



California Department of Public Health
Weekly Facility COVID-19 Update Call
January 12, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041

Access Code: 9837566

Available after 10am 01/12/2021

- I. **Welcome / Introduction** **Heidi Steinecker**
- II. **Overview** **Dr. Kathleen Jacobson**
- None Provided
- III. **Laboratory Update** **Dr. Carol Glaser**

On last week's call, Dr. Debra Wadford discussed two SARS-CoV-2 variants that are of interest to public health as well as to the clinical community. I will update the information we have on these variants today.

Before discussing these variants, important to point out that like other RNA viruses the SARS-CoV-2 mutates regularly and acquires 1-2 mutations in its genome ~ every month. Most of these mutations are not particularly noteworthy but a few of these mutations are important. In some cases, viral variants emerge or disappear by mere chance or, as may be important here, may be more fit than other viruses (e.g., natural selection because of more transmissible virus).

B1.1.7. (UK) variant

One of the variants is sometimes referred to as the "UK variants" because it was first detected in the United Kingdom in September of 2020 and is now the predominant strain there. It is also referred to as the B.1.1.7. variant. *(also called SARS-CoV-2 VOC 202001/01 (the first variant of concern from December)*

This B1.1.7 variant has several (17) mutations. Two of the mutations in the UK variant have testing and biological implications;

- One of the mutations is the deletion of 2 amino acids (69/70). The significance of this mutation is that in some molecular assays for COVID-19 there may be a failure of the assay to detect the S-spike protein. This phenomenon is referred to as the "S drop out." The ThermoFisher TaqPathCombo assay is where this "S drop out" can be seen. Importantly the ThermoFisher has two other gene targets that are not affected by this mutation and will still be positive. If/when a lab sees the combination of other positive gene targets (ORF1 and N genes) and a very low /or nonexistent S target on their test, this may be an important clue that this variant may be present,

Importantly, not all samples that have the “S drop out” are due to B.1.1.7. and need to have follow up sequencing.

- In addition to the ThermoFisher assay, other assays affected by this mutation include the [MesaBiotech Accula](#) and [Linea COVID-19 Assay Kit](#). (Based on limited data review, it appears that the ThermoFisher assay is the only assay used in CA with any frequency).
- Since most FDA approved tests have multiple targets to detect virus, even if a mutation impacts one of the targets, the other PCR targets provide redundancy to compensate for a possible missing viral gene target.
- The FDA is following this very closely and has stated that the impact does not appear to be significant and will continue to monitor closely.
- The other notable mutation in the B1.1.7 variant is a mutation in the receptor binding domain of the spike protein at position 501 (amino acid asparagine (N) replaced with tyrosine (Y) (shorthand N501Y). The significance of this mutation is that it appears to be associated with an increase in the ability of the virus to bind to the human cell receptor ACE-2 (angiotensin converting enzyme). This receptor is found in various human organs including the lower respiratory tract.

So far, this variant has been reported in at almost 50 countries including the US. A great place to track B.1.1.7. globally ; https://cov-lineages.org/global_report_B.1.1.7.html

In the US, as of Jan 11 2020, this variant has been found in at least 10 states with several dozen cases. *CDC website is updated every 1-2 days to reflect new cases and states.

In California, two counties have reported this novel variant. Two cases have been detected in San Bernardino and approximately 52 cases in San Diego with 38 confirmed and 14 additional epi-linked cases. In addition to the human cases, you may have heard in the Governor’s report yesterday that some of the gorillas at the San Diego zoo have also been infected (but not this variant). It is very likely additional cases will be found in other counties in CA as well as additional States in the next few weeks. The CDC estimates that currently the UK strain accounts for 0.5% of the circulating strains in the US.

In terms of the **clinical implications** of this variant—so far, there has no data to support that this variant causes an increase in severity of illness or an increased risk of death. There are, however, concerns that this variant is better adapted to the human host and more infectious > other circulating strains, individuals infected with this strain tend to have lower CT values on their molecular tests (equating to higher viral loads). Estimates vary on how much more infectious it may be and vary with R0 0.4-0.7 higher > most other strains.

There have also been concerns about whether this variant will affect **vaccine efficacy**. As you are likely aware, the “Spike” portion of the virus is the major viral antigen in current vaccines. So far, there is good news on this front. The FDA-approved vaccines are “polyclonal” and thus induce antibodies that target several parts of the spike protein rather than just one region. At least one study out of the University of Texas found “no reduction in neutralization activity” of this this mutation (<https://www.biorxiv.org/content/10.1101/2021.01.07.425740v1>). Also, a recent JAMA editorial suggesting that vaccine efficacy will not be affected by this variant. (<https://jamanetwork.com/journals/jama/fullarticle/2775006>).

