VDH Partner Call Notes
Friday, February 11, 2022

- **Introduction, Suzi Silverstein, VDH Office of Emergency Preparedness:**

    - Welcome to the partner call on Friday, February 11th. We are going to have a few updates this morning. We will start with an update on data and where we are currently at with COVID in Virginia. We are going talk about testing, vaccination, therapeutics and then we will have an update on modeling and how things are looking moving forward.
    - We will begin now with Dr. Laurie Forlano who is going to start on our update on where we are at.

- **COVID Data Update, Dr. Laurie Forlano, VDH:**

    - Our neighboring states that have rates higher than Virginia include North Carolina, West Virginia, Tennessee and Kentucky, District of Columbia and Maryland, however, have rates lower than Virginia.
    - Nationally, cases, hospitalizations and deaths are for the Mort part headed in the right direction, compared to last week nationally, cases decreased about 44% so that's daily -- looking at the daily average. Hospitalizations also decreased on a national level about 24%. Deaths stayed about the same.
    - In Virginia when we look at weekly data, so the number of cases each day, but we aggregate that into a week's worth of data, compared to the week prior, cases decreased to about 5,000 a day on a seven-day moving average. They previously were closer to seven or 8000 cases per day. So we were glad to see that 36% decrease. Hospitalizations in Virginia also, similarly, decreased about 23% compared to the last reporting period.
    - You can definitely see if you look at our epidemic curve online, we are glad -- although there was an extremely steep curve upwards with this omicron surge, we are seeing that downward trend very significantly. So, we are happy to see that trend in the favorable direction.
    - When you look at hospitalizations in Virginia, compared to the last week, again, there was about a 24% decrease. We also saw a decrease in ICU hospitalizations associated with COVID and also a decrease in the number of patients that were currently on ventilator support.
    - We look at data across six different regions in Virginia and we look at three key metrics among other data. So, for the weekly case incidents, this is the number of cases in a given week per 100,000 population, all regions in the Commonwealth are seeing decreasing trends. The far southwest or the tip of Virginia is still very much experiencing the highest rate. So, they had 1214 cases per 100,000 population versus northern region which was only seeing 298. So, those are both

still in that highest level of community transmission. But just wanted to speak to the range of numbers there.

- All regions are experiencing a declining trend. Same thing for test positivity. All regions are seeing that downward trend and southwest has the highest positivity rates right now. We are also seeing downward trends in our visits to emergency rooms for COVID-like illness across the entire commenting.
- It's important for us to look at nursing home data or long-term care home data. We track that closely. During this omicron surge we saw a surge in outbreaks in long-term facilities across all regions. That is also declining. So, we were happy to see that trend again this week. Nursing home resident's cases and cases in nursing home staff also are seeing a precipitous decline, which makes sense.
- Then we also look at vaccination data in nursing home residents and staff. For data that went through the end of January, we were showing 89% of nursing home residents were fully vaccinated. 92% of nursing home staff were fully vaccinated. So, that's indicating those two first doses of vaccine that does not include boosters. Of the nursing home residents eligible to receive an additional dose or booster dose, 76% of those nursing home residents had received an additional dose or booster. And of nursing home healthcare personnel eligible to receive those third or booster doses, only 43% had received those. So the vaccine team is working on that, because that's definitely where we need some improvement.
- Justin will likely talk about some of the modeling data. But all health districts are experiencing declining trajectories.
- Some continuing slow but steady progress with our vaccination campaigns, the booster doses still have quite a ways to go to catch up. We have the highest booster dose rates in older adults. So in the 65 plus population, 61% of those folks have a third dose or a booster. It was about a 1.5% increase in last week, lagging behind our all other age groups. For example, if you look at the adolescents who are most recently approved to get the booster doses, only 14% of 12 to 15-year-olds in Virginia have had that third dose or booster.
- To close out on the data portion of my remarks, just want to congratulate all of you out there in our vaccine team at V DH. With the exception of Maryland, compared to all our neighboring states, Virginia has the highest fully vaccinated coverage rate as compared to D.C., Kentucky, North Carolina and Tennessee and Virginia at a 70.6% rate of Virginians fully vaccinated.
- Just wanted to make a couple of comments, because this is the last call, I think. There's been some changes in what we call our containment approach or more shortly put, our case investigation and contact tracing strategy. You may have seen in late January we made an announcement about a shift there. VDH has transitioned away from what was previously more universal case investigation and contact tracing at this point in the pandemic. That universal strategy was effective during the initial -- and critical during the initial phases of the pandemic, but with the case volumes that came with omicron, it just wasn't achieving optimal results anymore, and the effectiveness of that strategy has really reduced.

