COVID-19 Series for Free & Charitable Clinics

October 13, 2022

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AT THE FOREFRONT UChicago Medicine

Vaccinate with Confidence

A National Strategy to Reinforce Confidence in COVID-19 Vaccines

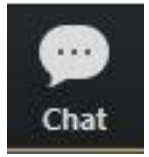
CDC's Strategy: **Empower Healthcare Personnel**: Promote confidence among healthcare personnel in their decisions to get vaccinated and recommend the vaccination to their patients.

Project Goal: Build and reinforce COVID-19 vaccine confidence among healthcare personnel in the safety net sector and, in turn, the patients they serve.

Partnerships: **The National Association of Free and Charitable Clinics** and **15 State Associations** and Federally Qualified Health Centers (FQHCs) in Puerto Rico and the U.S. Virgin Islands.

How: Provide tailored COVID-19 vaccine information to the free and charitable clinic sector through various channels and **give the FCC sector a direct line of communication to CDC**.

Reminders:

- Please use your first name and clinic name when you join the session
- Use the “chat” feature to ask questions 

- Please remember to mute your microphone 

- If you can’t connect audio via computer or you lose computer audio at anytime, you can call in to session at **(408) 638-0968, Meeting ID 932-6566-2201##**
- This activity has been approved for AMA PRA Category 1 Credit™ & Nursing CEUs

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Disclosures

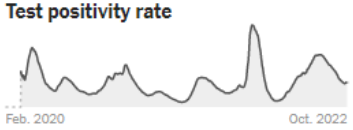
- We have no relevant financial interests to disclose.

Coronavirus in the U.S.: Latest Map and Case Count

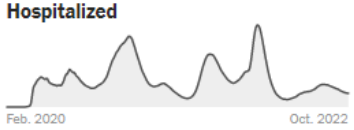
New reported cases

All time | Last 90 days

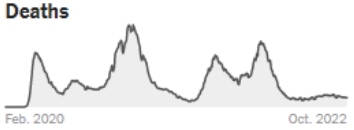
Test positivity rate



Hospitalized

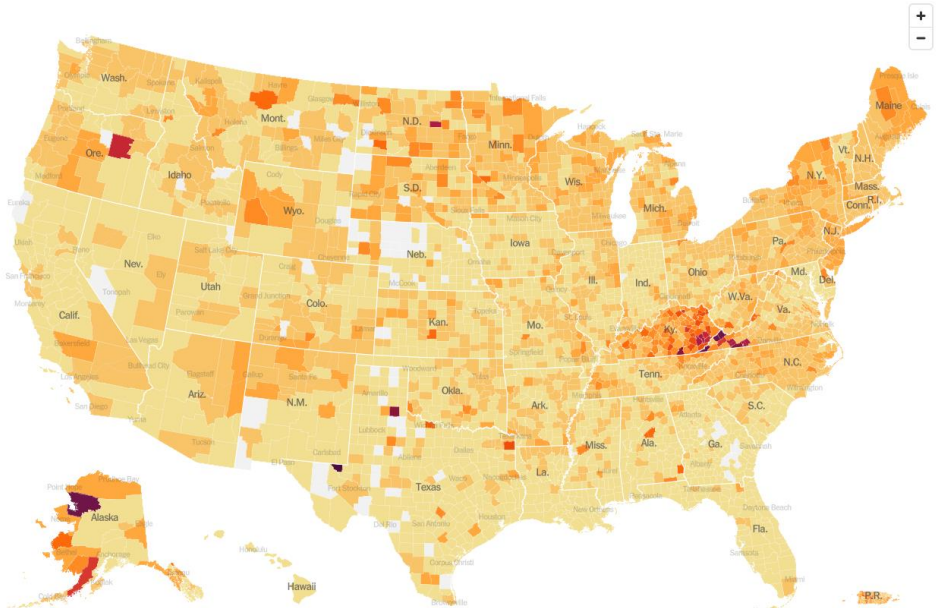


Deaths

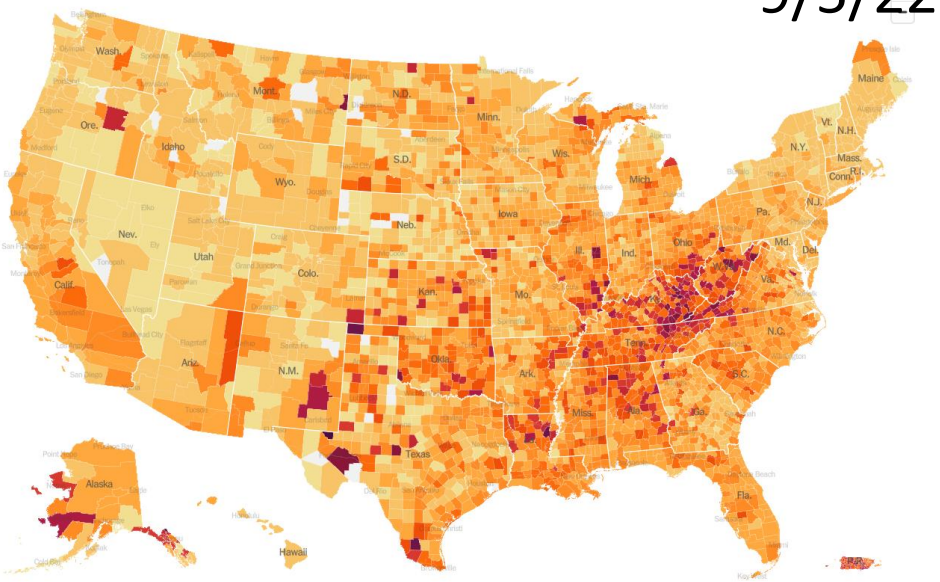


	DAILY AVG. ON OCT. 11	PER 100,000	14-DAY CHANGE
Cases	39,126	12	-24%
Test positivity	8.7%	—	—
Hospitalized	26,641	8	-8%
In I.C.U.s	3,153	<1	-11%
Deaths	383	<1	-3%

