California Department of Public Health
Weekly Facility COVID-19 Update Call
May 25, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 7993227
Available after 12 Noon 05/25/2021

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

- None Provided

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

- None Provided

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

CDC Variants of high consequence
There are NO SARS-CoV-2 variants that rise to this level.

CDC Variants of concern (VOC)
CDC's list of five VOCs remain the same; 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.

CDC Variants of interest
CDC's list of eight VOI remain the same; 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) and the B.1.617 lineages (first identified in India) ; B.1.617, B.1.617.1, B.1.617.2 and B.1.617.3.

World Health Organization (WHO)
The WHO list of VOC is similar, but not identical to CDC list. These include B.1.1.7, B.1.351, P.1 and as of last week, B.1.617 lineages were added. Reasons for adding B.1.617 lineages -less responsive to at least one of the monoclonals, mild reduction neutralizing antibodies, and most concerningly, high transmissibility.
https://reliefweb.int/sites/reliefweb.int/files/resources/20210511_Weekly_Epi_Update_39.pdf

International News
We continue to hear reports about the high transmissibility of B.1.617.2.
B.1.617.2 has been identified in 43 countries across 6 continents.

Estimates are that this particular strain is 50% more transmissible than B.1.1.1.7.

Brazil

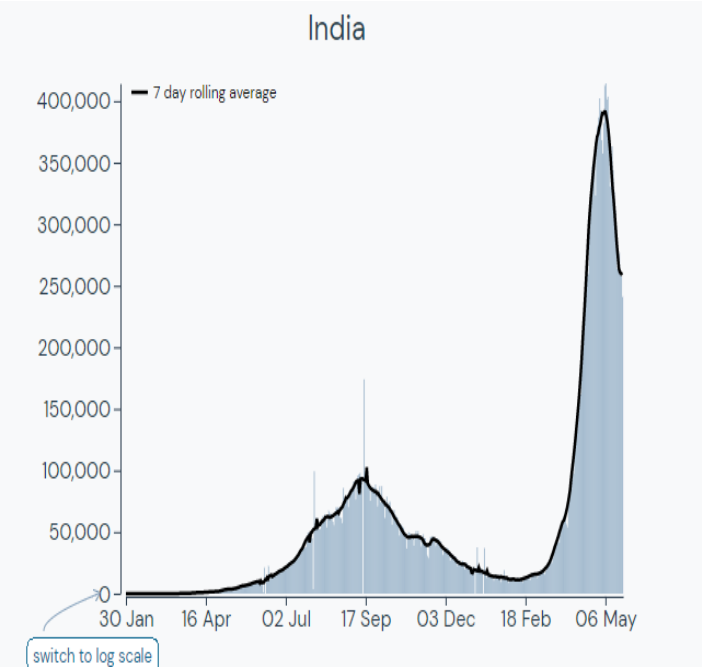
From Outbreak.info website: Almost exclusively P.1 (last 60 days; 92% P.1, 4% B117, 4% B.1.1.28).

South Africa

From Outbreak.info website 71% B.1.351, 5% 617.2

India

As we have discussed last few weeks, a dramatic increase of cases was noted ~ 1+ month ago with specific variants thought to be partially responsible for the increase. Overall numbers are now decreasing (see graph transcript Outbreak.info. Although number of cases decreasing, ~5 days ago reported a single-day record for deaths (4,452) (deaths are a lagging indicator) (Washington Post). Screenshots of graph from Outbreak info website (5/26/2020) shows a fall in cases but a very dramatic increase in B.1.617.2 cases.



Nationally

From CDC website (same info posted as last week)

B.1.1.7 remains the predominant variant (60-70% of variants sequenced). Additionally, **P.1** increasing in most regions of the US (5% of sequenced samples). Other variants mostly decreasing. (B.1.617.2 <0.5% per outbreak.info).

California

The proportion of B.1.1.7 among samples continues to increase and is now ~60+% of samples sequenced (compares with ~1-2% in January, ~4-5% in February, and ~20% in March). P.1 remains an important variant in several areas of the state with overall frequency of ~11-12%. B.1.617.2 is increasing but is still not a large percentage of cases. Given the transmissibility of this particular variant we are tracking it closely.