That's due to a lot of the asymptomatic and mild cases resulting from changes in the virus and widespread vaccination. Many infections are never identified by public health because of those asymptomatic and mild cases and the volume of them and a lot of folks are using over-the-counter or at home tests which are generally not reported to public health. Omicron has a shorter incubation period. There are of reasons why that universal strategy wasn't working anymore. It did have a substantial role in curtailing the pandemic and we are proud of that work. But the bottom line is that if a person suspects or confirms they are COVID-19 infection via a test, they shouldn't wait to get a call (their) from public health. They should isolate, testing, if you're having symptoms and notify their close contacts if you do get a positive result. So, you should not wait or expect a call from public health to take those steps but you should do that on your own accord.

- Our investigators will now focus our disease surveillance and investigation efforts on reports of clusters and outbreaks in more higher risk settings like cog Gant care facilities, long-term care facilities, confinement settings because of the populations that are served there are more vulnerable. And the local health districts are continuing to partner with K-12 schools on prevention strategies and responding to outbreaks there.

- **<u>Testing Update Suzanne Trotter, VDH:</u>**

  - Good morning, everyone, thank you for your attendance this morning. I will give you a brief update, perfectly patterned after Dr. Forlano's sharing of the decrease of cases. Testing has always been responsive to, obviously, what we see in the community. So, we have certainly seen a decrease in the number of tests requested, as well as steps going to get tested.
  - The new change that we are currently doing in launching next week, our main nine sites are CTC, the community testing centers that were set up at or near the CVCs were really well utilized. It was a rapid response FEMA project we set up due to the highest need we have had in this pandemic with the omicron surge. We set that up early January, continued to see pretty much robust testing. And over the last week and a half we have had about an 84% drop in the number of tests being conducted at the site.
  - we have pivoted now to standing down or demobilizing those large tents at the six sites and we are moving to what is called a CTC plus model, which is, again, the community testing center, but this time it is with mobile vans, fully equipped. It is still through our vendor AshBritt with their healthcare IEM. So still a nurse practitioner as well as qualified skilled individuals that are able to take the PCR test. Still the same age, three months and above.
  - What's different now is this is going to be a resource available to all health districts. It is global so it doesn't have to stay at the site. So we are going to be working with our districts this week. We will request this resource. And the hopes is that it will be able to get to those places we haven't been able to get to, looking

into our safety net, providing access where it hasn't been or whether people have difficulty getting to a site or there's low vaccination rate. It's really more of a flexible approach and really more intensive to get those that absolutely have difficulty finding testing. That will launch next week. And we will refine it to the rest of February and, again, the FEMA project itself runs to the end of March, March 31st.

- We will certainly watch the data and see how it compliments what's already going on. To that point, community testing is still going on with the district. We still have our other state vendors that provide testing. And we also are providing resources for if there's an outbreak, they can call the Health Department. We will work with the local and regional epidemiologists and ensure they have testing available.
- We have our other grants that are continuing so that with confinement, shelters, we are providing support with our vulnerable population with our at-home test kits as we can. There has certainly been a pinch in all areas and needs. So even the long-term care facilities that are CMS regulated are getting directly shipments from HHS.
- It's not necessarily at the time they actually need it when there is an increase in cases. So, they are able to request kits from us at the central office, as well as the three clinics and the federally qualified healthcare centers do as well. We, too, our challenge in getting resources, they are opening up. But we do have a lead who is in contact with vendors in the market. So, I'm hopeful, I think we are seeing the early changes where we have more access. But it's still a work in progress and we are dedicated to providing testing resources for those in most need and expanding probably where we can.
- Our library program is on hold currently. Of course, we did run out of the product at the end of December. And when we launch it again, we are looking at that low access areas geographically and doing a prioritization looking at the governor's action plan as well. And then, of course, we have our major K through 12 school grant which continues the (?) program as well as the test to stay has really gotten some traction and we will continue that through the period of performance.
- We do not expect that to stand down anytime soon. We also did do -- report through I CAT in three different localities across the state, which is a three-week project. Week 1 has completed. A little rough start as with anything logistically but everything is in place and we are looking for good things in the next two weeks.

- **Therapeutics, Alexis Page, VDH**

    - My name is Alexis Paige. I would -- since this is the first time on the partners call for me, I want to start with the basics as to what therapeutics we have available. So, I'm going to start with one therapeutic called Eddie shelled. This is an interesting therapeutic for COVID-19 because it's indicated for pre-exposure

prophylaxis. So, this therapeutic is really meant for not the treatment of COVID-19, but really to help those individuals who are at risk for developing severe COVID-19 if they are exposed to it. So, what that means is (Eddie Shell) is indicated for those that are vaccinated or unable to be vaccinated but have immuno compromising conditions or take immuno compromising medications and _____ will work to prevent them from acquiring COVID-19 or contracting COVID-19 disease.

