**California Department of Public Health**
**Weekly Facility COVID-19 Update Call**
**February 23, 2021**
**8:00 am – 9:00 am**

**AT&T Meeting Recording: 1 (866) 207-1041**
**Access Code: 5742224**
**Available after 12pm 02/23/2021**

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

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

- None Provided

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

I will continue to provide update on the 3 primary variants of concern (VOCs) as well other variants of interest that we have been following in CA.

**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 per a recent UK report may have higher morbidity/mortality.

As of Feb 22, 2021:

- **1661 cases in 44 states** : 195 in CA (Florida 433, NJ 210, Michigan 210) (for comparison; Feb 15; 1, 173 cases in US in 40 states (186 in CA))

**B.1.351**

This is the variant 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).Now detections in > 30 countries including US.

As of Feb 22, 2021:

- **22 cases in 10 states** (still 2 in CA as reported last week; Santa Clara and Alameda, both international travel and had been in appropriate isolation) (for comparison; Feb 15: 17 cases; 8 states including CA)

**P.1**

This is the variant 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), P.1 has been detected in at least 4 countries so far.

As of Feb 22, 2021:

- 5 cases in 4 states, none in CA (for comparison Feb 15; 3 cases detected in the US)

**Variant of Interests in CA**
Last 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. The clinical and epidemiologic significance is unknown at this time.

**B.1. 429** (aka L452R or 20C, Western US variant, **CAL.20C**)
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, but data are speculative.

Sequencing data showing high percentage of these variants in CA. Our sequencing efforts are yet not representative so don't know significance yet.

See summary table below.

**SEQUENCING efforts**
CDPH continues to expand their whole genome sequencing (WGS) efforts and in past few weeks significant increase in sequencing efforts (for week of 2/5 ; ~2500 sequenced, week of 2/16 ~3400). The goal is to test representative samples from diverse populations and wide geographic range over time at least 2% of all positive samples.

Encourage you to maintain high vigilance for outbreaks and work closely with your LHDs if you suspect VOC or VOI. Laboratories conducting WGS for SARS-CoV-2 that detect a VOC (B117, B.1.351, or P.1) should immediately report the VOC to their local health department for follow up and case investigation.

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**

In recent weeks, we have seen a trend of decreased testing volume throughout the state and country. It is unclear if this is temporary, perhaps due to a shift in focus to vaccination or pandemic fatigue. Irrespective of cause, continued testing is important as it is key to identifying new cases for isolation and contact tracing efforts to mitigate further spread. Further, these new cases also serve as important specimen sources for viral genomic surveillance, which will become ever 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 Lab updates;**

FDA issued guidance on testing Policy for Evaluating Impact of Viral Mutations on COVID-19 Tests https://www.fda.gov/regulatory-information/search-fda-guidance-documents/policy-evaluating-impact-viral-mutations-covid-19-tests

**Summary Table/VOC**

| Country of Origin | Pangolin Lineage | Clade | Spike protein mutations | Increased ACE2 binding | Increased virulence/ death | Immune escape | Reduced mAb and/or neut Ab effect | Reduced vaccine effect |
|---|---|---|---|---|---|---|---|---|
| UK | B.1.1.7 | 20I 501Y.V1 | H69/V70 del N501Y P681H | ~30-70% increase transmission | ~30% increase death | None reported | None reported | Pfizer & Moderna OK, but Novavax reduced |
| UK | B.1.1.7 with S:E484K | ? | H69/V70 del E484K N501Y P681H | ? | ? | ? | ? | ? |
| South Africa | B.1.351 | 20H 501Y.V2 | K417N E484K N501Y | ☑ | ? | ☑ | Yes | Moderna, Pfizer, J&J, Novavax reduced |
| Brazil | P.1 | 20J 501Y.V3 | K417T E484K N501Y | ☑ | ? | ☑ | Yes | ? |
| US - CA | B.1.429/7 | 20C | V13I W152C L452R | ☑ | ? | ☑ | Yes | ? |

**And VOI in CA**

**References**


JAMA article: SARS-CoV-2 Genetic Variants and what do they mean? https://jamanetwork.com/journals/jama/fullarticle/2775006

CDC links regarding SARS-CoV-2 variant viruses:

- Genomic surveillance dashboard: https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/variant-surveillance/genomic-surveillance-dashboard.html
- CDC Discussion of viral variants https://www.cdc.gov/coronavirus/2019-ncov/transmission/variant.html


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

1. Last week, CDC posted updated guidance on the duration of isolation and precautions and role of viral diagnostic testing (RT-PCR or antigen) to discontinue isolation or precautions:

- For most adults with COVID-19 illness, isolation and precautions can be discontinued 10 days after symptom onset and after resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptomsFor adults who never develop symptoms, isolation and other precautions can be discontinued 10 days after the date

of their first positive RT-PCR test result for SARS-CoV-2 RNA. This is unchanged from prior guidance.