10/12/22



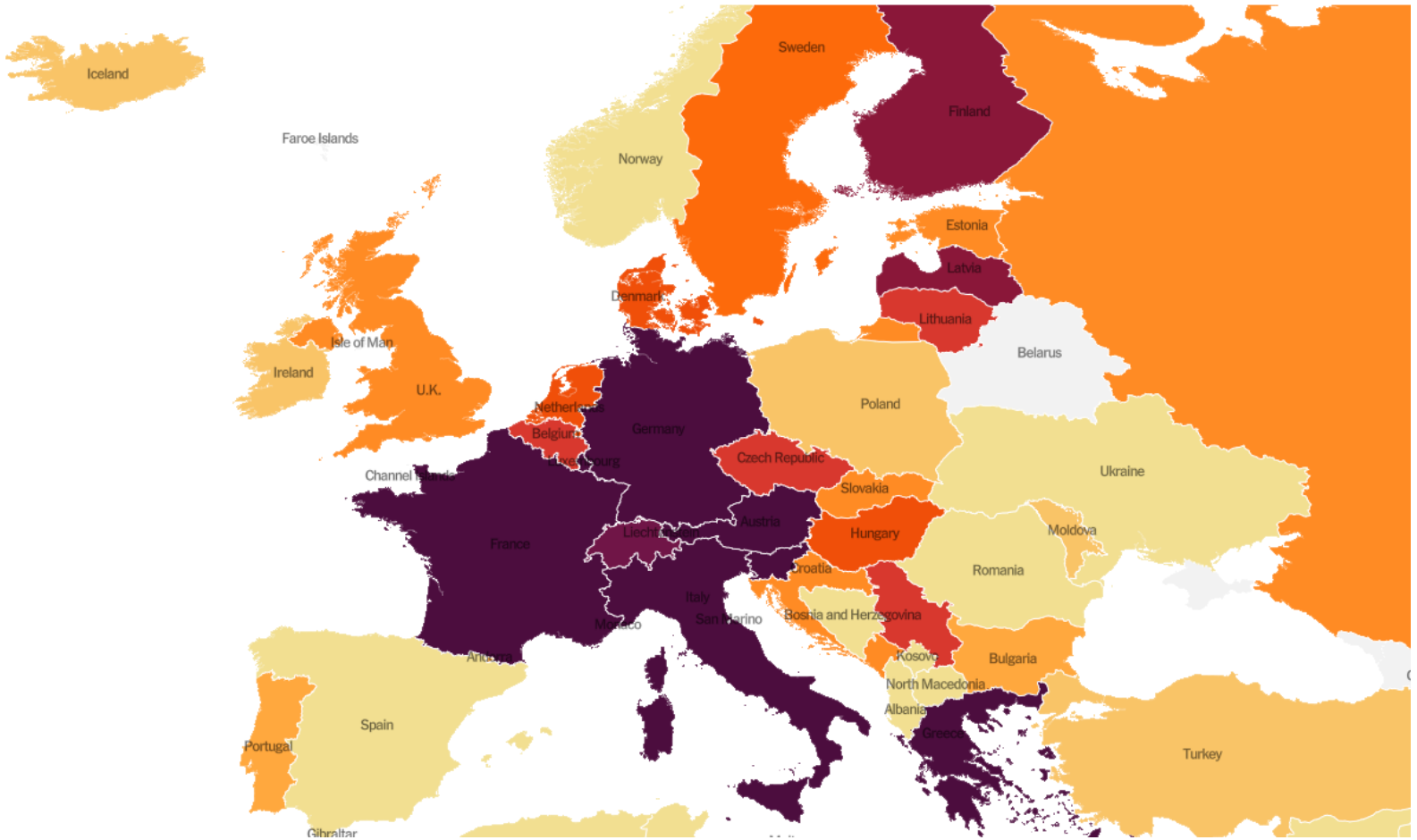
9/5/22



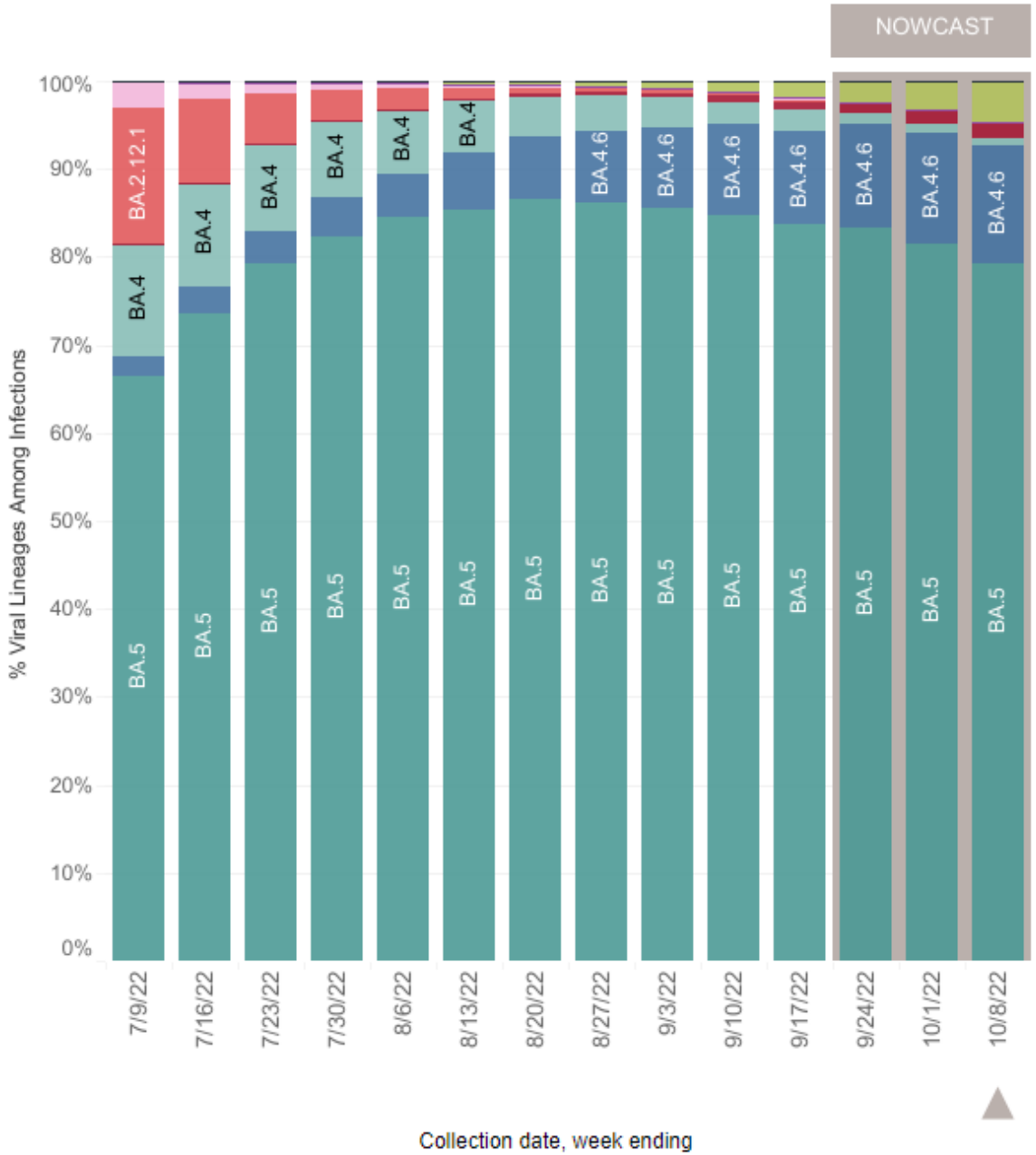
https://www.nytimes.com/interactive/2021/us/coronavirus-us-cases.html

Europe is seeing increasing rates

- Omicron subvariants BA.4/5 that dominated this summer are still behind the majority of infections, but newer Omicron subvariants are gaining ground



United States: 7/3/2022 – 10/8/2022



