The California Department of State Hospitals

COVID-19 Transmission-Based Precautions and Testing

Approved by the DSH Executive Team on August 14, 2025

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Introduction

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

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

These guidelines are updated regularly. This document reflects current guidance as of July 2025.

Definitions

Close Contact: Determined through proximity and duration of exposure:

Proximity: Someone who was < 6 feet away from an infected person (laboratory-confirmed or clinical diagnosis), AND

Duration: The exposure lasted for a TOTAL of 15 minutes or more over a 24-hour period. For example, 3 separate 5-minute exposures for a total of 15 minutes.

COVID-19 Illness Severity:

- Mild Illness: Individuals who have any of the signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
- Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
- Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
- Asymptomatic Illness: Individuals who test positive for COVID-19 but have no symptoms of disease. These people are still considered contagious.

COVID-19 Tests[1]:

- Antigen test: Detects proteins from the SARS-CoV-2 virus. Also known as "rapid test", "rapid antigen test" or "RAT". Provides rapid results, usually within 15-30 minutes. While positive tests are accurate and reliable, antigen tests are less sensitive than molecular tests, especially early in infection or for asymptomatic individuals.

- Polymerase Chain Reaction (PCR) test: A type of nucleic acid amplification test (NAAT) that is considered the "gold standard" for COVID-19 tests. Usually sent to a laboratory but can be done more quickly as a point-of-care test. DSH uses Cepheid Analyzers for on-site point of care tests. PCR tests can yield false positive if the patient has been infected with SARS-CoV-2 in the 90 days prior to the test.

[1] www.cdc.gov "Testing for COVID-19"

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

Facemask: The Occupational Safety and Health Administration (OSHA) defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is Food and Drug Administration (FDA)-cleared, authorized by an FDA Emergency Use Authorization (EUA), or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as 'medical procedure masks.'" Facemasks should be used according to product labeling and local, state, and federal requirements.

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

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

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

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

Quarantine Unit: Houses asymptomatic patients with no known COVID-19 infection that have been exposed to a person(s) with a confirmed COVID-19 infection.

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

Transmission-Based Precautions: The second tier of basic infection control precautions that are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain pathogens for which additional precautions are needed to prevent infection transmission. Please see individual Hospitals' Aerosol Transmissible Disease (ATD) Guidelines for more information.

Up-To-Date Vaccination Status: A person is considered up to date with their COVID-19 vaccine if they have received the most updated vaccine per CDC guidance. For example, as of January 2025, up to date is defined as having received a 2024-2025 updated COVID-19 vaccination.

Section I: Admission Testing to Any DSH Unit

Patients who are directly admitted to their home unit as a new admission or readmission (left the hospital for >24 hours) may undergo COVID-19 testing and may proceed to their designated home unit if they have a negative COVID test.

Serial testing is no longer required. Patients may undergo one COVID test at admission to DSH. In general, performance of pre-procedure or pre-admission testing is at the discretion of the facility. However, it is highly recommended that patients being admitted to units with medically fragile or elderly patients, such as Skilled Nursing Facilities (SNF), are tested for COVID-19 at admission.

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

At any time, if a test returns positive, the patient is immediately moved to an isolation room or unit.

Section II: Testing Close Contacts of a Person with COVID-19 (Patients and HCP)

A. General Principles

- Patients may be exposed to COVID-19 by another patient or a staff member.
- Patients with known exposure to a COVID-19 infection are evaluated to determine if they are considered a close contact; they may undergo testing and may be placed under quarantine. Whole units may be quarantined when indicated.
- HCP working in or around quarantined units may be required to test daily.
- HCP wearing a respirator are NOT considered exposed even if they meet the close contact definitions below.
- The first day of symptoms or the day of a positive COVID-19 test is considered day 0.

