California Department of Public Health
Weekly Facility COVID-19 Update Call
March 2, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 8526967
Available after 12pm 03/02/2021

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

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

- None Provided

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

Today, I will give a very brief overview of 3 primary variants of concern (VOCs), discuss a variant described first in NY and then spend some time discussing the variants of interest (VOI) that we have been following in CA. Remember SARS-CoV-19 virus is constantly mutating so we expect to see variants. For VOI, we do not know clinical or epi significance but are following closely.

B.1.1.7
This is the variant that was first identified in the UK and has now been detected in 70 countries. It is more infectious and likely to higher morbidity/mortality per UK report. This is also the variant that CDC had predicted would become the predominant strain in the US by the end of March.

As of March 1, 2021: **2400 cases in 46 states, 206 in CA**
Just a few weeks ago California had the highest number of cases in US but in past 2-3 weeks, very small increase in cases. For comparison; Feb 22-1661 cases in 44 states (195 in CA), Feb 15-173 cases in US in 40 states (186 in CA)

B.1.351
This is the variant that was first identified in South Africa. In addition to concerns about increased infectiousness there are concerns about vaccine effectiveness.
(other names 501.V2 20C/ variants). (Key mutations: K417N, E484K, N501Y and D614G).

As of March 1, 2021: **53 cases in 16 states, 3 in CA**
For comparison, Feb 22-22 cases in 10 states, Feb 15: 17 cases in 8 states.
(3 in CA, international travel, appropriate isolation)

P.1
This is the variant that was first identified in Brazil. Similar to B.1.351 there are concerns about increased infectiousness and vaccine effectiveness.
(total of 12 mutations including E484K, K417N/T, N501Y, D614G),

As of March 1, 2021: **10 in 5 states, Zero in CA**
For comparison Feb 22, 2021: 5 cases in 4 states / Feb 15; 3 cases detected in the US

Other variant of Interest
B.1.526 variant
Researchers from Columbia in New York recently reported B.1.526 variant which has emerged there.
https://www.medrxiv.org/content/10.1101/2021.02.23.21252259v1
This variant shares some of the concerning mutations VOC particularly as it pertains to vaccine effectiveness.
Lineage first detected in late November 2020 and are increasing in detection in NY area and now represent at least one-quarter of their cases. Most cases NY and New Jersey.
Three such variants have been detected in CA.

B.1. 429 and B.1.427
For the past few weeks mentioned two closely related variants B.1.429 and B.1.427. Both of these variants have a mutation in spike protein and have the potential for increase transmission and immune evasion.

B.1. 429 (aka L452R or 20C, Western US variant, **CAL.20C, West Coast variant)**
B.1.429 variant first detected in California in July and in recent months has increased in prevalence. There are concerns about this variant being more infectious as well as vaccine effectiveness, but data are speculative (in vitro data suggest the L452R mutation spike mutation will lead to immune evasion). Outbreaks noted with high attack rate.

B.1.427 (aka L452R)
Closely linked to variant B.1.429 (has at least one additional mutation in the ORF gene). Like B.1.429, there are concerns about this variant being more infectious and about vaccine effectiveness.

As you may have heard about in the news last week, some headlines included "The Stuff of Nightmares" and "the devil is coming" in stories about these variants. The press reports suggested that these variants are more contagious, result in higher viral loads and have increase morbidity and mortality. We are tracking what is happening with these variants closely.

What we do know
- Accumulating data showing that B.1.427/B.1.429 are common in California representing > 50 % of samples sequenced in several laboratories. A few months ago, a few percent of all sequences, in January ~50% and then in February 60% of what is sequenced.

Typically, I do not discuss unpublished data but given the heightened concerns about these variants in CA I wanted to share some information on unpublished data.

