California Department of Public Health
Weekly Facility COVID-19 Update Call
January 26, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 3290142
Available after 10am 01/26/2021

I. **Welcome / Introduction** **Heidi Steinecker**

II. **Overview** **Dr. Kathleen Jacobson**

- None Provided

III. **Laboratory Update** **Dr. Carol Glaser**

For the past few weeks on the laboratory portion of this call, we have been discussing SARS-CoV-2 variants. As mentioned before, when SARS-CoV-2 variants are discussed, the WHO strongly encourages that we use nomenclature such as B.1.1.7 or B1.351 rather than terms such as the UK, South African or Brazilin variants. However, I may use these terms since because individuals are more familiar with this terminology versus the formal nomenclature. Note, the nomenclature is confusing in part because there are different systems being used (PANGOLIN, GSAID, clade methodology).

There are currently 3 different variants of concern - the UK, the South American/Brazilian and the South African variants worldwide as well as the variant of interest in California.

UK variant (aka B.1.1.7/) (20I/501Y.V1 and VOC 202012/01)
Emerged Sept 2020 in UK, now in >55 counties, including the US and Canada.
Many mutations including N501Y, P681H ORF8 & 69/70 deletion (this deletion causes the S-gene target failure).

For the past several weeks we have heard that this particular variant is more transmissible than other variants and we know it is now the predominant strain in the UK.

Over the past weekend, there were news reports about this variant being associated with a realistic probability of increased risk of death. The reports were based on a paper by a UK group called the "New and Emerging Respiratory Virus Threats Advisory Group" (NERVTAG). As noted in this official UK document, the term "realistic probability" corresponds to 40%-50% "likelihood or confidence". Therefore, at this time we await more information to know if this is the case (keep in mind if more transmissible more cases increased human toll)

- In the US—(website not updated yet today but on a CDC call yesterday, it was announced that 195 cases have been detected in 22 states (72* in CA, 50 in Florida, 22 in New York)(CDC website 1/25/2021, 6pm, not updated yet which is why discrepancy)

- In California—90* cases (87 in San Diego, 1 in San Bernardino, 1 in LA).

Per MMWR, modeling data suggests that it is likely to become most prevalent strain in the US.

South African variant (aka 501Y.V2) (B.1.351 or 20C/ variants)
First detected in S Africa in Oct 2020, now in >15 countries, but not yet detected in the US. This variant has multiple substitutions on spike protein, including the 484 mutation which may affect antibody neutralization and vaccine effectiveness. Yesterday Moderna and Pfizer announced that their mRNA vaccines, while still effective against this variant, offer slightly less protection against it. As a precaution, Moderna has begun developing a new form of its vaccine that could be used as a booster shot against this variant if needed, and Pfizer is exploring this as well. CDC is obtaining viral cultures of this variant from international sources and is trying to generate a functional assay. More will be understood about the implications of this variant once these data are available (per CDC Lab call on 1/25/2021, Chris Elkins at CDC).

Brazilian P.1, 20J/501Y.V3, Branch off of 1.1.1.28 lineage
First reported in Japan who had traveled from Brazil
Mutations 17 unique amino acid changes including 3 deletions and the 484 mutation/
There are concerns that this variant, like the UK variant may be associated with increased transmission and immune evasion (ability to be recognized by antibodies)

- NOT DETECTED IN THE US <u>until this week</u> (yesterday)
- Minnesota; Minnesota resident with travel to Brazil.
- Not detected yet in California

Variant of Interest in California (aka L452R, 20VUI1, B.1.429)
Two weeks ago, there were media reports about a variant that was first detected in California in July but increased in prevalence. This variant has several mutations (ORF1a: I4205V, ORF1b: D1183Y, S: S13I, S: W152C AND S: L452R) and there is a suggestion that this variant may also be more transmissible and possibly be associated with immune evasion. We are not calling it a "variant of concern" but rather a variant of interest since data is speculative at this point. It now accounts for ~25% of recently sequenced specimens and has been detected in a number of CA counties and has been associated with outbreaks in Santa Clara County. Likely a biased sample (tend to do more sequencing for OBs). This variant has also been detected sporadically in several other states.

