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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR AN ORDER MODIFYING CDCR'S COVID-19 STAFF TESTING PLAN

Judge: Hon. Jon S. Tigar

INTRODUCTION

Plaintiffs ask this court to micromanage CDCR's existing and constantly evolving staff testing plan, which is updated as scientific knowledge and public health guidance warrant. Such an order would impose unduly restrictive and unworkable confines in an area where flexibility is necessitated by the constantly evolving nature of the COVID-19 pandemic. Moreover, this order is legally impermissible insofar as Plaintiffs have not – and cannot – establish CDCR's deliberate indifference to the COVID-19 pandemic response in general, and staff testing plan specifically, as they must in order to be entitled to relief under the Prison Litigation Reform Act (PLRA).

The current science and strategies to mitigate the risks associated with the spread of

COVID-19 improve daily, if not hourly. CDCR's current staff testing plan recognizes the dynamic nature of this situation, and was therefore created with the understanding that it would (and does) evolve as the science and public health guidance changes. In fact, the current iteration of CDCR's staff testing plan, dated July 23, is again in the process of being updated based on new guidance issued by the California Department of Public Health (CDPH) and the California Correctional Health Care Services (CCHCS). Therefore, it would be an unnecessary and inappropriate step for this Court to issue an order that would dictate the parameters of CDCR's staff testing plan and inhibit CDCR and CDPH's ability to modify CDCR's testing policies in the future as further scientific advances are made and public health guidance on the topic evolves.

Finally, Plaintiffs ignore that CDCR's current staff testing plan, which was developed based on input and recommendations received from CDPH and CCHCS, is already sufficient to mitigate the risks of COVID-19 for the incarcerated population and staff. While Plaintiffs and their expert, Dr. Lauring, might disagree with some of the provisions in CDCR's staff testing plan, mere difference of opinion does not amount to deliberate indifference, which is a finding this Court must make before it can issue the order Plaintiffs request.

Plaintiffs' motion must therefore be denied in its entirety.

BACKGROUND FACTS

CDCR's staff testing plan was developed based on recommendations and input from CDPH and CCHCS. (Declaration of Katherine Minnich (Minnich Decl.), at ¶ 3.) On July 15, Defendants produced the then-current iteration of CDCR's staff testing plan to Plaintiffs. (Declaration of Nasstaran Ruhparwar (Ruhparwar Decl.), at ¶ 2.) On July 23, Plaintiffs, Defendants, CCHCS, and CDPH met and conferred to discuss Plaintiffs' concerns with the plan. (*Id.*, at ¶ 3; Declaration of Dr. James Watt (Watt Decl.), at ¶ 9.) The parties' meet and confer efforts were, for the most part, successful. The same day, Defendants produced a revised version of CDCR's staff testing plan to Plaintiffs, which alleviated several of Plaintiffs' concerns. (Ruhparwar Decl., ¶ 4, Ex. A.) The only remaining concerns are the two modifications that Plaintiffs are seeking in their motion. Defendants did not agree to these two modifications because they are not required based on current CDC guidelines and recommendations from public

health experts.

Further, consistent with Defendants' representations to this Court and Plaintiffs that the staff testing plan is updated as guidance changes, the current (July 23) plan is in the process of being further updated based on new guidance from CDPH and CCHCS. Defendants will present the plan to Plaintiffs as soon as it is finalized and approved by all stakeholders.

LEGAL ARGUMENT

I. The State Is Entitled To Deference In Their Response to the COVID-19 Pandemic.

The separation of powers is one of the core principles upon which our federal and state governments are built. This constitutional construct mandates that the three branches of government — executive, legislative, and judicial — remain separate and not otherwise infringe upon the authority of one another. As it relates to prisons, the Supreme Court has aptly observed that "'courts are ill equipped to deal with the increasingly urgent problems of prison administration and reform,'" recognizing that "running a prison is an inordinately difficult undertaking that requires expertise, planning, and the commitment of resources, all of which are peculiarly within the province of the legislative and executive branches of government." *Turner v. Safley*, 482 U.S. 78, 84-85 (1987) (citing *Procunier v. Martinez*, 416 U.S. 396, 405 (1974) [overruled on other grounds in *Thornburgh v. Abbott*, 490 U.S. 401 (1989)]) (emphasis added). Critically, the Supreme Court has held that "[p]rison administration is, moreover, a task that has been committed to the responsibility of those branches, and separation of powers concerns counsel a policy of judicial restraint. Where a state penal system is involved, federal courts have, as we indicated in *Martinez*, additional reason to accord deference to the appropriate prison authorities." *Turner*, 482 U.S. at 85. These separation of powers interests are particularly salient when the executive branch is responding in real time to a global pandemic with no precedent.

The above separation of powers and deference concepts have been relied upon in a wide range of matters involving prison administration and reform. *See, e.g., O'Lone v. Estate of Shabazz*, 482 U.S. 342 (1987) (examining extent of incarcerated persons' free exercise of religion and deference given to prison officials); *Gates v. Rowland*, 39 F.3d 1439, 1448 (9th Cir. 1994)

(prison policy preventing HIV-positive incarcerated persons from holding food service jobs was properly within prison authorities' discretion); *Griffin v. Gomez*, 741 F.3d 10 (9th Cir. 2014) (holding district court improperly impeded state prison management by ordering release of an incarcerated person from administrative segregation unit during standard evaluation of his gang status); *see also, Sandin v. Conner*, 515 U.S. 472, 482-83 (1995) (observing that "federal courts ought to afford appropriate deference and flexibility to state officials trying to manage a volatile environment [in a prison]").

In short, the same longstanding and foundational principles must not be set aside in connection with Plaintiffs' motion. This is particularly true in a situation in which Plaintiffs are seeking a modification to CDCR's staff testing plan. Here, CDCR's plan was developed based on input and recommendations received from CDPH and CCHCS. (Minnich Decl., at ¶ 3.) But as with many things during this unprecedented pandemic, public health guidance and recommendations pertaining to testing protocols can evolve and change rapidly. Therefore, it is crucial that CDCR maintain flexibility to respond to such changes and modify the provisions of its staff testing plan in response, with the input of all stakeholders and public health experts. Should this Court issue the order that Plaintiffs are seeking and mandate certain provisions be included in CDCR's staff testing plan, it sets a harmful precedent that the testing plan must remain static at a time when flexibility is demanded most. Each time CDCR would seek to amend its plan, it would need to seek an order to modify the court's order on the staff testing plan first. This cumbersome routine is likely to result in a constantly outdated plan that, despite best efforts, cannot be based on current guidelines and science.

II. Plaintiffs Are Not Entitled To The Relief They Seek Because Defendants Are Not Deliberatively Indifferent To The Risk Of COVID-19.

Courts may only order prospective relief consistent with the PLRA when "necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs." 18 U.S.C. § 3626(a)(1)(A). In order to establish a violation of Plaintiffs' Federal rights, Plaintiffs must demonstrate that Defendants have acted with deliberate indifference toward those rights. Plaintiffs' reliance on *Coleman v. Brown*, 28 F. Supp. 3d 1068, 1077 (E.D. Cal. 2014) and

Coleman v. Brown, 756 Fed. Appx. 677, 678-79 (9th Cir. 2018) is entirely misplaced. There has not been a prior finding from this Court that CDCR's response to the COVID-19 pandemic violated the Eighth Amendment. Accordingly, there has not been a "persistence of objectively unconstitutional conditions" with respect to CDCR's response to the pandemic that warrants court intervention.

