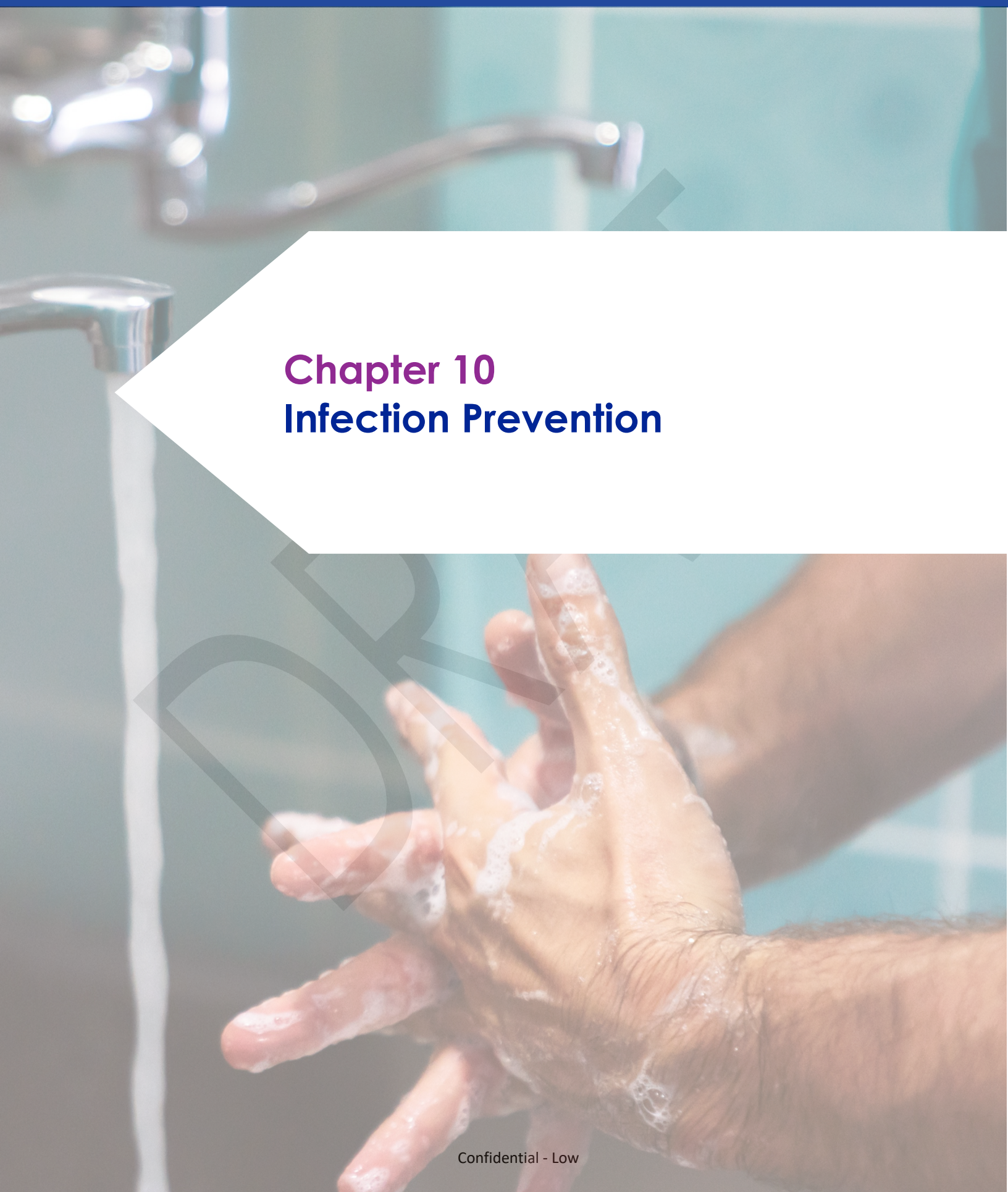

Chapter 10
Infection Prevention

Version History

Version #	Date	Notes
0.1	2/4/2022	First Draft submitted to CPR Team
0.2	7/6/2022	Final Draft revised per review by CPR Leadership
0.3	10/25/2022	Final Draft revised per review by CDPH Directorate
0.4	7/18/2023	Final Draft reformatted
0.5	3/14/2024	Final Draft revised per Expert Review and CPR Leadership Review
1.1	1/13/2025	Final rebranded

Table of Contents

10. Infection Prevention

Public Health Emergency Preparedness and Response Capabilities: Mass Care; Medical Materiel Management and Distribution; Medical Surge.

Related CDPH AAR chapters: Medical Surge.

In this chapter, some abbreviations may be used interchangeably with their respective full spellings for ease of reading.

Chapter Summary

Overview

This section provides a high-level overview of milestones and activities related to this chapter.

The unprecedented nature of the COVID-19 pandemic and its rapid early spread in skilled nursing facilities and other healthcare settings precipitated a renewed focus on infection prevention strategies and tactics. Within the context of this report, infection prevention only addresses California's efforts to prevent the spread of COVID-19 infection; other healthcare-associated infections (HAI) are not within the scope of this report.

CDPH's Center for Healthcare Quality (CHCQ) houses two major programs that played key roles in California's infection prevention efforts: the Licensing and Certification (L&C) Program and the Healthcare-Associated Infections Program. The HAI Program is responsible for the prevention, surveillance, and reporting of HAI and antimicrobial resistance in California's hospitals and other healthcare facilities. As part of this responsibility the program:

- Receives and publicly reports California hospital HAI data to the public and prompt providers to take action to prevent infections;
- Follows up with hospitals that have high infection rates;
- Convenes statewide and regional HAI prevention collaborators to coordinate prevention efforts among facilities that commonly share patients;
- Assists local public health agencies to investigate unusual infection occurrences and outbreaks in healthcare facilities; and
- Conducts assessments, evaluations, and trainings.

The HAI program provides education, training, and guidance to help support facilities in infection prevention practices and infection control management. The HAI Program is comprised of approximately 60 personnel, including a core team of Infection Preventionists (IPs), most of whom are registered nurses with a background in epidemiology in healthcare settings.

In contrast to the HAI Program, which does not serve an enforcement function, CHCQ's L&C Program provides regulatory oversight of California's licensed healthcare facilities and healthcare professionals. This includes certifications, enforcement, and citation for deficient practices. The L&C Program is organized into regional District Offices and has about 900 PYs across the State. The surveyors (also known as health facilities evaluator nurses or "HFENs") conduct on-site surveys of CDPH-licensed facilities (mostly skilled nursing facilities and intermediate care facilities) to determine compliance with federal and state regulations as well as investigate complaints.

CHCQ oversees the approximately 1,300 Skilled Nursing Facilities (SNFs) and 420 general acute care hospitals in California, in addition to other facilities including primary care clinics, hospices, rehabilitation clinics, and many others.