Exact number of cases sequenced in CA not known at this time but likely ~400-500. Variants with same mutations detected in several other states and other countries.
(In California, ~10,500 samples sequenced.)

SEQUENCING
Genomic surveillance is important because of the implications of variants for therapeutics, vaccines, diagnostics, virus characterization/pathogenesis and the animal-human interface.

COVIDNET/Sequencing is an active network of public health labs, academic and commercial labs that have formed a collaboration to track these viruses through sequencing in California. The goal is to sequence ~1% of positive samples.
Continue to ramp up capacity /COVIDNET

In the US at CDC there is a similar program called the National SARS-CoV-S Surveillance (aka NS3). Also ramping up sequencing.

Initially sequencing~600 specimens every two weeks. Now scaling up to ~1500 every 2 weeks. Striving for geographic, demographic and clinical diversity with low CT Values (< = 28)

In addition to enhancing the broad surveillance, there are weekly shipments of samples with specific criteria such as S-gene target failures (SGTF) to improve B117 variant detection. The collaboration is expanding with commercial lab support; contacts with Illumina and LabCorp and now Quest; allow sequencing of 2500□6000 samples per week. If you see something concerning in patient, discuss it with your local health department.

IV. **Healthcare Associated Infections** **Dr. Erin Epson**

During the past few months, the HAI Program has consulted on multiple outbreaks in acute care hospitals. Today, I'd like to tie together few pieces of relevant guidance on identification and response to COVID-19 outbreaks in hospitals. CDPH previously posted COVID outbreak investigation and reporting thresholds for hospitals in AFL 20-75, which include ≥2 cases of confirmed COVID-19 in a patient 7 or more days after admission for a non-COVID condition with epi-linkage, or, depending on the level of transmission in the surrounding community, either ≥2 or ≥3 cases of confirmed COVID-19 in HCP with epi-linkage. What is involved in the investigation and response to situations that meet these thresholds? CDC contact tracing guidance in the context of outbreaks notes that such investigations should be planned jointly as a collaboration between the facility and the health department, and include both the facility's occupational health services and infection prevention and control staff. Initial discussions should cover data sharing and division of responsibilities. When an outbreak meets the investigation and reporting threshold, infection prevention and control staff should collaborate with occupational health to identify potentially exposed HCP using CDC's HCP exposure risk assessment; of note, the determination of epi-linked and potentially exposed HCP in the context of an outbreak should generally be made irrespective of whether HCP were wearing a respirator or facemask. Although respirator or facemask use mitigates the risk of exposures, a cluster of cases meeting the investigation and reporting thresholds suggests a breach or lapse in practice (for example, HCP not using appropriate personal protective equipment while caring for a patient with unrecognized COVID-19, or HCP not physically distancing and wearing facemasks in breakrooms) that should be further investigated. Guidance addressing testing HCP, including asymptomatic HCP with known or suspected exposure to SARS-CoV-2, is available in Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2, which discusses testing initially and, if negative, again about 5-7 days post exposure to more quickly identify pre-symptomatic or asymptomatic HCP who could contribute to SARS-CoV-2 transmission, especially when exposed HCP are being allowed to continue to work according to CDC's Strategies to Mitigating HCP Staffing Shortages. The Healthcare Information and Management Systems Society (HIMSS), will be hosting a webinar on **February 10 at 1:00 PM ET** titled *Enhancing Hospital Infection Control During and Post-Pandemic*. The webinar will feature Linda Greene from University of Rochester Medical Center, Dr. Waleed Javaid from Mt. Sinai in New York, as well as Dr. Shereef Elnahal, President and CEO of the University Hospital Network in Newark, NJ. The webinar will include a Q&A about changes to hospital infection prevention and control programs to further protect their patients and staff from potential COVID-19 and other HAI exposures within their facilities. The discussion will cover what to consider when revamping your hospital's infection prevention/control program, the role of communication and coordination among multiple stakeholders, the role of the health IT and medical equipment provider, and how to future-proof your updated program. Registration is required.