Therefore, to be entitled to relief here, Plaintiffs must first demonstrate that prison administrators and state actors are acting with deliberate indifference to the COVID-19 pandemic. *Farmer v. Brennan*, 511 U.S. 825, 828 (1994). A showing of deliberate indifference requires Plaintiffs to establish that "the deprivation alleged must be, objectively, 'sufficiently serious'" and that, subjectively, Defendants are acting with a "'sufficiently culpable state of mind.'" *Farmer*, 511 U.S. at 834 (citations omitted). Under this second, subjective prong, Plaintiffs must also show that prison officials knew of and disregarded "an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Id.* at 837. This standard affords "due regard for prison officials' unenviable task of keeping dangerous men in safe custody under humane conditions." *Id.* at 845 (quoting *Spain v. Procunier*, 600 F.2d 189, 193 (9th Cir. 1979)). Prison officials must act to "'ensure reasonable safety.'" *Id.* at 844 (*quoting Helling v. McKinney*, 509 U.S. 25, 33 (1993)). Where prison officials act reasonably, they do not violate the Eighth Amendment's Cruel and Unusual Punishment Clause. *Id.* at 845.

For the reasons set forth below, Plaintiffs have not, and cannot, establish the second subjective prong under the deliberate indifference standard. This is particularly true in light of CDCR's overall response to the COVID-19 pandemic, and the fact that in July alone, CDCR coordinated over 49,000 tests as part of its statewide staff testing efforts. (Minnich Decl., at ¶ 4.)

A. CDCR's plan, which requires symptomatic staff to first be assessed by a healthcare provider, is consistent with public health guidance.

CDCR's July 23 staff testing plan provides that, "if a staff member has possible COVID-related symptoms, the staff member shall be directed to obtain a medical evaluation to determine

whether he or she should be tested for COVID-19." (Ruhparwar Decl., Ex. A, at page 1.) Plaintiffs take the position that CDCR's plan should be modified mandate testing of symptomatic staff (either at the institution or elsewhere) without exception. But this provision of CDCR's staff testing plan is supported by public health guidance. The list of potential COVID-19 symptoms (according to the most recent CDC guidelines) is "very long" and "includes symptoms that are often (and more likely) attributable to other causes." (Watt Decl., at ¶ 10.) It is therefore important for staff who believe they may have a symptom consistent with COVID-19 to undergo a medical evaluation and to be assessed by a medical professional who can better determine whether testing is warranted in light of their symptomatology. (*Id.*) This is particularly important given that testing resources are at a premium and testing volumes and turnaround times statewide are stretched thin. (*Id.* at ¶ 14.) CDC guidance pertaining to "Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities supports this approach, stating: "All staff with suspected or confirmed COVID-19 should wear cloth face coverings (unless contraindicated), self-isolate at home, *connect with appropriate medical care* as soon as possible, and *follow medical care and instructions.*" (Emphasis added.)[1]

In addition, to further safeguard the incarcerated population and staff members at its institutions from the risks of COVID-19, CDCR's plan also provides that staff who are sick shall stay home. (Ruhparwar Decl., Ex. A, at page 1.) Personnel who develop fever, respiratory symptoms, or other COVID-related symptoms shall be instructed not to report to work and to notify their supervisor. (*Id.*)

Thus, because CDCR's staff testing plan is based upon current CDC guidance and recommendations from CDPH experts, Defendants cannot possibly be disregarding an excessive risk to inmate health or safety. A mere difference in medical opinion cannot support a finding of deliberate indifference. (*See Toguchi v. Chung*, 391 F.3d 1051, 1058 (9th Cir. 2004); *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996); *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989);

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[1] CDC's Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities, last updated July 7, 2020, is available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html.

Colwell v. Bannister, 763 F.3d 1050, 1068 (9th Cir. 2014) ("A difference of opinion between a physician and the prisoner—or between medical professionals—concerning what medical care is appropriate does not amount to deliberate indifference." (citation and quotation marks omitted).) Accordingly, Plaintiffs are not entitled to the relief they seek here.

B. CDCR's focused re-testing of staff following an outbreak is consistent with public health guidance.

CDCR's plan provides that, after one or more COVID-19 positive individuals are identified at an institution, serial retesting of all staff should be performed every 14 days until no new cases are identified in two sequential rounds of testing. (Ruhparwar Decl., Ex. A, at page 2.) It states further that, for institutions that are organized by yard, initial testing can be limited to the yard where the positive incarcerated person is housed or staff is assigned. (*Id.*) If there are multiple yards at an institution, and those who have tested positive are clustered in one yard, serial retesting should only occur among staff regularly assigned to that yard. (*Id.*) The plan also states that it is not necessary to test staff across multiple yards as long as staff are not moving among buildings to provide services. (*Id.*, at page 3.) ("[I]t is not necessary to test staff across multiple yards [only] as long as staff are not moving among buildings to provide services.").)

Plaintiffs take the position that CDCR's plan should be modified to require retesting of all staff, not just those assigned to a particular yard, in response to an outbreak. However, Plaintiffs' suggested approach disregards the fact that testing and re-testing of staff, as CDCR's plan provides, should be driven by the objectives of the testing and what can realistically be accomplished in light of the availability of testing and the speed by which test results are received. (Watt Decl., at ¶ 11.) Moreover, surveillance testing is a lower priority than testing symptomatic people and people who may have been exposed. (*Id.* at ¶ 13.)

Further, and as mentioned above, testing resources are a challenge across the state. (*Id.*, at ¶ 14.) There are issues with testing volumes and turnaround times statewide, which is a crucial factor that must be considered when recommending a mass testing protocol. (*Id.*) Here, the kind of bi-weekly mass testing that Plaintiffs are seeking at all of CDCR's institutions would severely

strain the already scarce testing availability and increase lengthy turnaround times for results.

CDCR's approach to limit re-testing of staff to individual yards where the positive incarcerated person is housed or staff is assigned is not only reasonable, but also prudent in light of the current challenges with testing resources.

III. Plaintiffs' Motion Fails The PLRA's Needs-Narrowness-Intrusiveness Requirement.

The PLRA mandates that prospective relief be narrowly drawn, extend no further than necessary, and be the least intrusive means of addressing the violation of the Federal right. 18 U.S.C. § 3626(a)(1)(A). Plaintiffs' requested relief to modify CDCR's staff testing plan does not meet these exacting standards. Instead, Plaintiffs advocate for an inflexible approach that most certainly will ensure CDCR's staff testing plan will become outdated and remain outdated for an unnecessarily long period of time each time public health guidance is updated. CDCR will require court intervention each time it seeks to modify its plan in response to updated guidance, creating an unnecessarily burdensome and impractical approach.

But more tailored relief exists. This Court may simply mandate that CDCR's plan comply with current CDC and public health guidance. A court order mandating anything beyond that would hinder CDCR's ability to adjust its plan at a time when flexibility and adoption of evolving standards is critical to mitigating the spread of COVID-19.

CONCLUSION

Plaintiffs have not demonstrated that they are entitled to the relief they request. But even if they could demonstrate Defendants' deliberate indifference to the COVID-19 pandemic, they still would not be entitled to their requested relief because it is not narrowly drawn. Their motion should therefore be denied.

DATED: July 31, 2020

HANSON BRIDGETT LLP

By: */s/ Samantha D. Wolff*
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SAMANTHA D. WOLFF
KAYLEN KADOTANI
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DATED: July 31, 2020

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DECLARATION OF JAMES WATT IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR AN ORDER MODIFYING CDCR'S COVID-19 STAFF TESTING PLAN

Judge: Hon. Jon S. Tigar

I, James Watt, declare:

1. I am employed as the Chief of the Division of Communicable Disease Control at the California Department of Public Health ("CDPH"). I make this declaration in support of Defendants' Opposition to Plaintiff's Motion for an Order Modifying CDCR's COVID-19 Staff Testing Plan. If called as a witness, I could and would testify competently to the matters set forth below.

