Agenda Items

- COVID-19 epi update
- Brief Influenza Update
- *New*: Oregon’s Risk and Protection Framework
- COVID-19 vaccine update
- Monoclonal Ab therapies
- CDC quarantine guideline update
- Literature review (MIS-A)
- Closing
COVID-19 Update
As of December 2:

- 78,160 total cases
- 4,745 hospitalized cases
- 953 deaths
COVID-19 Situation in Oregon

For the week of November 23-29:

- 9,100 new cases were recorded
  - Up 5% from prior week (sixth consecutive week of record highs)
- Hospitalizations increased 8% (another record high)
- Eighty-six Oregonians died in association with COVID-19

From November 22-28:

- 8.6% of test results were positive last week
  - Represents a “test-based” method, whereby all electronic lab reports received by OHA are used to calculate percent positivity
Epidemiologic Link Trends

Figure 1. Epidemiologic link of COVID-19 cases by week of onset

Weekending date

CC  CL  HH  OB  SP
### COVID-19 Cases by Race, Ethnicity

#### Table 3. Severity and rates of COVID-19 by race

<table>
<thead>
<tr>
<th>Race</th>
<th>Cases</th>
<th>% of total cases</th>
<th>Cases per 100,000b</th>
<th>Hospitalized</th>
<th>% Hospitalized</th>
<th>Deaths</th>
<th>Case fatality</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI/AN</td>
<td>1,514</td>
<td>2</td>
<td>3106.4</td>
<td>123</td>
<td>8.1%</td>
<td>16</td>
<td>1.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>2,289</td>
<td>3</td>
<td>1263.9</td>
<td>154</td>
<td>6.7%</td>
<td>23</td>
<td>1.0%</td>
</tr>
<tr>
<td>Black</td>
<td>2,111</td>
<td>2.8</td>
<td>2614.8</td>
<td>157</td>
<td>7.4%</td>
<td>24</td>
<td>1.1%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1,383</td>
<td>1.8</td>
<td>688.1</td>
<td>78</td>
<td>5.6%</td>
<td>25</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other</td>
<td>20,830</td>
<td>27.6</td>
<td>15793</td>
<td>955</td>
<td>4.6%</td>
<td>96</td>
<td>0.5%</td>
</tr>
<tr>
<td>Pacific Is.</td>
<td>881</td>
<td>1.2</td>
<td>5303.4</td>
<td>101</td>
<td>11.5%</td>
<td>10</td>
<td>1.1%</td>
</tr>
<tr>
<td>Not Available</td>
<td>12,189</td>
<td>16.2</td>
<td>323</td>
<td></td>
<td></td>
<td>102</td>
<td>0.8%</td>
</tr>
<tr>
<td>White</td>
<td>34,236</td>
<td>45.4</td>
<td>957.3</td>
<td>2,627</td>
<td>7.7%</td>
<td>616</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total</td>
<td>75,433</td>
<td>100</td>
<td>1780.6</td>
<td>4,518</td>
<td>6.0%</td>
<td>912</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

#### Table 4. Severity and rates of COVID-19 by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Case count</th>
<th>% of total cases</th>
<th>Cases per 100,000a</th>
<th>Hospitalized</th>
<th>% Hospitalized</th>
<th>Deaths</th>
<th>Case fatality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>24,042</td>
<td>31.9%</td>
<td>4421.3</td>
<td>1,079</td>
<td>4.50%</td>
<td>116</td>
<td>0.50%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>36,750</td>
<td>48.7%</td>
<td>995.2</td>
<td>2,787</td>
<td>7.60%</td>
<td>620</td>
<td>1.70%</td>
</tr>
<tr>
<td>Not available</td>
<td>14,641</td>
<td>19.4%</td>
<td>652</td>
<td>4.50%</td>
<td></td>
<td>176</td>
<td>1.20%</td>
</tr>
<tr>
<td>Total</td>
<td>75,433</td>
<td>100%</td>
<td>1780.6</td>
<td>4,518</td>
<td>6%</td>
<td>912</td>
<td>1.20%</td>
</tr>
</tbody>
</table>
Hospital COVID Census: Statewide Trends

[Graph showing hospital COVID census trends over time, with lines representing different categories of patients.]
Hospital COVID Census: Regional Trends

COVID-positive patients in Oregon hospitals

[Graph showing the number of COVID-positive patients in Oregon hospitals by date, with a significant increase in late November/early December.]

