California Department of Public Health
Weekly Facility COVID-19 Update Call
May 11, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 3211232
Available after 12 Noon 05/11/2021

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

All Facilities Letter 20-26 will be updated and released on Monday, 5/17/21 to announce the 60 day advanced notice for withdrawal of the blanket waiver for space conversion.

To request to be added to CAHAN notice distribution lists, please locate your HAN contact at this link: CAHAN Alert System - FAQs https://member.everbridge.net/index/892807736722952#/faq
Additional questions regarding CAHAN participation should be addressed to CAHANinfo@cdph.ca.gov.

Individuals seeking enrollment should send the following information to the appropriate contact for your county indicating your request to be added to the system.

First Name/Last Name:
Work Email:
Position Title/Role:
Work Facility Name/Department Name:
Work Location Facility Type:
Work Location Address (#, Street, City, Zip):
Work Desk Phone:
Work Cell Phone:

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

- None Provided

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

Variants of high consequence
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.1.1.7 (first identified in UK), B.1.351 (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.

Variants of interest

List of VOI include B.1.526 (first identified in New York) and B.1.516.1 (first identified in NY), B.1.525 (first identified in Nigeria), P.2 (first identified in Brazil). B.1.617 (first identified India), B.1.617.1, B.1.617.2, B.1.617.3 are listed as variants of interest / CDC website.

International news

UK

This past week the UK added **B.1.617.2** to their list for variants of concern (VOC) with comment that "assessed as having at least equivalent transmissibility to B.1.1.7 based on available data." UK has seen a steep rise in cases of B.1.617.2 cases in last few weeks. In terms of immune escape – insufficient information.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984274/Variants_of_Concern_VOC_Technical_Briefing_10_England.pdf

Interestingly, **B.1.617.2** is not the one that has been referred to as the 'double mutant' (that is B.1.617.1). B.1.617.2 does not contain the E484Q* mutation but does contain the L452R mutation and thus it may be more transmissible (i.e., less concerns about immune evasion but increased concern about transmissibility).

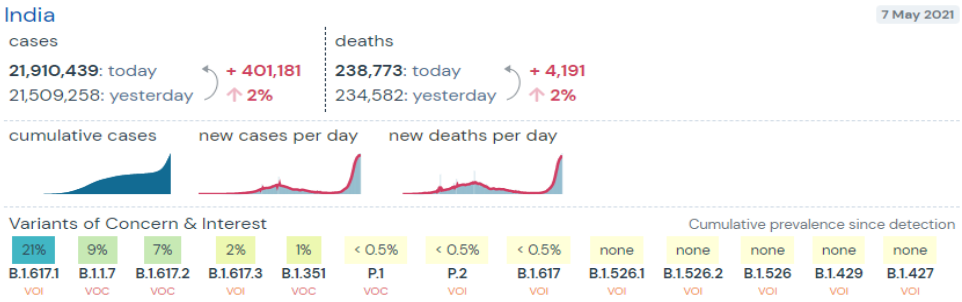
Note: on Mary 10, 2021, **the World Health Organization added B.1.617 as a variant of concern**. This was not mentioned during the call.

India

India continues to report extremely high numbers of cases with >400,000 cases per day and 3,000-4,000 deaths per day. Likely multifactorial with their large population of over 1 billion people and population density certainly playing a role. Additional factors include lack of belief in masking and social distance practices. Until recently most cases were in cities but during this 2nd wave cases are increasing in rural areas.

One of the issues being raised is what role variants have played in the rapid and catastrophic rise in cases there. Over 11,000 sequences have been uploaded to GISAID (reflecting a very small percentage of cases sequenced) with 1298 (12%) sequenced as B.1.617. There are anecdotal reports that the B.1.617 variant may be taking over. Vaccine coverage in India remains low (reports vary, but *<10% of the population has been vaccinated).*

India sequencing data from Outbreak.info



Nationally

From CDC website

B.1.1.7 continues to increase and is the most common VOC in the US as well the most common lineage sequenced with ~60% of variants sequenced while B.1.427/B.1.429 (aka West Coast variants) are both decreasing nationally. Additionally, P.1 is increasing in all regions of the US while B.1.351 is stable.

