California Department of Public Health
Weekly Facility COVID-19 Update Call
April 6, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 2628856
Available after 12 Noon 04/06/2021

I. **Welcome / Introduction** **Cassie Dunham**

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

- None Provided

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

As discussed a few weeks ago, there is a new Variant Classification scheme that defines 3 classes of SARS-CoV-2 variants:

- Variant of High Consequence
- Variant of Concern
- Variant of Interest

Most of the numbers presented below are from either CDC or CDPH websites (links below).

Variants of high consequence

Currently, there are NO SARS-CoV-2 variants that rise to this level.

Variants of concern (VOC)

Prior to CDC reclassification, B117, B351 and P1 were the only VOCs. CDC recently reclassified B.1.427 and B.1.429 (aka West Coast or California variants) from variants of interest to variants of concern. This is because these variants have

- approximately 20% increased transmissibility
- significant impact on neutralization by some, but not all, EUA therapeutics

VOC: B.1.427 and B.1.429

Both B.1.427 and B.1.429 have been detected throughout California.

Per CDC website, B.1.427 and B.1.429 account for 52.3% of viruses in CA sequenced by CDC (our local numbers varies a bit in CA and closer to 60% of variants in most labs).

VOC: B.1.1.7

This is the variant that was first identified in the UK. Higher transmissibility as well as higher mortality (28-day risk of death for B1117 was 64% higher > previously circulating strains)
Per CDC website as of April 5 2021-15,511 cases in 52 jurisdictions, 822 in CA

For comparison on March 29, 10,579 cases in 51 US jurisdictions, 536 in CA, March 22, 6390 cases in 50 US states, 471 in CA

Per CDC website, **1.7% of CA viruses sequenced by CDC were B117**.
(These numbers lag) Of note, the CDC director said this week that the increasing case counts in young adults is due to "more highly transmissible variants." In Minnesota, for instance, B117 is quite widespread and makes up > 50% of what is sequenced. Overall, it is estimated that B117 makes up 30% of US cases.

VOC: B.1.351
This is the variant that was first identified in South Africa.
Per CDC website as of April 5 2021, 374 cases in 33 US jurisdictions, 10 in CA.
For comparison, March 29,288 cases in 30 US jurisdictions, 6 in CA/March 22, 19 cases in 27 states, 4 in CA. No proportion given on CDC website due to low number.

P.1
This is the variant first identified in Brazil.
Per CDC website as of April 5, 2021, 289 cases in 25 jurisdictions, 33 in CA.
For comparison as of March 29, 118 cases in 22 states, 7 in CA, as of March 22, 54 cases in 18 states, 4 in CA. No proportion given on CDC website due to low number.

Variant of Interest
B.1.526, B.1.525 (originally found in New York) - 33 B.1.526 and 3 B.2.525 found so far in CA, P2 (originally identified in Brazil) - 22 in CA
(these numbers are on CDPH website).

Other
International news: Press recently reported a concerning variant in Philippines, not very much in the scientific literature, described as 3rd generation variant P1.

State news: You may have heard about on the news about a variant found by virologists at Stanford with the headlines including words such as "double mutant." One individual in the Bay Area has been found with this particular variant. This particular variant is thought to have originated in India where it makes up 15-20% of cases in one region. This variant has 2 spike substitutions (L452R in CA/West Coast variant and E484 or "eek", which is found in the S African and Brazilian variants). Both 452 and 484 are in the receptor binding domain and mutations at that location have been implicated in immune evasion. There is not much more info available on this one yet and CDC has not yet added this variant to their list.

SEQUENCING efforts

The variants underscore the importance of WGS. California has robust system for WGS and continues to expand it. As of 3/24/2021, 27,461 samples have been sequenced in California. (This is the number of sequences submitted GISAID and is not a complete list of sequences).

Guidance for breakthrough cases will be released soon. In meantime if you suspect vaccine breakthrough case particularly in a severely ill /hospitalized individual, please contact your LHD (and ensure that specimens are saved).

We encourage specimens to be submitted for WGS particularly from critically ill patients. (contact your local health department).

