



**California Department of Public Health
Weekly Facility COVID-19 Update Call
November 10, 2020
8:00 am – 9:00 am**

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

Access Code: 997429

Available after 5 PM 11/10/20

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| I. Welcome / Introduction | Heidi Steinecker |
| II. Overview <ul style="list-style-type: none">• None Provided | Dr. Kathleen Jacobson |
| III. Laboratory Update <ul style="list-style-type: none">• None Provided | Dr. Jill Hacker |
| IV. COVID-19 Vaccine Task Force Update | Dr. Louise McNitt |

Pfizer vaccine in the news – Pfizer released preliminary data on the effectiveness of their vaccine yesterday. Although this is good news, nothing has changed regarding the timing of vaccine availability. Pfizer still plans to submit data to the FDA at the end of November. The process for the FDA to review the safety and efficacy data and to release an Emergency Use Authorization (EUA), and for the Advisory Committee on Immunization Practices (ACIP) to make recommendations on vaccine eligibility, will take a few weeks. Even though vaccine manufacturers, including Pfizer, are manufacturing vaccine while completing safety/efficacy studies, there will still be only limited vaccine available once it is approved, so the first doses of vaccine are still expected to be available no earlier than mid to late December.

Information from CDC website:

[Understanding the Pharmacy Partnership for Long-Term Care Program](#) *The Pharmacy Partnership for Long-term Care (LTC) Program provides end-to-end management of the COVID-19 vaccination process, including cold chain management, on-site vaccinations, and fulfillment of reporting requirements, to facilitate safe vaccination of this patient population, while reducing burden on long-term care facilities (LTCFs) and jurisdictional health departments. LTCF staff who have not received COVID-19 vaccine can also be vaccinated as part of the program. This program provides critical vaccination services and is free of charge to facilities. This effort will require extensive coordination with jurisdictions, LTCFs, federal partners, including the Centers for Medicare and Medicaid Services (CMS), and professional organizations, including American Health Care*

Association (AHCA) and Leading Age, which include members across both nursing homes and assisted living facilities.

Sign-ups for the Pharmacy Partnership closed on Nov 6, but CDC would like more facilities to sign up. Although vaccine for the LTCF population may not be available until after the new year, the information provided in the sign-up survey is needed for vaccine planning. Signing up does not commit all of your residents to taking the vaccine – the usual consents will be required before any residents are given vaccine.

There were some technical issues with the REDCap survey: some facilities who entered their information in the survey did not show up as having registered. The link to the survey will remain open for another few days so that facilities can go back in, check their status, and make sure they have answered all the questions.

ALFs and SNFs can also use this link to enroll: <https://redcap.link/LTCF> if they have not signed up yet. When asked about facility type:

- CMS-certified SNFs and nursing homes should indicate their status, making sure to **include the CCN when prompted.**
- Other types of facilities should select their appropriate facility type.

Another option to enroll is to work with your local health department (LHD). LHDs are being asked to compile a list of LTCFs that have not yet signed up and send to CDPH. These will be compiled and sent to CDC.

Please sign up by either filling out the REDCap survey or communicating with your LHD as soon as possible. Facility information needs to be sent to CDC by **Thursday, 11/12/20 by noon.**

V. Healthcare-Associated Infections

Dr. Erin Epton

Last week, CDC updated their interim infection control guidance to provide different options for screening individuals (healthcare personnel, patients, visitors) prior to their entry into a healthcare facility, as well as information on factors that could impact thermometer readings.

CDC recommends establishing a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2 infection and that they are practicing source control.

Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, people report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 infection during the prior 14 days.

Fever can be either measured temperature $\geq 100.0^{\circ}\text{F}$ or subjective fever. People might not notice symptoms of fever at the lower temperature threshold that is used for those entering a healthcare

setting, so they should be encouraged to actively take their temperature at home or have their temperature taken upon arrival.

Obtaining reliable temperature readings is affected by multiple factors, including:

The ambient environment in which the temperature is measured: If the environment is extremely hot or cold, body temperature readings may be affected, regardless of the temperature-taking device that is used.

Proper calibration of the thermometers per manufacturer standards: Improper calibration can lead to incorrect temperature readings.