Per discussion with Dr. Joe DeRisi, researcher at UCSF, who has recently completed a large community-based study with over 12,000 participants in high prevalence area in SF with > 1000 positive tests. Of these 800 tests roughly, half were 427/429 vs. wild type. Their study showed the following (just submitted for preprint)
- 3-fold increase in B427/429 from November 2020 to January 2021 (16% in November to 55% in January)

- When they examined household contacts of these cases and compared to other strains spreading in CA at the same time, observed a modest increase in transmission (reproductive number approximately 10% higher (0.357 vs 0.293)
- However, they did not observe any increase morbidity or mortality when these variants were compared to wild type
- No difference in proportion symptomatic vs. asymptomatic
- And further, no difference in CT values in B427/429 when compared to wild type meaning no increase viral loads

Remember B117 was predicted to be the predominant variant by end of March. Difficult to say which variant is worse but at least in terms of infectiousness these variants appear to be less transmissible > B117 but modestly more than other circulating variants.

Pfizer and Moderna both recently announced that they are testing their mRNA vaccine against current variants. There are also discussions underway about testing a new vaccine modified to target the B.1.351 variant (the one originally found in S Africa).

SEQUENCING efforts

The variants really underscore the importance of these efforts.
CDPH continues to expand their whole genome sequencing (WGS) efforts and in past few weeks, additional samples have been sequenced the goal is to test representative samples from diverse populations and wide geographic range over time at least 2% of all positive samples.

To date, > 21,000 thousands of genomes have been sequenced in CA to date. CA number one in nation as far as sequencing efforts and we continue to ramp up sequencing.
I continue to encourage you to maintain high vigilance for outbreaks and work closely with your LHDs if you suspect VOC or VOI. Consider WGS in individuals with recent international travel, exposure to individuals with recent international travel, S gene drop out (only seen in some assays) and re-infection or vaccine failures. Also consider in a patient who receives monoclonal antibody treatment and fails to improve. If you do have any of these situations, please work with your local health department to request WSG.

Finally, important that suspect vaccine breakthrough* specimens undergo WGS to identify a VOC and to monitor for mutations that may confer immune evasion.

***Definition of Vaccine Breakthrough cases**; A possible Vaccine breakthrough case is defined as an individual who has SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected ≥14 days after completing the primary series (i.e., both doses) of an FDA-authorized COVID-19 vaccine. Symptoms are not required in order to meet the case definition. Individuals with SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected <45 days before the most recent positive test are excluded.

Decrease in SARS-CoV-2 testing volumes

We continue to see a trend of decreased testing volume throughout the state and country. Continued testing is important as it is key to identifying new cases for isolation and contact tracing efforts to mitigate further spread. Testing provides an important specimen source for viral genomic surveillance, which are more important as vaccination rates increase, so that we may monitor for mutations in the virus signifying adaptation and evolution to selective pressures such as vaccine and host immune response.

Other
These variants have no impact on testing except for those we have discussed for several weeks (the S gene drop out seen Thermo-Fisher).

IV. Healthcare Associated Infections — Dr. Erin Epson

1. The HAI Program has continued to receive inquiries about the topic of "double masking" and the CDC's recent updates to their infection control guidance section on Universal Use of Personal Protective Equipment to expand options for source control and describe strategies for improving fit of facemasks. In that guidance, CDC recommends that one of the following should be worn by HCP for source control while in the facility and for protection during patient care encounters:

- An N95 respirator OR
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators OR
- A well-fitting facemask (e.g., selection of a facemask with a nose wire to help the facemask conform to the face; selection of a facemask with ties rather than ear loops; use of a mask fitter; tying the facemask's ear loops and tucking in the side pleats; fastening the facemask's ear loops behind the wearer's head; use of a cloth mask over the facemask to help it conform to the wearer's face)

As we've stated, HCP that need respiratory protection as part of transmission-based precautions, such as while caring for patients or residents with suspected or confirmed COVID-19, should use a N95 respirator that serves as respiratory protection as well as source control, particularly when implementing extended use of the N95. This is not new. HCP who don't need to wear a respirator as part of transmission-based precautions may use a facemask for source control; what's new is that CDC is now making recommendations for various options to ensure the facemask fits well