Key websites
Science Brief: Background Rationale and Evidence for Public Health Recommendations for Fully Vaccinated People (cdc.gov)

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

- Variants of concern (VOCs) maps and resources
  - https://pbs.twimg.com/media/EvMTRfDU4AEYbSR?format=jpg&name=large
  - https://cov-lineages.org/index.html
  - https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/variant-surveillance/genomic-surveillance-dashboard.html
  - GSD PCR kit for B117 and B1351 free to PHLs: https://www.gsdx.us/rt-pcr-id
  - NS3 data https://nextstrain.org/groups/spheres

Other

Variants of high consequence

A variant of high consequence has clear evidence that prevention measures or medical countermeasures (MCMs) have significantly reduced effectiveness relative to previously circulating variants. For example, failure diagnostics, significant reduction in vaccine effectiveness, significantly decrease in therapeutics and more severe disease.

Variants of concern (VOC)

A variant for which there is evidence of an increase in transmissibility, more severe disease (increased hospitalizations or deaths), significant reduction in neutralization by antibodies generated during previous infection or vaccination, reduced effectiveness of treatments or vaccines, or diagnostic detection failures.

For example, impact on diagnostics treatment and vaccine (widespread interference with diagnostic test targets, evidence of substantially increased resistance to one or more class of therapies, significant decreased neutralization by antibodies generated during previous infection or vaccination, reduced vaccine-induced protection from severe disease, increased transmissibility or increased disease severity).

Variant of interest (VOI)

A variant with specific genetic markers that have been associated with changes to receptor binding, reduced neutralization by antibodies generated against previous infection or vaccination, reduced efficacy of treatments, potential diagnostic impact, or predicted increase in transmissibility or disease severity.
Possible attributes of a variant of interest:

- Specific genetic markers that are predicted to affect transmission, diagnostics, therapeutics, or immune escape
- Evidence that demonstrates it is the cause of an increased proportion of cases or unique outbreak clusters
- Limited prevalence or expansion in the US or in other countries

A variant of interest might require one or more appropriate public health actions, including enhanced sequence surveillance, enhanced laboratory characterization, or epidemiological investigations to assess how easily the virus spreads to others, the severity of disease, the risk of reinfection, and whether currently authorized vaccines offer protection.

Proportions of Variants of Concern by State/directly from CDC website April 5, 2021.

Variant proportions are based on representative CDC sequence data (NS3 + CDC-funded contract sequencing) collected over a 4-week period ending February 27, 2021. Proportions in Table 1 are only shown for states for which CDC has at least 300 sequences from specimens collected during this timeframe.

CDPH data:
The cases identified above are based on a sampling of SARS-CoV-2-positive specimens and do not represent the total number of infections due to the strains that may be circulating in California. The number of California samples sequenced is the number of sequences submitted to the international GISAID database and is not a complete list of all sequences completed to date. Numbers are updated on Thursdays by noon but reflect data posted on GISAID the day prior.

IV. **Healthcare Associated Infections** **Dr. Jane Siegel**

A. On Friday, April 2, 2021, the CDC posted new guidance for fully vaccinated individuals who are traveling **within the United States**.

Domestic Travel:
Fully vaccinated individuals, defined as >2 weeks after completion of the 2 dose series of Moderna or Pfizer vaccine and after the single dose of the J&J vaccine, and those who have recovered from COVID-19 in the past 3 months can travel safely within the U.S. because such travelers are less likely to acquire and spread SARS-CoV-2. **Testing before or after travel and self-quarantine after travel within the U.S. is no longer required for individuals who are fully vaccinated or COVID-19 recovered within 3 months as long as they are asymptomatic**. State, local and territorial governments may have travel restrictions in place, so please check before travel. These travelers should always wear a mask over the nose and mouth, avoid crowds, maintain a 6 foot distance from others, and perform frequent hand hygiene. Masks are required on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and in U.S. transportation hubs such as airports and stations. After travel, monitor for COVID-19 symptoms and get tested if symptoms develop.

For those who are not fully vaccinated:

1. Delay travel until fully vaccinated
2. Get tested with a viral test 1-3 days before your trip and 3-5 days after travel AND stay home and self quarantine for 7 days after travel even if the test is negative at 3-5 days. If there is no test after travel self quarantine for 10 days.
3. Wear a mask, avoid crowds and maintain 6 ft spatial distancing from others, and use frequent hand hygiene.

