COVID-19 Series for Free & Charitable Clinics

May 18, 2023

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AT THE FOREFRONT UChicago Medicine

Vaccinate with Confidence

A National Strategy to Reinforce Confidence in COVID-19 Vaccines

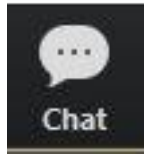
CDC's Strategy: **Empower Healthcare Personnel**: Promote confidence among healthcare personnel in their decisions to get vaccinated and recommend the vaccination to their patients.

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 **6 State Associations**: to consult directly with clinic personnel in highly vulnerable areas with low vaccination rates.

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

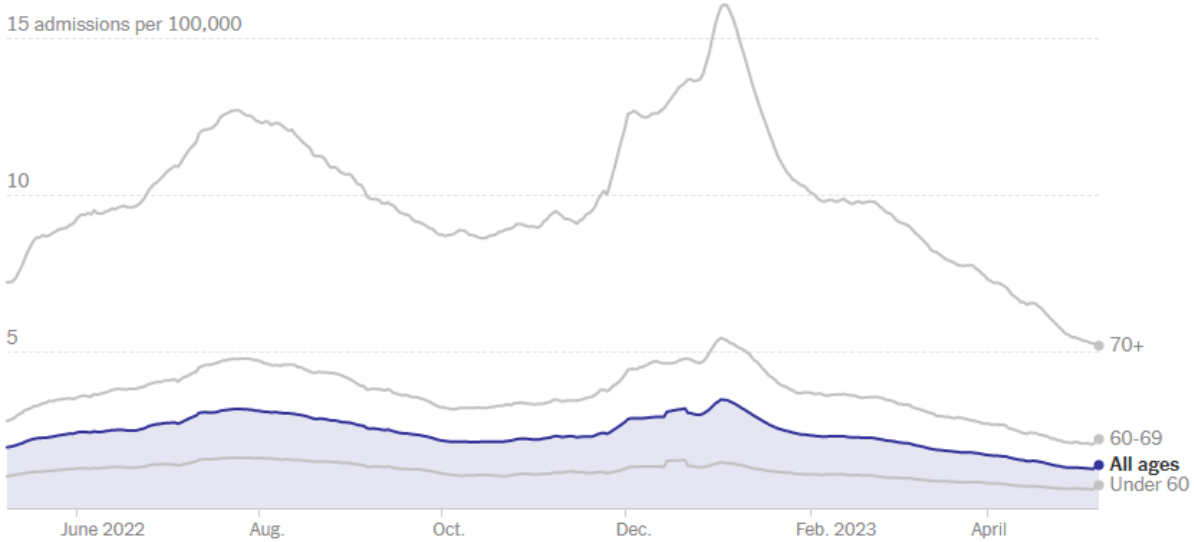
- We have no relevant financial interests to disclose.

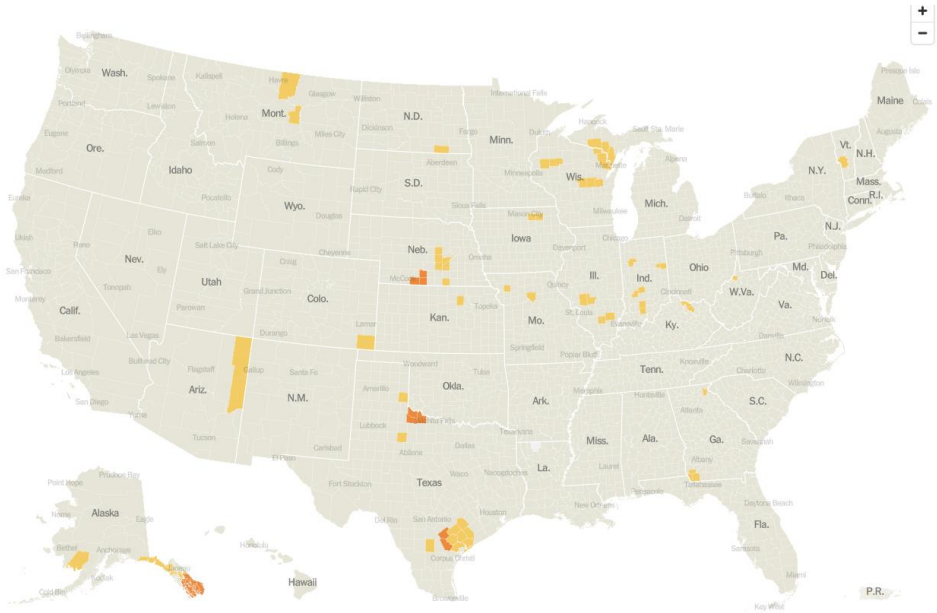
Track Covid-19 in the U.S.