1. Close Contacts
    a. A “close contact” is someone who was near enough to a person with COVID-19 that they may have been infected with the virus. For example:
        i. A person who was within 6 feet (2 meters) of an infected person for a total of 15 minutes or more within a 24-hour period.
            1. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period.
        ii. A person who had unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19 infection.
        iii. A household member of an infected person. In DSH, this could include patients living in the same unit as a person with COVID-19.
        iv. A person could be considered a close contact if there are extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) even if the cumulative duration is less than 15 minutes.
            1. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure without proper PPE precautions.

2. The close contact must have been exposed during the “infectious period”:
    a. A person with COVID-19 is considered able to spread the virus from 2 days before their first symptoms appear until they are no longer required to be

isolated.

b. A person with a positive COVID-19 test but no symptoms is considered able to spread disease to others starting 2 days before their test was taken until 10 days after their test.

B. Patient Close Contact or Exposure:

1. All close contacts or exposed patients undergo serial testing.
    a. Baseline: Test on **DAY 1** (Antigen or PCR testing), **not earlier than 24 hours after exposure**
2. Test on **DAY 3** and **DAY 5.** Consider unit quarantine if testing of patients reveals (+) case(s).
3. Consider quarantine based on contact tracing analysis.
4. If any patient chooses not to test, consider quarantine and release after Day 10 of exposure.
5. Any asymptomatic patient that is (+) by antigen testing or PCR is immediately placed in isolation, unless they have been recently infected with COVID-19 (see below). A positive antigen test does not need confirmatory PCR testing.
6. Any patient that develops symptoms is placed in an area of no contact with other patients and tested by antigen or PCR.
    a. If antigen for COVID-19 is (-), then do PCR.
    b. If PCR is (-), the patient is allowed to reintegrate to the unit.
    c. If antigen or PCR is (+) for COVID-19, the patient is placed in isolation. The patient may be placed with other patients positive for COVID-19.
7. Patients with a recent COVID infection:
    a. Testing is not recommended for asymptomatic patients who have recovered from COVID in the prior 30 days.
    b. Test using an antigen test for those recovered from COVID in the prior 31-90 days. The NAAT-PCR can remain positive and give a false positive result.

C. Staff Close Contact or Exposure:

1. If staff are identified through contact tracing as being a close contact, serial testing should be considered for those staff.
2. Any HCP that tests positive on antigen or PCR follows return to work protocol.

D. Unit Exposure from Staff (+) for COVID-19 who worked during infectious period:

1. If an HCP tests positive, contact tracing is initiated and serial testing of patients should be considered.

2. Consider unit quarantine if testing of patients reveals (+) case(s) or if contact tracing analysis supports immediate quarantine of the unit. Thresholds for quarantine vary by hospital depending on guidance from local County Public Health Departments.

E. Patient noncompliance with testing: please see section VI on how to approach patients who refuse to test for COVID-19.