B1.351 (South Africa) and B1.1.1.28 (Brazil) variants

There is also another variant known as the **South Africa variant**, which has the same mutation as the B.1.1.7 variant in the 501Y receptor binding domain and thus the same concerns for increased infectiousness. This variant has not yet been detected in US.

(see http://cov-lineages.org/global_report_B.1.351.html). Another variant being followed is a strain emerging in Brazil termed B1.248.

Neither of these viruses have been detected in the US.

These emerging strains all illustrate the importance of a robust surveillance system for the detection of novel variants. California has the most robust program for sequencing in the nation.

Sequencing for Variants

As Dr. Wadford outlined in last week's call, in California, we have active program for sequencing of the virus via a program called COVIDNet. This is an initiative established by the California TTF and a collaboration between CDPH (with the VRDL as lead), the Chan Zuckerberg Biohub, Invitae Corporation, Illumina, local public health labs as well as several academic and hospital labs throughout CA. Please consult with your local health department for how to pursue sequencing for any suspicious specimens or concerns about one of these new variants. We will continue to keep you updated on any new information on these, and other, variants.

Additional info /footnotes

*Yesterday CDC website several dozen cases (72) cases thus far (does not include updated cases from CA (from CDC website: CA (32) FL (22), NY (4), CT(2), Pa(1), IN (1) GA (1), TX (1), CO (3) and MN (5) (<https://www.cdc.gov/coronavirus/2019-ncov/transmission/variant-cases.html>)

IV. Healthcare-Associated Infections

Dr. Erin Epton

1. CDC recently posted [FAQ on COVID-19 Vaccination in Long-Term Care Facilities](#) which address various aspects of planning for vaccination, post-vaccination management of SNF healthcare personnel (HCP) and residents, as well as infection control and testing considerations. Importantly, CDC indicates that individuals residing in facilities with active outbreaks (except those isolated due to acute SARS-CoV-2 infection) should receive vaccination as soon as possible to avoid delays and missed opportunities for vaccination. Residents or staff with an exposure who are awaiting results of a SARS-CoV2 test may be vaccinated if the person does not have symptoms consistent with COVID-19. CDC does not recommend that mRNA vaccines be used for outbreak management or for post-exposure prophylaxis, however, because protection from the currently authorized mRNA vaccines is not immediate.

While they are in the facility, vaccination staff should follow all recommended infection prevention and control practices, including use of appropriate personal protective equipment (PPE). Measures should also be taken to maintain separation between individuals with known or suspected exposure to SARS-CoV-2 and other residents or healthcare personnel in the areas where vaccine is being administered and where residents are being monitored after vaccination. The HAI program is developing infection

control considerations and can be available to consult with SNF and their local health departments planning for vaccination of exposed or “yellow-status” residents. Finally, the CDC’s FAQ indicate that facilities should continue to follow recommendations for COVID-19 testing in nursing homes for HCP that have been vaccinated. We did hear on a recent call with CDC, however, that they are updating their general guidance on whether vaccinated individuals need continue routine screening testing or to quarantine after exposure. We’ll provide updates as soon as we have them.

V. **Monoclonal Antibody Updates**

Dr. Sohrab Sidhu

Topics for discussion:

- Monoclonal antibody allocation updates
- Continuing remdesivir after hospital discharge in skilled nursing facilities

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

The Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR) are now allocating the monoclonal products to the states from once every two weeks. Thus, allocations of the monoclonal products from CDPH will occur every two weeks.

HHS/ASPR is also strongly encouraging states/territories to use the monoclonal products and to not stockpile or hesitate to use based upon perceived scarcity. 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](#). If the MHOAC programs do not have any product, the MHOACs should make a request at the regional level, to the Regional Disaster Medical Health Coordinators (RDMHS). The RDMHS can check with other MHOAC programs and if the RDMHS is unable to obtain the necessary quantities, the resource request will move to the state. If the state has product in stock, the state will fill the request.

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. Two new specialty pharmacies, CareKinesis and Premier

Pharmacy Services, were added to the list bringing the total specialty pharmacies receiving direct allocations from the state to 12. The other 10 pharmacies that have received an allocation of bamlanivimab or casirivimab/imdevimab since week 1 are Pacific West Pharmacy, Skilled Nursing Pharmacy, Consonus Pharmacy Services, AlixaRx, Pharmera, Citrus Pharmacy, Ron's Pharmacy, OmniCare, AmeriPharm and Owens Pharmacy.

