COVID-19 ECHO

Session 94

COVID Case Data

<table>
<thead>
<tr>
<th>Cases</th>
<th>Hospitalized</th>
<th>Counties</th>
<th>People Tested</th>
<th>Test Encounters</th>
<th>Deaths Among Cases</th>
<th>Deaths Due to COVID-19</th>
<th>Outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>415,037</td>
<td>22,837</td>
<td>64</td>
<td>2,505,587</td>
<td>5,869,369</td>
<td>5,828</td>
<td>5,655</td>
<td>3,748</td>
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</tbody>
</table>

https://covid19.colorado.gov/data

Colorado Vaccination Data

<table>
<thead>
<tr>
<th>Colorado is in Phase 1A &amp; 1B</th>
<th>Total Vaccine Providers</th>
<th>People Immunized with One Dose</th>
<th>People Immunized with Two Doses</th>
<th>Cumulative Doses Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>817</td>
<td>704,052</td>
<td>313,842</td>
<td>1,019,072</td>
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</tr>
</tbody>
</table>

https://covid19.colorado.gov/vaccine

Updated as of 02/17/21

- **Speaker:** Heather Roth, Immunization Branch Chief, CDPHE
- CDPHE has been posting [vaccination data](https://covid19.colorado.gov/vaccine) publicly
  - Demographic data:
    - Age - focus on those who are 70 and older. Sex - female predominant
    - Race/Ethnicity - white individuals overrepresented, hispanic, black and asian coloradans are underrepresented compared to % of total population
  - Changes made to the vaccine distribution prioritization:
    - 1B.1 - moderate risk healthcare worker, first responder, persons over 70
    - 1B.2 - 65-59, school and support staff (pre-K through 12th), some Gov.
    - 1B.3 - frontline workers in certain fields, 16-64 with 2+ high risk conditions
    - 2 - ages 60-64 and individuals with 1 high risk condition
- **Timeline:** Goal to vaccinate 50% of phase 1B.2 and start 1B.3 on March 5th
  - Get 70% of age 70+ by the end of Feb (~55% currently, on track)
- No residency or ID requirements for vaccination
- Public health order to address disparity in vaccine administration:
  - To the best extent possible, providers should create a separate, easy to find link for individuals to sign up for vaccines, should be disability friendly.
  - Providers must have a vax appt. phone number to assist those without internet.
  - Providers to the best extent possible will provide demographics information
- Vaccine Equity Plan - providers must describe how they will provide vaccine equitably.
  - Denver Health, Stride and Salud are the FQHC organizations, and get additional vaccines outside of the normal CDPHE distribution (1M vaccines in first week)
  - What are we doing to address the disparity in race: 10-15% of vaccine distribution is being held for equity allocation. Support equity pop-up clinic in the community, 36 events and over 13,000 doses of the vaccine through this so far. Soon should have weekly, recurring clinics focusing on specific communities.
  - Transportation partnership, partnering with RTD, Lyft and Arrow Stage bus lines. Discussion of retrofitting busses to mobile vaccine clinics. 10 Healthcare providers of color volunteering their time going into communities and providing information and addressing hesitancy. English and Spanish speaking.
- **Federal Retail Pharmacy Program** - focus on vaccination by age (70+ now, 65-70 after)
Additional Questions and Answers

1. Q: Do we have a feel for how protected folks are if they just get the first dose?
   a. There is some data, I don’t have it at my fingertips. CDC still recommends completing the series, though second dose can be given as late as 42 days after the first dose. Recommendation is still 2 doses.

2. Q: Do we have an estimate of the percent of nursing home residents that are vaccinated?
   a. Again, I don’t have this data this AM. The uptake among residents anecdotally has been very high. The staffing piece is concerning to all of us since they can be the transmission vehicle. There is a lot going on in terms of health education for this population. CVS and Walgreens have been partnering at the Federal level to go into these facilities. Delayed uptake among staff as well.

3. Q: Some teachers that signed up for the vaccine have not received an invitation to be vaccinated after two weeks of registration. What should my answer to these teachers be?
   a. The education piece looks a bit different. My sister teaches in Jeff-Co and she has not heard anything for a while. Her colleagues are hunting around for open appointments wherever possible. Guidance: follow what the district is saying and be your own advocate as well. Find an appointment with someone who is not a designated vaccine provider with your district.

4. Q: Do we know if clinics like FQHCs in Colorado have access to provide the vaccines within the clinics?
   a. Yes, the federal program will assist with that piece as we are able to push more vaccines to that population. CO did a good job of prioritizing FQHCs, 10-15% reserved for these systems. Is this the amount overall that we want? No, but that is overall number constraints. This is why we are excited about this federal program.

5. Q: Do you have any insight as to why college level teachers were excluded from 1.b.2?
   a. I was not directly involved in this, but I think ultimately it comes down to the idea that educators and students in higher education can more readily distance and learn remotely. The emphasis on K-high school is to free up parents and allow them to get back to work as well.