International Travel

For those who are traveling by **air internationally** and are returning to the U.S:

1. Check destination requirements before leaving the U.S. International travel recommendations are updated weekly. If you do not follow your destination's requirements, you may be denied entry and required to return to the United States.
2. To be considered fully vaccinated, one must have received the complete course of an FDA-approved vaccine. Vaccines administered in other countries that are not FDA approved are not acceptable for fully vaccinated status.
3. **All international travelers:**
   a. Documentation of a negative antigen or molecular test no more than 3 days before boarding a plane to enter the U.S. or of recovery from COVID-19 within the previous 90 days. A copy of the test results or of the positive COVID test for those who are recovered with a signed letter on letterhead from a licensed health care provider or public health official with name, address, phone number stating the individual is recovered must be presented to the airline in order to board.
   b. After travel, get tested in 3-5 days. Self-monitor for symptoms.
4. **Fully vaccinated:** Quarantine is not required unless one becomes symptomatic.
5. **Not fully vaccinated** and cannot delay the travel:
   a. Follow the same as just described, but quarantine for 7 days if a test at 3-5 days is negative or 10 days if no test is obtained.
   b. Avoid being around people who are at increased risk for severe illness for 14 days, whether you get tested or not.

Resources:
Frequently Asked Travel Questions
Domestic Travel During COVID-19
International Travel

B. On April 4-5, CDC posted information about cleaning and disinfecting surfaces related to prevention of transmission of SARS-CoV-2 via fomites on three sites; the links will be provided in the notes.
   1. There is a scientific brief that reviews the science of fomite transmission of SARS-CoV-2 in indoor community environments (https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/surface-transmission.html)
   2. Cleaning, Disinfecting, and Ventilation (https://www.cdc.gov/coronavirus/2019-ncov/community/clean-disinfect/index.html)

3. Cleaning and Disinfecting your facility (https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html)

Of note, **this guidance is not intended for healthcare settings** or for operators of facilities such as food and agricultural production or processing workplace settings, manufacturing workplace settings, or food preparation and food service areas where specific regulations or practices for cleaning and disinfection may apply.

C. Visitation for Pediatric Long Term Care Facilities

Additional information related to the pediatric population in long term care facilities will be added to the SNF visitation AFL, but this is not final yet.

The following considerations in addition to the recommendations for visitation in adult facilities will be addressed:

- Involve Child Life workers in planning the facility visitation program and the most appropriate visitation program for each resident.
- Visitors may include parents, legal guardians, or authorized representatives of the pediatric resident and immediate family, regardless of age. Child visitors must be able to observe the required infection control practices, (e.g., source control, hand hygiene, physical distancing) and should be accompanied by an adult visitor. Children who visit should be up to date with their routine immunizations
- Physical contact may be allowed between the pediatric resident and fully vaccinated visitor.
- Encourage COVID-19 vaccination of staff, visitors, and residents who are 16 years or older for Pfizer-Biotech, 18 years or older for Moderna and Johnson & Johnson's Janssen vaccine

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

Topics for discussion:

- Reviewing latest developments re: direct ordering and variants of concern for the monoclonal antibodies
- Recent press release re: updated Phase 3 casirivimab/imdevimab data
- Medi-Cal billing code for bamlanivimab plus etesevimab administration now active
- HHS/ASPR Call Center for questions and information related to monoclonal antibodies now available

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 adult and pediatric patients who are at high risk for progression to severe disease. However, given concerns re: reduced clinical activity in the setting of SARS-CoV2 variants, only two of the three products are available for direct ordering from the federal government:

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

Clinical trial data in outpatients have shown that these products may reduce COVID-19-related hospitalization or emergency room visits in symptomatic patients who are treated early and who are at high risk for progression to severe disease.

The FDA has released revised fact sheets for health care providers, which now include additional information on susceptibility of SARS-CoV2 variants to each of the monoclonal antibody therapies. The revised FDA fact sheets, which include this data, can be found in the meeting notes.

Given the sustained increase in variants resistant to bamlanivimab alone, and availability of alternative authorized monoclonal antibodies, the U.S. government has stopped the distribution of bamlanivimab alone. CDPH does not recommend bamlanivimab monotherapy for treatment due to these concerns.

The aforementioned restriction only applies to the delivery and administration of bamlanivimab monotherapy. The other two authorized monoclonal antibody products, bamlanivimab plus etesevimab and casirivimab plus imdevimab, will continue to be available for direct ordering from AmeriSource Bergen Corporation (ABC).

In addition to these combination therapies, etesevimab alone is also available for direct ordering**. Note that etesevimab is only authorized for use in combination with bamlanivimab but can be ordered by itself to be combined with any bamlanivimab stock a facility already has on-hand.**

All treatment sites can now order these products directly from AmerisourceBergen Corporation (ABC), the drugs' sole distributor. The products remain free of charge to requesting sites. 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.

