

COVID-19 ECHO update May 24 2021

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No disclosures

Opinions expressed only my own

Agenda

FDA update on vaccine storage

Data Summary, Global, National,
Indian Country

Lessons Learned

FDA In Brief: FDA Authorizes Longer Time for Refrigerator Storage of Thawed Pfizer-BioNTech COVID-19 Vaccine Prior to Dilution, Making Vaccine More Widely Available

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For Immediate Release: May 19, 2021

The following quote is attributed to Peter Marks, M.D., Ph.D., director of the FDA's Center for Biologics Evaluation and Research

Making COVID-19 vaccines widely available is key to getting people vaccinated and bringing the pandemic to an end. Pfizer Inc. submitted data to the FDA to support storage of undiluted, thawed vials of its COVID-19 vaccine for up to one month at refrigerator temperatures. This change should make this vaccine more widely available to the American public by facilitating the ability of vaccine providers, such as community doctors' offices, to receive, store and administer the vaccine.

Additional Information

- Based on a review of recent data submitted by Pfizer Inc. today, the U.S. Food and Drug Administration is authorizing undiluted, thawed Pfizer-BioNTech COVID-19 Vaccine vials to be stored in the refrigerator at 2°C to 8°C (35°F to 46°F) for up to 1 month. Previously, thawed, undiluted vaccine vials could be stored in the refrigerator for up to 5 days.