In response to the early 2020 outbreaks of COVID-19 in California's SNFs and other congregate care settings, known as the "SNF Surge," the State invested in strengthening infection prevention and control practices at both the state and facility level. As the vulnerability of SNF populations became apparent and outbreaks grew, the State helped these facilities adopt and implement stronger tactics to prevent the spread of COVID-19. This was a new challenge since these facility types typically do not maintain the same rigorous infection prevention standards as acute-care settings like hospitals.

In collaboration with the California Department of Social Services (CDSS), the California Department of Aging (CDA), and other departments, CDPH offered increased training, education, and consultation to facilities and other State departments on how to prevent COVID-19 infections in SNF and other congregate settings. This collaboration was especially important and innovative, as it helped create a uniform response to congregate-type facilities statewide. To lead the training and consultation efforts, CDPH's HAI Program was expanded, and L&C surveyors assumed more consultative roles while also increasing the frequency of facility visits.

New daily reporting requirements allowed CDPH to monitor and respond to facilities, and the creation of predictive analytical modeling helped identify facilities before they became overwhelmed.

CDPH's response also included changes in policy and guidance that alleviated the burden on SNF and other facilities by granting waivers to certain licensing requirements. CDPH was granted the authority to issue these waivers through the Governor's Executive Orders. In addition to such policy changes, the infection prevention response also led to the creation two new important pieces of legislation that require SNFs to have full-time dedicated IPs and require SNF Medical Directors to obtain advanced certification. In April 2022, DSS also issued guidance that instituted new infection prevention measures in its licensed facilities.

Lastly, CDPH's medical epidemiology team played a pivotal role in investigating outbreaks and uncovering transmission patterns and trends—which was especially critical in early 2020 when much about the virus was unknown. This team's important work informed statewide guidance and facility-wide approaches.

Timeline and Key Milestones

	2020
Winter 2019/2020	• **January to March**: Focus on prevention & mitigation strategies • **February to March**: First Strike Teams deployed to SNFs and Long-Term Care Facilities (LTCFs)
Spring 2020	• **March:** Executive Order N-39-20 granted CDPH authority to waive licensing requirements • **March to April:** First Surge (SNF Surge) • **April:** SNF Survey123 initiated requiring facilities to report key daily metrics • **May 2:** Predictive analytics initiated for SNFs
Summer 2020	• **June to August:** Second Surge (Hospital Surge) • **June 1:** Due date for SNF Mitigation Plans
Fall 2020	• **September 30:** AB 2644 enacted (requiring full-time IPs for SNFs) • **November:** Beginning of Winter Surge
	2021
Winter 2020/2021	• **December to February**: Third Surge (Winter Surge)
Spring 2021	• **March:** Recovery from Winter Surge
Summer 2021	• **August 16:** Executive Order N-12-21 extended CDPH's authority to waive licensing requirements • **End of August:** Delta Variant emerged
Fall 2021	• **September to November**: Fourth Surge (Delta Variant) • **October 6:** AB 749 enacted (requiring SNF Medical Directors to obtain additional certification to improve quality of care)
	2022
Winter 2021/2022	• **December – February:** Fifth Surge (Omicron Surge) • **December 27**: CDC reduced isolation guidance from 10 to five days • **January 8**: CDPH suspended all "return to work" criteria for three weeks to alleviate Statewide staffing crisis
Spring 2022	• **April 4:** DSS issued new infection prevention requirements for its adult and senior care (ASC) facilities
	2023
Winter 2022/2023	• **February 28**: California's State of Emergency for COVID-19 ended
Summer 2023	• **June 30:** CDPH's Medical and Health Coordination Center (MHCC) deactivated from the COVID-19 pandemic response

Main Strengths and Successes

This section describes the Main Strengths and Successes, including findings and corrective actions, related to this chapter. Further elaboration and a more detailed discussion of these strengths and successes can be found in the Analysis of Activities section.

1. Local health jurisdictions and facilities increased their infection control and infection management capabilities.

CDPH's continued reinforcement, visits and surveys helped strengthen infection control practices in SNFs, Long-Term Care Facilities (LTCFs) and other congregate care facilities. The State's constant reminders and survey presence in the facilities helped "drive the point home" that the new protocols had to be followed. In general, SNFs are now capable of doing their own outbreak management, and "there is an amazing new confidence in these facilities," as one expert put it. The new legal mandate for every SNF to have a dedicated IP was "a huge win" and contributes to the new abilities and confidence of the facilities.

Similarly, local health jurisdictions (LHJs) have gained expertise in infection control and management and are increasingly self-sufficient, having benefited from State-provided training and consultation. The capacity for local jurisdictions to conduct facility visits and manage outbreaks has increased tremendously.

Finding/Corrective Action: There is an opportunity to encourage facilities to continue rigorous infection control practices once the COVID-19 pandemic has ended. This could be accomplished through a combination of new regulations, policy, and enforcement. *(ID: Infection Prevention 1)*

2. Data helped inform the response to facilities, especially the use of predictive data analytics and data dashboards.

Data dashboards helped inform the response to outbreaks in facilities and flag facilities in need of State intervention, such as technical assistance, supplies, and resources. In addition, the predictive analytics model developed for SNFs helped prove the value of such analytical modeling to CDPH leadership. The project demonstrated that even if the data was imperfect, valuable information could be collected to inform policy decisions.

Finding/Corrective Action: The use of data to help inform the response was successful and should be continued. *(ID: Infection Prevention 2)*

3. The CHCQ HAI Program and L&C Program increased collaboration. The HAI Program grew and become more visible.

As L&C surveyors found themselves in a more consultative role, a close partnership developed between HAI's IPs and L&C's surveyors. Stronger working relationships were forged between these two groups. In addition, the HAI Program has grown substantially, increasing its visibility and profile within CDPH and the State. With additional funding secured from CDC, the program's profile has been raised, furthering its ability to combat all healthcare-associated infections, not just COVID-19. CDPH IPs built close relationships with facility staff and are recognized by facilities as trusted messengers who provide expertise on infection control.

Finding/Corrective Action: CDPH has an opportunity to maintain the collaborative relationship between CHCQ programs, as well as the opportunity to leverage the newly expanded HAI Program to address all healthcare-associated infections. *(ID: Infection Prevention 3)*

4. CDPH, DSS, and CDA worked together to prevent infections. They also established trusted relationships and effective communication channels with facilities.

CDPH, DSS, and CDA, as the core collaborative State team, worked closely together to support and strengthen infection control practices in all congregate care/residential facilities statewide, regardless of the oversight entity. This team met regularly and instituted meetings with facilities (including SNFs, LTCFs, and others) multiple times a week. These meetings created a forum for candid dialogue and fostered a setting where facilities could openly ask questions to regulatory bodies.

Finding/Corrective Action: The collaborative relationships and new communication channels between State teams and facilities should be maintained and meetings should continue to occur. *(ID: Infection Prevention 4)*

5. Through the Governor's Executive Orders, CDPH created innovative and flexible solutions to help facilities prevent infections.