Updated May 8, 2023

Daily Covid hospital admissions

Avg. on May 8: 4,535
14-day change: +1%





Primary series vaccination rate

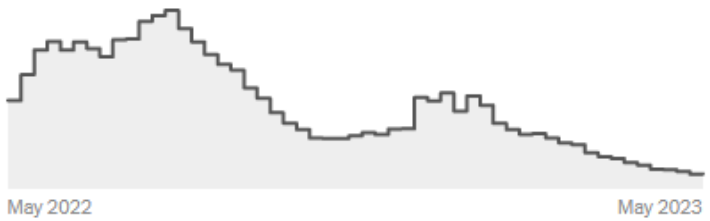
69% Total population
94% Ages 65 and up

Bivalent booster rate

17% Total population
43% Ages 65 and up

Weekly cases

April 27 to May 3: 77,263
14-day change: −22%



Test positivity rate

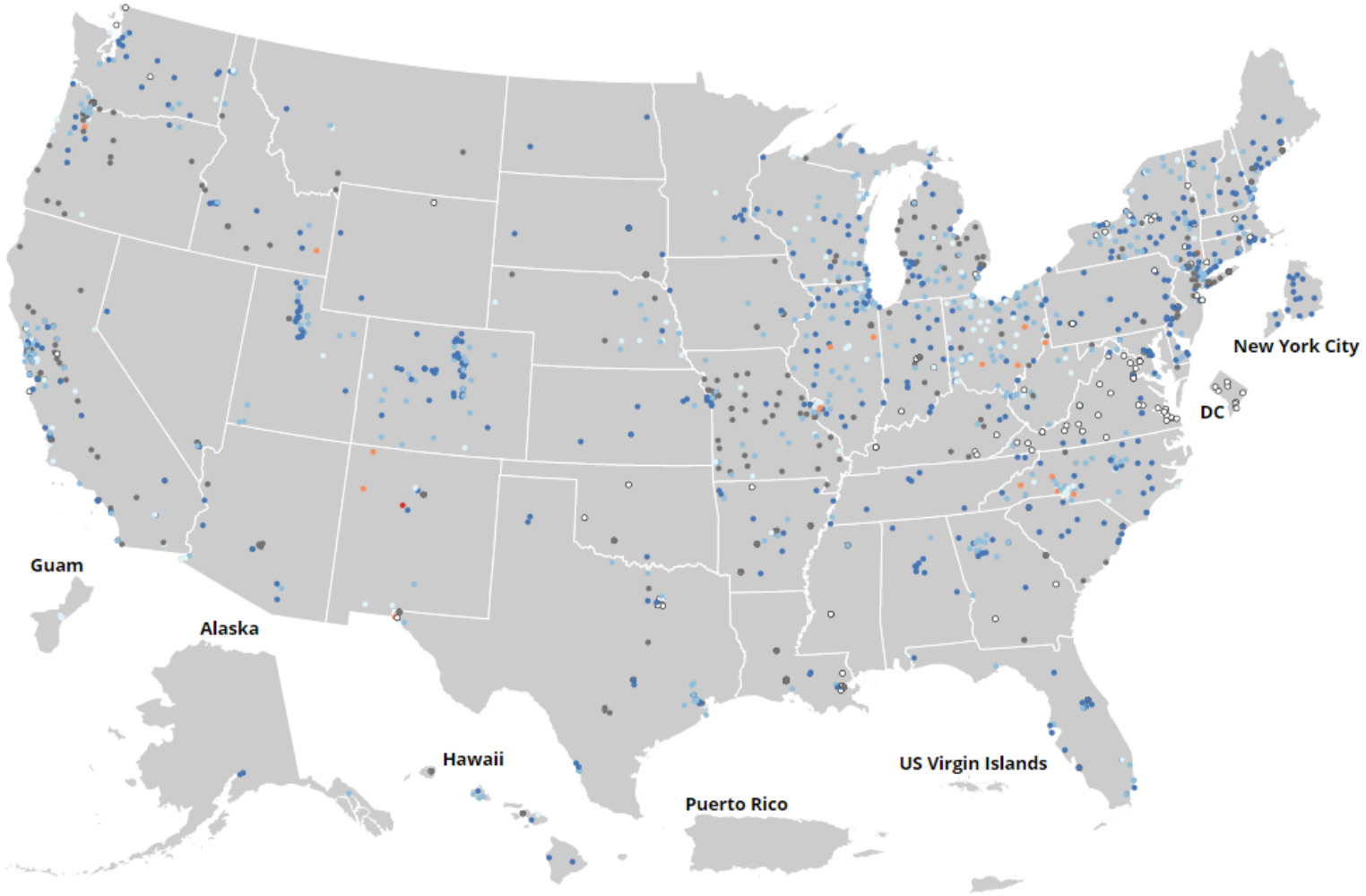
Avg. on May 5: 5.4%
14-day change: +3%

Weekly deaths

April 27 to May 3: 1,109
14-day change: −11%

https://www.nytimes.com/interactive/2023/us/covid-cases.html

Wastewater Surveillance



Current SARS-CoV-2 virus levels by site, United States

Current virus levels category	Num. sites	% sites	Category change in last 7 days
New Site	148	12	1%
0% to 19%	529	41	– 2%
20% to 39%	429	34	– 12%
40% to 59%	149	12	– 14%
60% to 79%	20	2	– 33%
80% to 100%	1	0	0%

