California Department of Public Health
Weekly Facility COVID-19 Update Call
June 1, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
Access Code: 7532835
Available after 12 Noon 6/1/2021

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

- None Provided

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

- None Provided

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

SARS-CoV-2 Whole Genome Sequencing and Title 17, Section 2505, subsection q. update
Last week, subsection (q) portion of Title 17, Section 2505 was finalized. This regulation will require that all laboratories performing sequencing for SARS-CoV-2 report lineages identified via ELR and the "raw" data to CDPH. This is in addition to the prior regulation, subsection (p) that went into effect early April 2021 requiring labs to submit the sample upon request of the health department.

The CDPH will release a detailed guidance letter for laboratories about what is expected from them and the timeframe for reporting to CDPH.

Global-World Health Organization (WHO)

Yesterday, the WHO announced new naming of COVID-19 variants. Rather than use the country of origin such as UK variant, S African variant or Indian variant, which can be stigmatizing to a given country the new system will be based on the letters of the Greek alphabet. When all 24 letters Greek alphabet have been used, WHO will decide on another series. Tables of variants and Greek letter assignments will be included in the notes from this call.

Variants of Concern

WHO label	Pango lineage	GISAID clade/variant	Nextstrain clade	Earliest documented samples	Date of designation
Alpha	B.1.1.7	GRY (formerly GR/501Y.V1)	20I/S:501Y.V1	United Kingdom, Sep-2020	18-Dec-2020
Beta	B.1.351	GH/501Y.V2	20H/S:501Y.V2	South Africa, May-2020	18-Dec-2020
Gamma	P.1	GR/501Y.V3	20J/S:501Y.V3	Brazil, Nov-2020	11-Jan-2021
Delta	B.1.617.2	G/452R.V3	21A/S:478K	India, Oct-2020	VOI: 4-Apr-2021 VOC: 11-May-2021

Variants of interest

Scientific name	Country where first identified	WHO label
B.1.427/429	United States	Ε Epsilon
P.2	Brazil	Ζ Zeta
B.1.525	Multiple countries	Η Eta
P.3	Philippines	Θ Theta
B.1.526	United States	Ι Iota
B.1.617.1	India	Κ Kappa

Source: World Health Organization
Graphic: Daniel Wolfe, CNN

Specific information about **B.1.617.2**, known now as ***Delta***
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 (now known as Alpha).

Notably several organizations including World Health Organization, Public Health England, European Centre for Disease Prevention and Control and Canada have elevated B.1.617, *or specifically B.1.617.2, to a VOC.* The UK may be "on the cusp" of a 3rd wave due to this variant as well. India's 2nd surge numbers are decreasing for last few weeks. B.1.617.2 cases continue to dominant making up 62% of sequenced virus in last 2 months (B.1.617.1 18%) per Outbreak.info.

Other variants to follow:
There is another variant , B.1.621, originally detected in Columbia (containing E4844K, N501Y, P681H mutations) identified in 11 countries and 22 states:
https://www.medrxiv.org/content/10.1101/2021.05.08.21256619v1.full-text

Also, per reports in lay press, a newly emerging variant in Vietnam has emerged that combo of characteristics of existing "India variant" (now known as Delta) and "UK variant." (now known as Alpha). We are likely to hear more about this in the next few days. Vietnam is experiencing increase in cases.

Nationally
CDC's list of five variant of concerns (VOCs) and eight variant of interest (VOI) have remained the same for several weeks. VOCs include B.1.1.7 (Alpha, UK), B.1.351 (Beta, South Africa), P.1 (Gamma, Brazil) and B.1.427 and B.1.429 (California, sometimes referred to as West Coast. Epsilon) VOI; ; B.1.526 (New York, Iota) and B.1.526.1 (New York), B.1.525 (Nigeria, Eta), P.2 (Brazil, Zeta) and the B.1.617 lineages (India) ; *B.1.617, B.1.617.1 (Kappa),* ***B.1.617.2 (Delta)*** *and B.1.617.3. (new WHO name/country where first identified).*

Note that CDC list VOC and VOI not identical to WHO.

No major changes national level-B.1.1.7 (Alpha) remains the predominant variant (60-70% of variants sequenced). Additionally, P.1 (Gamma) continues to slowly increase in many regions of the US (from 5%-->8.8 of sequenced samples in recent weeks). B.1.617.2 (Delta) (from <0.5% -→1.3%) still quite low overall but given high transmissibility will need to be followed). Other major variants are mostly decreasing.