Section III: Isolation Unit Timeline and Discontinuation

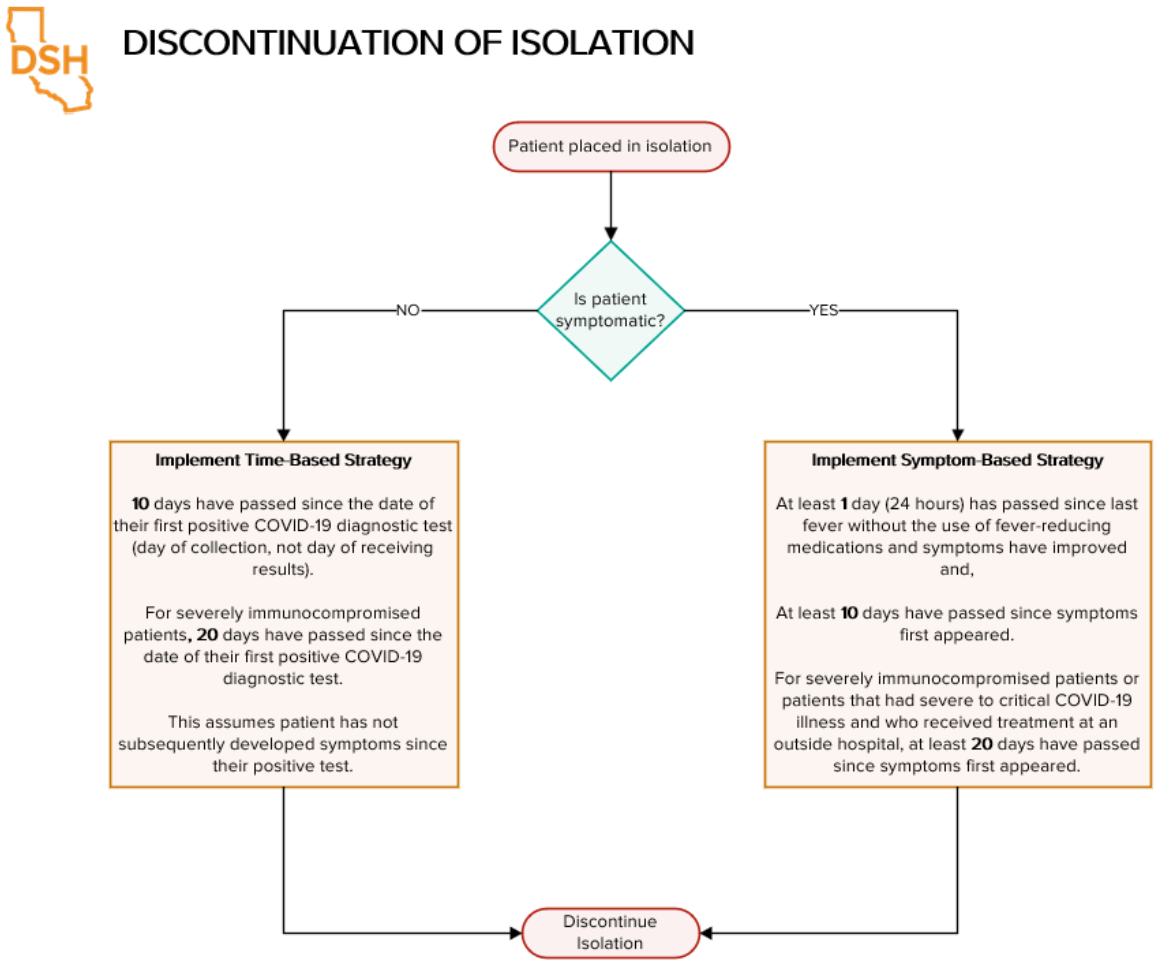
Isolation units house patients who are positive for COVID-19. The patient's isolation is discontinued using either a symptom-based or time-base strategy. Local public health officials may adjust this guidance based on hospital bed availability and other factors. In situations where local guidance differs from the guidance below, hospitals may defer to local guidance. For example, during outbreaks, hospitals may be permitted to have patients isolate in their housing unit or be released from isolation with negative testing on days 6 or 7[2].

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

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

[2] The day of symptom onset or positive test is considered day 0.

Figure 1[3]