[Map of Oregon showing regions 1 to 9, with different colors for each region.]

© 2020 Mapbox © OpenStreetMap
Brief Influenza Update
Influenza Activity: Flu Bites

<table>
<thead>
<tr>
<th>Data at a Glance</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 15—November 21, 2020 (Week 47)</td>
</tr>
<tr>
<td>Current Week (47)</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Percentage of emergency department visits for ILI&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Percentage positive influenza tests&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Portland tri-county influenza-associated hospitalizations&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Portland tri-county COVID-19-associated hospitalizations&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Reported influenza outbreaks</td>
</tr>
<tr>
<td>Influenza-associated pediatric mortality</td>
</tr>
<tr>
<td>Respiratory Syncytial Virus (RSV) activity&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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<sup>1</sup> Based on Oregon ESSENCE Syndromic Surveillance. Data represent statewide aggregate percent.

<sup>2</sup> Percent positivity based on data from Oregon reporters to the National Respiratory and Enteric Virus Surveillance System (NREVSS)

<sup>3</sup> Based on hospitalization surveillance in Clackamas, Multnomah, and Washington counties only.

<sup>4</sup> Percent positivity based on data from Oregon’s RSV Laboratory Surveillance System.

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Subscribe to OHA’s FluBites: [https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Pages/surveil.aspx](https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Pages/surveil.aspx)
Influenza Tests Results Nov 15- Nov 21

Table 1. Influenza Test Results in Oregon, NREVSS, Current Week, 2020–2021 Season

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Tests</th>
<th>Positive No.</th>
<th>Positive (%)</th>
<th>Flu A No.</th>
<th>Flu A (%)</th>
<th>Flu B No.</th>
<th>Flu B (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portland Metro</td>
<td>1477</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Southern Oregon</td>
<td>416</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Columbia Gorge</td>
<td>90</td>
<td>5</td>
<td>5.6%</td>
<td>1</td>
<td>20.0%</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td>Central Oregon</td>
<td>419</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Willamette Valley</td>
<td>121</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>State Total</strong></td>
<td><strong>2523</strong></td>
<td><strong>5</strong></td>
<td><strong>0.2%</strong></td>
<td><strong>1</strong></td>
<td><strong>20.0%</strong></td>
<td><strong>4</strong></td>
<td><strong>80.0%</strong></td>
</tr>
</tbody>
</table>

Subscribe to OHA’s FluBites: [https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Pages/surveil.aspx](https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Pages/surveil.aspx)
Influenza Immunizations by Week

Figure 7. 2020-21 Season Oregon Flu Vaccine Doses in ALERT IIS by Week

Figure 8: 2020-21 Flu Vaccination in ALERT IIS by Week, Cumulative Doses Compared to Last Season
New: Oregon’s Risk and Protection Framework
Oregon’s Risk and Protection Framework

Effective 12/3: Oregon’s Risk and Protection Framework

This new health and safety framework uses four different risk levels for counties based on their level of COVID-19 spread—Extreme Risk, High Risk, Moderate Risk, and Lower Risk—effective December 3.

On Monday, November 30, the Oregon Health Authority will reexamine county data to determine which counties qualify for each risk level on December 3, following the end of the 2-Week Freeze. In each subsequent two-week period, the Oregon Health Authority will examine and publish county data weekly, but county risk levels will not change until the end of the second week. In the first week, counties will be given Warning Week data to prepare for potential risk level changes. In the second week, county risk levels will be updated based on that week’s data. More detailed information will be posted before December 3.