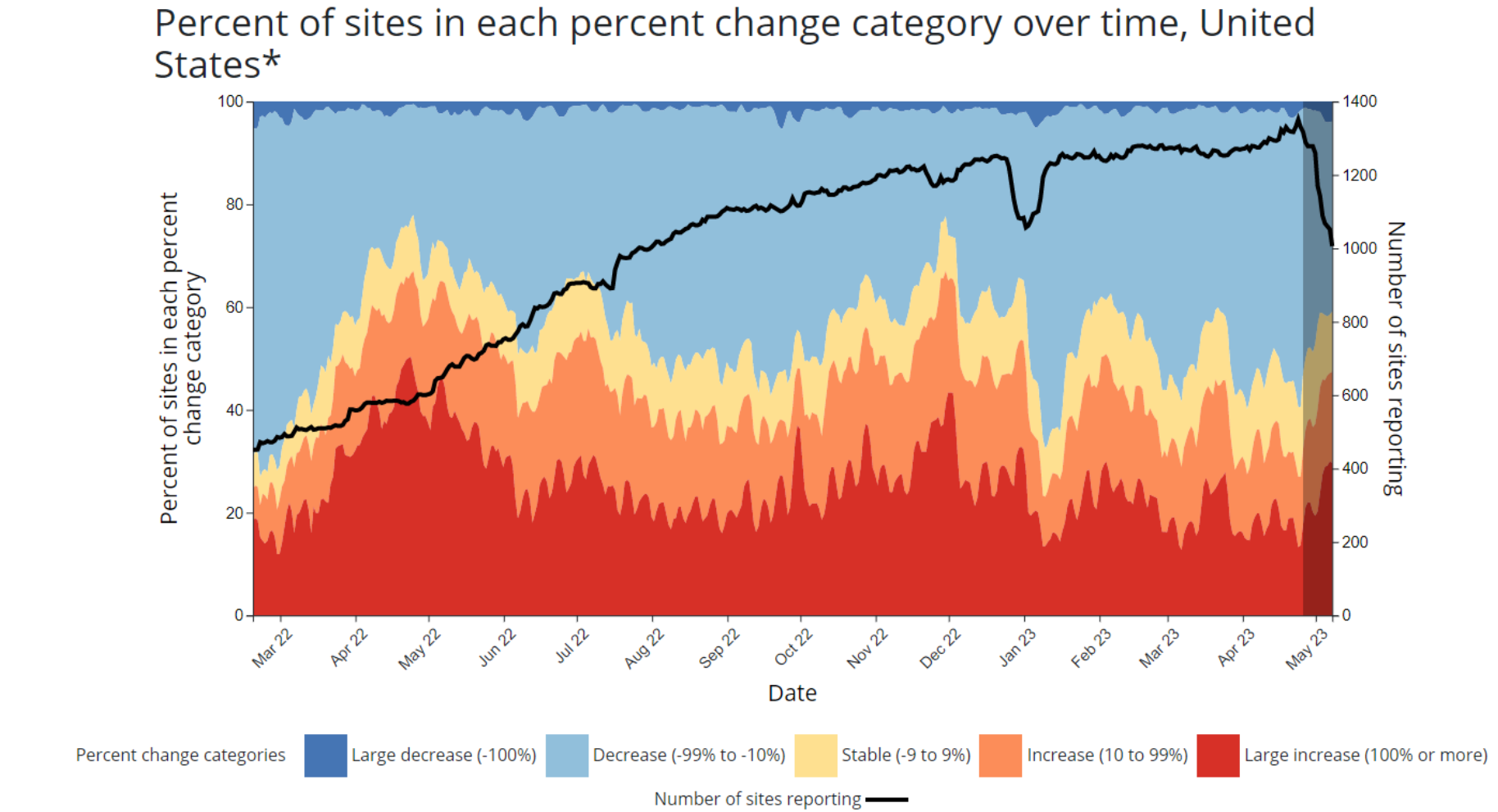
Total sites with current data: 1276

Total number of wastewater sampling sites: 1552

How is the current SARS-CoV-2 level compared to past levels calculated?

https://covid.cdc.gov/covid-data-tracker/#wastewater-surveillance

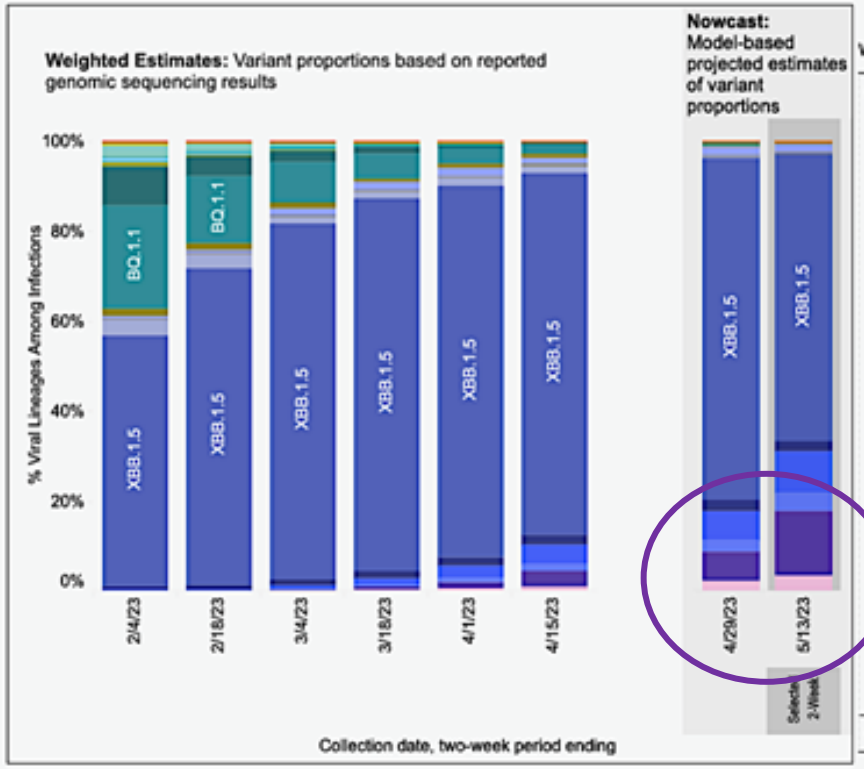
Wastewater Surveillance



*The darker bar on the right side of the figure highlights the most recent 2 weeks, which may be subject to reporting delays. The actual number of sites reporting during those 2 weeks will likely increase as historical data are added.

Weighted and Nowcast Estimates in United States for 2-Week Periods in 1/22/2023 – 5/13/2023

Hover over (or tap in mobile) any lineage of interest to see the amount of uncertainty in that lineage's estimate.