V. **Monoclonal Antibody Update** **Dr. Sohrab Sidhu**

- Monoclonal antibody allocation updates
- Management options for patients on remdesivir who are ready for hospital discharge

Monoclonal Antibody Overview

To summarize, two investigational monoclonal antibody products – bamlanivimab and casirivimab/imdevimab – received an emergency use authorization (EUA) in November for the treatment of mild-to-moderate COVID-19 in non-hospitalized adult and pediatric patients. Clinical trial data in outpatients have shown that both bamlanivimab and casirivimab/imdevimab may reduce COVID-19-related hospitalization or emergency room visits in patients who are treated early and who are at high risk for severe disease. Clinical trial data in hospitalized patients, however, have not shown a benefit with either bamlanivimab or casirivimab/imdevimab use in hospitalized patients and as such, the EUAs for both therapies are only to treat symptomatic outpatients. Given the limitations to using existing acute care hospital infrastructure during the ongoing surge, CDPH is allocating and encourages the distribution of both products to non-hospital outpatient settings.

General updates

Allocations of the monoclonal products from CDPH are occurring every two weeks.

Currently California has a sufficient supply of monoclonal antibodies for all providers who request them.

Should any facilities in California need more monoclonal product, they should contact as soon as possible their county's Medical and Health Operational Area Coordinators (MHOACs) according to local policies and procedures. Contact information for each MHOAC program can be found here.

Medical directors or other authorized prescribers at SNFs and PACE programs who contract with specialty pharmacies receiving state allocations can order bamlanivimab or casirivimab/imdevimab if they have a patient that qualifies for treatment. The pharmacy would prepare the product and send to the SNF or PACE program for infusion. One additional specialty pharmacy was added this past allocation cycle: Rivers Edge Pharmacy. The other 12 pharmacies that have received at least one allocation of bamlanivimab or casirivimab/imdevimab since week 1 are Pacific West Pharmacy, Skilled Nursing Pharmacy, Consonus Pharmacy Services, AlixaRx, Pharmerica, Citrus Pharmacy, Ron's Pharmacy, OmniCare, AmeriPharm, Owens Pharmacy, CareKinesis, and Premier Pharmacy Services

Please also note that for facilities who have received product before, they may now request product directly from the distributor, AmeriSource Bergen, should they require any in between allocations. These requests can be done in parallel and in addition to the previous methods described, namely acquiring the product via specialty pharmacies or requesting the product from their county MHOACs. Facilities who have received product before should have received an email from AmeriSource detailing the method for requesting additional product directly from HHS/ASPR.

Allocation numbers can be found in the meeting notes for this call. This information is also updated every other week and posted publicly in greater detail here (under the "Other" section and titled "California Monoclonal Antibody Allocation").

Bamlanivimab updates

For weeks 11-12, California received an allocation of 18,050 doses of bamlanivimab.

Specialty pharmacies received 240 doses.

400 doses were allocated directly to the California Department of Corrections and Rehabilitation (CDCR).

The remaining 17,410 doses of bamlanivimab were proportionally allocated to the counties' MHOACs (based on their 7-day average of new COVID-19 hospitalization and 7-day average of overall new COVID-19 diagnoses).

Of the product that was declined by various counties, some was re-allocated to other counties and 4,024 doses were sent to the CDPH warehouse.

CDPH continues to encourage counties to consider allocating bamlanivimab to more outpatient settings including federally qualified health centers (FQHCs), state hospitals, jails, and other congregate setting that may have clinical capacity to use.

Casirivimab / imdevimab updates
In weeks 11-12, California received an allocation of 2,460 treatment courses of casirivimab / imdevimab this week.

Specialty pharmacies received 36 treatment courses.

The remaining 2,424 treatment courses were proportionately allocated to the counties' MHOACs (using the same allocation formula as is used for the bamlanivimab product).