- That is one therapeutic we have available. It's for the pre-exposure prophylaxis so again indicated for those that are not currently infected with COVID-19. The rest of the therapeutics that we have available are for the treatment of COVID-19. So, one monoclonal antibody it's called pa Tyron man for the treatment of mild to moderate disease in adults and pediatrics. This is administered intravenously. So, _____ is on a little bit of a short supply based on allocations from HHS.
- Eddie shell we have a health supply of so we are not concerned about providers will have access to Eddie shell but the Tyron man is a strained supply.
- The other therapeutics we have available are oral antivirals so we have two that fall into that category. We have one that is called Paxlovid and another called multi peer veer. Paxlovid. They have pros and cons when they are indicated for patients but Pax vid has better efficacy but more drug interaction. And multi peer veer has less drug interactions but lower efficacy.
- Going back to the supply really quick, like I said, edi shell is in healthy supply. Multi peer veer is also in healthy supply. The two that are a little bit more constrained are so Tyron man and Paxlovid. However, what we are doing as a team at DHHS is making sure that the providers that are getting sa to be man and Pax vid are using it and reporting their inventory and those that have ebb shell and minute peer veer addressing for low utilization rate.
- We are also making sure we are doing a lot of webinars for providers and specifically targeting certain long-term care facilities, pharmacies and providers to make sure they are aware of ebb shell, again, with the purpose of trying to prevent contracting COVID-19 as opposed to treating it. So, there's a lot going on with therapeutics. Another big update was, you know, in the fall we had a couple other monoclonal antibodies called Regenco or bam Eddie. Because. Omicron surge, the government or HHS has stopped allocations of those two monoclonal antibodies to jurisdictions because those monoclonal antibodies are not effective against omicron.
- So, again, the ones that we really have in our toolkit against omicron for treatment are sa Tyron man, Pax vid and multi peer veer and ebb shell for preventing COVID-19. I do want to say, too, with this -- this aligns with the decrease in number of cases we are seeing decrease in demand, which is good.

- **Healthcare and Hospital Coordination Update, James Moss, VDH:**

    - As Dr. Forlano noted we are starting to see a decline in cases and hospitalizations which is easing the stresses and burden placed on our hospitals and healthcare systems. That said, there's still staffing shortages and that is a continued ongoing issue and problem that our healthcare partners are having to deal with across the spectrum.
    - As you likely saw, the administration altered and issued a new order that allowed flexibilities or alternates to staffing for our healthcare facilities and partners. That has proved to be extremely beneficial in helping to seek alternate ways and means to provide staffing supports to our hospitals and healthcare systems.

- **Modeling Justin Crow, VDH:**

    - So every state is in a declining trajectory as measured by the UVA bio complexity institute. Within Virginia this past -- when we ran this this past Wednesday morning, which would be data from the prior day, so data on Tuesday. Report 34 of Virginia's 35 health districts were in declining trajectories as well. The LAN wisco, far southwest Virginia district was still? Surge. However, it was starting to -- case numbers were starting to turn right then at that time period as well. And I think if we ran that today we would find that Lenowisco is in a plateau or declining trajectory as well at this point. The UVA, the way they have it set up it, it waits a few days once a turn happens to confirm that the decline is actually happening.
    - Looking at the next slide we do see transmission rates below one, and in some cases well below one and all regions of all of our six health planning regions in the state. I do want to point out if you look at the chart on the right, at the very end and this is in the area where we have the gray preliminary, we do see a few areas where the transmission rates have started to tick up a little bit. Don't know if that's meaningful or not. It could be, again, preliminary data. It could be more people going outside a little bit. It could be a variety of causes for that just reversion to the mean.
    - But we are watching as well BA2, the new omicron variant which is more transmissible than omicron but not to the extent that, say, delta was over wild type or that omicron was over delta.
    - Each variant we get seems tore more transmissible and that is all adding up to BA2 is rather transmissible at this point. We do expect that variant to -- it's beginning to appear in Virginia. It's about 4% now, just under 4% of cases, according to the CDC in the United States, the cases that are sequenced just under 4% are the BA2 variant. So, we do expect that to take hold in Virginia -- or I'm sorry, in the United States and probably affecting Virginia as well.
    - So, just something to keep in mind. We have had variants before that have come in to different environments and not taken off as we have seen in other countries.