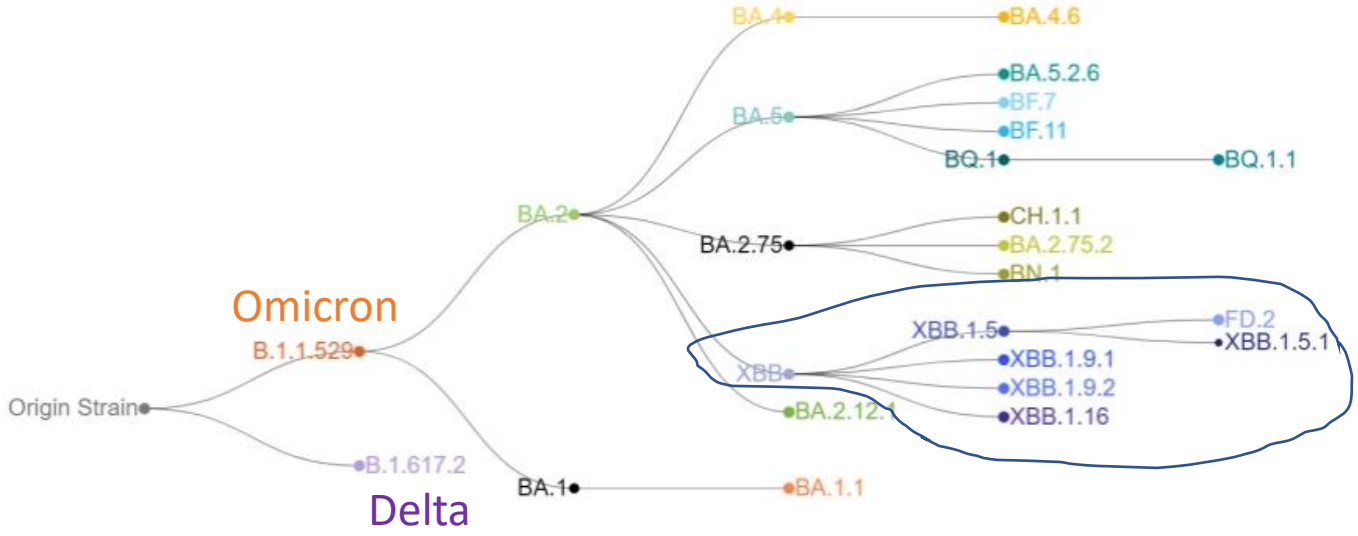


Nowcast Estimates in United States for 4/30/2023 – 5/13/2023

USA

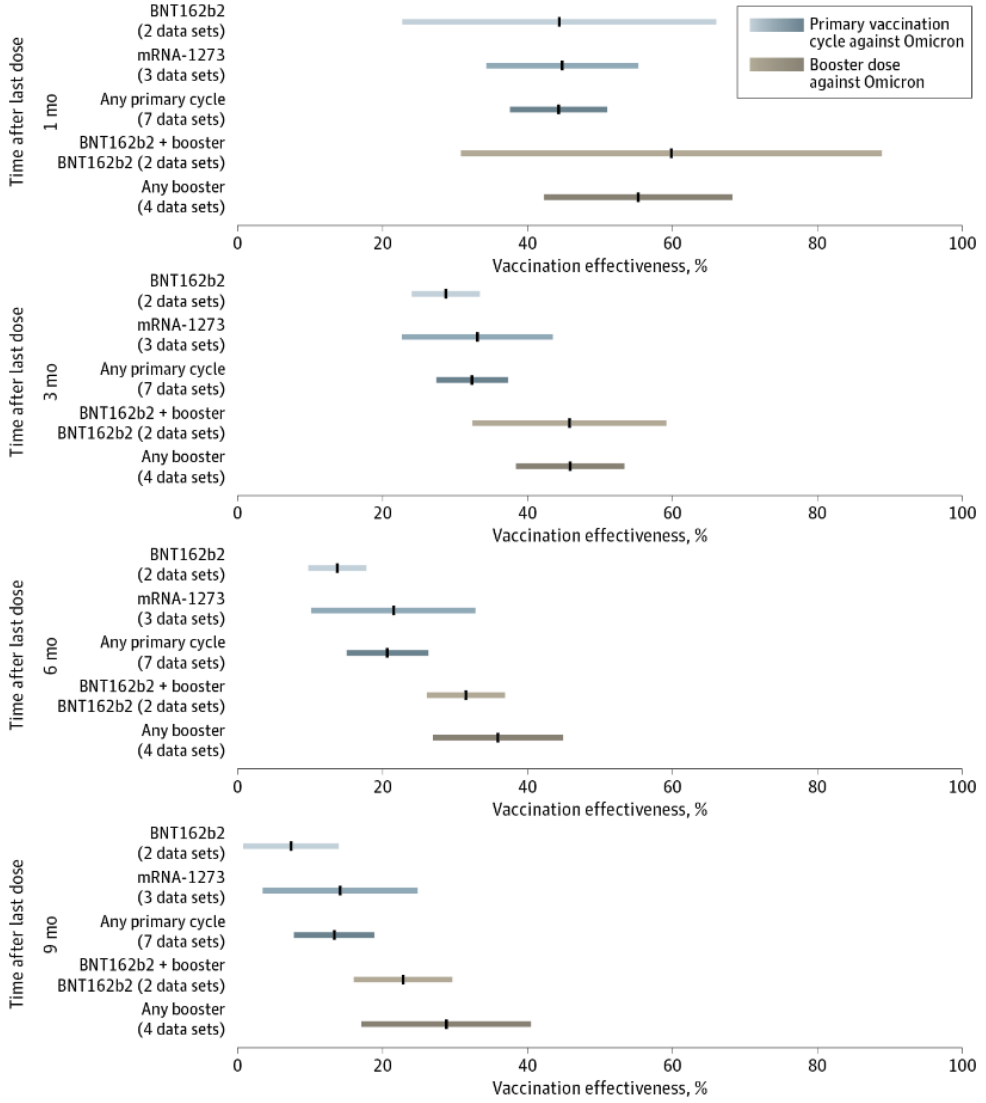
WHO label	Lineage #	US Class	%Total	95%PI
Omicron	XBB.1.5	VOC	64.0%	59.1-68.6%
	XBB.1.16	VOC	14.3%	11.1-18.1%
	XBB.1.9.1	VOC	9.2%	8.0-10.6%
	XBB.1.9.2	VOC	4.0%	3.2-5.1%
	XBB.2.3	VOC	3.5%	1.9-6.3%
	XBB.1.5.1	VOC	2.4%	1.9-3.0%
	FD.2	VOC	1.8%	0.8-4.0%
	BQ.1.1	VOC	0.3%	0.1-0.5%
	CH.1.1	VOC	0.2%	0.2-0.4%
	XBB	VOC	0.2%	0.1-0.4%
	BQ.1	VOC	0.0%	0.0-0.1%
	BN.1			
	BA.5			
	BA.2.12.			
	BA.2			
	BA.2.75			
	BF.7			
	BA.5.2.6			
Other	Other*			

Rise of “Arcturus”



Recent research on vaccine effectiveness

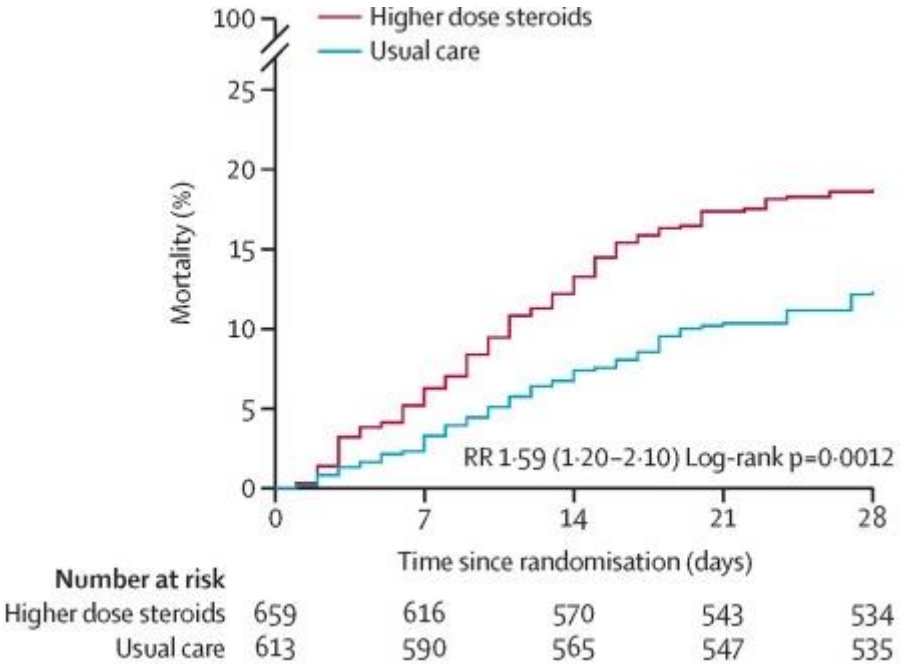
- Estimates of the rate of waning of vaccine effectiveness (VE) against COVID-19 are key to assess population levels of protection and future needs for booster doses to face the resurgence of epidemic waves.
- Meta-analysis of 40 studies with data
- Pooled estimates of VE of a primary vaccination cycle against laboratory-confirmed Omicron infection and symptomatic disease were both lower than 20% at 6 months from last dose administration. Booster doses restored VE to levels comparable to those acquired soon after the administration of the primary cycle. However, 9 months after booster administration, VE against Omicron was lower than 30% against laboratory-confirmed infection and symptomatic disease. The half-life of VE against symptomatic infection was estimated to be 87 days (95% CI, 67-129 days) for Omicron compared with 316 days (95% CI, 240-470 days) for Delta.
- Similar waning rates of VE were found for different age segments of the population.
- Findings suggest that the effectiveness of COVID-19 vaccines against laboratory-confirmed Omicron or Delta infection and symptomatic disease rapidly wanes over time after the primary vaccination cycle and booster dose.
- Suggests a strategy of regular boosters for at risk individuals



