California Department of Public Health
Weekly Facility COVID-19 Update Call
April 27, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 7650491
Available after 12 Noon 04/27/2021

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

- None Provided

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

- None Provided

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

Variants of high consequence

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

Variants of concern (VOC)

The list of VOCs have remained the same for past several weeks; B.117 (first identified in UK), B.351 (first identified in South Africa), P.1 (first identified in Brazil) and B.1.427 and B.1.429 (first identified in CA, sometimes referred to as West Coast or California variants) are currently on CDC's classification as variants of concern.

International news (possibly related to variants)

India experiencing ~300,000 new cases and ~2000 deaths per day (for comparison in February 2021 < 100 deaths/day). Clearly India experiencing 2nd wave but unclear why such a tremendous increase. Possibly due to a combination of factors including "social mixing" and possibly due to a variant called B.1.617 (sometimes referred to as the Indian variant). This particular variant was mentioned on the AFL call a few weeks ago since there was local press about a few of these cases. The press has referred to this variant as "double mutant.' The term double mutant is not accurate as B.1.617 has several mutations but the reason it was called double mutation is that it contains two of the 'famous' mutations of other variants. One of the mutations is that L452R mutation which is seen in the West Coast variant and thought to have mild increase transmissibility. Second mutation is one that is similar (E484Q), but not identical (E484K), to the mutations seen as the variants from South Africa (B1.351) and Brazil (P.1). California has seen a handful of these cases. This variant has not yet been added to CDC list of VOC or VOI.

Nationally: Not only is B.1.117 the most common VOC in the US but also the most common lineage sequenced and represents ~46% of variants sequenced. At least one expert (Trevor Bedford on Twitter) suggest that many states are seeing "B.1.117 epidemics seen on resolving non-B117 background." (i.e., as other variants decrease, B.1.117 increasing) while B.1.427/B.1.429 (aka West Coast variants) are both decreasing nationally.

The numbers of P.1 and B.351 remain relatively low. P.1 1.5 % nationally, B.1.351 0.7%
(but data is lagging as it was last updated March 27):
Source: https://covid.cdc.gov/covid-data-tracker/#variant-proportions

In California: As of April 21, over 38,000 samples have sequenced and uploaded to GISAID (data repository for sequencing data). The proportion of B.1.117 is increasing and 45% of recent samples sequenced. (In January B.1.117 was ~1-2%, February ~4-5% and in March increased to ~20% and now in CA the most common VOC/VOI making up ~45% of sequenced viruses). As of April 21, 2021, a total 345 individuals were identified in CA with P1 (more in March > April) and 46 B.1.351 (more in March > April). We will continue to track these but somewhat reassuring that total number less in April compared to March. See California data:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-Variants.aspx

Variant of Interest (VOI)

B.1.526 (first detected New York), B.1.525 (first detected in Nigeria) and P.2 (originally identified in Brazil). These variants have potential for immune evasion (reduction in neutralization by antibody as well as potential decrease neutralization monoclonal antibody). Nationally, B.1.526, now represents ~9% of all variants sequenced. California has some of these variants but remain in low numbers.

Sequencing efforts

The identification of these variants continues to underscore the importance of WGS. Through COVIDNet, WGS capacity has increased substantially in the last month. Currently ~10% of all positive samples are sequenced (this is ~ same level of UK).
Not only has capacity increased, VRDL and some local PHLs have WGS instruments (Clearview) that can expedite WGS with results within 24-36 hours for high priority and urgent samples.

We encourage physicians to submit samples for WGS. In particular, we are interested in samples from patients who are critically ill patients and any patient hospitalized with what appears to be a vaccine failure.

Information to be included

1) Fully vaccinated – Yes/No (Yes = 14 days post final vaccine)
2) Acute symptoms that could be explained by COVID-19 infection?
3) Hospitalized at time of report
4) If hospitalized, requiring ICU level of care at any time during hospital stay
5) If hospitalized, requiring mechanical ventilation at any time during hospital stay
6) Patient died of illness

Aware that several local public health departments have already reached out to their local hospitals and encouraged submission of samples. For those submitting samples, request that basic clinical information (as above). A web-based form all jurisdiction will be used while will notify us that samples from hospitalized patients are being submitted to a given jurisdiction.

