California Department of Public Health
Weekly Facility COVID-19 Update Call
May 5, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 1804569
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I. **Welcome / Introduction** — **Cassie Dunham**

- None Provided

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.

International news
Last week, I mentioned the situation in India because of their tremendously high numbers as well as the B.1.617 variant (which is sometimes referred to as the Indian variant) that was first identified there. Just a few days ago, India reported over 400,000 new cases in single day with deaths ranging 3,000-4,000 per day (for comparison, in February 2021, there were <100 deaths/day among India's population of 1.4 billion people. Clearly, India is experiencing a 2nd wave but it's unclear why there has been such a tremendous increase. It's likely due to a combination of factors including "social mixing" and possibly due to B.1.617. Unlike the US and other regions, vaccine coverage in India is quite low (reports vary; an estimated *1%-10% of population has been vaccinated).*

The B.1.617 variant has been as a "double mutant.' The term double mutant is not accurate as B.1.617 has several mutations. The reason it was called double mutation is that it contains two well-known, or 'famous, mutations found in other variants. One of the mutations is the L452R mutation, which is seen in the West Coast variants and is thought to have mildly increased transmissibility. Another mutation is

E484Q that is similar, but not identical to E484K, which is seen in variants from South Africa (B1.351) and Brazil (P.1) and is associated with immune evasion (mutations E484Q and L452R in the critical receptor binding domain that our antibodies target).
The B.1.617 variant has not yet been added to CDC list of VOC or VOI. Very limited data from India. According to the website, outbreak.info, one of the most populous states in India (Maharashtra) found that ~16% of samples sequenced were B.1.351. The percentage of this variant in other states ranges from 2-8%. Keep in mind these data are very incomplete (<<<0.1% of samples sequenced).

Nationally
From CDC website (updated April 10, 2021): 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.
Source: https://covid.cdc.gov/covid-data-tracker/#variant-proportions

California: As of April 30, over 50,000 samples have been sequenced and uploaded to GISAID (data repository for sequencing data). The proportion of B.1.1.7 among samples sequenced in April increased to 46% in April and it is now the most common VOC/VOI in California. This compares with ~1-2% in January, ~4-5% in February, and ~20% in March. Additionally, similar to national data, there has been a **modest increase in P1** in California (in early April) only two P.1 cases, early May 431 P.1 cases (table late April), with many, but not all cases, linked to travel.

The levels of B.1.351 are fairly steady (<50 cases).

Finally, we are seeing some cases of B.1.617 (aka "double mutant", "India mutant") in California (many linked to travel)

The following tables are from this website:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-Variants.aspx

Known Variants of Concern in California

As of April 28, 2021

Variant	Number of Cases Caused by Variant
B.1.1.7	3,478
B.1.351	67
P.1	389
B.1.427	5,064
B.1.429	9,862

Variants of Interest

B.1.526 (first detected New York), B.1.525 (first detected in Nigeria) and P.2 (originally identified in Brazil). These variants have the potential for immune evasion (reduction in neutralization by antibody as well as potentially decreased neutralization by monoclonal antibody). In California, we are seeing a steady increase in these cases (early April a few dozen, now a few hundred).

Known Variants of Interest in California

As of April 28, 2021

Variant	Number of Cases Caused by Variant
B.1.526	235
B.1.525	15
P.2	35

New addition to CDPH website giving OVERALL TRENDS:

How has the proportion of variants of concern and variants of interest in California changed over time?

The table below shows the percent of specimens sequenced that are variants of concern or variants of interest.

