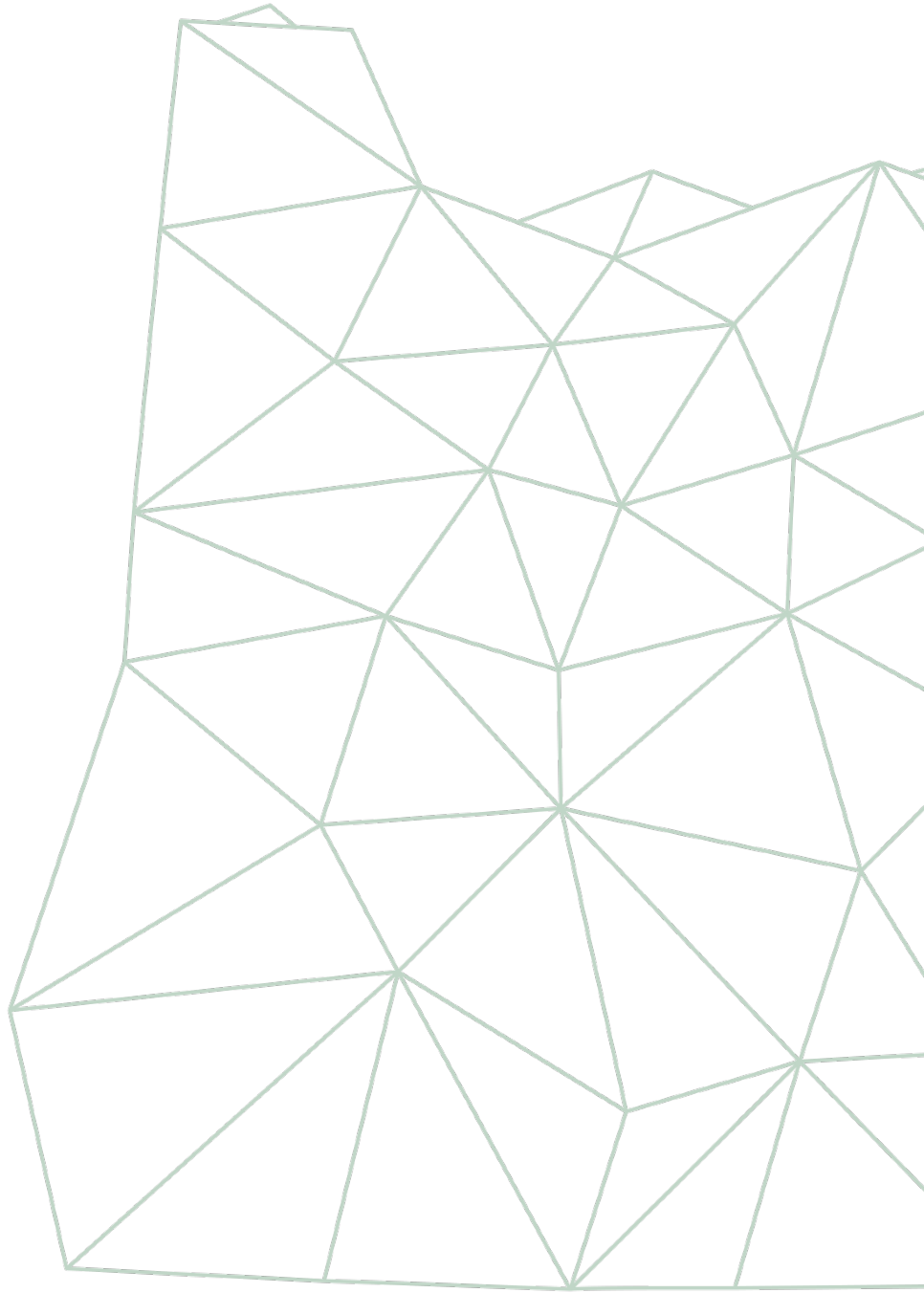
Project ECHO®
Oregon ECHO Network



SPECIAL Part 2

COVID-19 Response ECHO for Oregon Clinicians

Session 12 December 10, 2020

"Hope" is the thing with feathers-
That perches on the soul-
And sings the tune without the words-
And never stops- at all -

-Emily Dickenson

"You can cut all the flowers,
but you can not keep Spring from coming"

- Pablo Neruda

Oregon Health Authority

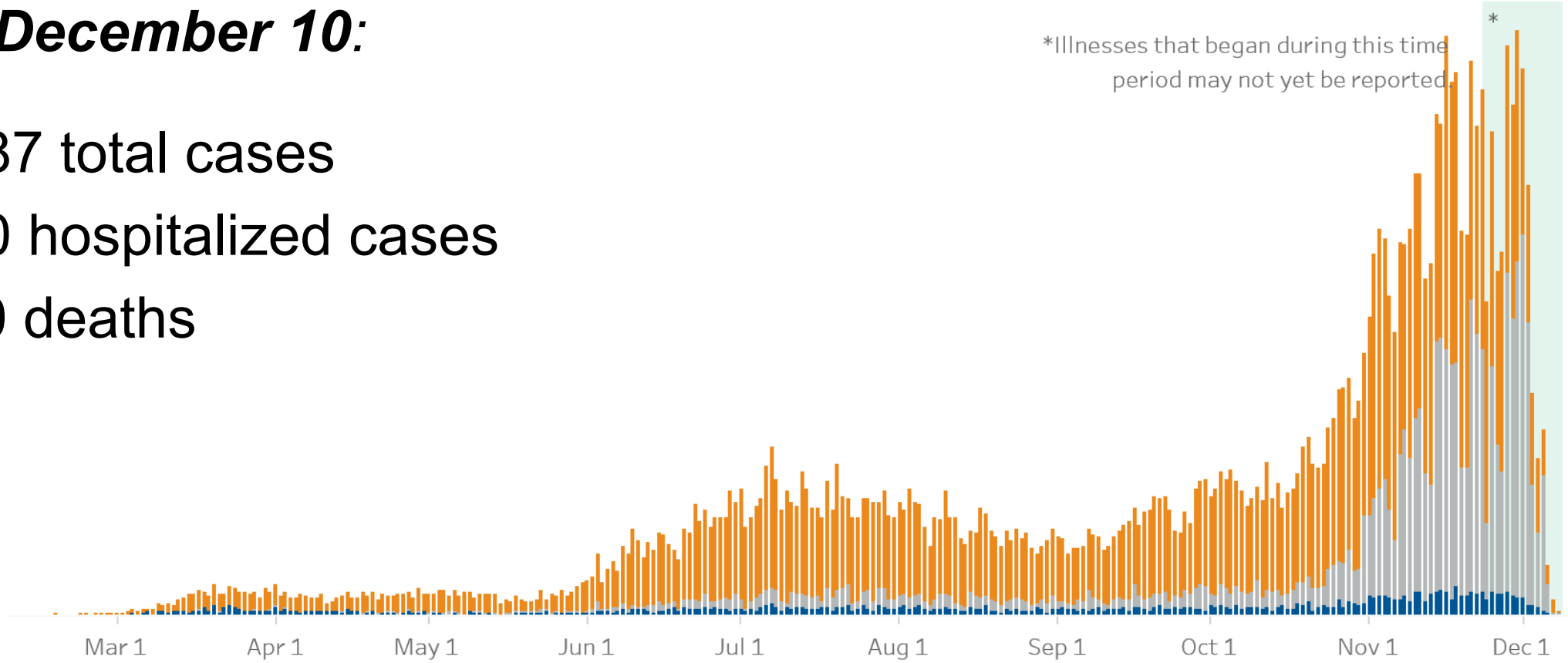
COVID-19 Update, December 10, 2020

Dana Hargunani, MD, MPH
Tom Jeanne, MD, MPH
Joe Sullivan, MD, MPH

Ongoing COVID-19 Pandemic

As of December 10:

- 88,287 total cases
- 5,240 hospitalized cases
- 1,110 deaths



Weekly COVID-19 Report

For the week of ***November 30 - December 6:***

10,355 new cases were recorded.