CDC recently posted a new FAQ on using two masks at the same time, including the use of a cloth mask over a medical facemask, to improve the fit of facemasks in healthcare settings, noting that "layering masks requires special care in healthcare settings." In addition, here are a few relevant sections:

- Although a cloth mask can be used over a medical facemask to improve fit, there may be better alternatives such as framed "fitters" or using a knot-and-tuck approach to achieve a good fit. If a good fit is achieved using a single medical facemask, additional approaches like adding layers to achieve a better fit might not be necessary.
- Cloth masks are not personal protective equipment (PPE). They should not be used in place of medical facemasks or NIOSH-approved respirators as part of Standard or Transmission-based Precautions.
- Wearing a medical facemask or cloth mask over an N95 respirator is not recommended for healthcare personnel in healthcare settings
- Wearing a medical facemask or cloth mask under an N95 respirator is never recommended as it will interfere with the seal.

V. Monoclonal Antibody Update — Dr. Sohrab Sidhu

- Reviewing direct ordering process for monoclonal antibodies
- New NIH COVID-19 Treatment Guidelines re: bamlanivimab plus etesevimab

Monoclonal Antibody Overview
To summarize, three investigational monoclonal antibody products have received an emergency use authorization (EUA) for the treatment of mild-to-moderate COVID-19 in non-hospitalized adult and pediatric patients who are at high risk for progression to severe disease. These products are:

1. Bamlanivimab (Eli Lilly, November EUA)
2. Casirivimab + Imdevimab (Regeneron, November EUA)
3. Etesevimab (Eli Lilly, February EUA)

Clinical trial data in outpatients have shown that these products may reduce COVID-19-related hospitalization or emergency room visits in patients who are treated early and who are at high risk for progression to severe disease. The EUAs for these therapies are only to treat symptomatic outpatients. Note that etesevimab is only authorized to be given in combination with bamlanivimab and has not been made available for distribution by the federal government yet.

General updates

Please note that there will be no further federal allocations to state health departments of bamlanivimab and casirivimab/imdevimab as the federal government is now making those products available through direct ordering only.

Additional update: the Regeneron product, which was undergoing repackaging, is now available for direct ordering as well

All treatment sites must now order bamlanivimab and casirivimab/imdevimab (when available for shipping) directly from AmerisourceBergen Corporation (ABC), the drugs' sole distributor. The products remain free of charge to requesting sites. The federal government will continue to monitor all direct orders, and retains the capacity to resume allocation of these and future therapies if needed. Treatment sites should review the direct ordering process guide and place orders directly with ABC at this site.

Should you have any questions or concerns regarding the direct order process for COVID-19 monoclonal antibodies, you may contact HHS/ASPR at COVID19Therapeutics@hhs.gov or ABC at C19therapies@amerisourcebergen.com.

For facilities and healthcare providers interested in setting up infusions for high-risk patients with COVID-19, ASPR has many resources available. This includes free digital content that your facility can use on social media platforms to help educate providers and patients. HHS has also provided CombatCovid.HHS.gov as a resource for your patients.

Should any facilities in California need more monoclonal product, they should order directly from ABC (see above) or can contact their county's Medical and Health Operational Area Coordinators (MHOACs) to access product from previous state allocations.

New NIH COVID-19 Treatment Guidelines re: bamlanivimab plus etesevimab

On February 23, the NIH COVID-19 Treatment Guideline Panel issued a statement on the EUA of the bamlanivimab plus etesevimab combination.

Based on the available evidence, the Panel has determined the following:

- The Panel recommends the use of bamlanivimab 700 mg plus etesevimab 1,400 mg for the treatment of outpatients with mild to moderate COVID-19 who are at high risk of clinical progression as defined by the EUA criteria (BIIa). Treatment should be started as soon as possible after the patient has received a positive result on a SARS-CoV-2 antigen or nucleic acid amplification test and within 10 days of symptom onset.
- It is important to note that the authorized dose of bamlanivimab 700 mg plus etesevimab 1,400 mg is lower than the dose given to participants in the Phase 3 study that provides clinical data in support of this therapy. The authorized dose was extrapolated from data demonstrating its

antiviral activity, as well as from in vitro studies and pharmacokinetic/pharmacodynamic modeling (see below).