Vaccine & Variants

- This past week, a preprint from the UK was posted with data demonstrating vaccine effectiveness (VE) against B.1.167.2 https://www.medrxiv.org/content/10.1101/2021.03.01.21252652v1

This is the first study to report on VE against this variant. The UK study found that Pfizer AND AstraZeneca vaccines are effective against the B.1.617.2 variant. The study did show a reduction in one dose effectiveness against symptomatic B.1.617.2 disease when compared to B.1.1.1.7, concluding there was a 'modest' reduction in effectiveness. Two weeks after the second dose, researchers found that the vaccine was still highly effective (88% effective for B617.2 vs. 93% for B1.1.1.7.) The table below includes some of the studies (including most recent study from UK).

Country study conducted, first author, journal & title	Type study/settings	Vaccine studied	Results	Conclusions/ Other comments
Israel, Kustin T, medRxiv April 2021 *"Evidence for increased breakthrough rates of SARS-CoV-2 variants of concerns in BNT162b2 mRNA vaccinated individuals"*	-case control (vax vs unvax) -B117 predominant strain during study -B.1.351 rare	Pfizer	800 + samples :-250 became infected after 1st dose -150 after 2nd dose ----------—-------- Higher rates of B1117 in partially vax vs controls,	**-i**ndividuals remain susceptible B117 single dose -protection vs B351 less > B117 and wild type (Ho-if vax less effective vs VOC ; proportion of VOC should be higher in vax > non-vax)
South Africa, NEJM, Shinde V, Efficacy of NVX-CoV2373 Covid-19 Vaccine against the B.1.351 Variant May 5, 2021	Phase 2a-b clinical trial, 16 sites in South Africa Aug-Nov 2020	Novavax vs. placebo	2,648 initially infected-15 infections vax vs. 29 infections/un vax. Of those Sequenced; 93% B.1.351	Novavax was "efficacious induced notable cross-protection vs. B.1.351"
Qatar, NEJM Abu-Raddad JJ, *Effectiveness of the BNT162b2 Covid-19 Vaccine against the B.1.1.7 and B.1.351 Variants* May 5, 2021	Cohort study Analyze B.1.351 & B117 March 2021	Pfizer	385,853 had 1 dose 265,410 had 2 doses VE=87% for B.117 VE=72% for B.1.351	-efficacy vs. B.1.351 was ~20% < prior report (done in Dec) "*the reduced protection vs. infection with B.1.351 did not seem to translate into poor protection vs. the most severe forms of infection (hospitalization or death), which was robust, at greater than 90%.*"
Israel, Lancet	Observational study May 2021	Pfizer (this is primary vax used in Israel)	232,268 cases: 7,694 hospitalizations with -mild/mod disease with severe and 1113 deaths. VE (at least 7 day after 2nd dose) = 95.3%	
UK, Science April 2021 Reynolds CJ *Prior SARS-CoV-2 infection rescues B and T cell responses to variants after first vaccine dose.*	Health care workers Purpose: determine if single dose vaccine, w, and w/o prior infection, provides protect vs. variant	Pfizer	Following 1 dose, those with prior infection showed enhance T-cell immunity, B cell response to spike and neut	Single dose vax in setting of prior infectious with different variant enhance neut. ab vs variants