6. Q: Is there any data on patients who have had MIS-C and then received the vaccine?
   a. There is not much data unfortunately. This is such a rare occurrence that the studies will likely take time to learn about this.

7. Q: You seem to have left out people with HIV or immunosuppression due to treatment for autoimmune disease in phase 1.b.3. Why?
   a. Again, I am not entirely sure what the decision making process was for this list. I think the intention was to align with ACIP. I have been hearing from a lot of physicians that there are many other categories that should be included. I am hopeful that before we get to 1B.3 that we can have some flexibility and let professionals make medical judgements on this. Other thoughts are to remove risk based and go to simple age based distribution.

8. Q: Patients who can receive covid vaccines in my clinic are sometimes also due for a couple of other vaccines, like shingles. Is it ok to give other vaccines along with covid or should the covid vaccine be given alone to maximize response?
   a. Such a good question, I would have to look for this answer and can follow up. If a patient has received a vaccine in the 14 days before they are not supposed to receive.

9. Q: It seems that opening to large populations before progress is made in underrepresented populations just makes access for them harder. Why not set goals for those giving vaccines and the state re: underrepresented groups before moving on?
   a. That’s a great question, and I don’t have a great answer. The equity clinics we have are focused on the top 100 census tracts for highest poverty and predominantly minority groups. We are establishing clinics in these communities, so there is a goal, but perhaps not the best one.

10. Q: Isn’t asking for an ID card the same as requiring it in terms of public perception and vaccine hesitancy?
a. We know that people are gaming the system and claiming that they are 70 and they are not. We have messaged far and wide to migrant and undocumented communities that they do not need an ID and that their information will not be shared. It probably does appear as a barrier.

11. Q: People sign up at multiple sites and then do not cancel at the other sites once they receive the vaccine. Any help or suggestions for this?
   a. One thing that I would think of is that they are creating a waiting list so that they can follow up in the case of a no-show. This would be the most straightforward way to deal with this.

12. Q: Do we know how much of the disparity in vaccination to minority groups is due to lack of access vs. vaccine hesitancy?
   a. I don't think we do, we are currently in the field right now. Specifically focused on the minority population, asking questions about access as well as hesitancy to hopefully better address this question and ultimately address the problem.

13. Q: Are the equity events all over the state?
   a. They have been spread far and wide, they are both urban and rural. We have not been in every county.

14. Any plan for a centralized state vaccine signup website/program to address people signing up at multiple sites?
   a. Yes, we did purchase an appointment scheduling system. We have talked about it, but there does not seem to be an interest from executive leadership to roll out for the whole state. Will likely be used for large scale vaccination days. For 1B.1 and 1B.2 individuals who have yet to find a vaccine, this system could collect information for those we haven't reached yet and be able to partner them with a vaccine provider.

15. Dr. Osterholm with CIDRAP is warning of an outbreak with the UK variant B.1.1.7 in the next 6 weeks. He is recommending a single dose vaccine for all high risk patients to maximize those vaccinated and decrease hospitalizations. Follow up with a second vaccine in 2-3 months after the outbreak. Should this be considered in Colorado?
   a. We follow ACIP guidelines. If we were to make any changes to our approach that would have to come from the top down.

16. Q: Is there a contact to share for community members to request an equity-based popup clinic?
   a. Yes, I will share the clinic application with this group and you are welcome to submit an application.

17. Q: Signup is still heavily internet literacy-dependent. Seniors without family support are struggling to get signed up. How are you reaching out to seniors who don’t use computers?
   a. We do have a call center staffed by over 200 agents, I will share that number. Seniors can call that center and get assistance getting linked up with an appointment. We also were thinking that it falls into the health equity bucket. Considered doing direct mail to seniors and outward bound calls to assist them.

18. Q: Any guidance for an approach to getting patients who had an “immediate allergic reaction” after mRNA vaccine to complete the series? Pre-treatment, receive in ER, allergist consultation first?
   a. I would go with an allergist consultation depending on how severe the allergic reaction was. If it was true anaphylaxis they will not complete the series.

19. Q: It makes sense to focus on FQHCs for vaccine distribution, but there are many community based, private practice, and DPC clinics who also serve rural and other underserved populations. Is there a plan to focus on those clinics to maximize vaccines to these communities?
   a. One thing that will come into play, probably later this week, is asking local public health agencies for input on where their allocation should be. Help direct vaccines with more local knowledge.

20. Q: Seems to me that there is heavy reliance on volunteers to give vaccines. How sustainable is this model as we hopefully move to 3 million vaccines a day?
a. We have a vaccine support team here at the state level. We can send these teams across the state to help support. We can also help pay individuals for these groups. FEMA is involved now and we are looking for ways to leverage FEMA resources to pull money or personnel to help fill some of these gaps.

21. Q: Regarding the unknown race/ethnicity information for provided vaccines, when we got information on some of those unknowns and decreased that percent from 22% to 14%, did those unknowns seem to differ from the overall pop or was it a similar (predominantly white) group?
   a. I don’t have the data on that. I can look into that, though I am not sure if we have done that analysis.