- Up 14% from prior week (seventh consecutive week of record highs)

Hospitalizations increased 8% (another record high).

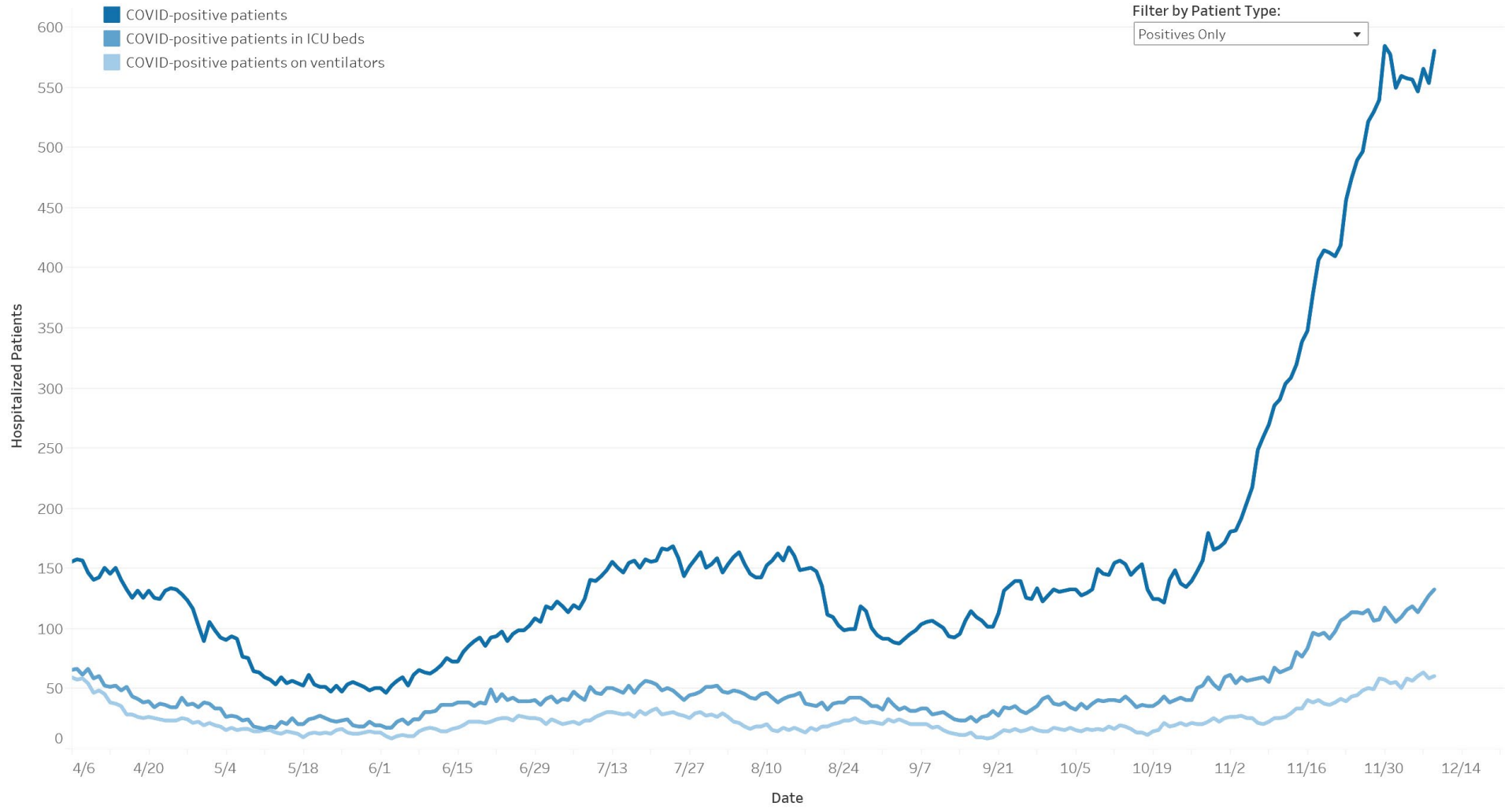
Eighty-six Oregonians died in association with COVID-19.

From ***November 29 December 5***:

8.1% 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

Surge in Hospital COVID Census: December 10



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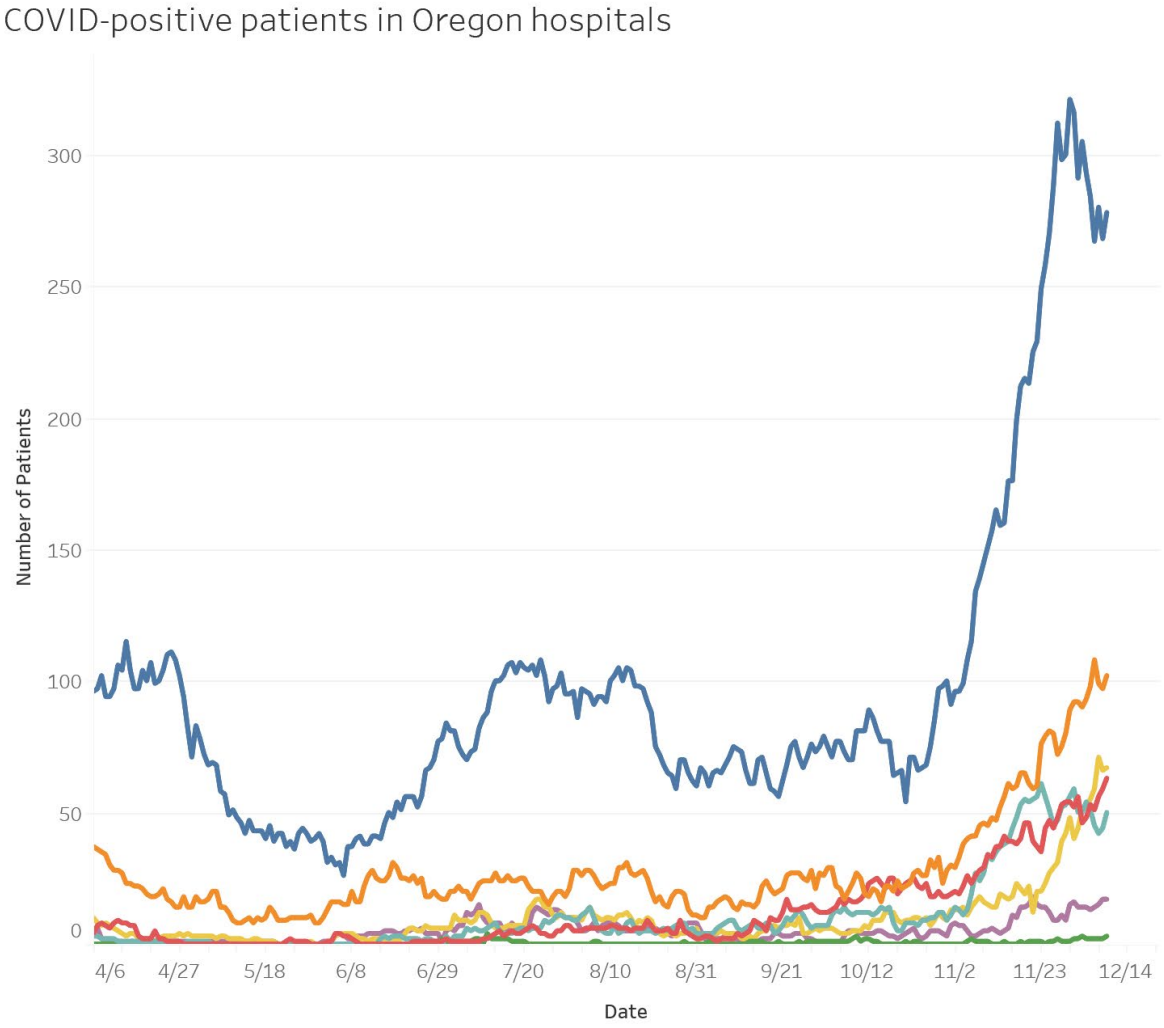
COVID-19 Patient Census by Region: December 10



NEW Principles in Promoting Health Equity During Resource Constrained Events

Our goal is for hospitals to continue to have adequate resources to provide usual standard of care for all patients. However, during public health crises such as this pandemic, health care demands may overwhelm capacity to offer potentially life-saving care to all who need it.