Of the product that was declined by various counties, some was re-allocated to other counties while 582 treatment courses of casirivimab/imdevimab were sent to the CDPH warehouse.

CDPH continues to encourage the allocation of casirivimab/imdevimab to appropriate non-hospital outpatient settings just like bamlanivimab.

Management options for patients on remdesivir who are ready for hospital discharge
We wanted to share some data regarding continuing remdesivir treatment in patients who are otherwise ready for hospital discharge. This information is sourced from the FAQs for Veklury (remdesivir) provided by the FDA.

"In the clinical trials supporting FDA's approval of [remdesivir] (i.e., ACTT-1, Gilead 5773 and 5774), patients who were ready for hospital discharge before completing their scheduled duration of treatment (either 5 or 10 days depending on the trial and arm) did not continue treatment upon discharge; the readmission rate after discharge in the ACTT-1 trial was low (4% overall). Therefore, currently available data does not support a benefit in continuing outpatient treatment with [remdesivir] if a patient is deemed medically ready for hospital discharge. Additionally, the safety and efficacy of administering [remdesivir] in a home setting, which is not capable of providing acute care that is comparable to inpatient hospital care, has not been established."

CDPH and DHCS recommend that, per FDA guidelines, "remdesivir should only be administered to patients requiring hospitalization – that is, patients with COVID-19 severity that necessitates receiving care in a hospital setting or at an alternative care site that is capable of providing acute care

comparable to inpatient hospital care." Such alternative care sites may include temporary facilities intended to provide additional hospital surge capacity and capabilities for communities that are overwhelmed by patients with COVID-19, or at-home care that is provided by hospitals which have received CMS waiver approval as part of the Centers for Medicare and Medicaid Services' Acute Hospital Care at Home (AHCaH) program. Alternatively, remdesivir treatment can be discontinued when the patient is ready for discharge.

(Source: Frequently Asked Questions About the EUA for Veklury (remdesivir) (fda.gov) – pg. 4)

Since per the FDA "the safety and efficacy of administering [remdesivir] in a home setting, which is not capable of providing acute care that is comparable to inpatient hospital care, has not been established", CDPH and DHCS do not recommend the initiation or continued administration in any setting that is not capable of providing acute care comparable to inpatient hospital level of care. CDPH does not object to the administration of remdesivir by SNFs meeting the FDA's remdesivir guidelines.

Additional Resources

Bamlanivimab links for further information:

- Bamlanivimab Distribution Fact Sheet (ca.gov)
- Fact sheet for healthcare providers: https://www.fda.gov/media/143603/download
- Fact sheet for patients, parents, and caregivers: https://www.fda.gov/media/143604/download
- FDA FAQ: https://www.fda.gov/media/143605/download
- Eli Lilly video for bamlanivimab preparation/administration: https://www.kaltura.com/index.php/extwidget/preview/partner_id/1759891/uiconf_id/30232671/entry_id/1_i3nkvs7k/embed/dynamic?
- Complete video transcript and more info: https://www.covid19.lilly.com/bamlanivimab/hcp/dosing-administration#dosing-and-administration

Casirivimab / Imdevimab links for further information:

- Casirivimab and Imdevimab Distribution Fact Sheet
- Fact sheet for health care providers: https://www.fda.gov/media/143892/download Fact sheet for patients, parents, and caregivers: https://www.fda.gov/media/143893/download
- FDA FAQ: https://www.fda.gov/media/143894/download

MHOAC County Contact Information:
https://emsa.ca.gov/medical-health-operational-area-coordinator/

NIH COVID-19 Treatment Guidelines:
https://www.covid19treatmentguidelines.nih.gov/whats-new/

IDSA COVID-19 Treatment Guidelines:
https://www.idsociety.org/practice-guideline/covid-19-guideline-treatment-and-management/#toc-10

VI. **Vaccine Update** **Dr.Caterina Lui**

- To summarize, two COVID-19 vaccines have received FDA emergency use authorization, one from Pfizer, and the other from Moderna.
- Enrollment:

