EOC Information Brief Notes 10/4/2021

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Mon 10/4/2021 11:53 AM

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All,

Attached are the presentation and meeting notes along with requested documents.

Thank you!

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Athens County

COVID-19 EMA Brief

Oct 04, 2021

U.S. Overview

https://covid.cdc.gov/covid-data-tracker/#trends_dailycases

United States
At a Glance

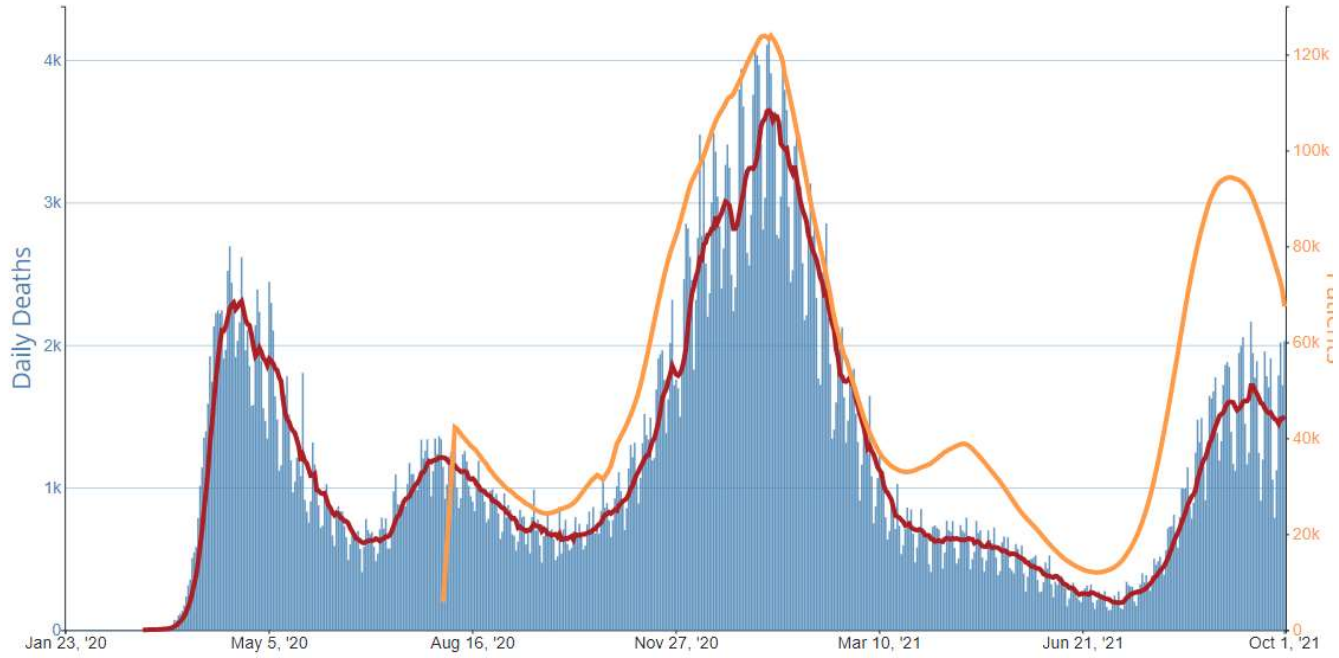
Cases Total 43,533,168 Up .76M 1 week Up 1.6M 2 week
Last 30 Days

Deaths Total 698,672 Up 13.7K 1 week Up 27.9K 2 week
Last 30 Days

75.8% of People 12+ with At Least One Vaccination

Community Transmission High

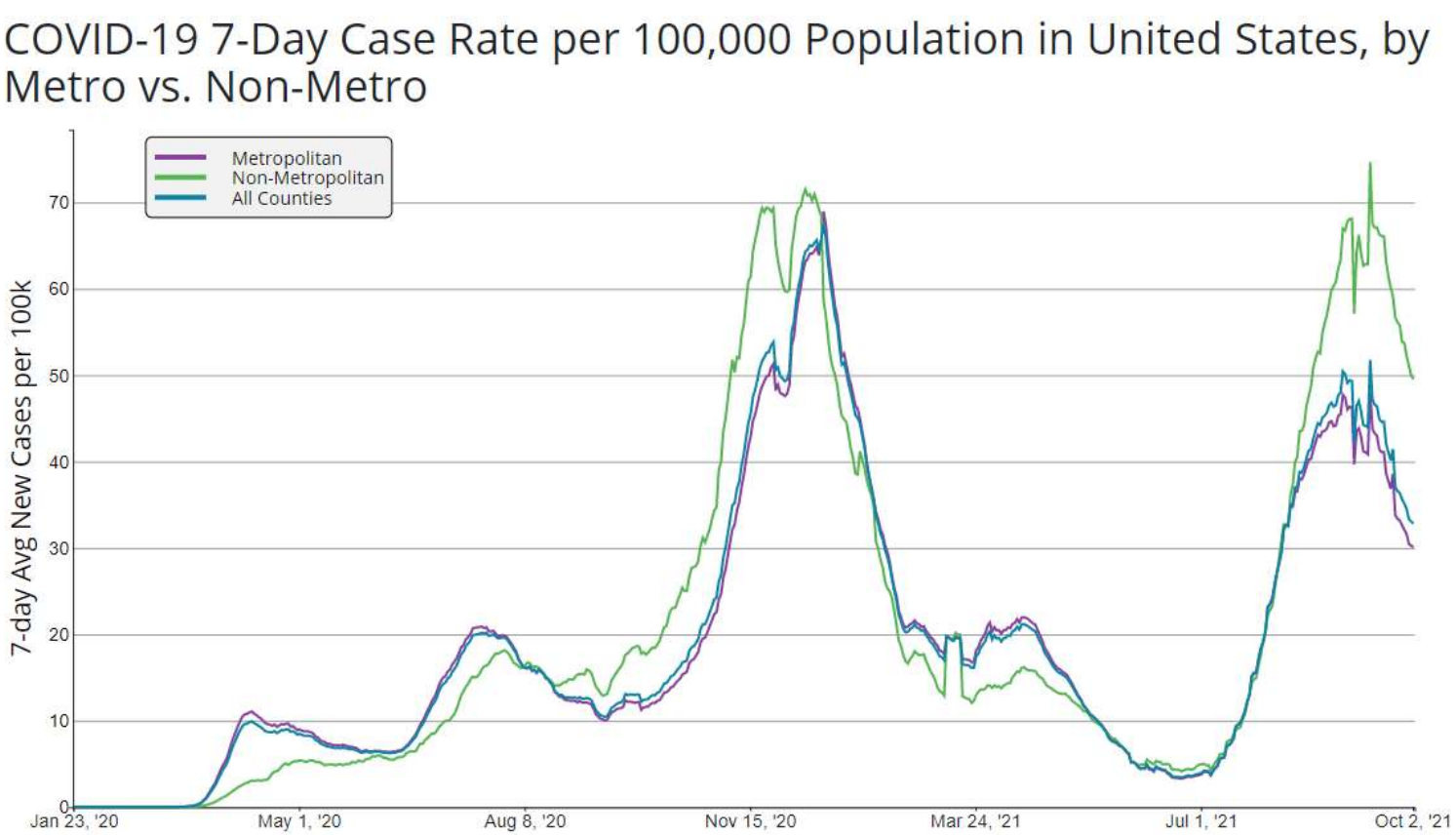
Daily Trends in Number of Deaths and 7-day Average of Current Hospitalized Patients with Confirmed COVID-19 in The United States Reported to CDC



- Blue bars show daily deaths.
- Red Line = 7 day moving average of deaths.
- Orange line represents current hospitalized patients.

U.S. Overview

https://covid.cdc.gov/covid-data-tracker/#trends_dailycases



- Fortunately, the US is on a downward trend with our new case rate.
- However, this graph still represents how hard the rural areas are being hit in comparison.
- This correlates to rural areas experiencing lower vaccination rates.

Ohio Overview

https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/current-trends

State of Ohio | COVID-19 Key Indicators

Last Updated: 10-03-21

Other states do not send death certificates to ODH's Bureau of Vital Statistics on a regular schedule and therefore fluctuations will be reflected in reported mortality data. Deaths are assigned to their appropriate date of death.

	Total Reported **Cases**	Last 24 Hour Reported **Cases** Change	21 Day Reported **Case** Average	21 Day Trend
Cases	**1,429,745**	**3,445**	**6,244**	8,447 / 5,568 / 3,445
	Total Reported **Hospitalizations**	Last 24 Reported Hours **Hospitalizations** Change	21 Day Reported **Hospitalization** Average	21 Day Trend
Hospitalizations	**73,691**	**72**	**262**	459 / 232 / 72
	Total Reported **ICU Admissions**	Last 24 Hours Reported **ICU Admissions** Change	21 Day Reported **ICU Admission** Average	21 Day Trend
ICU Admissions	**9,543**	**6**	**23**	47 / 19 / 6
	Total Reported **Deaths**	Last 24 Hours Reported **Deaths** Change	21 Day Reported **Death** Average	21 Day Trend
Deaths	**22,273**	**0**	**53**	328 / 0 / 0

Ohio's 21-Day trend is a good representative of the pressure surge placed on our Medical Services last month!

- On 9/17, 8,847 new case reported.
- On 9/21, 459 new hospitalizations.
- On 9/21, 47 new ICU admissions.
- On 10/01, 328 new deaths accounted to COVID.

(Approximately 2 weeks after above spike in other counts.)

Ohio Overview

Vaccine Started*	All Ages	12+	18+
% of Population	54.14%	63.28%	65.37%
# Recipients	6,328,450	6,328,251	5,955,886

Cases per 100,000 Residents Over 2 Weeks

Statewide Average: 616.7

Down 82 from last week's 698.7 count.

#	County	Cases Per 100K	Case Count	Population
1	Coshocton	1478.1	541	36,600
2	Perry	1383.7	500	36,134
3	Muskingum	1335.0	1,151	86,215
4	Adams	1321.4	366	27,698
5	Morrow	1307.7	462	35,328
6	Meigs	1287.8	295	22,907
7	Pike	1148.6	319	27,772
8	Lawrence	1146.9	682	59,463
9	Crawford	1113.4	462	41,494
10	Guernsey	1101.0	428	38,875
11	Marion	1086.1	707	65,093
12	Jackson	1082.9	351	32,413
13	Gallia	1080.3	323	29,898
14	Hocking	1057.9	299	28,264
15	Darke	1050.6	537	51,113
16	Richland	1038.3	1,258	121,154
17	Washington	1018.2	610	59,911
18	Vinton	978.2	128	13,085
19	Morgan	965.0	140	14,508
20	Scioto	964.0	726	75,314
21	Monroe	959.4	131	13,654
22	Brown	946.3	411	43,432

#	County	Cases Per 100K	Case Count	Population
23	Hardin	940.5	295	31,365
24	Fayette	894.0	255	28,525
25	Paulding	873.0	163	18,672
26	Jefferson	872.6	570	65,325
27	Knox	864.9	539	62,322
28	Columbiana	860.8	877	101,883
29	Pickaway	857.0	501	58,457
30	Preble	856.1	350	40,882
31	Noble	852.7	123	14,424
32	Clinton	850.6	357	41,968
33	Ross	838.7	643	76,666
34	Van Wert	834.7	236	28,275
35	Huron	832.4	485	58,266
36	Ashland	826.4	442	53,484
37	Highland	822.5	355	43,161
38	Miami	810.4	867	106,987
39	Williams	809.4	297	36,692
40	Allen	800.2	819	102,351
41	Hancock	791.7	600	75,783
42	Fulton	785.7	331	42,126
43	Wayne	785.6	909	115,710
44	Tuscarawas	781.6	719	91,987

#	County	Cases Per 100K	Case Count	Population
45	Defiance	777.2	296	38,087
46	Shelby	767.6	373	48,590
47	Belmont	765.6	513	67,006
48	Seneca	761.2	420	55,178
49	Clark	755.5	1,013	134,083
50	Wyandot	739.5	161	21,772
51	Harrison	731.4	110	15,040
52	Champaign	712.4	277	38,885
53	Mahoning	703.2	1,608	228,683
54	Athens	690.4	451	65,327
55	Clermont	680.6	1,405	206,428
56	Auglaize	670.2	306	45,656
57	Fairfield	669.5	1,055	157,574
58	Licking	666.1	1,178	176,862
59	Stark	644.9	2,390	370,606
60	Union	642.5	379	58,988
61	Sandusky	639.1	374	58,518
62	Henry	629.5	170	27,006
63	Montgomery	628.9	3,344	531,687
64	Putnam	620.2	210	33,861
65	Trumbull	611.7	1,211	197,974
66	Logan	578.0	264	45,672

#	County	Cases Per 100K	Case Count	Population
67	Warren	578.0	1356	234,602
68	Mercer	570.8	235	41,172
69	Lorain	559.3	1733	309,833
70	Portage	558.9	908	162,466
71	Butler	554.6	2125	383,134
72	Greene	551.7	932	168,937
73	Madison	550.0	246	44,731
74	Wood	539.7	706	130,817
75	Medina	529.1	951	179,746
76	Hamilton	528.7	4322	817,473
77	Lucas	522.9	2240	428,348
78	Carroll	520.2	140	26,914
79	Erie	498.2	370	74,266
80	Ashtabula	497.7	484	97,241
81	Ottawa	496.0	201	40,525
82	Franklin	479.7	6317	1,316,756
83	Delaware	458.5	959	209,177
84	Summit	424.8	2298	541,013
85	Cuyahoga	420.9	5199	1,235,072
86	Lake	371.5	855	230,149
87	Holmes	364.0	160	43,960
88	Geauga	300.1	281	93,649

https://coronavirus.ohio.gov/static/docs/statewide-and-county-case-rates.pdf

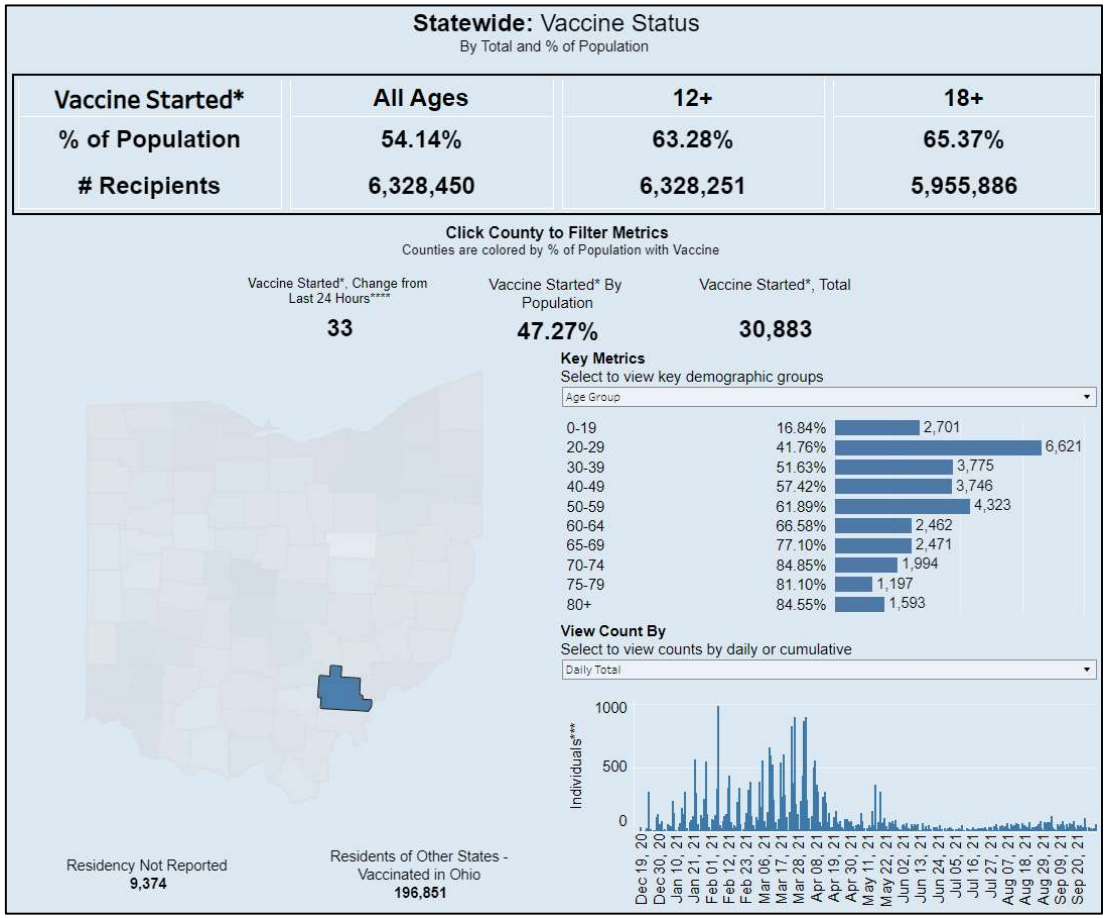
Vaccine Started Rates & New Contraction Rank amongst the 88 Counties

Athens = 47.27%	#54
Meigs = 40.30%	#6
Vinton = 36.48%	#18
Hocking = 44.39%	#14
Perry = 38.33%	#2
Morgan = 39.45%	#19
Washington = 48.84%	#17

Coshocton #1 contraction rate with a 36.68% vaccination. Their fair is this week – will monitor counts.

Athens County Vaccine Overview

https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/covid-19-vaccine/covid-19-vaccination-dashboard



Although vaccine percentages remain slightly lower than state average, Athens County still is one of the leading counties in SE Ohio for vaccine administration rates.

- A big thank you to the roll out efforts of the Athens City County Health Department that put Athens County in the forefront.
- And another big thank you to Ohio University, we know we can contribute the leading age group of 20-29 to your efforts!

Local Status Update

- 13 new cases were added to the Ohio Department of Health dashboard yesterday.

Zone 2 = 4, 7, and 8

Zone 2

COVID-19 PATIENT COUNT, BY DATE

Measure	9/28/21	9/29/21	9/30/21	10/1/21	10/2/21	10/3/21	10/4/21
COVID-19 Positive	995	969	948	929	877	891	884
Zone 2	995	969	948	929	877	891	884
COVID-19 Positive - ICU	265	260	264	251	245	247	242
Zone 2	265	260	264	251	245	247	242
COVID-19 Positive - Vent	183	184	193	181	179	175	182
Zone 2	183	184	193	181	179	175	182
COVID-19 Suspected	19	16	18	28	19	19	15
Zone 2	19	16	18	28	19	19	15

Region 7

COVID-19 PATIENT COUNT, BY DATE

Measure	9/28/21	9/29/21	9/30/21	10/1/21	10/2/21	10/3/21	10/4/21
COVID-19 Positive	147	137	130	117	121	126	111
Zone 2	147	137	130	117	121	126	111
COVID-19 Positive - ICU	22	18	20	19	13	13	14
Zone 2	22	18	20	19	13	13	14
COVID-19 Positive - Vent	16	14	15	15	12	12	13
Zone 2	16	14	15	15	12	12	13
COVID-19 Suspected	6	3	5	4	3	2	4
Zone 2	6	3	5	4	3	2	4

Region 8

COVID-19 PATIENT COUNT, BY DATE

Measure	9/28/21	9/29/21	9/30/21	10/1/21	10/2/21	10/3/21	10/4/21
COVID-19 Positive	220	224	214	213	196	195	188
Zone 2	220	224	214	213	196	195	188
COVID-19 Positive - ICU	53	53	57	56	59	53	47
Zone 2	53	53	57	56	59	53	47
COVID-19 Positive - Vent	33	39	40	42	37	36	35
Zone 2	33	39	40	42	37	36	35
COVID-19 Suspected	10	8	8	14	10	13	7
Zone 2	10	8	8	14	10	13	7

FLU SHOT

DRIVE-THRU CLINIC

WHEN: Monday October 11, 2021 9am-1pm
WHERE: Athens County Fairgrounds
WHO: Adults (18 years and older)

Monoclonal Antibody Treatment

https://combatcovid.hhs.gov/i-have-covid-19/how-do-i-know-if-im-high-risk

These treatments could help your immune system respond more effectively to the COVID-19 virus, reducing the chances that your symptoms will get worse. Your healthcare provider can help you decide if you are eligible for these mAb treatments.

Some early evidence suggests that mAb treatment can reduce the amount of the SARS-CoV-2 virus (the virus that causes COVID-19) in a person's system. This amount is known as viral load. Having a lower viral load means you may have milder symptoms thereby decreasing the likelihood of you needing to stay in the hospital.

mAb treatment may help people who:

- Have a positive COVID-19 test, and had symptoms for 10 days or less.
- Are at high risk of getting more serious symptoms

INDIVIDUALS 12 OR OLDER MAY QUALIFY FOR A MONOCLONAL ANTIBODY TREATMENT IF THEY HAVE CERTAIN AGE-BASED RISK FACTORS

AGES 12–17	AGES 18–54	AGES 55–64	AGES 65 OR OLDER
Obesity*	Obesity*	Obesity*	Anyone 65 or older qualifies
Diabetes	Diabetes	Diabetes	
Chronic kidney disease	Chronic kidney disease	Chronic kidney disease	
A condition or are taking medication that weakens the immune system**	Heart condition such as heart failure, cardiomyopathies, and possibly high blood pressure (hypertension)	A condition or are taking medication that weakens the immune system**	
Heart condition that is congenital or acquired such as heart failure, cardiomyopathies, and possibly high blood pressure (hypertension)	Pregnancy	Heart or circulatory disease	
Sickle cell disease	A condition or are taking medication that weakens the immune system**	High blood pressure	
A developmental condition like cerebral palsy	Dependent on regular use of medical technology like a ventilator or feeding tube	A long-term lung disease like chronic obstructive pulmonary disease (COPD) or asthma	
Daily medicine for asthma or another long-term lung disease		Dependent on regular use of medical technology like a ventilator or feeding tube	
Dependent on regular use of medical technology like a ventilator or feeding tube			

*Obesity is defined as: 18 or older with a body mass index (BMI) of 35 or above or for 12–17 year olds with a BMI above the 85th percentile for their age and gender based on Centers for Disease Control and Prevention growth charts.

**Up to the individual healthcare provider's judgment.

From last Thursday's Director All-Call Meeting

- Hospital information continues to paint a picture of over capacity statewide.
  - Data reported through hospital association and ODH seems to indicate a leveling of patient counts – still a high number overall.

- Ohio continues to receive allocation of monoclonal antibodies from HHS.
- ODH reporting that Ohio received a 13.5% increase in allocation from the previous week.
- Over 3,000 courses were reported as utilized last week.
- Importantly, it appears that hospitals, long term cares and FQHCs are working to allocate and administer antibodies in attempt to limit hospital admissions.

To today's notes and slides emailed out, attached will be;

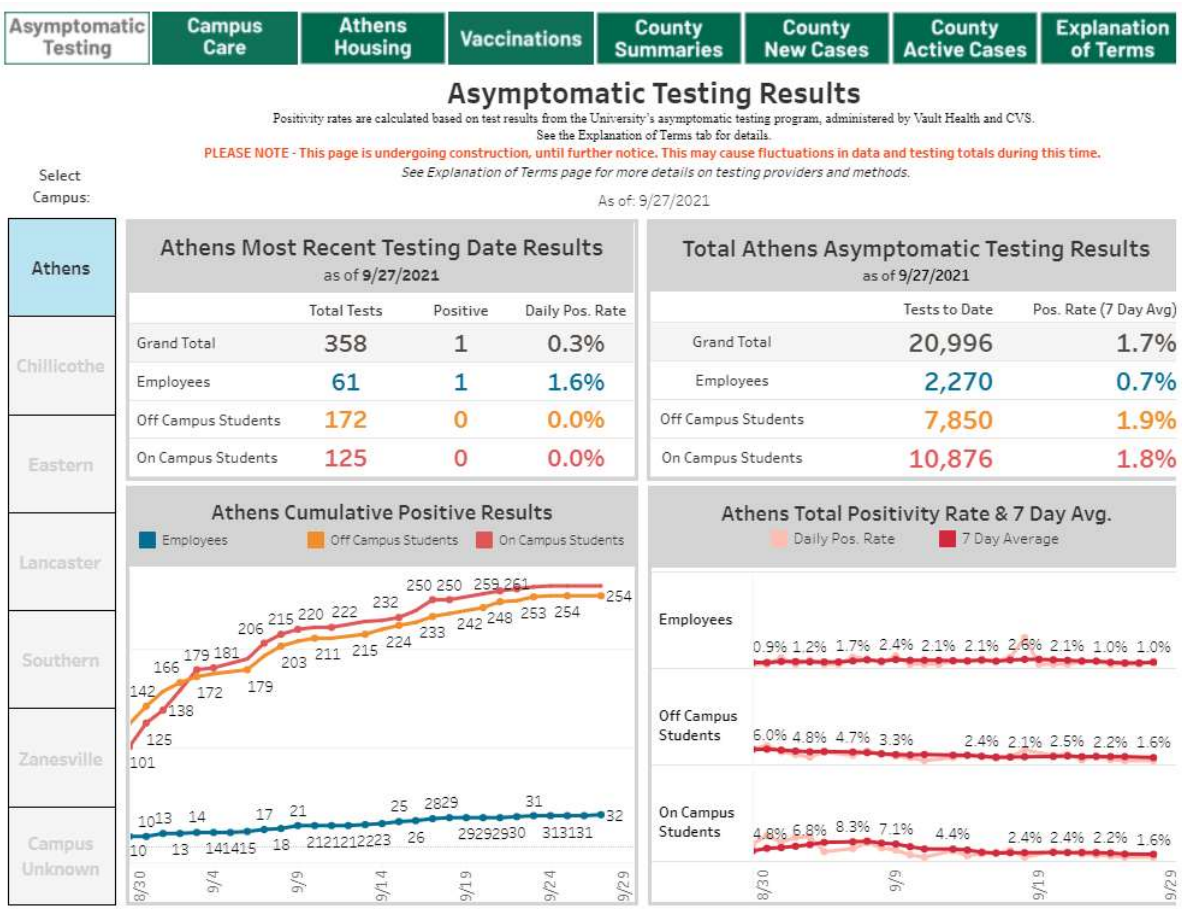
CDC's Health Advisory - COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19

ODH Media Advisory – Guidance on COVID-19 Vaccine Booster Doses

ODH Monoclonal Antibody FAQ – Provides resource links to answer the most common mAb treatment questions.