2. As the Chief of the Division of Communicable Disease Control, I coordinate the CDPH's epidemiologic response to disease outbreaks and emerging infectious health threats.

3. I have served as the Chief of the Division of Communicable Disease Control since 2010 and Deputy State Epidemiologist since 2012. A summary of my professional and employment background is attached as Exhibit A.

4. My background is in epidemiology. I completed my residency in pediatrics in 1993 and obtained a Masters in Public Health in Maternal and Child Health in 1995. In 1996, I joined the California Department of Health Services ("CDHS") as a Public Health Medical Officer II. In 1999, I joined the federal Centers for Disease Control and Prevention ("CDC") as an Epidemic Intelligence Service Officer in the Respiratory Diseases Branch. In 2001, I became an Assistant Scientist in the School of Public Health at John Hopkins University. In 2006, I joined the CDPH as a Public Health Medical Officer III (Epidemiology) and became Chief of the Tuberculosis Control Branch in 2008 and Chief of the Division of Communicable Disease Control in 2010. In 2012, I became Deputy State Epidemiologist at the CDPH. In addition to my current role, I am an Associate at the Johns Hopkins University School of Public Health and Clinical Professor at the University of California, San Francisco, School of Medicine. I have also served on a variety of advisory panels at, among others, the CDHS, CDC, and World Health Organization.

5. CDPH is one of sixteen departments and offices within the California Health and Human Services Agency and its fundamental responsibilities include infectious disease control and prevention, food safety, environmental health, laboratory services, patient safety, emergency preparedness, chronic disease prevention and health promotion, family health, health equity and vital records and statistics. Our mission is to advance the health and well-being of California's diverse people and communities.

6. The Center for Infectious Diseases (CID), of which the Division of Communicable Disease Control is a part, protects the people in California from the threat of preventable infectious diseases and assists those living with an infectious disease in securing prompt and appropriate access to healthcare, medications and associated support services.

7. I am familiar with the developing scientific literature regarding COVID-19, including the transmission and prevention of the virus.

8. I am also familiar generally with the California Department of Corrections and Rehabilitation's (CDCR) response to COVID-19 pandemic, including its efforts to develop and implement a staff testing plan.

9. On July 23, 2020, I participated in a telephonic conference with attorneys for the Prison Law Office and CDCR. During this call, attorneys from the Prison Law Office inquired about various aspects of CDCR's staff testing plan, and I provided responses to explain the public health rationale behind the various aspects of the plan.

10. Specifically as it relates to the portion of the plan at issue here, Plaintiffs asked why it would not be appropriate to require testing of all staff who report symptoms. As I explained during the call, the list of potential COVID-19 symptoms (according to the most recent CDC guidelines) is very long. It includes symptoms that are often (and more likely) attributable to other causes. It is therefore important for anyone who believes they may have a symptom consistent with COVID-19 to undergo a medical evaluation and to be assessed by a medical professional who can better determine whether testing is warranted in light of their symptomatology. In addition, another important factor is a person's history of exposure. An exposed person who develops any potential COVID-19 related symptoms should be tested. CDCR's current plan properly allows for this practice.

11. Testing and re-testing of staff, as CDCR's plan provides, should be driven by the objectives of the testing and what can realistically be accomplished in light of the availability of testing and the speed by which test results are received. One objective of re-testing staff would be to assess whether there is an ongoing transmission or not.

12. The general approach for all settings when there has been an exposure is to conduct a contact investigation and test anyone who could have been exposed. The definition of exposure depends on physical proximity and the type of PPE worn. Additionally, we do not recommend testing the contacts of those people who may have potentially been exposed until we first obtain the test results of the exposed people. We would not expand to the contacts of contacts until we know that the exposed people are positive.

13. Further, in terms of the rate of surveillance testing chosen, every congregate setting has different realities and so different strategies must be employed for different settings. Surveillance testing is a lower priority than testing symptomatic people and people who may have been exposed. The size of the facility and number of people is also very important. If there is a small number of people, you would need to test a larger proportion to determine if there is an asymptomatic presence. Conversely, with a larger number of people, a smaller proportion may need to be tested.

14. As mentioned above, it is also critical to know the availability of testing resources that have a turnaround time that will provide information to meet the objective of determining how to monitor the situation. Across the state, testing resources are a challenge. I understand there are issues with testing volumes and turnaround times statewide, and this is an important factor that must be considered when recommending mass testing protocol.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on July 30, 2020, in Albany, California.

James Watt

JAMES WATT

EXHIBIT A

CURRICULUM VITAE

Name: **James Watt, MD, MPH**

Position: Acting Deputy Director
Acting Chief
Center for Infectious Diseases
California Department of Public Health

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850 Marina Bay Parkway
Richmond, CA 94804

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EDUCATION AND TRAINING

1980-84	Stanford University, Stanford, CA	B.S. (Biology) B.A. (German Studies)
1985	Deutches Primatenzentrum, Goettingen, Germany	Krupp Fellowship
1985-90	University of California, San Diego	M.D.
1990-93	Oakland Children's Hospital, Oakland, CA	Resident (Pediatrics)
1994-95	University of California, Berkeley	M.P.H. (Maternal and Child Health)
1995-96	California Department of Health Services, San Francisco, CA	Resident (Preventive Medicine)

LICENSES, CERTIFICATION

1991-present: Medical Licensure, California
1995-present: Board Certification, Pediatrics

PRINCIPAL POSITIONS HELD

1996-99 Public Health Medical Officer II
Immunization Branch
Division of Communicable Disease Control
California Department of Health Services

1999-01 Epidemic Intelligence Service Officer
Respiratory Diseases Branch
Division of Bacterial and Mycotic Diseases
National Center for Infectious Disease
Centers for Disease Control and Prevention

2001-06 Assistant Scientist
Department of International Health
School of Public Health

Johns Hopkins University

2006-07 Public Health Medical Officer III (Epidemiology)
Tuberculosis Control Branch
Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health

2008-10 Chief
Tuberculosis Control Branch
Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health

2010-2019 Chief
Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health

2020-present Acting Deputy Director
Acting Chief
Center for Infectious Diseases
California Department of Public Health

OTHER POSITIONS HELD CONCURRENTLY

2006-present Associate
Johns Hopkins University
School of Public Health

2009-present Clinical Professor
University of California, San Francisco
School of Medicine

2009-2010 Member representing high incidence jurisdictions
Board of Directors
National Tuberculosis Controllers Association

2008-2010 Executive Committee (ex officio)
California Tuberculosis Controllers Association

2012-2019 Deputy State Epidemiologist
California Department of Public Health

2015 Acting State Health Officer, California

2020-present Interim State Epidemiologist
California Department of Public Health

HONORS AND AWARDS

1984	Phi Beta Kappa, Stanford University
2000	United States Public Health Service Achievement Medal
2001	Honor Award, National Center for Infectious Diseases
2002	Committee recognition award for two outstanding abstracts, International Symposium on Pneumococci and Pneumococcal Disease
2015	Outstanding Achievement Award, California Department of Public Health
2016	Outstanding Achievement Award, California Department of Public Health
2019	Outstanding Achievement Award, California Department of Public Health

INVITED PRESENTATIONS

INTERNATIONAL

International Symposium on the Global Reduction of Hib Disease; Scottsdale, Arizona, 2002 (invited talk)
Indian Academy of Pediatrics Meeting (Pedicon); Calcutta, 2005 (invited talk)
International Symposium on Pneumococci and Pneumococcal Disease; Alice Springs, Australia, 2006 (invited talk)