Specimen Collection Month	B.1.1.7	B.1.429	B.1.427	B.1.351	P.1	P.2	B.1.526	B.1.525
21-Apr	37.8%	20.3%	10.2%	0.70%	6.4%	0.3%	6.1%	0.1%
21-Mar	21.5%	35.2%	17.2%	0.40%	2.4%	0.1%	1.0%	0.0%
21-Feb	4.2%	41.4%	19.8%	0.0%	0.0%	0.1%	0.2%	0.0%
21-Jan	1.8%	31.8%	19.0%	0.0%	0.0%	0.1%	0.0%	0.0%
20-Dec	0.9%	16.6%	8.6%	0.0%	0.0%	0.1%	0.0%	0.0%
20-Nov	0.0%	7.9%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%
20-Oct	0.0%	0.8%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%
20-Sep	0.0%	0.4%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
20-Aug	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20-Jul	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20-Jun	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20-May	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20-Apr	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20-Mar	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%

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 has not been is 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, will be 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 jurisdictions. For those submitting samples, we request basic clinical information – acuity of illness (e.g. ward vs. ICU, intubated or not, and receipt of prior vaccine).
- We also request that serum be submitted along with respiratory samples. Serology at VRDL includes *BioRad ELISA is Ab to nucleoprotein (prior infection) and UBI ELISA is 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**

CDC has updated select healthcare infection prevention and control recommendations in response to COVID-19 vaccination. The updates include:

- They've addressed the limited data on COVID-19 vaccine protection in people who are immunocompromised, and recommend that in general, healthcare facilities should continue to follow the infection prevention and control recommendations for unvaccinated individuals (e.g., for quarantine and testing) when caring for fully vaccinated individuals with an immunocompromising condition such as: receiving chemotherapy for cancer, hematologic malignancies, being within one year from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 count <200, combined primary immunodeficiency disorder, and taking immunosuppressive medications such as drugs to suppress rejection of transplanted organs or to treat rheumatologic conditions such as mycophenolate and rituximab, receipt of prednisone >20mg/day for more than 14 days.

- They clarified, in the definition of fully vaccinated, that there is currently no post-vaccination time limit on fully vaccinated status for quarantine and testing purposes.
- They've described circumstances when, if all participants are fully vaccinated, visitation or communal activities and dining could occur without use of source control or physical distancing. This includes options for fully vaccinated HCP to eat or have in-person meetings with other fully vaccinated HCP without use of source control or physical distancing. **However, if any unvaccinated persons are present during any of these activities, then all participants in the activity should wear source control (when not eating/drinking) and unvaccinated individuals should physically distance from others**. When it is not possible to ensure all persons participating in an activity are fully vaccinated (e.g., in break rooms and other common areas where staff or residents may come and go), then all participants should follow all recommended infection prevention and control practices including physical distancing and wearing source control. As such, activities where participants do not use source control and physical distancing should be carefully planned in advance and monitored so that vaccination status of all participants can be verified. CDPH is in the process of updating pertinent AFLs to address these recommendations and provide guidance for safe implementation, so facilities should wait for those AFLs before finalizing any changes to their practices.
- CDC now no longer recommends expanded screening testing of asymptomatic HCP who are fully vaccinated. Vaccinated HCP should still be tested if symptomatic, however, following a higher-risk exposure, or is working in a facility experiencing an outbreak. CDC continues to recommend unvaccinated HCP continue expanded screening testing as previously recommended. CDPH is in the process of finalizing updated overall testing guidance, as well as updating pertinent AFLs that will generally align with these recommendations but likely with some contingencies, so facilities should wait for those AFLs before finalizing any plans for modifying their testing programs.

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

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.

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.

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 5/4/21, 38,560,120 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites. To date, 30,501,711 have been administered. 12,859,120 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.
- Vaccines.gov includes pharmacy vaccine information, as well as information regarding additional location to access COVID-19 vaccine

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 was updated on Tuesday 4/27/21. Key updates include the following:

- **Updated interim recommendations for the use of the Janssen COVID-19 vaccine.** As discussed last week, the pause on the Janssen vaccine was lifted on 4/23/21. The new clinical guidance includes considerations for the use of Janssen COVID-19 vaccine in certain populations:
    - Women <50 years can receive any FDA-authorized COVID-19 vaccine, but should be aware of the rare risk of Thrombosis with Thrombocytopenia Syndrome (TTS) after the receipt of Janssen COVID-19 vaccine and the availability of other FDA-authorized COVID-19 vaccines.
    - People with a history of thrombosis or risk factors for thrombosis can receive any FDA-authorized vaccine, including the Janssen COVID-19 vaccine.