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 - GRINCH report
  - 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

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

***Morbidity and Mortality Weekly Report (MMWR)* — COVID-19 Outbreak Associated with a SARS-CoV-2 R.1 Lineage Variant in a Skilled Nursing Facility After Vaccination Program — Kentucky, March 2021** *Morbidity and Mortality Weekly Report* —
Among 83 residents and 116 HCP in this facility, 75 (90.4%) residents and 61 (52.6%) of HCP were fully vaccinated. The index case occurred in an unvaccinated, symptomatic HCP identified during routine HCP antigen testing. Twenty-six residents and 20 HCP received positive test results for SARS-CoV-2, the virus that causes COVID-19, including 18 residents and four HCP who had received their second vaccine dose >14 days before the outbreak began. An R.1 lineage variant was detected with whole genome sequencing (WGS). Although the R.1 variant has multiple spike protein mutations, vaccinated residents and HCP were 87% less likely to have symptomatic COVID-19 compared with those who were unvaccinated. Unvaccinated residents and health care personnel (HCP) had 3.0 and 4.1 times the risk of infection as did vaccinated residents and HCP. Vaccination of SNF populations, including HCP, is critical to reduce the risk for SARS-CoV-2 introduction, transmission, and severe outcomes in SNFs.

***Morbidity and Mortality Weekly Report (MMWR)* — Postvaccination SARS-CoV-2 Infections Among Skilled Nursing Facility Residents and Staff Members — Chicago, Illinois, December 2020–March 2021** *Morbidity and Mortality Weekly Report* — In February 2021, through routine screening, the Chicago Department of Public Health identified SARS-CoV-2 cases, vaccination status, and possible vaccine breakthrough infections in SNF residents and staff by matching facility reports with state case and vaccination registries. Among 627 persons with SARS-CoV-2 infection across 75 SNFs since vaccination clinics began, 22 SARS-CoV-2 infections were identified among 12 residents and 10 staff members across 15 facilities ≥14 days after receiving their second vaccine dose (i.e., breakthrough infections in fully vaccinated persons). Among the 15 facilities with breakthrough cases, the attack rate for unvaccinated residents was 15% (89 of 604) and for vaccinated residents was 0.8% (15 of 1,781). Two thirds of persons with breakthrough infection were asymptomatic and a few experienced mild to

moderate COVID-19–like symptoms; two COVID-19–related hospitalizations and one death occurred. No facility-associated secondary transmission was identified, since any new cases that occurred after the initial breakthrough infection were not close contacts of the persons with breakthrough infections. Although a few SARS-CoV-2 infections in fully vaccinated persons were observed, these cases demonstrate the need to promote high vaccination coverage among SNF residents and staff members.

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

- Monoclonal antibody overview
- Update to the NIH COVID-19 Treatment Guidelines

To summarize, two investigational monoclonal antibody products are currently recommended for use in California:

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

These 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. 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. The NIH has strongly recommended (AIIa) these treatments for use in non-hospitalized COVID-19 patients.

All treatment sites can now order these products directly from AmerisourceBergen Corporation (ABC). 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.

Given the sustained increase in variants resistant to bamlanivimab alone, and availability of alternative authorized monoclonal antibodies, the U.S. government stopped the distribution of bamlanivimab alone on March 24, 2021. Shortly thereafter, CDPH stopped recommending bamlanivimab monotherapy. And on April 16, the FDA revoked the EUA for bamlanivimab monotherapy.

Sites that only have bamlanivimab and are administering monoclonal antibodies, should either:

- **Order etesevimab to pair with the current supply of bamlanivimab, or**
- **Order and use the casirivimab + imdevimab monoclonal antibody cocktail**

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.

Update to the NIH COVID-19 Treatment Guidelines

On April 21, the NIH COVID-19 Treatment Guidelines Panel announced it had released a new version of the COVID-19 Treatment Guidelines (nih.gov).

Key updates to this version of the Guidelines include:

- The new **Outpatient Management of Acute COVID-19** section provides recommendations for screening, triage, and therapeutic management of patients with mild to moderate COVID-19 who do not require hospitalization. This section also provides recommendations for managing patients with COVID-19 after they are discharged from the emergency department or the hospital.
- In a new section on **Colchicine**, the Panel finds insufficient data to recommend either for or against the use of colchicine in nonhospitalized patients with COVID-19. The Panel **recommends against** the use of colchicine in hospitalized patients, except in a clinical trial.
- A new section on **Fluvoxamine** reviews the results of a small randomized controlled trial and an observational study. The Panel has determined that there are insufficient data to recommend either for or against the use of fluvoxamine for the treatment of COVID-19.
- **Therapeutic Management of Adults With COVID-19** now includes recommendations for when to use combination anti-SARS-CoV-2 monoclonal antibodies and tocilizumab (in combination with dexamethasone) in certain patients with COVID-19.
- A new subsection has been added to **Overview of COVID-19** to discuss the emerging information on SARS-CoV-2 variants of concern.
- **Clinical Spectrum of SARS-CoV-2 Infection** describes reports of SARS-CoV-2 reinfection in individuals who had previously documented COVID-19. The discussion on patients who experience persistent symptoms or organ dysfunction after acute COVID-19 has also been updated.
- **Anti-SARS-CoV-2 Monoclonal Antibodies** now incorporates information and recommendations from the Panel's statement on the Emergency Use Authorizations for anti-SARS-CoV-2 monoclonal antibodies. This section also includes information on the reported SARS-CoV-2 variants and the potential impact of mutations on in vitro susceptibility to different anti-SARS-CoV-2 monoclonal antibodies.
- **Convalescent Plasma** includes new recommendations for using convalescent plasma in hospitalized patients with COVID-19 and in nonhospitalized patients with COVID-19. A new clinical data table summarizes the results from several randomized clinical trials and retrospective cohort studies of convalescent plasma use in patients with COVID-19.
- **Interleukin-6 Inhibitors** discusses the use of tocilizumab plus dexamethasone in certain hospitalized patients who are exhibiting rapid respiratory decompensation due to COVID-19. A new clinical data table summarizes the results from key studies of tocilizumab and sarilumab use in patients with COVID-19.
- The Panel has expanded the discussions on treatment considerations for children with acute COVID-19 in **Special Considerations in Children**. This section also includes updated information on the epidemiology and risk factors for COVID-19 in children, vertical transmission of SARS-CoV-2 infection, and multisystem inflammatory syndrome in children (MIS-C).

For a complete list of updates, please see What's New in the Guidelines on the COVID-19 Treatment Guidelines website.

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 (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
Fact Sheet For Health Care Providers Emergency Use Authorization (EUA) Of Regen Covtm (Casirivimab With Imdevimab) (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)

HHS/ASPR Call Center for Questions and Information Related to Monoclonal Antibodies:

Please share broadly with your networks of patients and providers.
English: 1-877-332-6585
Spanish:1-877-366-0310

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**

- As a reminder, three COVID-19 vaccines have received FDA emergency use authorization: Pfizer, Moderna, and Janssen.

- Janssen Pause Lifted: On 4/23/21, following a thorough safety review, including two meetings of the CDC's Advisory Committee on Immunization Practices, the U.S. Food and Drug Administration and the U.S. Centers for Disease Control and Prevention have determined that the recommended pause regarding the use of the Janssen (Johnson & Johnson) COVID-19 Vaccine in the U.S. should be lifted and use of the vaccine should resume. Press release.
    - The pause was recommended after reports of six cases of a rare and severe type of blood clot in individuals following administration of the Janssen COVID-19 Vaccine, which is now called TTS, or thrombosis with thrombocytopenia syndrome.
    - The FDA and CDC have confidence that this vaccine is safe and effective in preventing COVID-19.
    - The FDA has determined that the available data show that the vaccine's known and potential benefits outweigh its known and potential risks in individuals 18 years of age and older.
    - At this time, the available data suggest that the chance of TTS occurring is very low, but the FDA and CDC will remain vigilant in continuing to investigate this risk.
    - Health care providers administering the vaccine and vaccine recipients or caregivers should review the updated emergency use authorization fact sheets which have been revised to include information about the risk of this syndrome, which has occurred in a very small number of people who have received the Janssen COVID-19 Vaccine.
    - Healthcare Providers: https://www.fda.gov/media/146304/download
    - Caregivers: https://www.fda.gov/media/146305/download
    - On Tuesday 4/27/21, the CDC is hosting a COCA Call at 11AM Pacific Time on the Janssen COVID-19 Vaccine and Thrombosis with Thrombocytopenia syndrome. The call information is in the meeting notes, or can be found by searching CDC COCA call.
        - **Webinar Link:**
        - https://www.zoomgov.com/j/1601111927?pwd=UTliM1BEWnJ0SkpKUzZnZUVDTVBxUT09external icon
        - **Passcode:** 358595
        - **Dial In:**
        - US:+1 669 254 5252
        - or +1 646 828 7666
        - or +1 551 285 1373
        - or +1 669 216 1590
        - International numbersexternal icon
        - **One tap mobile:**
        - US: +16692545252,,1601111927#,,,,*358595# or +16468287666,,1601111927#,,,,*358595#
        - **Webinar ID:** 160 111 1927
    - As a reminder, health care providers are asked to report adverse events to the Vaccine Adverse Event Reporting System at https://vaers.hhs.gov/reportevent.html.
    - The American Society of Hematology released clinical guidance regarding the diagnosis and management of Vaccine-induced Immune Thrombotic Thrombocytopenia (VITT), which is linked in the meeting notes.
- Clinical considerations for vaccines The CDC clinical considerations website is updated with the most recent information about all three vaccines. The CDC will update this page after Tuesday 4/27/21 with updated clinical information related to the Janssen COVID-19 vaccine. There are a number of useful job aids linked on the website. Please refer to the link in the meeting notes for additional information: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