From 5 days to
1 month
storage

Data summary

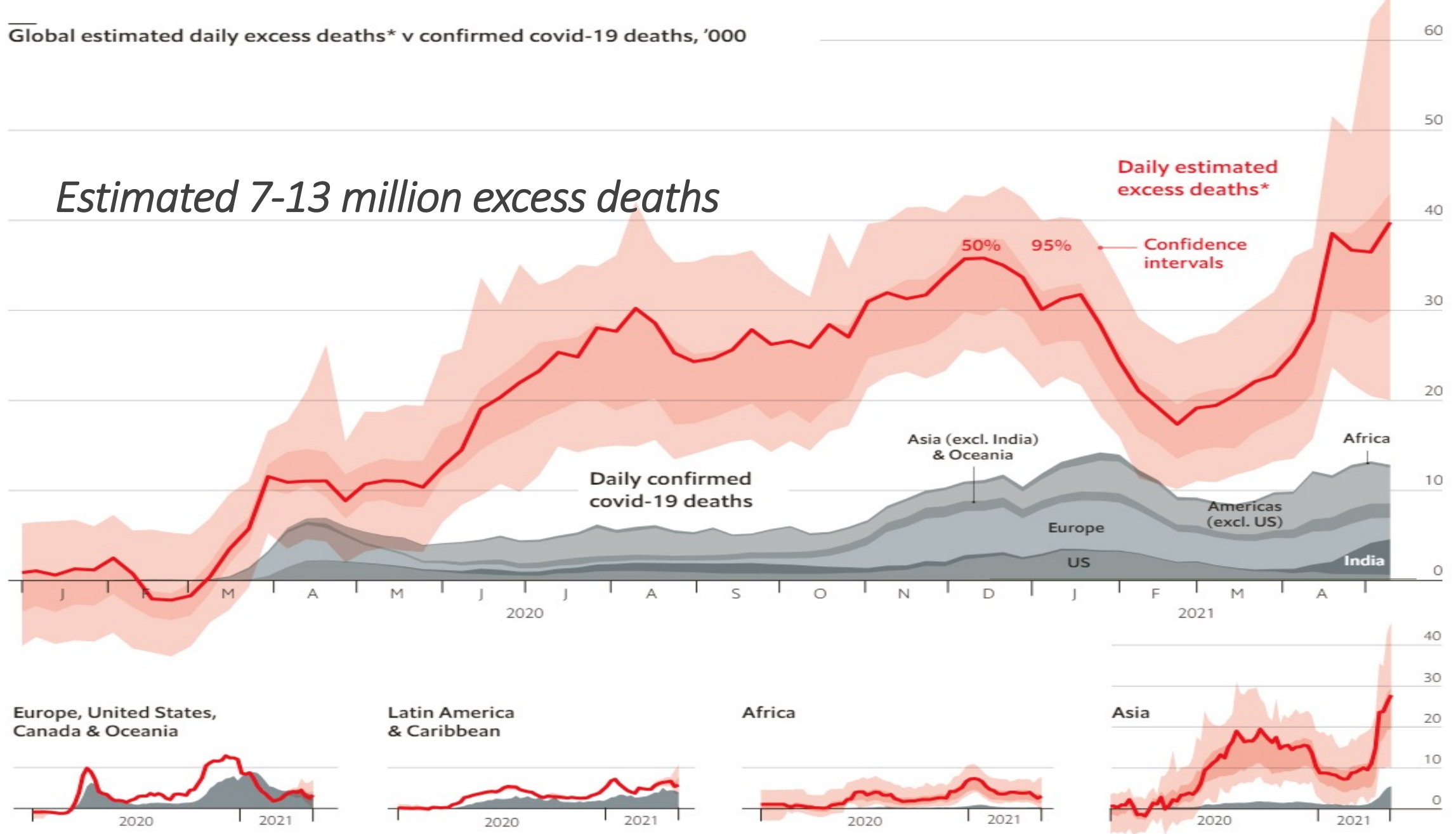
Cumulative and current data overview

Global Toll

166 million cases

3.5 million deaths

1.6 billion vaccine doses administered



Estimating mortality

- Many countries not testing/reporting
- Country demographics an important part of course of disease (average age of Japan is 48, in Uganda it is 17)