California:
The proportion of B.1.1.7 (Alpha) among samples continues to increase with ~60+% of samples sequenced. P.1 (Gamma) also increasing slowly. B.1.617.2 (Delta) is increasing but is still not a large percentage of cases.

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.

- Letter is being sent out too many clinicians in hospitals asking that they submit samples on any patient respiratory specimens for WGS and serum specimens to measure antibody response from hospitalized COVD-19 patients.

Background B.1.617 variants (presented 2 weeks ago)

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/10.1101/2021.05.08.21256619v1.full-text
- 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

Updates:

- Bamlanivimab plus etesevimab no longer available for ordering nor recommended for use in California.
- FDA authorizes additional monoclonal antibody for treatment of COVID-19.
- NIH updates recommendations on the use of baricitinib.

Bamlanivimab plus Etesevimab No Longer Available for Ordering nor Recommended for Use in California

On May 26, 2021, given the sustained increase in the P.1 and B.1.351 variants, HHS/ASPR stopped the distribution of bamlanivimab plus etesevimab to California. The Centers for Disease Control and Prevention (CDC) has identified that the combined frequency of the P.1 variant and the B.1.351 variant now exceeds 10% in California. Results from in vitro assays suggest that bamlanivimab and etesevimab administered together are not active against either the P.1 or B.1.351 variants.

Reminder that the FDA previously revoked the EUA for bamlanivimab monotherapy due to the sustained increase in variants resistant to bamlanivimab alone. The product is also no longer available for direct ordering and no longer recommended for use.

The FDA now recommends that health care providers in California instead use casirivimab plus imdevimab (i.e., REGEN-COV) therapy until further notice. Casirivimab plus imdevimab is an alternative monoclonal antibody therapy that is currently authorized for the same use as bamlanivimab plus etesevimab - for the treatment of mild-to-moderate COVID-19 in adult and pediatric patients who are at high risk for progression to severe disease. Based on similar in vitro assay data currently available, casirivimab plus imdevimab is likely to retain activity against the P.1 and B.1.351 variants**.**

Please see the HHS/ASPR notice regarding this update for more information.

Reminders re: casirivimab/imdevimab:

- The NIH has strongly recommended (AIIa) casirivimab plus imdevimab for use in non-hospitalized COVID-19 patients.
- The FDA issued major updates to the EUA for casirivimab plus imdevimab (REGEN-COV), which includes an expanded eligibility criteria for the definition of patients who high-risk for disease progression.
- **All treatment sites can continue ordering casirivimab plus imdevimab from the authorized distributer using the direct ordering process.**
- In addition to the above direct ordering process, casirivimab/imdevimab is readily available from CDPH. Contact your county's Medical and Health Operational Area Coordinator (MHOAC) to request either of these products from CDPH.

FDA Authorizes Additional Monoclonal Antibody for Treatment of COVID-19

On May 26, 2021, the FDA issued an emergency use authorization (EUA) for the investigational monoclonal antibody therapy sotrovimab for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing and who are at high risk for progression to severe COVID-19

Sotrovimab is a monoclonal antibody that is specifically directed against the spike protein of SARS-CoV-2 and is designed to block the virus' attachment and entry into human cells.

The data supporting this EUA for sotrovimab are based on an interim analysis from a phase 1/2/3 randomized, double-blind, placebo-controlled clinical trial in 583 non-hospitalized adults with mild-to-moderate COVID-19 symptoms and a positive SARS-CoV-2 test result. Of these patients, 291 received sotrovimab and 292 received a placebo within five days of onset of COVID-19 symptoms. The primary endpoint was progression of COVID-19 (defined as hospitalization for greater than 24 hours for acute management of any illness or death from any cause) through day 29. Hospitalization or death occurred in 21 (7%) patients who received placebo compared to 3 (1%) patients treated with sotrovimab, an 85% reduction.

Sotrovimab is not authorized for patients who are hospitalized due to COVID-19 or require oxygen therapy due to COVID-19. This treatment has not shown benefit in patients hospitalized due to COVID-19 and monoclonal antibodies may be associated with worse clinical outcomes when administered to hospitalized patients requiring high flow oxygen or mechanical ventilation.

Laboratory testing showed that sotrovimab retains activity against the current circulating variants first reported in the United Kingdom, South Africa, Brazil, California, New York and India.