United States: 10/2/2022 – 10/8/2022 NOWCAST

USA

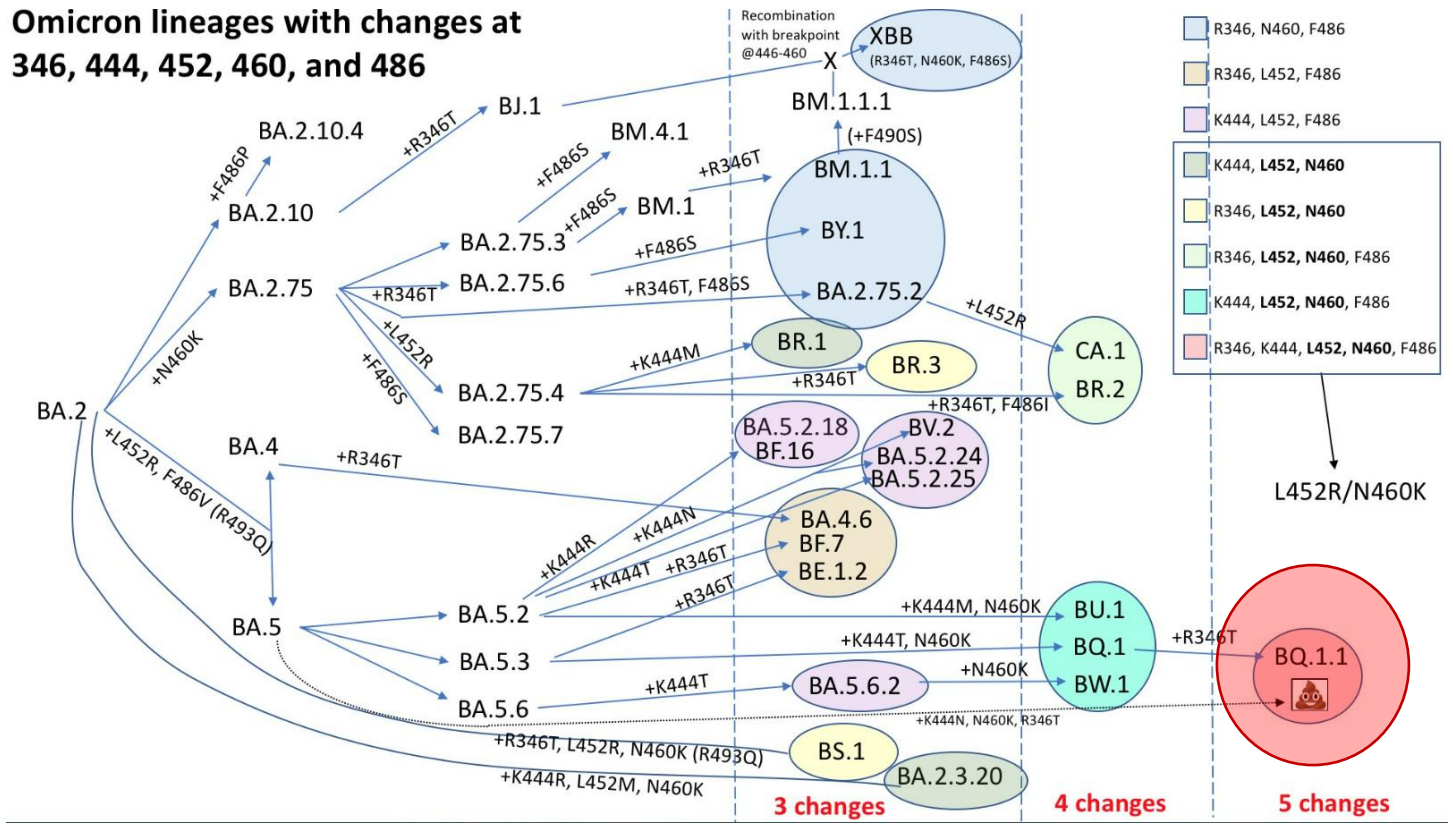
WHO label	Lineage #	US Class	%Total	95%PI
Omicron	BA.5	VOC	79.2%	77.5-80.7%
	BA.4.6	VOC	13.6%	12.4-14.9%
	BF.7	VOC	4.6%	3.9-5.4%
	BA.2.75	VOC	1.8%	1.4-2.4%
	BA.4	VOC	0.8%	0.7-0.9%
	BA.2.12.1	VOC	0.0%	0.0-0.0%
	BA.2	VOC	0.0%	0.0-0.0%
	B.1.1.529	VOC	0.0%	0.0-0.0%
	BA.1.1	VOC	0.0%	0.0-0.0%
Delta	B.1.617.2	VBM	0.0%	0.0-0.0%
Other	Other*		0.0%	0.0-0.0%