JAMA Netw Open. 2023;6(5):e2310650. doi:10.1001/jamanetworkopen.2023.10650

More is not better…

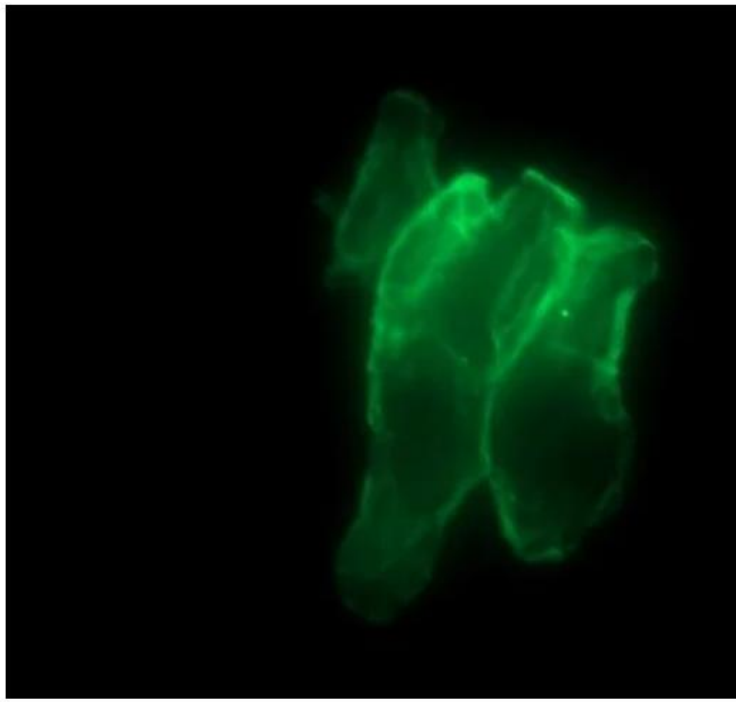
- Low-dose corticosteroids have been shown to reduce mortality for patients with COVID-19 requiring oxygen or ventilatory support (non-invasive mechanical ventilation, invasive mechanical ventilation, or extracorporeal membrane oxygenation)
- Patients hospitalized for COVID-19 with clinical hypoxia who required either no oxygen or simple oxygen only, higher dose corticosteroids significantly increased the risk of death compared with usual care, which included low-dose corticosteroids.
- The RECOVERY trial continues to assess the effects of higher dose corticosteroids in patients hospitalized with COVID-19 who require non-invasive ventilation, invasive mechanical ventilation, or extracorporeal membrane oxygenation.



https://doi.org/10.1016/S0140-6736(23)00510-X

Long COVID might be due to “microclots”

- *Per Dr. Pretorius:* "The spike protein has the capability to change your soluble clotting protein to insoluble little microclots and that's where everything starts," "So when you have acute COVID you will have activated platelets, you will have vascular damage in endothelial damage and you will have a micro cloud presence in some individuals." In some people, after around two weeks, the body will begin to break down those insoluble microclots and they will return to normal. But for others, those microclots hang around and they can damage blood vessels as well as block blood flow to many organs — which could help explain Long COVID's wide-ranging symptoms. "You get widespread and systemic-induced ... inflammation of your blood vessels—the inside of your blood vessels. If it's systemic, it means it's in every organ. It's in every part of your body,"
- Research is ongoing, but using an assay for microclots could be a biomarker for Long COVID