In addition to the above direct ordering process, both bamlanivimab and casirivimab/imdevimab are readily available from CDPH. Contact your county's Medical and Health Operational Area Coordinator (MHOAC) to request either of these products from CDPH.

- **Note again that bamlanivimab monotherapy is not recommended by CDPH for treatment of COVID-19 (see above).** However, under its EUA, bamlanivimab can be combined with etesevimab. See the Bamlanivimab plus Etesevimab EUA Fact Sheet for Providers for more information.

Recent Press Release re: Updated Phase 3 Casirivimab/Imdevimab Data
Last week, Regeneron, the manufacturer of casirivimab/imdevimab, released a press release detailing new Phase 3 data.

The data showed a statistically significant 70% relative reduction in hospitalizations and deaths at day 29 compared to placebo [treatment arm: 1.3% (18/1355) vs placebo arm: 4.6% (62/1341); p<0.0001]. All patients in the analysis had at least one risk factor, including obesity (58%), age > 50 years (51%), and cardiovascular disease, including hypertension (36%).

A safety assessment was conducted on all available patient data up to day 169, and identified no new safety signals. Serious adverse events (SAEs) were thought to be related to COVID-19 and occurred in 1.3% of patients in the treatment group and 4.0% in the placebo group. There was 1 death in the 2,400 mg group (n=1,849) and 5 deaths in the placebo groups (n=1,843).

The full press release can be found here: Phase 3 Trial Shows REGEN-COV™ (casirivimab with imdevimab) Antibody Cocktail Reduced Hospitalization or Death by 70% in Non-hospitalized COVID-19 Patients | Regeneron Pharmaceuticals Inc.

Medi-Cal Billing Code for Bamlanivimab plus Etesevimab Administration Now Active
The Medi-Cal reimbursement code for the administration of bamlanivimab plus etesevimab is now active. Medi-Cal will reimburse the cost of infusion when billed with the appropriate administrate code and when administered in accordance with the EUA. A Provider Notification is forthcoming. The cost of the product remains free, paid for by the federal government. More information re: the newly activated code can be found in the meeting notes.

M0245
- Bamlanivimab and etesevimab infusion
- Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring
- Effective date of 2/9/2021
- With a maximum allowable rate of $309.60

HHS/ASPR Call Center for Questions and Information Related to Monoclonal Antibodies Now Available:
Please share broadly with your networks of patients and providers.
- English: 1-877-332-6585
- Spanish:1-877-366-0310

Additional Resources
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.

Bamlanivimab—*bamlanivimab alone without etesevimab is not recommended for use in California:*

- HHS/ASPR Bamlanivimab Update re: SARS-CoV2 Variants of Concern
- Fact Sheet For Health Care Providers Emergency Use Authorization (EUA) Of Bamlanivimab (fda.gov)

Bamlanivimab/Etesevimab

- Fact Sheet For Health Care Providers Emergency Use Authorization (EUA) Of Bamlanivimab And Etesevimab 02092021 (fda.gov)
- Bamlanivimab and Etesevimab EUA Letter of Authorization February 9 2021
- Bamlanivimab plus Etesevimab FDA press release
- Bamlanivimab plus Etesevimab FDA FAQs

Casirivimab / Imdevimab:

- Casirivimab and Imdevimab Distribution Fact Sheet
- Casirivimab and Imdevimab EUA Fact Sheet for Healthcare Providers (fda.gov)

- Casirivimab and Imdevimab EUA Fact Sheet for Patients, Parents, and Caregivers (fda.gov)
- Casirivimab and Imdevimab EUA Frequently Asked Questions updated 02102021 (fda.gov)