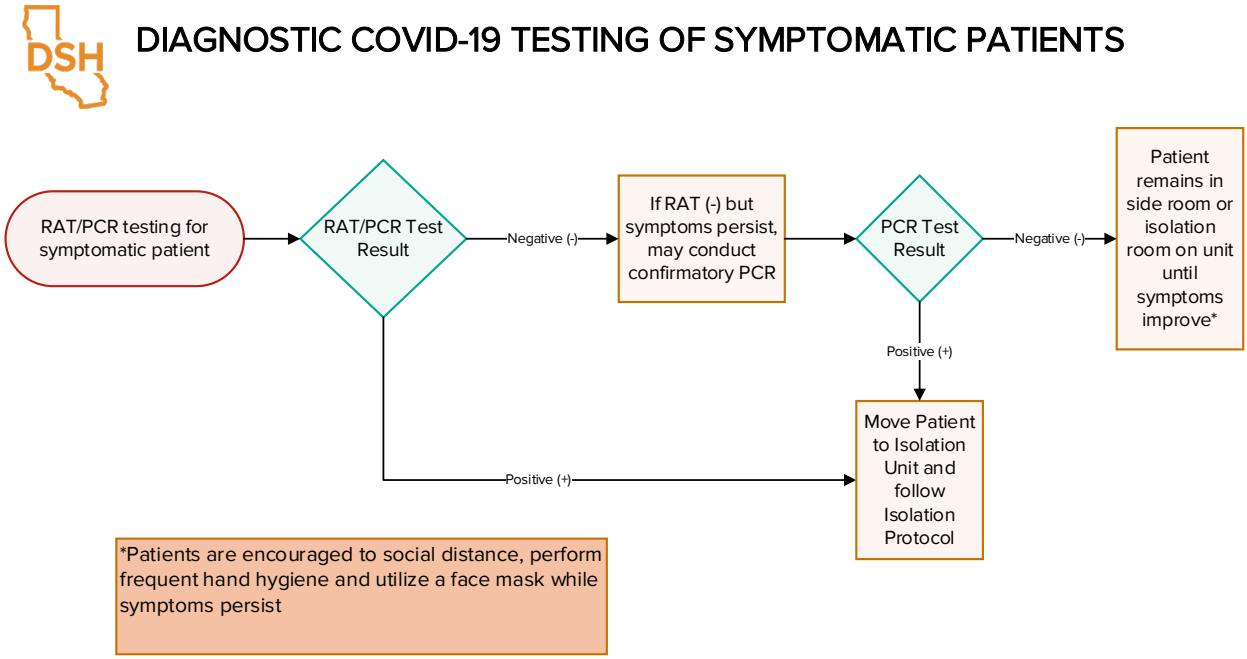
[3] While in quarantine or isolation, hospitals should avoid movement of patients that could lead to new exposures unless a consultation was made e.g. for urgent diagnostics or medical appointments.

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

A. Symptomatic Patient: See Figure 2

1. Patients with signs/symptoms consistent with COVID-19 should be tested immediately by antigen or PCR test.
2. For Initial Antigen Testing:
    - If initial antigen test is negative (-) but symptoms remain:
        - Place patient in area with no patient contact and perform confirmatory PCR .
        - May consider Multiplex Cepheid testing to rule-out other pathogens causing symptoms (Influenza A, B, or RSV).
    - If initial antigen test is positive (+):
        - No confirmatory COVID-19 test is needed.
        - Patient is transferred to an isolation unit.
    - If confirmatory PCR result is negative (-) but symptoms remain:
        - If influenza or another contagious disease is highly suspected after a negative COVID test, the patient should remain in area upon physician request, with no contact with other patients until the diagnosis is established.
    - If confirmatory PCR result is positive (+):
        - Patient is transferred to an isolation unit.
3. For Initial PCR Testing:
    - If initial PCR is negative (-) for COVID-19 but symptoms remain:
        - If influenza or another contagious disease is highly suspected after a negative COVID test, the patient should remain in area upon physician request, with no contact with other patients until the diagnosis is established.
    - If initial PCR is positive (+):
        - Patient is transferred to an isolation unit.

Figure 2



B. Symptomatic HCP: See Figure 3

CDPH updated recommendations for work exclusion in healthcare personnel with acute respiratory viral infections, including COVID-19 and Influenza, on January 10, 2025.[4] This guidance shall provide the framework for recommendations for DSH healthcare personnel to return to work; each hospital may implement additional testing or isolation measures according to local guidance.