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.

** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates

AY.1-AY.133 and their sublineages are aggregated with B.1.617.2. BA.1, BA.3 and their sublineages (except BA.1.1 and its sublineages) are aggregated with B.1.1.529. Except BA.2.12.1, BA.2.75 and their sublineages, BA.2 sublineages are aggregated with BA.2. Except BA.4.6, sublineages of BA.4 are aggregated to BA.4. Except BF.7, sublineages of BA.5 are aggregated to BA.5. Sublineages of BA.1.1 and BA.2.75 are aggregated to the parental BA.1.1 and BA.2.75 respectively. Previously, BA.2.75 was aggregated with BA.2, and BF.7 was aggregated with BA.5. Lineages BA.4.6, BF.7, and many BA.2.75 contain the spike substitution R346T.

Omicron Persists!

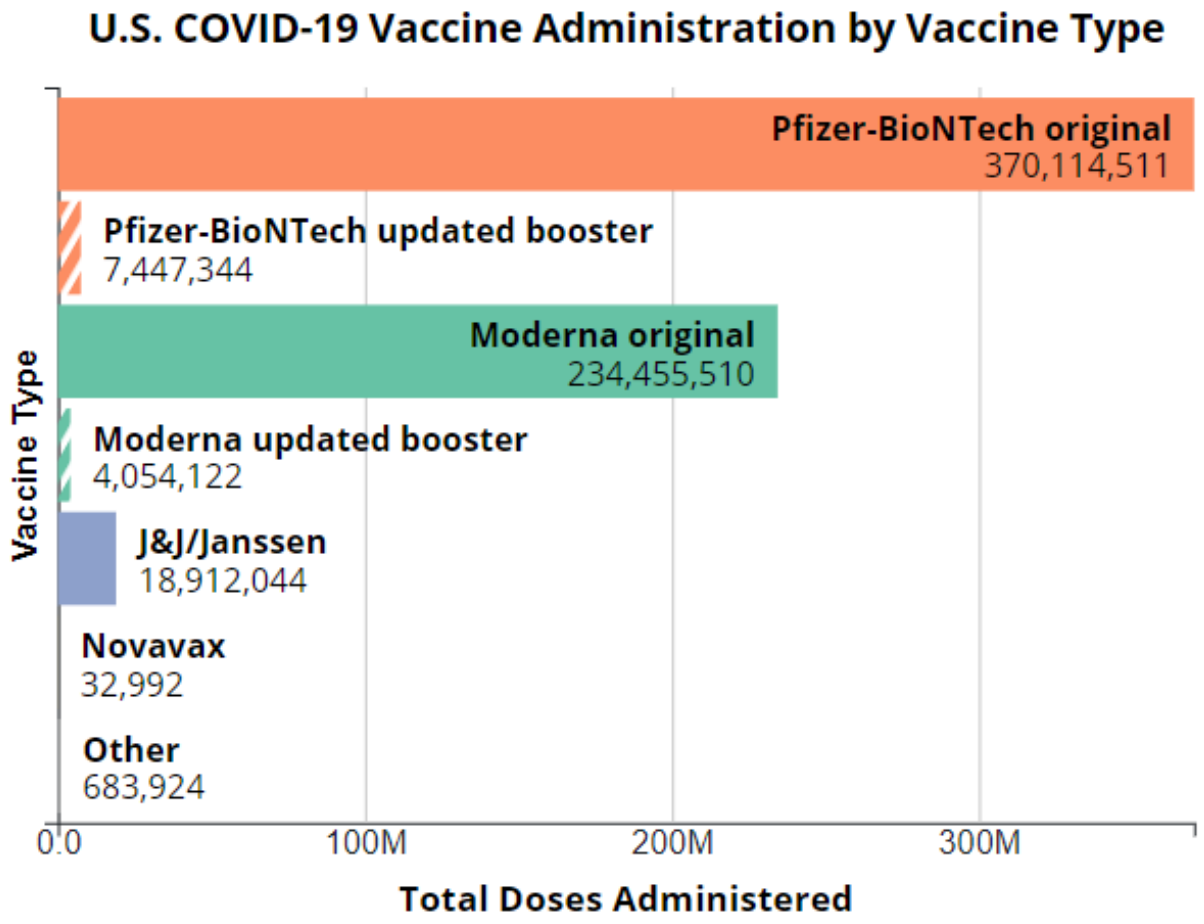


- Convergent evolution. Subvariants with similar mutations are popping up independently across the globe.
- **Notice BQ.1.1 (in red)**. This is a direct descendant of BA.5. While it has the most spike mutations, we picked the BA.5 formula for U.S. fall boosters. Our boosters will work best if this subvariant dominates in the future. For now, BQ.1.1 is winning the race in Europe, so this may have a good chance of taking over in the U.S. We may get lucky!
- This is what we know. More than 90% of testing and sequencing has been stopped across the globe. This means we are largely flying blind and there may be a surprise in the mix we are unaware of just yet.