Governor's Executive Orders enabled innovative solutions and granted CDPH "enormous flexibility" to respond quickly and creatively to medical surges and infection management challenges. CDPH's authority to temporarily waive licensing requirements was used to grant facilities increased flexibility in staffing, training, and use of space requirements – allowing them to focus on expanding capacity for care to avoid being overwhelmed. In addition, Executive Orders enabled expedited procurement and contracting processes, which allowed the State to quickly provide facilities with supplies and resources.

Finding/Corrective Action: Executive Orders gave CDPH flexibility to experiment with various tools and solutions to better support facilities. *(ID: Infection Prevention 5)*

See related the findings *Contracting and Procurement* – 1 (in the Contracting and Procurement chapter of this AAR) and *Enterprise Tech – 3* (in the Enterprise Technology chapter of this AAR).

Main Challenges and Lessons Learned

This section describes the Main Challenges and Lessons Learned, including findings and corrective actions, related to this chapter. Further elaboration and a more detailed discussion of these challenges and lessons learned can be found in the Analysis of Activities section.

6. Early in the response the lack of personal protective equipment (PPE), coupled with the lack of knowledge about how to properly use it, hindered infection prevention work.

The worldwide PPE shortage and supply chain issues in early Spring 2020 made it extremely difficult for the State to procure PPE, which, in turn, hindered IPs and surveyors from successfully carrying out their work. Without proper PPE, some staff did not feel safe and refused to visit facilities experiencing outbreaks. In addition, there was a lack of knowledge in facilities regarding proper PPE protocols, including the importance of "fit testing" and the need to change PPE when handling residents in the same zone or area.

Finding/Corrective Action: To prepare for future pandemics, it will be important to establish and maintain a State PPE stockpile and administer continuous training to both State and facility staff about how to properly use PPE, especially in quarantine zones. *(ID: Infection Prevention 6)*

7. State and facility staff experienced significant emotional and psychological burn-out.

Serving on the front lines by visiting facilities dealing with outbreaks took an enormous emotional and psychological toll on IPs and L&C surveyors, leading to burnout. Many facilities were overwhelmed by patient and staff infections and deaths, and in some instances facility staff had abandoned their patients. State staff, visiting facility after facility, were continually exposed to ongoing grief, fear, and stress. At the same time, surveyors were asked to work long hours (often without additional pay) due to staffing shortages and to adapt to constantly changing circumstances and priorities. "It was a very scary and eerie time. It was the hardest experience we've ever gone through. We'd go to facilities, and it would just break our hearts."

Finding/Corrective Action: CDPH can anticipate and plan for staff burnout in future pandemics through the development of a staffing mitigation plan. *(ID: Infection Prevention 7)*

8. Pay cuts, no overtime pay, and increased workload led to poor morale among State staff.

In June 2020, the Governor's administration reduced most workers' pay by almost 10% to address a projected budget deficit. This across-the-board reduction remained in effect throughout the winter 2020/2021 medical surge. The pay cut was reversed a year later in June 2021, but during the prior 12 months workers regularly worked 7-day work weeks without overtime compensation. This resulted in poor morale and discouragement—especially among the licensing and certification team—that still exists today. As one supervisor noted, "There was a pay decrease of 10% statewide, but we were supposed to be essential workers. Essential workers need to stay on the books."

Finding/Corrective Action: To motivate staff and improve morale, CDPH needs to consider authorizing overtime pay and/or reduction exemptions for essential workers. *(ID: Infection Prevention 8)*

9. Staffing shortages at the facilities and State placed additional strain on an already-overwhelmed workforce.

The shortage of staff at the facility and State level was a major challenge. At the State level, CHCQ experienced staffing shortages due to staff redirections, early retirements, and disability claims. These shortages placed additional stress on an already-overwhelmed State workforce. Additionally, since the IP role is highly specialized and unique, it is difficult to find qualified and willing personnel, which exacerbated staffing challenges.

At the facility level, staffing shortages were caused by school closures, family infections, and absenteeism due to fear of infection. During the winter 2020/2021 surge, entire facilities were being abandoned by staff. Leadership indicated that successful infection prevention relies on having a sufficient supply of trained and capable staff.

Finding/Corrective Action: CDPH needs to anticipate and plan for the impact of staffing level reductions at both the facility and State level. At the facility level, this could include identifying and prioritizing in advance

which State interventions to deploy to best support facilities experiencing severe staffing shortages. These interventions may include offering more IP cross-training to facility staff, deploying contract staff to support facilities, granting policy exceptions to allow employees to return to work when ill, providing additional tests and other materials, and others. *(ID: Infection Prevention 9)*

10. Conflicting messages from different State entities created confusion for both facility and State staff.

CHCQ's expanded responsibility to provide consultations, trainings, and visits for facilities licensed by other State departments was made more challenging by confusing and inconsistent messaging. The nature of the response necessitated quickly changing guidance and communications. However, facilities regulated by different entities often received direction from too many sources. This created conflicting messages and placed directives in opposition to each other. For instance, when State response teams began visiting SNFs during the spring 2020 surge, EMSA's CAL-MAT teams and CHCQ's surveyor teams initially followed their individual infection prevention policies and procedures, which were not aligned. Sometimes, when receiving conflicting instructions, facilities adhered to the guidance of the entity that was more punitive.

Finding/Corrective Action: Improved coordination between CDPH and other entities is needed to avoid confusion. In particular, CDPH can improve coordination with CDSS regarding messaging to congregate care facilities, and improve communication between CHCQ and its own District Offices. *(ID: Infection Prevention 10)*

11. Many SNFs lacked Certified Medical Directors.

In many SNFs, the lack of involvement or presence of medical directors placed an enormous burden on CHCQ and SNF IPs. Infection control and management is a team responsibility, but many SNFs simply did not have a medical director available to lead the effort. Facilities, in turn, depended wholly on State or facility IPs for guidance on medical issues, and the IPs felt overwhelmed by a complete responsibility that should have been shared. California has already taken action to close this gap with the passage of AB 749, which requires medical directors of SNFs to be certified within five years of starting their position. This additional

certification by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) is designed to improve facilities' quality of care by providing enhanced training and education for physicians serving as medical directors.

Finding/Corrective Action: Recently enacted legislation requiring additional certifications for SNF medical directors is an important step towards improving quality of care. *(ID: Infection Prevention 11)*

12. Suspending routine licensing, oversight, and enforcement activities during the pandemic created backlogs that will take years to resolve.

As CHCQ pivoted towards providing more educational and consultative services to help strengthen infection control practices in facilities, its traditional core licensing, oversight, and enforcement activities were put on hold. This created a backlog of cases without a plan to address them. Now that the L&C program is beginning to resume its survey cycle and investigating complaints and allegations, the prioritization of backlogged cases needs to be determined. Leaders estimate that it will take several years to recover from the suspension of regular duties and achieve a "normal" survey cadence.

Finding/Corrective Action: CHCQ will need to develop plans to continue critical oversight activities and complaint investigations even during public health emergencies. *(ID: Infection Prevention 12)*

13. Data and information-sharing challenges, including the lack of a dashboard, made it difficult to obtain a comprehensive regional picture of congregate care and congregate residential facilities.