Our hope is that Oregon never faces such constraints in health care resources that require crisis standards of care. However, if that situation arises, we want our health systems to be guided by the following principles:

- **Non-discrimination**
- **Health equity**
- **Patient-led decision making**
- **Transparent communication**

https://www.oregon.gov/oha/ERD/Pages/NewEquityDrivenCrisisCarePrinciplesSupportSurgePlanning.aspx

NEW: 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.

Disease Metrics (Table)

County Risk Levels (Table)

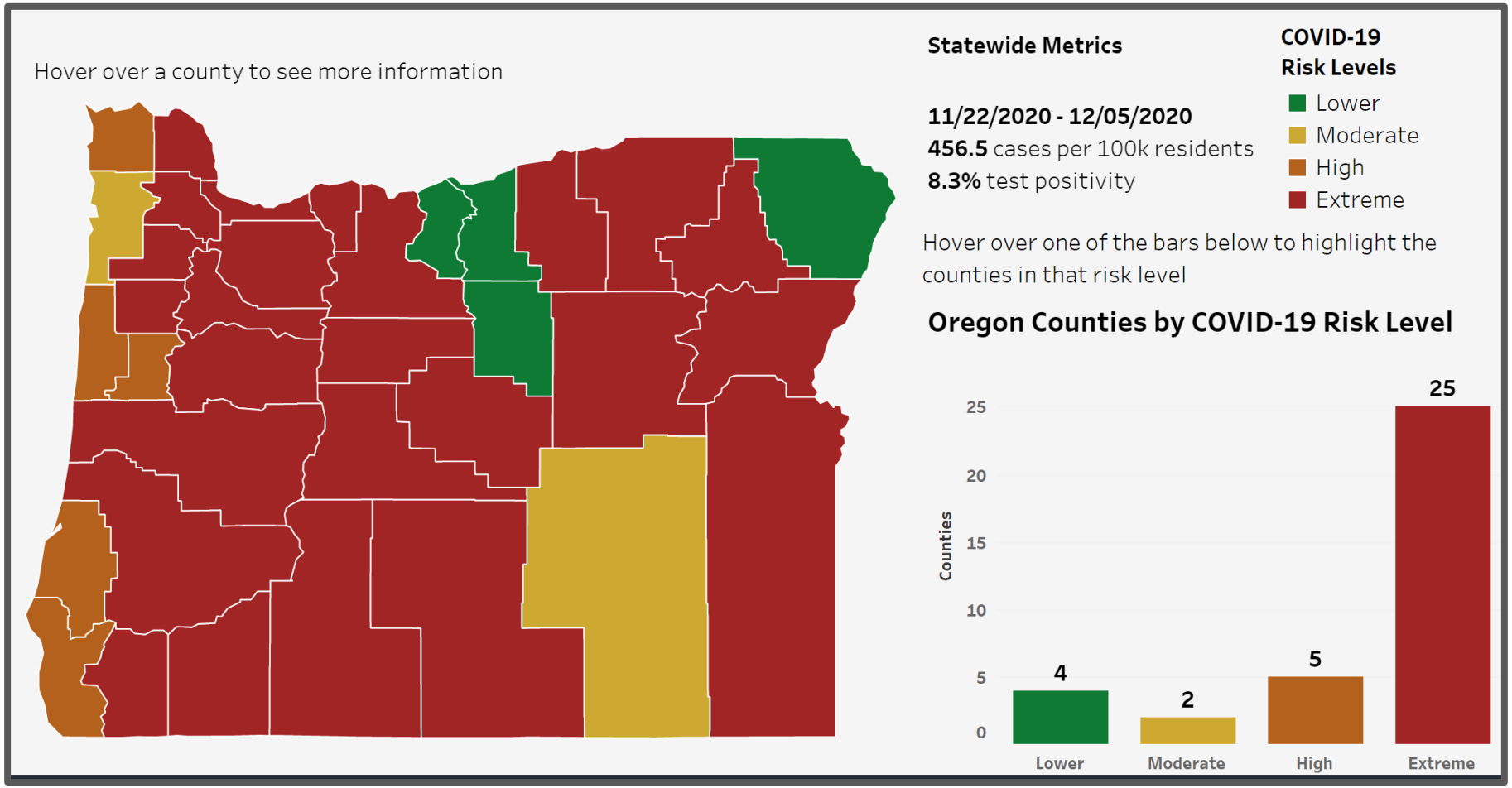
Guidance by Activity (Table)

County Risk Levels (Map)

Oregon COVID-19 Disease Metrics

Disease Activity	Lower Risk	Moderate Risk	High Risk	Extreme Risk
Rate of COVID-19 cases per 100,000 over 14 days (counties with 30,0000 or more people)	<50.0	50.0 to <100.0	100.0 to < 200.0	≥200.0
-or-				
Number of COVID-19 cases over 14 days (counties with less than 30,000 people)	<30	30 to <45	45 to <60	≥60
-and-				
Percentage test positivity over previous 14 days	<5.0%	5.0% to <8.0%	8.0% to <10.0%	≥10.0%

Map: County Risk Levels



https://public.tableau.com/profile/oregon.health.authority.covid.19#!/vizhome/OregonCOVID-19PublicHealthIndicators/Risk

Sector Risk Level Guidance (Excerpt)

Sector Risk Level Guidance Chart

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

CDC Quarantine Guideline Update

December 2, 2020 Update

https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-options-to-reduce-quarantine.html

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 health care 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

New: Updates to OHA's Clinical Care and Health Care Infection Prevention and Control Guidance

Recent Changes:

- **Personal protective equipment:** Directs to CDC language regarding use of PPE in health care settings. PPE requirements for aerosol-generating procedures adjusted, based on level of community COVID-19 transmission. Provides additional guidance related to the use of PPE in moderate to high-community transmission scenarios.
- **Health care personnel identified as contacts:** Clarifies that health care personnel identified as close contacts of COVID-19 cases may work during their quarantine period as long as they remain asymptomatic and practice source control. They should observe quarantine outside of work. High-risk exposures are listed to guide work exclusion decision-making.
- **Health care personnel identified as cases:** Allows risk assessment to guide notification of contacts of health care personnel identified as cases, provided strict criteria are met.
- **Temporary suspension of contact tracing:** Allows health care systems to temporarily suspend contact tracing when county COVID-19 risk level is extreme and staffing is insufficient to maintain this work.

New: Updates to OHA's Clinical Care and Health care Infection Prevention and Control Guidance

Oregon OSHA adopted a temporary administrative rule (OAR 437-001-0744) addressing COVID-19 Workplace Risks. The requirements in the rule were written with the intent to mitigate COVID-19 in all workplaces in Oregon. It is important to be familiar with OAR 437-001-0744, as several work practices addressed in this guidance are required by provisions in the rule. Language in this document is intended to provide context and direction around infection prevention and control practices in our state and does not exempt from provisions in the rule.