California:

Approximately 50,000 specimens sequenced and imported to GISAID. The proportion of B.1.1.7 among samples continues to increase with 50% of samples sequenced (compares with ~1-2% in January, ~4-5% in February, and ~20% in March). B.1.427/429 numbers continue to fall (had made up ~60% of our sequences in February, now only ~20%). The levels of B.1.351 are fairly steady (<50 cases). Last week I reported that we had seen a modest increase in P1 in California. This increase continues **and currently P.1 comprises ~8% of samples sequenced**. Finally, we are seeing some cases of B.1.617 in California (many linked to travel).

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. Most whole genome sequencing is not CLIA-validated and is almost never considered to be a diagnostic assay. However, we encourage physicians to submit samples for WGS. In particular, as you have heard me mention for the last few weeks, we are doing a 'call for cases' to obtain samples on individuals who are hospitalized.

- We are aware that several local public health departments have already reached out to their local hospitals and encouraged submission of samples. This request for specimens supplements and does not replace calls for samples by local health departments. For those submitting samples, we request basic clinical information – acuity of illness (e.g., ward vs. ICU, intubated or not, and prior receipt of vaccine).
- We also request that serum be submitted along with respiratory samples. Serology at VRDL includes *BioRad ELISA for Ab to nucleoprotein and UBI ELISA for IgG to nucleoprotein and spike. Antibody to nucleoprotein is consistent with infection while antibody to spike protein is consistent with natural infection or vaccine response. Unlike WGS, these results can be reported back to clinicians and to the patient.*

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

Last week CDC updated their scientific brief on SARS-CoV-2 transmission to reflect current understanding of the principal modes by which people are infected with SARS-CoV-2. Infectious exposures to respiratory fluids carrying SARS-CoV-2 occur in three principal ways:

1. Inhalation of air carrying very small fine droplets and aerosol particles that contain infectious virus. Risk of transmission is greatest within three to six feet of an infectious source where the concentration of these very fine droplets and particles is greatest.
2. Deposition of virus carried in exhaled droplets and particles onto exposed mucous membranes (i.e., "splashes and sprays", such as being coughed on). Risk of transmission is likewise greatest close to an infectious source where the concentration of these exhaled droplets and particles is greatest.
3. Touching mucous membranes with hands soiled by exhaled respiratory fluids containing virus or from touching inanimate surfaces contaminated with virus.

CDC emphasizes that although ***how*** we understand transmission occurs has evolved, the ***ways*** to prevent infection with this virus have not. Specifically, for healthcare settings, the constellation of administrative and engineering controls and personal protective equipment including respiratory protection recommended by CDC and CDPH, which were to account for these modes, have not changed since the beginning of the pandemic.

V. Monoclonal Antibody Update — Dr. Sohrab Sidhu

Topics:

Increased Medicare Reimbursement for Monoclonal Antibody Administration

Monoclonal Antibody Overview

To summarize, two investigational monoclonal antibody combinations 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.

On April 16, the FDA revoked the EUA for bamlanivimab monotherapy due to the sustained increase in variants resistant to bamlanivimab alone. The product is no longer available for direct ordering and no longer recommended for use.

Sites that 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 (for use in combination with etesevimab obtained via direct ordering) 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.

Increased Medicare Reimbursement for Monoclonal Antibody Administration

On May 6th, the Centers for Medicare & Medicaid Services (CMS) announced that it has increased the Medicare payment rate for administering monoclonal antibodies to treat beneficiaries with COVID-19, continuing coverage under the Medicare Part B COVID-19 vaccine benefit. Beneficiaries pay nothing out of pocket, regardless of where the service is furnished – including in a physician's office, healthcare facility or at home.

As of May 6, 2021, the national average payment rate increased from $310 to $450 for most health care settings. CMS will also establish a higher national payment rate of $750 when monoclonal antibodies are administered in the beneficiary's home, including the beneficiary's permanent residence or temporary lodging (e.g., hotel/motel, cruise ship, hostel, or homeless shelter).

Read the full announcement here.

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/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)

Bamlanivimab – *The EUA for bamlanivimab alone has been revoked by the FDA:*

- Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Monoclonal Antibody Bamlanivimab | FDA
- HHS/ASPR Bamlanivimab Update re: SARS-CoV2 Variants of Concern
- Fact Sheet For Health Care Providers Emergency Use Authorization (EUA) Of Bamlanivimab (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.