Proper usage and reading of the thermometers: Non-contact infrared thermometers frequently used for health screening must be held at an established distance from the temporal artery in the forehead to take the temperature correctly. Holding the device too far from or too close to the temporal artery affects the reading.

The update also includes resources for evaluating and managing ventilation systems in healthcare facilities.

Explore options, in consultation with facility engineers, to improve indoor air quality in all shared spaces.

- Optimize air-handling systems (ensuring appropriate directionality, filtration, exchange rate, proper installation, and up to date maintenance).
- Consider the addition of portable solutions (e.g., portable HEPA filtration units) to augment air quality in areas when permanent air-handling systems are not a feasible option.
- Guidance on ensuring that ventilation systems are operating properly are available in the following resources:
 - [Guidelines for Environmental Infection Control in Health-Care Facilities American Society of Heating, Refrigerating and Air-Conditioning Engineers \(ASHRAE\) resources for healthcare facilitiesexternal icon](#), which also provides [COVID-19 technical resources for healthcare facilitiesexternal icon](#)

On Thursday during CDPH's weekly skilled nursing facility (SNF) infection prevention call, the HAI Program will present on strategies for implementation of COVID-19 prevention and outbreak mitigation, as summarized in this HAI Program resource:

https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/ReferenceSheet_COVIDandMemoryCareFINAL_Oct2020.pdf

Next week, during the weekly SNF webinar and call, we plan to present infection prevention and containment strategies for *Candida auris*, other multidrug-resistant organisms (MDRO) during the COVID-19 pandemic, including how implementation and reinforcement of basic infection control practices can reduce transmission of both MDRO and SARS-CoV-2. I'll also provide an overview of this information on next Tuesday's all healthcare facility call, as it is also relevant to acute care hospitals. And during the first week of December, we plan to offer webinars for SNF and local public health on management of influenza outbreaks in SNF during the COVID-19 pandemic. We'll disseminate details of the day and time along with webinar registration information shortly.

On November 9th, the U.S. Food and Drug Administration (FDA) issued an emergency use -19-related hospitalization or emergency room visits in patients at high risk for severe disease. Importantly, bamlanivimab is authorized only for outpatient use and is not authorized for patients who are hospitalized due to COVID-19 or who require oxygen therapy due to COVID-19. In another randomized controlled trial called ACTIV-3, bamlanivimab was associated with no benefit in hospitalized patients.

A few Clinical and logistical details: Monoclonal antibodies are created in a lab to bind to SARS-CoV-2's receptor binding domain and neutralize the virus.

- Authorized for use to treat of mild-to-moderate COVID-19 in adult and pediatric (at least 12 years of age and weighing at least 40kg) patients who met high-risk criteria specified in the EUA for progression to severe disease
- May only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis
- Intravenous (IV) infusion of 700 mg administered over at least 60 minutes as soon as possible after positive viral test for SARS-CoV2 and within 10 days of symptom onset.
- Clinically monitor patients during infusion and observe patients for at least one hour after infusion
- Refrigerate unopened vials at 2°C to 8°C in the original carton to protect from light
- Instructions to prepare bamlanivimab solution for infusion are included in the EUA
- Product is donated (no cost to state or clinical sites) but costs for infusion services would need to be covered by insurance or another mechanism
- Similar to remdesivir distributions, Operation Warp Speed and ASPR will determine allocations to states and have stated that in phase one Amerisource Bergen will distribute donated product to hospitals only although the infusions would have to be given in non-hospitalized settings such as emergency departments, urgent care, and ambulatory centers that are able to administer this medication
- We have not received details yet regarding the timing of when California will start to receive this medication and what quantity California will receive

Links to the EUA including information for healthcare providers and patients is included in the meeting notes.