Updated guidance can be found at:
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2288J.pdf

Oregon COVID-19 Vaccine Update
Project ECHO

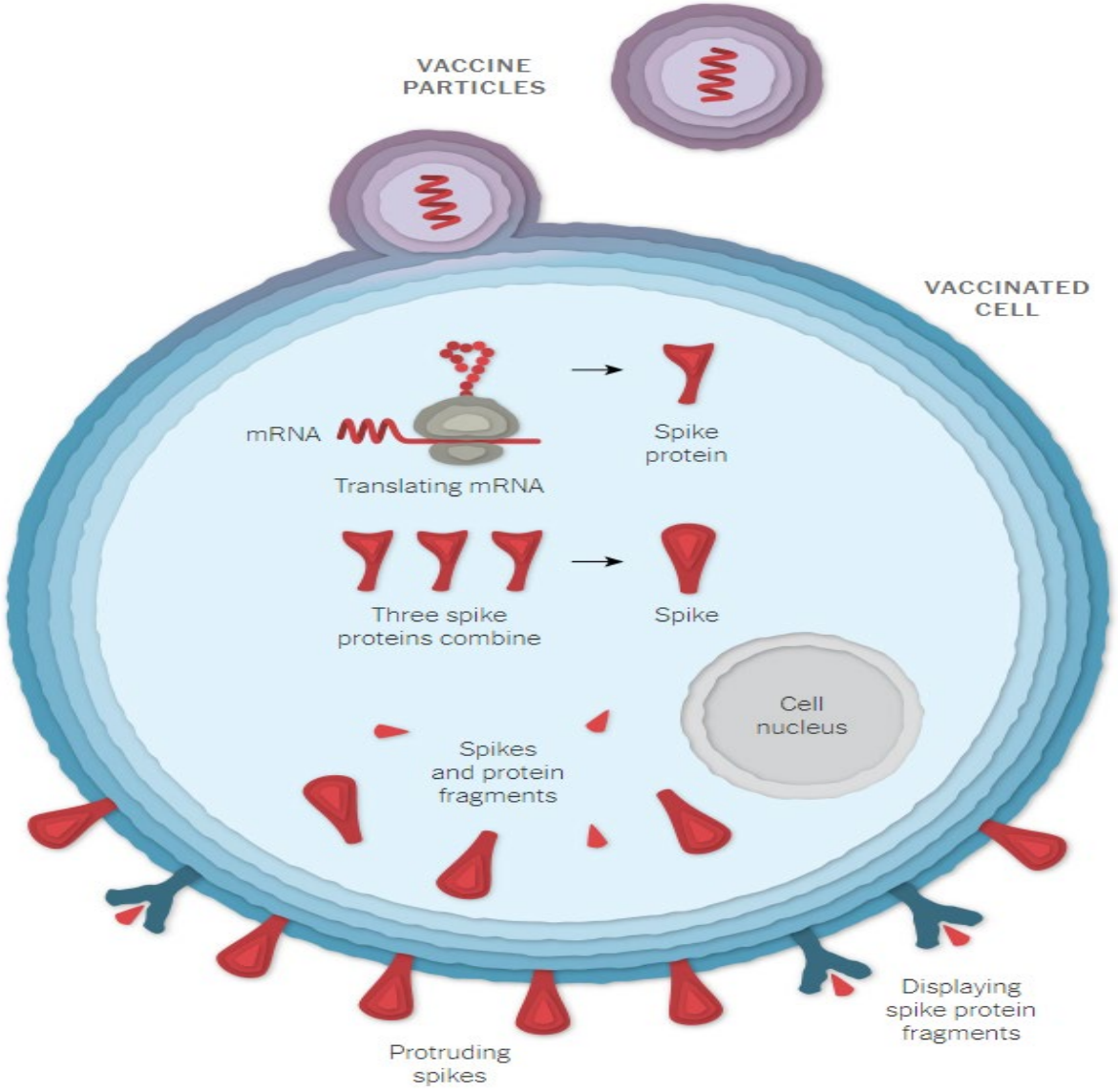
December 10, 2020

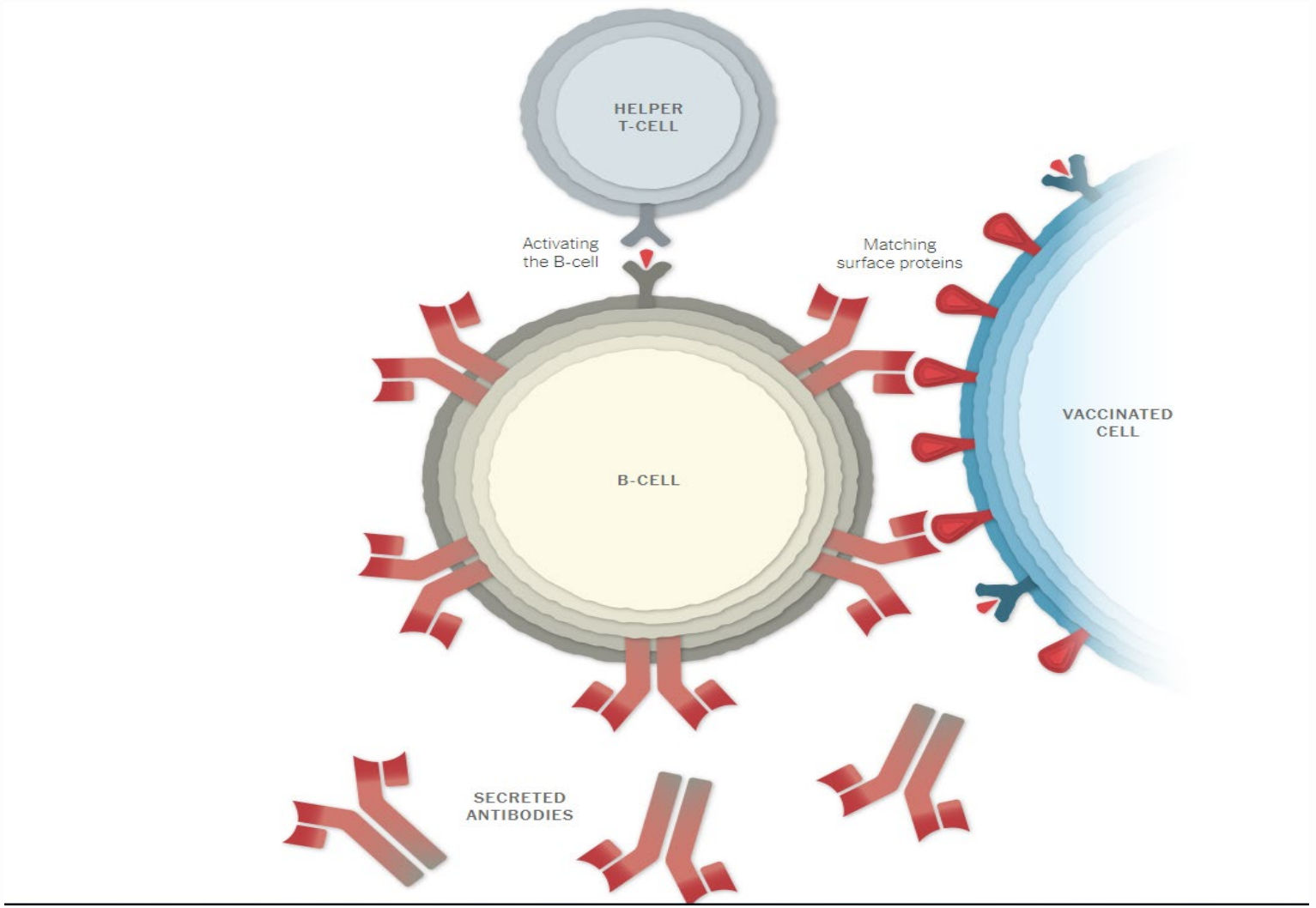
Joe Sullivan MD MPH
Senior Health Advisor
Oregon Health Authority