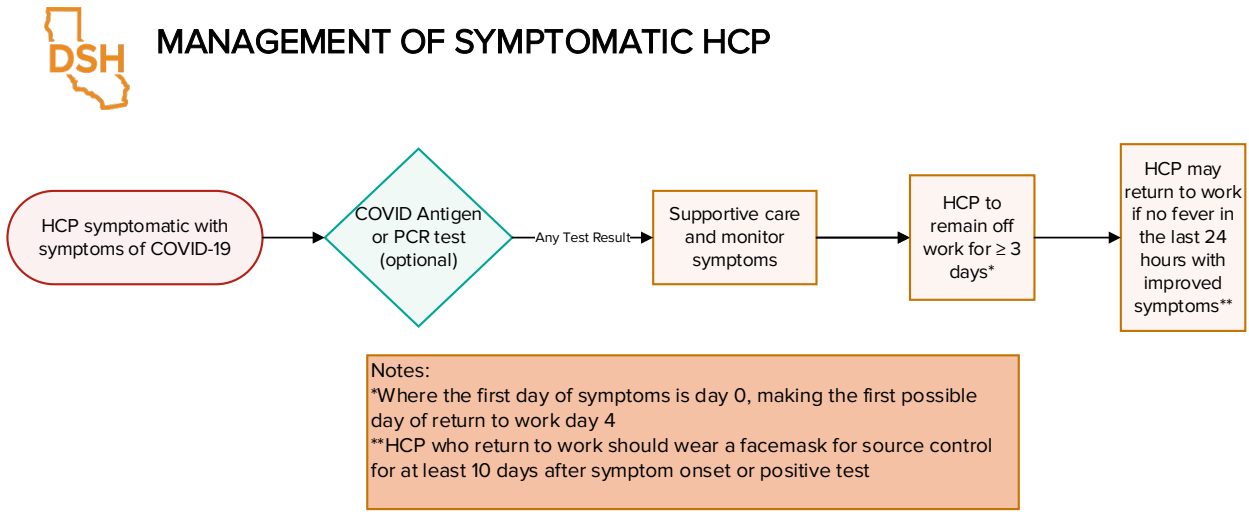
Per CDPH, HCP with a suspected or confirmed respiratory viral infection, regardless of whether testing is performed, should:

- Not return to work until at least 3 days have passed since symptom onset[5] and at least 24 hours have passed with no fever (without use of fever-reducing medicines), symptoms are improving, and they feel well enough to return to work.
- Wear a facemask for source control in all patient care and common areas of the facility for at least 10 days after symptom onset or positive test.
- Perform frequent hand hygiene, especially before and after each patient encounter or contact with respiratory secretions.

[4] CDPH AFL 25-01

[5] Where the first day of symptoms is day 0, making the first possible day of return to work on day 4

Figure 3



C. Any person (patient or HCP) with a prior positive test who develop new symptoms should be tested with an antigen test (not PCR) if the prior infection was between 31-90 days ago.

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

Considerations for reactivating daily antigen testing are based on whether the facility is having a COVID-19 outbreak. An outbreak may be defined locally by public health officials or by the definitions below.

COVID-19 Outbreak Definition for Non-Healthcare Settings:

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

Long-Term Care Facilities and Long-Term Acute Care Hospitals:[6]

≥2 cases of probable or confirmed COVID-19 among residents, with epi-linkage OR

≥2 cases of suspected, probable or confirmed COVID-19 among HCP AND ≥1 case of probable or confirmed COVID-19 among residents, with epi-linkage AND no other likely sources of exposure for at least 1 of the cases.

Hospitals may work with local County Public Health Offices on managing outbreaks depending on size of the outbreak, availability of isolation space, and other factors.

[6] CORHA CSTE Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings.

Section VI. Patient Noncompliance with COVID-19 Testing

Patients who do not agree to test for COVID-19 poses a challenging situation for other patients and staff. Reasons may be multifactorial and dependent on different situations. The hospital administration in consultation with clinical staff may address patient testing noncompliance on an individualized basis to maintain transmission-based precautions and safety.