Ohio University Stats

https://www.ohio.edu/coronavirus/dashboard



- Worthy to note, that while the entire state seen a significant spike through mid-September, OU showed minor to no reverberation in test results.
  - More vaccine efficacy proof.

Information Sharing Agenda

Health Department
Hospitals
EMS
Fire Departments
Law Enforcement
Ohio University
School Districts
Senior Care Centers
Stakeholders

Situational Assessment
Staffing
Impact
Need

Ohio | Department of Health

Media Advisory

www.odh.ohio.gov

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

FOR IMMEDIATE RELEASE **Sept. 25, 2021**

Contact: Office of Communications (614) 644-8562

Ohio Department of Health Releases Guidance on COVID-19 Vaccine Booster Doses

COLUMBUS – The Ohio Department of Health has issued guidance to the more than 3,500 COVID-19 vaccine providers statewide to ensure they have access to the latest information on administering booster doses of the Pfizer/Comirnaty COVID-19 vaccines. In addition, Ohioans can get information about the booster doses from the following recently released resources:

- Fact Sheet COVID-19 Vaccine Booster Doses
- Frequently Asked Questions COVID-19 Vaccine Booster Doses

In alignment with the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA), booster doses of the Pfizer/Comirnaty COVID-19 vaccine are now available for the following populations at least six months after completion of the primary Pfizer series, meaning at least six months after the second dose was administered:

- **People 65 years and older or residents in long-term care settings SHOULD** receive a booster shot.
- **People ages 50 to 64 with certain underlying medical conditions SHOULD** receive a booster shot.
- **People ages 18 to 49 with certain underlying medical conditions MAY** receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient, but those eligible are encouraged to talk to their healthcare providers if they have any questions.
- **People age 18 and older who are at increased risk for COVID-19 exposure and transmission because of their job or living in an institutional setting MAY** receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient.

There are many opportunities in Ohio to be vaccinated, including walk-in and scheduled appointments statewide at pharmacies, federally qualified health centers, doctor's offices, community vaccination sites, and local health departments. There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Ohioans will be able to check gettheshot.coronavirus.ohio.gov or call 1-833-427-5634 for the latest eligibility information and to find a vaccine provider near them.

Eligible booster recipients will be asked to attest they have one of the qualifying conditions, but specific proof will not be required. Eligible Ohioans should allow 2-3 weeks to get their booster dose, with many opportunities to be vaccinated in their local community.

COVID-19 vaccines are widely available throughout the state. Many providers offer walk-in appointments, or Ohioans can schedule a vaccination appointment at gettheshot.coronavirus.ohio.gov. Ohioans who want to learn more about the safety, efficacy, and side effects of COVID-19 vaccines should talk to their doctor, nurse, or pharmacist, or visit coronavirus.ohio.gov/vaccine to learn more.

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This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
September 29, 2021, 12:00 PM ET
CDCHAN-00453

COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19

Summary
The Centers for Disease Control and Prevention (CDC) recommends urgent action to increase Coronavirus Disease 2019 (COVID-19) vaccination among people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future. CDC strongly recommends COVID-19 vaccination either before or during pregnancy because the benefits of vaccination outweigh known or potential risks. As of September 27, 2021, more than 125,000 laboratory-confirmed COVID-19 cases have been reported in pregnant people, including more than 22,000 hospitalized cases and 161 deaths.[1] The highest number of COVID-19-related deaths in pregnant people (n=22) in a single month of the pandemic was reported in August 2021. Data from the COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) in 2021 indicate that approximately 97% of pregnant people hospitalized (either for illness or for labor and delivery) with confirmed SARS-CoV-2 infection were unvaccinated.[2] In addition to the risks of severe illness and death for pregnant and recently pregnant people, there is an increased risk for adverse pregnancy and neonatal outcomes, including preterm birth and admission of their neonate(s) to an intensive care unit (ICU). Other adverse pregnancy outcomes, such as stillbirth, have been reported. Despite the known risks of COVID-19, as of September 18, 2021, 31.0% of pregnant people were fully vaccinated before or during their pregnancy.[3] In addition, there are racial and ethnic disparities in vaccination coverage for pregnant people. Healthcare providers should communicate the risks of COVID-19, the benefits of vaccination, and information on the safety and effectiveness of COVID-19 vaccination in pregnancy. Healthcare providers should strongly recommend that people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future receive one of the authorized or approved COVID-19 vaccines as soon as possible.

Background
COVID-19 vaccination is recommended for pregnant people. CDC recommends COVID-19 vaccination for all people aged 12 years and older, including people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.[4] CDC recommendations align with those from professional medical organizations serving people who are pregnant, including the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. Accumulating data provide evidence of both the safety and effectiveness of COVID-19 vaccination in pregnancy. CDC strongly recommends COVID-19 vaccination either before or during pregnancy, because the benefits of vaccination for both pregnant persons and their fetus/infant outweigh known or potential risks. Getting a COVID-19 vaccine can prevent severe illness, death, and pregnancy complications related to COVID-19.

COVID-19 vaccination coverage for pregnant people remains low. Despite recommendations for vaccination, uptake of COVID-19 vaccination by pregnant people has been lower than that of non-pregnant people.[5] In addition, vaccination coverage for pregnant people differs by race and ethnicity, with vaccination coverage being lowest for non-Hispanic Black pregnant people (15.6%) as of September 18, 2021.[3] Although the proportion of fully vaccinated pregnant people has increased to 31.0% (as of

September 18, 2021), the majority of pregnant people remain unprotected against COVID-19, and significant disparities exist in vaccination coverage by race and ethnicity.

Pregnant and recently pregnant people with COVID-19 are at increased risk of severe illness, death, and pregnancy complications. Pregnant and recently pregnant people with COVID-19 are at increased risk for severe illness when compared with non-pregnant people. Severe illness includes illness that requires hospitalization, intensive care unit (ICU) admission, mechanical ventilation, or extracorporeal membrane oxygenation (ECMO), or illness that results in death. Although the absolute risk is low, compared with non-pregnant symptomatic people, symptomatic pregnant people have more than a two-fold increased risk of requiring ICU admission, invasive ventilation, and ECMO, and a 70% increased risk of death.[6] Pregnant people with COVID-19 are also at increased risk for preterm birth and some data suggest an increased risk for other adverse pregnancy complications and outcomes, such as preeclampsia, coagulopathy, and stillbirth, compared with pregnant people without COVID-19.[7-10] Neonates born to people with COVID-19 are also at increased risk for admission to the neonatal ICU.[9-11] In addition, although rare, pregnant people with COVID-19 can transmit infection to their neonates; among neonates born to women with COVID-19 during pregnancy, 1–4% of neonates tested were positive by rRT-PCR.[12,13]

Recommendations

CDC recommends urgent action to help protect pregnant people and their fetuses/infants. CDC recommends urgent action to accelerate primary vaccination for people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. Efforts should specifically address populations with lower vaccination coverage and use approaches to reduce racial and ethnic disparities. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits. In addition, pregnant people should continue to follow all recommended prevention measures and should seek care immediately for any symptoms of COVID-19. Healthcare providers should have a low threshold for increased monitoring during pregnancy due to the risk of severe illness.

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Leverage resources to promote vaccine equity: COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups.
    - Include focused efforts to increase vaccination coverage in pregnancy among people from racial and ethnic minority groups.
- Encourage healthcare providers to offer and recommend COVID-19 vaccination to their patients and community members who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Work with community partners and employers to make vaccination easily accessible for unvaccinated populations, including those who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Continue to implement additional prevention strategies where SARS-CoV-2 transmission is high and vaccination coverage is low, including in groups at increased risk, such as pregnant people.
- Continue to monitor community transmission and vaccination coverage levels and focus vaccine efforts on populations with low coverage.
- Disseminate and communicate information to key partners about vaccination coverage, risks posed by the highly transmissible Delta variant, and local transmission levels. Partner and share messaging with programs serving pregnant and recently pregnant people.

- Communicate accurate information about COVID-19 vaccines, respond to gaps in information, and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.

Recommendations for Healthcare Providers

- Ensure all clinical staff are aware of the recommendation for vaccination of people before and during pregnancy and the serious risks of COVID-19 to pregnant and recently pregnant people and their fetuses/infants.
- Increase outreach efforts to encourage, recommend, and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. A strong recommendation from a healthcare provider is a critical factor in COVID-19 vaccine acceptance and can make a meaningful difference to protect the health of pregnant and recently pregnant people and their fetuses/infants from COVID-19.
- For healthcare providers who see patients who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future:
    - Review patients' COVID-19 vaccination status at each pre- and post-natal visit and discuss COVID-19 vaccination with those who are unvaccinated.
    - Reach out to your patients with messages encouraging and recommending the critical need for vaccination.
    - Remind patients that vaccination is recommended even for those with prior COVID-19 infections. Studies have shown that vaccination provides increased protection in people who have recovered from COVID-19.
    - Support efforts to ensure people receiving the first dose of an mRNA COVID-19 vaccine (i.e., Pfizer-BioNTech, Moderna) return for their second dose to complete the series as close as possible to the recommended interval.
        - Consider a booster dose in eligible pregnant persons.[4]
    - Communicate accurate information about COVID-19 vaccines and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.
- Become a COVID-19 vaccine provider and vaccinate patients during their visit. More information can be found at How to Enroll as a COVID-19 Vaccination Provider.

For More Information

- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States
- COVID-19 Vaccines While Pregnant or Breastfeeding
- COVID-19 Vaccines for People Who Would Like to Have a Baby
- COVID-19 among Pregnant and Recently Pregnant People
- COVID Data Tracker
    - Vaccination Among Pregnant People
    - Data on COVID-19 during Pregnancy: Severity of Maternal Illness
- Toolkit for Pregnant People and New Parents
- Building Confidence in COVID-19 Vaccines

References

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2. COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) (unpublished data)
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4. CDC Interim Clinical Considerations for Use of COVID-19 Vaccines. (accessed September 27, 2021)
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13. Mullins E, Hudak ML, Banerjee J, et al. Pregnancy and neonatal outcomes of COVID-19: coreporting of common outcomes from PAN-COVID and AAP-SONPM registries. *Ultrasound Obstet Gynecol*. 2021;57(4):573-581. doi:10.1002/uog.23619

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HAN Info Service	Does not require immediate action; provides general public health information

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Monoclonal antibody FAQs (from ODH call center script revised 9/23/21):

1. How do I find a treatment center that uses monoclonal antibodies?

You can use the following locator to find facilities that have been allocated monoclonal antibodies: https://covid.infusioncenter.org/

2. Who is eligible for monoclonal antibodies treatment?

mAb treatment may help people who have a positive COVID-19 test, had symptoms for 10 days or less and are at high risk of getting more serious symptoms. Visit the page How Do I Know If I'm High Risk, and What Do I Do Next? to learn more.

3. Where can I request monoclonal antibodies for my clinic?

Requests for MABs are being handled by the state on a case-by-case basis due to the new allocation process. You can however reach out to ODH directly at hpp@odh.ohio.gov to be added to future distribution lists.

4. How is the state allocating monoclonal antibodies?

At this time state allocations are being are being made by the Ohio Department of Health in cooperation with state partners, associations, and clinical zone leadership to ensure equitable distribution.

5. I would like to set up an infusion center for monoclonal antibodies. How do I start?

The U.S. Department of Health and Human Services/Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR) has developed an outpatient administration guide for healthcare providers toolkit that offers guidance. Please visit https://www.phe.gov/emergency/events/COVID19/investigation-MCM/Documents/USG-COVID19-Tx-Playbook.pdf

6. Where can I check the status of my order?

https://asdorder.amerisourcebergen.com/btstoreui/trackmyshipment

7. How can I learn more about monoclonal antibodies?

Many other COVID-19 related guidance resources are also accessible through the U.S. Department of Health and Human Services/Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR) website by visiting: https://www.phe.gov/emergency/events/COVID19/therapeutics/Pages/default.aspx

8. Is Ohio getting a smaller supply of monoclonal antibodies than we used to get?

The first state allocation that was received was consistent with the overall supply distributed to facilities in Ohio over the last two weeks. Future state allocations will be calculated based on current COVID-19 cases and hospitalizations that will drive allocations across the state from week to week.

9. Will everyone be able to receive an allocation?

The goal of the Ohio Department of Health is to ensure equitable access to all residents across the state. Individual facility access will be based on past allocations, utilization rates, facility reporting, and amount allocated to the state. We are working on a process of establishing regional hubs that will be able to be contacted by smaller facilities looking for assistance with smaller quantities of monoclonal antibodies (mAbs) for immediate treatments.

Fwd: Health Advisory 447 - Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants

Crystal Jones <cjones@athenspublichealth.org>

Tue 7/27/2021 5:11 PM

To: **all users <allusers@athenspublichealth.org>**

Get Outlook for iOS

Crystal Jones , RN
Athens City-County Health Department
278 West Union St, Athens, OH 45701
cjones@athenspublichealth .org
740.447.5907

From: Ohio Health Alert Network <56e71afa-0005-3002-80c0-fceb55463ffe@notify.mir3.com>
Sent: Tuesday, July 27, 2021 5:08:31 PM
To: Crystal Jones <cjones@athenspublichealth.org>
Subject: Health Advisory 447 - Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants

Crystal Jones,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

July 27, 2021, 4:00 PM ET

CDCHAN-00447

Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021

Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network Health Advisory to notify public health practitioners and clinicians about the urgent need to increase COVID-

19 vaccination coverage (i.e., the percentage of the population fully vaccinated) across the United States to prevent surges in new infections that could increase COVID-19 related morbidity and mortality, overwhelm healthcare capacity, and widen existing COVID-19-related health disparities. Increasing vaccination coverage is especially urgent in areas where current coverage is low. Unvaccinated persons account for the majority of new COVID-19 infections, hospitalizations, and deaths. Currently circulating SARS-CoV-2 variants of concern, especially the highly infectious Delta variant (B.1.617.2), are accelerating spread of infection. Unvaccinated and partially vaccinated people need to practice all recommended prevention measures until fully vaccinated. In areas with substantial and high transmission, CDC recommends that fully vaccinated individuals wear a mask in public indoor settings to help prevent the spread of Delta and protect others.

Background

COVID-19 case rates are rising again after a period of decline: COVID-19 cases have increased over 300% nationally from June 19 to July 23, 2021, along with parallel increases in hospitalizations and deaths driven by the highly transmissible B.1.617.2 (Delta) variant. While significant progress has been made to make COVID-19 vaccine widely available, disparities in vaccination coverage persist across population groups and geographic areas. As of July 23, 2021, 1,856 (63.0%) of the 2,945 counties with available vaccination data have particularly low vaccination coverage, defined here as <40% of the population being fully vaccinated. As of July 23, 2021, among the counties with vaccine coverage <40%, 36.0% (N = 668) have COVID-19 incidence rates in the high burden level (≥100 cases/100,000 over the last seven days) (see figure below, and further data at COVID Tracker).

Overall, the majority (81.4%) of counties with high COVID-19 incidence rates are found in communities with low vaccination coverage. As COVID-19 case counts continue to rise nationally, areas with lower vaccination coverage are at especially high risk for a surge in cases.

Most cases of COVID-19 and hospitalizations are in unvaccinated individuals: While COVID-19 vaccines authorized in the United States remain effective against SARS-CoV-2 infection and severe disease, some infections among vaccinated persons (i.e., breakthrough infections) are anticipated and have been reported. However, the majority of COVID-19 cases and hospitalizations are occurring among individuals who are not fully vaccinated. From January through May 2021, of the more than 32,000 laboratory-confirmed COVID-19-associated hospitalizations in adults ≥18 years of age for whom vaccination status is known, <3% of hospitalizations occurred in fully vaccinated persons.

The COVID-19 Delta variant is widely prevalent and more infectious than prior strains: The COVID-19 Delta variant currently accounts for more than 80% of all COVID-19 cases in the United States. This variant is significantly more infectious than prior SARS-CoV-2 variants and has led to a rapid rise in COVID-19 cases in other countries, including the United Kingdom and Israel. Emerging evidence suggests that fully vaccinated people who do become infected with the Delta variant are at risk for transmitting it to others.

COVID-19 vaccination is our most effective strategy to prevent infection and severe disease: Vaccination is a priority national strategy to interrupt SARS-CoV-2 transmission, protect personal and public health, and preserve healthcare system capacity. COVID-19 vaccines are safe and recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Immunologic data support the role of Food and Drug Administration (FDA)-authorized COVID-19 vaccines in offering protection against the known currently circulating variants. By limiting viral spread, vaccination also minimizes opportunities for the introduction of more infectious variants through random mutation. Mutations could produce future variants that are more virulent and capable of evading diagnostic and therapeutic tools or overcoming vaccine-induced immunity.

COVID-19 vaccination coverage at skilled nursing facilities (SNF) helps prevent infection: Nursing home residents have been severely impacted by COVID-19 and are disproportionately represented in overall burden of COVID-19-related morbidity and mortality in the United States. While there has been significant progress in vaccinating SNF residents, vaccination coverage of staff at many facilities remains low. Preliminary data from CDC's National Healthcare Safety Network (NHSN) indicate residents of SNFs in which vaccination coverage of staff is 75% or lower experience higher crude rates of preventable COVID infection.

CDC recommends urgent action by all: CDC recommends continued efforts to accelerate primary vaccination efforts, especially in areas with lower vaccination coverage. Individuals who are not fully vaccinated need to maintain all recommended prevention measures. People who are immunocompromised should be counseled about the potential for reduced immune responses to COVID-19 vaccines and to follow current prevention measures to protect themselves against COVID-19 until advised otherwise by their healthcare provider. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits (see vaccine equity resources below).

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination. Co-lead the conversation by participating in community education and outreach events.
- Leverage resources to promote vaccine equity.
- Encourage clinicians to offer and recommend COVID-19 vaccination to their patients and community members.
- Work with community partners to make vaccination easily accessible for unvaccinated populations.
- Implement additional prevention strategies when transmission is high and vaccination coverage is low (*MMWR*).
- Continue to monitor community transmission levels, variant, and vaccination coverage levels, and focus vaccine efforts on populations with low coverage.
- Communicate vaccination coverage, variant, and transmission levels to key partners, including the key information on risk associated with the B.1.617.2 (Delta) variant.

Recommendations for Clinicians

- If you are a clinical provider and are not fully vaccinated, get vaccinated as soon as possible to protect yourself, your family, and your patients.
- Increase patient outreach efforts to encourage, recommend, and offer COVID-19 vaccination.
- Remind patients that vaccination is recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Follow trusted sources carefully for any new recommendations and changes in vaccine guidance.
- Support efforts to ensure people receiving a first dose of a COVID-19 mRNA vaccine (i.e., Pfizer-BioNTech or Moderna) return for their second dose to complete the series.
- Communicate with unvaccinated staff, patients, and other individuals to increase confidence in vaccination. CDC has many resources for providers to help increase vaccine confidence.
- Recommend that fully vaccinated patients who are immunocompromised continue to practice all recommended prevention measures for unvaccinated persons.

Recommendations for Healthcare Facilities and Systems, Nursing Homes, and Businesses

- Recommend and offer COVID-19 vaccine to your staff and employees and establish policies to encourage uptake such as time off to receive the vaccine.
- Consider offering COVID-19 vaccine at your workplace (Workplace COVID-19 Vaccine Toolkit).
- Evaluate whether your facility can implement vaccine requirements or vaccine incentives.

For More Information

- CDCWeekly *Morbidity and Mortality Weekly Report* (*MMWR)* Guidance for Implementing COVID-19 Prevention Strategies in the Context of Varying Community Transmission Levels and Vaccination Coverage
- Interim Public Health Recommendations for Fully Vaccinated People
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Sent by:

Ryan Morrison, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

Statewide LHD Leadership

Statewide LHD-Group

Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
July 27, 2021, 4:00 PM ET
CDCHAN-00447

Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021

Summary
The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network Health Advisory to notify public health practitioners and clinicians about the urgent need to increase COVID-19 vaccination coverage (i.e., the percentage of the population fully vaccinated) across the United States to prevent surges in new infections that could increase COVID-19 related morbidity and mortality, overwhelm healthcare capacity, and widen existing COVID-19-related health disparities. Increasing vaccination coverage is especially urgent in areas where current coverage is low. Unvaccinated persons account for the majority of new COVID-19 infections, hospitalizations, and deaths. Currently circulating SARS-CoV-2 variants of concern, especially the highly infectious Delta variant (B.1.617.2), are accelerating spread of infection. Unvaccinated and partially vaccinated people need to practice all recommended prevention measures until fully vaccinated. In areas with substantial and high transmission, CDC recommends that fully vaccinated individuals wear a mask in public indoor settings to help prevent the spread of Delta and protect others.

Background
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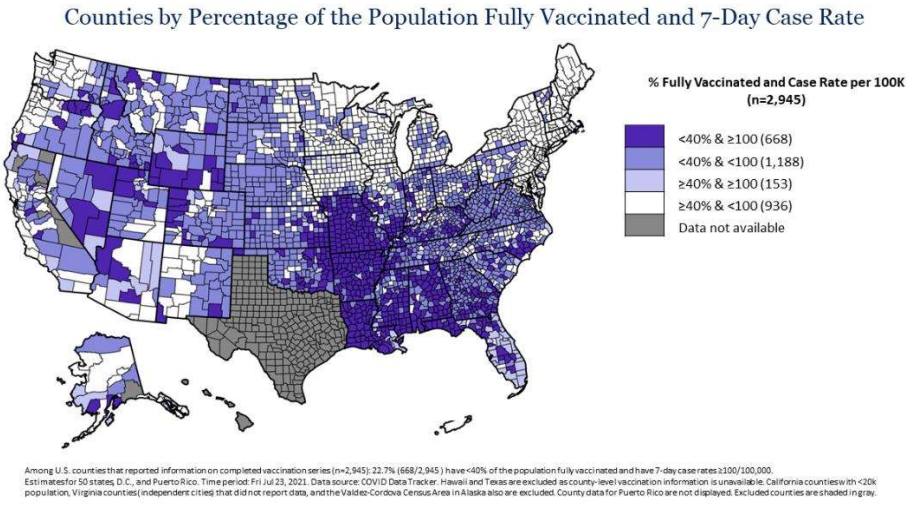

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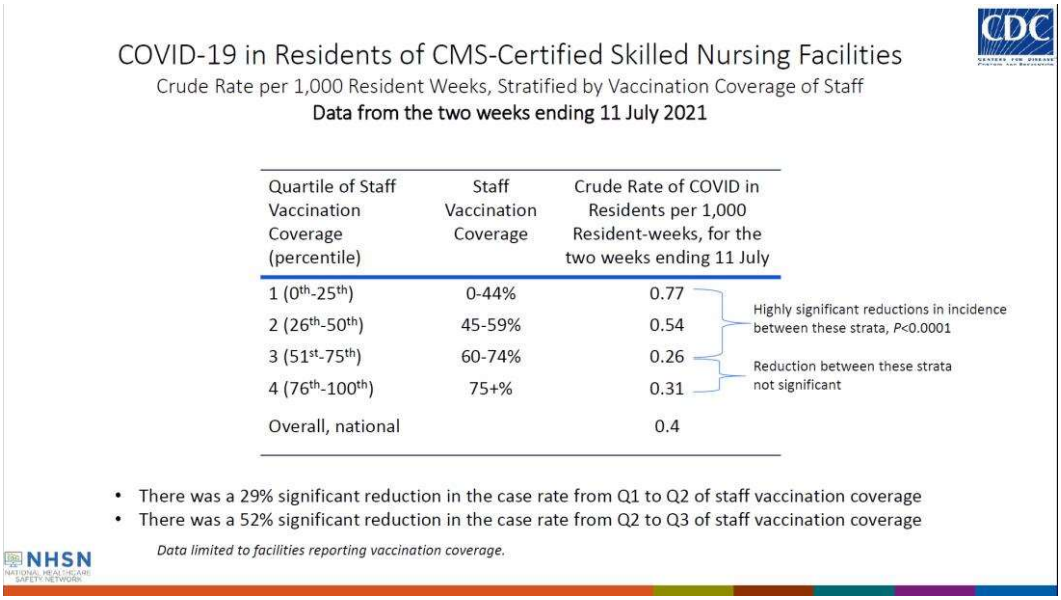

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- Support efforts to ensure people receiving a first dose of a COVID-19 mRNA vaccine (i.e., Pfizer-BioNTech or Moderna) return for their second dose to complete the series.
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- Recommend that fully vaccinated patients who are immunocompromised continue to practice all recommended prevention measures for unvaccinated persons.