    - General questions about Provider Enrollment can be directed to our COVID Call center at 833-502-1245 or COVIDCallCenter@CDPH.ca.gov
- Doses/allocation
    - As of 1/25/21, 4,793,825 doses of COVID-19 vaccine have been allocated to CA to be administered on a local level to Phase 1A and Phase 1B, Tier 1 populations. 681,525 doses of Pfizer vaccine have been allocated as part of the federal pharmacy partnership with CVS and Walgreens and 211,490 of those doses have been reported as administered. To date, 4,564,425 doses have shipped in CA. 2,046,907 first doses have been recorded in IISs as administered and 382,777 have been recorded as second doses administered. The CDPH vaccine dashboard has been posted and will continue to be modified to include maps and more local information VaccineDoses (ca.gov).
- Moderna Vaccine Lot # 041L20A Pause on Administration now **lifted**
    - As a reminder, on 1/17/21, CDPH had notified providers that received Moderna vaccine lot 041L20A to briefly pause its use. That pause
    - On 1/20/21, CDPH advised providers they can immediately resume the administration of lot 041L20A.
        - https://www.cdph.ca.gov/Programs/OPA/Pages/NR21-025.aspx
        - Official statement from press release: "Out of an abundance of caution, we recommended that providers pause the distribution of Moderna COVID-19 vaccine lot 41L20A on Sunday evening. Yesterday, we convened the Western States Scientific Safety Review Workgroup and additional allergy and immunology specialists to examine the evidence collected. We had further discussions with the County of San Diego Department of Public Health, the FDA, CDC and manufacturer, and found no scientific basis to continue the pause. Providers that paused vaccine administration from Moderna Lot 41L20A can immediately resume.
    - Providers of COVID-19 vaccine should continue their routine precautions to recognize and manage allergic reactions and potential adverse events.
        - https://www.cdc.gov/vaccines/covid-19/clinical-considerations/managing-anaphylaxis.html
- Vaccination in long-term care facilities continues with the CDC-Pharmacy Partnership program. CVS and Walgreens are reaching out to facilities directly to schedule vaccination clinics. Please provide your facility's best contact information and accurate numbers of staff and residents to be vaccinated. Please review documents, resources, and FAQs directly on pharmacy LTCF webpages:
    - CVS / Omnicare https://www.omnicare.com/covid-19-vaccine-resource/
    - Walgreens https://www.walgreens.com/topic/findcare/long-term-care-facility-covid-vaccine.jsp
- Clinical considerations
    - The CDC website is updated with the most recent information about both the Pfizer and Moderna vaccines
        - Link: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
        - Regarding vaccination after infection:
            - With additional information about time to rarely-detected reinfection being longer than 3 months, revised language below removes the 90 day language:

- "While there is no recommended minimum interval between infection and vaccination, current evidence suggests that the risk of SARS-CoV-2 reinfection is low in the months after initial infection but may increase with time due to waning immunity. Thus, while vaccine supply remains limited, persons with recent documented acute SARS-CoV-2 infection may choose to temporarily delay vaccination, if desired, recognizing that the risk of reinfection, and therefore the need for vaccination, may increase with time following initial infection."

- Vaccine use
  - On January 22nd, 2021, CDPH released new guidance providing authority to local health departments to redirect unused vaccine from providers who have not used at least 65% of the vaccine in its possession for more than 1 week.
    - Link: https://eziz.org/assets/docs/COVID19/CDPHrecoverCOVIDvaccine.pdf
- Prioritization:
  - The most current allocation guidance for COVID-19 vaccine is from January 13th: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Revision-of-Allocation-Guidelines-for-COVID-19-Vaccine.aspx
  - CDPH will release additional details on sub-prioritization during Phase 1b and 1c.
    - Link to the essential workforce list: https://covid19.ca.gov/essential-workforce/
    - Link to the current Phase 1a and 1c guidance:
      - https://covid19.ca.gov/vaccines/#When-can-I-get-vaccinated
- **Additional resources:**
  - On January 7th, CDPH published guidance regarding moving through the vaccine prioritization phases and tiers. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Prioritization.aspx
  - Link to COVID vaccine resources: https://eziz.org/covid/vaccine-administration/
  - The CDC website is updated with the most recent information about both the Pfizer and Modern vaccines.
    - Main landing page: https://www.cdc.gov/vaccines/covid-19/hcp/index.html
    - Clinical Considerations for Pfizer and Moderna vaccine: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
  - The ACIP's recommendations for prioritization of vaccine during phase 1b and 1c are now online: https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_w
  - Authorized Vaccinators: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Authorized-Licensees.aspx