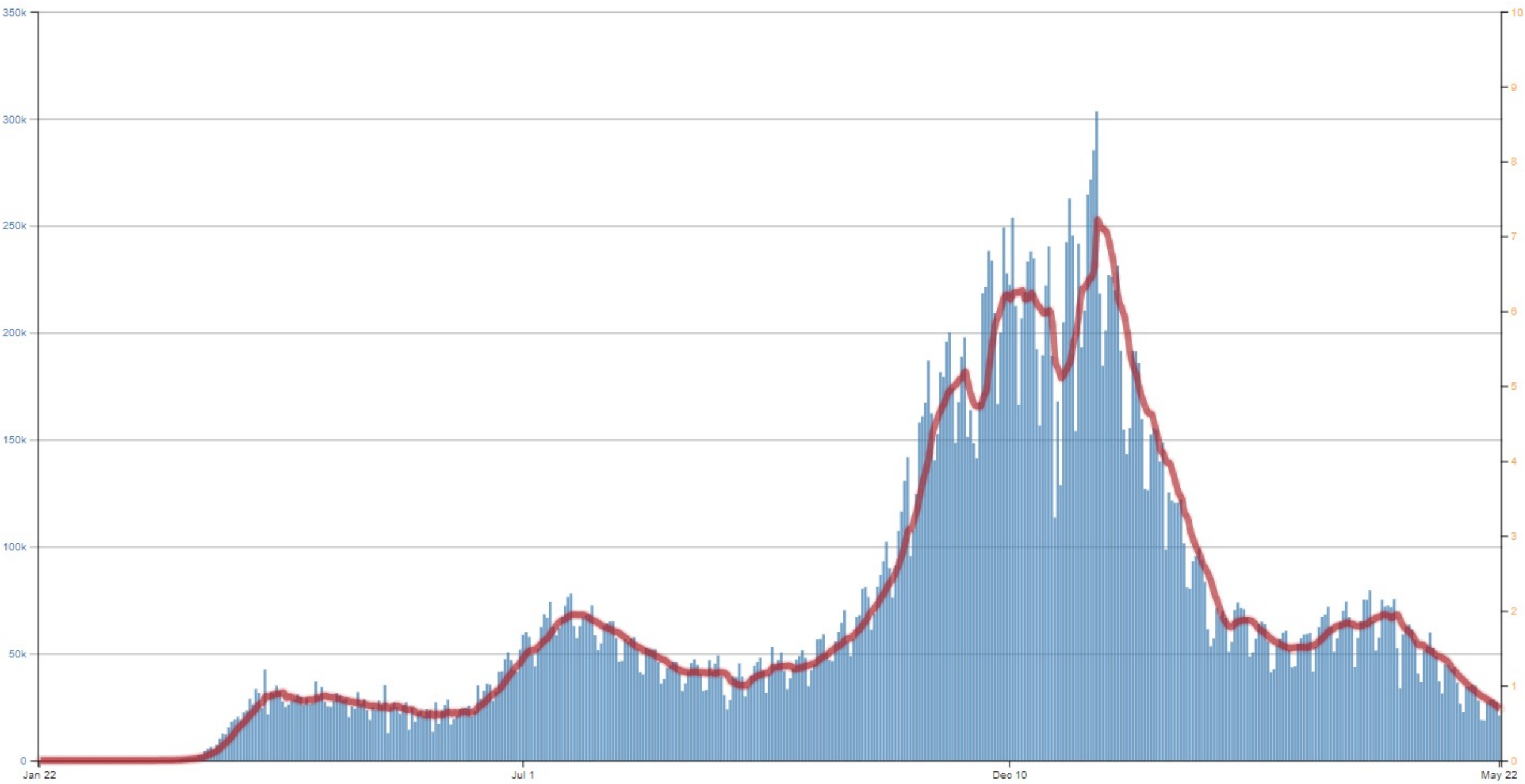
US only

33 million cases

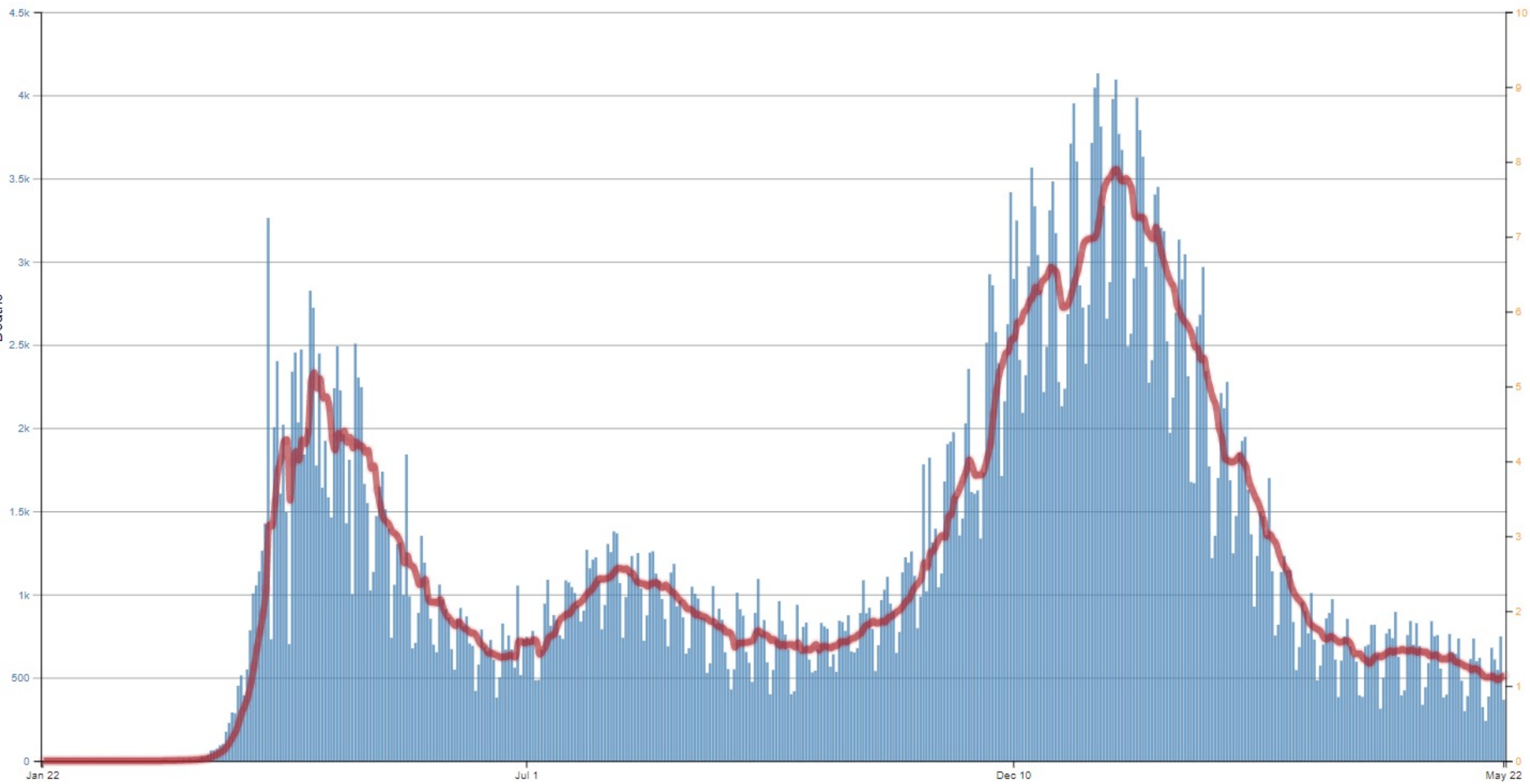
600,000 deaths

61% adults have at
least 1 vaccination

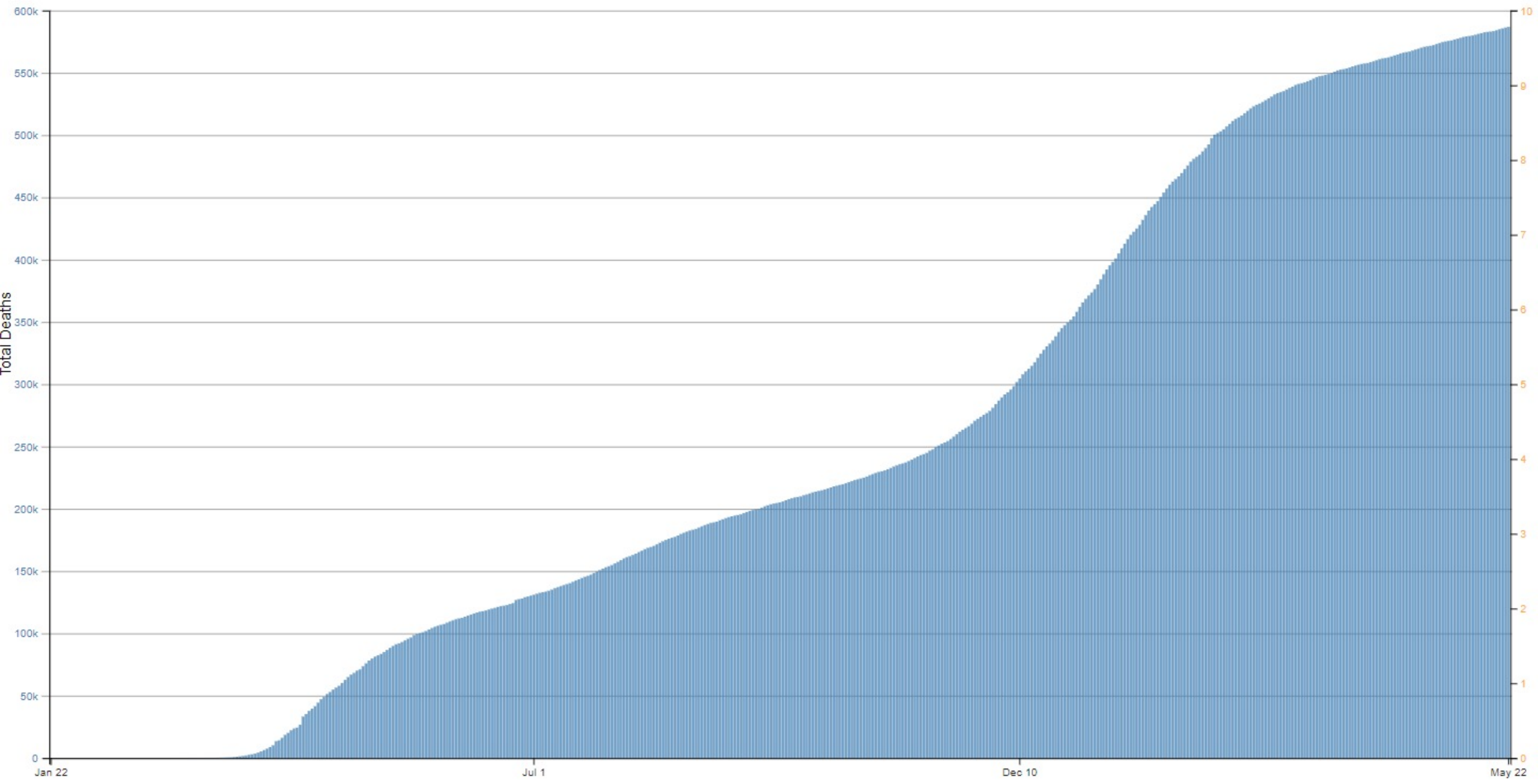
Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC



Daily Trends in Number of COVID-19 Deaths in the United States Reported to CDC



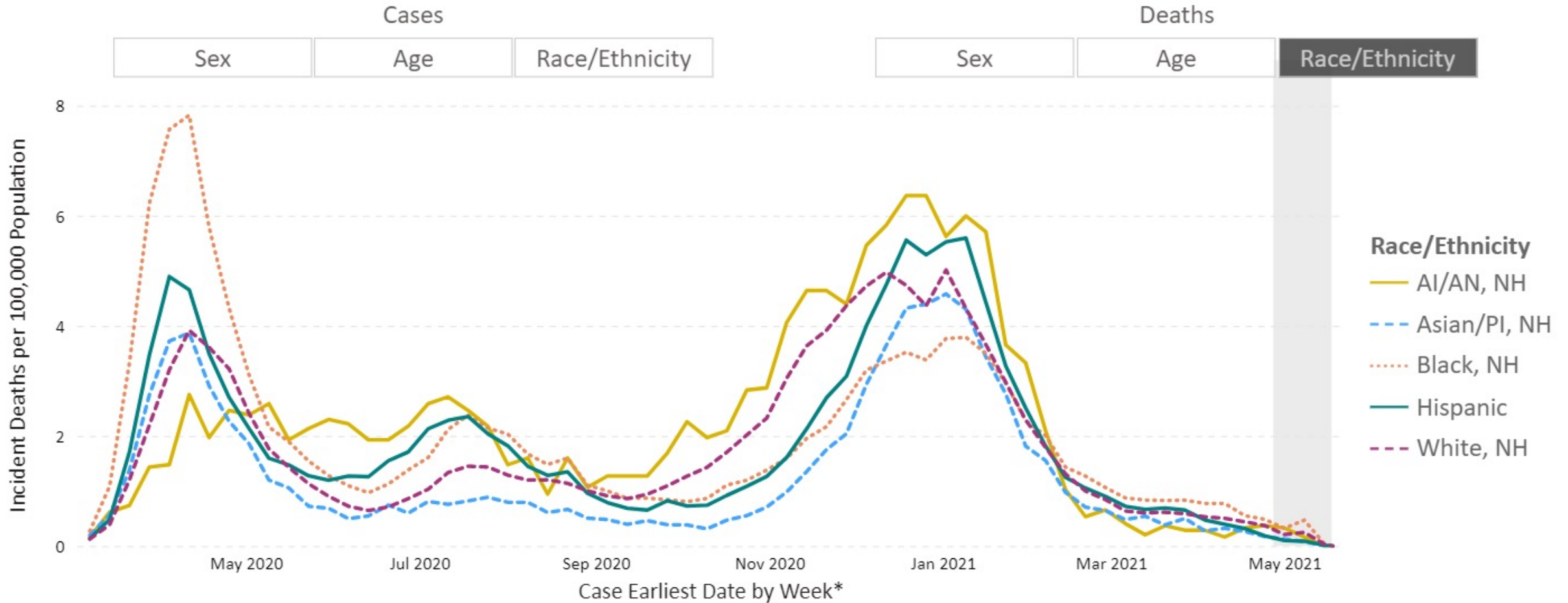
Trends in Total COVID-19 Deaths in the United States Reported to CDC