Source - Katelyn Jetelina: https://yourlocalepidemiologist.substack.com/p/covid-state-of-affairs-oct-5?utm_source=email

Slow Uptake of New Boosters

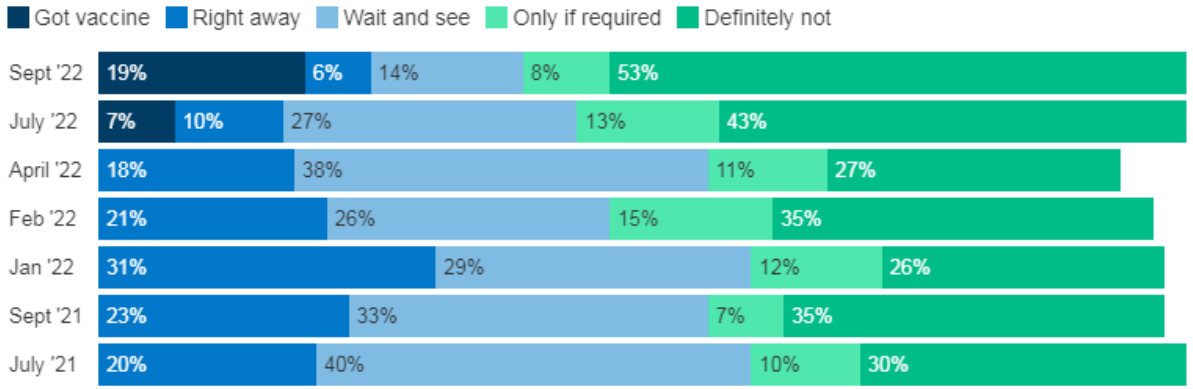
- According to the latest data shared by the CDC, only 11.5 million eligible people have received an updated booster. That is less than 5% of the 240 million people who qualify, and only around 7% of doses made available by the government
- A survey by the Kaiser Family Foundation points at important communication gaps when it as comes to the omicron booster. As of the end of September, about half the population had heard only a little, or nothing at all, about the booster shot. <u>40% of responders didn't know whether the booster was available to them</u>



https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-september-2022/
https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-people-additional-dose-totalpop

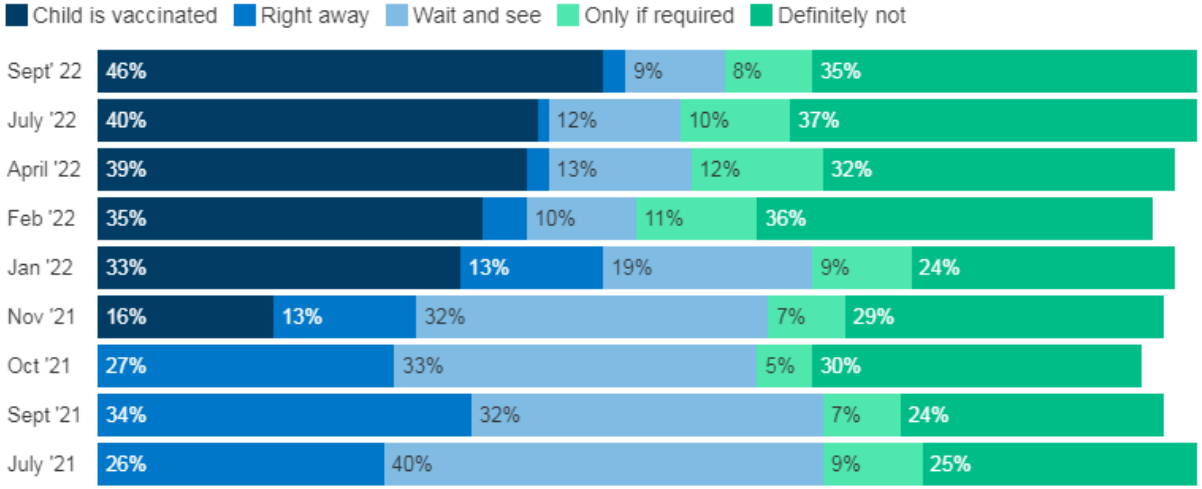
One In Five Parents Of Children Under Age Five Now Say Their Child Has Gotten Vaccinated, Half Say They "Definitely" Won't Get It

Thinking about your child between the ages of 6 months and 4 years, have they received at least one dose of a COVID-19 vaccine, or not? If not, do you think you will get them vaccinated…?