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FW: Additional dose of mRNA COVID-19 vaccine authorized for immunocompromised individuals

Crystal Jones <cjones@athenspublichealth.org>

Mon 8/16/2021 7:11 AM

To: **all users <allusers@athenspublichealth.org>**

From: COVIDVACCINE@odh.ohio.gov
Sent: Friday, August 13, 2021 6:15 PM
Subject: Additional dose of mRNA COVID-19 vaccine authorized for immunocompromised individuals

Aug. 13, 2021

Dear COVID-19 Vaccine Provider,

An additional dose of messenger RNA (mRNA) COVID-19 vaccines now can be administered to a small group of **immunocompromised individuals** following completion of a primary mRNA vaccine series, according to the U.S. Food & Drug Administration and the Centers for Disease Control and Prevention (CDC). Other fully vaccinated individuals do not need an additional vaccine dose at this time.

The FDA has updated its emergency use authorizations for the Pfizer and Moderna vaccines to include a recommended third dose for individuals with moderate to severe immunosuppression who are at heightened risk for serious outcomes from COVID-19. This includes solid organ transplant recipients or those who are "diagnosed with conditions that are considered to have an equivalent level of immunocompromise," according to the FDA. This group of eligible individuals is estimated to include less than 3% of the U.S. population and 3% of Ohioans.

The purpose of this additional dose is to strengthen the immune response when the initial immune response to the primary two-dose vaccine series is likely to be insufficient, according to the CDC's Advisory Committee on Immunization Practices (ACIP).

ACIP recommended Friday that an additional dose be recommended at least 28 days following completion of the primary vaccination series for qualifying immunocompromised individuals age 12 and older who have received the Pfizer series and individuals age 18 and older who have received the Moderna series, according to the CDC's updated clinical considerations for COVID-19 vaccinations. At this time, an additional dose is not recommended after the single-dose Johnson & Johnson (Janssen vaccine). Further evaluation and guidance specific to the Johnson & Johnson vaccine is pending, according to the CDC panel.

"Immunocompromised people are at a much higher risk for severe outcomes from COVID-19 and may not develop a sufficient immune response from their primary vaccination series," said Dr. Bruce Vanderhoff, Director of the Ohio Department of Health. "These individuals have a reduced ability to fight infections and are particularly vulnerable now as the more contagious and more dangerous Delta variant is driving a surge in cases. This additional dose, combined with other prevention strategies including wearing face masks, avoiding crowds and maintaining physical distance, offers another important layer of protection for this small but important population."

Eligibility

The CDC has further defined this eligible population to include:

- Individuals undergoing active treatment for cancer (solid tumor and hematologic malignancies).

- Individuals who have received a solid-organ transplant and are taking immunosuppressive therapy.
- Individuals who have received a CAR-T-cell or hematopoietic stem cell transplant (within two years of transplant or taking immunosuppression therapy).
- Individuals with moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Individuals with advanced or untreated HIV infection.
- Individuals undergoing active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.

Recommendations for COVID-19 vaccine providers

Healthcare providers are urged to consult with immunocompromised patients under their care to offer recommendations for timing of additional doses of COVID-19 vaccine, factoring in their other treatments.

- Individuals who believe they meet the criteria are urged to consult with their healthcare providers to determine next steps. A patient's clinical team is best positioned to determine the degree of immune system compromise and appropriate timing of vaccination.
- Factors to consider include disease severity, duration, clinical stability, complications, comorbidities, and any potentially immune-suppressing treatment.
- Providers should accept "self-attestation" when eligible individuals present for the additional dose.
- The additional dose should be the same mRNA vaccine as the primary two-dose series. An alternate mRNA product can be used if the primary series product is not available, provided the patient is age-eligible for that product.
- Whenever possible, mRNA COVID-19 vaccination doses (including the primary series and an additional dose) should be given at least two weeks before initiation of immunosuppressive therapies.

Recommended layered prevention

The CDC recommends extra precautions for immunocompromised individuals alongside an additional dose:

- Immunocompromised people (including those who receive an additional mRNA dose) should be aware of the potential for reduced immune response to COVID-19 vaccination and should follow ongoing prevention measures including:
    - Wearing a mask.
    - Staying 6 feet apart from others outside their household.
    - Avoiding crowds and poorly ventilated indoor spaces.
- Close contacts of immunocompromised people are *strongly encouraged* to be vaccinated against COVID-19.
-

Booster doses

These additional doses for immunocompromised persons should not be confused with booster doses. At this time, additional booster doses are not authorized or recommended for any individuals based upon waning immunity over time. The need for and timing of a COVID-19 booster dose have not been established, according to the FDA.

Updated resources:

FDA

- **Pfizer**

- Fact Sheet for Healthcare Providers Administering Vaccine
- Fact Sheet for Recipients and Caregivers

- **Moderna**
  - Fact Sheet for Healthcare Providers Administering Vaccine
  - Fact Sheet for Recipients and Caregivers

CDC

- Considerations for use of an additional mRNA COVID-19 vaccine dose after an initial 2-dose COVID-19 mRNA vaccine series for immunocompromised people

If you have any questions or issues, please call the ODH Provider Call Center between 8 a.m. – 7 p.m. Monday through Friday at 1-844-9ODHVAX (1-844-963-4829) or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

ODH COVID-19 Vaccine Provider Relations Team

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Stephanie McCloud, Director

Aug. 13, 2021

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The purpose of this additional dose is to strengthen the immune response when the initial immune response to the primary two-dose vaccine series is likely to be insufficient, according to the CDC's Advisory Committee on Immunization Practices (ACIP).

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"Immunocompromised people are at a much higher risk for severe outcomes from COVID-19 and may not develop a sufficient immune response from their primary vaccination series," said Dr. Bruce Vanderhoff, Director of the Ohio Department of Health. "These individuals have a reduced ability to fight infections and are particularly vulnerable now as the more contagious and more dangerous Delta variant is driving a surge in cases. This additional dose, combined with other prevention strategies including wearing face masks, avoiding crowds and maintaining physical distance, offers another important layer of protection for this small but important population."

Eligibility

The CDC has further defined this eligible population to include:

- Individuals undergoing active treatment for cancer (solid tumor and hematologic malignancies).
- Individuals who have received a solid-organ transplant and are taking immunosuppressive therapy.
- Individuals who have received a CAR-T-cell or hematopoietic stem cell transplant (within two years of transplant or taking immunosuppression therapy).
- Individuals with moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Individuals with advanced or untreated HIV infection.
- Individuals undergoing active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.

Recommendations for COVID-19 vaccine providers

Healthcare providers are urged to consult with immunocompromised patients under their care to offer recommendations for timing of additional doses of COVID-19 vaccine, factoring in their other treatments.

- Individuals who believe they meet the criteria are urged to consult with their healthcare providers to determine next steps. A patient's clinical team is best positioned to determine the degree of immune system compromise and appropriate timing of vaccination.
- Factors to consider include disease severity, duration, clinical stability, complications, comorbidities, and any potentially immune-suppressing treatment.
- Providers should accept "self-attestation" when eligible individuals present for the additional dose.
- The additional dose should be the same mRNA vaccine as the primary two-dose series. An alternate mRNA product can be used if the primary series product is not available, provided the patient is age-eligible for that product.
- Whenever possible, mRNA COVID-19 vaccination doses (including the primary series and an additional dose) should be given at least two weeks before initiation of immunosuppressive therapies.

Recommended layered prevention

The CDC recommends extra precautions for immunocompromised individuals alongside an additional dose:

- Immunocompromised people (including those who receive an additional mRNA dose) should be aware of the potential for reduced immune response to COVID-19 vaccination and should follow ongoing prevention measures including:
    - Wearing a mask.

    - Staying 6 feet apart from others outside their household.
    - Avoiding crowds and poorly ventilated indoor spaces.
- Close contacts of immunocompromised people are *strongly encouraged* to be vaccinated against COVID-19.

Booster doses

These additional doses for immunocompromised persons should not be confused with booster doses. At this time, additional booster doses are not authorized or recommended for any individuals based upon waning immunity over time. The need for and timing of a COVID-19 booster dose have not been established, according to the FDA.

Updated resources:

FDA

- **Pfizer**
    - Fact Sheet for Healthcare Providers Administering Vaccine
    - Fact Sheet for Recipients and Caregivers
- **Moderna**
    - Fact Sheet for Healthcare Providers Administering Vaccine
    - Fact Sheet for Recipients and Caregivers

CDC

- Considerations for use of an additional mRNA COVID-19 vaccine dose after an initial 2-dose COVID-19 mRNA vaccine series for immunocompromised people

If you have any questions or issues, please call the ODH Provider Call Center between 8 a.m. – 7 p.m. Monday through Friday at 1-844-9ODHVAX (1-844-963-4829) or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

ODH COVID-19 Vaccine Provider Relations Team

FW: Health Advisory 451: Increases in Availability of Cannabis Products Containing Delta-8 THC

Crystal Jones <cjones@athenspublichealth.org>

Tue 9/14/2021 4:16 PM

To: **all users <allusers@athenspublichealth.org>**

From: Ohio Health Alert Network
Sent: Tuesday, September 14, 2021 12:06 PM
To: Crystal Jones <cjones@athenspublichealth.org>
Subject: Health Advisory 451: Increases in Availability of Cannabis Products Containing Delta-8 THC

Crystal Jones,

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

September 14, 2021, 10:00 AM ET

CDCHAN-00451

Increases in Availability of Cannabis Products Containing Delta-8 THC and Reported Cases of Adverse Events

Summary

The purpose of this Health Alert Network (HAN) Health Advisory is to alert public health departments, healthcare professionals, first responders, poison control centers, laboratories, and the public to the increased availability of cannabis products containing delta-8

tetrahydrocannabinol (THC) and the potential for adverse events due to insufficient labeling of products containing THC and cannabidiol (CBD).

Background

Marijuana, which can also be called weed, pot, or dope, refers to all parts of the plant *Cannabis sativa L.*, including flower, seeds, and extracts with more than 0.3% delta-9 tetrahydrocannabinol (THC) by dry weight. Any part of the cannabis plant containing 0.3% or less THC by dry weight is defined as hemp.1 The cannabis plant contains more than 100 cannabinoids, including THC, which is psychoactive (i.e., impairing or mind-altering) and causes a "high".2 CBD is another active cannabinoid found in the cannabis plant that is not psychoactive and does not cause a "high".

The term THC most often refers to the delta-9 THC isomer, which is the most prominently occurring THC isomer in cannabis. However, THC has several other isomers that occur in the cannabis plant, including delta-8 THC. Delta-8 THC exists naturally in the cannabis plant in only small quantities and is estimated to be about 50-75% as psychoactive as delta-9 THC.3,4

CBD can be synthetically converted into delta-8 THC, as well as delta-9 THC and other THC isomers, with a solvent, acid, and heat to produce higher concentrations of delta-8 THC than those found naturally in the cannabis plant.5 This conversion process, used to produce some marketed products, may create harmful by-products that presently are not well-characterized.

Delta-8 THC products are increasingly appearing in both marijuana and hemp marketplaces, some of which operate legally under state, territorial, or tribal laws.6 Most states and territories permit full or restricted hemp marketplaces that sell hemp and hemp-derived CBD products.7 Products sold as concentrated delta-8 THC are also available online. Delta-8 THC products are sometimes marketed as "weed light" or "diet weed."

The health effects of delta-8 THC have not yet been researched extensively and are not well-understood. However, delta-8 THC is psychoactive and may have similar risks of impairment as delta-9 THC.4 As such, products that contain delta-8 THC but are labeled with only delta-9 THC content rather than with total THC content likely underestimate the psychoactive potential of these products for consumers. In addition, the sale of delta-8 THC products is not limited to regulated marijuana dispensaries in states, territories, or tribal nations where marketplaces operate under law. Rather, delta-8 THC products are sold by a wide range of businesses that sell hemp. As a

result, delta-8 THC products may also have the potential to be confused with hemp or CBD products that are not intoxicating. Consumers who use these products may therefore experience unexpected or increased THC intoxication.

A wide variety of delta-8 THC-containing products have entered the marketplace, including, but not limited to, vapes, smokable hemp sprayed with delta-8 THC extract, distillates, tinctures, gummies, chocolates, and infused beverages. In addition, because testing methods for products like synthetically derived delta-8 THC are still being developed, delta-8 THC products may not be tested systematically for contaminants such as heavy metals, solvents, or pesticides that may have adverse health effects.8

Recent increases in delta-8 THC-involved adverse events

In March 2021, the West Virginia Poison Control Center9 reported two cases of adverse events related to use of delta-8 THC products in adults. In both instances, individuals mistook the products containing delta-8 THC for CBD-like products. These exposures led to symptoms consistent with cannabis intoxication. The Michigan Poison Control Center10 also reported two cases of severe adverse events to delta-8 THC in two children who ingested a parent's delta-8 THC-infused gummies purchased from a vape shop. Both children experienced deep sedation and slowed breathing with initial increased heart rate progressing to slowed heart rate and decreased blood pressure. The children were admitted to the intensive care unit for further monitoring and oxygen supplementation.

In 2021, The American Association of Poison Control Centers (AAPCC) introduced a product code specific to delta-8 THC into its National Poison Data System (NPDS), allowing for the monitoring of delta-8 THC adverse events*. From January 1 to July 31, 2021, 660 delta-8 THC exposures were recorded with the new product code, and one additional case was recoded as a delta-8 THC exposure from October 2020. Eighteen percent of exposures (119 of 661 cases) required hospitalization, and 39% (258 of 661 cases) involved pediatric patients less than 18 years of age.

Syndromic surveillance data from emergency departments participating in the CDC's National Syndromic Surveillance Program (NSSP) show an increase in visits with a mention of delta-8 THC or some variation in the chief complaint text in recent months. More than 4,400 active emergency facilities that represent portions of 49 states and Washington, DC contribute data to NSSP, accounting for approximately 71% of all U.S. non-federal emergency departments. The first suspected visit associated with delta-8 THC in NSSP was observed in September 2020, with three additional visits observed through the end of 2020. Suspected visits have generally increased monthly in 2021 (three suspected visits were observed in January; six in February; 16 in March; 11 in April; 29 in May; 32 in June; and 48 in July 2021). The majority of these visits (73%, 109 of 149 visits) occurred in the Department of Health and Human Services' Regions 4 and 6, which are

composed primarily of Southern states that have not passed state laws to allow non-medical adult cannabis use.11 These numbers are likely an underestimate due to the potential for inaccurate and incomplete information about products used by consumers.

Several factors can influence both the type and severity of cannabis-related adverse events, including the type of cannabinoid ingested, concentration, route of exposure, and the individual characteristics of the person who consumed the cannabinoid such as their age, weight, and sex. Delta-8 THC intoxication can cause adverse effects similar to those observed during delta-9 THC intoxication10,12, and may include—

- Lethargy
- Uncoordinated movements and decreased psychomotor activity
- Slurred speech
- Increased heart rate progressing to slowed heart rate
- Low blood pressure
- Difficulty breathing
- Sedation
- Coma

Summary

The rise in delta-8 THC products in marijuana and hemp marketplaces has increased the availability of psychoactive cannabis products, even in states, territories, and tribal nations where non-medical adult cannabis use is not permitted under law. Variations in product content, manufacturing practices, labeling, and potential misunderstanding of the psychoactive properties of delta-8 THC may lead to unexpected effects among consumers. Adverse event reports involving products that contain delta-8 THC that resulted in consumers' hospital or emergency department treatment have been described. Increased reports of adverse events related to delta-8 THC, as well as preliminary reports of the emergence of other similarly produced products derived from cannabis warrant the continued monitoring and tracking of adverse events related to THC.

Recommendations for the Public and Consumers

- Consumers should be aware of possible limitations in the labeling of products containing THC and CBD even from approved marijuana and hemp retailers. Products reporting only delta-9 THC concentration, but not total THC may underestimate the psychoactive potential for consumers.

- Consumers should be aware that products labeled as hemp or CBD may contain delta-8 THC, and that products containing delta-8 THC can result in psychoactive effects. Delta-8 THC products are currently being sold in many states, territories, and tribal nations where non-medical adult cannabis use is not permitted by law. In addition, retailers may sell products outside of regulated dispensaries in states, territories, and tribal nations where cannabis use is permitted by law. This may provide consumers with a false sense of safety, as delta-8 THC products may be labeled as hemp or CBD, which consumers may not associate with psychoactive ingredients.
- Parents who consume edibles and other products that contain THC and CBD should store them safely away from children. Children may mistake some edibles that contain THC and CBD (e.g., fruit-flavored gummies containing delta-8 THC) as candy.
- If consumers experience adverse effects of THC- or CBD-containing products that are an immediate danger to their health, they should call their local or regional poison control center at 1-800-222-1222 or 911 or seek medical attention at their local emergency room and report the ingredients of ingested products to healthcare providers. Consumers are also encouraged to report adverse events to MedWatch.
- Consumers should be aware that the cannabis marketplace continues to evolve. Other cannabis-derived products of potential concern have emerged recently, such as those containing delta-10 THC and THC-O acetate. More research is needed to understand the health effects of products containing these compounds.

Recommendations for Public Health Departments and Poison Control Centers, including those in locations where laws only permit hemp marketplaces

- Release information to healthcare providers and the public about the psychoactive qualities and the potential health implications of using products containing delta-8 THC and that products labeled as hemp or CBD may contain delta-8 THC.

- Poison control centers have a new code available to identify delta-8 THC exposures. For patients or providers reporting delta-8 THC consumption, poison control centers should use the American Association of Poison Control Centers code 310146 or product code 8297130 to indicate delta-8 THC exposure and aid in the continued surveillance of these exposures.
- States, territories, and tribal nations that have passed laws allowing non-medical use of adult cannabis or that may allow such use in the future may consider requiring the reporting of total THC content, including ingredients like delta-8 THC and other compounds that may be synthetically produced, on product labeling.
- Community-based organizations, such as Drug-Free Communities coalitions, can use information from this report to raise awareness in their communities about the potential negative health effects associated with use of delta-8 THC-containing products, as well as the emergence of other cannabis-derived products of potential concern.

Recommendations for Retailers Selling Cannabis Products

- Retailers selling cannabis products should provide information to consumers about the psychoactive qualities of delta-8 THC.
- Retailers selling cannabis products should report total THC content on product labeling, including ingredients like delta-8 THC that may be synthetically produced to create a psychoactive effect.

Recommendations for Healthcare Providers

- Healthcare providers should be vigilant in observing patients presenting with THC-like intoxication symptoms who do not report an exposure to marijuana or history of use. Symptomatic patients should be questioned about their use of CBD or delta-8 THC products.
- There is no specific antidote for THC intoxication. Treatment is largely symptomatic and supportive care. The ability to detect delta-8 THC with laboratory tests that hospitals use to detect delta-9 THC currently is not fully characterized. Consult with your hospital's medical toxicologist or local poison control center for toxicology consultations on treatment.

For More Information

- CDC Marijuana homepage: "Marijuana and Public Health"
- FDA Delta-8 THC Consumer Update: "5 Things to Know about Delta-8 Tetrahydrocannabinol"
- Visit CDC-INFO or call CDC-INFO at 1-800-232-4636
- CDC 24/7 Emergency Operations Center (EOC) 770-488-7100

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1. Agriculture Improvement Act of 2018. H.R.2, 115th Cong. (2017-2018).

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6. Brightfield Group. What's the Fate of Delta-8? Consumer, Product, and Regulatory Trends. Published 2021. Accessed August 31, 2021.

7. National Conference of State Legislatures (2020, April 16). *State Industrial Hemp Statutes*.

8. Delta-8-THC, HB 3000, 2021 Oregon State Legislature Regular Session. Testimony of Steven Crowley.

9. West Virginia Substance Abuse Early Warning Network. Alert #WV003. Reported Cases of Adverse Reactions to Delta-8 THC Products in West Virginia. March 10, 2021.

10. Michigan Poison Center. Fact Sheet: Emerging Public Health Concern: Delta-8 THC. April 23, 2021.

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12. Grotenhermen F. Pharmacokinetics and pharmacodynamics of cannabinoids. Clin Pharmacokinet.2003;42(4):327-60.

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Christopher Zukoski, ODH

Recipients:

ODH Leadership

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Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

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Statewide LHD-Group

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Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

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CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
September 14, 2021, 10:00 AM ET
CDCHAN-00451

Increases in Availability of Cannabis Products Containing Delta-8 THC and Reported Cases of Adverse Events

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Background
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The term THC most often refers to the delta-9 THC isomer, which is the most prominently occurring THC isomer in cannabis. However, THC has several other isomers that occur in the cannabis plant, including delta-8 THC. Delta-8 THC exists naturally in the cannabis plant in only small quantities and is estimated to be about 50-75% as psychoactive as delta-9 THC.[3,4]

CBD can be synthetically converted into delta-8 THC, as well as delta-9 THC and other THC isomers, with a solvent, acid, and heat to produce higher concentrations of delta-8 THC than those found naturally in the cannabis plant.[5] This conversion process, used to produce some marketed products, may create harmful by-products that presently are not well-characterized.

Delta-8 THC products are increasingly appearing in both marijuana and hemp marketplaces, some of which operate legally under state, territorial, or tribal laws.[6] Most states and territories permit full or restricted hemp marketplaces that sell hemp and hemp-derived CBD products.[7] Products sold as concentrated delta-8 THC are also available online. Delta-8 THC products are sometimes marketed as "weed light" or "diet weed."

The health effects of delta-8 THC have not yet been researched extensively and are not well-understood. However, delta-8 THC is psychoactive and may have similar risks of impairment as delta-9 THC.[4] As such, products that contain delta-8 THC but are labeled with only delta-9 THC content rather than with total THC content likely underestimate the psychoactive potential of these products for consumers. In addition, the sale of delta-8 THC products is not limited to regulated marijuana dispensaries in states, territories, or tribal nations where marketplaces operate under law. Rather, delta-8 THC products are sold by a wide range of businesses that sell hemp. As a result, delta-8 THC products may also have the potential to be confused with hemp or CBD products that are not intoxicating. Consumers who use these products may therefore experience unexpected or increased THC intoxication.

A wide variety of delta-8 THC-containing products have entered the marketplace, including, but not limited to, vapes, smokable hemp sprayed with delta-8 THC extract, distillates, tinctures, gummies,

chocolates, and infused beverages. In addition, because testing methods for products like synthetically derived delta-8 THC are still being developed, delta-8 THC products may not be tested systematically for contaminants such as heavy metals, solvents, or pesticides that may have adverse health effects.[8]

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- Lethargy
- Uncoordinated movements and decreased psychomotor activity
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Summary

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For More Information

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- Visit CDC-INFO or call CDC-INFO at 1-800-232-4636
- CDC 24/7 Emergency Operations Center (EOC) 770-488-7100

References

1. Agriculture Improvement Act of 2018. H.R.2, 115th Cong. (2017-2018).
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12. Grotenhermen F. Pharmacokinetics and pharmacodynamics of cannabinoids. Clin Pharmacokinet.2003;42(4):327-60.

* *The American Association of Poison Control Centers (AAPCC) maintains the National Poison Data System (NPDS), which houses de-identified case records of self-reported information collected from callers during exposure management and poison information calls managed by the country's poison control centers (PCCs). NPDS data do not reflect the entire universe of exposures to a particular substance as additional exposures may go unreported to PCCs; accordingly, NPDS data should not be construed to represent the complete incidence of U.S. exposures to any substance(s). Exposures do not necessarily represent a poisoning or overdose and AAPCC is not able to completely verify the accuracy of every report. Findings based on NPDS data do not necessarily reflect the opinions of AAPCC.*

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention, highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Updated COVID 19 Case investigation guidance from ODH

Crystal Jones <cjones@athenspublichealth.org>

Thu 9/23/2021 7:20 AM

To: **all users <allusers@athenspublichealth.org>**

Good morning,

An updated COVID-19 IDCM chapter has been posted. This update includes an updated case definition, including criteria to enumerate a new cases if the new test result occurs more than 90 days after the previous illness onset or collection date of the positive specimen (event date).