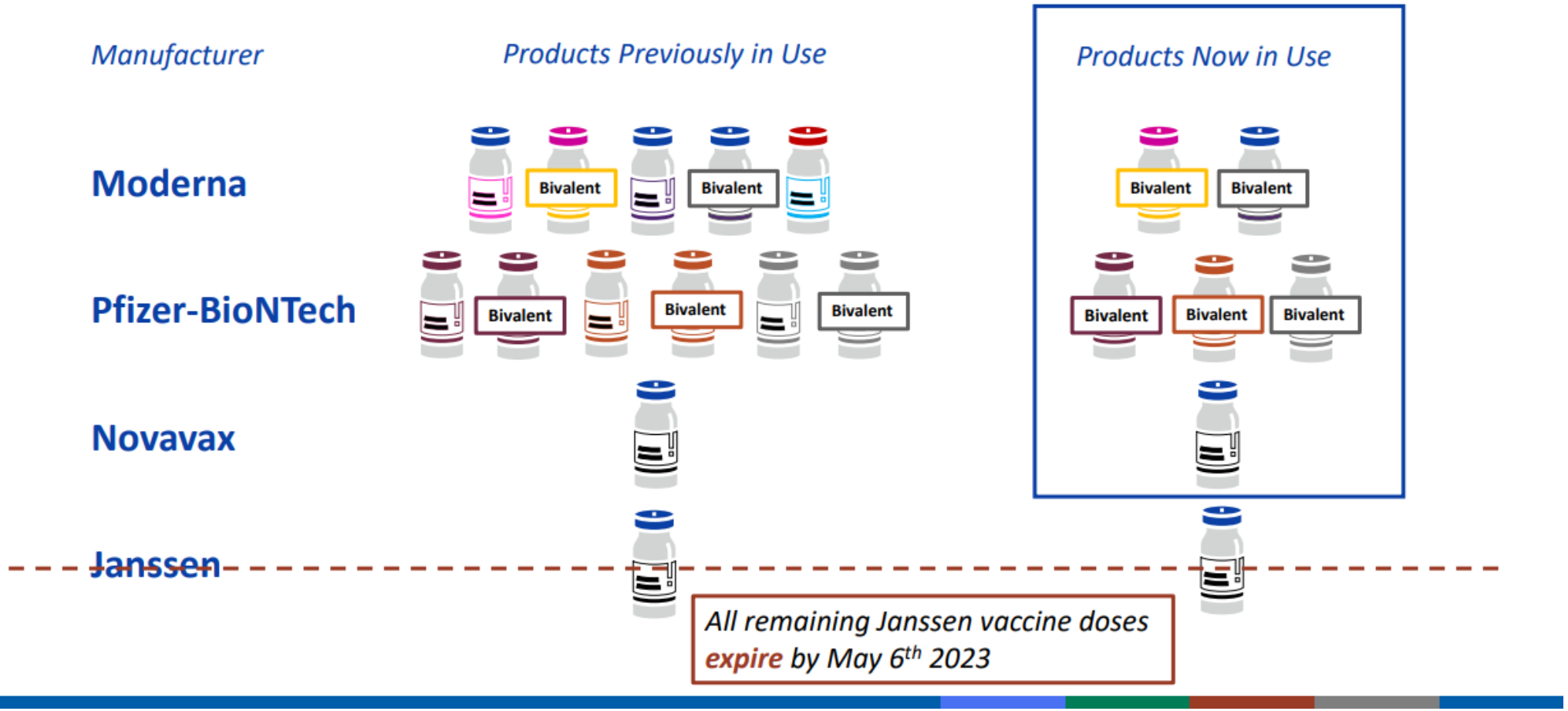


Fluorescent image of a microclot from a Long COVID patient shown at 40x magnification.

Mount Sinai Health System

Long COVID research after the public health emergency ends : Short Wave : NPR

Products in Use



https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2023-04-19/07-COVID-Twentyman-508.pdf

Monovalent mRNA Vaccines

- No longer authorized.
- Should be **immediately removed from inventory.**
- **All monovalent Moderna and Pfizer-BioNTech mRNA vaccines** should be disposed of in medical waste containers.
  - Medical waste disposal requirements may vary by jurisdiction.

https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html

AGES 12 YEARS AND OLDER

UNVACCINATED

dose/injection volume

Moderna Bivalent:
(**Do NOT** dilute before use)
Dark Blue Cap (gray label)

Pfizer Bivalent:
(**Do NOT** dilute before use)
Gray Cap

Moderna **BIVALENT** 50 µg/0.5 mL → Up-to-date

OR

Pfizer **BIVALENT** 30 µg/0.3 mL → Up-to-date

PREVIOUSLY VACCINATED

dose/injection volume

Previously Received COVID-19 Vaccines

Moderna Bivalent:
(**Do NOT** dilute before use)
Dark Blue Cap (gray label)

Pfizer Bivalent:
(**Do NOT** dilute before use)
Gray Cap

1+ DOSES Monovalent Moderna or Pfizer → In at least 8 weeks → Moderna **BIVALENT** 50 µg/0.5 mL

OR

In at least 8 weeks → Pfizer **BIVALENT** 30 µg/0.3 mL → Up-to-date

Moderna or Pfizer **BIVALENT** → Up-to-date

ADDITIONAL DOSES

dose/injection volume

Previously Received COVID-19 Vaccines

Moderna Bivalent:
(**Do NOT** dilute before use)
Dark Blue Cap (gray label)

Pfizer Bivalent:
(**Do NOT** dilute before use)
Gray Cap

65 YEARS AND OLDER

People ages 65 years and older have the option to receive 1 additional bivalent mRNA vaccine dose at least 4 months after the first dose of a bivalent mRNA vaccine.

Moderna or Pfizer **BIVALENT** → In at least 4 months → Moderna **BIVALENT** 50 µg/0.5 mL

OR

In at least 4 months → Pfizer **BIVALENT** 30 µg/0.3 mL → Up-to-date

AGES 12 YEARS AND OLDER

- At the time of initial vaccination, people ages 6 months and older are recommended to receive 3 bivalent mRNA doses
- Option to receive 1 additional dose of Moderna COVID-19 Vaccine (0.5 mL/50 ug; dark blue cap and label with a gray border) or Pfizer-BioNTech COVID-19 Vaccine (0.3 mL/30 ug; gray cap and label with a gray border) at least 2 months following the last recommended bivalent COVID-19 vaccine dose.
- Further additional dose(s) may be administered, informed by the clinical judgement of a healthcare provider and personal preference and circumstances. Any further additional doses should be administered at least 2 months after the last COVID-19 vaccine dose.

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromised

COVID-19 vaccination history	Bivalent vaccine	Number of bivalent doses indicated*	Dosage (mL/ug)	Vaccine vial cap and label colors	Interval between doses
Unvaccinated	Moderna† ___or___ Pfizer BioNTech‡	3	0.5 mL/50 ug	Blue cap; gray label border	Dose 1 and Dose 2: 4 weeks Dose 2 and Dose 3: At least 4 weeks
		3	0.3 mL/30 ug	Gray	Dose 1 and Dose 2: 3 weeks Dose 2 and dose 3: At least 4 weeks
1 dose monovalent Moderna	Moderna†	2	0.5 mL/50 ug	Blue cap; gray label border	Dose 1: 4 weeks after monovalent dose Dose 1 and Dose 2: At least 4 weeks
2 doses monovalent Moderna	Moderna†	1	0.5 mL/50 ug	Blue cap; gray label border	At least 4 weeks after last monovalent dose
3 doses monovalent Moderna	Moderna ___or___ Pfizer-BioNTech	1	0.5 mL/50 ug	Blue cap; gray label border	At least 8 weeks after last monovalent dose
		1	0.3 mL/30 ug	Gray	At least 8 weeks after last monovalent dose
3 doses monovalent Moderna and 1 dose bivalent mRNA	—	See footnote	—	—	—
1 dose monovalent Pfizer-BioNTech	Pfizer-BioNTech‡	2	0.3 mL/30 ug	Gray	Dose 1: 3 weeks after monovalent dose Dose 1 and Dose 2: At least 4 weeks
2 doses monovalent Pfizer	Pfizer-BioNTech‡	1	0.3 mL/30 ug	Gray	At least 4 weeks after last monovalent dose
3 doses monovalent Pfizer-BioNTech	Moderna ___or___ Pfizer-BioNTech	1	0.5 mL/50 ug	Blue cap; gray label border	At least 8 weeks after last monovalent dose
		1	0.3 mL/30 ug	Gray	At least 8 weeks after last monovalent dose
3 doses monovalent Pfizer-BioNTech and 1 dose bivalent mRNA	—	See footnote	—	—	—