- Some adults with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset**; however, severely immunocompromised patients (e.g., currently receiving chemotherapy for cancer, uncontrolled HIV infection with current CD4 <200, prednisone treatment >20mg/kg for more than 14 days) may produce replication-competent virus beyond 20 days and require additional testing and consultation with infectious diseases specialists and infection control experts. This is new guidance.**
- For adults who are severely immunocompromised, a test-based strategy could be considered in consultation with infectious diseases experts.
- For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strateg

2.CDC also made clarifications regarding their updated Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2 | CDC

- CDC clarified that work restriction of fully vaccinated HCP with **higher-risk exposures**, continues to be recommended, but the criteria for not requiring quarantine can be applied to allow these individuals to work as a strategy to alleviate staffing shortages; of note, exposed healthcare personnel would not be required to quarantine outside of work. Additional information from CDC is available here.
- Fully vaccinated inpatients and residents in healthcare settings should continue to quarantine following an exposure to someone with suspected or confirmed COVID-19.

An update to CDPH All Facilities Letter 21-08 is forthcoming.

In addition, CDC confirmed that at this time they do continue to recommend routine screening testing of fully vaccinated asymptomatic HCP as part of workplace testing programs.at this time. Vaccinated persons should continue to follow current guidance to protect themselves and others, including wearing a mask, staying at least 6 feet away from others, avoiding crowds and poorly ventilated spaces, covering coughs and sneezes, washing hands often, following CDC travel guidance, and following any applicable workplace guidance, including guidance related to personal protective equipment use or SARS-CoV-2 testing.

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

- Monoclonal antibody allocation updates

**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**
Allocations of the monoclonal products from CDPH were occurring every two weeks. Please note that this cycle will be the last federal to state allocation of the monoclonal antibody products as the federal government is now making bamlanivimab and casrivimab/imdevimab available through direct ordering only. As such, the federal government will no long be allocating these drugs to health departments.

**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.

Additionally, California currently 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 monoclonal product. The pharmacy would prepare the product and send to the SNF or PACE program for infusion. There are now 15 specialty pharmacies that have received at least one allocation of bamlanivimab or casirivimab/imdevimab since week 1. The complete list of pharmacies can be found in the meeting notes:

(These pharmacies are Pacific West Pharmacy, Skilled Nursing Pharmacy, Consonus Pharmacy Services, AlixaRx, Pharmerica, Citrus Pharmacy, Ron's Pharmacy, OmniCare, AmeriPharm, Owens Pharmacy, CareKinesis, Premier Pharmacy Services, Rivers Edge Pharmacy, Quality Home Infusion, and Physicians Plaza Pharmacy.)

This cycle's 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 "Treatment Guidance" section and titled "Monoclonal Antibody Allocation").

**Bamlanivimab updates**
For weeks 13-14, California received an allocation of 5,310 doses of bamlanivimab.

Specialty pharmacies did not request any bamlanivimab.

The bamlanivimab was proportionally allocated to the counties' MHOACs.
Of the product that was declined by various counties, some was re-allocated to other counties and 1,510 doses were sent to the CDPH warehouse.

**Casirivimab / imdevimab updates**
No allocation for casirivimab/imdevimab was made this cycle. The Regeneron product is currently undergoing repackaging. The product is expected to be available in the future. The CDPH warehouse currently has a supply of casirivimab/imdevimab. Requests for additional casirivimab/imdevimab can be made through county MHOACs.

**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**

- To summarize, two COVID-19 vaccines have received FDA emergency use authorization, one from Pfizer, and the other from Moderna. The FDA meeting to discuss the Johnson & Johnson 1-dose vaccine will be on February 26.
- General questions about Provider Enrollment into myCAvax can be directed to our COVID Call center at 833-502-1245 or COVIDCallCenter@CDPH.ca.gov
- MyTurn: For questions regarding MyTurn, including interface of the electronic health record with MyTurn, please email: myturninfo@cdph.ca.gov
- Doses/allocation
    - As of 2/22/21, 8,832,770 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, 7,437,925 doses have been administered. The CDPH vaccine dashboard has been posted and is updated daily at https://covid19.ca.gov/vaccines/#California-vaccines-dashboard. The dashboard also has a "Vaccination by Groups" feature, displaying administered first doses by race/ethnicity, age and gender.
    - Long-Term Care Doses via the Federal Pharmacy Partnership for LTC Program can be found on the CDC website: https://covid.cdc.gov/covid-data-tracker/#vaccinations-ltc
        - As of 2/23/21, 649,326 total long-term care doses have been administered in California. 434,323 individuals have had at least one dose of vaccine, and 212, 191 individuals
- The CDC Federal Retail Pharmacy Program has expanded to include CVS, Rite Aid, and Walgreens. The pharmacies are receiving federal allocations of Moderna and Pfizer vaccine. Persons eligible to make appointments at retail pharmacies include healthcare workers, long-term care residents, and people 65 and older. Eligible persons can make appointments at the pharmacies' individual websites.
- LTCF: 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
    - 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.
        - 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
- Clinical considerations: The CDC website is updated with the most recent information about both the Pfizer and Moderna vaccines. The most recent update was on 2/10/21 and was presented last week.
    - Link: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
- Prioritization
    - As a reminder from last week, on 2/13/21, CDPH released updated guidance on vaccine allocation during phase 1b.