Additionally, there is no longer an 'Other' drop-down in the Test Menu in the Laboratory Module. Please use one of the existing drop-down choices: Nucleic acid amplification tests (NAA or NAATs) should be entered under a PCR or RNA option and Point of Care (POCs) and rapid tests should be entered according to the specific test type (Abbot IDNOW is a rapid PCR; BinaxNOW and BD Veritor are rapid antigens). It is frequently possible to determine the type of test (PCR, antigen, antibody) using an internet search engine to search for the test manufacturer.

I will check in with staff that is completing case investigations to review changes and answer any questions you may have. Thanks again for your ongoing support!

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CORONAVIRUS DISEASE 2019
(COVID-19)

Includes information on Multisystem Inflammatory Syndrome in Children (MIS-C) under section, "SIGNS AND SYMPTOMS".

REPORTING INFORMATION

- **Class A with special reporting requirements:** ***Confirmed*** *and* ***Probable*** *cases* of COVID-19 should be reported **within twenty-four hours** to the local health district in which the person resides. If patient residence is unknown, report to the local health department in which the reporting health care provider or laboratory is located.
- Reporting Form(s) and/or Mechanism:
  - Persons in charge of any laboratory that examines specimens of human origin for evidence of COVID-19 infection shall electronically report within twenty-four (24) hours the results of all such examination, including, but not limited to: positive, negative, invalid, and inconclusive results.
  - Laboratory results should be electronically reported according to the protocols outlined for COVID-19 reporting on the Ohio Department of Health (ODH) Electronic Laboratory Reporting website.
    - Electronically reported negative, invalid, and inconclusive viral test results, in addition to all antibody results, will be stored within the Innovate Ohio Platform Data Lake. These results will be submitted to the Centers for Disease Control and Prevention (CDC) in accordance with national reporting requirements and will be used for percent positivity calculations. These results will not generate records within the Ohio Disease Reporting System (ODRS) as public health investigation is not required.
  - The local health department should enter the case into ODRS within 24 hours after receiving a report.
    - The CDC Human Infection with 2019 Novel Coronavirus Case Report Form is available for use to assist in local disease investigation. Information collected from the form should be entered into ODRS. If requested, the form can be uploaded to the ODRS record.
- Key information for ODRS reporting includes: illness onset date; sensitive occupation (including location); race and ethnicity (critical to address disparities); clinical information; hospitalization status; lab results, collection date and test type; signs/symptoms/comorbidities; known contact or linkage to COVID-19 cases; travel history; membership in a risk cohort as defined below.

AGENT

SARS-CoV-2 is a novel species of the *Coronaviridae* virus family, Beta-CoV lineage B.d

Infectious Dose: Unknown

CASE DEFINITION

Clinical Criteria

To meet the clinical criteria, a patient must meet either criteria 1 and 3, or criteria 2 and 3 below.

1)

- Acute onset or worsening of at least two of the following symptoms or signs:
  - fever (measured or subjective),
  - chills,
  - rigors,
  - myalgia,
  - headache,
  - sore throat,
  - nausea or vomiting,
  - diarrhea,
  - fatigue,
  - congestion or runny nose

  OR

- Acute onset or worsening of at least one of the following symptoms or signs:
  - cough,
  - shortness of breath,
  - difficulty breathing,
  - olfactory disorder,
  - taste disorder,
  - confusion or change in mental status,
  - persistent pain or pressure in the chest,
  - pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone,
  - inability to wake or stay awake

OR

2) Severe respiratory illness with at least one of the following:

- Clinical or radiographic evidence of pneumonia, or
- Acute respiratory distress syndrome (ARDS)

AND

3) No alternative more likely diagnosis

Laboratory Criteria

Laboratory evidence using a method approved or authorized by the U.S. Food and Drug Administration (FDA) or designated authority*:

Confirmatory laboratory evidence:

- Detection of SARS-CoV-2 RNA in a post-mortem respiratory swab or clinical specimen using a molecular amplification detection test; OR
- Detection of SARS-CoV-2 by genomic sequencing

Presumptive laboratory evidence:

- Detection of SARS-CoV-2 specific antigen in a post-mortem respiratory swab or clinical specimen

Supportive laboratory evidence:

- Detection of specific antibody in serum, plasma, or whole blood; OR
- Detection of specific antigen by immunocytochemistry in an autopsy specimen

*Laboratory developed tests (LDTs) are not currently being reviewed by the U.S. Food and Drug Administration. If a LDT is used, the case will be classified according to routine procedures. If a test-based strategy is being used to inform discontinuation of isolation or quarantine precautions, it must be a test designated for such purposes.

Epidemiologic Linkage
One or more of the following exposures in the 14 days before onset of symptoms (or, for asymptomatic persons, the 14 days before a positive test for SARS-CoV-2 was collected):

- Close contact* with someone with confirmatory or presumptive laboratory evidence of SARS-CoV-2 infection

OR

- Member of a risk cohort as defined by public health authorities during an outbreak.
    - In Ohio, the following are identified as risk cohorts:
        - Hospitalized patients
        - Healthcare workers
        - First responders (including law enforcement, fire services, emergency medical services, and emergency management officials)
        - Residents of long-term care facilities
        - Members of other congregate settings (e.g., group homes, schools, colleges or universities, correctional and detention facilities)

*Close contact is generally defined as being within 6 feet for a period of 15 minutes or more (cumulative/total time) depending upon the exposure level and setting. Please see section titled **Contacts** on page 6 for additional details. Data are insufficient to precisely define the duration of exposure that constitutes prolonged exposure and thus a close contact.

Vital Records Criteria
- A death certificate that lists COVID-19 disease or SARS-CoV-2 or an equivalent term as an underlying cause of death or a significant condition contributing to death.

CASE CLASSIFICATION

Suspected:
- Meet supportive laboratory evidence with no prior history of being a confirmed or probable case.

Probable:
- Meets presumptive laboratory evidence AND was reported on or after November 1, 2020; OR
    - For reports received prior to November 1, 2020: meets presumptive laboratory evidence **AND** either clinical criteria **OR** epidemiologic linkage; OR
- Meets clinical criteria **AND** epidemiologic linkage with no confirmatory or presumptive laboratory testing performed for SARS-CoV-2; OR
- Meets vital records criteria with no confirmatory laboratory evidence for SARS-CoV-2.

Confirmed:

- Meets confirmatory laboratory evidence.
    - NOTES: Asymptomatic infections are reportable as confirmed cases. In some cases, a SARS-CoV-2 genomic sequencing result may be available without an associated positive PCR result. These records should be classified as a confirmed case; however, public health action may be limited as SARS-CoV-2 genomic sequencing assays are non-diagnostic tests and generally not CLIA-validated.

Not a Case:

- This status will not generally be used when reporting a case, but may be used to reclassify a report if investigation revealed that it was not a case.
- For surveillance purposes, records should be classified as "Not a Case" if SARS-CoV-2 RNA in an initial clinical specimen is not detected using a confirmatory laboratory test and the confirmatory test was collected within 1 week of symptom onset; or if SARS-CoV-2 RNA is not detected using a confirmatory laboratory test within 2 days following a rapid antigen test. For considerations related to public health management, please see section titled **Public Health Management** on page 5.

Criteria to Distinguish a New Case from an Existing Case

- The following should be enumerated as a new case for cases reported on or after September 1, 2021:
    - SARS-CoV-2 sequencing results from the new positive specimen and a positive specimen from the most recent previous case demonstrate a different lineage; OR
    - Person was most recently enumerated as a confirmed or probable case with onset date (if available) or first positive specimen collection date for that classification >90 days prior*; OR
    - Person was previously reported but not enumerated as a confirmed or probable case (i.e., suspect)**, but now meets criteria for a confirmed or probable case.

    *Note: Some individuals, e.g., severely immunocompromised persons, can shed SARS-CoV-2 detected by molecular amplification tests >90 days after infection. For severely immunocompromised individuals, clinical judgment should be used to determine if a repeat positive test is likely to result from long term shedding and therefore not be enumerated as a new case. CDC defines severe immunocompromise as certain conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days.
    **Note: Repeat suspect cases should not be enumerated as a new case.

- Considerations for public health management of persons with persistent or recurrent positive tests are available in CDC's Clinical Questions about COVID-19: Questions and Answers. If a potential case of reinfection is suspected, guidance for public health management remains the same for reinfections as primary infection with SARS-CoV-2.

SIGNS AND SYMPTOMS

Symptoms of COVID-19 are non-specific and the disease presentation can range from no symptoms (asymptomatic) to severe pneumonia and death. COVID-19 presents as a mild to moderate illness for approximately 80% of individuals evaluated with the disease; 15% of

individuals experience severe illness requiring supplemental oxygen; and 5% experience critical illness requiring mechanical ventilation. People with COVID-19 generally develop signs and symptoms, including mild respiratory symptoms and fever ~5 days after infection (mean incubation period 4-5 days, range 1-14 days).

Multisystem Inflammatory Syndrome in Children (MIS-C)
MIS-C is a condition where different body parts can become inflamed, including the heart, lungs, kidneys, brain, skin, eyes, or gastrointestinal organs. Children with MIS-C may present with persistent fever, abdominal pain, vomiting, diarrhea, skin rash, mucocutaneous lesions, and in severe cases, hypotension and shock. Patients usually have elevated markers of inflammation, and some patients may develop myocarditis, cardiac dysfunction, and acute kidney injury. Additional clinical considerations are available in CDC's Information for Healthcare Providers about MIS-C. We do not currently know what causes MIS-C. However, many children with MIS-C were recently infected with SARS-CoV-2 or had been around someone with COVID-19.

The case definition for MIS-C is available here. Per the ODH Director's Journal Entry dated May 15, 2020, MIS-C is a reportable condition. LHDs who are notified of confirmed or suspected cases of MIS-C should notify ODH via entry into ODRS within 24 hours of identification. A MIS-C case report form should be completed and attached to the ODRS record; a fillable MIS-C case report form is available here.

DIAGNOSIS
Patients who present with symptoms consistent with COVID-19 should also be evaluated for common causes of community-acquired pneumonia (e.g., influenza A and B viruses, respiratory syncytial virus, *Streptococcus pneumoniae*, and *Legionella pneumophila*). This evaluation should be based on clinical presentation and epidemiologic and surveillance information.

If infection with COVID-19 is suspected based on current clinical and epidemiological screening criteria recommended by public health authorities, healthcare providers should consider testing clinical specimens.

Testing for other respiratory pathogens should not delay shipping of specimens for COVID-19 testing for suspected cases. If a suspected case tests positive for another respiratory pathogen, after clinical evaluation and consultation with public health authorities, they may no longer be considered a suspect case. This may evolve as more information becomes available on possible COVID-19 co-infections.

If testing is to be performed at ODH Laboratory, use nasopharyngeal swabs in viral transport media and include the ODH Laboratory Microbiology Specimen Submission Form (HEA 2530) with the specimen.

For initial diagnostic testing for SARS-CoV-2 (COVID-19), CDC recommends collecting an upper respiratory specimen. The following are acceptable specimens:
- Nasopharyngeal (NP) specimen collected by a healthcare professional, or
- Oropharyngeal (OP) specimen collected by a healthcare professional, or
- Nasal mid-turbinate (NMT) swab collected by a healthcare professional or by a supervised onsite self-collection (using a flocked tapered swab), or
- Anterior nares (nasal swab; NS) specimen collected by a healthcare professional or by onsite or home self-collection (using a flocked or spun polyester swab), or
- Nasopharyngeal wash/aspirate or nasal wash/aspirate (NW) specimen collected by a healthcare professional

Specimens should be collected as soon as possible once a suspected case is identified, regardless of the time of symptom onset. Maintain proper infection control when collecting specimens. Further guidance for collection, handling, and testing of clinical specimens is available at Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19)

Virus isolation in cell culture and initial characterization of viral agents recovered in cultures of COVID-19 specimens are NOT recommended at this time, except at a BSL3 facility.

See also:

- Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19)

Considerations for Interpreting Test Results and Public Health Management
Information on the performance of rapid antigen rests for SARS-CoV-2 and evaluation of results, including considerations for when confirmatory testing might be warranted, is available in CDC's Interim Guidance for Rapid Antigen Testing for SARS-CoV-2. Guidance specific to antigen testing in nursing homes is available in CDC's Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes. General recommendations for testing are available in CDC's Overview of Testing for SARS-CoV-2.

The "gold standard" for clinical diagnostic detection of SARS-CoV-2 remains RT-PCR; these tests are highly sensitive and specific, but a false negative result is possible.

- When a confirmatory test is negative but epidemiologic linkage and clinical criteria are met, persons should follow isolation protocols for COVID-19 unless an alternative etiology is identified after evaluation by a healthcare provider. If an alternative etiology is identified, persons should follow quarantine protocols for COVID-19 due to epidemiologic linkage.
- For asymptomatic persons, when a confirmatory test is negative but epidemiologic linkage criteria are met, persons should follow quarantine protocols for COVID-19.
- For residents or healthcare personnel in nursing homes, please follow CDC's guidance for Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes (testing algorithm available here).

EPIDEMIOLOGY

Chinese health officials identified COVID-19 in Wuhan City, Hubei Province, China in December 2019 based on testing of individuals with severe pneumonia. On January 21, 2020, the United States announced its first infection with COVID-19 detected in a traveler returning from Wuhan. On March 9, 2020, Ohio reported its first COVID-19 cases. For an updated list of COVID-19 travel recommendations by country, please visit the CDC website here.

Source

Early on, many of the patients at the epicenter of the outbreak in Wuhan, Hubei Province, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China, including in the United States. Most international destinations now have ongoing community spread with the virus that causes COVID-19, as does the United States.

Occurrence

COVID-19 is widespread through almost every country in the world. Variants of the SARS-CoV-2 virus have emerged and are circulating globally. At this time, strict adherence to existing precautions and containment measures is recommended to prevent the spread of SARS-CoV-2 variants. For more information, please see SARS-CoV-2 Variant Classifications and Definitions and COVID Data Tracker: Variant Proportions.

Mode of Transmission

COVID-19, like other coronaviruses, is thought to mainly spread from person-to-person between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs, sneezes, talks, or breathes. While evidence suggests that COVID-19 can sometimes be spread by airborne transmission, it most commonly spreads during close contact. COVID-19 may be spread by people who are not showing symptoms. The precise ways the virus spreads is an area of continued study.

Period of Communicability

Available data indicate that persons with mild to moderate COVID-19 remain infectious for no longer than 10 days after symptom onset. Persons with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset. Patients are believed to be contagious two days prior to symptom onset (or, for persons who tested positive for COVID-19 but have not had any symptoms, the two days before the date the first positive viral test was collected).

Incubation Period

The estimated incubation period is between 2 and 14 days with a median of 4-5 days from exposure to symptom onset. Not all infected individuals develop symptoms.

PUBLIC HEALTH MANAGEMENT

Case

Investigation

Healthcare providers/Local health departments should continue to routinely ask about travel history and healthcare facility exposure and consider a diagnosis of COVID-19 infection in persons who present with symptoms consistent with COVID-19. Detailed guidance on case investigation and contact tracing is available on the CDC website. See Developing a COVID-19 Case Investigation and Contact Tracing Plan.

Treatment

The National Institutes of Health (NIH) has published guidelines on testing and management of patients with COVID-19. For more information, please visit the NIH COVID-19 Treatment Guidelines. Current clinical management includes infection prevention and control measures and supportive care, including supplemental oxygen and mechanical ventilatory support when indicated. The U.S. Food and Drug Administration (FDA) has approved one drug, remdesivir (Veklury), for the treatment of COVID-19 in certain situations.

Early effective treatment of any disease can help avert progression to more serious illness, especially for patients at high risk of disease progression and severe illness, with the additional benefit of reducing the burden on healthcare systems. A number of novel therapeutics (e.g., monoclonal antibodies) are available under EUA for early outpatient treatment. Trials to assess the potential effectiveness of these therapeutics in outpatients at high risk of disease progression are ongoing. Clinicians and patients who wish to consider their use, or the use of any other available investigational therapies,

should review the COVID-19 Treatment Guidelines as well as the FDA EUA for the therapy.

Vaccines and General Public Health Recommendations for Fully Vaccinated Persons
Currently, three vaccines are authorized and recommended to prevent COVID-19:

- Pfizer-BioNTech COVID-19 vaccine
- Moderna COVID-19 vaccine
- Janssen COVID-19 vaccine (Johnson & Johnson)

Studies are ongoing to learn more about the duration of protection from these vaccines and the potential impact of SARS-CoV-2 variants on their effectiveness. At this time, COVID-19 vaccines appear to remain highly effective at preventing severe illness, though continued breakthrough cases are expected. Even in the event of breakthough cases, vaccination is expected to reduce disease severity.

In general, fully vaccinated persons should wear a mask in indoor public settings when community transmission levels of SARS-CoV-2 are substantial or high, and where required by federal, state, local, tribal, or territorial laws, rules, and regulations, including local business and workplace guidance. Persons who are fully vaccinated could consider wearing a mask regardless of community transmission levels, particularly if someone they live with is unvaccinated, immunocompromised, or at increased risk for severe disease. At this time, guidance related to the use of personal protective equipment by healthcare personnel remains unchanged.

Given currently limited information on vaccine protection in people with immunocompromising conditions, these individuals should discuss the need for personal protective measures with their healthcare provider after vaccination.

Due to an increased risk of getting and spreading COVID-19 during travel, it is recommended to delay travel until persons are fully vaccinated. Guidance for domestic and international travel during COVID-19, including recommendations for testing and quarantine by vaccination status, is available on the CDC website. All travelers, including those who are fully vaccinated, are required to wear a mask on all planes, buses, trains, and other forms of public transportation.

For quarantine and testing recommendations for fully vaccinated persons, please see information under "Contacts", below.

For isolation recommendations for fully vaccinated persons, please see information under "Isolation", below.

Please see CDC's Interim Public Health Recommendations for Fully Vaccinated People and Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination for additional details and most current information.

Isolation
Patients with suspected or confirmed SARS-CoV-2 infection should be asked to wear a facemask or cloth face covering, if tolerated, and be evaluated in a private room with the door closed and a dedicated bathroom. Airborne infection isolation rooms (AIIRs) should be reserved for patients who will be undergoing aerosol generating procedures. Healthcare personnel entering the room should use appropriate transmission-based precautions. Guidance on isolation measures for patient in healthcare settings is available in CDC's Interim Infection Prevention and Control Recommendations for

Healthcare Personnel During the COVID-19 Pandemic. Immediately notify your healthcare facility's infection control personnel and local health department.

Ill people who are being evaluated for SARS-CoV-2 infection and do not require hospitalization for medical reasons may be cared for and isolated in their home. Isolation is defined as the separation or restriction of activities of an ill person with a contagious disease from those who are well. Guidance on home care and isolation measures is available in CDC's Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for COVID-19. Most people with COVID-19 have mild illness and can recover at home without medical care. Ill individuals should stay home, except to get medical care and should not visit public areas. Visit the CDC page for What to Do If You Are Sick for more guidance on isolation.

The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis. This decision will depend on the clinical presentation, requirement for supportive care, potential risk factors for severe disease, and the ability of the patient to self-isolate at home. Patients with risk factors for severe illness should be monitored closely given the possible risk of progression to severe illness in the second week after symptom onset.

Fully Vaccinated People with COVID-19 Symptoms

Any fully vaccinated person who experiences symptoms consistent with COVID-19 should isolate themselves from others, be clinically evaluated for COVID-19, and tested for SARS-CoV-2 if indicated. Fully vaccinated persons should inform their healthcare provider of their vaccination status.

Vaccine Breakthrough Cases

Jurisdictions are asked to investigate SARS-CoV-2 infections among fully vaccinated persons to identify trends or clustering in patient characteristics, the administered vaccine, or the infecting virus.

Criteria for COVID-19 Vaccine Breakthrough Case Investigations

- COVID-19-related hospitalization or death
- U.S. Resident
- Completed full primary series of an FDA-authorized COVID-19 vaccine
- SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected ≥14 days after completing the primary series of an FDA-authorized COVID-19 vaccine
- No known positive test for SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected <45 days before the most recent positive test

If a vaccine breakthrough case is suspected or identified, local jurisdictions should contact the Vaccine-Preventable Disease (VPD) Epidemiology Program at (614) 995-5599, or email ORBIT@odh.ohio.gov, during normal business hours to approve and coordinate RNA specimen submissions to the Ohio Department of Health Laboratory (ODHL) for viral sequencing. Once the VPD Program has been notified and the criteria have been met, the PCR specimen can be sent with a completed SARS-CoV-2 Specimen Submission Form (found here). "Vaccine Breakthrough Whole Genome Sequencing (WGS)" should be written in the comments section of the form.

Healthcare providers should be instructed to additionally report cases of Multisystem Inflammatory Syndrome (MIS) in vaccinated persons and/or breakthrough cases of

COVID-19 that result in hospitalization or death to the Vaccine Adverse Event Reporting System (VAERS): https://vaers.hhs.gov/faq.html.

In addition to the key information for ODRS reporting, LHDs should enter complete vaccine information in the vaccine module of ODRS for any vaccine breakthrough case investigation.

Discontinuation of Isolation

For guidance on discontinuation of isolation and return to work criteria, please see:

- Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings
- Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection

Detailed guidance on testing, isolation, and quarantine for persons who have recovered from previous SARS-CoV-2 infection (including patients with persistent or recurrent positive tests) is available on the CDC website. See Clinical Questions about COVID-19: Questions and Answers.

Contacts

Close contact is defined as: someone who was within 6 feet of an infected person for at least 15 minutes (total/cumulative time) starting from 2 days before illness onset (or, for asymptomatic clients, 2 days prior to positive specimen collection) until the time the patient is isolated. Additionally, a person would be considered a close contact if they provided care in the home to someone who is sick with COVID-19, had direct physical contact with them (e.g., hugged or kissed them), shared eating or drinking utensils, or had unprotected direct contact with infectious secretions or excretions of the infected person (e.g., was coughed/sneezed on, touched used tissues with a bare hand). Data are limited to precisely define prolonged exposure to determine "close contact", however 15 minutes of close exposure can be used as an operational definition for contact investigation. Factors to consider when defining close contact include proximity, the duration of exposure (e.g., longer exposure time likely increases exposure risk) and whether the individual has symptoms (e.g., coughing likely increases exposure risk). At this time, differential determination of close contact for those using cloth face coverings or barriers (e.g., plastic dividers) is not recommended.

Guidance to assist with risk assessment and application of work restrictions for potential exposures in healthcare facilities is available on the CDC website, see Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2.

Evaluation and management of close contacts of a case should be discussed with state and local health departments. See CDC Public Health Guidance for Community-Related Exposure, Public Health Guidance for Potential COVID-19 Exposure Associated with International or Domestic Travel and Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.

Close contacts of a confirmed case who are ill and do not require hospitalization for medical reasons may, in consultation with the state and local health department, be cared for and isolated in their home while being evaluated for COVID-19 infection. Close contacts of a confirmed or probable case should be quarantined as described below. When COVID-19 is suspected, prompt initiation of quarantine protocols for close contacts may be recommended to prevent the potential spread of SARS-CoV-2 while the

individual with suspected COVID-19 awaits test results or evaluation by a healthcare provider.

Detailed guidance on quarantine for persons who have recovered from previous SARS-CoV-2 infection is available on the CDC website. See Clinical Questions about COVID-19: Questions and Answers.

- If a person has clinically recovered from SARS-CoV-2 infection and is then identified as a contact of a new case 3 months or more after the date of symptom onset of their previous illness episode (or date of first positive viral diagnostic test [PCR or antigen test] if the person never experienced symptoms), then they should follow quarantine recommendations for contacts and undergo repeat viral diagnostic testing.
- If a person has clinically recovered from SARS-CoV-2 infection that was verified with a viral diagnostic test and then, within 3 months since the date of symptom onset of the previous illness episode (or date of positive viral diagnostic test if the person never experienced symptoms), is identified as a contact of a new case and remains asymptomatic, then they do not need to be retested for SARS-CoV-2 and do not need to be quarantined. However, if the person experiences new symptoms consistent with COVID-19 and a clinical evaluation fails to identify a diagnosis other than SARS-CoV-2 infection, then repeat viral diagnostic testing may be warranted, in consultation with a clinical provider.

In general, testing is recommended for close contacts of persons with SARS-CoV-2 infection because of the potential for asymptomatic and pre-symptomatic transmission.

Persons who are not fully vaccinated are advised to be tested immediately and again in 5-7 days after exposure or if symptoms develop.

In most situations, persons who have recovered from previous SARS-CoV-2 infection do not need to be tested after exposure if the the exposure occurs within 90 days of the infection and they remain asymptomatic (see guidance for persons who have recovered from previous SARS-CoV-2 infection, above).