NATIONAL

National Vaccine Advisory Committee Conference on Pneumococcal Disease Prevention in Adults: Potential Vaccine Strategies; Baltimore, MD, 2003 (invited talk)
5th National Association of Public Health Laboratories Meeting on Essential Mycobacteriology Services; San Diego, CA, 2008 (invited talk)
Francis J. Curry National Tuberculosis Center National Web Training--Practical Applications of Genotyping in Tuberculosis Control; San Francisco, CA, 2008 (invited talk)

ADVISORY PANELS

Immunization Partnership, American Academy of Pediatrics/California Department of Health Services
Preventive Medicine Residency Advisory Committee, California Department of Health Services
Cost effectiveness of Hib conjugate vaccine in Egypt, Egyptian Ministry of Health and Population, WHO Eastern Mediterranean Regional Office, and CDC
A tool for rapidly assessing Hib disease burden, WHO
Standardized interpretation of chest radiographs for the diagnosis of pneumonia, WHO
Research Advisors, Pneumococcal Accelerated Development and Implementation Program
Estimating the burden of *Haemophilus influenzae,* type b in India, Indian Council for Medical Research
Estimating the global burden of Hib and pneumococcal disease, WHO
Development of guidelines for the control of tuberculosis in foreign born persons, CDC
Expert Group to Evaluate Molecular Drug Susceptibility Testing, NTCA

INTERNATIONAL CONSULTATIONS

2001	Estimating Hib disease burden, WHO Africa Regional Office personnel. Harare, Zimbabwe.
2002	Options for Assessing Disease Burden due to Hib in Mongolia, WHO Western Pacific Regional Office, Ulaan Baatar, Mongolia.
2004	Evaluation of Surveillance for Invasive Hib Disease in Mongolia, WHO Western Pacific Regional Office, Ulaan Baatar, Mongolia.
2011-12	Review of evidence on the effectiveness of different Hib conjugate vaccine schedules, WHO Secretariat, Geneva, Switzerland

TEACHING AND MENTORING

COURSES TAUGHT (Johns Hopkins University)

Introduction to Quantitative and Qualitative Research for American Indian Health (Summer Institute, 2006, Principal Instructor. Enrollment of 20).

Collecting, Analyzing and Using Public Health Data in Native American Communities (Summer Institute, 2005, Principal Instructor. Enrollment of 30).

Collecting, Analyzing and Using Public Health Data in Native American Communities (Summer Institute, 2004, Principal Instructor. Enrollment of 36).

COURSES TAUGHT (UC Berkeley)

Public Health in Practice: Communicable Disease Control in California (School of Public Health Spring Semester, 2019, Instructor. Enrollment of 40.)

STUDENTS MENTORED (Johns Hopkins University)

Aparna Roy (MPH, 2005)
Capstone Project Title: *Incidence of community acquired pneumonia in adults.*

Cecilia Young Kwak (MPH, 2004)
Capstone Project Title: *The incidence of community acquired pneumonia in adults: a literature review*

Laurel Murrow (medical student, summer internship 2003)
Project Title: *Evaluation of an Active, Laboratory-based Surveillance System for Invasive Bacterial Infections among the Navajo and White Mountain Apache*

Dahlia McGregor, MD (MPH, 2003)
Integrating Experience Title: *Population-based surveillance of invasive pneumococcal disease in Jamaican children: Providing data for cost-benefit analysis of conjugate pneumococcal vaccines*

FELLOWS MENTORED (CDPH)

Jessica Cunningham, MPH (CSTE fellow)
Major Project: Epidemiology of tuberculosis among homeless persons in California.

Darryl Kong, MPH (Cal-EIS fellow)
Major Project: Identification and management of tuberculosis patients co-infected with HIV in California.

Erin Murray, PhD (CDC EIS Officer)
Major Project: Identification of geographic areas with increased incidence of tuberculosis.

Jonathan Nunez, MD (CDC EIS Officer)
Major Project: Analysis of the impact of non-screening of immigrants prior to arrival on imported tuberculosis in the United States

Patrick Ayscue, DVM, PhD (CDC EIS Officer)
Major Project: Analysis of trends in hospitalization for Varicella and Zoster in California

Jacklyn Wong, PhD (CDC EIS Officer)
Increased tuberculosis risk among immigrants arriving to California with abnormal domestic chest radiographs.

Hope Biswas, PhD (CDC EIS Officer)
Major Project: Characteristics associated with delivery of an infant with congenital syphilis and missed opportunities for prevention—California 2012-2014.

Yasser Bakhsh, MD, MPH (CDC EIS Officer)
Major Project: Area based socioeconomic risk factors for tuberculosis in California.

Caterina Liu, MD (UCSF Resident)
Major Project: Homelessness and Infectious Disease in California

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AWARDS AND GRANTS

1. California Emerging Infections Program 1/1/12-present
(co-director)
Centers for Disease Control and Prevention

2. Cooperative Agreement for Epidemiology and Laboratory Capacity 1/1/11-present
(principal investigator)
Centers for Disease Control and Prevention

3. Determination of HIV status and prevalence of HIV co-infection among 7/1/09-6/31/10
tuberculosis cases in California (co-principal investigator)
Centers for Disease Control and Prevention

4. Cooperative Agreement for Tuberculosis Prevention, Control and Elimination 1/1/08-12/31/10
in the United States (principal investigator)
Centers for Disease Control and Prevention.

5. Hib Initiative (co-investigator) 9/1/04-7/31/06
Global Alliance for Vaccines and Immunization (GAVI)
Supporting evidence-based decision making about *Haemophilus influenzae*, type b (Hib) vaccine use in developing countries

6. India Hib Disease Burden Project (project lead) 9/1/04-7/31/06
GAVI, USAID, Government of India
Estimating the burden of Hib disease in India to support an evidence-based decision about vaccine use

7. Indirect effects of pneumococcal conjugate vaccine in the community (co-investigator) 1/1/00-12/31/03
Wyeth Lederle Vaccines

8. Epidemiology of pneumococcal pneumonia among Navajo and Apache adults 1/1/01-12/31/04
(co-investigator)
Aventis

9. Safety and Efficacy of Pentavalent (G1, G2, G3, G4 and P1) Human-Bovine 1/1/01-12/31/04
Reassortant Rotavirus Vaccine in Healthy Infants (co-investigator)
Merck & Co.

10. Pneumonia Epidemiology in White Mountain Apache Adults (principal investigator) 9/1/03-8/31/04
NIH/NIGM RO1 (under grant U26 94 00012-01)

11. A Phase 3 Study of MEDI-524 (Numax™), an Enhanced Potency Humanized Respiratory Syncitial Virus (RSV) Monoclonal Antibody, for the Prevention of RSV Disease Among Navajo and White Mountain Apache Infants (co-investigator) MedImmune, Inc. 1/1/04-7/31/06

PUBLICATIONS

1. Kahane SM, **Watt JP**, Newell K, Kellam S, Wight S, Smith NJ, et al. Immunization Levels and Risk Factors for Low Immunization Coverage Among Private Practices. *Pediatrics* 2000;105(6):e73.

2. Hyde TB, Gilbert M, Zell ER, **Watt JP**, Schwartz SB, Thacker WL, et al. Azithromycin prophylaxis during a hospital outbreak of *Mycoplasma pneumoniae* pneumonia. *Journal of Infectious Disease* 2001;183:907-12.

3. **Watt JP**, Schuchat A, Erickson K, Honig JE, Gibbs R, Schulkin J Group B Streptococcal Prevention Practices of Obstetrician-Gynecologists. *Obstetrics and Gynecology* 2001;98(1):7-13.