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineAllocationGuidelines.aspx

- Individuals eligible for COVID-19 vaccines under the new 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
- Please refer to the full guidance for additional details.
- Link to the essential workforce list: https://covid19.ca.gov/essential-workforce/
- Decisions about inclusion in Phase 1b, tier 2, and Phase 1c have not been finalized and released.

- **Additional resources:**
  - 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.

VII. **Questions and Answers**

Q: Along with the number meanings of the variants, can you give the names as well. It's difficult to keep track of those numbers.

A: I agree with you, that's why I always try to say the variants name. There are five different naming nomenclatures for this, and they can have five different numbers too. I agree with you and I'll try to always at least say one of their proper names and I'll make a point to do the more common name because I agree that it's almost impossible to follow.

Q: On March 15th as the guidance opens up for adults with disabilities and certain conditions, is there going to be any practitioner's leeway to interpret these guidance?

A: In the meeting notes, there is a link that to the provider bulletin which provides a list, it's not comprehensive if you've at it, of conditions. There is some language about if as a result of a developmental or severe high-risk disability, which doesn't specify whether that's acquired or developmental that does include your patients with acquired disabilities. The criteria for those people with disabilities include the individuals likely to develop severe life-threatening illness or death from COVID-19. Acquiring COVID-19 will limit the individual's ability to receive ongoing care services. And so, providing adequate and timely COVID care would be particularly challenging as a result of an

individual's disability. So, I would refer you to provider bulletin for further guidance, but it does provide clinicians with an opportunity to evaluate the specific circumstances of their patient.

Q: Just to clarify about fever, the discontinuation of transmission-based precautions guidance that comes from CDC discusses fever but yet does not quantify what a fever is. When they're talking about quarantining for communicable diseases or screening the homeless clients for fever, the threshold for fever is higher than that in healthcare settings. I was just trying to define better what fever is. I did find something in their post vaccine considerations and fever in health care setting is defined as a measured temperature of 100 degrees versus what they say in the code of federal regulations for reportable illnesses as 100.4. So would you agree that the threshold for fever is lower in healthcare personnel than it is for the general public and that we should go with the lower number.
A: I think you are right that CDC is recommending slightly lower threshold for considering fever when screening individuals entering healthcare facilities including healthcare personnel and visitors and they do recommend either a measured temperature of greater than or equal to 100.0 or subjective fever. This is a bit lower than what is recommended in general for evaluation of individuals for potentials communicable disease as you described.

Q: Regarding the Moderna vaccine, do we have any studies that shows that it's going to help against these other variants that are coming out right now wither it's the UK, South African or the Brazilian variants? Second, will the PCR testing that we are doing now automatically be able to detect those variants? And one last question, we are a SNF setting and we are currently testing two times a week in our facility. Do you know when we will switch to one time a week for testing.
A: As far as the UK variant, we know that the Pfizer/Moderna is fine for that. There is some data that they South African or the BB351 variant, that they vaccine efficacy is likely to be reduced. For the Brazilian or P1 variant, the vaccine efficacy is also likely to be reduced. I do want to mention that there will be quite a bit of press today about what we've been calling the variance of interest and that is the 429 and 427. The 429 is also called Cal.20C. This was the variant that there was a lot of information about four weeks ago in the news. This is 50 percent of sequence viruses in a lot of the labs right now. There is pretty strong suggestion that it has a higher transmissibility, so you are going to be seeing that today. Currently, there's no concerns about the vaccine efficacy with those two variants. When I say there are no concerns, we don't have any data to support that. This is all the more reason we really need to increase our sequencing effort and we are asking you as physicians to submit anybody if there are any concerns of a variant of either concern or interest.
A: All the tests right now can detect the variants. There's one assay that is used in California and that the Thermo Fisher assay. In that assay there are three different gene targets that it looks for. Only two of gene targets would be positive but a lab would know that something is wrong and that's called the S dropout. Everything now still picks up the variant but if you use once of those assays called the Thermo Fisher, there would be an actual clue that that's the variant. For the most part, the other assays won't have that clue. You have to use clinical information or international travel to help us figure out whether it could be a variant of interest or a variant concern. And of course, anybody that has been vaccinated and you think there might be a vaccine failure, we really want to be looking at those specimens.
A: For your last question you had about the frequency of routine screening testing for your skilled nursing facility healthcare personnel, you are currently testing twice week. I would refer you to the CMS QSO 20-38-Nursing home or NH which indicates you that need to continue testing at the higher