<table>
<thead>
<tr>
<th>Disease Metrics (Table)</th>
<th>County Risk Levels (Table)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidance by Activity (Table)</td>
<td>County Risk Levels (Map)</td>
</tr>
</tbody>
</table>

https://govstatus.egov.com/or-covid-19/
## Oregon COVID-19 Disease Metrics

<table>
<thead>
<tr>
<th>Disease Activity</th>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
<th>Extreme Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of COVID-19 cases per 100,000 over 14 days (counties with 30,000 or more people)</td>
<td>&lt;50.0</td>
<td>50.0 to &lt;100.0</td>
<td>100.0 to &lt;200.0</td>
<td>≥200.0</td>
</tr>
<tr>
<td>- or -</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of COVID-19 cases over 14 days (counties with less than 30,000 people)</td>
<td>&lt;30</td>
<td>30 to &lt;45</td>
<td>45 to &lt;60</td>
<td>≥60</td>
</tr>
<tr>
<td>- and -</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage test positivity over previous 14 days</td>
<td>&lt;5.0%</td>
<td>5.0% to &lt;8.0%</td>
<td>8.0% to &lt;10.0%</td>
<td>≥10.0%</td>
</tr>
</tbody>
</table>
County Risk Levels: MAP
# Sector Risk Level Guidance (snapshot)

## Sector Risk Level Guidance Chart

<table>
<thead>
<tr>
<th>Activities</th>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
<th>Extreme Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social and At-Home Gathering Size —</td>
<td>Maximum 10 people</td>
<td>Maximum 8 people</td>
<td>Maximum 6 people</td>
<td>Maximum 6 people</td>
</tr>
<tr>
<td>Indoor</td>
<td>Recommended limit: 4 households</td>
<td>Recommended limit: 2 households</td>
<td>Recommended limit: 2 households</td>
<td>Recommended limit: 2 households</td>
</tr>
<tr>
<td>Social and At-Home Gathering Size —</td>
<td>Maximum 12 people</td>
<td>Maximum 10 people</td>
<td>Maximum 8 people</td>
<td>Maximum 6 people</td>
</tr>
<tr>
<td>Outdoor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating and Drinking Establishments</td>
<td>Indoor dining allowed</td>
<td>Indoor dining allowed</td>
<td>Indoor dining allowed</td>
<td>Indoor dining prohibited</td>
</tr>
<tr>
<td></td>
<td>Indoor capacity: not to exceed 50% maximum occupancy</td>
<td>Indoor capacity: not to exceed 50% maximum occupancy or 100 people, whichever is smaller</td>
<td>Takeout highly recommended</td>
<td>Outdoor dining allowed</td>
</tr>
<tr>
<td></td>
<td>Outdoor dining allowed</td>
<td>Indoor seating: 6 people per table maximum</td>
<td>Outdoor dining allowed</td>
<td>Outdoor dining allowed</td>
</tr>
<tr>
<td></td>
<td>Outdoor capacity: 300 people maximum</td>
<td>Outdoor dining allowed</td>
<td>Outdoor capacity: 75 people maximum</td>
<td>Outdoor capacity: 50 people maximum</td>
</tr>
<tr>
<td></td>
<td>Indoor and outdoor seating: 8 people per table maximum</td>
<td>Outdoor capacity: 150 people maximum</td>
<td>Outdoor seating: 6 people per party and per table maximum, limit 2 households</td>
<td>Outdoor capacity: 50 people maximum</td>
</tr>
<tr>
<td></td>
<td>12:00 a.m. closing time</td>
<td>Outdoor seating: 8 people per table maximum</td>
<td>11:00 p.m. closing time</td>
<td>11:00 p.m. closing time</td>
</tr>
<tr>
<td>Indoor Recreation and Fitness</td>
<td>Capacity: Maximum 50% occupancy</td>
<td>Capacity: Maximum 50% occupancy or 100 people total, whichever is smaller</td>
<td>Capacity: Maximum 25% occupancy or 50 people total, whichever is smaller</td>
<td>Prohibited</td>
</tr>
<tr>
<td>Establishments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes gyms, fitness organizations,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>indoor recreational sports, indoor pools)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[https://govstatus.egov.com/or-covid-19/](https://govstatus.egov.com/or-covid-19/)
COVID-19 Vaccine Update
mRNA vaccines