			antibodies vs. B117 and B.351	
Press release http://www.modernatx.com Background:6-8 months after primary vax, wild type remains high but titers vs B351 and P! lower	On-going phase 2 study, 3 strategies for boosting neut titers in previously vax. 1) mRNA-1275.351 2) mRNA-1273.211 3) mRNA-1273.351	Moderna	Preliminary data ongoing single dose , given as booster to those with two-dose regimen 2 weeks after vax, neut titers increased	Authors concluded "*The strong and rapid boost in titers to levels above primary vaccination also clearly demonstrates the ability of mRNA-1273 (original Moderna vaccine) to induce immune memory*."
New York, US Hacisuleyman E, NEJM April 2021 *"Vaccine Breakthrough Infections with SARS-CoV-2 Variants"*	Case report, 2 cases	Pfizer	Patient 1: ~ 3 weeks after 2nd vax, mutations-E4844K and D614G Patient 2: ~4 weeks after 2nd vax, mutations: D614 G and S477N Both w/high neutralizing ab	"potential risk of illness after successful vaccination and subsequent infection with variant virus" Both outpatient & recovered fully at home
Florida, US Magalis BR, medRxiv	?case series (several HCW but exposure outside work)	Pfizer	10 vaccine breakthrough, 8 with mild symptoms c/w COVID-19. Able to sequence 5 of those; combo of variants:	Authors concluded ".indicate limited protection of the BNT162b2 MRNA vaccine against emerging variants of SARS-CoV-2." None hospitalized thus "corona virus the vaccine 100% efficacy' against severe disease."
UK Bernal, JL, , medRxiv, May 2021 ***"Early effectiveness of COVID-19 vaccination with BNT162b2 mRNA vaccine and ChAdOx1 adenovirus vector vaccine on symptomatic disease, hospitalizations and mortality in older adults in England"***	Case control to estimate VE against symptomatic disease with both B117 and B617.2 variants. April 5-May 16	Pfizer & AstraZeneca	Pfizer only- VE 1 dose B617-33.5% B117-51% ---------- VE 2 doses B.1.617-88% B117-93%	After 1 dose; VE ~20% lower for B167.2 variant compared with B117 ---------- Authors concluded "After 2 doses of either vaccine there were only modest differences in VE with the B.1.617.2 variant. Absolute difference in VE were more marked with dose 1."

Sequencing efforts

Identification of variants continues to underscore the need for WGS.

We continue to 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.*

About B.1.617 (cover last week)

The lineages all have the L452R mutation and three have the E484Q so concerns about decrease effective of monoclonal antibody and increase transmissibility. Of very limited data, slight decrease in neutralization (two-fold which is less important than P1 and B351). Included in transcript table from CDC:

Name (Pango lineage)	Spike Protein Substitutions	Name (Nextstrain)	First Detected		Attributes
B.1.617	**L452R, E484Q,** D614G	20A	India	February 2021	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Slightly reduced neutralization by post-vaccination sera
B.1.617.1	(T95I), G142D, E154K, **L452R, E484Q**, D614G, P681R, Q1071H	20A/S:154K	India	December 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Potential reduction in neutralization by post-vaccination sera
B.1.617.2	T19R, (G142D), **Δ156, Δ157,** R158G, **L452R,** T478K, D614G, P681R, D950N	20A/S:478K	India	December 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Potential reduction in neutralization by post-vaccination sera
B.1.617.3	T19R, G142D, **L452R, E484Q,** D614G, P681R, D950N	20A	India	October 2020	• Potential reduction in neutralization by some EUA monoclonal antibody treatments • Potential reduction in neutralization by post-vaccination sera

Links:

- https://outbreak.info/
- https://www.medrxiv.org/content/10.1101/2021.03.01.21252652v1
- https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-Variants.aspx
- 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**

- None Provided

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

Topics: Updates to EUA fact sheets for monoclonal antibody treatments.

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.

Updates to EUA Fact Sheets for Monoclonal Antibody Treatments

As a reminder, on Friday, May 14, 2021, the FDA issued major updates to the EUAs for bamlanivimab and etesevimab administered together and casirivimab plus imdevimab (REGEN-COV), which includes an expanded eligibility criteria for the definition of patients who high-risk for disease progression.

The updated Fact Sheets for both treatments can be accessed at the links above.

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

- Bamlanivimab plus Etesevimab Distribution Fact Sheet
- 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 Cov (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 5/24/21, 45,119,680 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites. To date, 36,364,200 have been administered. 16,691,024 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.

- CDPH and the California Medical Association are hosting a free webinar today, 5/25/21 at 5-6pm for providers of adolescent services on what to expect after enrolling in the California COVID-19 vaccination program. This event will also be recorded
    - To register, you can go to EZIZ.org and the link is on the front page.
    - Registration Link: https://www.cmadocs.org/event-info/sessionaltcd/CMA21_0525_CDPH/t

- CDPH is developing a system called the "Vaccine Marketplace", which will allow providers to add or request expiring doses. All providers enrolled in myCAvax are eligible for this program, and more information will be shared soon to all providers when the system is set up.