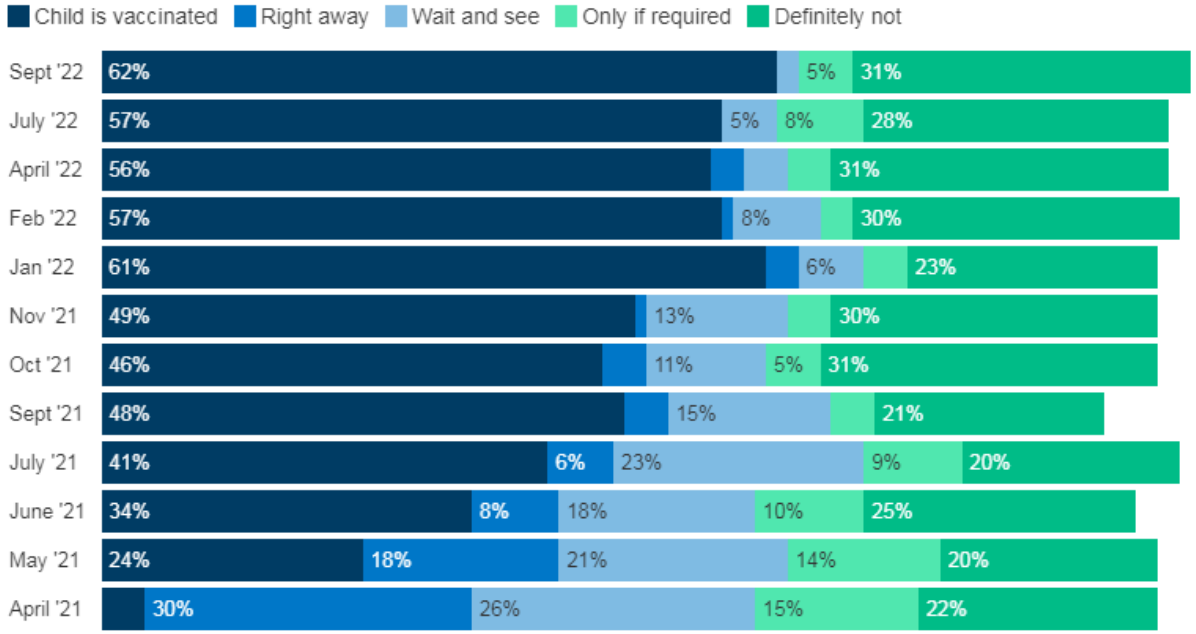
Almost Half Of Parents Of Kids Ages 5-11 Say Their Child Has Been Vaccinated

Thinking about your child between the ages of 5 and 11, have they received at least one dose of a COVID-19 vaccine, or not? If not, do you think you will get them vaccinated…?



Reported Vaccination Rates For Teenagers Remain Steady, A Third Of Parents Say Their Child Won't Get The COVID-19 Vaccine

Thinking about your child between the ages of 12 and 17, have they received at least one dose of a COVID-19 vaccine, or not? If not, do you think you will get them vaccinated…?



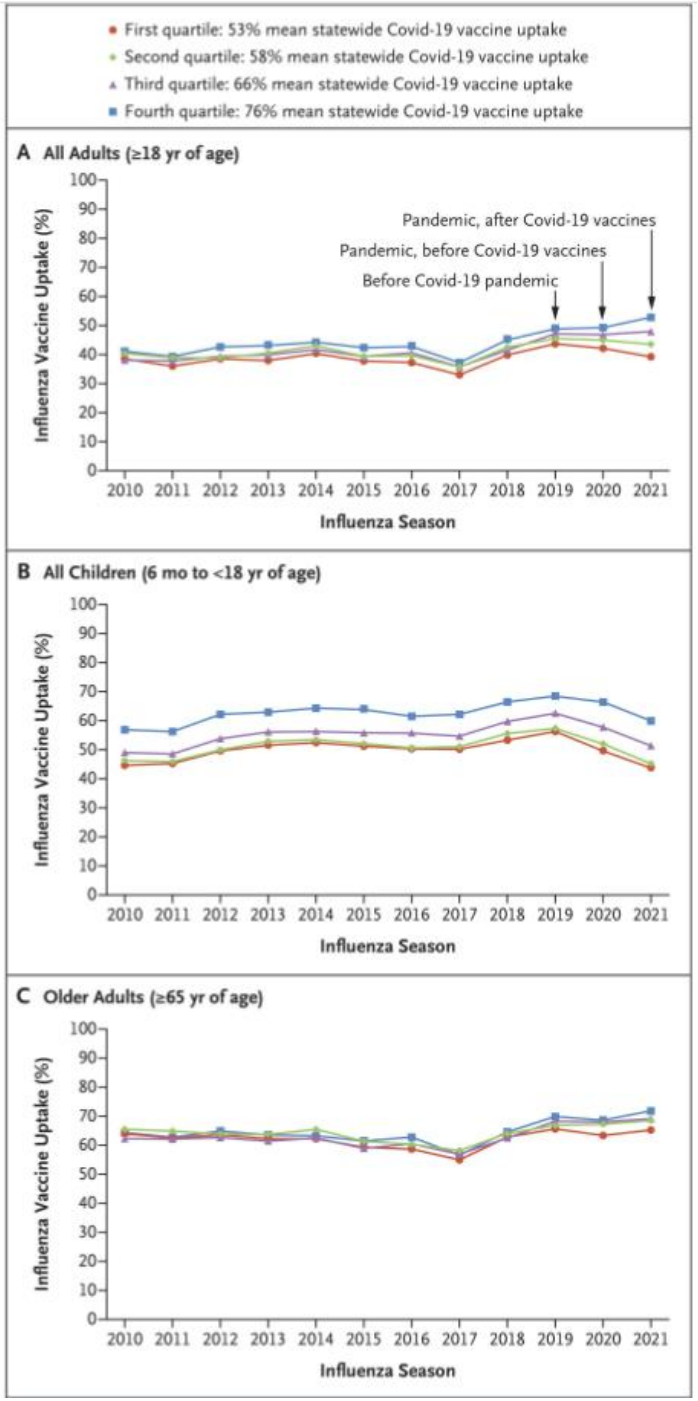
https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-september-2022/