- The Panel recommends against the use of bamlanivimab 700 mg plus etesevimab 1,400 mg for patients **who are hospitalized** because of COVID-19, except in a clinical trial. However, bamlanivimab 700 mg plus etesevimab 1,400 mg should be considered for persons with mild to moderate COVID-19 who are hospitalized for a reason other than COVID-19 but who otherwise meet the EUA criteria.
- Given the possibility of a limited supply of bamlanivimab plus etesevimab, as well as challenges of distributing and administering the drugs, priority should be given to patients who are at highest risk for COVID-19 progression based on the EUA criteria.
- Efforts should be made to ensure that communities most affected by COVID-19 have equitable access to bamlanivimab plus etesevimab.
- Bamlanivimab plus etesevimab should not be withheld from a pregnant individual who has a condition that poses a high risk of progression to severe COVID-19 if the clinician thinks that the potential benefit of the combination outweighs the potential risk.
- There are insufficient pediatric data to recommend either for or against the use of bamlanivimab plus etesevimab or other monoclonal antibody products for children with COVID-19 who are not hospitalized but who have risk factors for severe disease. Based on adult studies, bamlanivimab plus etesevimab may be considered on a case-by-case basis for children who meet EUA criteria, especially those who meet more than one criterion or are aged ≥16 years. In such cases, consultation with a pediatric infectious disease specialist is recommended.

Read the full statement here.

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

Bamlanivimab/Etesevimab

- Bamlanivimab and Etesevimab EUA Letter of Authorization February 9 2021 (fda.gov)
- FDA press release
- FAQ

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

Remdesivir:

- Frequently Asked Questions for Veklury (remdesivir) (fda.gov)

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**

- **Three** COVID-19 vaccines have received FDA emergency use authorization: Pfizer, Moderna, and Janssen (also known as the Johnson & Johnson vaccine), which received emergency use authorization on February 27 for persons 18 years and older. Janssen is part of the Johnson & Johnson company.
- Janssen COVID-19 Vaccine Update (Ad26.COV2.S):
  - The Janssen COVID-19 vaccine is a 1-dose non-replicating Adenovirus 26-based vaccine that can be transported and stored at normal refrigerated temperatures. These characteristics make it ideal for sites without freezer capacity or mobile clinics, and ideal for populations who want to be fully vaccinated quickly, who don't want to return for a second dose, or who are mobile or homebound. The CDC estimates that 20 million doses of the Janssen vaccine will be available by the end of March 2021.
  - It was found to be effective and safe in a large Phase 3 trial which enrolled >44,000 participants. The technology for this vaccine has been used in other vaccines, including the Ebola vaccine, and is safe in many different populations, including elderly people and breastfeeding and pregnant women.
  - It offers strong protection against severe COVID-19. Vaccine efficacy is 85% against severe/critical COVID-19. Vaccine efficacy is 93% against hospitalizations, and there were no COVID-associated deaths in the vaccinated groups. Overall vaccine efficacy against moderate to severe COVID-19 disease was 66.3%.
  - The vaccine is very well tolerated, and side effects were less common compared to the mRNA vaccines. Local adverse events, including injection site pain, redness, or swelling occurred in approximately 50% of vaccine recipients. Systemic adverse events, including fatigue, headache, myalgias, nausea, and fever occurred in approximately 55% of vaccine recipients. Most symptoms were mild and resolved after 1-2 days. By comparison, up to 90% of Moderna vaccine recipients experienced any type of local reaction after dose #2, and up to 82% experienced any systemic reaction after dose #2. (Moderna reactogenicity data)
  - CDC Advisory Committee on Immunization Practices states no preference for any of the three authorized vaccines.
  - The CDC notes that the results of the Janssen Phase III trials are not comparable with those of the mRNA vaccines due to different circulating variants and higher background incidence of COVID-19.
  - The CDC's full clinical guidance will be posted in the coming days, but initial recommendations are linked in the ACIP notes. COVID-19 vaccines are not interchangeable. However, if the first dose of mRNA vaccine was received, but the patient was unable to complete the series, a single dose of Janssen COVDI-19 vaccine may be administered at a minimum interval of 28 days from the mRNA dose.