- CDC updated the Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC webpage on 5/14/21. There are several useful job aids linked on the website. Key updates from last week include.

- CDC is closely following rare reports of myocarditis or pericarditis following COVID-19 vaccination
    - Investigation of these reports is in progress to determine whether or not COVID-19 vaccines are a cause
    - Evaluating providers should report cases of myocarditis/ pericarditis after vaccination promptly to the Vaccine Adverse Events Reporting System (VAERS): https://vaers.hhs.gov/reportevent.html

- CDC's Vaccine Safety Technical (VaST) Work Group reviewed updates from several national vaccine safety surveillance systems (DoD, VAERS, VSD, VA, CISA): https://www.cdc.gov/vaccines/acip/work-groups-vast/technical-report-2021-05-17.html
    - Few reports of myocarditis to date following receipt of mRNA vaccines
    - Most cases appear to be mild and of brief duration
    - Follow-up of cases is ongoing
    - Cases seem to occur:
        - predominantly in adolescents and young adults
        - more often in males than females
        - more often following dose 2 than dose 1
        - typically, within 4 days after vaccination

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.

VII. Questions and Answers

Q: Regarding social distancing in the healthcare setting, when will we be able to not adhere to the six feet of social distancing?

A: Updated guidance around visitation are forthcoming in an updated version of AFL 20-22. We anticipate that these will address and include some of the circumstances that CDC indicated in their updated guidance. There are a few specified circumstances when verified that all participants in a given activity or communal dining are known to be fully vaccinated, they can do so without wearing masks or physical distancing. I would like to really emphasize that those are very specific situations where vaccination status is known and can be verified and monitored, otherwise the default in healthcare settings remains that we have universal face masks for source control as well as physical distancing.

Q: So, we don't have any clear direction yet in an AFL that allows us to go back to dining back the way we used to. My facility is 98 percent vaccinated. I'm just looking for it to be official where I can go back to dining and activity program as usual. When through an AFL, will we be able to go back to testing once a month for those who are not vaccinated?

A: There is an update to AFL 20-53 which is also pending approval. This describes updates to the testing as it relates to healthcare personnel vaccination status. This will generally align with the CDC and the CMS updated guidance. There are additional considerations that may be included in the AFL for the updated implementation of this updated guidance in California. California has always had a more frequent minimum testing cadence then the once a month per CMS requirement. In California, we have required that the testing be done at a minimum of a weekly cadence regardless of the county positivity rate. It might not go back to once a month.

Q: About the temperature and symptom screening required for acute hospitals and SNFs, do you perceive that going away? Do you think CMS is going to no longer require that as healthcare workers and visitors enter a healthcare facility?

A: No, I don't foresee that going away. The CDC guidance updates to infection prevention and control practices in response to vaccination has not included or signaled any change in screening for

symptoms. I would emphasize that, especially with regards to visitors, it's often going to be challenging to determine or verify their vaccination status. Even if someone is fully vaccinated, if they have any symptoms consistent with COVID, they should still be tested.

Q: I heard there was a reference to develop an injectable parenteral intramuscular monoclonal antibody treatment. I was wondering if you are aware of any progress in that front because it would increase the sites where this would be given. And second, I was also wondering if there was any word on antivirals that can be administered in outpatient sites in case we have a spike in the winter again?

A: Regarding your first question, there are efforts for subcutaneous injection. I know Regeneron showed some promising Phase 2/3 results. Last I heard on some update calls with HHS ASPR, they were pursuing an expanded EUA for alternative routes of administration, but beyond that, I don't have much more information except for it does seem to be developing and the next development with these treatments seems like routes of administration can be addressed. Regarding other outpatient treatments, there are some oral antivirals that are in development. I think one of the front runners is a medication called Molnupiravir which has some promising study results in a Phase 2 study and expected to have some additional results due here at the end of May. And then I believe that Pfizer and some other oral antiviral are also in development and showing varying degrees of success. So certainly there's a lot of emerging therapeutics probably still yet to come and I know that finding an oral outpatient treatment is something that a lot of folks are focused on but right now, there's not too much more information that I have.

Q: Can you give us any better idea on when these updated AFLs are coming out?