4. Benin AL, O'Brien KL, **Watt JP**, Reid R, Zell ER, Katz S, Donaldson C, Parkinson A, Schuchat A, Santosham M, Whitney CG. Effectiveness of the 23-valent polysaccharide vaccine against invasive pneumococcal disease in Navajo adults. *Journal of Infectious Diseases* 2003;188(1):81-9.

5. **Watt JP,** Levine OS, Santosham M. Global reduction of Hib disease: what are the next steps? Proceedings of the meeting. *Journal of Pediatrics* 2003;143(6 Suppl):S163-87.

6. **Watt JP**, O'Brien KL, Benin AL, Whitney CG, Robinson K, Parkinson AJ, Reid R, Santosham M. Invasive Pneumococcal Disease among Navajo Adults, 1989-1998. *Clinical Infectious Diseases* 2004;38(4):496-501.

7. Feikin DR, Nelson CB, **Watt JP,** Mohsni E, Wenger JD, Levine OS. Rapid Assessment Tool for *Haemophilus influenzae,* type b Disease in Developing Countries. *Emerging Infectious Diseases* 2004;10(7):1270-6.

8. **Watt JP,** O'Brien KL, Katz S, Bronsdon MA, Elliott J, Dallas J, Perilla MP, Reid R, Murrow L, Facklam R, Santosham M, Whitney CG. Nasopharyngeal versus Oropharyngeal Sampling for Detection of Pneumococcal Carriage in Adults. *Journal of Clinical Microbiology* 2004;42(11):4974-6.

9. O'Brien KL, Shaw J, Weatherholtz R, Reid R, **Watt J**, Croll J, Dagan R, Parkinson AJ, Santosham M. Epidemiology of invasive Streptococcus pneumoniae among Navajo children in the era before use of conjugate pneumcoccal vaccines, 1989-1996. American Journal of Epidemiology. 2004;160(3):270-8.

10. Millar EV, O'Brien KL, **Watt JP,** Lingappa J, Pallipamu R, Rosenstein N, Hu D, Reid R, Santosham M. Epidemiology of Invasive Haemophilus influenzae Type a Disease among Navajo and White Mountain Apache Children, 1988-2003. *Clinical Infectious Disease.* 2005;40(6):823-30.

11. Benin AL, **Watt JP**, O'Brien KL, Zell E, Donaldson C, Schuchat A, Santosham M. Delivering Pneumococcal Vaccine to a High Risk Population: The Navajo Experience. *Human Vaccines.* 2005;1(2):e2-5.

12. Chandran A, **Watt JP**, Santosham M. Prevention of *Haemophilus influenzae* Type b (Hib) Disease: Past Success and Future Challenges. *Expert Review of Vaccines*. 2005;4(6):819-27.

13. Vesikari T, Matson DO, Dennehy P, Van Damme P, Santosham M, Rodriguez Z, Dallas MJ, Heyse JF, Goveia MG, Black SB, Shinefield HR, Christie CDC, Ylitalo S, Itzler RF, Coia ML, Onorato MT, Adeyi

BA, Marshall GS, Gothefors L, Campens D, Karvonen A, **Watt JP,** O'Brien KL, DiNubile MJ, Clark HF, Boslego JW, Offit, PA, Heaton, PM. Safety and Efficacy of a Pentavalent Human-Bovine (WC3) Reassortant Rotavirus Vaccine. *New England Journal of Medicine.* 2006;354(1):23-33.

14. Millar EV, O'Brien KL, **Watt JP,** Bronsdon MA, Dallas J, Witney CG, Reid R, Santosham M. Effect of community wide conjugate pneumococcal vaccine use in infancy on nasopharyngeal carriage through 3 years of age: a cross-sectional study in a high-risk population. *Clinical Infectious Disease.* 2006;43(1):8-15.

15. Moisi JC, Levine OS, **Watt JP.** Sensitivity of Surveillance for *Haemophilus influenzae,* type b Meningitis. *Pediatric Infectious Disease Journal.* 2006;25(10):960.

16. **Watt JP,** O'Brien KL, Benin AL, McCoy SI, Donaldson CM, Reid R, Schuchat A, Zell ER, Hochman M, Santosham M, Whitney CG. Risk Factors for Invasive Pneumococcal Disease Among Navajo Adults. *American Journal of Epidemiology.* 2007 Nov 1;166(9):1080-7.

17. Hochman ME, **Watt JP,** Reid R, O'Brien KL. The Prevalence of End Stage Renal Disease in Native American Adults on the Navajo Reservation. *Kidney International.* 2007;71(9):931-7.

18. Rossi I, Zuber P, Dumolard L, Walker D, **Watt JP**. Introduction of Hib vaccine into national immunization programmes: a descriptive analysis of global trends. *Vaccine.* 2007;25:7075-80.

19. Santosham M, Reid R, Chandran A, Millar EV, **Watt JP**, Weatherholtz R, Donaldson C, Croll J, Moulton LH, Thompson CM, Siber GR, O'Brien KL. Contributions of Native Americans to the global control of infectious diseases. *Vaccine.* 2007;22:2366-74.

20. Menzies R, McIntyre P, Reid R, O'Brien K, Santosham M, **Watt JP,** et al. Vaccine preventable diseases in indigenous populations—International perspectives. *Vaccine.* 2007;25:7281-4.

21. Millar EV, **Watt JP,** Bronsdon MA, Dallas J, Reid R, Santosham M, O'Brien KL. Indirect effect of 7-valent pneumococcal conjugate vaccine (Pnc7-CRM) on pneumococcal colonization among unvaccinated household members. *Clinical Infectious Disease.* 2008;47(8):989-96.

22. Mendsaikhan J, **Watt JP,** Mansoor O, Suvdmaa N, Edmond K, Litt DJ, Nymadawa P, Baoping Y, Altantsetseg D, Slack M. Childhood Bacterial Meningitis in Ulaanbaatar, Mongolia, 2002-2004. *Clinical Infectious Disease.* 2009;48(S2):S141-146.

23. Wolfson LJ, O'Brien KL, **Watt JP**, Henkle E, Deloria-Knoll M, McCall N, Lee E, Mulholland K, Levine OS, Cherian T. Methods to estimate the global burden of disease due to *Haemophilus influenzae* type b and *Streptococcus pneumoniae* in children less than 5 years of age. *Lancet.* 2009; published online.

24. O'Brien KL, Wolfson LJ, **Watt JP**, Henkle E, Deloria-Knoll M, McCall N, Lee E, Mulholland K, Levine OS, Cherian T. The global burden of disease due to *Streptococcus pneumoniae* in children less than 5 years of age. *Lancet.* 2009;374:893-902.

25. **Watt JP**, Wolfson LJ, O'Brien KL, Henkle E, Deloria-Knoll M, McCall N, Lee E, Levine OS, Hajjeh R, Mulholland K, Cherian T. The global burden of disease due to *Haemophilus influenzae,* type b in children less than 5 years of age. *Lancet.* 2009;374:903-911.

26. **Watt JP,** Moïsi JC, Donaldson RLA, Reid R, Ferro S, Whitney CG, Santosham, M, O'Brien KL. Measuring the Incidence of Community Acquired Pneumonia in a Native American Community. *Epidemiology and Infection.* 2010; 138:1146-54.

27. **Watt JP,** Moïsi JC, Donaldson RLA, Reid R, Ferro S, Whitney CG, Santosham, M, O'Brien KL. Use of serology and urine antigen detection to estimate the proportion of adult community-acquired pneumonia attributable to *Streptococcus pneumoniae. Epidemiology and Infection.* 2010;138:1796-803

28. Gupta M, Kumar R, Deb AK, Bhattacharya SK, Bose A, John J, Balraj V, Ganguly NK, Kant L, Kapoor AN, **Watt J**, Shearer J, Santosham M. Multi-center surveillance for pneumonia and meningitis in children. *Indian J Med Res.* 2010;131:649-58.