    - People who take aspirin or blood thinners as part of their routine medications do not need to stop these medicines prior to the receipt of the Janssen COVID-19 vaccine.
- **New 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. At this time, the only vaccine that is not available in the United States currently but is authorized by emergency use by the WHO is the AstraZeneca vaccine.
    - People who are partially vaccinated with a WHO-authorized vaccine, or who received a partial or complete series with a vaccine that was not authorized by the FDA or WHO are NOT considered fully vaccinated and may be offered an FDA-authorized COVID-19 vaccine series.
    - The minimum interval between the last dose of a non-FDA authorized vaccine and an FDA-authorized COVID-19 vaccine is 28 days.
- **Updates to the contraindications/precautions section.** Known polysorbate allergy is no longer a contraindication to mRNA vaccination; however, known polysorbate allergy is a contraindication to Janssen COVID-19 vaccine and thus, a precaution to mRNA COVID-19 vaccination.
- 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

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: How long are we going wait for the two AFLs that you mentioned to be released?

A: AFL 20-26.7 for space waivers, I suspect we'll probably send an additional update in the next week or two. The additional AFLs are under development right now with regard to healthcare professional testing and adjusting our guidance to align with the guidance that came out from CMS and CDC. They are being modified right now and would need to go through our approval process. I hope to have those out maybe by the end of this week, but that would be pretty fast, so it could possibly be early next week before those go out. We are trying to get those out as quickly as possible.

Q: CDC has issued new guidance around when people can go around without masking and social distancing. The new guidance around healthcare facilities has created a quagmire. We're talking about people getting together for conferences, teaching rounds, in breakrooms etcetera. The issue of identifying individuals who have not had vaccines, raises considerable problems around stigmatization of those who haven't gotten vaccines, how they are to be identified, the fact that you can get fraudulent vaccination cards online, the whole thing. I think this creates a real vulnerability for healthcare facilities and for the patients. I was interested in how CDPH is going to approach all of those issues in their new guidance.

A: These types of events or situations where individuals in healthcare facilities would be gathering without masks or distancing should be more of the exception than the rule at this point. We also know that the substantial proportion of healthcare personnel are not fully vaccinated so we cannot assume or count on a level of vaccine coverage that would rendering it safe to conduct these types of activities safe without some kind of advanced planning. I don't think one can do that planning and assurance of vaccination coverage among all participants in settings like breakrooms or other common areas. I think those types of areas should be managed as they have been in terms of masking and distancing. For preplanned conferences and meeting where individuals would not be masked, I think you highlight some of the challenges with insuring vaccination status but I think those are still important processes to consider when planning for a meeting or conference. Hopefully some of these considerations will be more emphasized on what we put out. I think that it is, as is said, in the fine print of the CDC guidance as well but not part of the headline. I think that there are potentially a lot of individuals out there that are reading the headlines and thinking it's ok to start mingling in breakrooms without masking or distancing and I agree with you, that is not the case.

Q: I work in an acute care hospital and we are continuing to screen all asymptomatic patients that are admitted for COVID, unless within three months they have been positive, then we recommend not to do the screening. I was wondering if there's any new evidence or discussion about this three month time frame because we are seeing more and more patients come in, who are totally asymptomatic, come in for abdominal pain or a finger infection, we test them and they are still positive. At that point, we have been instructed by our ID group, because we have no further instructions, to go ahead and isolate because they are continuing to be positive. I was wondering if that three-month time frame has been discussed to be lengthened at this point.