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/

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

- **Three** COVID-19 vaccines have received FDA emergency use authorization: Pfizer, Moderna, and Janssen
- 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.
- Doses/allocation
    - As of 4/5/21, 24,530,300 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites. To date, 19,894,885 have been administered. 7,349,899 people have been fully vaccinated. 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 4/5/21, 833,315 vaccine doses have been administered to long term care facility patients and HCWs in California via the CDC-LTC Pharmacy program with CVS and Walgreens. 495,081 individuals have had at least one dose of Pfizer vaccine, and 331,248 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. This program officially concluded on March 31st, although both CVS and Walgreens have a small number of clinics remaining through mid-April.
- The CDC Federal Retail Pharmacy Program continues to expand. The following pharmacy partners are receiving doses:
    - Long-term care pharmacies: Innovatix, GeriMed, MHA, and select Cardinal member pharmacies. A link to the pharmacies included under each of these pharmacy groups can be found on the CDC website: https://www.cdc.gov/vaccines/covid-19/downloads/participating-ltc-pharmacy-list.pdf
    - Retail pharmacies: CVS, Rite Aid, Walgreens, Albertson's, Cardinal, Walmart, Topco, Kroger, CPESN, HealthMart, and GoodNeighbor. The pharmacies are receiving federal allocations of Moderna, Pfizer, and Janssen vaccine. Eligible persons can make appointments at the pharmacies' individual websites. Link with pharmacy scheduling links.
- Clinical considerations for vaccines The CDC clinical considerations website is updated with the most recent information about all three vaccines, and the most recent update was from 3/5/21. 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

- On 3/29/21, the CDC released a report on the real-world effectiveness of the Pfizer and Moderna mRNA COVID-19 vaccines, and found that vaccine effectiveness of full immunization (>=14 days after the second dose) was 90% against infection, and the vaccine effectiveness of partial immunization (>=14 days after the first dose, but before the second dose) was 80%.
- On 3/31/21, Pfizer announced results of their Phase III COVID-19 vaccine trial in adolescents 12-15 years old, demonstrating 100% vaccine efficacy. Pfizer plans to submit that to the FDA for amendment to the EUA as soon as possible. Press release link. Moderna and Janssen have ongoing clinical trials in adolescents 12-17, but results have not yet been released. Moderna press release. Janssen press release.

- Prioritization
  - CDPH's guidance on vaccine prioritization was updated on March 25.
  - As of April 1, 2021, individuals age 50-64 years old are eligible for COVID-19 vaccines.
  - Beginning April 15, 2021, every Californian age 16 and older will become eligible for COVID-19 vaccines.
  - COVID-19 vaccine clinic volunteers are eligible for vaccination if they complete at least one clinic shift and are approved by the clinic's organizer.
  - The full guidance is linked in the meeting notes: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineAllocationGuidelines.aspx
- **Additional resources:**
  - Useful contacts
    - MyTurn: myturninfo@cdph.ca.gov
    - MyTurn onboarding: https://eziz.org/covid/myturn/
  - 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/
  - 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: Regarding testing healthcare workers that are fully vaccinated, it was originally stated that if someone was fully vaccinated, had no symptoms, no known exposure and if they had a positive PCR value during weekly testing that we would look at the CT value. If it was high, we would order another PCR test and if that was negative, they can be released from isolation to continue work. A few weeks ago, the mentioned the same scenario but there was no mention of the CT value. What is the current approach?

A: This is a very complicated situation and it's difficult to answer over the phone. I can say that there is no change to the recommendation to continue to test vaccinated individuals who are healthcare personnel in high risk settings such as SNFs. I think each situation needs to be individualized. The CT values can be helpful if they are high. That suggests that in a vaccinated person, it is unlikely to be a transmissible virus but I think those individuals should be isolated or restricted from work for at least two days to make sure that they don't develop symptoms because we know that there can be vaccine breakthrough. If you repeat the test and it's negative within 24 to 48 hours, then you may be able to

release them from any restrictions. But again, I would urge you to be certain to take this in context of the potential exposures and clusters and what is actually happening in the specific facility. We are happy to take questions about individual situations. You can write to the COV HAI box.

Q: We haven't seen an end date to the okay to travel domestically after vaccination from the CDC or elsewhere for those who received their vaccination in January. Have you seen any indication of an end date for these clear to travel instructions or any plans for a booster shot possibly at a year or six months?
A: I have not seen any kind of end date for the travel instructions.
A: What we know about boosters right now is that they're under development but beyond the fact that they are in clinical trials, we don't have any other further guidance. We will share that when we do hear about it and how it might affect any type of guidance.