29. Banerjee R, Allen J, Lin SYG, Westenhouse J, Desmond E, Schecter GF, Scott C, Raftery A, Mase S, **Watt JP**, Flood J. Rapid Drug Susceptibility Testing with a Molecular Beacon Assay Is Associated with Earlier Diagnosis and Treatment of Multidrug-Resistant Tuberculosis in California. J Clin Microbiol. 2010;48(10):3779-81.

30. Metcalfe J, Facer M, Damesyn M, Xia Q, **Watt J**, Hill J, Hopewell P, Westenhouse J, Flood J. Evolution of tuberculosis/HIV co-infection in California during the HAART Era, 1996-2007. Retrovirology. 2010;7(Suppl1):01.

31. Fitzwater S, **Watt JP,** Levine OS, Santosham M. *Haemophilus influenzae* type B conjugate vaccines: considerations for vaccination schedules and implications for developing countries. *Human Vaccines.* 2010;6:810-8.

32. Lowenthal P, Westenhouse J, Moore M, Posey DL, **Watt JP**, Flood J. Reduced importation of tuberculosis after the implementation of an enhanced pre-immigration screening protocol. *International J Tuberculosis Lung Dis.* 2011;15:761-6.

33. Grant LR, Gentsch JR, Esona MD, **Watt J,** Reid R, Weatherholtz RC, Santosham M, Parashar UD, O'Brien KL. Detection of G3P[3] and G3P[9] rotavirus strains in American Indian children with evidence of gene reassortment between human and animal rotaviruses. *J Med Virol.* 2011;83:1288-99.

34. Pascopella L, DeRiemer K, **Watt JP,** Flood JM. When tuberculosis comes back: Who develops recurrent tuberculosis in California? *PLOS One* 2011;6:e26541

35. Grant LR*, **Watt JP*,** Weatherholtz RC, Moulton LH, Reid R, Santosham M, O'Brien, KL. Efficacy of a pentavalent human-bovine reassortant rotavirus vaccine against rotavirus gastroenteritis among American Indian children. *Pediatr Infect Dis J* 2012;31:184-8. *equal contribution

36. Grant L, Vinje J, Parashar U, **Watt J**, Reid R, Weatherholtz R, Santosham M, Gentsch J, O'Brien K. Epidemiologic and Clinical Features of Other Enteric Viruses Associated with Acute Gastroenteritis in American Indian Infants. *J Pediatr* 2012;161:110-5.e1.

37. Winter K, Harriman K, Zipprich J, Schechter R, Talarico J, **Watt JP**, Chavez G. California Pertussis Epidemic, 2010. *J Pediatr* 2012;161:1091-6.

38. Said MA, Johnson HL, Nonyane BA, Deloria-Knoll M, O'Brien KL, AGEDD Adult Pneumococcal Burden Study Team (**Watt JP** study team member). Estimating the burden of pneumococcal pneumonia among adults: a systematic review and meta-analysis of diagnostic techniques. *PLoS One* 2013;8(4):e60273.

39. Kong D, **Watt JP**, Marks S, Flood J**.** HIV Status Determination Among Tuberculosis Patients From California During 2008. *J Public Health Management Practice* 2013;19:169-77.

40. Grant J, **Watt J,** Moulton L, Weatherholtz R, Reid R, Santosham M, O'Brien K. Lack of non-specific protection against all-cause, non-rotavirus gastroenteritis by vaccination with orally administered rotavirus vaccine. *J Pediatr Gastroent Nutr* 2013;epub ahead of print.

41. Murray EL, Samuel MC, Brodsky J, Akiba CF, King C, Li M, Wollesen M, Gonzales PE, **Watt JP**, Bolan G. *Neisseria gonorrhoeae* Outbreak: Unintended Consequences of Electronic Medical Records and Using an Out-of-State Laboratory—California, July 2009-February 2010. *Sex Trans Dis* 2013;40:556-8.

42. Metcalfe JZ, Porco TC, Westenhouse J, Damesyn M, Facer M, Hill J, Xia Q, **Watt JP,** Hopewell PC, Flood J. Tuberculosis and HIV co-infection, California, USA, 1993–2008. *Emerg Infect Dis* 2013; 19:400-6.

43. Scott S, Altanseseg D, Sodbayer D, Nymadawa P, Bulgan D, Mendsaikhan J, **Watt JP**, Slack M, Carvalho MG, Hajjeh R, Edmond KM. Impact of Haemophilus influenzae Type b Conjugate Vaccine in Mongolia: Prospective Population-Based Surveillance, 2002-2010. *J Peds* 2013;163(1 Suppl):S8-11.

44. Núñez JJ, Fritz CL, Knust B, Buttke D, Enge B, Novak MG, Kramer V, Osadebe L, Messenger S, Albariño CG, Ströher U, Niemela M, Amman BR, Wong D, Manning CR, Nichol ST, Rollin PE, Xia D, **Watt JP**, Vugia DJ. An Outbreak of Hantavirus Infections Among Overnight Visitors to Yosemite National Park, California, USA, 2012. *Emer Inf Dis* 2014;20(3):386-93.

45. Kong D, **Watt JP**, Marks SM, Flood JM. Timely HIV Diagnosis and HIV/TB Comanagement among California Patients in 2008. *Publ Health Rep* 2014;129:170-7.

46. Ayscue P, Murray E, Uyeki T, Zipprich J, Harriman K, Salibay C, Kang M, Luu A, Glenn-Finer R, **Watt J**, Glaser C, Louie J. Influenza-Associated Intensive-Care Unit Admissions and Deaths—California, September 29, 2013—January 18, 2014. *MMWR* 2014;63(7):143-7.

47. Winter K, Glaser C, Watt J, Harriman K. Pertussis epidemic—California, 2014. *MMWR* 2014;63(48):1129-32.

48. Ayscue P, Van Haren K, Sheriff H, Waubant E, Waldron P, Yagi S, Yen C, Clayton A, Padilla T, Pan C, Reichel J, Harriman K, Watt J, Sejvar J, Nix WA, Feikin D, Glaser C. Acute flaccid paralysis with anterior myelitis—California, June 2012-June 2014. *MMWR* 2014;63(40):903-6.

49. Greninger AL, Naccache SN, Messacar K, Clayton A, Yu G, Somasekar S, Federman S, Stryke D, Anterson C, Yagi S, Messenger S, Wadford D, Xia D, **Watt JP**, Van Haren K, Dominguez SR, Glaser C, Aldrovandi G, Chiu CY. A novel outbreak enterovirus D68 strain associated with acute flaccid myelitis cases in the USA (2012-14): a retrospective cohort study. *Lancet Infect Dis* 2015; epub March 31.

50. Shahkarami M, Yen C, Glaser C, Xia D, **Watt J,** Wadford DA. Laboratory Testing for Middle East Respiratory Syndrome Coronavirus, California, USA, 2013-2014. *Emerg Inf Dis* 2015;21(9):epub.

51. Zipprich J, Winter K, Hacker J, Xia D, **Watt J**, Harriman K. Measles outbreak—California, December 2014-February 2015. *MMWR* 2015;64(6):153-4.

52. Smith EM, Khan MA, Reingold A, **Watt JP.** Group B streptococcus infections of soft tissue and bone in California adults, 1995-2012. *Epidemiol Infect* 2015;143(15)3343-50.

53. Van Haren K, Ayscue P, Waubant E, Clayton A, Sheriff H, Yagi S, Glenn-Finer R, Padilla T, Strober, JB, Aldrovandi G, Wadford DA, Chiu, CY, Xia D, Harriman K, **Watt JP,** Glaser Ca. Acute flaccid myelitis of unknown etiology in California, 2012-2015. *JAMA* 2015; 314(24):2663-71.