VII. **Questions and Answers**

Q: Regarding the news about the new variant and that cloth face masks may no longer be sufficient when used in areas where you may come in contact with less than six feet of social distancing, Is there anything that's going to come out from CDPH related to this and what facilities should be doing now in the areas that they are currently using cloth face masks?

A: What you have been seeing about cloth face masks and double masking is really a message for the general public and not necessarily applies to health care personnel at working in health care settings.

The reason is that the general public doesn't necessarily have access to N95s or higher-level protection. So, the recommendation is that more layers with a cloth mask might provide additional protection to the wearer of the mask. This is all the more important with a variant that might be more transmissible. But again, this isn't really applicable to health care personnel in the workplace where they really should have access to fit tested N95 or higher-level respirators for more optimal respiratory protection, when appropriate, and when caring for residents or patients with suspected or confirmed COVID-19.

Q: Related to the Valencia Lab, we have reached out to try to get a contract related to them and one of the things we're running into is that the lab has told us they have no resources to get tests to the lab. We are in Northern California and they recommend, to get to the lab, that we courier them or hire a driver to drive the tests down twice a week. That really isn't a solution that I think is very viable. I wanted you to be aware of that particular issue with the lab, to see if there is something that can be done to help support those of us that are in the northern part of the state in getting tests down to be processed.
A: If you can give me your contact info, I may be able to help you individually with this. The state is working on developing a courier network where facilities can drop off specimens and then have them brought to the lab. That is due to be available soon. That will be a way to make using the lab easier for some groups. We look forward to formally announcing that but in the meantime, if there are groups that are interested in using a courier, 94 percent of the state should have a drop box site within 60 minutes. If you are interested in setting that up, feel free to contact me directly and we can work on that. My email address is Eric.Foote@cdph.ca.gov.

Q: With the regional stay at home orders being lifted, are we able to resume elective surgeries? I'm in Orange County.
A: The regional stay at home order is lifted but not Public Health order regarding surge. We still have that order that is still in effect regarding surgeries and transfers. On our website, we have the list of counties that are still under that public surge health order. I know there has been a lot of confusion between those two orders but the one regarding surgeries and transfers is still in effect.

Q: Has there been any updates to guidance on collegiate athletic events? We're aware that testing frequency needs to be 48 hours for high risk events but what about for the sports that are in the category of non-high risk? Is there a testing frequency recommendation there or any other guidance updates?
A: There should be an updated guidance coming out on sports. Low contact sports such as golf or things like that, it's likely that the guidance will not recommend any particular testing cadence, particular to those very low contact sports, whether students participating in those sports can be tested the way other students can be tested. Don't quote me on that because the final guidance has not come out yet, but it should come out soon.

Q: What's the best way to make sure we are made aware of that new guidance?
A: It would be posted on the CDPH website under Institutions of Higher Education. If you send me an email, I'll try to remember to send it to you.

Q: With Governor Newsom's announcement about moving to age prioritization after the initial tier, I was wondering, other than the food and agricultural industry, what is the prioritization based on social inequities such as homeless, Latinx and people who have challenges with access to care?
A: I do know there has been lots of discussion internally with our Vaccine Task Force regarding looking at different disparities from an equity lens but also trying to keep this as simple as possible, as far as trying to roll this out to as many people as quickly as possible, given that it's a very scarce resource.
A: There has been a lot of discussion focused on this issue. We do anticipate more detailed guidance to come out that will clarify what's already been published. I'll share that as soon as that is available.