End of international emergency

Statement on the fifteenth meeting of the IHR (2005) Emergency Committee on the COVID-19 pandemic

The WHO Director-General concurs with the advice offered by the Committee regarding the ongoing COVID-19 pandemic. He determines that COVID-19 is now an established and ongoing health issue which no longer constitutes a public health emergency of international concern (PHEIC).

https://www.who.int/news/item/05-05-2023-statement-on-the-fifteenth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic

What does this mean……

The WHO Emergency Committee believes three things:

1. *COVID-19 is not unusual and unexpected.*
2. *Cross-border transmission can't (and won't) be stopped.*
3. *COVID-19 does not require a coordinated international response.*

Essentially the end of the PHEIC means:

- The end of **mobilizing** international coordination
- The end of **streamlining** international funding
- The end of **accelerating** the advancement of the development of vaccines, therapeutics and diagnostics under emergency use authorization.

YLE. Katelyn Jetelina. May 5, 2023

What this does not mean…

- ***This doesn't mean the end of a pandemic.*** Declaring a PHEIC is not the same thing as declaring the end of a pandemic. "Pandemic" is rhetoric that governments use as a communication tool—it indicates the widespread occurrence of an infectious disease across the globe at a particular time. In theory, the end of a PHEIC comes far before the end of a pandemic.
- ***This doesn't mean that COVID-19 is gone.*** SARS-CoV-2 is currently mutating 2 times faster than the flu. We will get future waves, but hopefully these will be "wavelets" given the population-level immunity from vaccines and infections. And wavelets will happen several times a year. The probability of a variant of concern is still ~20% in the next 1.5 years. If one emerges, it will likely cause a tsunami. (We saw something similar happen after the 1918 flu emergency ended.) And we cannot ignore the fact that COVID-19 is a leading cause of death in many countries. This will likely remain for years.
- ***This doesn't mean that we can go back to pre-pandemic times***. This does not mean that the US does not have serious underlying problems that need to be addressed. It's beyond time to confront the threats to our individual and collective health so we are not in a constant state of emergency. We cannot keep living in a perpetual cycle of panic and neglect.

Adapted from Katelyn Jetelina, YLE May 5, 2023

Adapted from Katelyn Jetelina, YLE May 5, 2023

End of PHE in USA: Impact on surveillance data

The PHE ending means that data flow, from county → nation, is no longer *required*. But this doesn't mean that everything is disappearing:

1. Health departments may still update locally
2. Some health departments are still willing to report data to CDC, even if not required
3. The CDC has sentinel surveillance programs— a set of locations chosen for intensive surveillance. This will allow us to see *trends* but not *counts*

Adapted from Katelyn Jetelina, YLE May 10, 2023

What to expect?

No change:

1. **Wastewater** and **genomic surveillance**, which will allow us to track variants and transmission.
2. **Emergency room data,** which is one of the best early indicators of state-level transmission.

Little change:

1. **Hospitalization** data will remain through April 2024, but frequency of reporting will change. This will help us track severe disease.
2. **Death data** will remain, but the data source is changing.

Greater change:

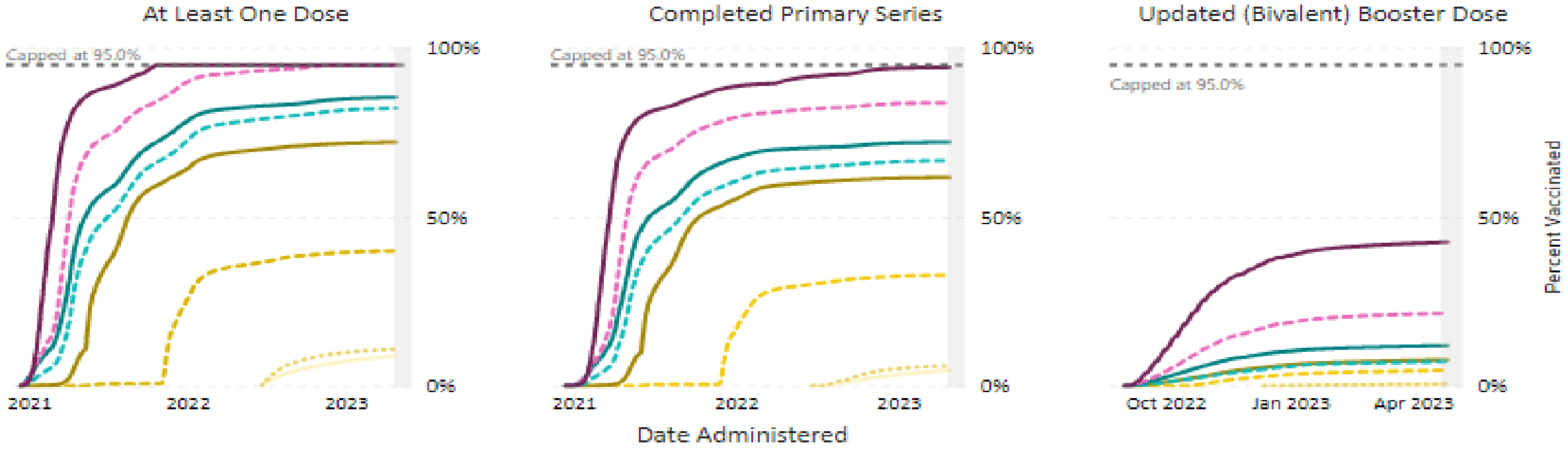
4. **Test positivity rates** —one of our earliest metrics of transmission—will no longer be national, state, or county-wide. Negative tests no longer have to be reported. However, some pharmacies will still report.
5. **Cases** will be dropped. This makes sense given at-home antigen tests.
6. **Vaccination coverage** will be spotty. The frequency of updates will also change.