Fully vaccinated persons* with an exposure to someone with suspected or confirmed COVID-19 are advised to be tested 3-5 days after exposure and wear a mask in public indoor settings for 14 days or until they receive a negative test result. They should monitor for symptoms of COVID-19 for 14 days following the exposure and follow recommended isolation protocols if they develop symptoms of COVID-19. However, they are not required to quarantine if they meet the following criteria:

- Are fully vaccinated (i.e., ≥ 2 weeks following receipt of the second dose in a 2-dose series, or ≥ 2 weeks following receipt of one dose of a single-dose vaccine) with a vaccine currently authorized for emergency use by the U.S. Food and Drug Administration or the World Health Organization.
- Have remained asymptomatic since the current COVID-19 exposure

*Exceptions:

- For healthcare settings:
    - Healthcare facilities should continue to follow all applicable state and federal requirements related to testing and quarantine of healthcare personnel and patients. Detailed guidance on testing and quarantine in healthcare settings, and considerations for vaccinated and unvaccinated persons, is available on the CDC website: See updated Healthcare

Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination. Guidance from the Centers for Medicare and Medicaid Services (CMS) can be found at QSO-20-38-NH REVISED (cms.gov).

For additional information on post-vaccination recommendations in non-healthcare settings, please see Interim Public Health Recommendations for Fully Vaccinated People.

For additional information on post-vaccination recommendations in healthcare settings, please see Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.

Options for Quarantine

On December 2, 2020, the Centers for Disease Control and Prevention (CDC) released a scientific brief with considerations for reducing quarantine for COVID-19. Recommendations for quarantine adapted by ODH support efficient use of resources and a reduced risk of post-quarantine transmission:

- **Optimal Duration to Minimize Risk of Transmission:** Standard 14-day quarantine period. A 14-day quarantine period presents the lowest risk of post-quarantine transmission. This strategy is preferred for people living, working at, or visiting congregate living facilities, high density workplaces, or other settings where potential extensive transmission or contact with people at increased risk for severe illness from COVID-19 is possible.
- **Reduced Duration 1:** Stay at home for at least 10 days after last exposure AND symptom monitoring through day 14. Consider obtaining a viral test at the end of this period (day 8 or later) to increase certainty that the individual is not infected, but quarantine cannot be discontinued earlier than after day 10.
- **Reduced Duration 2:** Negative viral test result for SARS-CoV-2 from a test collected on day 5 or later after last exposure AND stay at home for at least 7 days after last exposure AND symptom monitoring through day 14.

Recommended actions during quarantine, regardless of duration, include staying at home until quarantine may be discontinued, maintaining social distance (at least 6 feet) from others, wearing a mask when around other people, and self-monitoring for symptoms of COVID-19 through day 14. Persons who develops symptoms of COVID-19 or who test positive for SARS-COV-2 should self-isolate and follow recommendations for discontinuing isolation.

Special Considerations for Quarantine in In-Person K-12 Classroom Environments

Quarantine is not necessary for students and adults possibly exposed to COVID-19 within a K-12 learning environment or on required school transportation, regardless of vaccination status, if all of the following prevention measures were in place:

- Masking for students and staff (regardless of vaccination status)
- Physical distancing is maximized (at least 3 feet between desks)
- Documented COVID-19 prevention policies (e.g., identification of individuals experiencing symptoms, strategies to increase ventilation, protocols for cleaning, etc.)

If not all prevention measures listed above were in place, additional management of close contacts is advised to prevent the spread of COVID-19. Please refer to the ODH Guidelines for Quarantine After Exposure in K-12 Classroom Settings and K-12 Classroom Exposure Quarantine Flowchart for the public health management of close contacts. If exposure to COVID-19 occurred in the community, extracurrircular, or sports environment, special considerations for quarantine in in-person K-12 classroom environments do not apply; routine quarantine protocols for the general public should be applied.

Students and adults within K-12 schools who are identified as a close contact of someone with COVID-19 should be notified of their exposure based on normal public health and school policies. Such notifications help ensure that families can make informed decisions for activities which occur outside of the classroom setting, including interaction with vulnerable populations. Students and their parents or guardians should be advised to restrict their activities outside of the classroom, including gatherings with individuals outside of their household—particularly people who are at higher risk of severe illness from COVID-19—and activities where face masks cannot be safely or effectively worn.

Outbreaks

Please follow existing ODH guidance on outbreaks in Section 3 of the IDCM. For COVID-19, an outbreak is defined as two or more cases who are epidemiologically linked with a common exposure in a community, institutional, or healthcare setting*, do not share a household, and were not identified as close contacts of each other in another setting during standard case investigation and contact tracing.

> *For long-term care facilities**, one case of facility-onset COVID-19 in a resident is considered an outbreak. Facility-onset COVID-19 is defined as a COVID-19 diagnosis 14 days or more after admission for a non-COVID condition, without an exposure during the previous 14 days to another setting where an outbreak was known or suspected to be occurring; it does not include residents who were known to have COVID-19 on admission or who were placed into transmission-based precautions upon admission and developed COVID-19 within 14 days after admission.
>
> **Including long-term acute care hospitals, skilled nursing facilities, assisted living facilities, residential care facilities, intermediate care facilities for the intellectually disabled, wrap-around facilities, and any other facilities providing comparable services.

Outbreak resolution is defined as: No new symptomatic/asymptomatic probable or confirmed COVID-19 cases after 28 days (two incubation periods) have passed since the last case's onset date or specimen collection date (whichever is later). Facilities should follow appropriate local, state, or federal guidance on timing for outbreak testing activities.

Prevention and Control

The best way to prevent illness is to avoid being exposed to COVID-19. The virus that causes COVID-19 is thought to spread mainly from person-to-person through respiratory droplets produced when an infected person coughs, sneezes, talks, or breathes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. Spread is more likely between people who are in close contact with one another (within about 6 feet). To prevent illness:

- Get vaccinated
- Avoid close contact with people who are sick, stay at home as much as possible, and put distance between yourself and other people.
- Cover your mouth and nose with a cloth face cover when around others.
- Clean and disinfect frequently touched surfaces daily.
- Wash hands often with soap and water for at least 20 seconds especially after you have been in a public place or after blowing your nose, coughing or sneezing.
- If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- Avoid touching your eyes, nose and mouth with unwashed hands.

Additional Resources

CDC Coronavirus (COVID-19)

Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)

CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)

CDC Information for Pediatric Healthcare Providers

CDC How to Protect Yourself & Others

Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19)

Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19)

Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19

WHO Clinical management of severe acute respiratory infection when COVID-19 is suspected

What is COVID-19?
COVID-19 is a respiratory illness. It is caused by a virus called SARS-CoV-2. This virus was first identified in 2019 in Wuhan City, Hubei Province, China. It is different from any other coronaviruses that have been found in people before.

What are the symptoms and complications of COVID-19?
People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may include:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle pain or body aches
- Headache
- Sore throat
- New loss of taste or smell
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Complications of COVID-19 may include respiratory failure, shock or multiorgan system dysfunction.

How does the virus spread?
The virus that causes COVID-19 spreads easily and sustainably between people, mainly through respiratory droplets produced when an infected person coughs, sneezes, talks, or breathes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. COVID-19 can sometimes be spread by airborne transmission (when small droplets are able to infect people who are further than 6 feet away from the infected person or after that person has left the space), however, spread is more likely between people who are in close contact with one another (within about 6 feet). COVID-19 may be spread by people who are not displaying symptoms. Less commonly, a person can get COVID-19 by touching a contaminated surface or object and then touching their own, mouth, nose, or possibly their eyes (this is not thought to be the main way the virus spreads).

Prevention and Control
The best way to prevent illness is to avoid being exposed to COVID-19. The virus that causes COVID-19 is thought to spread mainly from person-to-person through respiratory droplets produced when an infected person coughs, sneezes, talks, or breathes. These droplets can land in the mouths and noses of people who are nearby or possibly be inhaled into the lungs. Spread is more likely between people who are in close contact with one another (within about 6 feet). To prevent illness:

- Get vaccinated
- Avoid close contact with people who are sick, stay at home as much as possible, and put distance between yourself and other people.
- Cover your mouth and nose with a cloth face cover when around others.
- Clean and disinfect frequently touched surfaces daily.

- Wash hands often with soap and water for at least 20 seconds especially after you have been in a public place or after blowing your nose, coughing or sneezing.
- If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- Avoid touching your eyes, nose and mouth with unwashed hands.

Is there a vaccine?
Currently, three vaccines are authorized and recommended to prevent COVID-19:
- Pfizer-BioNTech COVID-19 vaccine
- Moderna COVID-19 vaccine
- Johnson & Johnson's Janssen COVID-19 vaccine

What are the treatments?
Treatment is supportive. The U.S. Food and Drug Administration (FDA) has approved one drug, remdesivir (Veklury), for the treatment of COVID-19 in certain situations. Early effective management of any disease can help prevent progression to more serious illness, especially for patients at high risk of disease progression and severe illness. If you are sick with COVID-19 or suspect you have COVID-19, please call your healthcare provider.

What do I do if I am sick with COVID-19 and have pets?
If you are sick with COVID-19 (either suspected or confirmed by a test), you should restrict contact with your pets and other animals, just like you would with people.
- Have another member of your household care for your pets while you are sick, if possible.
- Avoid contact with your pet including petting, snuggling, being kissed or licked and sharing food or bedding.
- If you must care for your pet or be around other animals while you are sick, wear a cloth face covering and wash your hands before and after you interact with them.

If you are sick with COVID-19 and your pet becomes sick, do not take your pet to the veterinary clinic yourself. Call your veterinarian and let them know you have been sick with COVID-19. Some veterinarians may offer telemedicine consultations or other plans for seeing sick pets. Your veterinarian can evaluate your pet and determine the next steps for your pet's treatment and care. Routine testing of animals is not recommended at this time.

What can I do to protect my pet and my family from COVID-19?
Until we learn more about how this virus affects animals, treat pets as you would other human family members to protect them from a possible infection.
- Do not let pets interact with people or other animals outside the household.
- Keep cats indoors when possible to prevent them from interacting with other animals or people.
- Walk dogs on a leash, maintaining at least 6 feet (2 meters) from other people and animals.
- Avoid dog parks or public places where a large number of people and dogs gather.

Can I get COVID-19 from my pets or other animals?
Based on the limited information available to date, the risk of animals spreading COVID-19 to people is considered to be low. See If You Have Pets for more information about pets and COVID-19. However, since animals can spread other diseases to people, it's always good to practice healthy habits around pets and other animals, such as washing your hands and maintaining good hygiene. For more information on the many benefits of pet ownership, as well as staying safe and healthy around animals including pets, livestock, and wildlife, visit CDC's Healthy Pets, Healthy People website.

Can animals carry the virus that causes COVID-19 on their skin or fur?
Although we know certain bacteria and fungi can be carried on fur and hair, there is no evidence that viruses, including the virus that causes COVID-19, can spread to people from the skin, fur, or hair of pets. However, because animals can sometimes carry other germs that can make people sick, it's always a good idea to practice healthy habits around pets and other animals, including washing hands before and after interacting with them.

Can I use hand sanitizer on pets?
Do not wipe or bathe your pet with chemical disinfectants, alcohol, hydrogen peroxide, or other products, such as hand sanitizer, counter-cleaning wipes, or other industrial or surface cleaners. If you have questions about appropriate products for bathing or cleaning your pet, talk to your veterinarian. If your pet gets hand sanitizer on their skin or fur, rinse or wipe down your pet with water immediately. If your pet ingests hand sanitizer (such as by chewing the bottle) or is showing signs of illness after use, contact your veterinarian or pet poison control immediately.

What is known about COVID-19 and mink?
- SARS-CoV-2 has been reported in mink on farms in the Netherlands, Denmark, Spain, Italy, Sweden, and the United States.
- Because some workers on these farms had COVID-19, it is likely that infected farm workers were the initial source of the mink infections.
- Currently, there is no evidence that animals play a significant role in the spread of SARS-CoV-2 to people.

FW: UPDATED GUIDANCE: Booster doses approved for Moderna, Johnson & Johnson COVID-19 vaccines

Crystal Jones <cjones@athenspublichealth.org>

Fri 10/22/2021 2:00 PM

To: **all users <allusers@athenspublichealth.org>**

Good afternoon,

Attached please find the ODH guidance for boosters doses of Moderna and Johnson & Johnson vaccine. We will have a clinic Friday, October 29th, 8:30 am to 11:30 am at Heritage Hall for Moderna & Pfizer vaccines that can be scheduled through VMS.

Once we receive our shipment of J & J vaccine, we will update VMS for those wanting to schedule a J & J booster. We should receive a shipment by Tuesday.

Please let us know if you have any questions. We appreciate everyone's flexibility as we try to plan clinics on such short notice.

Thanks,

Crystal Jones, RN
Director of Nursing
Athens City-Country Health Department
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From: COVIDVACCINE@odh.ohio.gov
Sent: Friday, October 22, 2021 11:21 AM
Subject: UPDATED GUIDANCE: Booster doses approved for Moderna, Johnson & Johnson COVID-19 vaccines

Oct. 22, 2021

To All Enrolled COVID-19 Vaccine Providers,
Eligible Ohioans who received the Moderna and Johnson & Johnson COVID-19 vaccines are now able to receive booster doses, and may choose any approved COVID-19 vaccine for their booster dose. Booster doses are now available for certain populations who have received all three COVID-19 vaccines authorized or approved in the United States.

The Centers for Disease Control and Prevention has reviewed authorizations from the U.S. Food and Drug Administration earlier this week and recommended the following:

Moderna booster dose

People who received the Moderna vaccine for their primary vaccine series can now receive a booster dose.

For individuals who received a Pfizer-BioNTech or Moderna COVID-19 vaccine, the following groups are eligible for a booster shot **at least six months after their initial series**:

- 65 years and older.
- Age 18 and older who live in long-term care settings.
- Age 18 and older who have underlying medical conditions.
- Age 18 and older who work or live in high-risk settings.

The Moderna booster dose is NOT the same dosage given for the primary series (0.5 mL). **The booster dose is a half-dose (0.25 mL)**, and providers will need to draw the appropriate dosage for boosters. Additional ancillary supplies will be provided.

Johnson & Johnson booster dose

Booster doses are authorized for all recipients of the single-dose Johnson & Johnson/Janssen COVID-19 vaccine. Anyone age 18 or older who received a Johnson & Johnson vaccine can get a booster dose **at least two months following the initial dose**.

The Johnson & Johnson booster dose is the same dosage as the first dose.

Mix-and-match doses

Eligible individuals may choose which vaccine they receive as a booster dose. Some people may have a preference for the vaccine type that they originally received and others, may prefer to get a different booster.

This mix-and-match approach applies only to booster doses. The primary series of the two-dose mRNA vaccines must be from the same product.

NEXT STEPS

The CDC is expected to issue more detailed clinical considerations around booster doses, including guidance on weighing individual risks and benefits and mix-and-match booster doses. The Ohio Department of Health (ODH) will review these final recommendations and share important updates as soon as they become available.

Ohio COVID-19 vaccine providers can begin offering booster doses as soon as practical. Eligible booster recipients will be asked to attest they have one of the qualifying conditions, but specific proof will not be required. ODH is advising that it may take eligible Ohioans 2-3 weeks to get their booster dose, and is emphasizing that there will be many opportunities to receive these boosters in their local community, whether they walk in to get their third dose or make an appointment with a nearby provider. Ohioans will be able to schedule an appointment online at gettheshot.coronavirus.ohio.gov or by phone at 1-833-427-5634.

UPDATED RESOURCES:

- UPDATED: Guidance for Ohio Vaccine Providers for Administering Booster Doses
- Moderna COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers
- Johnson & Johnson (Janssen) COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers
- Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers

Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

Ohio COVID-19 Vaccine Provider Relations Team

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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COVID-19 Vaccine Program
Guidance for Vaccine Providers for Administering Booster Doses

The U.S. Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) have authorized a single booster dose for the three COVID-19 vaccines available in the United States (Pfizer/Comirnaty, Moderna, and Johnson & Johnson/Janssen) to strengthen protection against serious outcomes from COVID-19 and/or against COVID-19 infection.

Eligibility, dosage, and timing of booster doses vary by individual COVID-19 vaccine product. Not all Ohioans are eligible to receive a booster dose at this time, including people who are younger than 18. Factors that determine booster dose eligibility include age, health conditions, and work or living settings. Please read eligibility requirements by product below.

Following required actions by the U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) for each vaccine product, Ohio COVID-19 vaccine providers can administer booster doses, as soon as practical and people are determined eligible, to individuals as outlined below.

Eligible vaccine recipients may now receive a booster dose of any available COVID-19 vaccine product. The booster dose does not have to match the original dose/series.

The CDC is expected to share additional guidance and resources for providers about booster dose administration in its Interim Clinical Considerations for Use of the COVID-19 Vaccines, and its Morbidity and Mortality Weekly Report (MMWR). That guidance will include considerations for mix-and-match boosters. This guidance is forthcoming.

As booster dose administration expands, it's important to note the top priority for vaccine providers remains continued vaccination of unvaccinated individuals to protect against serious illness, hospitalization and death from COVID-19.

PROOF OF ELIGIBILITY

BOOSTER DOSE ELIGIBILITY REQUIREMENTS

Eligibility for booster doses is determined based upon the vaccine product used for the primary series, and in the cases of the two messenger RNA (mRNA) vaccines (Pfizer-BioNTech/Comirnaty and Moderna), age, health conditions, and living/work settings.

Pfizer-BioNTech/Comirnaty

If an individual received the Pfizer/Comirnaty vaccine for the primary series, booster doses can be given to adults who are at high risk for severe disease and complications from COVID-19 or high risk for exposure to COVID-19.

Eligibility includes those who meet any of the following criteria:

- 65 years and older.
- Age 18 and older who live in long-term care settings.
- Age 18 and older who have underlying medical conditions.
- Age 18 and older who work or live in high-risk settings.

Dosage: The Pfizer/Comirnaty booster dose is the same dosage given for the primary series.

Mix-and-match booster: Someone who received the primary series of the Pfizer/Comirnaty vaccine and is eligible to receive a

booster dose may get a booster dose of **any** COVID-19 vaccine approved or authorized for use in the United States.

Booster dose timing: At least six months following completion of the standard primary Pfizer series (two doses spaced at least 21 days apart).

Additional dose for people who are immunocompromised: A third dose can be added to the primary vaccine series at least 28 days following the second dose for individuals at least 12 years of age who have had a solid organ transplant or a condition that results in moderate to severe immunocompromise. **At this time, the maximum number of doses of an mRNA vaccine that can be given to any individual is three. Therefore, if someone received an additional dose because they are immunocompromised, they should not receive a fourth booster dose.**

More info: Pfizer-BioNTech COVID-19 Vaccine Fact Sheet for Healthcare Providers

Moderna

If an individual received the Moderna vaccine for the primary series, booster doses can be given to adults who are at high risk for severe disease and complications from COVID-19 or high risk for exposure to COVID-19.

Eligibility includes those who meet any of the following criteria:

- 65 years and older.
- Age 18 and older who live in long-term care settings.
- Age 18 and older who have underlying medical conditions.
- Age 18 and older who work or live in high-risk settings.

Dosage: The Moderna booster dose is NOT the same dosage given for the primary series (0.5 mL). The booster dose is a half-dose (0.25 mL).

- Moderna booster doses will not be packaged or distributed separately.
- Primary series doses (0.5 mL) or booster doses (0.25 mL) may be extracted from a vial, preferentially using low dead-volume syringes and/or needles.
- When extracting only primary series doses, depending on the syringes and needles used, a maximum of 11 doses (range: 10-11 doses) may be extracted from the vial containing 5.5 mL or a maximum of 15 doses (range: 13-15 doses) may be extracted from the vial containing 7.5 mL.
- **When extracting only booster doses or a combination of primary series and booster doses, the maximum number of doses that may be extracted from either vial presentation should not exceed 20 doses. Do not puncture the vial stopper more than 20 times.**
- If the amount of vaccine remaining in the vial cannot provide a full dose of 0.5 mL or 0.25 mL, discard the vial and contents. Do not pool excess vaccine from multiple vials.
- Ancillary kits will be doubled to ensure adequate supply.
- More info: Moderna letter to healthcare providers (Oct. 20, 2021)

Mix-and-match booster: Someone who received the primary series of the Moderna vaccine and is eligible to receive a booster dose may get a booster dose of **any** COVID-19 vaccine approved or authorized for use in the United States.

Booster dose timing: At least six months following completion of the primary Moderna series (two doses spaced at least 28 days apart).

Additional dose for people who are immunocompromised: A third dose can be added to the primary vaccine series at least 28 days following the second dose for individuals at least 18 years of age who have had a solid organ transplant or a condition that results in moderate to severe immunocompromise. **At this time, the maximum number of doses of an mRNA vaccine that can be given to any individual is three. Therefore, if someone received an additional dose because they are immunocompromised, they should not receive a fourth booster dose.**

More info: Moderna COVID-19 Vaccine Fact Sheet for Healthcare Providers

Johnson & Johnson/Janssen

Booster doses are authorized for all recipients of the single-dose Johnson & Johnson/Janssen COVID-19 vaccine. **Anyone age 18 or older who received a Johnson & Johnson vaccine can get a booster dose at least two months following the initial dose.**

Dosage: The Johnson & Johnson booster dose is the same formulation and dosage given for the first dose.

Mix-and-match booster: Someone who received the Johnson & Johnson vaccine may get a booster dose of **any** COVID-19 vaccine approved or authorized for use in the United States.

Booster dose timing: At least two months following the first dose of the Johnson & Johnson vaccine.

More info: Johnson & Johnson/Janssen COVID-19 Vaccine Fact Sheet for Healthcare Providers

IDENTIFICATION REQUIREMENTS

- Providers should ask to see identification that proves name, age, and identity.
    - Ask for identification to verify only the patient's identity, name, and age. Patients do not need to show proof of citizenship or residency status. Identification should still be accepted if it is expired or from another state or country.
    - Acceptable forms of identification are listed below:
        - Driver's license or any photo ID, regardless of expiration date or place of origin.
        - Active/retired military ID.
        - Physician statement (including shot records).
        - Census records.
        - Adoption records.
        - Naturalization certificate.
        - Birth certificate: Birth record, either original or certified copy.
        - Consulate ID or matricula consular.
        - Passport or a passport card.
        - Certificate of citizenship.
        - Permanent resident card.
        - Application for replacement naturalization/citizenship document.
        - Department of State forms.
            - Military service records (DD-214)
            - Certification of Birth Abroad of a Citizen of the United States (FS-545)
            - Certification of Report of Birth Abroad of a United States Citizen (DS-1350)
            - Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)
            - Employment Authorization Document (I-766/EAD)
            - Transportation letter (I-797F)

PROOF OF ELIGIBILITY

Eligible booster recipients will be asked to attest they meet one of the eligibility requirements, but specific proof will not be required. Individuals ages 18 to 49 with certain underlying medical conditions or who live/work in high-risk institutional or occupational settings are encouraged to discuss the benefits and risks of getting a booster dose with their healthcare providers.

VACCINE CARDS

Eligible Ohioans are encouraged to bring their COVID-19 vaccine card to their booster appointment. If they cannot find their vaccine card, they should first contact their original vaccine provider to see if their records can be located. If the original vaccine provider is unable to assist, they should contact their local health department. The final available option is to review this information on how to mail a request for your vaccination records to the Ohio Department of Health. Replacement vaccine cards are not available from the Ohio Department of Health. If a vaccine recipient does not have their original vaccine card, that should not be a barrier to prevent them from being vaccinated.

MIX-AND-MATCH BOOSTER DOSES

Eligible individuals who have completed the primary vaccination series can receive a booster dose of a different authorized or approved COVID-19 vaccine. This means:

- A person who originally received the Johnson & Johnson vaccine can receive a booster dose of the Johnson & Johnson, Pfizer, or Moderna vaccine.
- A person who originally received the Moderna primary vaccine series can receive a booster dose of the Moderna, Pfizer, or Johnson & Johnson vaccine.
- A person who originally received the Pfizer primary vaccine series can receive a booster dose of the Pfizer, Moderna, or Johnson & Johnson vaccine.

This mix-and-match approach applies only to booster doses. The primary series of the two-dose mRNA vaccines must be from the same product.

The half-dose Moderna booster dose should be given to all booster recipients, even if the primary series was different.

Additional recommendations around mix-and-match booster doses, including how individuals can assess their own benefits and risks, and how healthcare providers can best offer advice to patients, will be published in the CDC's final clinical recommendations. Those recommendations will be published soon in the CDC's Interim Clinical Considerations for Use of the COVID-19 Vaccines, and its Morbidity and Mortality Weekly Report (MMWR).

BOOSTER DOSE AVAILABILITY

Eligible Ohioans will have many opportunities to receive a booster dose, including at pharmacies, federally qualified health centers, doctor's offices, community vaccination sites, and local health departments.