Previously, CDPH allocated product directly to Skilled Nursing Facilities (SNFs) prior to allocating to the counties. During the last allocation, in addition to SNFs and because there is currently a sufficient supply of monoclonal antibodies for all providers who request them, CDPH began allocating directly to state prisons prior to allocating to counties. Like SNFs, state prisons have been identified as ideal non-hospital settings for treatment with these products; they serve a population with a high prevalence of high-risk medical conditions; testing occurs frequently resulting in early diagnoses; and they can infuse these products onsite or have locations near their facilities that are able to do so.

California Department of Public Health (CDPH) will continue to monitor demand for these products from all sites and counties and adjust the allocation scheme accordingly so that the process remains data-driven, equity-informed and transparent.

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 9-10, California received an allocation of 14,420 doses.

Specialty pharmacies received 287 doses.

2,350 doses were proportionately allocated directly to 21 state prisons. Fourteen new prison locations were added to receive the product this cycle.

The remaining 11,783 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, much was re-allocated to other counties and 1,491 vials 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.

(Please note the [EUA fact sheet](#) for bamlanivimab has been officially updated to reflect the elimination of the step to first withdraw 70 mL from the saline bag, thus simplifying the preparation of the drug. Please refer to the EUA fact sheet included in the resources list for more information.)

(Eli Lilly also released a short video detailing the preparation and administration of bamlanivimab. Link to the video can be found in the meeting notes.)

Casirivimab / imdevimab updates

In weeks 9-10, California received an allocation of 1,570 treatment courses of casirivimab / imdevimab this week.

Specialty pharmacies received 54 treatment courses.

The remaining 1,516 treatment courses were proportionately allocated to the counties' MHOACs using the same allocation formula as is used for the bamlanivimab product. The MHOACs then allocate the product within their county.

Of the product that was declined by various counties, much was re-allocated to other counties while 112 treatment courses of casirivimab/imdevimab were sent to the CDPH warehouse.

While casirivimab/imdevimab was previously only allocated to acute care hospitals and their affiliated settings, the federal government has expanded the eligible locations casirivimab/imdevimab can be distributed to. Now, CDPH is encouraging the allocation of casirivimab/imdevimab to appropriate non-hospital outpatient settings just like bamlanivimab.

Finally, casirivimab / imdevimab continues to only be shipped in increments of 6, per the distributor Amerisource Bergen. Counties will need to consider these new shipping rules and alter their distribution plan accordingly for this week and all future weeks.

(Please note the [EUA fact sheet](#) has been officially updated to reflect the elimination of the step to first withdraw 20 mL from the saline bag, thus simplifying the preparation of the drug. Please refer to the EUA fact sheet included in the resources list for more information.)

Continuing remdesivir treatment in SNFs after hospital discharge:

For patients that are otherwise ready for discharge, we have received questions as to what criteria need to be met to continue administering remdesivir in a SNF once started in the acute care hospital setting.

As a reminder, the [remdesivir prescribing information](#) states, remdesivir “should only be administered in a hospital or in a healthcare setting capable of providing acute care comparable to inpatient hospital care.” Per the [NIH treatment guidelines](#), remdesivir “should be given for 5 days or until hospital discharge (unless the patient is in a health care setting that can provide acute care that is similar to inpatient hospital care).”

Therefore, for remdesivir treatment, appropriate non-hospital healthcare facilities are expected to provide the types of services similar to that of a hospital. Specifically to continue treating patients on remdesivir who are otherwise ready for discharge from the acute care hospital setting, this would mean a SNF:

- Has pharmacy services
- Is checking LFTs daily
- Has room and board for patients
- Has a physician rounding on the patient every day and reviewing labs
- Has a physician on call 24/7
- Provides 24/7 nursing care

- Can monitor the patient with close medical supervision for hypersensitivity reactions during and following administration
- Has immediate access to medications to treat a severe reaction (such as anaphylaxis)
- Has the ability to activate the emergency medical system if necessary.