A. Noncompliance with admission COVID-19 test, (asymptomatic patient):
    1. If patient agrees to test, they may transfer to a regular unit.
    2. HCP to provide patient education about monitoring for symptoms and reporting any symptoms to health care personnel.
    3. Treatment team members to develop an incentivization plan for patient participation.

B. Noncompliance with testing after COVID-19 exposure (asymptomatic patient):
    1. Consider placing unit on quarantine if patient(s) who declined testing can't be housed separately.
    2. If able to house separately, release the patient(s) who declined testing after 10 days or earlier if they agree to test.
    3. HCP to provide patient education.

C. Symptomatic patient who declines COVID-19 testing:
    1. Isolate the patient, if possible.
    2. Continue to offer testing and educate patient around importance of diagnostic testing.
    3. If the patient continues to decline testing, isolation can be discontinued after 10 days if symptoms have improved.

Section VII: HCP Screening

All DSH facilities shall post signage or utilize other broad communications to individuals entering the facility to screen themselves for COVID-19. A DSH facility may also elect to maintain HCP screening, which may be conducted in-person, at sign-in, or electronically. Reportable symptoms or findings include:

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

HCP exhibiting a reportable symptom or exposure risk should immediately contact their supervisor for further instructions. Also see Section IV. Diagnostic COVID-19 Testing of Symptomatic Patients and HCP.

Section VIII. Vaccinations

COVID-19 vaccination is available at all DSH facilities for staff and patients, per CDC guidance.

COVID-19 vaccination is an important way to protect staff and patients from contracting or having serious illness from COVID-19. COVID-19 vaccines are updated on an ongoing basis to adjust to new strains, and people need to receive updated COVID-19 vaccines to remain "up to date" in their vaccination status.

DSH follows CDC's COVID-19 vaccine guidance. See CDC COVID-19 Staying Up to Date with COVID-19 Vaccines webpage[7].

[7] www.cdc.gov Staying Up to Date with COVID-19 Vaccines

Section IX. Return to Work[8]

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

Hospitals always have the option to implement more protective measures and follow prior guidance for a longer isolation period for infected HCP. In addition, Local Public Health Officials may provide guidance that shortens isolation or quarantine time. Hospitals may defer to local authority.

A. Exposure Risk Assessment for HCP

Hospitals shall use the CDC's risk assessment framework to determine exposure risk for HCP with potential exposure to patients, residents, visitors, and other HCP with confirmed COVID-19 in a health care setting[9].

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

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

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

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

- HCP was not wearing a respirator (or if wearing a facemask, the person with

[8] See Figure 3

[9] CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

COVID-19 infection was not wearing a cloth mask or facemask)

- HCP was not wearing eye protection if the person with COVID-19 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure. For more details, please refer to individual DSH Hospital's Aerosolized Transmissible Disease (ATD) plans, section on High Hazard Procedures.

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

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

B. Isolation and Work Restriction for HCP

CDPH has provided interim guidance[10] for work exclusion of HCP with suspected or confirmed respiratory viral infections. This guidance applies to HCP with COVID-19, influenza, and other acute respiratory viral infections, regardless of whether diagnostic testing for viral pathogens is performed or the results of such testing. This guidance does not apply to novel viral pathogens including avian influenza, for which other public health guidance is available.

HCP with suspected or confirmed respiratory viral infection, regardless of whether testing is performed, should:

- Not return to work until at least 3 days have passed since symptom onset[11] and at least 24 hours have passed with no fever (without use of fever-reducing medicines), symptoms are improving, and they feel well enough to return to work.
    - If testing is performed that renders a positive result, but the individual is asymptomatic throughout their infection, HCP should not return to work until at least 3 days have passed since their first positive test.
- Wear a facemask for source control in all patient care and common areas of the facility (e.g., HCP breakrooms) for at least 10 days after symptom onset or positive test (if asymptomatic), if not already wearing a facemask as part of universal source control masking.