A: I understand your frustration. We are scheduling weekly meetings and setting time aside to get these reviewed. Hopefully we can have some things out by Friday this week.

Q: If you look at statistics worldwide, COVID reinfection is really extremely rare in those who are diagnosed with COVID previously and even those reports are iffy. Will there ever be a point where people that have had COVID will be considered fully equal to fully vaccinated people in these social settings and why couldn't antibody or serology testes be used the same as a fully vaccinated card?

A: I can say that the 90-day time interval that the CDC has indicated, reinfection is extremely rare has been discussed. A potential for extending that time interval beyond 90 days has been also discussed as well. CDC has signaled a while back that that extension was forthcoming but then held off making that change pending more data and experience with the emerging variants. I'm not aware nor do I anticipate that there will be any kind of similar management of individuals with prior infection as compared to those for fully vaccinated as far as masking or distancing. I think that others could speak more to this on this call that the immunity following vaccination is thought to be more robust and studied.

Q: I would say it's probably better studied, but if you look at the people that are coming out with reinfection of COVID that have been fully vaccinated, I think that argument, when you look at the statistics of people that have been infected with COVID. Our immune system recognizes that the same

as it would the spike protein in the vaccination, in fact, maybe even more because it's recognizing the whole virus. There are parts of the virus that are probably unique to it besides the spike protein. I just think that we are ignoring a whole population of people that could be socially considered same as fully vaccinated. That's just my opinion.

A: I would add that the duration of protection following full vaccination is also continuing to be monitored. There has been discussions and indications that booster doses may be required at some point. These are all factors that are going into an ongoing and evolving approach to management. Stay tuned for those updates.

Q: About presurgical testing for fully vaccinated patients, is there any guidance on that coming out? Also, for patients that have had COVID in the past 90 days, is there specific guidance on whether or not to test these patients and what to do if they test positive because that keeps happening.

A: CDC has provided some updated considerations and we anticipate but don't yet have approval to post the relevant all facilities letter that includes preadmission or pre procedure testing. CDC has indicated in their guidance that hospitals and facilities may consider modifying their protocols for preadmission or pre procedure tests for individuals whose vaccinations status is known. I think this is becoming a more of a nuanced and risk assessment-based determination around testing for admission. You had mentioned individuals who have had previous COVID and I think the guidance around not testing unless symptomatic for individuals who have had prior infection and are within 90 days of that infection, can be reasonably applied in this population. We know that persons can continue to test positive on a PCR test following resolved natural infection for some time. We know that they risk of actual reinfection during that 90-day period, and it may be even longer, is really very low. The ongoing PCR positivity of those who meet the criteria of prior infection within 90 days, they've resolved and are asymptomatic, not known to by symptomatic or recently exposed, is most likely residual fragments of the virus that is being detected at low levels by PCR and so we would not recommend routinely screening those individuals as part of a routine screening testing program or preadmission or pre procedure.

Q: Could you direct me to the AFL that talks about patient outings that's not medically necessary?

A: I believe that will be forthcoming. There has been updated CDC guidance on the management of residents of long-term care setting. There will be updates to our guidance that will reflect CDC's guidance. The current version is AFL 22.22.7.

Q: So currently right now, there is no AFL that addresses outings.

A: I believe there was never any direction issued by the department that stated that residents could not leave the facility or go out for an outing. The difference was, upon return where that resident needed to be. Whether it be in a yellow zone, for known exposure, or prior to vaccination etcetera. So, this point, similarly if a resident were to leave and go out on an outing, much of then the resident would need to be upon return would be based on the vaccination status.

Q: I was wondering if you could address if temperature screening is going to be part of either visitor or acute care healthcare facility employee screening guidance. We found this to be both insensitive and nonspecific. I wonder if there will be specific language around screening for temperature for anyone entering an acute care facility in upcoming AFLs?

A: With regards to screening for symptoms upon entry to facilities, that requirement for symptom screening is likely to continue and hasn't been changing any of the latest CDC guidance updates on how things changed with vaccination. With regards to specifically to temperature taking as part of that, we continue to emphasize that, again an active screening process that includes verifying absence of symptoms potentially consistent with COVID or known exposure will likely continue to be for some time, an important practice. We continue to see far too many people who come to work while symptomatic and those individuals need to be excluded and tested. At this point the CDC still recommends testing individuals who are symptomatic, regardless of their vaccination status. The CDC guidance that we've been pointing to on this screening process includes some options. I'm not aware of any plans to change that.