So BA2 just for background has taken off into the Netherlands and the UK. That doesn't necessarily mean it will take off in the United States. Previous variants such as mu and gamma have also taken off in other countries but not other countries. It depends on the mix and the situation in other countries. But we are watching that closely. Diving into the models, as I think everyone is aware at this point, the model does project a number of scenarios each week, based on, you know, what we see going on and what we expect to happen here in Virginia. The adaptive scenario is basically the current course of the pandemic and just projects it forward at the county level.

- The adaptive spring, as we are calling it now, is, basically, just takes the trends that we saw from the previous year and layers them on top of the adaptive model. So, previously we called this the adaptive fall/winter and we were modeling the fall/winter rises that we saw in 2020 and 2021. Now that we are entering spring, we are past those peaks, we are layering the declines that we saw in early 2021 into the summer on top of the current projections.
- The decrease control scenario just, kind of, models if everyone -- if, you know, we go back to, I guess, pre-pandemic levels of prevention, so a lack of prevention generally and more people out and about, less social distancing, less mask wearing, what effect that might have on cases. And then we do have the omicron BA2 scenario which there's not too, too much solid information yet on what the characteristics of BA2 quite yet. As I said it does have a higher transmission rate, which is reasonably higher but not excessively higher so they include that scenario in here as well. So, just looking at the projections, we are beginning to highlight hospitalizations.
- There are a few reasons for that. One as more people are exposed or have a vaccination, cases -- you know, severity becomes more important than the number of cases. It used to be proportional because it was some variation. But across time and boundaries is continues. Now we are seeing it diverge, both over time and across countries. Countries like Israel that have robust programs, have a huge number of cases but their hospitalizations proportionately are smaller. We are moving in that direction as you can see on this Slade, we have emphasized hospitalizations here. But if you look at the green -- sorry, the blue line, that shows the current course and we do, of course, project cases to continue to decline, if nothing else happens.
- Hopefully we will follow that spring decline, which is a little bit more, you know -- declines a little bit faster with the seasonal effects. If we do have a sudden increase in, you know -- decrease in mask wearing, increase in social activity, et cetera, we could see a little plateau here in the next couple of weeks, and then see the decline continuing. And basically BA2 does become predominant in Virginia, which is (if, basically,) I think most people think is the most likely scenario at some point here, we could see, basically, a slowing of the decline, a little bit of a plateau and, basically, cases staying really at the fall levels that we had this past

fall through April and declining into the summer. And I'm sorry, I meant hospitalizations. Cases follows a similar pattern.

- Fortunately, our deaths have -- deaths have declined as well. So we do not expect to see -- we expect to continue to see declines in deaths in Virginia. There's a little bit of difference regionally. Omicron moved really quickly through the United States and through Virginia. So, in areas where it hit earlier in Northern Virginia we are already seeing cases at very low levels and expect that to continue. Northwest and central Virginia hit a little bit later and we have a little bit more time with cases and hospitalizations in those regions, and as I mentioned earlier, we are just seeing plateaus and declines in southwest and in particular the far southwest. So, we do expect to see hospitalizations and cases continue for a bit in those areas as well, high levels.
- Fortunately, and the UVA team has now adjusted their model to account for omicron, so, they have shortened the length of stay that we are seeing with omicron and they have, you know, decreased the proportion of hospital admissions as well, so with that in mind, we did not see and we don't expect to see hospitalizations exceed any of the normal thresholds we use. So, that 80% threshold we use as, you know, putting substantial pressure on hospitals, we don't expect that to be breached in any region.
- Finally, we have been discussing what does a pandemic look like. Hopefully we are moving into an endemic phase. We are passed the pandemic phase and moving into a more steady phase (endemic). Just looking back at what that might look like theoretically. The UVA team is, basically, stating that when omicron came through it might have been a sinking event. So everyone who hadn't previously been exposed or vaccinated was at this point, probably had some level of exposure or infection and develop antibodies.
- In an ideal situation, if you have the slide, if you look at that green line that would mean COVID would go instinct. It would simply run out of host and that would be the end of it. We don't expect that to happen. Through every variant we have seen reinfection. Early indications and I do want to stress these are early indications, we are seeing more reinfections with omicron. That will be sorted out as we go. But we will have probably likely some level of reinfection so we do expect omicron to stick around and that would be represented by the blue line. Of course we also have waning immunity, so we know that, you know, for folks who don't keep up with their vaccinations, their immunity will wane. Those who were not vaccinated but exposed against omicron waved their immunity will wane as well.
- That's generally about every six months and you can see that's represented by the yellow line. And, of course, COVID has shown a robust ability to create new variants. There are plenty of hosts out there both human and animal for new variants to appear in and we don't know what those will look like. So, those red lines, kind of, indicate different ways that a variant could emerge and what it could do but things to keep in mind.