The EUA allows for sotrovimab to be distributed and administered as a 500 milligram single dose intravenously by health care providers. The EUA requires that fact sheets that provide important information about using sotrovimab in treating COVID-19 be made available to health care providers and to patients, parents and caregivers, including dosing instructions, potential side effects and drug interactions.

The safety and effectiveness of this investigational therapy continues to be evaluated for treatment of COVID-19. Potential side effects of sotrovimab include anaphylaxis and infusion-related reactions, rash and diarrhea.

Currently, HHS/ASPR has not shared how the product will be made available to providers.

Additional resources re: sotrovimab

- Sotrovimab EUA Letter of Authorization
- Health Care Providers Fact Sheet
- Patients, Parents and Caregivers Fact Sheet

NIH Updates Recommendations on the Use of Baricitinib for COVID-19

Since their last statement of baricitinib was released, the COVID-19 Treatment Panel has reviewed the preliminary results (not yet peer reviewed) from COV-BARRIER, a trial of baricitinib in hospitalized adults. Based on this review, the Panel has updated its recommendations on the use of baricitinib for the treatment of adults with COVID-19, as outlined below.

- The Panel recommends using either baricitinib (BIIa) or tocilizumab (BIIa) (listed alphabetically) in combination with dexamethasone alone or dexamethasone plus remdesivir for the treatment of COVID-19 in hospitalized patients on high-flow oxygen or noninvasive ventilation who have evidence of clinical progression or increased markers of inflammation.

- Among hospitalized patients with hypoxemia who require supplemental oxygen therapy, there is insufficient evidence to identify which patients would benefit from the addition of baricitinib or tocilizumab to dexamethasone (with or without remdesivir). Some Panel members would add either baricitinib or tocilizumab to patients who are exhibiting signs of systemic inflammation and rapidly increasing oxygen needs while on dexamethasone, but who do not yet require high-flow oxygen or noninvasive ventilation.
- In the rare circumstance when corticosteroids cannot be used, the Panel recommends using baricitinib in combination with remdesivir for the treatment of COVID-19 in hospitalized, nonintubated patients who require oxygen supplementation (BIIa).
- There is insufficient evidence for the Panel to recommend either for or against the use of baricitinib in combination with dexamethasone for the treatment of COVID-19 in hospitalized patients who require invasive mechanical ventilation.
- The Panel recommends against the use of baricitinib in combination with tocilizumab for the treatment of COVID-19, except in a clinical trial (AIII). Because both baricitinib and tocilizumab are potent immunosuppressants, there is the potential for an additive risk of infection.
- There is insufficient evidence for the Panel to recommend either for or against the use of baricitinib for the treatment of COVID-19 in children.
- For more information, please read the full statement on the COVID-19 Treatment Guidelines website.

Additional Resources

For facilities and healthcare providers interested in setting up infusions for high-risk patients with COVID-19, ASPR has many resources available. This includes free digital content that your facility can use on social media platforms to help educate providers and patients. HHS has also provided CombatCovid.HHS.gov as a resource for your patients.

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)

Bamlanivimab/Etesevimab – *no longer available or recommended for use in California*

- HHS/ASPR Bamlanivimab plus Etesevimab Update re: SARS-CoV2 Variants of Concern

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**

To summarize, three COVID-19 vaccines have received FDA emergency use authorization: Pfizer, Moderna, and Janssen. All Californians 12 and older are eligible for COVID-19 vaccination.

Doses/allocation

- As of 5/31/21, 46,298,020 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites. To date, 37,513,067 have been administered. 17,347,782 people have been fully vaccinated, representing 51.1% of the total eligible population. 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. MyTurn.ca.gov or Vaccines.gov can be to find doses at pharmacies.

In order to accelerate the use of vaccine before it expires, CDPH has released the **myCAVax Vaccine Marketplace.** This new feature is open to **all** providers in the COVID-19 Vaccination Program who are approved in myCAvax, including newly enrolled providers and all other providers, regardless of TPA network enrollment or if they have never received doses.

- More information about the Vaccine Marketplace is available online.

On 5/27/21, California announced a new vaccine incentive program as part of the larger Vax for the Win program. The incentive program encourages Californians who have not yet been vaccinated to get started today. The first 2 million Californians who start and complete their COVID-19 vaccination process beginning May 27 will be eligible for a $50 incentive card. More information here.

- More information can be found on the Vax for the Win website about the $15 million in prizes that are available (https://covid19.ca.gov/vax-for-the-win/).