- In summary, with the emergency use authorization of the Janssen vaccine, there are now three safe and effective COVID-19 vaccines in the United States, and all three offer very high protection from severe COVID-19.
- The CDC has a COCA Clinician Update call on the Janssen vaccine **today, March 2 at 11AM Pacific Time**. The link is in the meeting notes, or you can search "CDC COCA Janssen" to get the meeting link: https://www.zoomgov.com/j/1603748312?pwd=anlmUURkSEtmdzBLSmNOV0pJSzZUQT09
- Please refer to the Janssen Vaccine EUA factsheet in the meeting notes: https://www.janssencovid19vaccine.com/
- Additional information can be found on the CDC website: https://www.cdc.gov/vaccines/acip/meetings/slides-2021-02-28-03-01.html
  - Adverse event information: https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-02/28-03-01/02-COVID-Douoguih.pdf

- Clinical considerations for mRNA vaccines: The CDC website is updated with the most recent information about both the Pfizer and Moderna mRNA vaccines. The most recent update was on 2/10/21. Please refer to the link in the meeting notes for additional information: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
- Blue Shield of California is California's Third Party Administrator to build an enhanced vaccine network, and a transition to the new allocation process will occur over the next few weeks. Providers interested in becoming part of the vaccine network should contact Blue Shield at CovidVaccineNetwork@blueshieldca.com. Existing providers registered in California's COVID-19 vaccine system will receive information from the existing provider communication channel. A link with complete information is in the meeting notes: https://eziz.org/assets/docs/COVID19/2021Feb26_TPA-ProviderLetter.pdf
- Doses/allocation
  - As of 3/1/21, 11,158,090 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites, including the LTC facility sites participating in the federal pharmacy partnership program. To date, 9,087,899 doses have been administered. The CDPH vaccine dashboard has been posted and is updated daily. The link to the dashboard is in the meeting notes: https://covid19.ca.gov/vaccines/#California-vaccines-dashboard.
  - As of 3/1/21, 740,116 total long-term care doses have been administered in California. 468,457 individuals have had at least one dose of Pfizer vaccine, and 268,278 have had 2 doses of Pfizer vaccine. Data on doses delivered to the Federal Pharmacy Partnership for LTC Program can be found on the CDC website: https://covid.cdc.gov/covid-data-tracker/#vaccinations-ltc
- The CDC Federal Retail Pharmacy Program has expanded to include CVS, Rite Aid, Walgreens, and Albertson's. The pharmacies are receiving federal allocations of Moderna, Pfizer, and Janssen vaccine. Persons eligible to make appointments at retail pharmacies include healthcare workers, long-term care residents, people 65 and older, and food and agricultural workers. Eligible persons can make appointments at the pharmacies' individual websites.
- Vaccination in long-term care facilities continues with the CDC-Pharmacy Partnership program. Both CVS and Walgreens will give dose #1 at clinic #3. If you are having problems with specific facilities, please contact CVS/Walgreens. If you are still having problems, reach out to your local health department. Links and contact information are provided in the meeting notes.
  - CVS / Omnicare https://www.omnicare.com/covid-19-vaccine-resource/
  - Walgreens https://www.walgreens.com/topic/findcare/long-term-care-facility-covid-vaccine.jsp
    - CVS: CovidVaccineClinicsLTCF@CVSHealth.com