**Pfizer**
- mRNA codes for prefusion spike protein
- 2 doses 21 days apart
- Vaccine Effectiveness = 95%
- 162 cases of symptomatic disease in placebo; 8 in vaccine group
- 10 cases of severe disease; 9 in placebo, 1 in vaccine group
- Effectiveness in those over 65 years old = 94%
- Requires ultra-cold transport

**Moderna**
- mRNA codes for prefusion spike protein
- 2 doses 28 days apart
- Vaccine Effectiveness=94.1%
- 185 cases of symptomatic disease in placebo; 11 in vaccine group
- 30 cases of severe COVID and 1 death, all in placebo group
- No difference in effectiveness by age or ethnicity
- Normal freezer temp
Non-Relicating Viral Vector Vaccine  
AstraZenica (AZD1222)

• How it works: It adds DNA that code for the SARS-CoV-2 spike protein into a weakened cold virus (Simian adenovirus) that infects human cells and hijacks the cellular mechanism to produce the spike protein.

  – 11,000+ volunteers (2,744 in UK and 8,895 in Brazil) showed an average efficacy of 70%
  – 2 different dosing regimens showed between 62-90% effectiveness
  – No hospitalization or severe cases of COVID-19 in participants given AZD1222 vaccine
  – No serious safety events related to the vaccine have been confirmed. AZD1222 was well tolerated across both dosing regimens
  – 2 shots 28 days apart- Store in normal refrigerator
What is different AZ vs mRNA vaccine trials?

- Endpoints: AZ- used weekly swabs to detect infection whereas the mRNA trials looked at prevention of symptomatic disease. (AZ endpoint may be better at determining the ability to stop transmission)
- AZ used a meningitis vaccine for the placebo with the first immunization vs saline in the mRNA trials
- Cost: AZ $3-$4 /dose vs $20-$30/dose for the mRNA vaccines
- AZD 1222 was paused in July and September after 2 volunteers reported neurologic symptoms – investigators found no link to the vaccine. Like the mRNA vaccines the AZ company reports no serious safety events
Factors Affecting Timeline

- EUA submission (Pfizer-current, Moderna- 11/30/20, AstraZenica – coming soon)
- Vaccines and Related Biological Products Advisory Committee (VRBPAC) – Advises the FDA- Meets December 8,9 and 10 to review the Pfizer EUA application and December 17 to consider the Moderna EUA
- Advisory Committee on Immunization Practices (ACIP) – Advises the CDC regarding the guidelines for usage. This process begins simultaneously while VRBPAC committee is deliberating but their guidelines come out after official FDA authorization.
- Western States Scientific COVID-19 Vaccine Safety Workgroup- Also will work concurrently with other committees
- Pfizer vaccine is scheduled to be shipped to Oregon December 15 and Moderna as early as December 21
Expectations and Hopes

• The US Government has purchased 100 million doses of each mRNA vaccine and 300 million of the AZ vaccine with an option to purchase more.

• Timeline is uncertain but supposedly the US will get these cumulative doses by April/May 2021
  o 22 million Pfizer and 18 million Moderna in December
  o 30 million Pfizer and 20 million Moderna in January
  o 35 million Pfizer and 25 million Moderna in February and March – This should take us through most of the 1a and 1b groups.

• Additional vaccines may speed this timeline.
  o AstraZenica- Will likely apply for an EUA soon
  o Jannsen- Will likely have interim analysis readout by early January which might let them apply for EUA
Phase 1a group for vaccination

- Frontline healthcare workers and staff - hospital based
- EMS providers who care for patients
- Residents and workers in long-term and congregate care settings (this will be done through the federal-pharmacy partnership)
- HCWs and staff in out-patient settings

- Do not give vaccine within 90 days of a known COVID-19 infection
Oregon’s Initial Allocations and Implications