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:
 - COVIDReadi will soon be replaced by a system named CalVax to handle provider enrollments. Final details will be announced when the new system is ready.
 - General questions about Provider Enrollment can be directed to our COVID Call center at 833-502-1245 or COVIDCallCenter@CDPH.ca.gov
 - Note: a question came up last week regarding CalVax.org and public vaccination bookings. CalVax.org is separate from the CalVax Provider Enrollment system. CalVax.org is the PrepMod vaccination booking platform that was originally used for flu vaccinations, and some counties are using this platform to organize COVID-19 clinics. The ability for the public

to book appointments was an error. Please contact the COVID Call Center if you note a concern with CalVax.org

- Doses/allocation
 - As of 1/10/21, 2,691,675 first doses of COVID-19 vaccine and 1,187,400 second doses of COVID-19 vaccine have been allocated to CA to be administered on a local level to Phase 1A populations. 544,050 doses of Pfizer vaccine have been allocated as part of the federal pharmacy partnership with CVS and Walgreens. To date, 2,466,125 doses have been shipped and 691,215 doses have been reported in immunization registries as administered first dose. There have been 88,636 doses reported as administered second doses. CDPH is also in the process of creating a dashboard where this information will be published and an interim webpage exists with shipped and administered doses at [VaccineDoses \(ca.gov\)](#).
- 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.
 - [Vaccination after SARS-CoV-2 infection: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.htm](https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.htm)
 - "Vaccination of persons with known current SARS-CoV-2 infection should be deferred until the person has recovered from the acute illness (if the person had symptoms) and [criteria](#) have been met for them to discontinue isolation. This recommendation applies to persons who develop SARS-CoV-2 infection before receiving any vaccine doses as well as those who develop SARS-CoV-2 infection after the first dose but before receipt of the second dose. While there is otherwise no recommended minimum interval between infection and vaccination, [current evidence](#) suggests that reinfection is uncommon in the 90 days after initial infection. Thus, persons with documented acute SARS-CoV-2 infection in the preceding 90 days may delay vaccination until near the end of this period, if desired."
 - Authorized Vaccinators:
<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Authorized-Licensees.aspx>
 - If you have questions about groups of vaccinators that are not on this list, please email COVIDCallCenter@cdph.ca.gov.
- Prioritization:
 - 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>.

- This guidance states that after focused and appropriate efforts to reach the individual groups currently prioritized, health departments and providers may offer doses promptly to people in lower priority groups when:
 - Demand subsidies in the current groups, or
 - Doses are about to expire according to labeling instructions.
- To maximize vaccine administration and reduce the potential for vaccine wastage, local health departments and providers should immediately administer COVID-19 vaccines to individuals in all tiers of Phase 1a. Providers offering vaccines should consider partnering with other providers or organizations to provide vaccinations for individuals in the prioritized tiers. However, local health departments and providers should make special efforts to administer the vaccine to vaccinators.

CDPH will release additional details on sub-prioritization during Phase 1b and 1c. The following general prioritization guidance is on California’s COVID-19 webpage, and the occupations listed in each sector are on the Essential Workforce website.

Phase 1B	Phase 1C
<p>1B Tier One:</p> <ul style="list-style-type: none"> • Individuals 75 and older • Those at risk of exposure at work in the following sectors: education, childcare, emergency services, and food and agriculture <p>1B Tier Two:</p> <ul style="list-style-type: none"> • Individuals 65 -74 years of age • Those at risk of exposure at work in the following sectors: transportation and logistics; industrial, commercial, residential, and sheltering facilities and services; critical manufacturing • Congregate settings with outbreak risk: incarcerated and homeless 	<ul style="list-style-type: none"> • Individuals 50 -64 years of age • People 16-49 years of age and have an underlying health condition or disability which increases their risk of severe COVID-19 • Those at risk of exposure at work in the following sectors: water and wastewater; defense; energy; chemical and hazardous materials; communications and IT; financial services; government operations / community-based essential functions

- 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:
 - 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

VII. Questions and Answers

Q: Can you address Governor Newsom's plan of opening up the sports stadiums and vaccinating people on a mass scale instead of following a strict prioritization. We are finding as a county hospital, that it is difficult to stick to the prioritization especially for patients.

A: We do encourage you to make the effort to reach individuals in the groups prioritized. It can be challenging but the guidance does provide some flexibility to vaccinate out of priority order. I would recommend you refer to the guidance.

Q: When are families of healthcare workers going to be included in the vaccination prioritization?

A: There are further details that will be coming out about the Phase 1B and C prioritization. I can share that once it is ready.

Q: Last week you said that if a healthcare worker gets COVID between dose 1 and dose 2 of the vaccine, you said that dose 2 can be administered as soon as the person recovers from their acute infection preventive quarantine. That might mean that dose 2 is delayed by a little bit for some people but it's to be given as soon as that period is over. The minutes from the call made it seem that you should wait 90 days from dose 1 to dose 2 if someone gets COVID between dose 1 and dose 2. Can you shed some light on that?

A: You are correct, the CDC guidance is that vaccination of people who have current SARS-CoV-2 infection should be deferred until the person is recovered from acute illness and the criteria has been met for them to discontinue isolation. There is no minimum interval between infection and vaccination but the CDC evidence does say that reinfection is uncommon within 90 days and a person may delay vaccination up to 90 days if desired.