See the discussion on Data and Information-Sharing Challenges in the Infection Prevention, Data & Technology section.

Finding/Corrective Action: While data issues have improved throughout the response, different facility reporting requirements still make it difficult to use data to inform decision-making. *(ID: Infection Prevention 13)*

14. Lack of State authority, suspensions of facility licensing visits, and facility diversity, made it difficult to implement infection control practices in congregate residential and other facilities.

While CDPH enjoyed a strong collaborative leadership with CDSS, the limitations of the State's authority over CDSS-licensed facilities made it difficult to implement infection prevention practices. These congregate residential facilities provide services for vulnerable individuals, and while they experienced the same outbreaks as SNFs congregate residential facilities are not healthcare settings. Crucially, they do not possess medical directors or healthcare personnel and are not intended to provide adequate infection control. While CDPH was able to make recommendations to these facilities via CDSS, it does not have legal authority over these facilities, and even CDSS's authority is limited. Furthermore, while CDPH field staff continued visiting its facilities throughout the pandemic after implementing safety measures, not all departments possessed the same safety tools, and where sometimes unable to continue regular licensing visits.

An additional challenge is the diversity of facility type and size. Congregate residential facilities are far more varied in terms of size and population, ranging from small 6-bed households to larger corporate-owned facilities. The diversity of facility types led to different and diverse challenges. For instance, several experts mentioned the unique infection prevention challenges associated with memory care units for residents with dementia, who are prone to wandering. According to leadership, "we haven't solved yet how to optimally implement infection control practices in these facilities."

Finding/Corrective Action: The State needs to develop centralized solutions to help implement infection prevention practices in congregate residential facilities, especially those that fall outside of CDPH's regulatory purview. *(ID: Infection Prevention 14)*

15. Infection prevention training needs to be more versatile, convenient, and timely.

While CDPH and CDSS developed and delivered new infection prevention trainings, there is a need for more versatile, convenient, and timely training. Infection prevention training should be available in real-time and should be better integrated into the onboarding process for facilities. Experts indicated that training should be more nuanced, available in different language and formats, and customized for different audiences. For example, there should be training for facility

staff, as well as the State staff who oversee the facilities so they can provide better assistance. Lastly, if CDPH were to recommend that SNFs implement a red/yellow/green quarantine framework in the future, it should provide training and education around yellow zones, which were a common source of confusing during the COVID-19 pandemic.

Finding/Corrective Action: While CDPH created and delivered new infection prevention trainings during the pandemic, training can still be improved by customizing content to different audiences, making content available in different formats and languages, and addressing commonly misunderstood topics. *(ID: Infection Prevention 15)*

16. Communication with facilities needs to be improved by providing written guidance in multiple languages that is easily understood.

While guidance to facilities was provided in multiple, required languages, it was not always clearly written and easily understandable in multiple languages. State guidance needs to be understood not only by the facility leadership, but by the line staff as well. Much State guidance is written in very complex legal terms, and if facilities do not understand it, they run the risk of being cited. According to one respondent, "it's a matter of changing the culture of how we write guidance and balancing between the need to have a legally enforceable document with something that is also understandable." While this challenge is not unique to the pandemic, the need to quickly disseminate information to facilities during the pandemic made this challenge particularly visible.

Finding/Corrective Action: CDPH can improve its communication with facilities by trying to write guidance that is simple, clear, and easily understood in multiple languages. *(ID: Infection Prevention 16)*

17. During the Omicron surge, policy decisions and testing shortages contributed to a large discrepancy between requirements for SNF visitors and SNF healthcare workers.

During the Omicron Surge over Winter 2021/2022, a number of factors, including surging case numbers, a statewide staffing shortage, and revised guidance that shortened isolation from 10 to five days, led CDPH to relax criteria in order to let SNF workers return to work. At the same

time, in order to mitigate risks within facilities, the State enacted stringent vaccination and testing requirements for all visitors. As visitors struggled to obtain scarce testing supplies so they could visit their loved ones, many were angered at what one leader termed "the disconnect between what was required for visitors and what was required for healthcare personnel." While there was a shortage in tests, leaders suggested that much testing was occurring in settings that were not as critical as SNFs, which could be remedied in the future by earmarking tests for SNF residents and workers.

Finding/Corrective Action: CDPH should develop a strategy to ensure there are enough tests dedicated to the SNF population and SNF workers, potentially by allocating tests in the stockpile to specific purposes and populations. *(ID: Infection Prevention 17)*

Analysis of Activities

This section elaborates and provides more detail on the findings, corrective actions, and lessons learned that are presented in the Main Strengths and Successes and the Main Challenges and Lessons Learned sections.

Expanded HAI Infection Prevention Program to Non-Acute Healthcare Settings and other Congregate Care and Residential Settings

- Prior to the pandemic, CDPH's HAI Program included only acute care hospitals. However, as COVID-19 outbreaks occurred in skilled nursing facilities, assisted living facilities, and other non-acute congregate care and congregate residential settings, California had to adapt the HAI program to include these facilities that have traditionally not been required to maintain the same level of infection prevention standards as acute care hospitals.
- While these types of non-medical settings have basic infection control and basic sanitation practices in place, until the pandemic there had not been the need for more rigorous hospital-level infection prevention strategies. The rapid outbreaks of COVID-19 in such settings, however, made it clear that to control the spread of the disease, more robust infection control practices had to be put in place quickly.
- This required coordination with departments who oversee different facility types. CDPH coordinated the State's response to all State-operated congregate care and congregate residential facilities, including those licensed by other departments and agencies. As the subject matter expert on infection prevention, CDPH triaged its expertise to congregate residents that were most at risk. With CDPH coordinating the congregate response and providing subject matter expertise, it helped "the State have a single voice and avoid conflicting advice for one type of facility versus another," as one expert put it.
- The expanded types of facilities included assisted living, residential care, and adult day care, which are licensed by the CDSS. CDSS oversees approximately 45,000 facilities throughout the State; of those, 14,500 are considered adult and senior care facilities. Additionally, CDPH and CDSS coordinated with the California Department of Aging (CDA). CDA advised on resident rights, provided input on policy and guidance related

to congregate facilities, and conducted outreach. CDPH, CDSS, and CDA partnered in disseminating rapidly changing information and guidance, while tailoring the guidance to their unique stakeholders.