Q: My takeaway is that the active symptom check and not necessarily the check on a sign like temperature that's important from a public health perspective.

A: I agree with you. I think that from a public health perspective, what's most important is that there's an active verification of the absence of those symptoms.

Q: My question is on the guidance on how to navigate resident rights versus what we're required to do. Unfortunately, a lot of the restrictions and the PPE that we have to follow has been politicalized. We live in a community where a lot of people don't agree with wearing a mask and so we're trying to bridge the gap where they feel that they don't need to wear one and then we tell them "Hey you can't come in and visit your loved ones if you're not going to adhere to this". Then they're calling the ombudsman and getting that involved. The other part of that is, I have family members wanting to come and visit at eight or seven o'clock at night when we don't have somebody to monitor to ensure that those principles are being followed. I hired a couple of people just to monitor visitation so that we can have visitation seven days a week, so I feel like what we did was reasonable. From the ombudsman perspective, it's the right to have visitors. I feel like I'm caught in the middle.

A: Are you providing opportunity for visitors to come after hours, after a typical business workday to accommodate those visitors who may need to be reporting to work during the daytime but limits their visitation opportunity to the evening?

Q: No, I guess I would have to hire another person to use the evening shift. But I thought that having seven days a week visitation was enough, but I guess that's not enough.

A: I think that depending what the needs are for your residents; I think that each facility is going to need to look at what the needs are for their particular composition of residents for visitation. We have been speaking along the duration of this making sure that if visitation policies need to be updated and disseminated to family members to explain the limitations that are in place to not only protect their loved ones but also those other residents within the facility, certainly making that clear. I would just encourage that if there's a shift that can be made, I can't necessarily tell you that you need to hire another person per se because that's your business decision but I would encourage you to look at

perhaps alternatives or creative ways that you can accommodate visitors that can't come during the normal business day. I think that as we progress with more opportunities for what visitation looks like and opportunities to potentially use outdoor visitation or distancing, things like that, or where the guidance may eventually change that perhaps requires less monitoring of visitors in a facility based on vaccination status is kind of yet to be seen but that would be my initial recommendation, is to perhaps consider that if there is way to shift you visitation hours to accommodate those individuals.

Q: I have my visitation monitor's hours are different every day to try to accommodate different people's schedules. I also have window set up where no monitoring is required because there's a window and phone system to be able to hear each other but that's still not good enough for some people. I just want to make sure that what I'm doing is considered reasonable as far as their rights go or if I really should be doing something more?

A: It sounds like you're providing alternatives and I think that's what could be reasonably expected at this point. I understand it's not going to meet everyone's expectations but again, I think that having those conversations with family members and making them aware of what your policies are for the time being according to the guidance associated with limiting spread or exposure. And it's not just for their loved ones but for everyone in the facility including healthcare workers and other residents and other visitors to the facility. I think what's important is that you're providing options and alternatives to family members and that wouldn't allow them to have their visitation.

Q: Regarding the BinaxNOW cards, is that acceptable for weekly surveillance testing given that when we read the manufacturer's instructions it says it really for symptomatic individuals. Do we have any problems using that as our testing method?

A: The antigen tests can be used for the routine screening of asymptomatic individuals such as healthcare personnel in a routine screening testing program. The minimum frequency that the Testing Task Force has recommended for that however is twice per week.

Q: Ok. For my second question, will you be coordinating for coordinating for communities that are CCRCs or have residential care that has to do 25 percent a week 100 percent a month, will you be coordinating recommendations with Department of Social Services on testing of those staff?

A: I believe that the Department of Social Services is updating their Provider Information Notice (PIN) regarding testing and including accounting for fully vaccinated status. I'm not directly aware of where that is in the approval process and posting. I would say in general the intent is to similarly again with the modifications to the routine screening testing programs in skilled nursing facilities as well, as it relates to both the vaccination status and the minimum frequency, that would need to be continued for screening of unvaccinated healthcare personnel.

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