Doses/allocation

- As of 5/11/21, 40,942,280 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites. To date, 32,669,323 have been administered. 14,361,281 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 MyTurn.ca.gov or Vaccines.gov to find doses at available pharmacies.

On 5/10/21, FDA extended the Emergency Use Authorization for Pfizer-BioNTech's COVID-19 Vaccine to ages 12 and older.

- The updated fact sheets for providers and recipient and caregivers are linked on the FDA website here.
- CDC's independent Advisory Committee on Immunization Practices meets on Wednesday, May 12th from 11am–5pm ET. ACIP will review data on the safety, immunogenicity, and efficacy of COVID-19 vaccines as well as clinical considerations for use of Pfizer-BioNTech COVID-19 vaccines in adolescents under the EUA. The vote regarding adolescent vaccination likely around 3pm. Link to webcast: https://www.cdc.gov/vaccines/acip/index.html
- The CDC website will reflect changes regarding the EUA and ACIP recommendations starting today and through Thursday (post ACIP).
- The CDC anticipates hosting a COCA Call for Clinicians on Friday 5/14/21
- CDPH is hosting a webinar today, May 11, 2021 from 5-6pm Pacific Time for Pediatric Providers who wish to enroll in California's COVID-19 Vaccination Program.
    - Registration link is in the meeting notes: https://www.cmadocs.org/event-info/sessionaltcd/CMA21_0511_CDPH/t
    - This session will be recorded and will be posted at EZIZ.org/covid

- The CDC clinical considerations website is updated with the most recent information about all three vaccines. There are a number of useful job aids linked on the website. This website will be updated on Thursday to reflect updated ACIP recommendations.
    - Last week, we shared an update on CDC's guidance for people vaccinated with COVID-19 vaccines not authorized in the United States. People who **completed** a COVID-19 vaccination series with a vaccine that has been authorized for emergency use by the World Health Organization (WHO) do not need any additional doses with an FDA-authorized COVID-19 vaccine.
        - On 5/7/21, the WHO granted Emergency Use Listing to an additional vaccine: the Sinopharm/BIBP vaccine, which is an inactivated COVID-19 vaccine.
        - The WHO website with a list of the COVID-19 vaccines with emergency use listing is linked in the meeting notes**:** https://extranet.who.int/pqweb/vaccines/covid-19-vaccines

Additional resources:

- Providers interested in becoming part of the vaccine network should contact Blue Shield at CovidVaccineNetwork@blueshieldca.com.
- 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: I was looking for additional info on the AFL's that you mentioned about last week. Are there any updates?

A: Those AFLs are regarding quarantine and testing and are in their final stages of review and hope to have those out in the next couple of days.

Q: Regarding the Janssen vaccine, specifically the thrombosis with thrombocytopenia, there are patients who are a bit concerned regarding this vaccine. If they ask about the risks, do we have anything available documentation that has specific risks such as obesity, estrogen use or anything that they patient might be concerned with this particular vaccine or if this is not known at this time?

A: The CDC guidance only refers to women under 50 as being an increased risk but has not identified any other specific risk factors. The CDC's clinical guidance has some language about people's history of clotting or risk factors for thrombosis. The CDC's expert opinion is that they do not think that a history of risk factors for clotting disorders or a history of the use of hormonal contraceptive increased the risk but all that is not known. So, their official expert opinion is that they do not have any other risk factors that are known at this time.

Q: Last week a question was asked about AFL 20-33.2 about COVID positive patients at hospitals and SNFs having to check in with their local health department before that transfer happens. I understand that your answer was that the intention of this AFL, it doesn't make sense for every COVID positive patient that goes through the local health department at this time. However, with that said, our hospitals and our SNF partners are going by the AFL and contacting the local health department. I was just wondering if there was an update to that AFL and when we can expect some kind of update on that?

A: I don't have a specific update. We do know that local health departments have the authority to apply different standards for the facilities that are operating in their regions. There may be particular steps or rules that they're expected to follow. We would defer to that guidance.

Q: I'm calling from San Francisco Public Health. We can't do a less restrictive recommendation or policy than what the CDPH has put out so that was my concern.

A: I do think that over the course of the pandemic, many local health departments have provided more specific guidance to their facilities about when to contact them and under which circumstances. I think that's always reasonable. We can take that back and look at that AFL along with many others that will need to be updated and adjusted as we move out of the blueprint tiered framework. As things change in terms of overall incidents, as fewer facilities have cases, we might want to institute a direct follow up like we did early in the pandemic. I think all of those things are fluid.