While it will be important for providers to administer booster doses to eligible Ohioans, there are still many Ohioans who have not yet received their first dose of vaccine. Please continue to prioritize vaccination for new vaccine recipients while administering booster doses.

VACCINE MANAGEMENT SOLUTION (VMS): GETTHESHOT.CORONAVIRUS.OHIO.GOV

Eligible Ohioans will be able to determine their eligibility for booster doses and, if determined to be eligible, schedule an appointment at gettheshot.coronavirus.ohio.gov. Providers may continue to offer walk-in availability as appropriate.

Providers can start programming appointment availability in VMS now. For those providers who are scheduling appointments and whose schedulers can accommodate, please open schedulers at least three weeks out for future appointments if possible.

Providers are encouraged to offer all COVID-19 vaccine products, and should ensure that VMS displays which vaccine products are available. Providers are also encouraged to share available vaccine products on their websites and social media pages so people can find an appointment for their preferred product.

VACCINE LOCATIONS

Eligible Ohioans can find a provider and schedule an appointment online at gettheshot.coronavirus.ohio.gov or by calling 1-833-427-5634.

- Most retail and independent pharmacies will offer either walk-in or scheduled appointments.
- Local health departments in some of our largest cities will offer special community vaccination sites, and health departments in virtually every county are prepared to offer booster doses, including to homebound individuals.
- Community health centers and participating primary care providers will also offer booster doses.
- Participating long-term care facilities will offer doses of the Pfizer vaccine to residents through Ohio's COVID-19 Vaccine Maintenance Program, and state agencies and state-owned veterans homes will vaccinate eligible staff and residents.
- Affordable senior housing communities will work with local partners to host special vaccination opportunities for booster doses. Ohio will have ample supply of vaccine for boosters and for first and second doses. It may take 2-3 weeks, or more, for every eligible person who wants a booster to receive one.

DIRECT ORDERING

There will be no changes to the standard ordering process as a result of the start of booster dose administration. Vaccine providers should factor booster dose supply into current ordering cadences. All Ohio COVID-19 Vaccine Providers are responsible for placing vaccine orders through the ImpactSIIS Vaccine Ordering Management System (VOMS). VOMS is open for providers to place orders 24 hours a day, 7 days a week. Providers can order COVID-19 vaccine at their convenience. ODH is committed to getting COVID-19 vaccines to our providers as quickly as possible.

To ensure adequate inventory levels, providers should anticipate a window of 7 days from the date your order is entered into VOMS to the date the vaccine is delivered to your facility. Orders for products that are shipped directly from the manufacturer will be approved and processed Monday through Friday.

MINIMUM ORDER/SHIPPING QUANTITIES

Pfizer (adult/adolescent formulation)

- Minimum order quantity for direct shipment from the manufacturer is 1,170 doses, available in increments of 1,170 doses.
- The ODH Receipt, Store, and Stage (RSS) warehouse will break down Pfizer shipments into smaller sizes.
    - Minimum order quantity is 120 doses, available in increments of 120.
    - In rare cases, smaller increments of 30 doses are available for small providers such as pediatric practices or primary care providers with special approval.

Moderna

- **Moderna booster doses will not be packaged or distributed separately.** Vaccine providers will draw the appropriate booster dosage from existing inventories (vials include the equivalent of 14 full doses).
- Minimum order quantity for direct shipment from the CDC/McKesson Distribution Center is 140 doses.

Johnson & Johnson

- Minimum order quantity for direct shipment from the CDC/McKesson Distribution Center is 100 doses.

COVID-19 orders processed through the ODH RSS Warehouse will be delivered Tuesdays, Thursdays, and Fridays. The Friday delivery option is only available to pharmacies. These products are available for distribution from the ODH RSS Warehouse:

- Federal holidays that occur on weekdays may interrupt the delivery schedule.

Ancillary kits – containing needles, syringes, alcohol pads, vaccination cards and surgical masks/face shields for vaccinators – are shipped separately. Moderna ancillary kits will be doubled to ensure adequate supply.

VACCINE ADMINISTRATION

- **Timing of booster doses:** Booster doses can be administered 6 months or longer after completion of the primary series for people who received Pfizer or Moderna shots. For those who had Johnson & Johnson/Janssen, the boosters may be given after two months. Immunity wanes gradually over time, therefore a booster may be given at the appropriate interval .
- **Coadministration:** Booster doses may be given with other vaccines without regard to timing. This includes simultaneous administration of COVID-19 and other vaccines on the same day. Best practices for administering more than one vaccine, including COVID-19 vaccines and influenza vaccines, include:
    - When preparing more than one vaccine, label each with the name and dosage (amount) of vaccine, lot number, the initials of the preparer, and the exact beyond-use time, if applicable.
    - Always inject vaccines into different injection sites.
    - Separate injection sites by 1 inch or more, if possible, so that any local reactions can be differentiated. Each muscle (deltoid, vastus lateralis) has multiple injection sites.
    - If administered at the same time, COVID-19 vaccines and vaccines that might be more likely to cause a local injection site reaction (for example, high-dose and adjuvanted inactivated influenza vaccines) should be administered in different arms (or legs), if possible.
- Contraindications and precautions for a booster dose are the same as for the primary series.
- For individuals who had myocarditis and myopericarditis, it is recommended to defer a subsequent dose until myocarditis and myopericarditis has completely resolved.

View the CDC's Interim Clinical Considerations for use of COVID-19 vaccines for more detailed guidance for vaccine providers.

DATA REPORTING

The Ohio Department of Health (ODH) is committed to releasing data to inform the public in the midst of the COVID-19 crisis while also protecting the privacy rights of Ohioans. ODH has developed several online data dashboards reflecting information from multiple sources, including vaccination data provided by all enrolled providers.

VACCINE ADMINISTRATION DATA

The COVID-19 Vaccination Dashboard at coronavirus.ohio.gov displays the most recent data reported to the Ohio Department of Health (ODH) regarding the number of individuals that have started and completed the COVID-19 vaccination series by various demographics and county of residence.

To ensure timely data reporting and sharing, all COVID-19 vaccine providers must report all vaccinations within 24 hours through the Ohio Impact Statewide Immunization Information System (ImpactSIIS). **This includes the reporting of booster doses.**

VACCINE ADMINISTRATION ERRORS AND ADVERSE EVENTS

As part of essential ongoing vaccine safety monitoring efforts, vaccine providers are required to report any adverse events, including vaccine administration errors, to the Vaccine Adverse Event Reporting System.

VAERS is the nation's early warning system that monitors the safety of vaccines after they are authorized or licensed for use by the U.S. Food and Drug Administration (FDA). VAERS is part of the larger vaccine safety system in the United States that helps make sure vaccines are safe. The system is co-managed by the Centers for Disease Control and Prevention (CDC) and FDA.

VAERS accepts and analyzes reports of possible health problems — also called "adverse events" — after vaccination. If VAERS detects a pattern of adverse events following vaccination, other vaccine safety monitoring systems conduct follow-up studies.

Visit VAERS for a complete listing of requirements and step-by-step instructions on how to submit a report.

MESSAGING

Primary care providers are asked to recommend booster doses to eligible patients to boost their immunity to help prevent severe outcomes from COVID-19, including hospitalization or death.

KEY MESSAGES

- A booster dose will help provide continued protection against severe disease, including hospitalization and death, in populations who are especially at risk for severe COVID-19.
    - Because residents in long-term care (LTC) settings live closely together in group settings and are often older adults and/or have underlying medical conditions, they are at increased risk of infection and severe illness from COVID-19.
    - The risk of severe illness from COVID-19 increases with age, and can also increase for adults of any age with certain underlying medical conditions.
    - And while COVID-19 vaccine effectiveness against severe disease remains high for healthcare personnel and other essential workers, those with even mild illness often cannot work. In addition, some individuals may care for or live with at-risk people, such as the immunocompromised, and others may live in a congregate setting such as a homeless shelter or correctional facility where there is higher risk for transmission. For these reasons – as well as continued strain on the U.S. healthcare infrastructure due to the widely circulating Delta variant – CDC recommends that adults at high risk of disease from occupational and institutional exposures to COVID-19 get a booster based on their individual benefits and risks.
    - The COVID-19 vaccines approved and authorized in the United States continue to be highly effective in reducing risk of severe disease, hospitalization, and death, even against the widely circulating Delta variant.

PATIENT REMINDER MESSAGE TEMPLATE

COVID-19 boosters are now available for select Ohioans who completed the primary vaccine series. Vaccine booster doses have been authorized for all Johnson & Johnson vaccine recipients. Booster doses have been authorized for Pfizer or Moderna vaccine recipients if they are 65+, or if they are 18+ and have an underlying medical condition, or live or work in a setting that puts them at risk for exposure. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

[Provider name] is now offering #COVID19 booster doses to eligible Ohioans for the Pfizer, Moderna, and Johnson & Johnson vaccines. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

SOCIAL MEDIA POSTS

We are now offering #COVID19 booster doses to eligible Ohioans. If you received the Pfizer or Moderna vaccine series and are either 65 or older, or if you are 18 or older and have underlying conditions, or live or work in a setting that puts you at risk for exposure, you can get a booster dose 6 months after your second dose. All Johnson & Johnson vaccine recipients can get a booster dose at least 2 months after the first dose. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

EMAIL OR WEBSITE ARTICLE

The following groups of Ohioans who originally received the Pfizer or Moderna COVID-19 vaccine series are now eligible to receive a single booster dose, to be administered at least six months after completion of the primary series:

Eligibility includes those who meet any of the following criteria:

- 65 years and older.
- Age 18 and older who live in long-term care settings.
- Age 18 and older who have underlying medical conditions.
- Age 18 and older who work or live in high-risk settings.

Ohioans who received the Johnson & Johnson COVID-19 vaccine are eligible for a booster dose if it has been at least two months since the first dose.

Booster doses can now be given using any available COVID-19 vaccine. Booster doses do not have to be the same product given during the primary vaccine series.

There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Vaccinations are available at [Provider name] either by making an appointment or by walking in [insert details including days of the week and start time and end time]. While you do not have to get your booster dose at the same location where you received your first and second doses, you are welcome to continue to visit [Provider name] for your COVID-19 vaccine needs. You are encouraged to bring your COVID-19 vaccine card, and if you cannot find your vaccine card, please review this fact sheet from the Ohio Department of Health for options to access to your vaccination records. In short, you should first contact your original vaccine provider to see if they can locate your records. If they are unable to assist, please contact your local health department. If they are unable to assist, please review this information on how to mail a request for your vaccination records to the Ohio Department of Health.

Eligible Ohioans should allow 2-3 weeks to get their booster dose, with many opportunities to be vaccinated in their local community, whether they walk in to get their third dose or make an appointment with a nearby provider.

Updated Oct. 22, 2021.

For additional information, visit coronavirus.ohio.gov.

The Ohio Department of Health COVID-19 Provider website is a hub for a variety of resources for vaccine providers. Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

FW: IMPORTANT UPDATE: FDA grants EUA for Pfizer vaccine for ages 5-11

Crystal Jones <cjones@athenspublichealth.org>

Mon 11/1/2021 8:24 AM

To: **all users <allusers@athenspublichealth.org>**

From: COVIDVACCINE@odh.ohio.gov
Sent: Monday, November 1, 2021 8:22 AM
Subject: IMPORTANT UPDATE: FDA grants EUA for Pfizer vaccine for ages 5-11

Monday, Nov. 1, 2021

To All Enrolled COVID-19 Providers,

On Friday, the U.S. Food and Drug Administration granted an emergency use authorization for the Pfizer-BioNTech COVID-19 Vaccine for Children ages 5-11.

This authorization paves the way for shipments of the new Pfizer-BioNTech COVID-19 vaccine pediatric formulation to begin; however, **doses CANNOT be administered until the Centers for Disease Control and Prevention completes its review and makes its recommendations.**

The FDA has published emergency use authorization fact sheets for the Pfizer-BioNTech COVID-19 vaccine pediatric formulation for healthcare providers and for recipients and caregivers.

The CDC's Advisory Committee on Immunization Practices (ACIP) will meet beginning Tuesday, Nov. 2, to complete its review and make recommendations to the CDC, which will then issue guidance. Following final CDC action, the Ohio Department of Health will share updated guidance with Ohio providers. Providers who plan to administer doses to children ages 5-11 upon approval can continue to prepare by consulting the Ohio Department of Health's Interim Provider Guidance for Pfizer-BioNTech COVID-19 Vaccines for Children Ages 5-11.

Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

Ohio COVID-19 Vaccine Provider Relations Team

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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All Users

Crystal Jones <cjones@athenspublichealth.org>

Mon 11/22/2021 10:20 AM

To: **all users <allusers@athenspublichealth.org>**

We have opened a mass COVID 19 vaccine clinic for booster doses on Friday, December 3rd , from 9 am to 11:00 am at Heritage Hall. The appointments should be scheduled via VMS. - https://gettheshot.coronavirus.ohio.gov/

We have appointments available for the 5-11 year age group on 11/23, 11/24, 11/29, 11/30 here at the health department. Morgan, Kat and Chasity will schedule appointments for those that call our office.

Thanks,

Crystal

From: Crystal Jones
Sent: Monday, November 22, 2021 7:41 AM
To: all users <allusers@athenspublichealth.org>
Subject: FW: IMPORTANT UPDATE: COVID-19 booster doses authorized for fully vaccinated Ohioans age 18 and older

Good morning,

Please see the guidance for COVID -19 Vaccine Boosters for fully vaccinated adults 18 years and over. I will update staff later this morning on a mass vaccine clinic if we are able to secure a location and staff. We are evaluating adding appointments on the morning of December 3rd at Heritage Hall. Please direct callers to our Facebook page for updates on our plan for booster doses.

Thanks everyone for your patience and flexibility.

Crystal Jones, RN
Director of Nursing
Athens City-Country Health Department
278 West Union Street • Athens, OH 45701
740-592-4431, ext :5907 • 740-594-2370 (fax)
Email Addres• www.cjones@athenspubllichealth.org • Check us out on Facebook!

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From: COVIDVACCINE@odh.ohio.gov
Sent: Friday, November 19, 2021 7:07 PM
Subject: IMPORTANT UPDATE: COVID-19 booster doses authorized for fully vaccinated Ohioans age 18 and older

Nov. 19, 2021

To All Enrolled COVID-19 Vaccine Providers,
All fully vaccinated Ohioans age 18 and older are now eligible to receive a booster dose of the COVID-19 vaccine of their choice following action by the U.S. Food and Drug Administration and the Centers for Disease Control and Prevention.
The Centers for Disease Control and Prevention has reviewed the authorization from the U.S. Food and Drug Administration on Nov. 19, 2021, and recommended the following:

Pfizer/Comirnaty and Moderna booster dose

People age 18 and older who received the Pfizer-BioNTech/Comirnaty or Moderna COVID-19 vaccine for their primary vaccine series can receive a booster dose of any of the three approved COVID-19 vaccines (Pfizer/Comirnaty, Moderna, or Johnson & Johnson) **at least six months after their second dose (or third dose if immunocompromised)**.
Individuals younger than 18 are not eligible for booster doses at this time. The FDA and CDC will continue to evaluate vaccine data to determine if or when that eligibility will be extended to teens or children.

Johnson & Johnson booster dose

Booster doses are authorized for all recipients of the single-dose Johnson & Johnson/Janssen COVID-19 vaccine age 18 or older. These individuals can receive a booster dose of any of the three approved COVID-19 vaccines (Pfizer, Moderna, or Johnson & Johnson) **at least two months following the initial dose**.

NEXT STEPS

Ohio COVID-19 vaccine providers can begin offering booster doses to all eligible individuals as soon as practical. Ohioans are encouraged to schedule an appointment online at gettheshot.coronavirus.ohio.gov or by phone at 1-833-427-5634.

UPDATED RESOURCES:

- UPDATED: Guidance for Ohio Vaccine Providers for Administering Booster Doses
- Moderna COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers
- Johnson & Johnson (Janssen) COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers
- Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers

Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

Ohio COVID-19 Vaccine Provider Relations Team

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

Nov. 19, 2021

To All Enrolled COVID-19 Vaccine Providers,

All fully vaccinated Ohioans age 18 and older are now eligible to receive a booster dose of the COVID-19 vaccine of their choice following action by the U.S. Food and Drug Administration and the Centers for Disease Control and Prevention.

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Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

Ohio COVID-19 Vaccine Provider Relations Team

FW: Health Advisory 458: Increasing Seasonal Influenza A (H3N2) Activity, Especially Among Young Adults

Crystal Jones <cjones@athenspublichealth.org>

Mon 11/29/2021 12:26 PM

To: **all users <allusers@athenspublichealth.org>**

From: Ohio Health Alert Network
Sent: Monday, November 29, 2021 11:26 AM
To: Crystal Jones <cjones@athenspublichealth.org>
Subject: Health Advisory 458: Increasing Seasonal Influenza A (H3N2) Activity, Especially Among Young Adults

Crystal Jones,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

November 24, 2021, 11:00 AM ET

CDCHAN-00458

Increasing Seasonal Influenza A (H3N2) Activity, Especially Among Young Adults and in College and University Settings, During SARS-CoV-2 Circulation

Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory about increased influenza A(H3N2) activity that could mark the beginning of the 2021-2022 influenza season. The purpose of this HAN Health Advisory is to

1. Remind public health practitioners and clinicians to recommend and offer the current seasonal influenza vaccine to all eligible personsaged six months and older (Flu vaccine and COVID-19 vaccine can be given at the same visit).
2. Remind clinicians to consider testing for both influenza virus and SARS-CoV-2 in patients with influenza-like illness (ILI).
3. Advise clinicians that antiviral treatment is recommended as early as possible for any patient with confirmed or suspected influenza who is: a) hospitalized; b) at higher risk for influenza complications; or c)

developing progressive illness. In patients with suspected influenza, decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza, however COVID-19 should be excluded if a rapid assay is available.

4. Remind public health practitioners and clinicians to consider mitigation measures including antiviral post-exposure prophylaxis during influenza outbreaks in institutions (e.g., long-term care facilities, university dormitories) in the setting of co-circulation of SARS-CoV-2.
5. Remind the public to use non-pharmaceutical interventions (NPI) or everyday preventive actions, in addition to getting a flu vaccine. Everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing hands often.

Background

Recent increases in influenza activity in many places in the United States could mark the beginning of the 2021-2022 influenza season in the United States. While influenza activity is still low overall nationally, an increase of influenza A(H3N2) viruses has been detected in recent weeks, with most of these infections occurring in young adults. CDC also is aware of influenza outbreaks in colleges and universities in several states. Influenza vaccination coverage is still low and there is still time this season to benefit from getting an annual influenza vaccine.

Available seasonal influenza vaccines in the United States provide protection against four different influenza viruses: A(H1N1)pdm09, A(H3N2), B/Victoria lineage, and B/Yamagata lineage viruses. In the past, influenza A(H3N2) virus-predominant seasons were associated with more hospitalizations and deaths in persons aged 65 years and older than other age groups than other influenza viruses. Influenza A(H3N2) viruses evolve more rapidly to escape human immunity. The influenza A(H3N2) component of this season's vaccines was recently updated in response to the evolution of a new group of viruses called 2a (i.e., 3C.2a1b.2a) that did not circulate widely last year and were not included in last season's H3N2 vaccine component.1 Most H3N2 viruses that have been analyzed in the United States so far are genetically closely related to the current vaccine's H3N2 component. However, this emerging group has continued to evolve, and there are now two subgroups (2a.1 and 2a.2) that are genetically closely related to each other, but do have some antigenic differences from each other (i.e., post-infection ferretantibodies from one virus might not efficiently bind the other virus).2 CDC virus surveillance data shows that most of the A(H3N2) viruses recently identified in the United States (October–November 2021) are in the 2a.2 group that is related to but distinguishable from the vaccine component (i.e., 2a.1). It is not known what impact the differences in the circulating viruses and the vaccine viruses may have on vaccine effectiveness. However, influenza vaccine effectiveness in general has been lower against A(H3N2) viruses than against the other three influenza viruses that could circulate [influenza A(H1N1)pdm09 or influenza B viruses].3 Influenza activity during the 2020–2021 season was low throughout the United States and the timing and intensity of the upcoming 2021–2022 influenza season is uncertain. Because influenza activity was low last season, we are anticipating a lower level of community protection that we rely on year after year to reduce the risk of a severe influenza season. Thus, CDC is anticipating an increase of influenza illness this winter, and both A(H3N2) and B-Victoria viruses are already co-circulating. Moreover, as SARS-CoV-2 continues to circulate in the United States, illnesses associated with both viruses might stress healthcare systems. A growing body of scientific studies suggest that even when vaccination does not prevent infection it can reduce the severity of influenza illness, helping to avert serious outcomes including hospitalization and death.

CDC recommends that healthcare providers continue to recommend and offer influenza vaccination to persons aged six months and older because influenza activity is ongoing. Vaccination protects against four different viruses and is likely to reduce hospitalization and death associated with currently circulating influenza viruses and other influenza viruses that might circulate later in the season. Influenza antiviral medications are an important adjunct that should be used in addition to influenza vaccination. While vaccination is the primary means for preventing influenza, antiviral medications are a second line of defense used to treat influenza after infection has occurred. Early treatment with influenza antiviral medications is the most effective way to treat influenza and reduce complications.4-8

Influenza antivirals also can be used for post-exposure prophylaxis (PEP) to prevent infection.4,5,9 This can reduce the risk of influenza among persons who are exposed to someone who has influenza. Influenza antivirals have historically been used for PEP among residents in institutional settings, such as long-term care facilities, to help control influenza outbreaks. In the context of SARS-CoV-2 co-circulation, influenza antiviral treatment and PEP could also be considered in other communal settings (e.g., shelters, university dormitories, prisons) to reduce strain on healthcare services in these institutions during influenza outbreaks. In general, CDC recommends initiating influenza antiviral PEP within 48 hours of contact with someone who has influenza.

Recommendations for Clinicians and Public Health Practitioners

1**. Recommend and offer influenza vaccination for all eligible persons aged six months and older**

Anyone who has not received an influenza vaccine this season should get vaccinated now. For 2021-2022, CDC recommends using any licensed, age-appropriate influenza vaccine as an option for vaccination this season.10 Vaccination coverage is lower this season as of the week ending November 6, 2021 in certain groups at higher risk of severe influenza illness, such as pregnant persons and children, compared with the same period in 2020.11 Vaccination is the best way to reduce the spread of influenza and reduce influenza illness and complications that can result in hospitalization and death. Both influenza and COVID-19 vaccines can be administered at the same visit, without regard to timing. If a patient is due for both vaccines, providers are encouraged to offer both vaccines at the same visit.

2**. Treat patients with suspected or confirmed influenza who meet clinical criteria with influenza antivirals**

CDC recommends influenza antiviral medications to treat influenza as an important adjunct to vaccination. Treatment with influenza antivirals has been shown to be safe. Influenza antivirals benefit clinical and public health by reducing illness and severe outcomes of influenza based on evidence from observational studies, randomized controlled trials, and meta-analyses of randomized controlled trials.4-8,12

- CDC recommends influenza antiviral treatment **as soon as possible** for patients with suspected or confirmed influenza who are:
    - Hospitalized
    - Outpatients at increased risk for complications9

    - Outpatients with progressive disease 9
- Influenza antiviral treatment may be offered to patients with uncomplicated influenza based on clinician judgment to shorten their illness duration or lessen symptoms. The use of antiviral treatment in patients with uncomplicated influenza might help lessen the stress on healthcare systems when both influenza and SARS-CoV-2 are co-circulating.
- Antivirals are most effective when started **within two days after the beginning of illness**. It is also possible that antiviral treatment started after 48 hours may offer some benefit.4,8,12
- Potential also exists for co-infection of influenza and SARS-CoV-2 viruses. In such situations, influenza antivirals can be given for influenza illness.
- Because of the importance of early treatment, **decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza.** However, COVID-19 should be excluded with a rapid diagnostic assay if one is available.

There are two oral influenza antiviral medications approved by the U.S. Food and Drug Administration (FDA) **commonly available by prescription** to treat influenza virus infection that can also be used for PEP following influenza exposure.9These include *oseltamivir* (trade name Tamiflu), and *baloxavir marboxil* (trade name Xofluza) (Table 1). *Inhaled zanamivir and intravenous peramivir* **antiviral medications are used less frequently**.9 Additional information on these influenza antiviral medications is available here.