On 5/25/21, Moderna announced the results of its COVID-19 vaccine trial in adolescents 12-17, which demonstrated vaccine efficacy of 100%. Moderna plans to submit data to regulators in early June.

- Press release: https://investors.modernatx.com/news-releases/news-release-details/moderna-announces-teencove-study-its-covid-19-vaccine.

CDC is investigating recent reports of myocarditis and pericarditis in young adults and adolescents shortly after receipt of mRNA COVID-19 vaccines.

- CDPH released a health advisory on 5/28/21 on this topic. The full advisory can be found in the meeting notes.
- COVID-19 immunization is still recommended for persons 12 years of age and older.
- All cases of myocarditis following receipt of COVID-19 vaccine, as well as other adverse events following vaccination, should be reported promptly to the CDC/FDA Vaccine Adverse Event Reporting System (VAERS).
- **CDC has posted updated clinical recommendations related to myocarditis and pericarditis following COVID-19 vaccination: Clinical Considerations: Myocarditis and Pericarditis.**

Please refer to CDC's Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC for the most updated clinical guidance on COVID-19 vaccination and job aids. This page was last updated on 5/14/21.

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.
- Link to COVID vaccine resources: https://eziz.org/covid/vaccine-administration/.
- Authorized Vaccinators.
- How to report inventory in Vaccine Finder.

VII. Questions and Answers

Q: Has CDPH made any updated recommendations to air exchange in operating rooms for COVID scenarios?
A: There are no updated guidance regarding management of air exchange in operating rooms from CDPH nor, that I'm aware of from CDC. I advise you to continue your current practice. I'll double check but I don't think that we have updated or changed guidance in that regard.

Q: Related to fully vaccinated team members, my understanding that we can meet with team members, no residents present, and not be required to wear masks if we are 100 percent vaccinated, everyone that is involved. Regarding our kitchen crew, they are 100 percent vaccinated and residents never go into that environment. While there are working, are they required to wear masks?
A: I think what you are describing is consistent with the updated CDC guidance. I appreciate you verifying and ensuring that anyone who is participating in an activity or working in a kitchen together where there isn't an in and out of staff or residents, that could be safe implementation of that guidance. I would just want to be clear on the assurance piece in terms of monitoring to make sure

that there are indeed no unvaccinated staff that might come and go in and out of the kitchen or meeting area.

Q: Regarding sequencing recommendations, right now we are doing all hospitalized patients. The CDC has come out and said that's all they want to do including people who are hospitalized for reasons other than COVID and found that breakthrough infections asymptomatic on admission. I understand you have more capacity it just makes it harder for me to come up with guidance that makes sense for everyone to follow. Can you clarify where you're going with that?
A: For now, our recommendations are that for those who are hospitalized with a positive COVID illness, we would want to sequence that particular case assuming the CT value is less than 34 is known. Our current case counts are so low right now and our capacity is so great that eventually we might get to the point where we ask for everything. We haven't formally decided whether we're going to do that or not. I would think that would make it easier rather than a lab trying to go through what's hospitalized or not. It might be easier to save everything with CT values.
Q: You also have the local county health department that are screening and kind of blocking that too. It kind of gets complicated.
A: We're meeting with them in a couple of days to talk about this more. Basically the way we've set it up is if a local health department does do sequencing and they want the samples, they should sequence. But if they don't want to do it or they don't have the capacity, they can either send it to us or it can be sent directly with their approval. This is outlined in the letter that's about to be sent out. It's been approved and really just needs to be sent if it hasn't already gone out.
Q: You said that the B6172 is about 50 percent more contagious than the 117?
A: That's the estimate. There haven't been great studies. That's what's in a lot of the lay press and some of the experts are suggesting.
Q: And the 117 is about 30 or 40 percent more contagious than the 614g?
A: Yes.
Q: And the 614g is not 30 or 40 percent more contagious than the original Wuhan strain?
A: It all gets kind of tied up. I think we have to be a little bit skeptical about exact percentages here but the idea is that the 617.2 in particular, what's now going to be called the delta variant in other words the one from India originally, is supposed to be more transmissible than pretty much everything else out there other than this other one we're hearing about in Vietnam. It doesn't yet have a designation.
Q: Yeah but that kind of means for about 90 percent more contagious than the original strain, is that right?
A: No one has come out and said that but if you do that math, it does appear that way. Again these are all kind of people talking about it. I haven't seen studies like when we came to the B117 or the UK or now the alpha variant, there were actually studies from the UK showing that is was more transmissible. There were household studies and there were other studies done. I have yet to see a real study showing this transmission of the delta variant.
Q: My point being that compare to another strain that is circulating, we have to maintain sight on the fact that we've had several different strains were we talk about this one is more contagious than that one but it really should go back to the original strain and the contagion is dramatically higher than that.
A: You are correct, it's higher. Even for the B117 or now the alpha or UK variant, studies are showing that it's more transmissible but it's variable on how much more. So I think it depends a bit on the setting too.