A: I don't think at this point, from what I hear from the CDC, to extend that interval. I would like to clarify that the time limit on when someone would be considered to be fully vaccinated, that was also three months, has been removed and I mentioned that in my update. For those who are previously positive, it can be challenging to interpret the results of the screening testing when they are asymptomatic. I think that in the forthcoming updates to our guidance and I think as reflected in the CDC guidance as well, with decreases in overall transmission and instances in our communities, it is reasonable for hospitals to consider modifying their testing protocols especially as it pertains to patients prior to admission or prior to procedures and especially to consider whether or not fully vaccinated individuals need to be screened. I agree it's a challenge for those who were previously

positive, to interpret their results. We've developed, at least for those, depending on their vaccination status and prior positivity, an algorithm which we shared with local public health to take into account factors such as cycle threshold value of a molecular test. The results of the second test, in some circumstances, might be obtained and can help guide the management of these individuals and whether or not they would be considered infectious. I think your infection diseases physician has recommended is probably the safest approach in terms of managing these individuals as positive based on this test as a precautionary measure. Again, I agree it's challenging and I don't know of any update. They have been talking about if for a while but I think, especially given the variants and such, that the CDC is not changing that 90-day interval at this point.

Q: A fully vaccinated patient would like to go out to do activities such as have dinner with their family. Is there any guidance for that?

A: Yes, CDC has updated their guidance for fully vaccinated patients who are newly admitted or leave the facility. Fully vaccinated residents can leave the facility and do not need to be quarantined upon return unless there is a known exposure when they leave the facility. By in large they can leave the facility including for over 24 hour overnight visits outside the facility. They do not need to be quarantined or routinely tested upon return so long as they are fully vaccinated.

Q: Do you have the AFL number for that?

A: I believe the CDC guidance is in the link that's included in the transcripts. There are updates to several AFLs that include at least the testing quarantine recommendation. Those updates are in process and so you will see an update to AFL 20-53 with testing considerations and resident placement and also visitation AFL 20-22 that also addresses some of these issues.

Q: Regarding the yellow and green zone, if we are 100 percent vaccinated for our healthcare personnel, are we able to cross over between a yellow and green zone in terms of providing care? Is there any guidance on that?

A: The assignment of dedicated staffing for different grouping of residents or zones is regardless of the healthcare personnel vaccination status. We are recommending dedicated staffing in part to facilitate PPE conservation strategies, although we've moved beyond some of those, but also to help prevent the low risk but still present cross transmissions via contaminated hands or clothing of healthcare personnel when they move from resident to resident. That is not thought to be a driving major route of transmission but that is a rationale for maintaining dedicated staffing. To be clear, it is not because we think those staff members, in a course of providing care in yellow or red zones, are more likely to get exposed and infected themselves and then carry and transmit to other residents. That's why we are using personal protective equipment etcetera. Those healthcare personnel who work in a red zone with COVID positives or in a yellow zone with COVID exposed or unknown status on one shift, they can, on the next shift, so long as they appropriately change PPE, maybe change their uniform, perform hand hygiene etcetera, can work with non-exposed or green zone residents. Again, it doesn't matter necessarily their vaccination status, although it's certainly preferrable and important that they are

vaccinated so that any risk of potential exposure they have outside the facility as well, will not lead to an infection that could then introduce COVID and transmit within the facility.

Q: It's just harder for us operationally as we dwindle down our yellow zone because most of our new admissions are fully vaccinated so they can technically go into the green zone. It's hard to staff just a few in the yellow zone. How do we separate the yellow zone from the green zone and how do we deal with the operational issues that come with it?