CDC and FDA Expands Updated COVID-19 Vaccines to Include Children Ages 5 Through 11

- Today, CDC's Director Rochelle P. Walensky, M.D., M.P.H., signed a decision memo expanding the use of updated (bivalent) COVID-19 vaccines to children ages 5 through 11 years. This follows the Food and Drug Administration's (FDA) authorization of updated COVID-19 vaccines from Pfizer-BioNTech for children ages 5 through 11 years, and from Moderna for children and adolescents ages 6 through 17 years.
  - Dosage is same as earlier iterations of the vaccine (10 microgram for Pfizer)
  - Moderna: ages 6 years through 11 years, a single booster dose is 0.25 mL, ages 12 years and older, a single booster dose is 0.5 mL

Association between Covid-19 Vaccination and Influenza Vaccination Rates

- The polarizing nature of vaccination against coronavirus disease 2019 (Covid-19) within the United States threatens public health and has contributed to variable statewide vaccine uptake that ranged from 50 to 80% as of January 2022. Given the divided national landscape and anecdotal evidence from our own patients, authors hypothesized that low Covid-19 vaccination rates would be associated with decreases in influenza vaccination rates.
- Areas that had more vaccine skepticism may have worsened



Influenza Vaccine Can be Administered at Same Time

- It is safe and recommended to give both immunizations simultaneously
- Initial safety findings from v-safe for simultaneously administered COVID-19 mRNA booster dose and seasonal influenza vaccines indicate that respondents who received simultaneous administration were slightly more likely to report systemic reactions in the week following vaccination than respondents who received COVID-19 mRNA booster alone. In both groups, most reactions reported in the week following vaccination were generally mild.

JAMA Netw Open. 2022;5(7):e2222241. doi:10.1001/jamanetworkopen.2022.22241

Influenza and COVID-19

Last Updated: September 30, 2022

Summary Recommendations

Influenza Vaccination

- People with acute COVID-19 should receive an inactivated influenza vaccine (BIII).
  - Clinicians should consider deferring influenza vaccination for symptomatic patients with COVID-19 until these patients are no longer moderately or severely ill and have completed their COVID-19 isolation period.
  - Clinicians should advise people with asymptomatic SARS-CoV-2 infection or mild COVID-19 symptoms to seek influenza vaccination when they no longer require isolation. They can be vaccinated sooner if they are in a health care setting for other reasons.
- An influenza vaccine and a COVID-19 vaccine may be administered concurrently at different injection sites. See the recommendations from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices for more information.

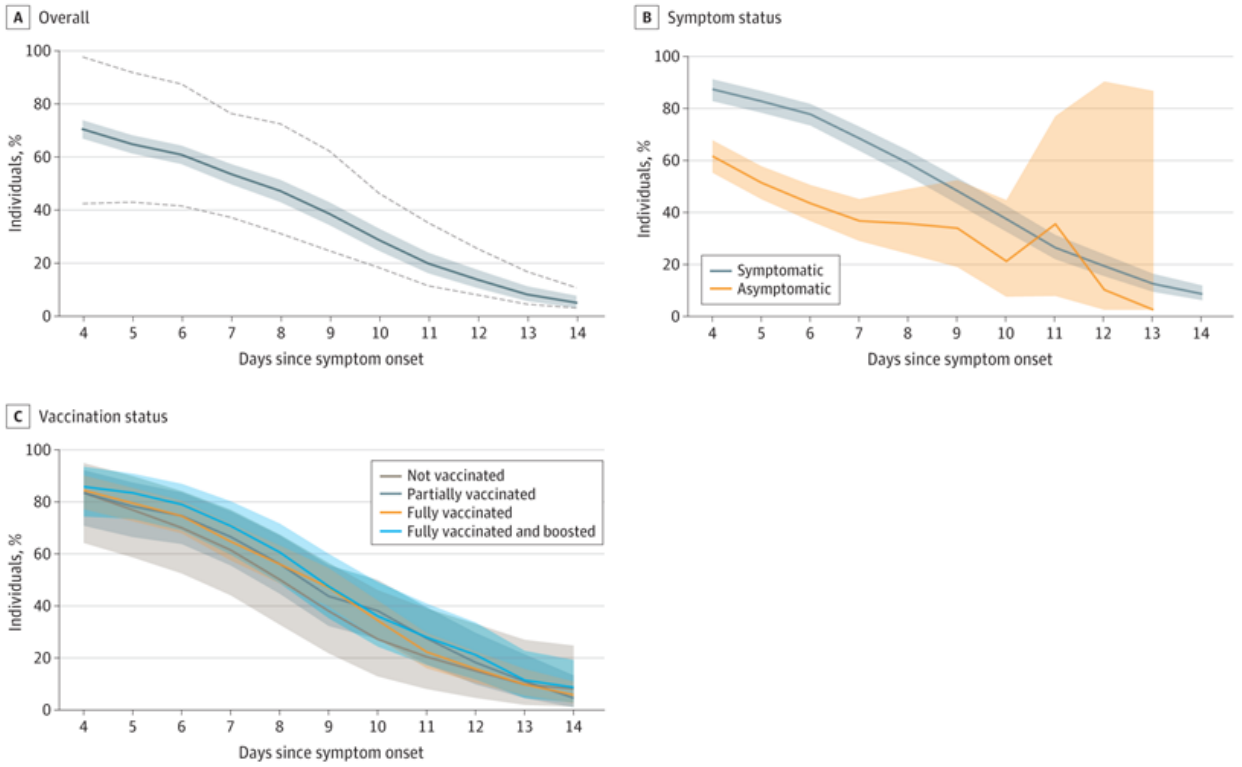
Diagnosis of Influenza and COVID-19 When Influenza Viruses and SARS-CoV-2 Are Cocirculating