Q: Patients have been coming into our clinics and facilities with cloth masks but we have been telling them to use one of our supplied masks. How are we supposed to handle it when they say they are willing to wear our mask but want to continue to use their cloth mask on it? Do we put up any resistance to that? The second thing is that some people come in with non-fit tested N95s and we've also got health care workers who want to wear double masks and they will wear a non-fit tested N95 and they will put a regular procedure mask over that so they can try to keep the N95 clean. Can you address that?
A: For the patients coming in, I don't see any reason why they couldn't wear your provided mask with a cloth face mask over that if that is their preference. The primary reason for anyone entering a health care facility is really about source control. The added layers of double masking is an additional precaution for the wearer that might offer more protection than a single layer mask alone when they don't have access to a fit tested N95 respirator. I think the same would generally apply to a patient or visitor that has a N95 or KN95 or any type of respirator that they are using to get more protection. They can add another layer to that. The issue or concern that I have about health care personnel that need respiratory protection and need to wear a respirator because of caring for patients with suspected or confirmed COVID, is that the use of a face mask in addition to a respirator can impact the respirators seal. We would definitely recommend against wearing the face mask underneath the N95 respirator as that would impair the seal, which is critically important for protection so that the inhaled air is filtering through the respirator and not though cracks on the side of the face. Wearing a face mask over the top of the N95, there are concerns that that would impact the seal or fit. If the intent is to protect that respirator form contamination, the preferred way would be with a face shield that covers the respirator. The only other situation where one might wear a face mask over is respirator is if that respirator has an exhalation valve. But again, health care personnel who are wearing respirators for respiratory protection really should not have or use respirators with exhalation valves.

Q: Relating to psychiatric facilities wanting patients to be tested for COVID before they are accepted and transferred, the situation came up where the patient had COVID in the last 90 days, is asymptomatic and the psychiatric facilities are demanding that a COVID test be performed before they'll accept the patient and obviously they are high risk of having false positives. Is there anything that the state has put out or can put out to provide information on that?
A: I will stay that for the purposes of transfer from an Acute Care Hospital to a Skilled Nursing Facility, I believe we've said that individuals that have been positive, in the proceeding 90 days, do not need to be tested again if they are asymptomatic as part of screening upon transfers for the reasons that you outlined. I don't know if we have anything specific to that about transfers to acute psychiatric hospitals but I would think the same principles would apply.

Q: I agree with that. I guess the question is whether there is a way to notify the psychiatric facilities that it applies to what you said to the SNFs? Psychiatric facilities are not following CDPH guideline about retesting people who've had COVID and are asymptomatic. They are saying that they can't take the patient, so they don't get the right level of care. I'm not sure if the psychiatric facilities for Behavioral Health actually understand that the guidance applies to them. Could you let people know at Behavioral Health facilities know that the guidance for nursing homes is the same?
A: Thank you for bringing that up. No, a negative test is not required, particularly within the 30 days because it could possibly still come up as positive.

Q: Is there any consideration for using ring vaccination techniques to help contain the variant? For example, allocating extra vaccines to the communities where the variant has been found and surging vaccination efforts to those areas while we still have limited distribution of the variant. Thank you.
A: We will take that back. Thank you for bringing that up. That's definitely a strategy for the Vaccine Test Force to be considering when we are looking at variants that could perhaps have faster spread rates so thank you for that.

Additional Resources:

The intent is for the waivers to apply to counties under the surge public health order: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Amendment-to-the-Order-of-the-State-Public-Health-Officer-Hospital-Surge-1-15-2020.aspx

This order is still in effect. The counties under the surge public health order are listed: https://www.cdph.ca.gov/Programs/OPA/Pages/NR21-029.aspx

Wednesday Webinar: 3–4 p.m., Attendee Information:
Register at: https://www.hsag.com/cdph-ip-webinars
Call-In Number: 415.655.0003 Access Code: 133 788 3426