Table 1: Summary of most common antiviral medications for treatment and post-exposure prophylaxis of influenza9

	Oseltamivir (Tamiflu)	**Baloxavir (Xofluza)**
Approved by FDA	1999	2018
Mechanism	Neuraminidase inhibitor	Cap-dependent endonuclease inhibitor
Route of administration	**Oral**	**Oral**
Treatment dosing	**Daily dosing for 5 days** • Adults: 75 mg **twice daily** • Children: varies by age/weight9	**Single dose only** • 80 kg: 80 mg
Post-exposure prophylaxis dosing	**Daily dosing for 7 days** • Adults: 75 mg **once daily** • Children: varies by age/weight9	**Single dose only** • 80 kg: 80 mg
Age	**Treatment**: any age for treatment **PEP**: 3 months	**Treatment or PEP**: 12 years

Contraindications	Known hypersensitivity	Known hypersensitivity

3. **Use of influenza antivirals for post-exposure prophylaxis (PEP)**

Both oseltamivir and baloxavir are FDA-approved for influenza PEP. The efficacy of PEP in reducing virus acquisition to uninfected household contacts is high for oseltamivir (68%-89%)13 and baloxavir (86%).5 In general, before the COVID-19 pandemic, CDC did not recommend widespread or routine use of influenza antiviral medications for PEP in the community.9 However, PEP has been recommended previously in closed settings such as long-term care facilities or crowded group settings such as refugee resettlement facilities. In these situations, CDC has recommended using clinical judgment for antiviral PEP for certain exposed non-ill close contacts of persons with suspected or confirmed influenza. Given the unique considerations of influenza outbreaks in various settings in the context of co-circulation with SARS-CoV-2, influenza antiviral PEP might be considered for persons

- Who have had recent close contact with a person with influenza (e.g., roommates)
- In confined quarters (e.g., dormitories, shelters, prisons) with increasing incidence of influenza
- Who are at increased risk for severe illness from influenza14
- Who have had recent close contact with a person with influenza and will be traveling for the holidays to reduce transmission during travel as well as to reduce transmission to family members or friends who may be at higher risk for influenza complications14

Considerations for choice of PEP antivirals (Table 1):

- A key difference between the drugs relates to the longer half-life of baloxavir (days) vs. the shorter half-life of oseltamivir (hours). Thus, for PEP, **baloxavir can be administered as a single dose** while **oseltamivir requires daily dosing for seven days**.
- **Dosing:** Treatment and prophylaxis (prevention) dosing is the same for baloxavir, but for oseltamivir, treatment dosing is twice daily, and prophylaxis is once daily.

- **Timing of PEP***:* CDC recommends initiating PEP within 48 hours of contact with an influenza case, if PEP is provided. In general, PEP for oseltamivir should not be started >48 hours after exposure due to concerns about resistance with lower PEP dose in persons with active influenza.
- **Duration of PEP:** Antiviral medications are effective as PEP only if a person takes them the entire time they are around another person who has influenza.
- Rates of oseltamivir and baloxavir resistance among circulating influenza A viruses remain low. However, additional monitoring is necessary, especially with baloxavir, which has had limited use compared to oseltamivir.

4**. Influenza testing**

Information to assist clinicians about influenza testing decisions, including in the context of SARS-CoV-2 co-circulation, is available here. The most accurate influenza tests (high sensitivity and specificity) are molecular assays. Molecular assays are recommended for hospitalized patients with suspected influenza. Information on influenza molecular assays is available here.

1. **Non-pharmaceutical interventions**

Because no single intervention can provide complete protection against influenza virus transmission, emphasis should be placed on multiple strategies, including pharmaceutical (e.g., influenza vaccines

and antiviral medications) and non-pharmaceutical interventions. Measures that are used for COVID-19 might also provide protection against influenza. Non-pharmaceutical interventions may include

- Community measures (e.g., physical distancing, masking)
- Environmental measures (e.g., routine surface cleaning)
- Advising and encouraging symptomatic persons to stay home and use frequent hand hygiene, and proper cough etiquette

Recommendations for the Public

1. **Get a flu vaccine as soon as possible.** There's still time to protect yourself from flu this season. You can get a flu vaccine and a COVID-19 vaccine at the same time. Vaccines are the best tool for preventing influenza and can reduce the risk of severe illness and death associated with influenza.
2. **Take everyday preventive actions that can help reduce the spread of germs, like flu.**

· These everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing your hands often. While CDC does not recommend wearing a face mask to protect you from getting flu, wearing a face mask is recommended to protect you and others against COVID-19 at this time.

1. If you develop flu symptoms (which can be similar to symptoms of other respiratory viruses), reach out to your healthcare provider who may test you to determine if your sickness is due to flu or another virus that has similar symptoms, such as COVID-19.
2. **Take antiviral drugs if prescribed by your healthcare provider.**

- It's important to remember that there also are drugs that can be used to treat flu illness.
- Antiviral drugs are not meant to replace flu vaccine. A flu vaccine is the best way to help prevent seasonal flu and its potentially serious complications. Antiviral drugs are a second line of defense that can be used to treat flu if you do get sick.
- Flu antiviral drugs work best when started within two days of a person getting sick.
- CDC recommends that people who are very sick or who are at higher risk of developing serious flu complications get antiviral treatment as early as possible without waiting for test results.
- Many patients might not be aware that drugs to treat influenza illness are available. A fact sheet for patients is available here.

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Chris Zukoski, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

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1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
November 24, 2021, 11:00 AM ET
CDCHAN-00458

Increasing Seasonal Influenza A (H3N2) Activity, Especially Among Young Adults and in College and University Settings, During SARS-CoV-2 Circulation

Summary
The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory about increased influenza A(H3N2) activity that could mark the beginning of the 2021-2022 influenza season. The purpose of this HAN Health Advisory is to

1. Remind public health practitioners and clinicians to recommend and offer the current seasonal influenza vaccine to all eligible persons aged six months and older (Flu vaccine and COVID-19 vaccine can be given at the same visit).
2. Remind clinicians to consider testing for both influenza virus and SARS-CoV-2 in patients with influenza-like illness (ILI).
3. Advise clinicians that antiviral treatment is recommended as early as possible for any patient with confirmed or suspected influenza who is: a) hospitalized; b) at higher risk for influenza complications; or c) developing progressive illness. In patients with suspected influenza, decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza, however COVID-19 should be excluded if a rapid assay is available.
4. Remind public health practitioners and clinicians to consider mitigation measures including antiviral post-exposure prophylaxis during influenza outbreaks in institutions (e.g., long-term care facilities, university dormitories) in the setting of co-circulation of SARS-CoV-2.
5. Remind the public to use non-pharmaceutical interventions (NPI) or everyday preventive actions, in addition to getting a flu vaccine. Everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing hands often.

Background
Recent increases in influenza activity in many places in the United States could mark the beginning of the 2021-2022 influenza season in the United States. While influenza activity is still low overall nationally, an increase of influenza A(H3N2) viruses has been detected in recent weeks, with most of these infections occurring in young adults. CDC also is aware of influenza outbreaks in colleges and universities in several states. Influenza vaccination coverage is still low and there is still time this season to benefit from getting an annual influenza vaccine.

Available seasonal influenza vaccines in the United States provide protection against four different influenza viruses: A(H1N1)pdm09, A(H3N2), B/Victoria lineage, and B/Yamagata lineage viruses. In the past, influenza A(H3N2) virus-predominant seasons were associated with more hospitalizations and deaths in persons aged 65 years and older than other age groups than other influenza viruses. Influenza A(H3N2) viruses evolve more rapidly to escape human immunity. The influenza A(H3N2) component of this season's vaccines was recently updated in response to the evolution of a new group of viruses called 2a (i.e., 3C.2a1b.2a) that did not circulate widely last year and were not included in last season's H3N2 vaccine component.[1] Most H3N2 viruses that have been analyzed in the United States so far are genetically closely related to the current vaccine's H3N2 component. However, this emerging group has continued to evolve, and there are now two subgroups (2a.1 and 2a.2) that are genetically closely related to each other, but do have some antigenic differences from each other (i.e., post-infection ferret

antibodies from one virus might not efficiently bind the other virus).[2] CDC virus surveillance data shows that most of the A(H3N2) viruses recently identified in the United States (October–November 2021) are in the 2a.2 group that is related to but distinguishable from the vaccine component (i.e., 2a.1). It is not known what impact the differences in the circulating viruses and the vaccine viruses may have on vaccine effectiveness. However, influenza vaccine effectiveness in general has been lower against A(H3N2) viruses than against the other three influenza viruses that could circulate [influenza A(H1N1)pdm09 or influenza B viruses].[3] Influenza activity during the 2020–2021 season was low throughout the United States and the timing and intensity of the upcoming 2021–2022 influenza season is uncertain. Because influenza activity was low last season, we are anticipating a lower level of community protection that we rely on year after year to reduce the risk of a severe influenza season. Thus, CDC is anticipating an increase of influenza illness this winter, and both A(H3N2) and B-Victoria viruses are already co-circulating. Moreover, as SARS-CoV-2 continues to circulate in the United States, illnesses associated with both viruses might stress healthcare systems. A growing body of scientific studies suggest that even when vaccination does not prevent infection it can reduce the severity of influenza illness, helping to avert serious outcomes including hospitalization and death.

CDC recommends that healthcare providers continue to recommend and offer influenza vaccination to persons aged six months and older because influenza activity is ongoing. Vaccination protects against four different viruses and is likely to reduce hospitalization and death associated with currently circulating influenza viruses and other influenza viruses that might circulate later in the season. Influenza antiviral medications are an important adjunct that should be used in addition to influenza vaccination. While vaccination is the primary means for preventing influenza, antiviral medications are a second line of defense used to treat influenza after infection has occurred. Early treatment with influenza antiviral medications is the most effective way to treat influenza and reduce complications.[4-8]

Influenza antivirals also can be used for post-exposure prophylaxis (PEP) to prevent infection.[4,5,9] This can reduce the risk of influenza among persons who are exposed to someone who has influenza. Influenza antivirals have historically been used for PEP among residents in institutional settings, such as long-term care facilities, to help control influenza outbreaks. In the context of SARS-CoV-2 co-circulation, influenza antiviral treatment and PEP could also be considered in other communal settings (e.g., shelters, university dormitories, prisons) to reduce strain on healthcare services in these institutions during influenza outbreaks. In general, CDC recommends initiating influenza antiviral PEP within 48 hours of contact with someone who has influenza.

Recommendations for Clinicians and Public Health Practitioners

1**. Recommend and offer influenza vaccination for all eligible persons aged six months and older**

Anyone who has not received an influenza vaccine this season should get vaccinated now. For 2021-2022, CDC recommends using any licensed, age-appropriate influenza vaccine as an option for vaccination this season.[10] Vaccination coverage is lower this season as of the week ending November 6, 2021 in certain groups at higher risk of severe influenza illness, such as pregnant persons and children, compared with the same period in 2020.[11] Vaccination is the best way to reduce the spread of influenza and reduce influenza illness and complications that can result in hospitalization and death. Both influenza and COVID-19 vaccines can be administered at the same visit, without regard to timing. If a patient is due for both vaccines, providers are encouraged to offer both vaccines at the same visit.

2**. Treat patients with suspected or confirmed influenza who meet clinical criteria with influenza antivirals**

CDC recommends influenza antiviral medications to treat influenza as an important adjunct to vaccination. Treatment with influenza antivirals has been shown to be safe. Influenza antivirals benefit clinical and public health by reducing illness and severe outcomes of influenza based on evidence from observational studies, randomized controlled trials, and meta-analyses of randomized controlled trials.[4-8,12]

- CDC recommends influenza antiviral treatment **as soon as possible** for patients with suspected or confirmed influenza who are:
    - Hospitalized

    - Outpatients at increased risk for complications[9]
    - Outpatients with progressive disease [9]
- Influenza antiviral treatment may be offered to patients with uncomplicated influenza based on clinician judgment to shorten their illness duration or lessen symptoms. The use of antiviral treatment in patients with uncomplicated influenza might help lessen the stress on healthcare systems when both influenza and SARS-CoV-2 are co-circulating.
- Antivirals are most effective when started **within two days after the beginning of illness**. It is also possible that antiviral treatment started after 48 hours may offer some benefit.[4,8,12]
- Potential also exists for co-infection of influenza and SARS-CoV-2 viruses. In such situations, influenza antivirals can be given for influenza illness.
- Because of the importance of early treatment, **decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza.** However, COVID-19 should be excluded with a rapid diagnostic assay if one is available.

There are two oral influenza antiviral medications approved by the U.S. Food and Drug Administration (FDA) **commonly available by prescription** to treat influenza virus infection that can also be used for PEP following influenza exposure.[9] These include *oseltamivir* (trade name Tamiflu®), and *baloxavir marboxil* (trade name Xofluza®) (Table 1). *Inhaled zanamivir and intravenous peramivir* **antiviral medications are used less frequently**.[9] Additional information on these influenza antiviral medications is available here.

Table 1: Summary of most common antiviral medications for treatment and post-exposure prophylaxis of influenza[9]

Drug	Oseltamivir (Tamiflu®)	Baloxavir (Xofluza®)
Approved by FDA	1999	2018
Mechanism	Neuraminidase inhibitor	Cap-dependent endonuclease inhibitor
Route of administration	**Oral**	**Oral**
Treatment dosing	**Daily dosing for 5 days** • Adults: 75 mg **twice daily** • Children: varies by age/weight[9]	**Single dose only** • <80 kg: 40 mg • ≥80 kg: 80 mg
Post-exposure prophylaxis dosing	**Daily dosing for 7 days** • Adults: 75 mg **once daily** • Children: varies by age/weight[9]	**Single dose only** • <80 kg: 40 mg • ≥80 kg: 80 mg
Age	**Treatment**: any age for treatment **PEP**: ≥3 months	**Treatment or PEP**: ≥12 years
Contraindications	Known hypersensitivity	Known hypersensitivity

3. **Use of influenza antivirals for post-exposure prophylaxis (PEP)**

Both oseltamivir and baloxavir are FDA-approved for influenza PEP. The efficacy of PEP in reducing virus acquisition to uninfected household contacts is high for oseltamivir (68%-89%)[13] and baloxavir (86%).[5] In general, before the COVID-19 pandemic, CDC did not recommend widespread or routine use of influenza antiviral medications for PEP in the community.[9] However, PEP has been recommended previously in closed settings such as long-term care facilities or crowded group settings such as refugee resettlement facilities. In these situations, CDC has recommended using clinical judgment for antiviral PEP for certain exposed non-ill close contacts of persons with suspected or confirmed influenza. Given the unique considerations of influenza outbreaks in various settings in the context of co-circulation with SARS-CoV-2, influenza antiviral PEP might be considered for persons

- Who have had recent close contact with a person with influenza (e.g., roommates)
- In confined quarters (e.g., dormitories, shelters, prisons) with increasing incidence of influenza

- Who are at increased risk for severe illness from influenza[14]
- Who have had recent close contact with a person with influenza and will be traveling for the holidays to reduce transmission during travel as well as to reduce transmission to family members or friends who may be at higher risk for influenza complications[14]

Considerations for choice of PEP antivirals (Table 1):

- A key difference between the drugs relates to the longer half-life of baloxavir (days) vs. the shorter half-life of oseltamivir (hours). Thus, for PEP, **baloxavir can be administered as a single dose** while **oseltamivir requires daily dosing for seven days**.
- **Dosing:** Treatment and prophylaxis (prevention) dosing is the same for baloxavir, but for oseltamivir, treatment dosing is twice daily, and prophylaxis is once daily.
- **Timing of PEP***:* CDC recommends initiating PEP within 48 hours of contact with an influenza case, if PEP is provided. In general, PEP for oseltamivir should not be started >48 hours after exposure due to concerns about resistance with lower PEP dose in persons with active influenza.
- **Duration of PEP:** Antiviral medications are effective as PEP only if a person takes them the entire time they are around another person who has influenza.
- Rates of oseltamivir and baloxavir resistance among circulating influenza A viruses remain low. However, additional monitoring is necessary, especially with baloxavir, which has had limited use compared to oseltamivir.

4**. Influenza testing**
Information to assist clinicians about influenza testing decisions, including in the context of SARS-CoV-2 co-circulation, is available here. The most accurate influenza tests (high sensitivity and specificity) are molecular assays. Molecular assays are recommended for hospitalized patients with suspected influenza. Information on influenza molecular assays is available here.

5. Non-pharmaceutical interventions
Because no single intervention can provide complete protection against influenza virus transmission, emphasis should be placed on multiple strategies, including pharmaceutical (e.g., influenza vaccines and antiviral medications) and non-pharmaceutical interventions. Measures that are used for COVID-19 might also provide protection against influenza. Non-pharmaceutical interventions may include

- Community measures (e.g., physical distancing, masking)
- Environmental measures (e.g., routine surface cleaning)
- Advising and encouraging symptomatic persons to stay home and use frequent hand hygiene, and proper cough etiquette

Recommendations for the Public

1. **Get a flu vaccine as soon as possible.** There's still time to protect yourself from flu this season. You can get a flu vaccine and a COVID-19 vaccine at the same time. Vaccines are the best tool for preventing influenza and can reduce the risk of severe illness and death associated with influenza.
2. **Take everyday preventive actions that can help reduce the spread of germs, like flu.**
    - These everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing your hands often. While CDC does not recommend wearing a face mask to protect you from getting flu, wearing a face mask is recommended to protect you and others against COVID-19 at this time.
3. If you develop flu symptoms (which can be similar to symptoms of other respiratory viruses), reach out to your healthcare provider who may test you to determine if your sickness is due to flu or another virus that has similar symptoms, such as COVID-19.
4. **Take antiviral drugs if prescribed by your healthcare provider.**
    - It's important to remember that there also are drugs that can be used to treat flu illness.
    - Antiviral drugs are not meant to replace flu vaccine. A flu vaccine is the best way to help prevent seasonal flu and its potentially serious complications. Antiviral drugs are a second line of defense that can be used to treat flu if you do get sick.

- Flu antiviral drugs work best when started within two days of a person getting sick.
- CDC recommends that people who are very sick or who are at higher risk of developing serious flu complications get antiviral treatment as early as possible without waiting for test results.
- Many patients might not be aware that drugs to treat influenza illness are available. A fact sheet for patients is available here.

For More Information
CDC Tracking Flu in Young Adults
Healthy Habits to Help Protect Against Flu

Additional Resources for Clinicians:
- Summary of Influenza Antiviral Treatment Recommendations for Clinicians
- Clinical Description and Lab Diagnosis of Influenza
- Interim Guidance for Influenza Outbreak Management in Long-Term and Post-Acute Care Facilities
  Influenza Virus Testing in Investigational Outbreaks in Institutional or Other Closed Settings

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The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention; highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

FW: IMPORTANT UPDATE: FDA, CDC authorize Pfizer booster doses for 16- and 17-year-olds

Crystal Jones <cjones@athenspublichealth.org>

Fri 12/10/2021 12:33 PM

To: **all users <allusers@athenspublichealth.org>**

Cc: Rachel Esselburn <music45701@yahoo.com>; Lauren Williams <lewilliams91@yahoo.com>

Please see the latest update for COVID 19 boosters. We will offer COVID 19 vaccines to eligible 16 an d 17 year-olds during our COVID 19 clinics we have scheduled at the health department.

Please let us know if you have any questions. Thanks for all you do!

Crystal Jones, RN

Director of Nursing

Athens City-Country Health Department

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From: COVIDVACCINE@odh.ohio.gov
Sent: Friday, December 10, 2021 9:22 AM
Subject: IMPORTANT UPDATE: FDA, CDC authorize Pfizer booster doses for 16- and 17-year-olds

Dec. 10, 2021

To All Enrolled COVID-19 Vaccine Providers,

On Thursday, the U.S. Food and Drug Administration amended the emergency use authorization for the Pfizer-BioNTech/Comirnaty COVID-19 vaccine to extend booster dose eligibility to fully vaccinated people ages 16-17. Also Thursday, the Centers for Disease Control and Prevention (CDC) issued a recommendation for booster dose use for this age group. This is an important step toward strengthening protection against COVID-19 for teens ages 16 and 17.

COVID-19 vaccine providers in Ohio can immediately begin offering booster doses to 16- and 17-year-olds **at least six months** following completion of their primary vaccination series.

Booster doses are now recommended for everyone age 16 and older. People who received the Pfizer or Moderna COVID-19 vaccine should get a booster at least six months after the primary vaccination series. People who received the Johnson & Johnson COVID-19 vaccine should get a booster at least two months after the initial dose.

Mix-and-match booster doses – in which fully vaccinated people can choose any of the three U.S. approved COVID-19 vaccines for their booster – is an option only for adults 18 and older. **Because the Pfizer vaccine is the only COVID-19 vaccine authorized for any person younger than 18, people age 16 or 17 can only receive a booster dose of the Pfizer vaccine.**

At this time, booster doses are not authorized for any children younger than age 16.

RESOURCES:

- **UPDATED** - Guidance for Ohio Vaccine Providers for Administering Booster Doses (Age 16 and older)
- **Centers for Disease Control and Prevention:** Booster Shots Eligibility and FAQs
- Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers
- Moderna COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers
- Johnson & Johnson (Janssen) COVID-19 Vaccine EUA Fact Sheet for Healthcare Providers

Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

Ohio COVID-19 Vaccine Provider Relations Team

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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COVID-19 Vaccine Program
Guidance for Vaccine Providers for Administering Booster Doses

The U.S. Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) have authorized a single booster dose of the three COVID-19 vaccines available in the United States (Pfizer/Comirnaty, Moderna, and Johnson & Johnson/Janssen) to strengthen protection against serious outcomes from COVID-19 and/or against COVID-19 infection.

Ohioans age 16 years and older are now eligible to receive booster doses. Dosage and timing of booster shots vary by COVID-19 vaccine product. *Please read eligibility information by product in the guidance below.*

Fully vaccinated individuals 18 years old and older are eligible to receive a booster dose of the COVID-19 vaccine of their choice (Pfizer/Comirnaty, Moderna or Johnson & Johnson). Johnson & Johnson vaccine recipients are eligible two months following their original dose; Pfizer/Comirnaty and Moderna vaccine recipients are eligible six months following their second dose (or third dose if immunocompromised).

Fully vaccinated individuals ages 16-17 years are now eligible to receive a booster dose of the Pfizer vaccine, as it is the only COVID-19 vaccine authorized for people younger than 18 years.

It's important to note the top priority for vaccine providers remains continued vaccination of unvaccinated individuals to protect against serious illness, hospitalization, and death from COVID-19.

PROOF OF ELIGIBILITY

BOOSTER DOSE ELIGIBILITY REQUIREMENTS

At this time, fully vaccinated people who are 16 years old and older are eligible for a booster dose. The timing of booster doses varies by vaccine product (see below). Children ages 15 years and younger are not eligible to receive a booster dose at this time. Children ages 12-15 years who have an immunocompromising condition are eligible to receive an additional/third dose of the Pfizer vaccine to strengthen protection.

Pfizer-BioNTech/Comirnaty

Eligibility: If an individual received the Pfizer/Comirnaty vaccine for the primary series, booster doses can be given to fully vaccinated people age 16 years and older.

Dosage: The Pfizer/Comirnaty booster dose is the same dosage given for the primary series.

Mix-and-match booster: People age 18 years or older who received the primary series of the Pfizer/Comirnaty vaccine may get a booster dose of **any** COVID-19 vaccine approved or authorized for use in the United States. People ages 16 or 17 years who received the primary series of the Pfizer/Comirnaty vaccine may get a booster dose of only the Pfizer/Comirnaty vaccine, as it is the only COVID-19 vaccine available for people younger than 18.

Booster dose timing: At least six months after the completion of the initial series.

Booster doses for people who are immunocompromised: Pfizer vaccine recipients 12 years and older who are moderately to

severely immunocompromised can receive a third dose for the primary vaccine series at least 28 days following the second dose. **Those 16 years and older also are eligible for a single COVID-19 booster dose (Pfizer/Comirnaty, Moderna or Janssen) at least six months after completing the third mRNA vaccine dose.**

More info: Pfizer-BioNTech COVID-19 Vaccine Fact Sheet for Healthcare Providers

Moderna

Eligibility: If an individual received the Moderna vaccine for the primary series, booster doses can be given to fully vaccinated people age 18 years and older.

Dosage: The Moderna booster dose is NOT the same dosage given for the primary series (0.5 mL). The booster dose is a half-dose (0.25 mL).

- Moderna booster doses will not be packaged or distributed separately.
- Primary series doses (0.5 mL) or booster doses (0.25 mL) may be extracted from a vial, preferentially using low dead-volume syringes and/or needles.
- When extracting only primary series doses, depending on the syringes and needles used, a maximum of 11 doses (range: 10-11 doses) may be extracted from the vial containing 5.5 mL or a maximum of 15 doses (range: 13-15 doses) may be extracted from the vial containing 7.5 mL.
- **When extracting only booster doses or a combination of primary series and booster doses, the maximum number of doses that may be extracted from either vial presentation should not exceed 20 doses. Do not puncture the vial stopper more than 20 times.**
- If the amount of vaccine remaining in the vial cannot provide a full dose of 0.5 mL or 0.25 mL, discard the vial and contents. Do not pool excess vaccine from multiple vials.
- Ancillary kits will be doubled to ensure adequate supply.

Mix-and-match booster: Someone who received the primary series of the Moderna vaccine may get a booster dose of **any** COVID-19 vaccine approved or authorized for use in the United States (Pfizer/Comirnaty, Moderna, or Johnson & Johnson).