COVID-19 Weekly Deaths per 100,000 Population by Race/Ethnicity, United States



March 1, 2020 - May 18, 2021



Percentage of records reporting: Death = 61.86%, Race/Ethnicity = 82.64%

US territories are included in case and death counts but not in population counts. Potential two-week delay in case reporting to CDC denoted by gray box. AI = American Indian, AN = Alaska Native, NH = Non-Hispanic, PI = Pacific Islander.

*Case Earliest Date is the earliest of the clinical date (related to illness or specimen collection and chosen by a defined hierarchy) and the Date Received by CDC.

IHS Dashboard

No trends available in positive test data

~1.4 million vaccine doses administered

7-day positivity rate 3.3%. Range 1.2% (AK) to 6.4% (PHX)

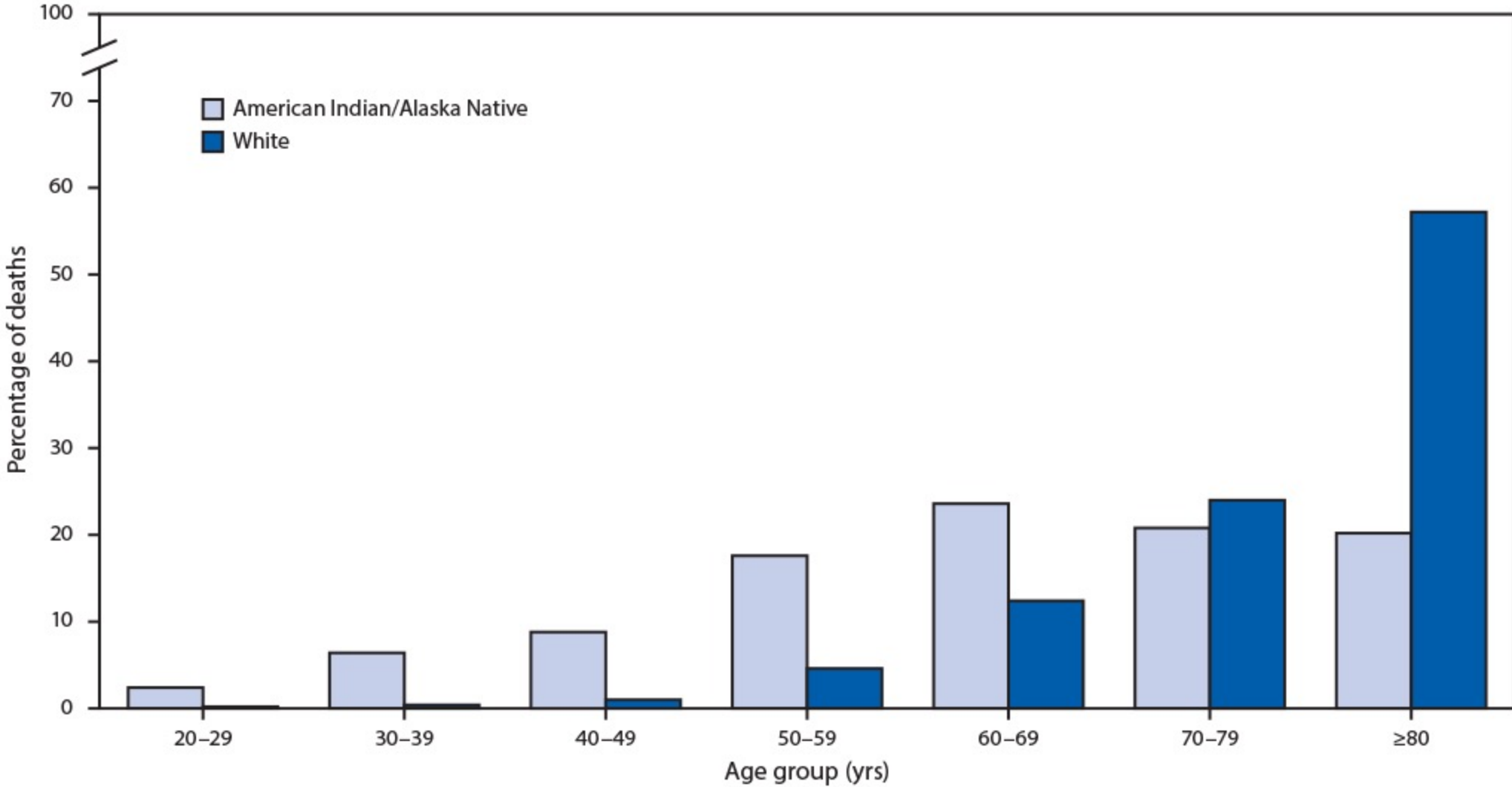
CDC data by race/ethnicity:

AI/AN 158,189 cases and 3,391 deaths (2.1% mortality rate)

Proportionally higher in younger patients, such as 30-39 years old (2.8% of total deaths) and 40-49 years old (2.5%)

3.5x higher hospitalization, 2.4x higher deaths (Rate Ratio compared to Whites)

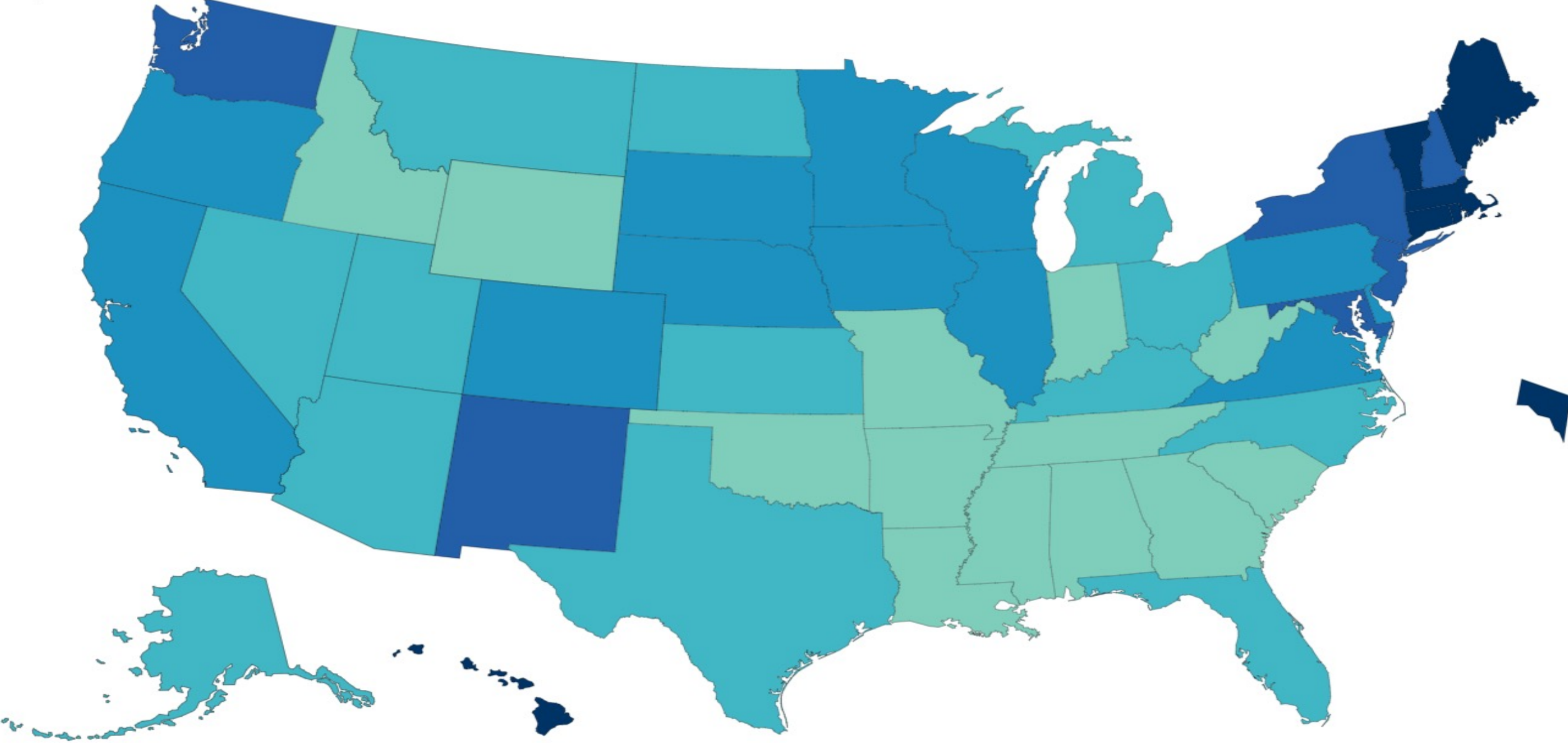
FIGURE. Percentage distribution of COVID-19–associated deaths among American Indian/Alaska Native* and non-Hispanic White persons aged ≥20 years, by age group[†] — 14 states,[§] January 1–June 30, 2020



[COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020 | MMWR \(cdc.gov\)](#)

Vaccination

Total Doses Administered Reported to the CDC by State/Territory and for Select Federal Entities per 100,000 of the Total Population



Total Doses Administered per 100,000

○ No Data ● 0 ● 1 - 75,000 ● 75,001 - 85,000 ● 85,001 - 95,000 ● 95,001 - 105,000 ● 105,001+

Tribe records 13 assists, vaccinates most of the Portland Trail Blazers

03.22.2021 - DANIELLE HARRISON HEALTH & WELLNESS



Thirteen of the Portland Trail Blazers, including center Enes Kanter, received their first dose of the Moderna COVID-19 vaccine at the Confederated Tribes of Grand Ronde gym on Monday, March 22. The Tribe has been vaccinating the general public since February.

Cherokee Nation Latest, Largest Oklahoma Tribe To Offer COVID Vaccine To Anyone Who Wants One

By CHRIS POLANSKY • MAR 19, 2021

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Jason Stanfill, 44, traveled from Broken Arrow to receive his COVID-19 vaccine at the Cherokee Nation Outpatient Health Center in Tahlequah on March 18.

COURTESY CHEROKEE NATION

US tribe shares vaccine with relatives, neighbors in Canada

By IRIS SAMUELS May 5, 2021



COVID-19 Vaccination among American Indian and Alaska Native People

Latoya Hill  and Samantha Artiga 

Published: Apr 09, 2021

Data available to date show that AIAN people are being vaccinated at a higher rate compared to other racial/ethnic groups. Federal data show that 32% of AIAN people had received at least one dose of a COVID-19 vaccine, compared to 19% of White people, 16% of Asian people, 12% of Black people and 9% Hispanic people as of April 5, 2021. State data similarly find higher vaccination rates among AIAN people compared to other groups.

The high vaccination rate among AIAN people largely reflects Tribal leadership in implementing vaccine prioritization and distribution strategies that meet the preferences and needs of their communities. The high rates may also, in part, reflect the greater supply of vaccine doses delivered to the IHS relative to the number of people served compared to state vaccination programs. Tribes have supported and built on existing trusted community resources and providers to distribute vaccines. The success Tribes have achieved in vaccinating their communities provide lessons learned that may help inform broader vaccination efforts going forward.

[COVID-19 Vaccination among American Indian and Alaska Native People | KFF](#)

CORONAVIRUS

Makah, Quileute tribes extend reservation closure

Visitors barred from Neah Bay, La Push

By [Zach Jablonski](#)

Thursday, May 20, 2021 5:15pm | [NEWS](#) [CLALLAM COUNTY](#) [CORONAVIRUS](#)

[JEFFERSON COUNTY](#)



Lessons Learned

Non-clinical

Clinical (from October 2020)—how far we've come

Lessons learned responding to the COVID-19 pandemic

[Anna C. Sick-Samuels](#), MD, MPH^{1,2}


1. Listen and let people finish. Sometimes it is most important to stop talking and listen. Especially when we are using teleconference or zoom calls and we cannot actually see each other's facial expressions, try to let people finish their sentences. Not only because people have important things to say but also because we feel valued when we are heard. Listening is a way to show respect.
2. Repeat important messages. When the issues and guidance are changing rapidly, we need to repeat the important messages. Repeat to your immediate circle or leadership. Repeat to the broader audience. Repeat with written communications. Repeat with pictures or videos. Repeat in person with individuals.

3. Anxiety is a strong motivator. Especially when working with thoughtful and detail-oriented colleagues. When people do not feel comfortable with a plan, it will not proceed as anticipated and individuals may modify the plan to align with their concerns. Decisions need to consider both physical safety and emotional safety.
4. Brainstorming is different than decision making. As many of us grappled with making decisions for a novel situation with limited data without a precedent to build on, brainstorming discussions occurred on widely attended forums. Sometimes ideas were interpreted as decisions, which can lead to confusion. For those listening, it is important to flag brainstorming from decision points. As a listener, it is important to ask for clarity when it is unclear whether a decision was made.