        - Walgreens: immunizeltc@walgreens.com
        - Local Health Department: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Local-Health-Department.aspx
- Prioritization
    - CDPH's guidance on vaccine prioritization has not changed since 2/13/21, and is linked in the meeting notes: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineAllocationGuidelines.aspx
    - Individuals eligible for COVID-19 vaccines under the current guidance include:
        - Phase 1a, all tiers
        - Phase 1b, tier 1:
            - Persons 65 years of age and older
            - Essential workforce sector populations with risk of exposure: Education and Childcare** , Emergency Services*** , Food and Agriculture***.
        - Beginning March 15, healthcare providers may use their clinical judgement to vaccinate individuals age 16-64 who are deemed to be at the very highest risk for morbidity and mortality from COVID-19 as a direct result of one or more of the severe health conditions included in this provider bulletin
- **Additional resources:**
    - Useful contacts
        - MyTurn: myturninfo@cdph.ca.gov
    - CDC communications toolkit: https://www.cdc.gov/coronavirus/2019-ncov/communication/toolkits/index.html
    - 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 Moderna vaccines.
        - Main landing page: https://www.cdc.gov/vaccines/covid-19/hcp/index.html
    - Authorized Vaccinators: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Authorized-Licensees.aspx
    - How to report inventory in Vaccine Finder.
    - Link to the essential workforce list: https://covid19.ca.gov/essential-workforce/

VII. **Questions and Answers**

Q: Is routine surveillance going to continue in skilled nursing facilities?
A: All of the current testing recommendations remain the same for now, even with vaccinated individuals. Until we know more, the current testing recommendations will remain the same.

Q: Can you discuss what should be done in the case of a vaccinated healthcare worker who has had a high-risk exposure?
A: The CDC does recommend quarantine for fully vaccinated healthcare personnel who have had a known higher risk exposure however, they do have criteria to allow the exposed healthcare personnel to continue to work during that 14-day period to alleviate staffing shortages. There still is some flexibility in case to case determinations.

Q: How soon will vaccines be distributed to the local pharmacies like Walgreens and CVS in Northern California? When I checked around and checked our local CVS, they said it was not here and it's not coming. I am in Fairfield.
A: The number of doses that goes to this program is limited but it's increasing. Across the state, it's approximately 100,000 doses each of Pfizer and Moderna. Not every store has doses. We would have to looks specifically to see but the reason I would say that the reason your local store does not have doses is due to the fact that there is not enough for the pharmacies to put it in all of their stores. Our hope is that as the CDC provides more doses, they will be able to expand into more stores and offer more appointments.

Q: Is there a recommendation on how long to wait after a COVID vaccine before administering a TB skin test?
A: I believe it's 4 weeks. I believe the TB skin test can be administered at the same time that they COVID vaccine is administered for those who are initiating their series.
A: It's also on the CDC clinical guidance for mRNA COVID-19 vaccines. If you need to refer to it again, you can go there.

Q: As we are setting up our ability to refer positive tests in vaccinated individuals for genomic sequencing, on the of the questions that's arisen is whether or not we are going to get feedback on the results of that sequencing to know whether or not we are seeing patients with any of these variants. Can you comment on that?
A: Right now, we don't consider it a diagnostic test, so we don't go back into the charts of the patients. I think we can set up a process potentially to report it back, but we are kind of struggling with that issue. Is there any suggestions that you have, it would be helpful but it doesn't serve as a diagnostic test.

Q: This request actually came from our infection preventionist. Just wanted to add a sense of what's going on in the hospital so we could have a system to receive that feedback while making sure that it did not go into the charts. With limited of personnel, that would be doable, but I don't know if the benefits outweigh the risks if you want to keep that out of the patient's charts.
A: That's definitely something that we are talking a lot about, but we haven't sorted it out yet.

Q: You mentioned that retail pharmacies are going to be able to have access to the vaccines. You mentioned the tiers but in what you mentioned, you didn't say whether or not teachers and the additional people that are listed by like San Diego County, as being part of Tier 1B, are also going to be able to use the pharmacies.
A: Currently the criteria for retail pharmacies is more restrictive than the overall state prioritization. This is a concern that many people have raised, and we are working with our leadership to make sure we can align those priority categories. Right now, it does not include those two occupations, emergency services and teachers, but I will share with you when we have more information as we update the prioritization for retail pharmacies.