Q: Are we going to have to teach everyone how to recognize all the different Greek letters or all we going to be spelling them all out?
A: That's a great question. I'm hoping that they're going to be spelled out. This is a pretty big change. I guess if we were doing this in the beginning it wouldn't feel so difficult but I think that we finally know what B117 is and what P1 is but now we're having to learn this whole other application. So far it looks like they are spelling them out.

Q: We are finding that we are running out of people to vaccinate and we have vaccines that are going to expire and we are having to throw them away. Is there any program available or does CDPH mind if we have vaccines that are going to expire and we have no reasonable chance to use, if people visiting from other hospitals take the vaccines with them for use in their facility? We had a nurse from Cameroon ask if he could take them back with him.
A: There is the My Vaccine Marketplace that I mentioned earlier. There is more information on the link about how to use that feature. In terms of sending vaccines internationally, that's currently not an option per the guidance from the CDC but we will keep you updated when we have more information.

Q: Recent guidance from LA County has indicated that posting signage is good enough for facility entry screening without any additional measures needed. I just wanted to confirm CDPH's position on this.
A: We've been pointing to the CDC guidance which still includes an active process. I'll be happy to discuss this with LA County Public Health colleagues about their updated guidance but this is the CDC guidance which is what we've been generally pointing to. Could you forward me what you are referring to?
Q: Sure.

Q: What should we do with our current supply of Bamlanivimab and Etesevimab since they are no longer recommended in California.
A: HHS ASPR does give some instructions as to how to return products to the original manufacturers. My understanding is that the products won't be reused because they can't ensure its integrity. But essentially, go to the product page with Eli Lilly for Bamlanivimab plus Etesevimab and they have links that essentially instruct folks how to return unused products. Anything that's been reconstituted, they can just dispose of it.
Q: Regarding the Delta variant in California, in those particular cases, were the patients vaccinated?
A: It's a mix and we are still looking at that data but at least a number that I am aware of had not yet received the vaccine but we do not have complete data by any means on that.
Q: Do we know the area?
A: It's been in different areas of the state. Normal sequencing in itself takes several days. It takes a while to gather all that data. We're really just beginning to put together the data specific to that particular variant.

Q: A couple of speakers mentioned meeting notes. Where can these be found? Also It sounds like the regulation update was specific to COVID-19. I'm wondering if there's any way to revise the regulations such that every time a new disease comes up like COVID-26 or COVID-32, the regulations don't have to be revised so often, that is, perhaps the director of CDPH could just say that labs shall report X or Y variant.

A: So the way that Title 17 section 2505 section Q reads is for all lineages so it's for all SARS COV 2 linages. So no matter what lineage is found, it has to be reported.
Q: I was thinking about the next pandemic. It already more than a year into this one and now the regulations are coming out.
A: That's true. I don't disagree with you. That would be a decision made quite a bit above me but I do agree. Of course a lot of labs a year ago weren't sequencing. Sequencing is something that I think a lot of labs started in earnest several months ago. Many of them are reporting it's just that now it's going to be mandatory.
Q: So many diseases can be sequenced so I'm thinking that if the regulation was general, the next time we have a pandemic, this would be faster.
A: I agree.
A: About your first question, you can send an email with your contact information, the facility category in which you are interested in receiving information, including your facility name, address, telephone number and email address for your contact. The email address you will send that information to is CAHANinfo@cdph.ca.gov and they can put you on that alert distribution list.

Q: We haven't had an outbreak in our facility for over a couple of months and we do not have any more COVID in the facility but we are still testing staff weekly. I just wanted to know if that was still going on or if we can stop that?
A: AFL 20-53 is being updated to reflect updated guidance around screening testing for staff members that accounts for vaccination status. Fully vaccinated staff members would no longer need to be routinely screening tested. However, unvaccinated staff members would continue to need to be routinely screening tested.
Q: Would that be weekly or biweekly?
A: I believe that minimum cadence will be weekly but need to see the final AFL.