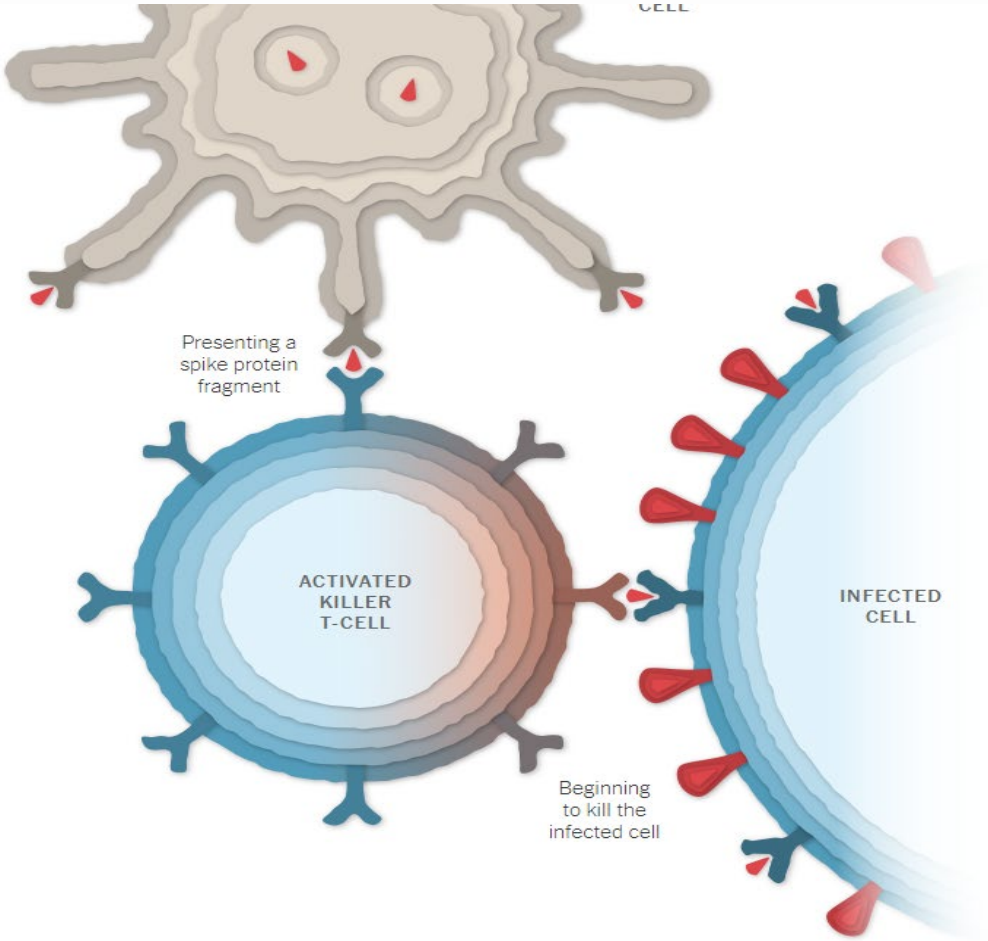
Oregon Health Authority

Questions patients may ask you

- How do the mRNA vaccines work?
  - How were they made so fast?
  - Are they safer than other vaccines?
- The FDA just authorized the Pfizer vaccine (EUA; ≠ FDA approval)
  - Is it effective?
  - What safety concerns are there?
- How is the Moderna mRNA vaccine different?
- What other vaccines are coming?
- What is the timeline for when the general public will be vaccinated?
- Who is in the 1a vaccination group and why?


VACCINE PARTICLES
VACCINATED CELL
mRNA
Translating mRNA
Spike protein
Three spike proteins combine
Spike
Cell nucleus
Spikes and protein fragments
Displaying spike protein fragments
Protruding spikes


HELPER
T-CELL
Activating
the B-cell
Matching
surface proteins
VACCINATED
CELL
B-CELL
SECRETED
ANTIBODIES


Presenting a
spike protein
fragment
ACTIVATED
KILLER
T-CELL
INFECTED
CELL
Beginning
to kill the
infected cell

Pfizer mRNA Vaccine Efficacy

- Ongoing phase 3 trial with approximately 44,000 participants ages 16 years and up, in a 1:1 placebo-controlled, double-blind study
  - 95% efficacy in preventing symptomatic COVID-19 disease
  - 8 cases in the vaccine group and 162 cases in the placebo group

- Subgroup analyses of the primary efficacy endpoint showed similar efficacy across age groups, genders, racial and ethnic groups, and participants with medical comorbidities associated with high risk of severe COVID-19

- Secondary analysis suggests
  - Protection against severe COVID-19
  - At least 50% effective at preventing symptomatic disease after the first dose

Pfizer mRNA Vaccine Safety

- Data confirms no vaccine-related serious adverse reactions reported.
- 4 episodes of Bell's palsy in the vaccine group; within expected background for the population size
- Post-vaccination side effects are common and should be taken into consideration in planning vaccination program and staffing.
- In UK, 2 anaphylactoid reactions in people with prior severe allergic reactions and carried epi-pens
  - Cause? No preservatives or animal products in Pfizer vaccine
  - UK recommended that those with h/o severe allergic reaction to food, medicine or vaccines should not take the Pfizer vaccine

Other Pfizer News

Pfizer announced that the US will not be able to purchase more of its vaccine (more than the original 100 million doses) until mid-summer because it has obligations to other international buyers.

Moderna mRNA Vaccine

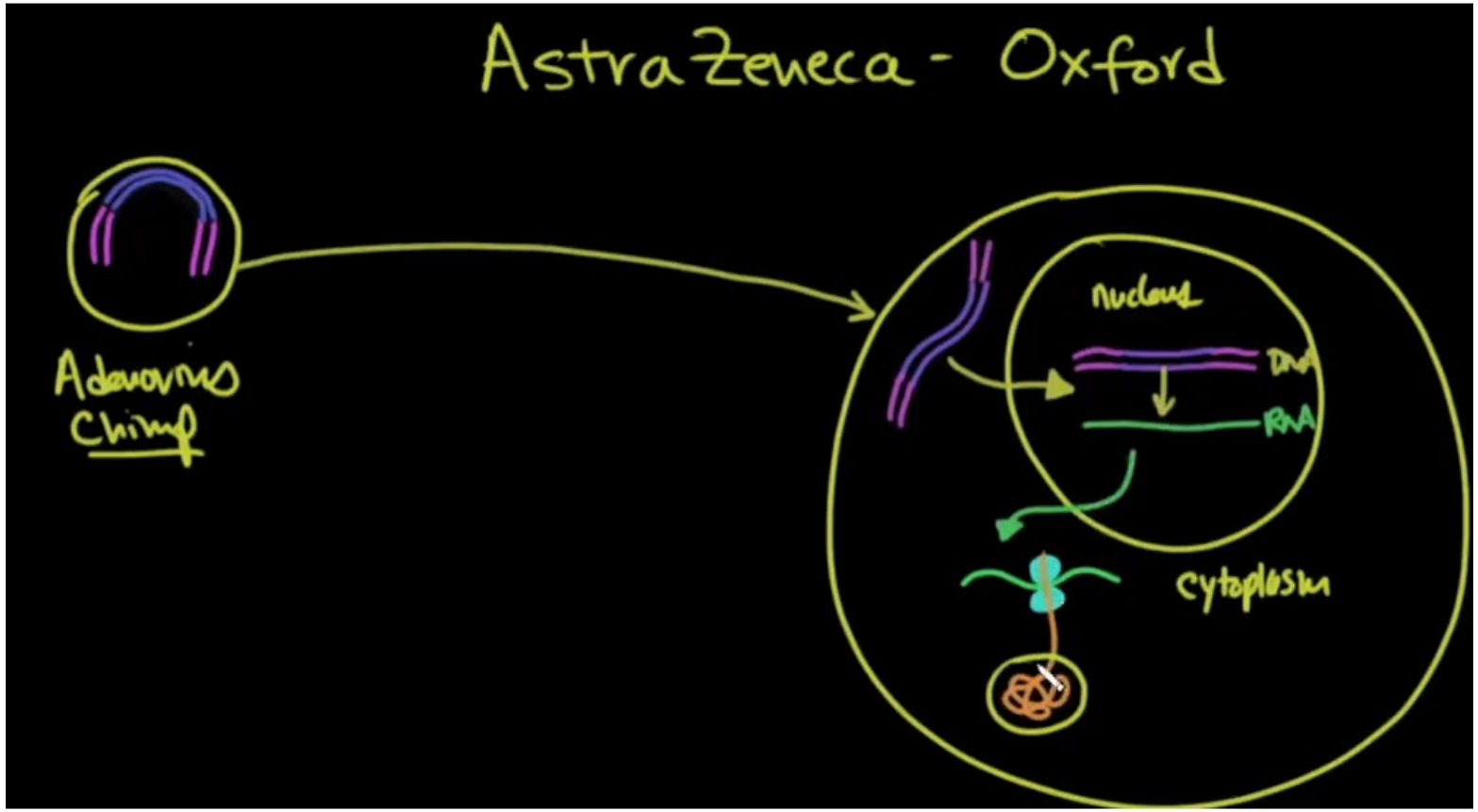
- Vaccine Efficacy – 94.5% at preventing symptomatic COVID -19

- Safety :
  - Side effect profile similar to Pfizer's – no serious adverse reactions
  - Common time-limited, post-vaccination side effect, such as fatigue, headache, soreness at injection site, achy muscles and fever

- Storage:
  - Store for 6 months at normal freezer temperature.
  - Store at refrigerator temperature for 30 days.

