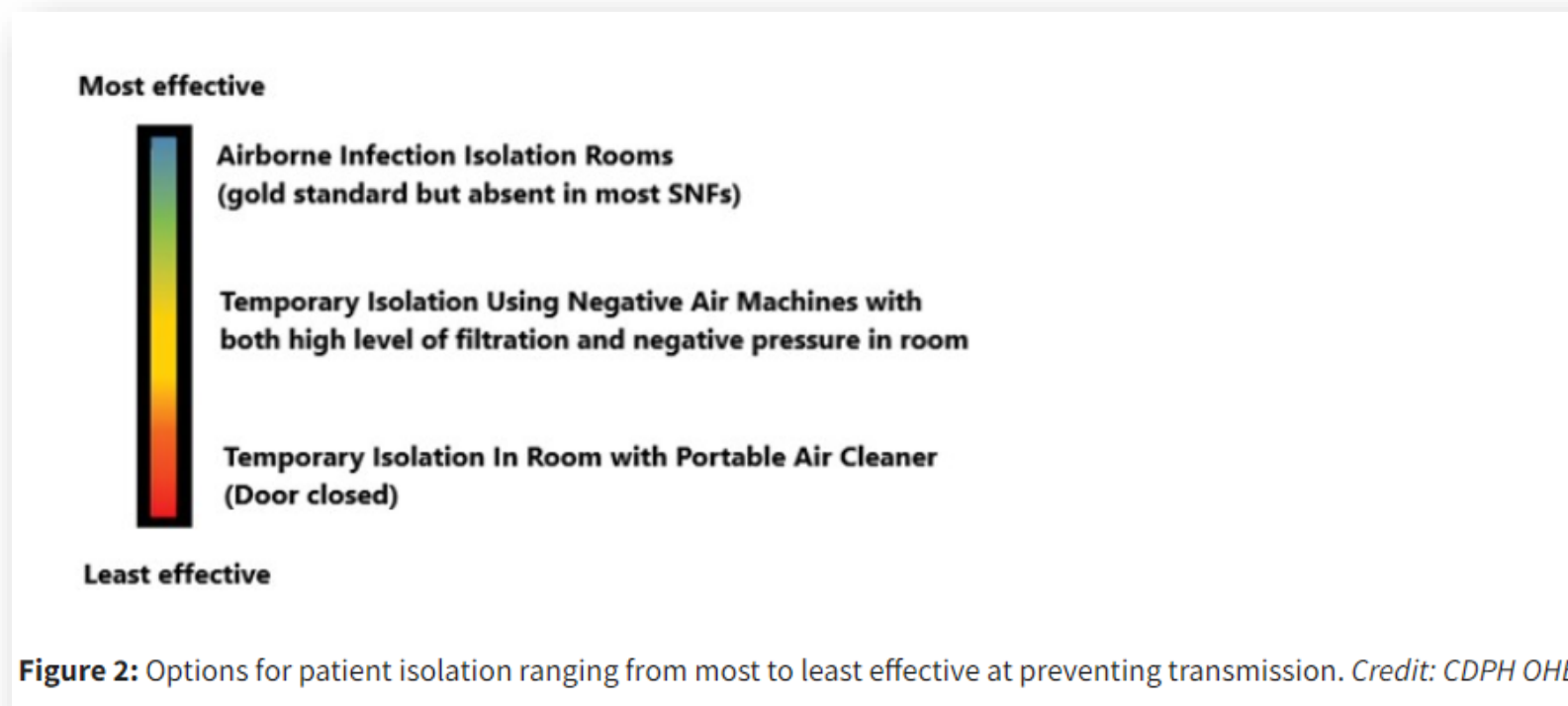


6. ADDITIONAL TERMS

- This Order does not, in any way, restrict: (i) First responder access to the Site(s) named in this Order during an emergency or (ii) local, state or federal officers, investigators, or medical or law enforcement personnel from carrying out their lawful duties at the Site(s) named in this Order.
- If any subsection, sentence, clause, phrase, or word of this Order or any application of it to any person, structure, gathering, or circumstance is held to be invalid or unconstitutional by a decision of a court of competent jurisdiction, then such decision will not affect the validity of the remaining portions or applications of this Order.
- The violation of any provision of this Order constitutes an imminent threat and creates an immediate menace to public health, safety, and welfare. To protect the public's health, the County Health Officer may take additional action(s) for failure to comply with this Order.
- This Order is issued pursuant to California Health and Section Code sections 120175, 120220, and 120225; section 11.02.030 of the Los Angeles County Code; and Title 17 California Codes of Regulations section 2501.

- <https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-120225/>
- http://lacounty-ca.elaws.us/code/coor_title11_div1_ch11.02_pt1_art1_sec11.02.030
- <https://www.law.cornell.edu/regulations/california/17-CCR-2501>

New Guidance for Improving Ventilation to Reduce COVID-19 Transmission Risk



- [Best Practices for Ventilation of Isolation Areas to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities, Long-Term Care Facilities, Hospices, Drug Treatment Facilities, and Homeless Shelters \(June 29, 2023\)](#)
- Describes several practical methods that can be applied in nursing homes and when HCAI (formerly OSHPD) approval is indicated.
- **Collaboration** between facility engineers, HVAC professional consultants, administrators, and IP team

SNFs must be ready to re-establish COVID Isolation Areas (Red Zone) to care for confirmed COVID-19 cases whether admissions, readmissions, or current residents

Table 4. Summary of Isolation and Infection Control Guidance for Residents

Who	Infection Control Measures
Confirmed COVID-19 Case	• Isolate in a designated COVID-19 isolation area (formerly Red Zone)* as per CDPH AFL 23-12. • Place on COVID-19 transmission-based precautions  (staff dons full PPE prior to entering care area or providing care) • Residents should wear well-fitting masks indoors when not in their room for the duration of their isolation period. • Typically, time-based strategy is recommended for determining the isolation duration:

Isolation in place is ONLY for suspected cases (not confirmed yet).
Isolation in place is NOT acceptable for confirmed cases.





Thank you!

**For additional questions, please contact:
LACSNF@ph.lacounty.gov.**