- Allocation is based on a pro rata (population based) basis. Oregon has roughly 2% of the US population.
- It appears that with initial allocations of Pfizer and Moderna vaccines Oregon will be given enough vaccine to fully vaccinate over 100K HCWs and staff in December (though to fully vaccinate this group will extend into January).
- This number will be inadequate to cover all healthcare workers and others in group 1a.
- Some sub-prioritization will be necessary.
- Most, if not all, hospitals will likely receive the Pfizer ultra-cold mRNA vaccine.
- A hub and spoke distribution method is being developed to address the ultra-cold requirement for the Pfizer vaccine.
Provider Office Hours and Web Resources

Topic: **COVID-19 Vaccine Office Hours**

- **Monday Noon-1pm**
- **Wednesdays**
  - Dec 2, 2020 07:00 AM
  - Dec 9, 2020 07:00 AM
  - Dec 16, 2020 07:00 AM
  - Dec 23, 2020 07:00 AM
  - Dec 30, 2020 07:00 AM

- Please download and import the following iCalendar (.ics) files to your calendar system.
- Weekly:
  - https://www.zoomgov.com/meeting/vJlsceurrDwtHFyV0M_Cmc4WB7OSsbRRd8k/ics?icsToken=98tyKuiurz0oGdaStx_Bei86FYn4bOnIFlWjmjLprzDLalC1QNjTUYc1xibBNltyl
  - Join ZoomGov Meeting
  - https://www.zoomgov.com/j/1616232776?pwd=cGs0NDA4UjV3UVhyd3BvOFNKWDArUT09
  - Meeting ID: 161 623 2776
  - Passcode: 813375

[Link to Oregon Health Authority](https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRESOURCES/Pages/COVIDvaccine.aspx)
References

• Moderna press release https://www.modernatx.com/cove-study
• ACIP slide review of Phase 3 trials https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-08/COVID-07-Oliver.pdf
• ACIP guidelines for Ethical framework for vaccine allocation MMWR%20Allocation%20guidelines%202020
• National Academies Framework for Equitable Allocation of Coronavirus Vaccine Framework%20for%20Equitable%20Allocation%20of%20COVID-19%20Vaccine_Highlights%202020
• Pfizer release https://www.Pfizer.com/science/coronavirus/vaccine
References

• Moderna Primate Challenge study:

• Moderna mRNA 1273 Phase 1 Trial results
    DOI: 10.1056/NEJMoa2022483

• Moderna’s press release on EUA submission:
Monoclonal Antibody Therapies
Bamlanivimab, Casirivimab + Imdevimab
Monoclonal Antibody mAb

- Several manufacturers have produced neutralizing monoclonal antibodies (mAbs) targeting the SARS-CoV-2 virus
- mAbs are most effective when given early in the course of COVID-19 disease and help prevent progression
- Most target the coronavirus spike protein binding domain and prevent viral penetration into cells
- On November 9, 2020, Eli Lily received an Emergency Use Authorization (EUA) for its monoclonal antibody therapy, bamlanivimab
- On November 21, 2020 Regeneron received an EUA for its monoclonal antibody cocktail, Casirivimab and Imdevimab
Major Points:

- This phase 2 trial showed a decline in viral load after a single infusion with one of three doses of bamlanivimab.
  - This decline was only statistically significant in comparison to placebo for the 700-mg dose (i.e., the middle dose studied).

- Secondary outcomes:
  - On Day 29, the percentage of patients who were hospitalized with COVID-19 was 1.6% (5 of 309 patients) in the treatment group compared to 6% (9 of 143 patients) in the placebo group.
  - Among patients 65 years and older and those with BMI of 35 or more: the percentage of hospitalization was 4% in the treatment group (4 of 95) compared to 15% in the placebo group (7 of 48 patients)

- Safety profile showed 1 case of anaphylaxis and risk for infusion reaction.
Casirivimab + Imdevimab Combination