Q: The information that we have to enter to provided vaccines is an extreme slowdown for us to process additional patients. It caused the need for additional staff for data entry and it really slows

down the number of people we can process in a day. Is there anything the CDC can do to help support systems like FQHCs and decrease some of the data entry that's required would be really helpful.
A: I can take that back.

Q: We have received several emails from different counties stating that they are not accepting any more vaccinator vendors at this time. With the need that out there, I'm trying to understand why they would be declining any more applications. Do you have any insight on that?
A: There is a transition to Blue Shield's network. There been a number of changes and pauses in enrollment. That may explain some of the messaging that you're getting because there were transitions that were happening. Our current understanding is that Blue Shield is accepting inquiries to their inbox for providers that are interested in enrolling and becoming part of the provider network. They can share with you the requirement. That email is in the meeting notes.

Q: They've changed it about three times in this process. Is Blue Shield going to be the final change?
A: We understand everyone's frustrations given that the system has been changed and renamed multiple times. That is our current understanding that the Blue Shield system is what we are going to go with moving forward.

Q: About the TB skin testing, DSS just issued a statewide waiver saying that it's OK for us to wait up to five weeks after the person's final dose. Will there be any kind of waiver from CDPH since we are supposed to do it within seven days of employment for a new hire or do, we have to request program flexibility for each facility?
A: At this point, start with the program flex. We do have an AFL that went out prior to pandemic about program flexibility in general around TB. The TB in Title 22 was already very much different than recent CDC guidelines. We had issued out that program flex as a template for everyone to be able to submit it that way because that's faster than being able to try to change Title 22 at this point. So, go ahead and submit the program flex.

Q: Many of the healthcare providers at UC Irvine and elsewhere are within a week or so of being at 90 days form the endo f having had their second vaccine so that 90 day rule is going to expire as it relates to quarantine etcetera. Any hints of news about boosters or revaccination or what the plan is after that 90 days for the many healthcare providers and others that are hitting their 90 days after getting their two shots?
A: We and also the CDC recognize that fact and this is a continuously evolving area and we will expect to receive updates. My guess is that in the near term, until there is an update to the 90 days, it's likely the quarantine after exposure will become recommended again. I think we will see updates to the recommendations as we get more data on the durability of protection from the vaccine and also as we see how things pan out with the variants of concern.

Q: At one point there was an AFL recommendation that general acute care hospitals do weekly testing of all healthcare workers. Now that a large portion of our healthcare workers are vaccinated as well as the test positivity rates are dipping significantly, I'm just wondering if that still the recommendation or is there talk about rescinding that recommendation?
A: At this point, until we have more information, our recommendation is still to maintain testing until further guidance. We are discussing internally, and I know Dr. Epson works collaboratively with CDC

but at this time, we are not changing that recommendation yet. We will certainly let everyone know when we are getting closer to that.
A: We also provided some information about prioritizations that acute care hospitals can use if there are limited testing resources. Those are in a transcript for one of these calls I believe back in December or January.

Q: Relating to visitations, you mentioned that was going to be focused on skilled nursing facilities, but will that also include general acute care hospitals as well?
A: We revied the most recent visitation guidance to general acute care hospitals. They still have that tiered approach. Hospitals do have the ability, in Title 22, to expand and have their P&Ps because those are just guidance for that particular visitation AFL for GACHs. We will be looking at that to see if there are ways that we need to expand that guidance even further. We do support reopening or providing visitation when you're able to. We understand that many of our facilities are still in what we call purple tier counties using the blueprint data where there's still high rates of spread. So just being mindful of what the spread rate for your county is key. We will be issuing out new guidance on that but probably not until the following week because this week we are focused on getting the SNF visitation AFL out.

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