54. Langley G, Hao Y, Pondo T, Miller L, Petit, S, Thomas A, Lindegren ML, Farley MM, Dumyati G, Como-Sabetti K, Harrison LH, Baumbach J, **Watt J**, Van Beneden C. The Impact of Obesity and Diabetes on the Risk of Disease and Death due to Invasive Group A *Streptococcus* Infections in Adults. *Clin Infect Dis* 2016;62(7):845-52.

55. Nelson GE, Pondo T, Toews K, Farley MM, Lindegren ML, Lynfield R, Aragon D, Zansky SM, **Watt JP**, Cieslak PR, Angeles K, Harrison LH, Petit S, Beall B, Van Beneden CA. The Epidemiology of Invasive Group A Streptococcal Infection in the United States, Implications for Vaccine Prevention. *Clin Infect Dis* 2016; epub April 22.

56. Barry PM, Kay AW, Flood JM, **Watt J**. Getting to Zero: Tuberculosis Elimination in California. *Curr Epidemiol Rep* 2016;epub March 29.

57. Kozyreva VK, Jospin G, Greninger AL, **Watt JP**, Eisen JA, Chaturvedi V. Recent Outbreaks of Shigellosis in California Caused by Two Distinct Populations of *Shigella sonnei* with either Increased Virulence or Fluoroquinolone Resistance. mSphere 2016;1(6); e00344-16.

58. Blain AE, Lewis M, Banerjee E, Kudish K, Liko J, McGuire S, Selvage D, **Watt J**, Martin SW, Skoff TH. An Assessment of the Cocooning Strategy for Preventing Infant Pertussis—United States, 2011. *Clin Infect Dis* 2016;63(suppl 4):S221-S226.

59. Skoff TH, Blain AE, **Watt J**, Scherzinger K, McMahon M, Zansky SM, Kudish K, Cieslak PR, Lewis M, Shang N, Martin SW. Impact of the US Maternal Tetanus, Diphtheria, and Acellular Pertussis Vaccination Program on Preventing Pertussis in Infants <2 Months of Age: A Case-Control Evaluation. *Clin Infect Dis* 2017: epub 2017.

60. Wong J, Lowenthal P, Flood J, **Watt J,** Barry PM. Increased tuberculosis risk among immigrants arriving to California with abnormal domestic chest radiographs. *Intl J Tuberculosis Lung Dis* 2018;22(1):73-79

61. Biswas HH, Ng RA, Murray EL, Chow JM, Stoltey JE, **Watt JP,** Bauer HM. Characteristics Associated with Delivery of an Infant with Congenital Syphilis and Missed Opportunities for Prevention—California, 2012-2014. *Sexually Trans Dis.* 2018;45(7):435-441.

62. Porse CC, Messenger S, Vugia DJ, Jilek W, Salas W, **Watt J,** Kramer V. Travel-Associated Zika Cases and the Threat of Local Zika Transmission in California during the Global Zika Outbreak. *Emerging Infect Dis.* 2018;24(2):1626-32.

63. Pitts SI, Maruthur NM, Langley GE, Pondo T, Shutt KA, Hollick R, Schrag SJ, Thomas A, Nichols M, Farley M, **Watt JP**, Miller L, Schaffner W, Holtzman C, Harrison LH. Obesity, Diabetes, and the Risk of Invasive Group B Streptococcal Disease in Nonpregnant Adults in the United States. *Open Forum Infect Dis.* 2018;5(6):ofy030.

64. Francois Watkins LK, McGee L, Schrag SJ, Beall B, Jain JH, Pondo T, Farley MM, Harrison LH, Zansky SM, Baumbach J, Lynfield R, Snippes Vagnone P, Miller LA, Schaffner W, Thomas AR, **Watt JP,** Petit S, Langley GE. Epidemiology of Invasive Group B Streptococcal Infections among Nonpregnant Adults in the United States, 2008-2016. *JAMA Intern Med.* 2019;epub ahead of print.

65. Abedi GR, Messacar K, Luong W, Nix WA, Rogers S, Queen K, Tong S, Oberste MS, **Watt J,** Rothrock G, Dominguez S, Gerber SI, Watson JT. Picornavirus etiology of acute infections among hospitalized infants. *J Clin Virology.* 2019;116:39-43.

BOOKS AND CHAPTERS

1. Chandran A, **Watt JP,** Santosham M. Chapter 11: *Haemophilus influenzae* Vaccines. Plotkin SA, Orenstein WA, Offit PA, Editors. *Vaccines*. Fifth edition. Philadelphia: W.B. Saunders Co. 2007.

2. Chandran A, **Watt JP,** Santosham M. Chapter 11: *Haemophilus influenzae* Vaccines. Plotkin SA, Orenstein WA, Offit PA, Editors. *Vaccines*. Sixth edition. Philadelphia: W.B. Saunders Co. 2012.

OTHER PUBLICATIONS

1. Estimating the local burden of *Haemophilus influenzae* type b (Hib) disease preventable by vaccination. WHO/V&B/01.27. World Health Organization, Geneva, 2001. *(contributor)*

2. Expert review of a tool for rapidly assessing *Haemophilus influenzae* type b (Hib) disease burden. WHO/V&B/01.25. World Health Organization, Geneva, 2001. *(rapporteur/primary author of meeting summary)*

3. Centers for Disease Control and Prevention. Adoption of Perinatal Group B Streptococcal Disease Prevention Recommendations by Prenatal-Care Providers--Connecticut and Minnesota, 1998. *MMWR* 2000;49(11):228-31. *(primary author)*

4. Global Literature Review of *Haemophilus influenzae* type b and *Streptococcus pneumoniae* invasive disease among children less than five years of age, 1980-2005. World Health Organization, Geneva, 2008. *(co-author)*

5. Centers for Disease Control and Prevention. Notes from the Field: Hantavirus Pulmonary Syndrome in Visitors to a National Park—Yosemite Valley, California, 2012. *MMWR* 2012;61(46):952. *(co-author)*

6. Centers for Disease Control and Prevention. Mumps Outbreak on a University Campus, 2011. *MMWR* 2012;61:986-9. *(co-author)*

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DECLARATION OF KATHERINE MINNICH IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR AN ORDER MODIFYING CDCR'S COVID-19 STAFF TESTING PLAN

Judge: Hon. Jon S. Tigar

I, Katherine Minnich, declare:

1. I am employed by the California Department of Corrections and Rehabilitation (CDCR) as the Deputy Director, Human Resources – Division of Administrative Services. I have held this position since November 2016. I have personal knowledge of the matters set forth in this declaration and could and would competently testify to them. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion for an order modifying CDCR's COVID-19 staff testing plan.

2. CDCR's Division of Administrative Services has been responsible for establishing CDCR's staff testing plan.

3. CDCR's staff testing plan was developed based on recommendations and input from the California Department of Public Health (CDPH) and California Correctional Health Care Services (CCHCS).

4. In July 2020, CDCR coordinated over 49,000 COVID-19 tests as part of its statewide staff testing efforts.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on 31st day of July, 2020, in Sacramento, California.

Katherine Minnich

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DECLARATION OF NASSTARAN RUHPARWAR IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR AN ORDER MODIFYING CDCR'S COVID-19 STAFF TESTING PLAN

Judge: Hon. Jon S. Tigar

I, Nasstaran Ruhparwar, declare:

1. I am an attorney admitted to practice before the courts of the State of California and this Court. I am employed as a Deputy Attorney General in the Correctional Law Section of the California Attorney General's Office, and I serve as counsel of record for Defendants in this matter. I am competent to testify to the matters set forth in this declaration and, if called upon to do so, I would and could so testify. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion for an order modifying CDCR's COVID-19 staff testing plan.