Q: If we are collecting masks and send them out for decontamination and then store them for crisis shortages, is that acceptable?

A: Yes that is acceptable for crisis storage.

Q: Do you have any information in regards to ivermectin being a treatment for positive patients who may be displaying symptoms.

A: Our advisory board is reviewing the data. At this point, we don't have enough of a consensus to promote that treatment but we have information available online and we are planning on reviewing the data later this week. Hopefully we have an update about that.

Q: Would you recommend advise to use or wait on more information?

A: We can't promote it as a treatment but we are planning on revisiting this issue.

A: The current NIH COVID treatment guidelines does not recommend the use of ivermectin.

Q: With a healthcare worker who has received both COVID vaccinations and experience as a high-risk exposure, is it necessary for that healthcare worker to quarantine after exposure? The second related question also has to do with the need for a healthcare worker to quarantine, not considering the vaccination status but having clinical disease, so natural immunity and having a high risk exposure in the subsequent weeks, let's say six weeks after resolution of the first infection. Do they need to quarantine if they experience a high-risk exposure after that first infection?

A: Currently there isn't explicit guidance on this. The CDC plans release guidance that would address the issue of the need to quarantine following completion of both doses of vaccine. It seems to indicate that there is a recommendation to not quarantine but we don't have that recommendation yet so stay tuned. With regard to healthcare personnel who've had a prior infection and are exposed within 90 days from their prior infection, current CDC guidance is that they don't necessarily need to quarantine so long as they are asymptomatic during that 90 day period in which reinfection is considered very uncommon. On a recent call, they indicated that the time interval might be extended from 90 day to 180 days. Again, we don't have that yet officially so stay tuned. It's also unclear considerations around previously vaccinated and prior infected individuals will apply universally or if they will apply differently in different settings. We will provide updates on those guidances as soon as we get them.

Q: I'm advising education sectors and as we move into these non-medical phases and tiers could CDCH better describe the term "Risk of Exposure" for some of these groups?

A: We can bring that back to the team that is working on providing more detailed guidance.

Q: I was on call a couple of weeks ago with NHSN about reporting and they said that California didn't need to report on the vaccination for nursing homes and Skilled Nursing Facilities (SNFs). Can you clarify if that was wrong?

A: For SNFs, they are required. It is actually going to be built into the SNF daily survey.

Q: Under last week's vaccination guidance, is a provider required to obtain approval from the county before moving on to vaccinate Phase 1B if they've otherwise maximized use of their vaccine to vaccinate those in Phase 1A?

A: I can take this back to the team but based on the guidance that we've released, so far I think it would be advisable to communicate with the local health department that you finished with Phase 1A and to coordinate. We do not have specific guidance on not moving to Phase 1B but I can clarify with our team in terms of what our communication will be about Phase 1B.

Q: You talked about if someone starts remdesivir therapy in acute care, to continue that for five days in the SNF. Someone made a comment on today's call that it should not be given unless you are capable

of giving acute hospital care. SNF do not do that. We are capable of giving emergency care and have access to EMS. I'm a little bit concerned and confused. Could you clarify please?

A: We have left some guidance in the meeting notes as to what SNF can do additionally to reach the level of comparable acute care. We feel as if a patient is otherwise ready for discharge, they simply just have to complete their remdesivir course so long as the SNF can provide these additional services. That would be appropriate.

Q: Can you give any guidance on whether there are additional groups of people that can be vaccinators? Can volunteers who are retired who are unlicensed or any other group be added to the group that can vaccinate so we can have more of a workforce?

A: There is a link on the CDPH page that I can add to the meeting notes that includes a list of authorized licensees that can deliver vaccines. There are also some other groups that are being reviewed. If you have questions about specific groups, you can email the COVID call center. I will also include that link in the meeting notes as well.

Q: Will the new strain of the virus be picked up with the PCR lab test?

A: It will be right now. The lab folks will see a S dropout for the various parts of the COVID virus. They will see something that's a bit unusual but they would still call it positive and again that would be one we want to have sent off for sequencing righty away. Right now all molecular tests will still pick it up but they might see a little bit of an anomaly in the test results.

Q: Is there a waiver for licensed nurses coming from another state that do not hold a California license to be able to come and practice.

A: The process in which we acquire staff from out of country or out of state is that you go through EMSA. You can have them say that they can provide nursing services in California. That's the fastest way. There is also a waiver for the staff to be expedited in. Reach out to me offline, I can connect you to the correct person offline.

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