Q: This is about the kitchen crew question. Since this conflicts with Cal OSHA's guidelines and even the revised guidelines that haven't been published yet, how are we supposed to be resolving these conflicts when you have Department of Public Health saying one thing and some department saying something different? Who takes precedence?
A: That's a good question and something we can take back. I'm referring to the CDC guidance. That's something that we can discuss with Occupational Health and Cal OSHA colleagues as they're updated and regulations move forward.
Q: We're running into this because CDC says one thing and then CDPH is mirroring that and then you have this one body who you definitely do not want to run afoul of and they are kind of off doing their own thing and making it really complicated to do business.
A: Understood. Thank you for bringing that up. That's something that we can work to try to understand or clarify.

Q: Regarding the masking mandate with OSHA and how that gets confusing with the staff here. My understanding and clarification really is that I thought the CDC guideline were clear and indicated that that's not for hospitals and it did not apply to hospitals. Does that guidance still stand or has it changed in the last couple of days?
A: The CDC guidance that was recently released about fully vaccinated and unmasking indoors, you are correct, it does not apply to healthcare settings. However, CDC did issue separate guidance for

healthcare settings in response to vaccination in which they described special circumstances when as long as everyone present in a room or participating in an activity is fully vaccinated, while in that room or participating in that activity, they can go without masks. However, at all other time within a healthcare facility, the guidance remains to continue wearing masks even for fully vaccinated and that applies to staff members as well as visitors. It's really just the specific circumstances. For example, once a visitor has entered the room of the patient that they are visiting, so long as both are fully vaccinated, they can take their masks off and have their visit. Otherwise at all times within the facility, the guidance is still to wear masks for source control regardless of vaccination status.

Q: About the COVID waiver for temporary staffing, we all know that there is an end date on that on June 30th in the information that came out and we are really struggling still for staffing as a company and as an industry. I'm wondering what's going to happen with that staffing temporary waiver as we know is going to end on the 30th?
A: So right now there is not an anticipation that that waiver will be extended. Are you looking at staffing shortages at the CNA level or nursing level or kind of across the board?
Q: It's at both but we do have licensed nurses from other states that have been granted temporary licenses that we know will end with this waiver.
A: I think it's important that you work early with various registries that you may have contracts with for opportunities to bring in individuals that are licensed in California to begin to practice. If you are a part of a larger chain working with your leadership on the ability to redistribute resources throughout your portfolio, things like that. Working with recruitment strategies to build up your work force. The opportunities for flexibility on an individual facility level, I don't know how much of that will continue. That's something you can reach out and have a conversation with your local district office about potential opportunities there. I think that really the focus needs to be aimed at trying to recruit and establish more permanent staffing resources as we move into a more poste acute pandemic level. Long term sustainability of operations is going to require that you build up your workforce to a more permanent level. Some of the other strategies that we did see to address a staffing shortage during various surges was to look at ways to shift your work shifts from 8 hour shifts to 12 hour shifts to maximize the use of the facility staff that you have and not require additional numbers to cover multiple traditional three shift day. We'll take this back and perhaps be able to revisit any other alternative strategies either later this week on phone calls or perhaps next week's call.
Q: Thank you. We are exploring all those options and we are still staffing challenged in many of our rural areas especially.
A: Yes, I imagine that to be exactly the case.

Q: Regarding on June 15th, if the governor rescinds the different tiers, will the AFL still stand and our County of San Francisco is pointing more towards CDPH. We're finding a real void in terms of figuring out whether CDPH is exactly going to follow CDC regulations which I know a few are slightly different, and how soon to expect that AFL to come out or whether we should really rely on AFLs at all going forward after June 15th if our county should be adjusting for that void. Thank you.
A: I'm not sure if it's in reference to specific guidance from CDC but speaking in general terms, yes facilities should be following All Facilities Letters. We are rapidly reviewing all of the facility letters that we have issued over the last year and a half that link to any reference or any requirements that are associated with the blueprint. And so many of those AFLs will be updated between now and June 15th to provide that guidance that goes beyond the blueprint.

Q: I would just urge that the testing and visitation are super germane and if you have any updates on how that process is going, if it could be accelerated that would be my request at the local health jurisdiction. It really is really helpful to have the updates but even the indoor unmasking between staff that are fully vaccinated, that is very confusing to me because to this point, I thought that we had not adopted that at the AFL level.

A: We are actively working on getting those updated guidances approved and they should be published very soon. I do completely understand the confusion.

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