Q: Just on last comment regarding the AFL. Our SNF and hospital partners have done a wonderful job with transferring COVID positive patients and keeping the transmission rates down within our SNF facilities and would like to applaud all of our groups here who have done a tremendous job. With the AFL, I understand that the transmissibility's have gone down quite substantially and our SNF residents are getting vaccinated at high numbers around 90 percent or higher. With that said, with that AFL out there, our hospital and SNF partners are going to call the local health department to check on every COVID positive patient. That was my only point. Thank you.

A: We do appreciate the feedback. It lets us know when we need to know when modifications need to be made to the guidance to make sure that we're staying current with appropriate practices out there in the field.

Q: My question is fairly broad but there is need for guidance in the outpatient clinical care area. As rates have gone down to the 1 percent you mentioned, we have increasing demand in our healthcare facilities, both acute and outpatient. For resuming primary care, it puts pressure on our systems to maintain the current CDC guidelines with distancing etcetera. It was mentioned that we're dealing with variants that may be 50 percent more transmissible and also in the area of outpatient elective surgery. What sort of guidance can be offered in regards to perioperative testing as we have vaccination rates in the 45 to 50 percent range in our general population and we're potentially moving away from the blueprint framework? I'd apricate if anyone could address how CDPH is going to look at those issues in the outpatient clinic world. Thank you.

A: With regards specifically to testing, with much of the population being fully vaccinated and decreased overall incidents, this somewhat limits the yield for identifying asymptomatic infection among vaccinated patients that come in. I think it's a sort of risk benefit decision making to decide whether or not to continue to routinely test perioperatively or preoperatively. I think one can make the case to no longer routinely test unless the procedure that someone is undergoing is a higher risk procedure for aerosolizing respiratory particles for example. I think that overall, the guidance is shifting to a nuanced and risk-based approach to things like preadmission or preprocedural testing that accounts for vaccination status and also whether or not vaccination status can be known. Of course, individuals presenting to an emergency department where they're not an established patient and there is no record or no vaccination status, those continue to be routinely tested. As far as other guidance relative to outpatient setting, we will mention that there has a lot of question about universal eye protection for PPE for healthcare personnel. The CDC guidance a while back, I think from last summer, was for areas there were moderate to substantial community transmission which translates in California with the blueprint framework to areas that are in orange or higher tiers that the CDC recommended, and we've also recommended, that healthcare personnel wear eye protection as PPE

universally. Now that many parts of our state are in the yellow tier, that guidance is no longer applicable. Healthcare personnel can no longer use the eye protections, although they still recommend wearing a mask for source control and a respirator is needed for transmission-based precautions for suspected or confirmed COVID patients. Even when the blueprint framework goes away, the guidance around minimal, moderate, or substantial community transmission could still reasonably be applied. Again, on a case by case basis depending on the level of risk, one could reasonably continue to use empiric precautions as well as tests.

Q: Regarding the visitation guidance AFL 20-38.6 about visitation hours. I know many hospitals have implemented visitation hours due to increased screening and just trying to reduce flow but with our COVID situation turning around, I was wondering if we can get some guidance on the allowance for visitation hour restrictions and when they will be implemented.

A: Are you asking if hospitals may still implement visitation hours?

Q: Correct. The AFL is kind of silent on it. From pre COVID, CMS kind of had this, the hospitals should be open 24 hours unless we have safety concerns or other things that we can put in policy on why we are restricting that. Because the AFL is silent in it, we are left with being different hours being implemented at different hospital systems across the state which is creating confusion amongst our communities. I was just trying to get some guidance from where CDPH was seeing this.

A: Where the AFL is silent on the specifics around hours, I think it sort of defers to the default of routine visitation policies and procedures that hospitals had pre pandemic. During the pandemic, I think that the assumption was that to be able to safely implement visitation with all of the necessary need for distancing and for monitoring visitor adherence to masking and distancing, that would likely require some modification to existing protocols for hours and time for visitation. I think it is silent because there is the acknowledgment of the need to modify, depending on local circumstances, but certainly that can create some confusion in differences between how hospitals implement that.