2. On July 15, Defendants produced the then-current iteration of CDCR's staff testing plan to Plaintiffs.

3. On July 23, Plaintiffs, Defendants, CCHCS, and CDPH met and conferred to discuss Plaintiffs' concerns with the plan.

4. The same day, Defendants produced a revised version of CDCR's staff testing plan to Plaintiffs, which was revised to incorporate some of Plaintiffs' previous suggestions. Attached as **Exhibit A** is a true and correct copy of the staff testing plan Defendants produced to Plaintiffs on July 23.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on 31st day of July, 2020, in San Francisco, California.

/s/ Nasstaran Ruhparwar
NASSTARAN RUHPARWAR

EXHIBIT A

California Department of Corrections and Rehabilitation
COVID-19 Staff Testing Guidance-July 7, 2020

The following applies to all California Department of Corrections and Rehabilitation (CDCR) institutions, except for the California Medical Facility (CMF), Central California Women's Facility (CCWF), and California Health Care Facility (CHCF), identified by the Receiver, which provide skilled nursing level of care. These three institutions should follow the Skilled Nursing Facility (SNF) testing guidance issued by the California Department of Public Health (CDPH). The SNF protocols are currently as follows:

> Regular surveillance testing requires testing 25 percent of staff every 7 days so that 100 percent of staff are tested each month. As soon as possible after one (or more) COVID-19 positive individuals (resident or staff) is identified in a facility, serial retesting of all staff should be performed every 7 days until no new cases are identified in two sequential rounds of testing; the facility may then resume their regular surveillance testing schedule.

Testing does not replace or preclude other infection prevention and control interventions, including monitoring all staff and inmates for signs and symptoms of COVID-19, universal masking by staff and inmates for source control, use of recommended personal protective equipment, maintaining appropriate physical distancing, and environmental cleaning and disinfection. When testing is performed, a negative test only indicates an individual did not have detectable infection at the time of testing; individuals might have SARS-CoV-2 infection that is still in the incubation period or could have ongoing or future exposures that lead to infection.

In all institutions, all staff should be screened for fever, respiratory symptoms, or other COVID-related symptoms each time they enter any institution. If a staff member has possible COVID-related symptoms, the staff member shall be directed to obtain a medical evaluation to determine whether he or she should be tested for COVID-19. To the extent possible, the institution should limit staff movement among multiple yards to limit exposure. Additionally, staff who are sick should stay home. Personnel who develop fever, respiratory symptoms, or other COVID-related symptoms should be instructed not to report to work and notify their supervisor.

All Institution Baseline Staff Testing

CDCR is attempting to complete mandatory baseline staff testing (i.e., testing all staff) at all institutions by July 16, 2020. Efforts are being made to prioritize institutions with the highest numbers of laboratory-confirmed staff or inmate cases.

Institutions without COVID-19 Cases (Surveillance Testing)

In institutions that do not have any newly diagnosed COVID-19 cases among inmates or staff within the last 14 days, CDCR will follow CDPH recommendations regarding surveillance testing. The purpose of a surveillance testing strategy is to monitor the spread of the virus in order to isolate the virus and mitigate outbreaks.

Testing of 10 percent of all staff every 14 days including staff from multiple shifts and various locations within the institution will occur. The institution must ensure that a different cohort of staff are tested every 14 days. CDCR expects surveillance testing to be in place at applicable institutions by the July 30, 2020.

In addition, specific testing is recommended for the following groups:

1) All employees who have not had a prior confirmed case of COVID-19 and who are regularly assigned to work in a Correctional Treatment Center, Outpatient Housing Unit, hospice, Psychiatric Inpatient Program, or Mental Health Crisis Bed shall be tested per the SNF testing guidance issued by CDPH, which includes testing 25% of staff every 7 days, to ensure 100% of staff are tested each month.

2) Employees who have previously tested positive for COVID-19 and since recovered or resolved need only be tested in accordance with Centers for Disease Control's (CDC) recommendations for testing such individuals. Currently, the CDC recommends that individuals who have previously tested positive need not be tested again for at least three months, but that CDC guidance may change.

3) All regularly assigned (i.e. staff assigned five days a week) transportation staff who have not had a prior confirmed case of COVID-19 shall be tested at least once every month, with testing occurring throughout the month.

3) All staff who are regularly assigned to hospital custody coverage and who have not had a prior confirmed case of COVID-19, shall be tested at least once every month, with testing occurring throughout the month.

4) All regularly assigned culinary area staff who have not had a prior confirmed case of COVID-19 shall be tested once every month with testing occurring throughout the month.

NOTE: State may adjust the scope and frequency of staff testing based on community spread data and prevalence of the virus in the community.

Institutions with COVID-19 Cases (Serial Testing)

As soon as possible, after one (or more) COVID-19 positive individual(s) (inmate or staff) is identified in an institution, serial retesting of all staff should be performed every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above. CDCR expects to be able to implement serial testing at applicable institutions by July 30, 2020.

For institutions that are organized by yard, initial testing can be limited to the yard where the positive inmate is housed or staff is assigned. If there are multiple yards at an institution, and those who have tested positive are clustered in one yard, serial testing should only occur among

staff regularly assigned to that yard. It is not necessary to test staff across multiple yards as long as staff are not moving among buildings to provide services.

If there are positive cases across multiple yards at any given institution, all staff across all yards should be tested every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above.

Staff Testing Results

Staff who are pending a COVID test result:

Staff who are pending a COVID test result and are asymptomatic can continue to work while wearing face coverings and utilizing appropriate PPE. The exception to this is staff returning to their home institution after being redirected to an institution with a COVID outbreak, which is described below. All staff should be screened for fever, respiratory symptoms, or other COVID-related symptoms each time they enter any Institution.

Staff who test positive:

Staff who test positive for COVID-19 and who have had NO symptoms shall be instructed to isolate themselves at home and shall not return to work until the following condition is met:

- At least 10 days have passed since the date of the positive COVID-19 diagnostic (federally approved Emergency Use Authorized molecular assay) test.

Staff who test positive for COVID-19, initially have no symptoms, but then develop symptoms during their 10-day home isolation period may return to work once the following conditions are met:

- At least 10 days have passed since symptoms first appeared; **AND**
- At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications; **AND**
- Improvement in respiratory symptoms[1] (e.g., cough and shortness of breath)

Staff should be provided information about how to appropriately isolate within their home. (See Attachment A).

Testing of New Employees or Employees Returning from a Leave of Absence

[1] It is possible that individuals may still have residual respiratory symptoms despite meeting the criteria to discontinue isolation. These individuals should continue to wear a facemask/cloth face covering when within 6 feet of others until symptoms are completely resolved or at baseline.

All new institution-based employees or employees returning from a leave of absence shall be added into the testing cycles referenced above for COVID-19.

Testing off Staff Redirected to Assist with a COVID-19 Outbreak

All staff redirected to assist an institution that has of COVID-19 outbreak (staff or inmate), must be retested with a negative test result before returning to work in their home institution. As of 7/13/2020, this applies to staff redirected to San Quentin State Prison.

Next Steps

CDCR and CCHCS are working to hire a permanent Occupational Health Physician to advise and guide the Department's response to the pandemic, including any adjustments to the staff testing plan. In the interim, CDCR and CCHCS will be securing the services of a Licensed Occupational Medicine Specialist to fill this advisory role until the permanent position is filled. Based on these efforts, CDCR and CCHCS expect updates to this plan in the near future.

This policy is subject to change as CDC and CDPH guidelines are updated as well as PPE availability and testing options change.