- CDPH also coordinated with the California Department of State Hospitals (DSH) on infection control, as well as the California Department of Corrections and Rehabilitation (CDCR), which oversees California's prison system. CDPH's HAI Program provided consultation services and clinical expertise to CDCR on preventing infection outbreaks in prison settings.
- As part of its central coordinating role, CDPH's HAI Program also provided technical assistance to facilities and departments who were not well-versed in infection control. In general, congregate residential facilities—and the departments who oversee them—have historically not had to maintain the infection prevention practices common in acute care hospitals, or even skilled nursing facilities. To help educate these facilities and departments, CDPH's team of IPs provided training and consultation on infection control practices (such as hand hygiene, injection safety, environmental cleaning, disinfection, and mask fit testing). They would also visit facilities experiencing COVID-19 outbreaks, conduct an assessment, and make recommendations. All of these efforts were supported by the redirection of 30 staff to the HAI Program in spring 2020.
- Despite the technical assistance provided to other departments and centers within CalHHS on how to conduct facility visits safely, not all were able to resume licensing visits during the pandemic. This contributed to a lopsided approach: while facilities of all types were experiencing outbreaks, for the most part, only those licensed by CDPH received in-person visits and support.

Transitioned Licensing Surveyors from Enforcement to Consultative Roles

- Historically CHCQ's licensing and certification program enforces, assesses, evaluates, and, if necessary, cites facilities for deficient practices. However, the unprecedented and overwhelming nature of the pandemic led to licensing and certification staff assuming a consultative and educational role during their facility visits. In the early months of the pandemic (Spring 2020), there was uncertainty and limited knowledge about COVID-19. As one expert put it, "we were not going to cite facilities for something that wasn't understood." Infection prevention leadership

indicated that as more was learned about COVID-19, more regulations and guidance were developed. Correspondingly, the licensing and certification teams ultimately returned to more of an enforcement function and were instructed to cite facilities who were not following new guidance.

- However, expanding enforcement to training and education created ambiguity with some surveyors, who, in early 2020, were sometimes unsure when they should be consulting with facilities versus assessing and enforcing infection control practices.

SNF Populations Extremely Vulnerable to COVID-19 Infection and Worker Transmission

- In 2020, patients in SNFs were generally sicker and needed more support than their historical counterparts. As one expert put it, "the nursing home residents of today would have been in the hospital 30 years ago." These facilities were not originally designed to care for such a sick population at high risk of infectious diseases and outbreaks: "that's just not what they were set up to do, and it's catching up to us now," one SME noted.
- Although infection prevention controls in SNFs lagged behind the more rigorous hospital practices, simply implementing more aggressive practices in these non-acute facilities was also not advisable. SNF and other congregate facilities are often "people's homes," as one expert commented, and implementing "hospital-level infection prevention measures, such as isolation or quarantine, is not possible for the long-term."
- The vulnerability of this population, coupled with the lack of early understanding about COVID-19 transmission, lack of testing, PPE shortages, and staffing shortages, led to outbreaks in SNF and other congregate facilities. Asymptomatic staff members were the primary drivers of outbreaks in these facilities, according to interviews with SMEs. Facility workers were the main "vectors" of the virus in terms of bringing it into the facilities, where it spread rapidly among residents and other staff. The role played by facility workers and staff members in transmission was not recognized early in the pandemic.

CDPH Released Guidance on "Red/Yellow/Green" Framework for SNFs

- In late fall 2020, CDPH released AFL 20-74, which provided recommendations to SNFS on resident placement and movement according to a "red/yellow/green" framework. This framework or system was a way of designating zones within SNFs where COVID-19-positive residents were isolated (red zones) and residents with known COVID-19 exposures were quarantined (yellow zones) while awaiting test results. All other areas in the facility without known exposures were considered green zones. Facilities were advised to group residents into these three separate cohorts.
- Although the red/yellow/green framework was easy to teach, there were misunderstandings and challenges with the framework, especially related to the yellow zone designation. According to one SME, it was a common misconception that all residents who had been exposed (e.g., whose roommate had tested positive) should be moved from their rooms to a yellow zone. The practice of moving residents frequently led to new COVID-19 exposures, in which one resident who turned positive would then exposure their new roommate who was still negative following their prior exposure. Moreover, staff efforts to conserve PPE through extended use and reuse of gowns and gloves, especially with zones, led to common misunderstandings; many staff assumed they did not need to change gowns or gloves and perform hand hygiene between residents in the same zone, even when PPE supplies were adequate.
- HAI spent considerable time clarifying the guidance around quarantine and the yellow zone, emphasizing that the yellow zone is not a designated area within a facility, but rather a status that should be applied to exposed residents within their existing room.
- Furthermore, moving residents based only on COVID-19 status led to many exposures between residents with discordant multidrug resistant organisms (MDRO) status, including Candida auris. According to one SME, as a result of this patient movement and widespread extended use and reuse of PPE within zones, "we saw substantial outbreaks of MDROs during the first couple of years of the pandemic, and the increased incidence of MDROs and has persisted."
- Overall, the challenges associated with implementing the red/yellow/green framework revealed an important lesson learned for CDPH's HAI program. Going forward, one SME noted that the program's focus is on better educating healthcare personnel and staff around

proper infection control principles and practices, including changing PPE and practicing hand hygiene—even for those residents or roommates are residing in the same "zone."

Increased Facility Visits via State Mitigation Plan and Federal Surveys

- Historically, according to federal and State guidance, licensed facility survey cycles include a single annual visit to facilities. However, it became clear very early in the pandemic that this typical level of oversight would be insufficient to effectively prevent and control COVID-19 infections in SNFs, which were at the epicenter of the first surge.
- On May 11, 2020, CDPH issued All Facilities Letter 20-52 (AFL) requiring SNFs to develop and implement a facility-specific COVID-19 mitigation plan. The AFL also enabled CHCQ surveyors to visit SNFs every 6 to 8 weeks to verify adherence to the plans. This allowed surveyors to visit SNFs much more regularly, giving the State a critical "real-time" view of current outbreaks.
- In addition to these State mitigation plan surveys, the federal Centers for Medicaid and Medicare Services (CMS) tasked CHCQ with performing federal infection control (FIC) surveys. Any California facility with a patient in their facility on Medicare receives reimbursement from Medicare and must therefore be certified federally by CMS. Each week CMS identified a list of facilities for CHCQ to survey based on reported outbreaks.

New Legislation Required Full-Time SNF Infection Preventionists and Medical Director Certification, and New Guidance Updated Infection Control Requirements for DSS-Licensed Facilities

- Another milestone that helped strengthen infection prevention practices across the State was Assembly Bill 2644. The bill, which was signed on September 29, 2020, and went into effect on January 1, 2021, mandated that SNFs 1) have a full-time, dedicated IP; 2) have a plan in place for infection prevention quality control; and 3) require all healthcare personnel receive annual infection prevention control training. CDPH developed a recommended minimum number of hours and content for this training in AFL-20-84. CDPH will verify compliance with the training requirements via record review during periodic surveys. AB 2644 also requires SNFs to report communicable disease data to CDPH during a declared emergency related to the communicable disease.