Q: I know new guidance has stated that for family visitation in the yellow zone, they have to wear full PPE which means N95 masks instead of surgical masks. Does this also apply to face shields and if so, is the facility required to provide the N95 and the face shield or can we have families provide their own?
A: My understanding is that the N95 is required. I think the expectation is that the facility will provide the N95 and also provide instructions on how to do a seal check. Per AFL 20-22.6, full personal protective equipment (PPE) must be worn for indoor yellow zone visitation and that includes N95 and eye protection (a face shield or goggles) that should be provided by the facility. If the visitation with the yellow zone resident is outdoors, then visitors only need to wear a facemask for source control. If the resident is unable to wear a facemask for source control, it would not be safe for the resident to leave the room for outside visitation.

Q: On the travel advisory where there is no quarantine required, does that apply to visitors that are coming to visit family members at a Continuing Care Retirement Community (CCRC) or SNF?
A: My understanding is that if they are fully vaccinated, that is correct for domestic travel. However, a facility or local health department may want to have other requirements.

Q: I saw in the news that CDPH is considering ending the colored tiers in California. How valid is that?
A: The individuals on this panel don't have that level of information to respond. That's something that we can take back and probably address on a future call or a broader notification.

Q: About mitigation plans, now that we're no longer being surveyed per mitigation plan, are the still effective? Is there a change in their status in any way? And secondarily to that question, we were wondering since so many things have changed with vaccination visitation, can we downgrade some of the residents screening that we've been doing such as multiple checks per day of vital and O2 stats if residents are fully vaccinated and do we need to modify the mitigation plan according to that?
A: As far as mitigation plan goes by monitoring by the department, we have terminated the mitigation plan survey as of the 31st of March. April 1st, we began stepping back into traditional surveys, both relicensing and recertification surveys. With regard to resident screening, I think it's important to continue based on clinical need of the resident for monitoring. I think what's important is to follow whatever is necessary to monitor and assure the health and safety of the residents in your care. Currently CHCQ is not currently conducting mitigation plan surveys. It's important that you consider what is in your mitigation plan because we still are in a situation where there may be positive or new

cases that pop up in your facility. Actions that you've been taking to mitigate spread in the facility or mitigate serious harm to residents because of becoming infected, I think you need to continue those practices to the extent that they are necessary to keep people healthy and safe. We do need to stay the course and continue to apply certain practices to continue to reduce and avoid additional spread. I'm not suggesting you abandon your mitigation plan. It may be appropriate for facilities to evaluate your mitigation plans and make determinations as to what practices are still necessary and appropriate given the condition of your particular building or geographic area.

Q: I have an employee who has had a nose surgery and the doctor has advised against nasal swabs and wearing a N95 for some time. Do you have any recommendations for an employee who can't test for six months and wear N95s? They are fully vaccinated.
A: It sounds like perhaps a PAPR would be the best choice for the individual. You may want to consult with your LHD concerning the waiver for testing.

Q: My question is regarding the April 2nd update on travel from the CDC, does that applies to healthcare personnel working in SNFs and long-term care facilities? My second question is about screening for staff and SNFs whether there is any thought on excluding individuals who are greater than 90 days post their initial infection because we're seeing a fairly long tail off and we find that when we start screening staff who have recovered from COVID at 90 days, many are still turning out positive and then there is difficulty getting their CT value. Any thoughts on using some of the other studies to look at 180 days before we restart screening asymptomatic staff rather than 90 days post infection?
A: About the travel, those would apply to healthcare setting unless the specific facility or local health department wants to have a different requirement but there would not be an exception. Some of that may be influenced by where the person is traveling and what they person is doing and who they are exposed to. As far as the testing for staff, right now, there is not a recommendation to not test those individuals. When you do test them and you receive those results, I think you need to manage those people based on the context of what's happing in the facility.

Q: Can you please clarify on the 90 days for screening testing for staff members and was there any new guidance in regard to that in regard to the tier of the county? Do we need to screen test our employees a certain percentage if it's a different kind of colored tier for the county?
A: There has been no change in that recommendation to date. CDPH to date, has determined the recommendation that they should be tested at least once a week.
Q: We can test them after 90 days if they've been positive before, correct?
A: You can test them after 90 days, yes.

Q: In considerations of patients that are asymptomatic however, fully vaccinated and test positive for COVID, do we keep them in isolation, or do we base that upon symptoms?
A: They certainly should be isolated for two days to determine whether or not they develop symptoms. After that, there are many factors that can be considered including the CT value and whether there was a cluster in the facility. I don't think I can give a one size fits all answer, but I think completing the isolation for 10 days is determined by a variety of factors. It's hard to give just one straight answer. If you can get a repeat test within 24-48 hours and the CT values, that would be helpful.

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