• The data for efficacy are scant and unpublished
  – Triple-arm randomized, double-blind placebo-controlled study with 799 non-hospitalized adults with mild to moderate COVID-19
    • 266 received single IV dose of 2,400 mg (1,200 of each Ab)
    • 267 received 8000mg (4000mg of each Ab) and 266 -placebo.
    • Doses given within 3 days of positive test.
  – The primary endpoint showed decreased viral load in treated groups compared with placebo
  – The reason for the EUA: In a small subset of the volunteers at high risk (78 patients), the treatment group had a lower risk of ER or hospital visits within 28 days of treatment
    • 3% in the treated group vs. 9% in the placebo group
  – Dose did not seem to make a difference with regards to viral load or ER/hospital visits, so the company is marketing the 2,400 mg dose.
EUA: Eligibility and Exclusions

Bamlanivimab and the combination of Casirivimab and Imdevimab have been authorized for treatment of **COVID-19 test-positive, symptomatic adults and children over age 12** who weigh at least 40kg:

- With mild to moderate disease
- Early in the course of the disease (w/i 10 days of symptom onset)
- With the following additional risk factors:
  - Body mass index (BMI) ≥35 or
  - Are ≥65 years of age or
  - Have a chronic medical condition from a predetermined list

These patients are **excluded** from treatment at this time:

- Patients hospitalized due to COVID-19, or
- Patients requiring oxygen therapy due to COVID-19, or
- Patients on chronic oxygen therapy who require an increase in baseline oxygen flow rate due to COVID-19
Administration of Monoclonal Therapies

- Must be administered intravenously over 1 hour
- Must be observed for 1-hour post-infusion to observe for adverse events
- May only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the emergency medical system (EMS), as necessary.
Reservations and feedback

• Ongoing concerns about the **data informing both EUAs** – secondary analyses with only effect noted on hospitalizations in subgroups

• Ongoing challenges with **logistics** of delivering the product – infusion, time incurred, training of personnel

• Ongoing concerns about **alternatives** such as the vaccine in relationship to the availability of this product
Current Plan for Allocation

• Fulfill existing requests for doses by hospital systems across the state
• Target broader group of health systems including those representing outpatient settings including:
  – Home health agencies
  – Long term care facilities
  – Surge capacity facilities (SNFs)
  – Dialysis Units
• Continue consideration of the following in ongoing allocation:
  – Ensuring access for those disproportionately impacted by COVID-19
  – Ensuring geographic equity in distribution
  – Reducing hospital burden in heavily impacted regions
References:

- Fact Sheet for Patients, Parents and Caregivers: [https://www.fda.gov/media/143604/download](https://www.fda.gov/media/143604/download)
- FDA FAQ regarding the EUA: [https://www.fda.gov/media/143605/download](https://www.fda.gov/media/143605/download)
References

• FDA Emergency Use Authorization: Regeneron: Casirivimab and Imdevimab  https://www.fda.gov/media/143891/download
• FAQ’s regarding Casirivimab and Imdevimab: https://www.fda.gov/media/143894/download
• Fact Sheets for Providers and Patients, Parents and Caregivers:
• Article on how Mab cocktails prevent résistance: A. Baum et al., Science 10.1126/science.abd0831 (2020).
CDC Quarantine Guideline Update
CDC Quarantine Guideline Update

• December 2, 2020 Update
• Quarantine is used to separate someone who might have been exposed to COVID-19 and may develop illness away from other people
• CDC currently recommends a quarantine period of 14 days. However, based on local circumstances and resources, the following options to shorten quarantine are acceptable alternatives.
  – 1) Quarantine can end after Day 10 without testing and if no symptoms have been reported during daily monitoring.
    • With this strategy, residual post-quarantine transmission risk is estimated to be about 1% (range 0.1%-10.6%)
CDC Quarantine Guideline Update

- 2) *When diagnostic testing resources are sufficient and available*, then quarantine can end after Day 7 if a diagnostic specimen tests negative and if no symptoms were reported during daily monitoring. The specimen may be collected and tested within 48 hours before the time of planned quarantine discontinuation (e.g., in anticipation of testing delays), but quarantine cannot be discontinued earlier than after Day 7.
  - With this strategy, the residual post-quarantine transmission risk is estimated to be about 5% with an upper limit of about 12%.
  - In both cases, additional criteria (e.g., continued symptom monitoring and masking through Day 14) must be met (see next slide)
CDC Quarantine Guideline Update