- Blue Shield is California's Third Party Administrator to build an enhanced vaccine network. Many local health jurisdictions have been added to the Blue Shield Network. Providers interested in becoming part of the vaccine network should contact Blue Shield at CovidVaccineNetwork@blueshieldca.com.

Doses/allocation:

- As of 4/26/21, 35,058,910 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites. To date, 28,398,915 have been administered. 11,622,180 people have been fully vaccinated. The CDPH vaccine dashboard has been posted and is linked in the meeting notes: https://covid19.ca.gov/vaccination-progress-data/
- Pharmacies continue to receive doses via the CDC Federal Retail Pharmacy Program:
    - Eligible persons can make appointments at the pharmacies' individual websites. Please refer to the link in the meeting notes with the list of pharmacies receiving doses and scheduling links. Link with pharmacy scheduling links.

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.**
- **Prioritization: All Californians 16 and older are eligible for COVID-19 vaccines as of April 15, 2021. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineAllocationGuidelines.aspx**

VII. **Questions and Answers**

Q: Regarding ICU care for patients with COVID, nursing relations recommends that nurses in the ICU only take care of patients with COVID and not go between other patients. What is your opinion on that? The CDC guidance said that as a measure to limit healthcare provider exposure and conserve PPE, facilities could consider designating entire units within the facility but dedicate healthcare providers to care for patients with suspected or confirmed. That means that they are only assigned to those patients during their shift. But again, that was when we had dedicated units and shortages of PPE.
A: I would like to reiterate CDC guidance and the purpose of having dedicated staffing is about limiting potential exposure, conserving PPE and limit any potential cross transmission that could occur. That can be prevented with proper doffing of PPE and performing hand hygiene between patients. There has been some misconception that staff members who are assigned to working in red zones aren't able to work in the non COVID positive areas even on a different shift. That's not the purpose of having dedicated staffing. It is as you indicated as you were asking your question. When there was multiple patients or residents that were positive in facilities, that made sense to have dedicated staffing. But I agree with you that it doesn't necessarily make sense when you have one who is in the ICU with COVID infection and need to maintain appropriate nursing ratios.

Q: About the India surge, have they been finding that the cases are associated with vaccine breakthrough or mostly with unvaccinated individuals?
A: We have been looking for more information. There is a lot of missing information.

Q: Is there any proof of reinfection?
A: I have been looking but there has not been much data coming out of India right now.

Q: Is there any guidance on the need for asymptomatic fully vaccinated individuals to be tested prior to undergoing operating procedures? Is there a need to preop screen them with COVID testing?
A: I think that we will have updated guidance on that shortly regarding testing fully vaccinated individuals. I think that the current CDC recommendation and I think is reflected in our All Facilities Letter recommendations for hospitals is that person be tested upon or prior to admission for certain operative procedures that involve aerosol generating procedures or operations involving the head or neck. I think those are largely linked to rates of community transmission in the current guidance and don't necessarily count for an individual's vaccination status. Again, we are anticipating that CDC will be forthcoming with updated guidance. This is certainly discussed within CDPH with plans to update our guidance so stay tuned. But again, the guidance and recommendations are exactly that, they're recommendations. I think it's reasonable for facilities to make some risk-based determinations or modifications to their testing program for this particular population of individuals.

Q: Regarding the Johnson & Johnson vaccine, the concern that we are seeing more in the clinical and ethics community is whether or not we should be offering the J&J to women under 50. Many people are saying that even with the risk benefit profile to women from 18 to 49, given the J&J parameters, is an issue. Are you aware of any conversations about that at the state level because it doesn't look like we are getting guidance on this?
A: I will bring this back and hopefully get an answer for you next week.

Q: I received a letter in the mail yesterday from CDPH asking me to do a test and fingerprint. I'm curious to know the methodology and how that data will be used.
A: We don't have the people on the call to answer this. We can bring that back to our colleagues to see if they can answer it.