- Only testing can distinguish between SARS-CoV-2 and influenza virus infections and identify SARS-CoV-2 and influenza virus coinfection.
- The COVID-19 Treatment Guidelines Panel (the Panel) recommends influenza testing in addition to SARS-CoV-2 testing in outpatients with acute respiratory illness if the results will change the clinical management strategy for the patient (e.g., administering antiviral treatment for influenza) (**BIII**).
- The Panel recommends testing for both viruses in all hospitalized patients with acute respiratory illness (**AIII**).
- Clinicians should consider testing patients for other pathogens based on the specific clinical circumstances. Additional testing for bacterial pathogens is important for patients with influenza and clinical signs that suggest bacterial superinfections, especially for patients who are immunocompromised or intubated.
- See the CDC webpage Information for Clinicians on Influenza Virus Testing and the Infectious Diseases Society of America (IDSA) clinical practice guidelines for more information.

COVID-19 Symptoms and Duration of Rapid Antigen Test Positivity at a Community Testing and Surveillance Site During Pre-Delta, Delta, and Omicron BA.1 Periods

- Cross-sectional study: upper respiratory tract symptoms were more commonly reported during the Omicron BA.1 period than during the pre-Delta and Delta periods, with differences by vaccination status.
- Rapid antigen test positivity remained high 5 days after symptom onset, supporting guidelines requiring a negative test to inform the length of the isolation period.

Figure 2. Rapid Antigen Diagnostic Test Positivity Among 942 People With COVID-19 Who Underwent Repeated Testing During the Omicron BA.1 Period by Day of Symptom Onset (if Symptomatic) or Day Since Initial Positive Test (if Asymptomatic)



JAMA Netw Open. 2022;5(10):e2235844. doi:10.1001/jamanetworkopen.2022.35844

HHS Announces Initiative to Help Uninsured and Underinsured Americans Access COVID-19 Monoclonal Antibody Treatment

- HHS is making 60,000 doses of the product available to support the bebtelovimab product replacement initiative. Through this new initiative, which is effective immediately, health care providers who use a commercially procured dose of bebtelovimab to treat an uninsured or underinsured patient may be eligible to have the dose replaced for free by HHS.
- Health care providers can use their own established methods for determining uninsured or underinsured status, such as eligibility criteria for existing programs for which a patient may already be eligible.
- At the current rate of use, the additional doses purchased for this initiative are expected to be available through September 2023.

Pre-Exposure Prophylaxis

- CDC/FDA continue to recommends using tixagevimab plus cilgavimab (Evusheld) as SARS-CoV-2 PrEP for adults and adolescents who do not have SARS-CoV-2 infection or recent exposure to an individual with SARS-CoV-2 infection and who are moderately to severely immunocompromised and may have an inadequate immune response to COVID-19 vaccination
- **Recent study showed BA 4.6 is not neutralized by tixagevimab/cilgavimab**
- The federal government is trying to make it easier for immunocompromised patients to access a treatment that can protect them against COVID-19 by allowing individual health care providers to order small amounts
- Available through a subset of federal pharmacy partners, including Albertsons, Acme, Jewel-Osco, Pavilions, Randalls, Safeway, Star Market, and Vons, CPESN, Amber Specialty Pharmacy, Managed Healthcare Associates and Thrifty White.
- The government is also working with AstraZeneca, to set up a toll-free number (1-833-EVUSHLD — 1-833-388-7453)

Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 Infection

- HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays.
- When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.
- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.
- For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Return to Work Criteria for HCP Who Were Exposed to Individuals with Confirmed SARS-CoV-2 Infection

- **In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2**
- For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and:
  - HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask; eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- Following a higher-risk exposure, HCP should:
  - Have a series of three viral tests for SARS-CoV-2 infection.
  - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
  - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Return to Work Criteria for HCP with SARS-CoV-2 Infection

- HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
  - At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and at least 24 hours have passed since last fever without the use of fever-reducing medications, a
  - Symptoms (e.g., cough, shortness of breath) have improved.
- HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met:
  - At least 7 days have passed since the date of their first positive viral test if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing not performed or if a positive test at day 5-7)
  - Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later
- HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.
  - Use of a test-based strategy and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Questions?

Thank you!

Next Session: Thursday, November 17th ,12-1 pm CST

Resources & recording of the session

https://www.echo-chicago.org/resources/covid19/

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