A: Many facilities are asking the same questions as well. Not to be overly prescriptive here but I believe it's reasonable to reevaluate and scale down your designated red and designated yellow areas or rooms that you have allotted for those residents with a reasonable plan in mind to rapidly scale up if needed. As you have scaled down, in the yellow, the concept for new admission is ideally to have geologically separate rooms, distinct from the rest of your facility. Ideally, they are single rooms because if you are admitting unvaccinated individuals from different places, they may well have very different exposure status and so ideally, they are single rooms. Again we've indicated this in writing in AFL 20-74. There is an accompanying table. Ideally, you have dedicated staffing for different zones but really it should be prioritized for your red zone and if it's infeasible for your yellow zone then it is permissible to not completely separate or designate your staff for yellow versus green. So long as you are emphasizing the need for those healthcare personnel to essentially continue as they should always be doing. Treating each bed space in multi occupational room as a separate bed space, perform hand hygiene, change PPE between caring for different residents and especially between those who have different potential exposure status.

Q: Around screening of employees for symptoms of COVID, we are considering having employees screen themselves using specific algorithms at home prior to showing up at the facility with clear instructions on who they could call should they fall out etcetera. Do you have any concerns about this strategy?

A: Frankly yes. We have observed outbreaks that have resulted in the past from this sort of self-screening practice then leading to employees showing up and working while symptomatic, even though technically they shouldn't, based on a self-screening protocol. I think it is problematic and we've seen non-adherence to that especially since we really haven't seen the level of vaccination uptake in coverage in healthcare personnel. I think the need to continue some form of active screening remains necessary to ensure that there is somebody overseeing an active process of healthcare personnel when they show up each day, verifying that they do not have symptoms according to a defined list of symptoms. Somebody needs to be overseeing and monitoring that process so that healthcare personnel that are screening positive are appropriately instructed and tested.

Q: I would like to mention that that we have achieved almost 98% vaccination for our physicians and almost 70 plus percent for our employees.

A: That's good to hear. I think my comments and concerns are still the same at this time.

Q: My question is about the vaccine efficacy of all the vaccines compared to the variants that we've seen. Does anyone have any data on that or is that something that is still being worked on?

A: There has been a number of studies on the variants whether it's the South African variant, the Brazilian variant etcetera. Of course they are not all identical and I think we still need more studies. Essentially as far as the vaccine efficacy for the B117 or the UK variant, it looks to be very good. There appears to be some lessening of vaccine efficacy for the 351 or the South African as well as the P1. How much significance that will play, it's not as if it goes from 95 percent to zero. It may diminish by 10 or 20 percent and a number of studies are still coming out. I can try to review some of this next week. Again, there may be a study of Pfizer and so there's a lot of different studies and pooling them together, but overall there are concerns as far as the Brazil and South African variant and that is part of the reason we are following this so closely. Again, it doesn't go to zero percent, it just diminishes it a bit. Even with the variant from India, there are concerns that that will have a decrease in vaccine efficacy but we really don't have any studies on that. This is part of the reason we are really pushing for whole genome sequencing to try to understand what we have here and certainly looking at whether somebody has been previously vaccinated is really important.

Q: On the AFLs that are coming out, will there any mention on screening for visitors and any changes for that for visitors coming into acute care hospitals who are vaccinated?

A: If you're getting at symptom screenings, I don't believe there are any changes even to the CDC guidance for the need to screen for symptoms for healthcare personnel as I discuss earlier or for visitors. Even for fully vaccinated individuals, we would still recommend testing if they have symptoms regardless of their vaccination status if they are coming into a healthcare facility. I don't believe those recommendations for symptom screening will change, at least not at this point. I think there is some increased consideration around risk benefits of testing asymptomatic fully vaccinated individuals before coming in like preadmission or upon admission or pre-procedure which are really case by case. Perhaps depending on how much transmission is in the surrounding community and what type of procedure is being done and risk of aerosol generating procedures etcetera to figure out whether or not it remains worthwhile to continue to test those individuals. Again for symptoms, that continues.

Q: So just to be clear, for visitors that are coming into the acute care hospital, they still have to go through the temperature taking and asking if they have the signs and symptoms even if they are vaccinated?

A: Yes, I will double check. I don't believe there has been any change to that recommendation.

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