- California is the first state in the U.S. to require that every SNF have a full-time IP—a significant accomplishment. The CHCQ team, with input from its medical epidemiologists, provided subject matter expertise in drafting AB 2644.
- In addition to this legislation, California also passed Assembly Bill 749 in October 2021. This bill requires all SNF medical directors to be certified by the American Board of Post-Acute and Long-Term Care Medicine within 5 years of starting work as a medical director. The theory being that the presence of a certified medical director in a facility increases the quality of care provided in that facility. California currently requires no qualifications for medical directors beyond an active medical license. Many subject matter experts noted that the lack of direction from SNF medical directors during the surges as a huge issue that caused sole responsibility for medical decision-making to fall to IPs.
- In April 2022, DSS issued updated infection prevention regulations for its adult and senior care facilities via its rule-making process. The new requirements, as communicated in the Provider Information Notice, include the requirement for all facilities to include an infection control plan in the Plan of Operation. The plan must include training requirements, documentation requirements, and the designation of an IP staffing role.

New Trainings Developed for State Staff and Congregate Facilities

- The need to immediately strengthen infection prevention practices in congregate facilities quickly prompted the creation of new training programs. CHQC developed an online training program for SNF infection preventionists, and DSS leveraged this training, reaching out to its approximately 45,000 facilities to offer this virtual training. Additionally, the HAI Program held an expedited education program and competency evaluation for its 30 new redirected IPs to provide them with expertise in healthcare-associated infections.
- The need for ongoing training was emphasized during the response to the Omicron surge, which occurred over Fall 2021/Winter 2022. During this surge, almost two years into the pandemic, facilities were already weary and experiencing COVID-19 fatigue and chronic staffing shortages. Yet CDPH emphasized the importance of "doubling down" on outbreak prevention and management strategies that had been taught over the previous year to SNFs, hospitals, and other healthcare settings. "There is so

much turnover, you really do need to reinforce the training and make sure that people working at these facilities understand why it's important," one leader noted.

Policy Response: Waiving Licensing Requirements via All Facility Letters

- See discussion in the Medical Surge chapter in this AAR.

Developed Predictive Analytics for SNFs to Anticipate Outbreaks

- One of the most important data developments related to Infection Prevention was the creation of a predictive analytics model that helped CDPH identify which SNFs were at highest risk for COVID-19 outbreaks. CDPH data teams developed this analytics model, which became known as the "SNF Priority Level Index," synthesized various data sets and assigned a risk score to skilled nursing facilities based on several variables that were correlated with COVID-19 incidence—such as the amount of PPE supply on-hand, staffing rations, bed counts, and if the facility had a staffing waiver in place.
- The goal of using the Priority Level Index model was not to focus on facilities currently experiencing outbreaks, but rather to identify facilities at high risk of *future* outbreaks so that CDPH could intervene and provide support proactively. The Priority Level Index was produced and distributed each morning, and CHCQ District Offices would proactively reach out to facilities scoring above a certain index to help or resources. Multiple leaders noted how successful the model was; it was a "gamechanger" that helped the State be more proactive and have a targeted, precise approach.
- The predictive analytics model developed for SNFs informed the broader predictive analytics schema for many other response workstreams in California.

Medical Epidemiology: Investigating Early Outbreaks and Developing Responses

- CHCQ's team of medical epidemiologists played an important role in developing and strengthening infection prevention practices, as well as investigating outbreaks in skilled nursing facilities in early 2020. These physicians, who possess specialized training in infectious diseases and public health, were tasked with investigating how outbreaks started, how

the virus spreads in facilities, and how to prevent future transmissions. The medical epidemiology team played a critical role in spring 2020, when there were many unknowns about COVID-19, including how it spread.

- The team conducted epidemiological investigations of outbreaks at skilled nursing facilities and acute care hospitals. During initial in-depth investigations, CDPH gathered knowledge about outbreak patterns and virus transmission, including the role played by asymptomatic transmission. The resulting recognition of the importance of asymptomatic transmission informed testing guidance and facility-wide approaches.
- In summer 2020, once transmission was better understood, the medical epidemiology team transitioned from conducting in-depth investigations of most outbreaks to investigations of unusual situations. Since outbreaks typically follow a known pattern, CHCQ's Infection Preventionists could provide on-site assistance and LHJs were also able to assist facilities with outbreak management. Having laid this important foundation and response principles, the medical epidemiology team shifted to answering specific questions about outbreaks and conducting investigations of more unusual patterns.
- In addition to epidemiological investigations, the team also provided technical feedback on State policies and requirements for facilities as they were developed. Beginning in January 2020, they were also early champions of the use of N95 masks for healthcare workers who were caring for COVID-positive patients. Before transmission was widely understood, the use of N95s for healthcare workers was controversial, but CDPH's medical epidemiologist team continued to advocate for their use until it was widely accepted.

Omicron Surge: Applying Lessons Learned from Previous Four Surges

- By the time the Omicron surge began in late Fall 2021, the State had been through four surges and was able to draw on this experience during the Omicron response. The pandemic landscape had also changed: whereas there were no vaccines available during the first surge, by the time Omicron hit most SNF residents had been vaccinated and received their first booster shots. From an infection prevention standpoint, CDPH's response "really showed a lot of success in implementing lessons learned,

not just on the State side, but on the facility side as well," one leader noted.

- The availability of vaccines and boosters, increased testing, masking, and stronger infection control practices all contributed to lower case numbers, hospitalizations, and deaths for the SNF population compared to the rest of the community. Despite this variant's infectiousness, SNF resident case numbers and deaths was "proportionally much lower during Omicron than during previous surges." Armed with these multiple interventions, "we knew better how to implement them this time around."
- Comparing the State's response to the Omicron surge with previous surges, one leader summarized, "with more data and more experience, we were able to better put policies and practices into place to help protect people."

Omicron Surge: Severe Staffing Shortage Prompts Difficult Policy Decisions

- In late Fall 2021, as the Omicron surge grew, the dramatic spike in case numbers helped contributed to a severe staffing shortage. At the same time, in late December, the CDC adjusted its recommended isolation duration from 10 days to five days along with recommended testing and "return to work" strategies. California also shortened its recommendation isolation duration, which was designed in part to alleviate the severe shortage of healthcare personnel in all facility type, including GACHs and SNFs. According to one leader, "it was very challenging to calibrate the guidance to balance infection control purposes, but also meet staffing needs in the facilities given the huge shortage."
- It soon became clear that even with the shortened isolation, the State was still in a critical staffing shortage. In response, the State temporarily suspended all of its "return to work" criteria—which, in some cases, allowed healthcare workers who had been exposed to and/or tested positive to COVID-19 to resume their duties (e.g., to care for COVID-19 positive patients). This unique three-week period took place between January 8—February 1, 2022. Once it ended, the shortened isolation guidance, which called for testing to return to work early, went back into effect—during a widespread shortage of tests. In this complicated landscape, CDPH had to develop IP guidance around the shortened duration and testing to end isolation early, and "we were communicating

all of this and recommending the test to work in the context of shortages in testing supplies," as one leader noted.