BLAZE-1 trial: <https://www.nejm.org/doi/full/10.1056/NEJMoa2029849>

FDA press release: <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-monoclonal-antibody-treatment-covid-19>

FAQ: <https://www.fda.gov/media/143605/download>

Fact sheet for health care providers: <https://www.fda.gov/media/143603/download>

Fact sheet for patients, parents, and caregivers: <https://www.fda.gov/media/143604/download>

Finally, as a reminder that the California Medical Association in collaboration with CDPH will be hosting another virtual grand rounds today (November 10th) at noon. The topic will be a COVID-19 Vaccine Update and will feature four excellent speakers who will discuss the latest updates on the vaccine's progress, status of clinical trials and California's distribution plans. Grand rounds attendees will also hear from the lead of a statewide National Institutes of Health (NIH) grant focused on vaccine trials among vulnerable and underserved populations. You can find more information on the CMA website and I've included a link in the notes as well: https://www.cmadoocs.org/event-info/sessionaltcd/CME20_1110_GRCOVID

VII. Questions and Answers

Q: Regarding AFL on visitation is there an operational definition for prolonged hospitalization?

A: I'm not aware of a specific operational definition. Individual hospitals would kind of be expected to define their institution.

Q: Is there any guidance for facilities with staff who refuse flu shot?

A: I would refer you to your local public health department since there are more stringent health requirements for healthcare personnel.

Q: For green unit residence Are non-medical services such, as salon, allowed back in the residence

A: I would refer you to the All Facilities Letter (AFL) visitation letter about requirements based on county positivity rate for visitors. For non-essential personnel to enter the facility certainly screening and source control are critical.

Q: How do we receive call notes for this call and how do we access the call notes?

A: We can have the operator provide the information about calling in to access the recording. Today after 5 PM call into 1-866-207-1041 and enter access code #997429. International callers dial 402-970-0847 access code #997429

A: Also, please email CDPHdutyofficer@cdph.ca.gov to get on list for emails

Q: Regarding AFL 20-38.5- We're looking at specifics for overnight stay for pediatric and labor/delivery patients. Is that allowed?

A: I agree it's not explicitly stated, especially for these groups of patients. A facility could address as their policy for visitation the presence of visitors that would stay overnight. Ensuring that the other infection prevention and limitation on moving and screening in that policy.

Q: If the hospital has enough supply but they're in tier 1 is that justification for use of N95?

A: Please find guideline by CAL OSHA from August 6, in that guideline CAL OSHA describes strategies for conservation of N95 respirators. This includes allowance for extended use, wearing the same N95 respirator over the course of a single shift. Not changing between patients. Only removing for meal breaks and ensuring that the respirator is taken off and put back on no more than 5 times.

Q: Eli Lilly's Monoclonal Antibody, is there an expected date for when distribution will be being? Will they ask for the hospital information in the same way as Remdesivir. What can we expect and when?

A: We should find out later today when it will be available, perhaps as early as this weekend. If Amerisource Bergen distributed Remdesivir to your hospital, then there is no need to set up another account.

Q: When should we prepare, and should we expect communication directly from Amerisource or our public health?

A: It should be both, communication from local Medical Health Operational Area Coordinator (MHOAC). Should be given sometime this week either Wednesday or Thursday. When we hear the distribution details, Amerisource Bergen, if they have a certain number of doses, they will send to the hospital they will reach out to the hospital directly

Q: Last week it was reported that we can get through to the new state lab and we've reached out to multiple Local Health Department (LHD) and no one can give us any information on how to access that.

A: Please forward concerns to CDPHdutyofficer@cdph.ca.gov and In one to two weeks there will also be a testing taskforce website to sign up as an organization to work directly with the lab.

Q: Regarding the 14-day quarantine, can you please clarify when do we start the counting?

A: For new admissions to SNF, in general it is 14 days from the date of the last potential exposure. Depending on Local Health Jurisdiction they may require on the date of admission to your facility. Some LHJ allow facilities to consider, as described in AFL 20-63, Whether or not there is a known outbreak occurring in a hospital and a hospital testing practices for new admissions and cohorting practices to count those acute care hospital days towards the 14-day hospital period.

Q: Do you have specific guidelines for acute care facilities that serve more as a long-term/congregate living facility? Sometimes we have two patients in a room and then both of those patients have visitors and we find it's hard to social distance, so we move them to a hall or consult room. Trying to get more guidance on this.

A: I think we addressed some of those considerations in AFL that describes visitation requirements for Skilled nursing facilities, but the concept about visitation in long term settings where you may have multi-occupancy room. Preferably visitation is done without roommate in the room. Schedule and arrange for visits such that the roommate is not in the room or create a separate room again where visits can be carried out with individual patient and visitors with physical distancing and source control.