- Timeline for authorization: December 17, 2020
  - VRBPAC meeting at FDA

Non-Replicating DNA Viral Vector Vaccines



Non-Replicating Viral Vector Vaccines

- AstraZenica/Oxford – COVID-19 Vaccine AZD1222
  - Phase 3 trial interim analysis -131 cases (from press release 11/23/20) 11,000+ volunteers (2,744 in UK and 8,895 in Brazil) showed an average efficacy of 70%
  - 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.
  - AZ pledged no profit from the vaccine: cost is $3–5 per dose.

Issues with the Astra/Zenica trial

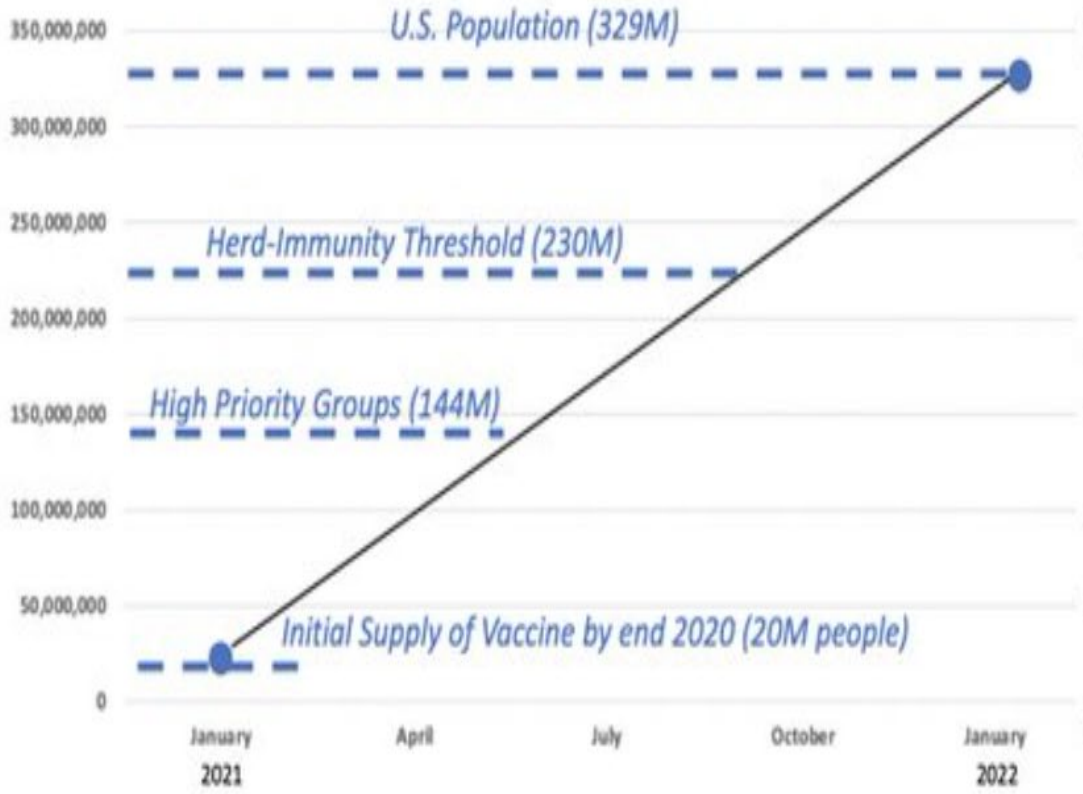
- Not transparent with FDA re 2 episodes of TM in July and Sept
- Outside manufacturer measured viral concentration per ml at twice the level that was measured at Oxford so elected to use half of the protocol dose
- The results were dramatically different based on the dosing schedule
  - ½ dose then full dose: 90% effective and no significant safety issues
  - Full prime and booster dose: 62% effective
- The half initial dose regimen only tested people <55
- Restarting in the US! Last week halfway through enrolling 30,000 in US including OHSU

Timeline for Non-Replicating Viral Vector Vaccines

- AstraZenica – likely data readout in January 2021

- Janssen/Johnson & Johnson –
  - Adenovirus 26 DNA vaccine
  - Likely data readout in January

U.S. Vaccine Availability and Eligible Groups



Some Useful Numbers to Gauge Vaccine Timing (Ariadne estimates)

- Healthcare workers & first responders: 19.3M
- Patients with one or more comorbidities: 92M
- Patients over 65 with no comorbidities: 1.3M
- Over 65 in congregate settings: 2.3M
- Essential workers not fitting other categories: 22M
- Homeless: 6.7M
  Incarcerated: 0.7M

Total: ~144M

Number of people in U.S.: 329M

Herd immunity threshold (~70% of total population): 230M

Oregon Health Authority

COVID-19 Vaccine: Phase 1a

Phase 1a distribution is broadly defined at the federal level as including:

- Health care personnel
- LTCF residents

Oregon has flexibility to define who is included in Phase 1a. OHA is working with various partners to finalize how we define health care personnel broadly for inclusion in this phase, as well as consideration of our diverse congregate care settings.

OHA is continuing to center our focus on health equity as we work with our partners to consider our definition of recipients in Phase 1a.

Health Equity

Health equity must be at the center when considering the allocation of scarce critical resources in the face of a public health crisis. OHA defines health equity as follows:

> Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
>
> Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
>
> – The equitable distribution or redistribution of resources and power; and
> – Recognizing, reconciling and rectifying historical and contemporary injustices.

Phase 1a Distribution Priorities

Beyond defining the Phase 1a group, OHA is working to make sure the following priorities are ensured during vaccine distribution:

- ***Vaccine is accessible*** for those who are included and want to be vaccinated in Phase 1a.
- ***Informed consent*** takes place.
- ***Linguistically accessible and culturally responsive information*** is available about the COVID-19 vaccine(s).

These priorities are critical to be responsive to the diversity of people living in Oregon, and to mitigate historical and contemporary injustice and stigma of communities of color, tribal communities, people with disabilities, and longstanding mistrust of the system and distrust of vaccines.