- At the same time, CDPH enacted very stringent SNF visitation requirements, requiring visitors to be vaccinated and test negative to have an indoor visit with their loved ones. One SME explained the conundrum: "It was so sad that visitors were being excluded or required to get their hands on these precious tests to have a visit, yet workers were coming in every day, and not all of them were vaccinated and were getting tested less frequently than visitors." While this was a "well-meaning intervention" designed to mitigate risk, it severely limited visitation options and was perceived by some to "penalize" visitors while allowed COVID-19 positive workers return to work.
- The combination of these unique events created an extremely challenging situation. An important lesson learned related to the "disconnect" in testing requirements for SNF visitors and SNF workers is the need to designate adequate tests specifically for this purpose and population. "Broadly speaking, there was a shortage in tests," one leader noted, "but perhaps there were a lot of tests being done in settings that weren't as critical as these."

Equity

This section describes equity considerations specific to this chapter.

- Health equity was not a formal metric or consideration during the infection prevention work that was accomplished during California's medical surges related to congregate care settings. In general, CDPH aims to prevent infections whenever there is an opportunity. During the first surge in early spring 2020, amidst outbreaks in skilled nursing facilities and other congregate care facilities, the focus was on preventing and responding to any facility in need.
- Although equity was not a formal metric, it was a part of CDPH's response and drove operational work on the ground. "We weren't framing it that way, but we did have the lens in that we were focusing on facilities that served lower-income individuals," one leader noted. Facilities that served individuals on SSI generally had a limited ability to pay for extra PPE or staffing, as they "simply weren't able to afford it." The State therefore paid special attention to these vulnerable facilities and worked to provide them with access to training and other resources such as vaccines as early as possible.
- For CDSS-licensed facilities, equity was incorporated as a factor when allocating assistance to different facility types. In terms of providing assistance, CDSS emphasized smaller, independently owned "mom and pop" facilities since they lack the infrastructure or resources available to facilities owned by large chains or corporations. The CDPH/CDSS team worked to target and direct resources to smaller, independently owned facilities (e.g., less than 10 beds). These facilities, especially those serving low-income residents, such as SSI recipients, were targeted in terms of outreach, technical assistance, and resources such as PPE.
- However, many experts acknowledged there is now an opportunity to conduct a retrospective analysis and to develop preventive practices with an equity lens. CHCQ conducted a preliminary analysis involving neighborhood-level social determinants of health and found associations between lower socio-economic status associated with SNFs in those neighborhoods with higher number of COVID-19 cases.
- For further information on the allocation of scarce resources, see the MAC Group and Scarce Resource Allocation chapter in this AAR.

Data and Technology

This section describes data and technology specific to this chapter.

Skilled Nursing Facility Data

SNF Survey123

- In spring 2020, following a spike in cases in SNFs, CDPH began requiring SNFs to report daily on several key metrics using Survey123. This daily real-time report was known as the SNF Survey123 and it collected key data points at the facility level, including COVID-19 cases among patients and staff, number of beds available, and urgent staffing needs. The survey evolved over time to include additional data elements.
- Ultimately, SNF reporting through Survey123 was fairly robust and established a communication chain that allowed the State to obtain insight into skilled nursing facilities, enabling them to quickly offer assistance to those in need. SNF Survey123 was the key data source that informed decision-making around SNFs, especially as cases surged. CDPH assigned teams to monitor and analyze the data on a daily basis and used it to inform and adjust policy decisions. For example, at one point during the pandemic, CDPH was allowing staffing waivers with the expectation that facilities would increase patient capacity. However, the data indicated that this was not the case, so this waiver was discontinued.
- In fall and winter 2020/2021, CHCQ's data team used SNF Survey123 data to create more sophisticated data dashboards and epidemic (epi) curves. These dashboards helped refine the response and investigation process: IPs monitored the dashboards to identify facilities with outbreaks in need of State assistance, and the medical epidemiology team reviewed the dashboard to identify facilities with unusual patterns, indicated the need for a more detailed med epi investigation.

National Health Safety Network Survey

- While all SNF facilities in California are licensed by CHCQ, those receiving Medicare reimbursement for patients in their facility must also be federally certified by CMS.
- In fall 2020, CMS began requiring SNFs to report on very similar data elements to those in the California-based SNF Survey123. The new federal

reporting requirements mandated the use of CDC's National Healthcare Safety Network (NHSN) Survey, an existing web-based surveillance system used for HAIs.

- To avoid duplication, and since SNFs were already reporting data through California's Survey123, CDPH assisted SNFs to enroll in the NHSN Survey. CDPH also modified its survey elements to align with the federal survey, so SNFs could continue reporting through Survey123. CDPH then uploaded survey results to the federal NHSN network on the facilities' behalf.
- Enrolling all California SNFs in the federal NHSN survey system was a large task and major accomplishment. Now that SNFs are enrolled in the federal system and are familiar with a daily reporting cadence, the opportunity exists to require regular reporting of other healthcare-associated infections in skilled nursing facilities. Having these facilities track and report on HAIs would enable California to improve infection control practices and, ultimately, patient safety in these facilities overall.

Priority Level Index

- See the discussion of predictive analytics in the Analysis of Activities section above.

Other Facilities: Data and Information-Sharing Challenges

- Since CDPH was tasked with coordinating California's response to all congregate care and residential facilities, it was important to know what was happening at a regional level across the entire congregate landscape. It was critical to obtain this regional picture of the congregate regardless of what department licensed the facility—however, the data needed to provide this comprehensive picture was hard to obtain. Data completeness, reporting, and quality varied substantially depending on facility type. For instance, since many CDSS-licensed facilities do not receive federal funding, there are no reporting mandates, so it is challenging to compel facilities to voluntarily self-report their data. On the other hand, data from State-operated facilities (such as the Department of State Hospitals) was more complete.
- Much of the data consolidation was labor-intensive. To create dashboards, CDPH had to collect data manually. Even with the

finalization of a new CalHHS Agency-wide data sharing agreement, it still took two months to finalize an agreement with all departments to share data that they were already sharing in different formats. In summer 2021, CDPH partially automated the manual data consolidation process. Over the fall and winter of 2020/2021, the medical epidemiology team benefited from the creation of specific dashboards that included epi curve functionality, but this feature would have been useful to have earlier in the response.

- Lastly, it was challenging to obtain data from CDCR, due to it not being housed within the same Agency. CDPH had to obtain CDCR data posted on its public-facing websites to generate congregate care reports.
- As the response continued, data sources improved and were increasingly refined. In fall 2021, CDPH explored the idea of developing a congregate care dashboard designed to provide a comprehensive view of all congregate facility types statewide.
- Unfortunately, efforts to develop a technology solution for a congregate care dashboard were difficult and unfruitful. Even after much work, the solution still produced inaccurate results, requiring continuous manual correction by departments.

Communications

This section describes communications specific to this chapter.