Q: I can send you the letter if you want?
A: You can send it to CovHAI@cdph.ca.gov.

Q: Where can I get the minutes from this call?
A: I believe that there is a CAHAN alert that distributes the minutes. You can email me and I can forward your information to be added to the distribution list.

Q: Is there any visitation in the red zone if the visitor is fully vaccinated and the patient is on end of life care?
A: For end of life care, that's always considered a compassionate care situation so yes, visitation should always be facilitated. Even if the visitor is fully vaccinated, we would recommend that if they are visiting in the red zone for compassionate care purposes, that they wear PPE provided by the facility.

Q: Would there be a limit as to how long or could they stay as long as they wanted to?
A: I think that's somewhat up to the facility to determine. I think we indicated in the AFL that visitations should be no less than 30 minutes and certainly makes sense for end of life and compassionate care to provide as much time as possible within reason. We acknowledge there are logistic issues with providing and overseeing visitation. Do place limits on the duration and total number of visitors that can be accommodated at a given time but again, within those reasonable logistics parameters, there is otherwise no set limit on the amount of time a visitor can visit.

Q: I have a CNA who came back from India. Do we need to do any special precautions for her or is 14-day quarantine with two negative PCR tests enough?
A: For fully vaccinated international returning travelers, the CDC no longer recommends that they need to be quarantined or excluded from work although they do continue to recommend a test between 3 to 5 days after return. I am not aware of any different recommendation for returning travelers from India. Individual facilities can make case by case determinations.

Q: My question is in regard to my General Acute Care Hospital and the AFL and updated visitor guideline. The current guidelines are that when your facility is in a county that is either in the substantial, moderate, or minimal tier of community transmission, you should allow up to two visitors from the same household at the same time. Is that meant to be the visitors from the same household as the patient or is that meant to be for any visitors from the same household?
A: They don't need to be visitors from the same household as the patient. The reason for that consideration about the same household, is to allow more visitors, up to two visitors at a time. If they are from the same household then they don't necessarily need to physically distance from one another. So that really is more of a logistics consideration in terms of the space to be able to accommodate a need to oversee and monitor physical distancing. They don't need to be from the same household of the patient that they are visiting.

Q: The first questing is regarding the J&J vaccine. An earlier caller mentioned that there was a big debate about vaccinating women under the age of 50 due to the risk of the vaccine mediated thrombosis. One thing that we are debating is how to vaccinate hospital discharges and the J&J vaccine is certainly more appealing because of it's a single dose. If that is the main one for hospital discharges, are we required to document in the chart that the risk of this particular complication was reviewed with the patient and the patient consented? If that's the case, are you going to provide us with some kind of boilerplate language for that? My second question pertains to the MMWR outbreak that share in which a non-vaccinated healthcare personnel brought COVID into a skilled nursing facility causing large outbreaks among residents and healthcare personnel. There has been a lot of pressure to reopen in person teaching, in person meetings, etc. and vaccination uptake is not at 100 percent. Even though these vaccines are emergency use authorization, some institutions like the Huston Methodist Hospital for instance has made vaccinations mandatory. So, my question to CDPH is, are you in support of institutions making COVID vaccinations mandatory before full approval by the FDA and if not, is that likely to change after full approval by the FDA?
A: We are not in a position to speak about the department position on mandatory vaccinations. That's not something that we are prepared to talk about on the call today. I personally don't have any information about that.

A: I don't either. We don't have the correct people to address your first question. We will take that back to get an answer. I think what you highlight is important in these MMWRs that vaccination of healthcare personnel is a critical infection prevention and control and outbreak prevention strategy. I certainty encourage any strategies that hospitals as well as any other healthcare facility can employ to increase vaccination uptake among healthcare personnel. That can include a number of different strategies, not just mandating, but to really work with your staff to better understand the reasons for hesitancy and offering repeatedly that there are a number of tools available to help with that. We would encourage taking advantage of that until there is more guidance or an approval that will likely facilitate mandates.

Q: Do you have any recommendations for residents who are wanting to go out on a day pass, say with their family?
A: Residents are permitted to leave the facility. The issue is whether or not they need to quarantine upon return. If they are fully vaccinated, they do not need to quarantine. For unvaccinated individuals, CDC guidance does not necessarily recommend quarantine for those who are gone for less than 24 hours. For unvaccinated individuals who leave for greater than 24 hours, CDC recommends that those residents are managed like new admissions who are unvaccinated and would recommend quarantine for them. It really comes down to their vaccination status.

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