A: It would be challenging for the Department to be very prescriptive about what the range of visitation hours would be because circumstances are unique for each facility whether it be long term care congregate setting or a hospital setting. I think it really leans on the ability to monitor and screen, depending on the size of the hospital and the number of staff you have, to be able to oversee those visitations as well as current census and flow, what type of patients that you may have and how your facility is organized. So, I think that the intention behind that is to support the flexibility that facilities may need to be able to define their visitation policies based on what's practical for that particular facility. I certainly understand and acknowledge the confusion that that can create for the community. I think that's something that we have been monitoring and aware of throughout this phase where we've been trying to open the state up for visitation and health facilities across the continuum of both short term care and long term care. I think things will ~~likely more~~ stabilize as we get further into a pandemic recovery phase. Right now, I think the flexibility is something that is an intended offering to facilities to do what would be manageable or at least define their visitation policies based on what's manageable for that particular facility.

Q: We have some construction workers working on our roof. Do we have a responsibility to test them? They don't come into the building. They are working outside and have minimal interaction with the staff and if they do, they are wearing masks. Do I still need to swab them and test for COVID-19 if they are around us?

A: I think the definition for healthcare personnel that would require routine testing you know, is fairly broad. It includes individuals who are not just direct clinical care providers but others who are in and out of the facility and potentially exposed to or may expose others including other facility staff. If these workers never enter the building and not interacting in break areas or common areas with facility staff, I guess you could make the case that they don't meet those criteria. But if there is some uncertainty of whether or not you can be assured where there are common areas or break areas where they, in particular spending time eating without face masks, would be around other facility staff then I think it would be prudent to include them in your testing program.

Q: A lot of our short-term acute care has moved away from screening the staff or visitors when they're coming into the facility while the SNFs are still doing stricter screening. What are the recommendations for specific long-term acute care and also where can I find the guidance about the required PPE in relation to the tiers?

A: Recommendations for screening applies to all healthcare settings and includes short term acute care hospitals as well.

Q: From what I heard from several of our physicians is that no one screens them anymore at multiple facilities.

A: Again, our recommendation is to continue an active screening process. I think there are a number of ways to implement that. It doesn't necessarily have to be a person standing at the entrance asking these questions every day. I think it's reflected as well in the CDC guidance that staff members can monitor their own temperature and symptoms before they come into work. I think the intent is to have some process for attesting for the absence of those symptoms each day when reporting to work is still recommended. We just emphasize that we have achieved a number of outbreaks including in the acute care setting that are linked to healthcare personnel that were self-screening and self-monitoring so there is still an important aspect of some active screening.

A: It's not terribly explicit with regards to the tiers. We just emphasize that with regard to what PPE is needed for confirmed positive and patients with suspected or confirmed COVID, none of that changes according to the tier. It's only that universal eye protection and that is in the CDC infection control guidance for COVID which applies across any healthcare setting that links the need for universal eye protection to the level of community transmission. They use the term moderate and substantial, which happens to correspond with those two-tier designations in California. Even thought that framework goes away, the applicability of that guidance to areas where there's moderate or substantial community transmission would apply or not apply depending on what's going on in your local area.

Q: We haven't had an update to the Institutes for Higher Education guidance documents since September of last year and that was a very mild update with athletics, so we are still working off guidance that was written in August of 2020. My second question is that there seems to be significant conflict between the CDC/CDCH guidance regarding masks and some other things and what Cal OSHA considers to be acceptable. Are there any plans on reconciling that guidance so that there are more consistent rules?

A: We don't have anyone available on the line to speak on that. I am getting questions about that internally from our own staff. There is some additional information review that we need to conduct before we would be able to speak on that.

Q: How do I request a copy of the notes for this call?

A: You can contact CAHANinfo@cdph.ca.gov to be added to the distribution list.

Q: As our ambulatory care settings continue to ramp up, the issue we're coming across, with our limited entrances, a lot of big crowds are grouping up although we're trying to keep people distanced. We're already implementing an active self-attestation process for symptoms for our staff and employees. One of the issues with opening up other entrances to help clear our limited entrance points is that our county, early in the pandemic, has mandated temperature screenings for all entry points. We just don't have the staff to do that. I couldn't find a specific mandate for temperature screening from the state or the CDC. I just wanted to make sure that there wasn't, or is there?