• Persons can discontinue quarantine at these time points only if the following criteria are also met:
  – No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the entirety of quarantine up to the time at which quarantine is discontinued; and,
  – Daily symptom monitoring continues through quarantine Day 14; and,
  – Persons are counseled regarding the need to adhere strictly through quarantine Day 14 to all recommended non-pharmaceutical interventions especially. They should be advised that if any symptoms develop, they should immediately self-isolate and contact the local public health authority or their healthcare provider to report this change in clinical status.
CDC Quarantine Guideline Update

• Testing for the purpose of earlier discontinuation of quarantine should be considered only if it will have no impact on community diagnostic testing. Testing of persons seeking evaluation for infection must be prioritized.

• Persons can continue to be quarantined for 14 days without testing per existing recommendations. This option maximally reduces risk of post-quarantine transmission risk and is the strategy with the greatest collective experience at present.
CDC Quarantine Guideline Update

• Rationale:
  – Longer quarantine periods may result in personal/financial hardship that may reduce compliance
  – Implementing quarantines can also pose additional burdens on public health systems and communities, especially during periods when new infections, and consequently the number of contacts needing to quarantine, are rapidly rising
  – The prospect of quarantine may dissuade recently diagnosed persons from naming contacts and may dissuade contacts from responding to contact tracer outreach if they perceive the length of quarantine as onerous

• Evidence
  – Several pre-print articles referenced but not available for review
COVID-19 Literature Updates
Multisystem Inflammatory Syndrome in Adults (MIS-A)

• MMWR, October 9, 2020; Case Series of Multisystem Inflammatory Syndrome in Adults Associated with SARS-CoV-2 Infection — United Kingdom and United States, March–August 2020
  – N=27 patients
  – Working MIS-A case definition used in this report:
    • a severe illness requiring hospitalization in a person aged ≥21 years;
    • a positive test result for current or previous SARS-CoV-2 infection (nucleic acid, antigen, or antibody) during admission or in the previous 12 weeks;
    • severe dysfunction of one or more extrapulmonary organ systems (e.g., hypotension or shock, cardiac dysfunction, arterial or venous thrombosis or thromboembolism, or acute liver injury);
    • laboratory evidence of severe inflammation (e.g., elevated CRP, ferritin, D-dimer, or interleukin-6); and
    • absence of severe respiratory illness (to exclude patients in which inflammation and organ dysfunction might be attributable simply to tissue hypoxia).
Multisystem Inflammatory Syndrome in Adults (MIS-A)

- Ages 21-50; all but one of the patients with MIS-A described in this report belonged to racial or ethnic minority groups
- If patients had preceding COVID symptoms, MIS-A symptoms were reported 2-5 weeks later
- Antibody testing was required to identify SARS-CoV-2 infection in approximately one third of 27 cases.
- Treatment was with intravenous immunoglobulin, corticosteroids, or the interleukin-6 inhibitor tocilizumab
- 10 patients required intensive care
- 3 of 27 patients died
- Clinicians and health departments should consider MIS-A in adults with compatible signs and symptoms. These patients might not have positive SARS-CoV-2 PCR or antigen test results, and antibody testing might be needed to confirm previous SARS-CoV-2 infection.
Upcoming Health Care Provider Sessions on COVID-19

Dec 3: OHA COVID-19 Information Session for HCPs*
Dec 10: Project Echo COVID-19 Response for Clinicians Part II^
Jan 6: OHA COVID-19 Information Session for HCPs*

*Oregon Health Authority COVID-19 Information Sessions for Oregon Health Care Providers
– Session information, slides and recordings at:
  www.healthoregon.org/coronavirushcp

^OHSU’s COVID-19 Response ECHO for Oregon Clinicians Part 2
– https://connect.oregonechonetwork.org/Series/Registration/278
Thank you