5. Kindness is vital. Recognize where people are coming from, and respond kindly, even if you do not agree. Everyone showing up is present because they care and are willing to chip in. We must be kind to each other and build together.
6. Disagreement is an opportunity. Many times disagreement ultimately leads to better plans. It may take time and patience to revisit decisions and consider different angles. However, these discussions typically lead to a better plan, or an improved communication of the same plan.
7. Be honest about uncertainty. This is a lesson learned during clinical training- that one should not pretend to know the answer when one does not know. Sometimes communicating uncertainty is extremely difficult but it is important to distinguish opinions from facts.
8. Fatigue is real. Physical or emotional. We are all human. It is necessary to self-recognize and protect one's own health, especially when others are counting on you. When we are so tired we cannot think clearly, or so drained we cannot be kind, we are no longer effective leaders, colleagues, parents or partners.

CORRECTED PROOF

COVID-19—Lessons Learned and Questions Remaining FREE

Ferric C Fang , Constance A Benson, Carlos del Rio, Kathryn M Edwards, Vance G Fowler, Jr, David N Fredricks, Ajit P Limaye, Barbara E Murray, Susanna Naggie, Peter G Pappas ... [Show more](#)

Clinical Infectious Diseases, ciaa1654, <https://doi.org/10.1093/cid/ciaa1654>

Published: 26 October 2020 **Article history** ▼

Table 1.

COVID-19: Lessons Learned

Epidemiology

- Presymptomatic transmission plays an important role in community spread.
- 10–20% of individuals may be responsible for 80% of transmission.
- Short range aerosol transmission is an important route of spread, and longer-range transmission can occur in closed, poorly-ventilated spaces.
- Racial and socioeconomic disparities in illness are similar those seen in the HIV pandemic.

Prevention

- Vaccines are being rapidly developed and tested.
 - Universal face mask use can reduce the efficiency of transmission.
 - Health care workers are at risk but can be protected by appropriate PPE.
-

Other lessons learned?

-Tribal governments and health officials leading from the front: guidance, action, messaging, outreach, vaccination

-Federal and State partnerships delivered better than in past emergencies with resources, respect, prioritization

Coming back



Impact of the COVID-19 Pandemic on Chlamydia and Gonorrhea Screening in the U.S.

Casey N. Pinto, PhD, MPH, NP-C   • Justin K. Niles, MA • Harvey W. Kaufman, MD • ...

Damian P. Alagia, MD • Guangqing Chi, PhD • Barbara Van Der Pol, PhD, MPH • [Show all authors](#)

[Open Access](#) • Published: May 19, 2021 • DOI: <https://doi.org/10.1016/j.amepre.2021.03.009>

Results

Chlamydia and gonorrhea testing reached a nadir in early April 2020, with decreases (relative to the baseline level) of 59% for female patients and 63% for male patients. Declines in testing were strongly associated with increases in weekly positivity rates for chlamydia ($R^2=0.96$) and gonorrhea ($R^2=0.85$). From March 2020 through June 2020, an expected 27,659 (26.4%) chlamydia and 5,577 (16.5%) gonorrhea cases were potentially missed.

Conclusions

The COVID-19 pandemic impacted routine sexually transmitted infection services, suggesting an increase in syndromic sexually transmitted infection testing and missed asymptomatic cases. Follow-up analyses will be needed to assess the long-term implications of missed screening opportunities. These findings should serve as a warning for the potential sexual and reproductive health implications that can be expected from the overall decline in testing and potential missed cases.

Let's hear from
you

-COVID lessons learned

-Post COVID ways of
working

-via link in the chat or
dstephens@npaihb.org

Additional questions

Clinical questions from CID journal as of 10/2020

Epidemiology

- How can superspreader events be avoided?
- Why do infection rates and severity vary so widely among individuals and countries?
- Why are global COVID-19 mortality rates falling?

Virology

- Does viral diversity influence illness severity?
- Can early administration of agents such as vitamin D, famotidine or interferon prevent infection or arrest disease progression?
- What is the impact of prior exposure to endemic seasonal coronaviruses?

Clinical

- What are late complications and how can they be managed and/or prevented?

Treatment

- What is the treatment for mild disease?
- When should antifungal prophylaxis be considered?
- Is there a role for immunomodulatory agents in addition to corticosteroids?
- How should the timing of immunomodulatory interventions be optimized?
- Is convalescent plasma beneficial?
- What is the role and optimal dosing of anticoagulant therapy?

Diagnosis

- What is the accuracy of antigen compared to viral RNA testing?
- What are the correlates and durability of protective immunity?

Prevention

- Can effective vaccines and other targeted immunotherapeutics be found?
- Does low-level viral exposure lead to protective immunity?
- How can communities reopen and resume essential activities without incurring new waves of epidemic spread?
- Can upgrading ventilation systems in businesses and schools facilitate reopening?