A: I think that the CDC guidance, which CPDH has been following and recommending, included different options for temperature screening. It acknowledges that employees may monitor or take their own temperature, again, emphasizing as part of an active process of daily upon reporting to work testing. Now your local health department may have more stringent requirements so I would defer you to your local health department and encourage you to reach out them to address the question you are describing. Every facility is going to have different permutations and considerations and you're balancing a number of things. Of course, not wanting people to be crowding and congregating outside a small number of entrances but again that's balanced with the need to make sure that there is some sort of active screening process. Again, from the CDC or our guidance, it doesn't absolutely have to be a person physically standing there, but some sort of process that is overseen and monitored and it's an active process is what we recommend and again, you will need to check with our local health department.

Q: Could you please give a clarification regarding COVID vaccinations given outside the US. If it's not an FDA approved vaccination, do they have to get another series with one of our FDA approved vaccines?

A: The CDC has COVID-19 vaccine guidance has much more detail that you can review and it's linked in the meeting notes. In brief, people who completed a COVID-19 series that was authorized by the WHO but not the FDA, those people don't need to complete a new series but if they don't meet that criteria,

then they would need to complete the FDA authorized series. The two vaccines that are on the WHO list that are not on the FDA list are the AstraZeneca vaccine and the Sinopharm vaccine but that's subject to change. You can review the list on the WHO website of the currently authorized vaccines.

Q: Regarding AFL 20-53.3 that's going to be updated, we just wanted to make sure that if vaccination status is a variable, whether it's regarding for fully vaccinated staff who don't work may not require weekly testing anymore or whether it's like if 70 percent of the residents are fully vaccinated then applying a certain testing requirement, how to make confirmation of vaccination status among both the resident and the staff, as everyone know which is PHI, how to make that systematic and equitable for those of us who don't have access to care to or care both for the facility level but also at the local health jurisdiction. I'm at the San Francisco Department of Health. So how to obtain that vaccination confirmation without resorting to making people reveal their passports or their vaccination status or also just systematic. And number two, for confirmatory testing, we really appreciate that April 26, there was a release from CDPH on what to do now that we are testing among a very low positivity rate in post-vacs, especially positives, where you need confirmatory testing to determine really is that somebody who has post-vac breakthrough or is it somebody who has a post-infection/reinfection versus viral shedding and I'm wondering if there's a way to make that guidance more public as well as to consider, I'm going to keep asking this every time, if there is a way to consider not a 90 day but a 180 day black out in terms of people who've been previously positive , not being tested again at least by PCR because that method is overly sensitive in my opinion and then you end up with people potentially looking at time in isolation or quarantine where that actually wasn't required because we're waiting for confirmatory testing.

A: I'll start with your question around confirming vaccination status, which is critical for implementing some of the modifications to the testing programs that we've seen from CDC and will be included in the forthcoming all facilities letter. I would like to emphasize that regardless of the contingency around percentages of residents that are fully vaccinated etcetera, there is going to continue to be the need to do routine screening testing of unvaccinated healthcare personnel. We're moving towards a program of no longer routinely screening testing fully vaccinated healthcare personnel but continuing to routinely screening test unvaccinated healthcare personnel will of course, naturally require that as part of the facilities occupational health program, that the facility maintain documentation of the vaccination status of their individual healthcare personnel in similar fashion to how facilities have previously implemented masking when healthcare personnel were not vaccinated against influenza in previous years. It is important, as you implied, to make sure that information is collected and maintained confidentially to protect an individual's personal health information for both employees and patients or residents.

A: Your second question about the algorithm for interpretation and management of positive tests in individuals who are fully vaccinated and potentially as well have had prior infection, that algorithm that we developed is really intended for local health departments to use when assisting facilities with interpretation and management. It's a fairly complicated algorithm, requires potentially a second test and looking at CT values and the concern is that putting this out there for anyone to use without working with the local health department could potentially lead to assumptions about test being false positives that were not truly appropriately considered false positive. So again, we wanted to make sure

that local health departments were engaged in that evaluation and management process for those types of test results. Hopefully these will become a less common occurrence as we move toward no longer routinely screening testing fully vaccinated healthcare personnel as discussed earlier in this response. Hopefully those will become fewer and father between but likely will be even more nuanced because people will be getting tested as part of response testing and not necessarily routinely but in response to an exposure, which is a different pretest probability. It sounds like you are from a local health department so feel free to email us if you would like a copy of the algorithm that we provided.

A: I can reach out to you through email to follow up with you.

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