frequency until your county positivity rate has decreased to below 10 percent for at least two weeks before reducing to the once weekly testing which is the minimum that we're recommending in California. You'll need to refer to the California Blueprint for a Safer Economy website to see for your county what they test percentage positivity rate is. Once it's below 10 percent for at least two weeks, then you can decrease from twice to once weekly.

Q: Probably two or three weeks there was a report that you did on how we're as facilities. What percentage of residents and or team members have been vaccinated statewide? I was wondering if we could get an update on that information.
A: I don't have that information right now, but I can see if I can find any good information to share in the meeting notes or next week.

Q: Could you review again the directions for fully vaccinated staff after two weeks regarding quarantine as far as if they've had an exposure.
A: The CDC has clarified they do continue to recommend work exclusion for fully vaccinated healthcare personnel who are past two weeks after the second dose in a two-dose series and are still within 90 days of completing their vaccine series. Except in situations where there are staffing shortages, in which case they can be allowed to continue to work with all the usual monitoring in place that they wouldn't need to quarantine outside of work anymore. As in consistent with guidance for the general public. When the CDC put out this guidance about no longer requiring quarantine for fully vaccinated individuals meeting that criteria, that was a general guidance for the general public. They've clarified that that they still want to recommend more stringent guidance in terms of work restrictions for healthcare personnel if they've had a higher risk exposure. They would still recommend work restriction even though outside of work, these individuals wouldn't need to quarantine necessarily.

Q: I'm looking to get some clarification. CDC has a FAQ page that has a question that answers what PPE should be worn by EDS and specifically they should delay entry into the room until time has elapsed for enough air exchangers to remove potentially infectious particles. After that, they can enter the room and wear a facemask along with gown and gloves. In an earlier version of a CDPH COVID playbook, it stated that if the housekeeper must clean the room before an hour prior to proper filtration of the air, they should wear full PPE to protect themselves from airborne or contact with COVID-19. Is it acceptable for housekeeping personnel to enter a COVID patient's room for terminal cleaning prior to the hour elapsing if they are wearing full PPE?
A: Yes. In general, to minimize potential exposures for a terminal cleaning, we would recommend waiting until enough time has elapsed to decrease the potential viral particle concentration and minimize any potential exposure. If needed to maintain room turnover, EDS staff can wear full PPE including respiratory protection and enter the room before the time has elapsed.

Q: I heard earlier in a statement that was made regarding temperature screening and continuous symptom monitoring for individuals entering the healthcare facility and of course healthcare workers. Is that still the recommendation for both? We know that some facilities are not doing the temperature screening, so I just want to get your recommendation.
A: The recommendation from CDC for screening individuals who enter the facility includes assessing for symptoms or exposure to others who have suspected or confirmed COVID infection and the option for this screening process include but are not limited to individuals screening on arrival or implementing

an electronic monitoring system in which people report absence of fever and symptoms of COVID-19. Regarding to fever, fever can be either measured temperature greater than 100 or subjective fever. CDC encourages people to take their temperature at home or have their temperature taken upon arrival. To be certain of what is required, we would check with your licensing and certification district office.

Q: There is a six-hour expiration once it punctured on the Moderna and there are 10 doses per vial. It's going to be a logistical nightmare trying to hold it until facilities get 10 people at a time. Has there been any discussion on how that's going to work in any leniency on the 10 residents per vial? Secondly to that, will hospitals start vaccinating their patients when they've been transferred to long term care settings as a rule? I know it spotty right now.
A: I would stay that they current allocation guidance does offer some flexibility to vaccinate people who are in lower priority groups if they vaccine is about to go to waste. It does seem like this is a situation by situation evaluation. Whether you're going into a situation where you know you are going to be vaccinating people who don't meet criteria currently. This is something we are working on. To answer you second question, this is also another area that we are working on as well in terms of clarifying the roll of hospitals and in providing vaccines prior to discharge. I'll update you all once I have more information.

Q: What is CDPH's guidance is for co-administration of vaccines directly related to our employee health vaccines such as MMR and Hep B because if we are to wait, there's a big delay in insuring that our employees are safe, especially with the Hep B series.
A: The CDC guidance has been that there should be a minimum interval of 14 days before or after the administration of any other vaccine. We are following CDC's guidance on this issue.

**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