Phase 1a Distribution: Hospitals

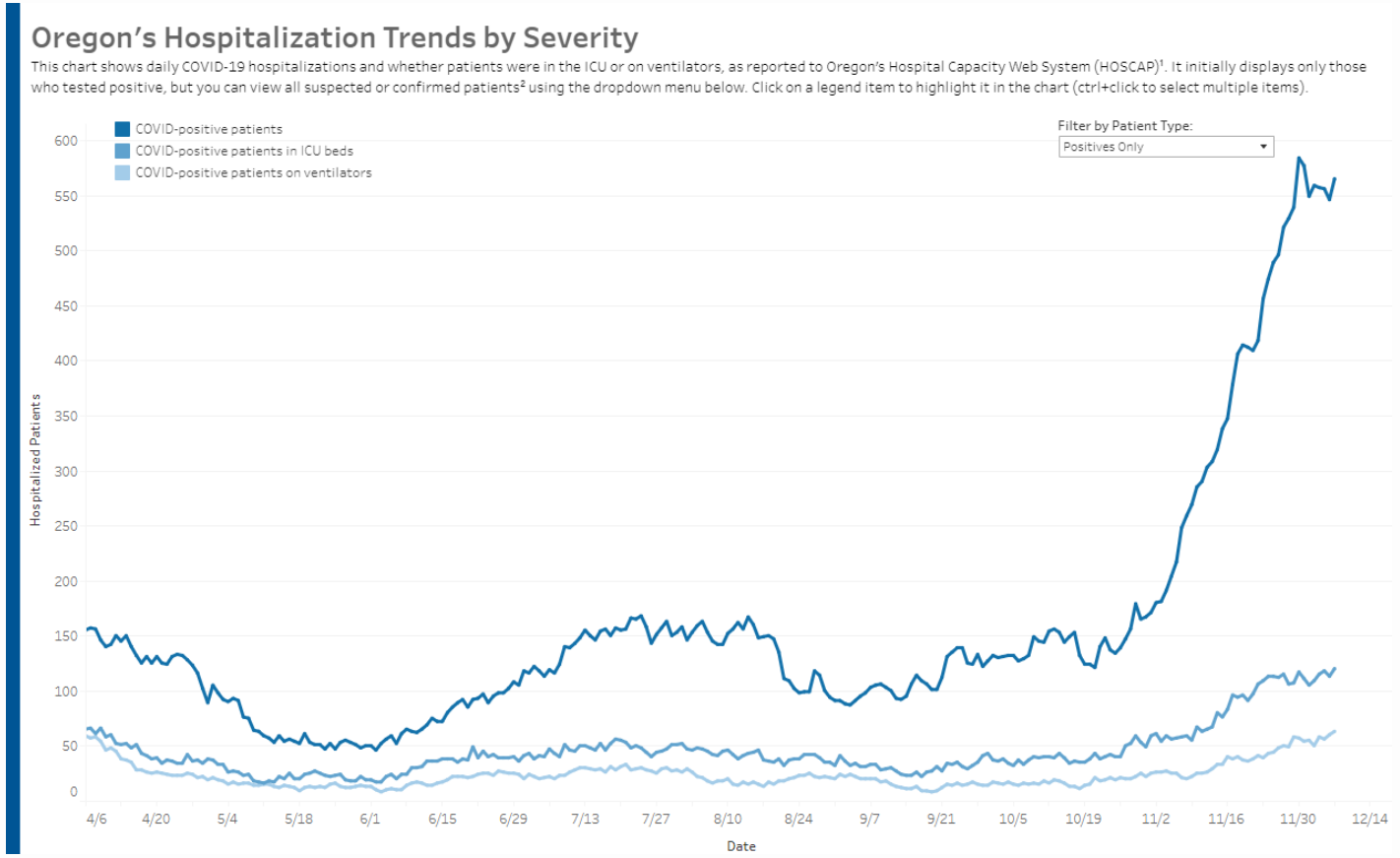
Hospitals will be included in Phase 1a, including all employees (clinical and non-clinical), contracted individuals, volunteers and students, and acute care psychiatric hospitals.

This includes all health care professionals and all other employee or contracted staff types, e.g., including but not limited to administrative, dietary service and environmental service staff.

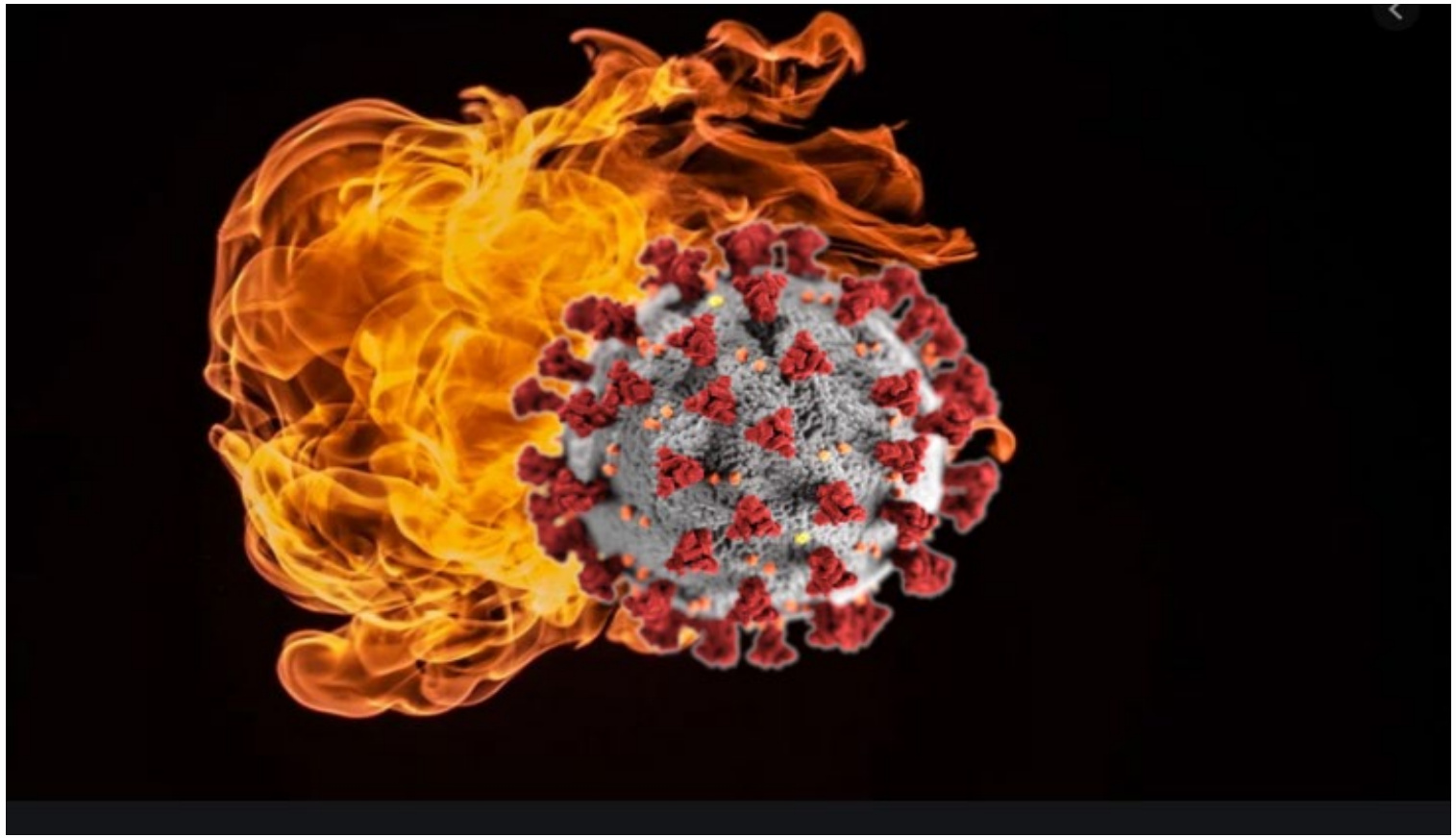
Also including in this group:

- ***Traditional Health Workers*** who provide services in a hospital.
- ***Health Care Interpreters*** who provide services in a hospital.