- We will probably see some combination of those last three, steady reinfections with some periodic surges and declines due to waning immunity. And then, of course, new variants affecting that in ways we can't participate. All of this, we hope, occurs in an environment of decreased severity and also we are not sure and still trying to figure out just how seasonal COVID is. So, that's something to keep in mind as well.

- **<u>Vaccination, Christy Gray, VDH:</u>**

  - There's been several changes that have happened since we last chatted. The FDA printed school approval to the Moderna vaccine (?) for two dose primary vaccine series for COVID-19 for adults 18 years of age and up. The advisory committee on immunization practices recommends that the use of Spikevax for this purpose and the recommendation was endorsed by the CDC on February 4th.
  - Spikevax has the same formation as the existing Moderna vaccine under emergency use authorization. The Moderna vaccination under EUA can still be used to provide the primary series, third dose for Mulan compromised persons as far as a onetime booster vaccine for adults engineer years of age and up.
  - Moderna is not expected to start manufacturing the vaccine under the tradename of Spikevax until the existing supply of the vaccine under the EUA is used up reaching the full FDA approval may give those persons waiting for the vaccine to receive that status, the (?) they need to get vaccinated.
  - Those who are unvaccinated remain at the highest risk for severe illness or death due to SARS-CoV-2. (?) also as much as a change in booster recommendations for -- expected CDC clinical considerations changes are to reduce the interval from five months to three months and to allow for those that received the J&J vaccine to receive a second primary dose 28 days after their initial dose.
  - Previously only those immuno compromised persons who received an MRNA primary vaccine were recommended for a third primary dose. We will continue to watch for these changes in the CDC (?) consideration but they have not been published yet. As (?) mentioned we still have much progress to make regarding our younger populations getting their booster vaccine.
  - We are working with our Health District to conduct a vaccine reminder called checked program where we send a short message to people that our records indicate are due for a booster vaccine and provide a link and the phone number to make an appointment. We have found in a pilot of this initiative that in those districts where we sent text and voice calls had twice the booster uptake rate in the same time frame as the general population.
  - We are excited to expand this to more as a population and work with districts to communicate locally that this is -- that the initiative is legitimate and to schedule their booster vaccine appointment. In anticipation of the five-year vaccine for six months to 4 years old being authorized for emergency use by the FDA and the CDC recommending this vaccine, coordinating pre ordering to preposition

vaccine across the Commonwealth. VDH is working with its local health districts, private providers, pharmacies, FQHCs and health systems to identify the COVID-19 vaccine providers to order and administer this vaccine. This is a similar process that we have done previously with new vaccines as they are introduced into our rollout although vaccines is being pre ordered it will not be shipped unless the FDA authorizes its emergency use and it cannot be administered unless the CDC publishes their recommendations.

- The age of the population will rely even more so on the medical homes than in previous populations as a (?) would not allow pharmacists to vaccinate children younger than three years of age. Often visiting their medical homes regularly for their well child visit and that might help primary care providers integrate the vaccine into their existing program.
- VDH is working to coordinator operations logistics for this effort. There will be enough allocation vaccine in the Commonwealth. However, patients already encouraged with providers -- with parents to ensure that providers have time to receive the vaccine, understand and train their staff on how to store and handle it and incorporate it into their operations.
- VDH continues to monitor more information that is becoming available regarding this vaccine and share resources and training opportunities with our providers including hosting webinars and sharing information.

- **Question and Answer Session:**

  - **Question: Robert Morrow, Virginia 211:** Good morning, Suzi and everyone. Just one quick question. I did not see any of the slides talked about today on the website. So I'm assuming that I am looking in the right place and they are not up yet. The other item was just a quick comment with the texting.
  - We had a similar experience last year with Department of Social Services doing outbound texting to notify people that there were resources to do their taxes. And we had a lot of calls to 211, people asking if it was fraud.
  - Because we have so many things out there now that folks, you know, are told that no one will ever call you, no one will ever text you. So you may want to do some messaging out there around that. And as always, you can give us a heads up and we can help out. Thank you. That's all I have.
  - **Response: Suzi Silverstein:** Thanks, Robert. Dr. Forlano's slides will be posted up on Monday along with the minutes from today's meeting. And Justin's slides are up on the web page but we will make sure they are highlighted for anybody that had difficulty finding them.