External: CDPH-Licensed Facilities

- CDPH communicated with skilled nursing facilities in various ways: CHCQ infection preventionists and surveyors conducted in-person site visits; CDPH reached out to facilities via LHJs; CHCQ District Offices reached out to individual distressed facilities via phone; CDPH issued All-Facilities Letters to communicate changes to licensing waivers and other guidance; and the HAI Program instituted weekly regional calls for SNFs in summer 2020. Since these regional calls quickly grew to thousands of participants, CDPH brought in a contractor to support meeting logistics, including facilitation, call support, and notetaking. The partnership with the contractor successfully alleviated this administrative strain, allowing CDPH to focus on its infection prevention work.
- These Statewide calls continued throughout Omicron surge in over Fall 2021/Winter 2022. Leaders noted that these frequent touchpoints with facilities remained productive and helpful, and the collaboration with facilities and LHJs went very well during Omicron. During on-site consultations, the IP team worked with facilities to make sure they weren't relaxing their IP strategies and implementation.

Internal: CDPH, CDSS, and CDA Team

- Starting in April and May 2020, statewide policies and guidance related to infection control began to be aligned. CDPH, CDSS, and CDA instituted frequent coordination meetings, and began collectively reviewing guidance to ensure consistency and alignment for all impacted facility types. By February 2021, CDPH had well-established processes for developing and aligning policy and guidance. These relationships and processes continued throughout the Omicron surge and remain in place today. If, for instance, DSS is preparing to issue guidance for their facilities, they will coordinate with CDPH to review it from an IP perspective. "We have the opportunity to look at what the other agency is thinking and work in a cohesive way," one leader noted.

- Still, when developing guidance, especially early in the pandemic, there was a tendency to think of CDPH-licensed facilities first, which created a "bias that still exists." As one leader noted, "we constantly need to remind and prompt people to include these other facility types too—it's not just CDPH facilities that need to be considered." While this has improved over time, SMEs noted that policymakers should be continually reminded to consider the needs of other non-CDPH facility types in order to keep it "top of mind."

Workplan

This section is designed to be used as a workplan for future pandemics.

Definitions:

- **Phase**: The phase of the response in which the major tasks should be conducted (Planning; Initial start-up, Ongoing operations, or Close-out).
- **Major Tasks:** The tasks and activities that have to be conducted as part of the public health emergency response to a respiratory pandemic.
- **Success Criteria:** Criteria used to assess whether a task has been achieved successfully.
- **Considerations Based on COVID-19 Response:** Things to consider, including pitfalls, risks, and lessons learned, based on the COVID-19 response.

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
Initial start-up	Create and deliver infection prevention trainings	• Provide timely and appropriate training to the right audience via the right channel to strengthen infection prevention practices. • Audiences: o State staff (IPs; L&C surveyors; staff at other	• Training materials created for COVID-19 should be assessed for relevance and update as needed. • New training content may need to be created throughout the response depending on changing priorities / situations.	• Infection Prevention 1, 15	

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
		oversight departments such as DSS). ○ Facility staff (IPs; workers; medical directors). • Training types ○ New hire. ○ "Refresher." ○ Just-in-time. • Channels ○ Online live. ○ Online on-demand. • Written materials / job aids.	• Offer trainings in different languages. • Be prepared for many facilities / staff to need "basic" training, especially around proper PPE protocols. • Develop and offering training on the red/yellow/green framework (as needed) to dispel common misconceptions.		
Initial start-up; Ongoing operations	Coordinate program areas within CHCQ to promote collaboration and continuation of regular services	• The HAI and L&C programs collaborate and maintain a strong partnership. • Critical licensing, oversight, and enforcement activities can continue without interruption.	• Main the collaborative relationship that was forged between HAI's IPs and L&C's surveyors. • While the suspension of some traditional licensing, oversight, and enforcement activities is to be expected during a pandemic response, continue those that	• Infection Prevention 3, 12	

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
			are critical. A total suspension of these activities will create an enormous backlog.		
Initial start-up; Ongoing operations	Coordinate with other State departments who oversee congregate care / residential facilities	• Achieve a unified approach to all congregate care and congregate residential facilities, regardless of oversight entity.	• Not all departments possess the same regulatory authority over their facilities. • Different departments may be more or less collaborative. • Designate a lead department (e.g., CDPH).	• Infection Prevention 4, 14	
Initial start-up	Obtain data- and information-sharing agreements and establish a comprehensive dashboard	• Accurate and complete data and information is shared in a timely manner amongst departments, allowing leadership to make key policy decisions. • Data-sharing is automated to the extent possible, avoiding	• Have CalHHS direct its departments to share data. • Anticipate and plan for data-sharing challenges involving departments in different agencies.	• Infection Prevention 2, 13	

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
		inefficient manual processing.			
Initial start-up; Ongoing operations	Obtain Executive Orders that facilitate innovative, flexible solutions	• Waiving certain requirements allows CDPH to provide facilities with innovation tools and solutions to expand facility capacity. • Issuing waivers via AFL to all facilities increases communication efficiency.	• Anticipate and plan for healthcare worker resistance to certain waivers, such as changes to staffing ratios. • Monitor data for any unexpected consequences of waiving requirements.	• Infection Prevention 5; Contracting and Procurement 1; Enterprise Tech 3	
Initial start-up	Anticipate and plan for staffing challenges at both the facility and State level	• Staff can take breaks and "deactivate" to avoid burnout. • Continuity of coverage is ensured by having enough staff to backfill positions.	• Anticipate staff burnout and develop a staffing burnout mitigation plan. • Train leaders to recognize staff burnout. • Authorize overtime pay and/or reduction exemptions. • Prioritize the interventions/support to be offered to facilities in times of	• Infection Prevention 7, 8, 9	

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
			severe staffing shortages.		
Initial start-up; Ongoing operations	Establish and maintain clear, consistent communications to facilities, including guidance	• Messaging between different State entities is coordinated and consistent. • Facilities understand guidance and are able to comply.	• Maintain the open lines of communication between CDPH and EMSA. • Develop a communications plan that includes messenger, audience, and method, as well as scenarios on how to resolve inconsistent messaging.	• Infection Prevention 4, 10, 16	
Initial start-up	Create stockpile of State PPE and testing supplies and improve supply staging* *For more details on PPE, see the Medical Surge chapter in this AAR.	• State staff have sufficient high-quality PPE to safely perform their duties, including facility visits. • Facilities running low on PPE can obtain sufficient, high-quality PPE from the State stockpile. • Supply staging enables the	• Be prepared for facilities to reach out to CDPH programs or contacts directly, leading to bifurcated resource requesting channels. • Develop and communicate consistent PPE supply staging and resource requesting processes. • Large discrepancies between testing	• Infection Prevention 6, 17	

Phase	Major Tasks	Success Criteria	Considerations	Finding ID	Lead
		efficient movement of PPE across the State. • Adequate testing supplies are allocated for SNF residents and workers.	requirements for SNF visitors vs. SNF workers may lead to public anger.		
Initial start-up; Ongoing operations	Ensure that SNFs have Certified Medical Directors	• SNF Certified Medical Director are able to lead the infection control and management effort within their facilities.	• Consider ways to validate or verify compliance with AB 749, which requires medical directors of SNFs to be certified within five years of starting their position.	• Infection Prevention 11	