Oregon's Hospital Situation



Oregon's Latest Wildfire



Prioritization 1a

Consideration for hospitals

As hospitals prepare to roll out COVID-19 vaccine as it becomes available for your employees, contractors, students and volunteers, OHA recommends you consider the following:

- Prioritizing staff who are critical for maintaining hospital capacity to serve the greatest number of patients, and reduce the need to implement crisis standards of care, for example:
  - Staff working in certain hospital settings (e.g., intensive care units, emergency departments); or
  - Specific types of medical providers (e.g., respiratory therapists, nurses, or other critical care specialists)
- Prioritizing staff with most potential for direct exposure to SARS-CoV-2, whether through workplace exposure or community transmission
- Staggering access to the vaccine among staff to reduce staffing shortages in face of potential post-vaccination side effects

Skilled Nursing Residents and Staff

References

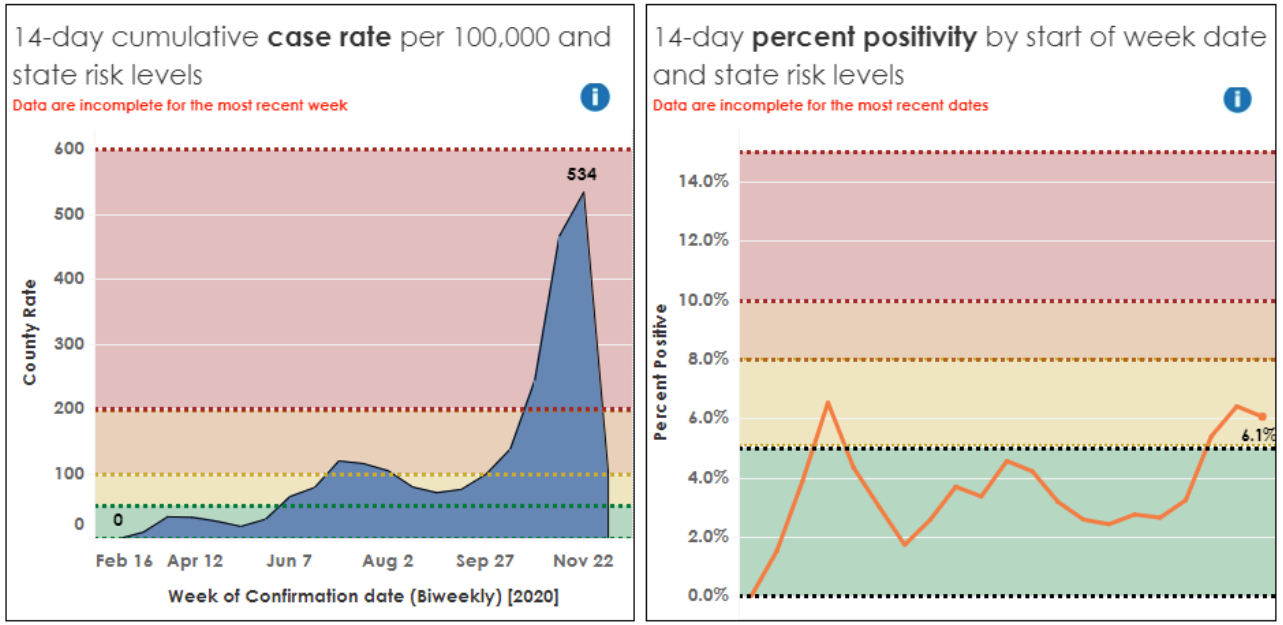
- FDA documents for Pfizer trials https://www.fda.gov/media/144245/download
- AstraaZenica Press release https://www.astrazeneca.com/media-centre/press-releases/2020/azd1222hlr.html
- Lancet article – AZ vaccine Phase 3 interim analysis https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2932661-1

Oregon Health Authority

Questions

Portland Metro Updates- 12/10/20

- The rapid increase in cases of SARS-CoV2 across our region means local public health will focus contact tracing and disease investigation on highest risk situations.
- This means that not all positive COVID cases will get full public health follow up and contacts may not hear directly from local public health.



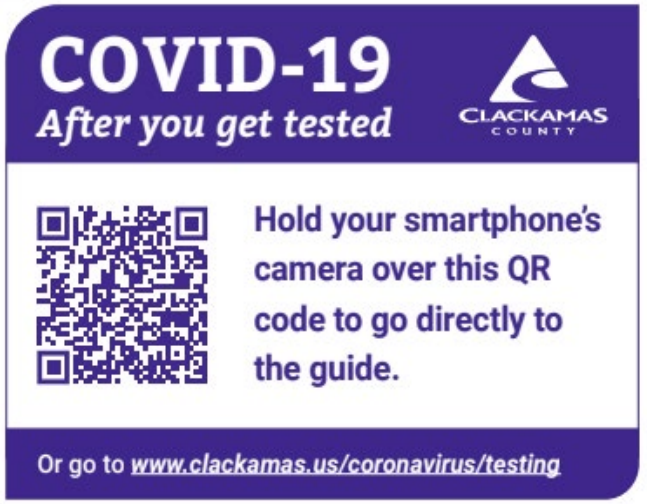
Ordering clinicians will need to assure that all patients tested receive:

1) Timely notification of their results

2) Clear recommendations for the length of isolation

3) If positive, coaching on how to immediately identify and notify their contacts.

4) A work exclusion letter if needed in order to stay home to isolate for 10 days after symptom onset (cases) or quarantine for 14 days from last contact to case (contacts).



Key points for clinicians

- Prioritize testing for people who are symptomatic or known close contacts to COVID positive individuals.
- Testing close contacts soon after their exposure helps identify the next round of contacts and slow transmission.
- **Contacts who test negative must still stay home for 14 days since their last exposure as test conversion may take more than 10 days.**
- An “indeterminate” or “inconclusive” test result should be considered positive.
- Use clinical judgement to decide if an indeterminate test should be repeated in order to clarify the patient’s status.
- An “unsatisfactory” result is related to the quality of the specimen and should NOT be considered positive. The specimen should be re-collected if there was a strong clinical reason for it to be collected initially.
- Close contacts to known cases who develop compatible symptoms are considered presumptive cases regardless of test results (positive or negative). OHA definition of compatible symptoms for a presumptive case: an acute illness featuring at least two of the following: shortness of breath, cough, fever, new loss of smell or taste, radiographic evidence of viral pneumonia;
- Create a plan with patients who are positive for what to do if they get worse. All patients need clear guidance about the need to isolate while waiting for test results. Exceptions include asymptomatic individuals with no known contact who are tested as part of routine community screening or long-term care facility surveillance screening.

In addition, other members of their household should stay home for the duration of the patient’s isolation and for an additional 14 days after the ill person is no longer infectious. If the patient is able to completely isolate from other household members (no contact, no shared spaces), household members should stay home for 14 days after the patient began isolating (contact is broken).

Isolation—for those who have disease

If Patient is Positive for COVID-19 and Symptomatic

A patient can resume contact with others when:

- They have no fever for 24 hours without the use of medicine, AND
- Other symptoms improve, AND
- At least 10 days have passed since symptoms first appeared.

If Patient is Positive for COVID-19 and Asymptomatic

A patient can resume contact with others when:

- 10 days have passed since their test, and they continue to remain asymptomatic.

Quarantine—for those exposed to the disease

Local public health authorities determine and establish the quarantine options for their jurisdictions. 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.

- 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% with an upper limit of about 10%.
- *When diagnostic testing resources are sufficient and available (see bullet 3, below),* 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 and are outlined in the full text.

COVID-19 Healthcare Resources

OHA Healthcare Partner Resources

https://www.oregon.gov/oha/covid19/Pages/Healthcare-Partners.aspx

OHA All COVID-19 Data Dashboards

https://public.tableau.com/profile/oregon.health.authority.covid.19#!/#!%2Fvizhome%2FOregonsCOVID-19DataDashboards-TableofContents%2FTableofContentsStatewide

This Week in Virology (TWIV)- Podcasts and Resources

https://www.microbe.tv/twiv/

Cheng A, Coruso D, and McDougall C. Outpatient Management of COVID-19: Rapid Evidence Review. *Am Family Physician,* 2020;102(8):478-486. *https://www.aafp.org/afp/2020/1015/p478.html*

COVID-19 Response ECHO for Oregon Clinicians: Starts Thursday, January 7, 2021

- 12-sessions ECHO
- Sessions take place on the 1st and 3rd Thursdays of each month
- Register at: www.oregonechonetwork.org/covid-19

Project ECHO Oregon ECHO Network

ORPRN Oregon Rural Practice-Based Research Network OHSU

oregonechonetwork.org