Adapted from Katelyn Jetelina, YLE May 10, 2023

Percent of People Receiving COVID-19 Vaccine by Age and Date Administered, United States

December 14, 2020 – April 26, 2023

	<2 yrs	2-4 yrs	5-11 yrs	12-17 yrs	18-24 yrs	25-49 yrs	50-64 yrs	+65 yrs
At Least One Dose	8.8%	10.8%	40.0%	72.2%	82.3%	85.5%	95.0%	95.0%
Completed Primary Series	4.6%	6.0%	32.9%	61.8%	66.8%	72.2%	83.8%	94.3%
Updated (Bivalent) Booster Dose	0.6%	0.6%	4.7%	7.7%	7.3%	12.0%	21.5%	42.6%



CDC COVID Data Tracker. https://covid.cdc.gov/covid-data-tracker/#vaccination-demographics-trends

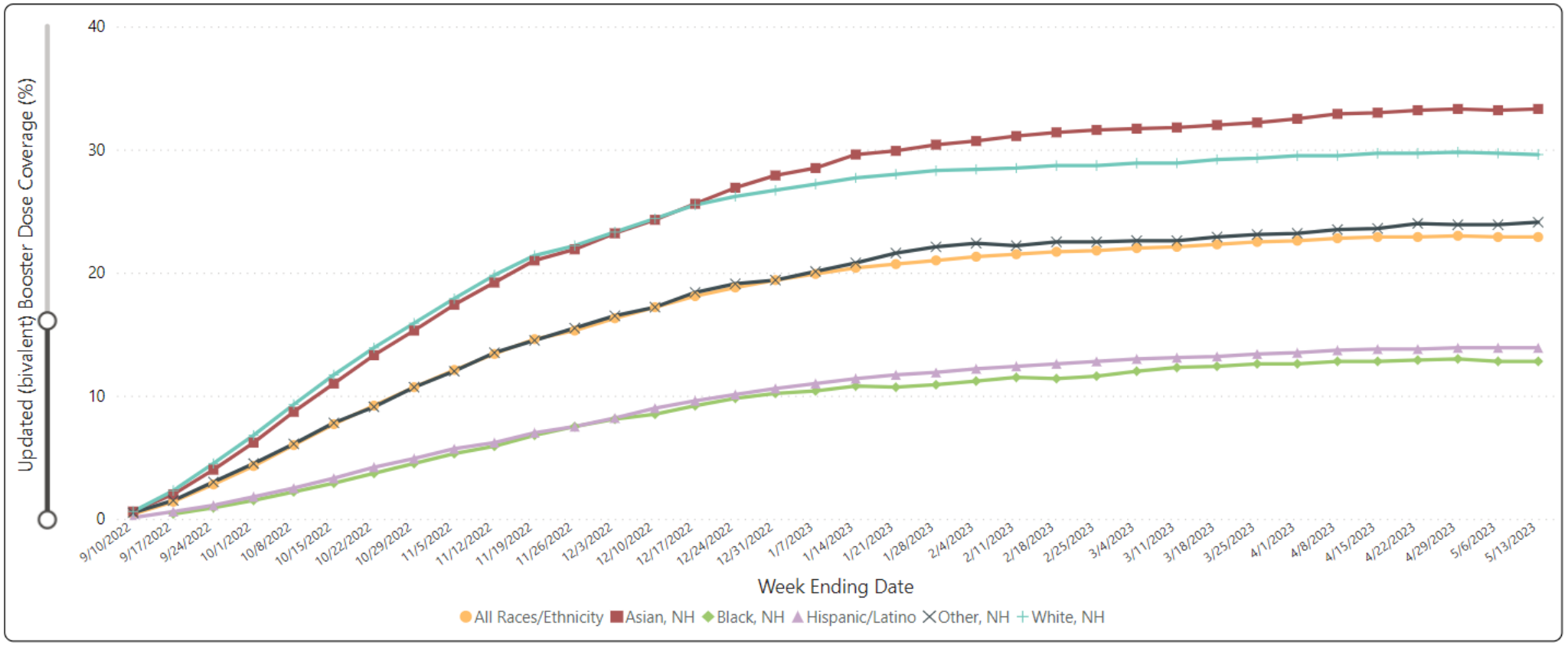
Vaccine Hesitancy Persists

- Cross-sectional survey study of adult patients at 5 safety-net hospital EDs in 4 US cities from mid-January to mid-July 2022
- Of 802 participants, 373 (47%) were women, 478 (60%) were non-White, 182 (23%) lacked primary care, 110 (14%) primarily spoke Spanish, and 370 (46%) were publicly insured. Of the 771 participants who completed their primary series, 316 (41%) had not received a booster vaccine; the primary reason for nonreceipt was lack of opportunity (38%).
- Of the non-boosted participants, **179 (57%) expressed hesitancy**, citing need for more information (25%), concerns about side effects (24%), and the belief that a booster was unnecessary after the initial series (20%). In the multivariable analysis, Asian participants were less likely to be booster hesitant than White participants (adjusted odds ratio [aOR] 0.21, 95% confidence interval [CI] 0.05 to 0.93), non-English-speaking participants were more likely to be booster hesitant than English-speaking participants (aOR 2.35, 95% CI 1.49 to 3.71), and Republican participants were more likely to be booster hesitant than Democrat participants (aOR 6.07, 95% CI 4.21 to 8.75).

https://doi.org/10.1016/j.annemergmed.2023.04.009.

Need to Keep Pregnant Patients in Mind

Figure 3: Percent of Pregnant People Ages 18–49 Years Who Received an Updated (Bivalent) Booster Dose Before or During Pregnancy Overall, by race and ethnicity, and Week Ending date — Vaccine Safety Datalink, September 1, 2022 – May 13, 2023



https://covid.cdc.gov/covid-data-tracker/#vaccinations-pregnant-women

What do we recommend to our patients?

1. Be up to date with COVID-19 vaccinations!

2. The CDC transmission levels data is going away. Moving forward the CDC recommends using hospitalization data to guide behavior.

Alternate suggestion:

Use local wastewater trends to guide recommendations. If rate of detection is trending upwards consider mitigation strategies including masking.

Questions?

Thank you!

Next Session: Thursday, June 15th ,12-1 pm CST

Resources & recording of the session

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

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