[10] CDPH AFL 25-01

[11] Where the first day of symptoms is day 0, making the first possible day of return to work on day 4.

- Perform frequent hand hygiene, especially before and after each patient encounter or contact with respiratory secretions.

HCP should be encouraged to stay up to date on influenza and COVID-19 immunizations and follow healthcare facility policies for source control masking.

Section X: COVID-19 Units/Process and Personal Protective Equipment

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

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

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

Table 1. COVID-19 Units/Process and Personal Protective Equipment[12]

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Isolation Unit:	• N95 Respirator • Face Shield (when providing direct patient care) • Gloves (when providing direct patient care)	• Gown
PUI Room(s)	• Surgical mask in all areas when not providing direct patient care • N95 Respirator (when providing direct patient care) • Face Shield (when providing direct patient care) • Gloves (when providing direct patient care)	• Gown

[12] Please refer to individual DSH Hospital's Aerosolized Transmissible Diseases (ATD) Guidelines for more detailed information on these recommendations.

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Quarantine Unit	• Surgical mask in all areas when not providing direct patient care N95 Respirator (when providing direct patient care). • N95 Respirator strongly encouraged to be always worn by staff not up to date with COVID-19 vaccination. • Gloves (when providing direct patient care) • Face shield when testing patients for Covid	• Gown • Face Shield
Regular Unit: • Unit that has not been placed on quarantine and does not have patients being treated, under investigation, or being observed for COVID-19.	• Surgical mask is strongly encouraged in all patient care areas and where HCP may encounter patients within 6 feet indoors or outdoors.	• N95 Respirator • Face Shield • Gloves
CPR/ACLS for COVID+ patient	• CAPR/PAPR* • Gloves • Gown	
Aerosol Generating Procedures	• CAPR/PAPR • Gloves • Gown	
Transportation Staff: • Any staff assigned to transport or escort a COVID+ patient or PUI in a vehicle (Example: To OMF appointments or inter/intra-facility transfers).	• N-95 Respirator • Face Shield • Gloves	

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Administrative or Non-Treatment Areas with No Patient Contact	None	• Surgical mask • N95 Respirator

*In cases where a PAPR would interfere with the required tasks, an N95 is an acceptable alternative. In such an instance, documentation explaining the decision shall be required for management review.

References:

1. CDC Staying Up to Date with COVID-19 Vaccines (June 6, 2025)
    - https://www.cdc.gov/covid/vaccines/stay-up-to-date.html#:~:text=What%20to%20know,illness%2C%20hospitalization%2C%20and%20death.

2. CDPH All Facilities Letter (AFL) 25-01: Interim Work Exclusion Guidance for Healthcare Personnel with COVID-19, Influenza, and Other Acute Respiratory Viral Infections (January 10, 2025)
    - https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-25-01.aspx

3. CDC Testing for COVID-19
    - https://www.cdc.gov/covid/testing/index.html

4. CDC Infection Control Guidance: SARS-CoV-2, Health Care Providers (June 24, 2024)
    - https://www.cdc.gov/covid/hcp/infection-control/index.html

5. CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (March 18, 2024)
    - https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html

6. Council for Outbreak Response: Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings (January 2, 2024)
    - https://corha.org/assets/documents/COVID-19-HC-Outbreak-Definition-Guidance_January-2024.pdf

7. CDPH AFL 23-12: Coronavirus Disease 2019 (COVID-19) Recommendations for Personal Protective Equipment (PPE), Resident Placement/Movement, and Staffing in Skilled Nursing Facilities (January 24, 2023)
    - https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-12.aspx

8. CDPH AFL 23-08: Requirements to Report Outbreaks and Unusual Infectious Disease Occurrences (January 18, 2023)
    - https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-08.aspx#

9. CDPH Healthcare-Associated Infections Program: COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category (July 22, 2021)
    - https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-74-Attachment-01.pdf

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