Booster dose timing: At least six months after completion of mRNA series.

Booster doses for people who are immunocompromised: Moderna vaccine recipients who are moderately to severely immunocompromised can add a third dose to their primary vaccine series at least 28 days following the second dose**. These individuals also will be eligible for a single COVID-19 booster dose (Pfizer/Comirnaty, Moderna or Janssen) at least six months after completing their third mRNA vaccine dose.**

More info: Moderna COVID-19 Vaccine Fact Sheet for Healthcare Providers

Johnson & Johnson/Janssen

Booster doses are authorized for all recipients of the single-dose Johnson & Johnson/Janssen COVID-19 vaccine. **Anyone age 18 years or older who received a Johnson & Johnson vaccine can get a booster dose at least two months following the initial dose.**

Dosage: The Johnson & Johnson booster dose is the same formulation and dosage given for the first dose.

Mix-and-match booster: Someone who received the Johnson & Johnson vaccine may get a booster dose of **any** COVID-19 vaccine approved or authorized for use in the United States.

Booster dose timing: At least two months following the first dose of the Johnson & Johnson vaccine.

More info: Johnson & Johnson/Janssen COVID-19 Vaccine Fact Sheet for Healthcare Providers

IDENTIFICATION REQUIREMENTS

- Providers should ask to see identification that proves name, age, and identity.
    - Ask for identification to verify only the patient's identity, name, and age. Patients do not need to show proof of citizenship or residency status. Identification should still be accepted if it is expired or from another state or country.
    - Acceptable forms of identification are listed below:
        - Driver's license or any photo ID, regardless of expiration date or place of origin.
        - Active/retired military ID.
        - Physician statement (including shot records).
        - Census records.
        - Adoption records.
        - Naturalization certificate.
        - Birth certificate: Birth record, either original or certified copy.
        - Consulate ID or matricula consular.
        - Passport or a passport card.
        - Certificate of citizenship.
        - Permanent resident card.
        - Application for replacement naturalization/citizenship document.
        - Department of State forms.
            - Military service records (DD-214)
            - Certification of Birth Abroad of a Citizen of the United States (FS-545)
            - Certification of Report of Birth Abroad of a United States Citizen (DS-1350)
            - Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)
            - Employment Authorization Document (I-766/EAD)
            - Transportation letter (I-797F)

PARENTAL CONSENT

Children younger than age 18 who are not emancipated must have parental or legal guardian consent for any vaccine. A parent or legal guardian generally should accompany the minor to receive the vaccine, unless the administration of the vaccine occurs in a physician's office, school-based or school-associated clinic setting or similar setting.

VACCINE CARDS

Eligible Ohioans are encouraged to bring their COVID-19 vaccine card to their booster appointment. If they cannot find their vaccine card, they should first contact their original vaccine provider to see if their records can be located. If the original vaccine provider is unable to assist, they should contact their local health department. The final available option is to review this information on how to mail a request for your vaccination records to the Ohio Department of Health. Replacement vaccine cards are not available from the Ohio Department of Health. If a vaccine recipient does not have their original vaccine card, that should not be a barrier to prevent them from being vaccinated.

MIX-AND-MATCH BOOSTER DOSES

Eligible individuals ages 18 years and older who have completed the primary vaccination series can receive a booster dose of any authorized or approved COVID-19 vaccine, regardless of the vaccine used for initial vaccination. This means:

- A person who originally received the Johnson & Johnson vaccine can receive a booster dose of the Johnson & Johnson, Pfizer, or Moderna vaccine.
- A person who originally received the Moderna primary vaccine series can receive a booster dose of the Moderna, Pfizer, or Johnson & Johnson vaccine.
- A person who originally received the Pfizer primary vaccine series can receive a booster dose of the Pfizer, Moderna, or Johnson & Johnson vaccine.

People may consider the benefits and risks of each product and discuss with their healthcare provider which product is most appropriate for them based on their age, gender, medical history, reactions after past vaccinations, or overall allergy history.

This mix-and-match approach applies only to booster doses for adults. People ages 16-17 years may only receive a Pfizer vaccine booster.

The half-dose Moderna booster dose should be given to all booster recipients, even if the primary series was different.

Additional recommendations around mix-and-match booster doses, including data and studies around homologous (same vaccine as primary series) or heterologous (different vaccine from primary series) boosters, are included in the CDC's Interim Clinical Considerations for Use of the COVID-19 Vaccines.

BOOSTER DOSE AVAILABILITY

Eligible Ohioans will have many opportunities to receive a booster dose, including at pharmacies, federally qualified health centers, doctor's offices, community vaccination sites, and local health departments.

While it will be important for providers to administer booster doses to eligible Ohioans, there are still many Ohioans who have not yet received their first dose of vaccine. Please continue to prioritize vaccination for new vaccine recipients while administering booster doses.

VACCINE MANAGEMENT SOLUTION (VMS): GETTHESHOT.CORONAVIRUS.OHIO.GOV

Eligible Ohioans will be able to determine their eligibility for booster doses and, if determined to be eligible, schedule an appointment at gettheshot.coronavirus.ohio.gov. Providers may continue to offer walk-in availability as appropriate.

Providers can start programming appointment availability in VMS now. For those providers who are scheduling appointments and whose schedulers can accommodate, please open schedulers at least three weeks out for future appointments if possible.

Providers are encouraged to offer all COVID-19 vaccine products, and should ensure that VMS displays which vaccine products are available. Providers are also encouraged to share available vaccine products on their websites and social media pages so people can find an appointment for their preferred product.

View updated training materials on the Ohio Department of Health VMS training page.

VACCINE LOCATIONS

Eligible Ohioans can find a provider and schedule an appointment online at gettheshot.coronavirus.ohio.gov or by calling 1-833-427-5634.

- Most retail and independent pharmacies will offer either walk-in or scheduled appointments.
- Local health departments in some of our largest cities will offer special community vaccination sites, and health departments in virtually every county are prepared to offer booster doses, including to homebound individuals.
- Community health centers and participating primary care providers will also offer booster doses.
- Participating long-term care facilities will offer doses of the Pfizer vaccine to residents through Ohio's COVID-19 Vaccine Maintenance Program, and state agencies and state-owned veterans homes will vaccinate eligible staff and residents.
- Affordable senior housing communities will work with local partners to host special vaccination opportunities for booster doses. Ohio will have ample supply of vaccine for boosters and for first and second doses. It may take 2-3 weeks, or more, for every eligible person who wants a booster to receive one.

DIRECT ORDERING

There will be no changes to the standard ordering process as a result of the start of booster dose administration. Vaccine providers should factor booster dose supply into current ordering cadences. All Ohio COVID-19 Vaccine Providers are responsible for placing vaccine orders through the ImpactSIIS Vaccine Ordering Management System (VOMS). VOMS is open for providers to place orders 24 hours a day, seven days a week. Providers can order COVID-19 vaccine at their convenience. ODH is committed to getting COVID-19 vaccines to our providers as quickly as possible.

To ensure adequate inventory levels, providers should anticipate a window of seven days from the date your order is entered into VOMS to the date the vaccine is delivered to your facility. Orders for products that are shipped directly from the manufacturer will be approved and processed Monday through Friday.

MINIMUM ORDER/SHIPPING QUANTITIES

Pfizer (adult/adolescent formulation)

- Minimum order quantity for direct shipment from the manufacturer is 1,170 doses, available in increments of 1,170 doses.
- The ODH Receipt, Store, and Stage (RSS) warehouse will break down Pfizer shipments into smaller sizes.
    - Minimum order quantity is 120 doses, available in increments of 120.
    - In rare cases, smaller increments of 30 doses are available for small providers such as pediatric practices or primary care providers with special approval.

Moderna

- **Moderna booster doses will not be packaged or distributed separately.** Vaccine providers will draw the appropriate booster dosage from existing inventories (vials include the equivalent of 14 full doses).
- Minimum order quantity for direct shipment from the CDC/McKesson Distribution Center is 140 doses.

Johnson & Johnson

- Minimum order quantity for direct shipment from the CDC/McKesson Distribution Center is 100 doses.

COVID-19 orders processed through the ODH RSS Warehouse will be delivered Tuesdays, Thursdays, and Fridays. The Friday delivery option is only available to pharmacies. Federal holidays that occur on weekdays may interrupt the delivery schedule.

Ancillary kits – containing needles, syringes, alcohol pads, vaccination cards and surgical masks/face shields for vaccinators – are shipped separately. Moderna ancillary kits will be doubled to ensure adequate supply.

VACCINE ADMINISTRATION

- **Timing of booster doses:** Booster doses can be administered six months or longer after completion of the primary series for people who received Pfizer or Moderna shots. For those who had Johnson & Johnson/Janssen, the boosters may be given after two months.
- **Coadministration:** Booster doses may be given with other vaccines without regard to timing. This includes simultaneous administration of COVID-19 and other vaccines on the same day. Best practices for administering more than one vaccine, including COVID-19 vaccines and influenza vaccines, include:
    - When preparing more than one vaccine, label each with the name and dosage (amount) of vaccine, lot number, the initials of the preparer, and the exact beyond-use time, if applicable.
    - Always inject vaccines into different injection sites.
    - Separate injection sites by 1 inch or more, if possible, so that any local reactions can be differentiated. Each muscle (deltoid, vastus lateralis) has multiple injection sites.
    - If administered at the same time, COVID-19 vaccines and vaccines that might be more likely to cause a local injection site reaction (for example, high-dose and adjuvanted inactivated influenza vaccines) should be administered in different arms (or legs), if possible.
- Contraindications and precautions for a booster dose are the same as for the primary series.
- For individuals who had myocarditis and myopericarditis, it is recommended to defer a subsequent dose until myocarditis and myopericarditis has completely resolved.

View the CDC's Interim Clinical Considerations for use of COVID-19 vaccines for more detailed guidance for vaccine providers.

DATA REPORTING

The Ohio Department of Health (ODH) is committed to releasing data to inform the public in the midst of the COVID-19 crisis while also protecting the privacy rights of Ohioans. ODH has developed several online data dashboards reflecting information from multiple sources, including vaccination data provided by all enrolled providers.

VACCINE ADMINISTRATION DATA

The COVID-19 Vaccination Dashboard at coronavirus.ohio.gov displays the most recent data reported to the Ohio Department of Health (ODH) regarding the number of individuals that have started and completed the COVID-19 vaccination series by various demographics and county of residence.

To ensure timely data reporting and sharing, all COVID-19 vaccine providers must report all vaccinations within 24 hours through the Ohio Impact Statewide Immunization Information System (ImpactSIIS). **This includes the reporting of booster doses.**

VACCINE ADMINISTRATION ERRORS AND ADVERSE EVENTS

As part of essential ongoing vaccine safety monitoring efforts, vaccine providers are required to report any adverse events, including vaccine administration errors, to the Vaccine Adverse Event Reporting System.

VAERS is the nation's early warning system that monitors the safety of vaccines after they are authorized or licensed for use by the U.S. Food and Drug Administration (FDA). VAERS is part of the larger vaccine safety system in the United States that helps make sure vaccines are safe. The system is co-managed by the Centers for Disease Control and Prevention (CDC) and FDA.

VAERS accepts and analyzes reports of possible health problems — also called "adverse events" — after vaccination. If VAERS detects a pattern of adverse events following vaccination, other vaccine safety monitoring systems conduct follow-up studies.

Visit VAERS for a complete listing of requirements and step-by-step instructions on how to submit a report.

MESSAGING

Primary care providers are asked to recommend booster doses to eligible patients to boost their immunity to help prevent severe outcomes from COVID-19, including hospitalization or death.

KEY MESSAGES

- The COVID-19 vaccines continue to be incredibly effective. There is a natural tendency for immunity to wane over time, whether natural immunity or immunity from a vaccine, and many immunizations require at least one booster dose, including hepatitis A; hepatitis B; Haemophilus influenzae type B (Hib); measles-mumps-rubella (MMR); tetanus, diphtheria, and pertussis (Tdap); and varicella (chickenpox).
- Millions of Americans are now eligible for COVID-19 booster shots.
    - For people who received the Pfizer/Comirnaty primary series: People who are age 16 and older can get a booster dose at least six months after the second dose (or third dose if immunocompromised).
    - For people who received the Moderna primary series: People who are age 18 and older can get a booster dose at least six months after the second dose (or third dose if immunocompromised).
    - For people who received the Johnson & Johnson single dose: People who are age 18 and older can get a booster dose at least two months after the first dose.
- Who is eligible for a booster dose? Fully vaccinated recipients 16 years and older are eligible to receive a booster dose of COVID-19 vaccine. Recipients 18 years and older can receive the vaccine product of their choice, and timing and dosage are based on the chosen vaccine.

- We are focused on staying ahead of the virus by making sure people have optimal protection against COVID-19 infection, severe illness, and death. A booster dose will help provide continued protection against severe disease, including hospitalization and death.
- The U.S. Food and Drug Administration and Centers for Disease Control and Prevention have determined these booster shots are safe and effective, based on the latest data and evidence, after a thorough, independent, and transparent review process. They will continue to evaluate data as it is available to determine when people younger than age 16 may become eligible for booster shots.
- Side effects, which are expected with any vaccination, were similar to those from second COVID-19 vaccine doses, and were mostly mild, moderate, and short-lived.
- The COVID-19 vaccines approved and authorized in the United States continue to be highly effective in reducing risk of severe disease, hospitalization, and death, even against the widely circulating Delta variant. Booster shots may result in increases in antibody levels, and may result in increased effectiveness.
    - Although we don't have all the answers on the new Omicron variant, initial data suggests that COVID-19 boosters help strengthen the protection against Omicron and other variants. We are closely monitoring new data and emerging research as it is released.
    - While we still have much to learn about Omicron, this variant's arrival underscores the importance of our best prevention tool – choosing to be vaccinated and getting a booster dose when eligible.
- For fully vaccinated adults, getting a booster shot is convenient, and as simple as visiting your local pharmacy, health department, or doctor's office.
    - Additionally, if a patient is eligible, both flu and COVID-19 vaccines can be administered at the same visit.
    - A COVID-19 vaccine can be given with other vaccines, such as shingles and pneumonia, as well.

PATIENT REMINDER MESSAGE TEMPLATE

COVID-19 boosters are now available for fully vaccinated recipients 16 years old and older. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

[Provider name] is now offering #COVID19 booster doses to eligible Ohioans for the Pfizer, Moderna, and Johnson & Johnson vaccines. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

SOCIAL MEDIA POSTS

We are now offering #COVID19 booster doses to fully vaccinated recipients ages 16 or older. Those who received the Pfizer or Moderna vaccines can get a booster dose 6 months after the second dose (or third dose if immunocompromised). All Johnson & Johnson vaccine recipients can get a booster dose at least 2 months after the first dose. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

EMAIL OR WEBSITE ARTICLE

At this time, fully vaccinated recipients 16 years and older are eligible to receive a booster dose of the COVID-19 vaccine of their choice. Booster doses can now be given using any available COVID-19 vaccine if you are at least18 years old (those age 16-17 years can only receive the Pfizer/Comirnaty vaccine).

Pfizer/Comirnaty and Moderna vaccine recipients can receive a booster dose at least six months after the second dose (or third dose if immunocompromised). Johnson & Johnson vaccine recipients can receive a booster dose at least two months after the first dose.

There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Vaccinations are available at [Provider name] either by making an appointment or by walking in [insert details including days of the week and start time and end time]. While you do not have to get your booster dose at the same location where you received your first and second doses, you are welcome to continue to visit [Provider name] for your COVID-19 vaccine needs.

You are encouraged to bring your COVID-19 vaccine card, and if you cannot find your vaccine card, please review this fact sheet from the Ohio Department of Health for options to access to your vaccination records. In short, you should first contact

your original vaccine provider to see if they can locate your records. If they are unable to assist, please contact your local health department. If they are unable to assist, please review this information on how to mail a request for your vaccination records to the Ohio Department of Health.

Eligible Ohioans have many opportunities to be vaccinated in their local community, whether they walk in to get their booster dose or make an appointment with a nearby provider.

Updated Dec. 10, 2021.

For additional information, visit coronavirus.ohio.gov.

The Ohio Department of Health COVID-19 Provider website is a hub for a variety of resources for vaccine providers. Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Fwd: Health Advisory 460: Rapid Increase of Omicron Variant Infections in the United States

Crystal Jones <cjones@athenspublichealth.org>

Mon 12/27/2021 8:27 AM

To: **all users <allusers@athenspublichealth.org>**

CDC updated isolation and quarantine guidelines/ options for healthcare staff.

Get Outlook for iOS

Crystal Jones , RN
Athens City-County Health Department
278 West Union St, Athens, OH 45701
cjones@athenspublichealth .org
740.447.5907

From: Ohio Health Alert Network <5c712cb6-0005-3002-80c0-fceb55463ffe@notify.mir3.com>
Sent: Monday, December 27, 2021 8:11:36 AM
To: Crystal Jones <cjones@athenspublichealth.org>
Subject: Health Advisory 460: Rapid Increase of Omicron Variant Infections in the United States

Crystal Jones,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

Friday, December 24, 2021, 7:00 ET PM

CDCHAN-00460

Rapid Increase of Omicron Variant Infections in the United States: Management of Healthcare Personnel with

SARS-CoV-2 Infection or Exposure

Summary

Due to the increased transmissibility of the SARS-CoV-2 Omicron variant and concerns about potential impacts on the healthcare system, the Centers for Disease Control and Prevention (CDC) is updating recommendations to enhance protection for healthcare personnel, patients, and visitors, and ensure adequate staffing in healthcare facilities. The guidance is based on the limited information currently available about the Omicron variant and will be updated as needed as new information becomes available.

Background

On November 24, 2021, a new variant of SARS-CoV-2, B.1.1.529 (Omicron), was reported to the World Health Organization (WHO). Current COVID-19 vaccines are expected to protect against severe illness, hospitalizations, and deaths from infection with the Omicron variant. Omicron might cause more breakthrough infections than prior variants, and some studies have found lower effectiveness of the primary series of vaccines against infection (1-3).

On December 1, 2021, the first case attributed to Omicron was reported in the United States. Omicron has now been reported in all 50 states. CDC has been working with state and local public health officials to monitor the spread of Omicron in the United States and has identified a rapid increase in infections consistent with what has been observed in other countries. Multiple large clusters of Omicron variant cases have demonstrated the rapid spread of the virus. Holiday-related travel and gatherings may further accelerate these trends. Plausible scenarios include steep epidemic trajectories that would require prompt public health action to prevent severe impacts on the health of individuals and healthcare systems.

The clinical severity profile of Omicron infection will strongly influence its impact on U.S. hospitalizations and deaths. Early data suggest Omicron infection might be less severe than infection with prior variants (3,4); however, reliable data on clinical severity remain limited (5). Even if the proportion of infections associated with severe outcomes is lower than with previous variants, a rapid, large increase in the number of infections could still result in many people with severe outcomes requiring medical care and hospitalization in a short period. Demand for ambulatory care, supportive care for treatment of mild cases, and staffing shortages resulting from work restriction of healthcare personnel with SARS-CoV-2 infection or with higher-risk exposures could also stress the healthcare system.

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel and safe patient care. CDC's mitigation strategies offer a continuum of options for addressing healthcare staffing shortages and are meant to be implemented sequentially. These strategies were updated on December 23, 2021. If conventional strategies cannot be sustained during a surge in cases, facilities may consider implementing contingency strategies,

then crisis strategies, in an incremental manner. Facilities are best positioned to evaluate their own needs as to whether conventional, contingency, or crisis strategies are most appropriate at a given time.

Consider options to address a healthcare surge by shortening the duration of work restrictions.

When staffing shortages are anticipated, healthcare facilities and employers should plan and prepare to address these shortages in collaboration with staff leadership, human resources, and occupational health services. This can include adjusting staff schedules, hiring additional healthcare personnel, and rotating personnel to positions that support patient care activities. It can also include modifications in practices for work restrictions of healthcare personnel who have had higher-risk exposures to SARS-CoV-2 or who have been infected with SARS-CoV-2, as described below. Conventional, contingency, and crisis strategies to mitigate staffing shortages are described in CDC guidance and are intended to allow flexibility to maintain adequate staffing for safe and effective patient care while minimizing the risk of SARS-CoV-2 transmission in healthcare facilities. Protecting the health and safety of healthcare personnel remains critical and includes ensuring the recommended personal protective equipment (PPE) is available and that healthcare personnel are trained to use it properly.

Healthcare personnel with higher-risk exposure

- *Personnel who have received all COVID-19 vaccine and booster doses as recommended by CDC.* Under conventional strategies, asymptomatic healthcare personnel who have received all COVID-19 vaccine and booster doses as recommended by CDC do not need to be restricted from work if they have had a higher-risk exposure but do not have symptoms. They should follow all recommended infection prevention and control practices and isolate immediately if they develop symptoms. Under conventional strategies, such personnel should be tested for SARS-CoV-2, per CDC guidance. Under contingency or crisis strategies, testing is not required, and the duration of quarantine may be shortened.

- *Personnel who have not received all COVID-19 vaccine and booster doses as recommended by CDC.* Under conventional conditions, asymptomatic healthcare personnel who have not received all COVID-19 vaccine and booster doses as recommended by CDC, and who have had a higher-risk exposure to SARS-CoV-2, can return to the workplace after day ten without testing, or facilities can limit the duration of work restriction under certain circumstances as outlined in CDC guidance. Under contingency conditions such personnel can continue to work using a "test-to-stay" strategy under certain circumstances. Under crisis conditions, such personnel can continue to work without testing as long as they remain asymptomatic.

- Healthcare personnel who are exposed should use well-fitting respiratory source control all times while in the facility and follow all conventional, contingency, and crisis strategies and follow all recommended infection prevention and control practices.

Healthcare personnel with SARS-CoV-2 infection

Under conventional conditions, healthcare facilities can allow asymptomatic healthcare personnel with SARS-CoV-2 infection, regardless of vaccination status, to return to work after seven days and a negative test in accordance with CDC guidance. For healthcare personnel who were symptomatic, fever should have resolved without medications, as detailed in Return to Work Criteria. Under contingency conditions, healthcare personnel with SARS-CoV-2 infection can return to work at five days, if asymptomatic, with facilities having the option to include a negative viral test in the criteria to return to work. Under crisis conditions, such personnel can remain at work or can return to work at less than five days, if asymptomatic or mildly symptomatic, as a last resort, without testing. These healthcare personnel should wear a respirator or well-fitting facemask even when they are in non-patient care areas. Facilities should consider assigning these healthcare personnel to duties that do not include care of immunocompromised patients.

Conventional work restrictions for healthcare personnel should not be shortened under certain circumstances. This includes healthcare personnel who are moderately to severely immunocompromised. Also, in the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to using more stringent work restriction for healthcare personnel with higher-risk exposures. There might be other circumstances for which a jurisdiction's public health authority recommends these and additional precautions for directing healthcare personnel to follow work restrictions.

Recommendations for Healthcare Personnel

- Get all doses of COVID-19 vaccines, including additional and booster doses as recommended by CDC as well as influenza vaccine to protect yourself, your family, and your patients.
- Increase patient outreach efforts to recommend, encourage, and offer COVID-19 vaccination and boosters.
- Recommend that all healthcare personnel who are immunocompromised continue to practice all prevention measures to protect themselves against COVID-19 even if they have received all COVID-19 vaccines, additional and booster doses as recommended by CDC.
- When spending time in community settings, take all recommended steps to protect yourself and others from SARS-CoV-2 infection to decrease the risk of introducing new transmission into the healthcare setting.

Recommendations for Healthcare Facilities and Systems and Nursing Homes

- Implement new CDC guidance for contingency and crisis conditions to shorten duration of work restrictions for healthcare personnel with SARS-CoV-2 infection and those who had a higher-risk exposure to SARS-CoV-2, when needed to alleviate healthcare staffing shortages and maintain a safe environment for patients, visitors, and healthcare personnel.
- Recommend and offer COVID-19 vaccine and boosters to your staff and employees and establish policies to encourage uptake such as time off to get COVID-19 vaccinations and boosters. See resources at Workplace COVID-19 Vaccine Toolkit.
- Provide resources and support to assist healthcare personnel with stress and physical demands.

- Ensure that SARS-CoV-2 testing is performed with a test that can detect SARS-CoV-2 considering currently circulating variants. For more information, see SARS-CoV-2 Viral Mutations: Impact on COVID-19 Tests | FDA.

For More Information

- Omicron Variant: What You Need to Know | CDC
- Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC
- CDC COVID Data Tracker

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The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert Requires immediate action or attention, highest level of importance

Health Advisory May not require immediate action; provides important information for a specific incident or situation

Health Update Unlikely to require immediate action; provides updated information regarding an incident or situation

HAN Info Service Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Christopher Zukoski, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

Statewide LHD Leadership

Statewide LHD-Group

Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# Response:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
Friday, December 24, 2021, 7:00 PM ET
CDCHAN-00460

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- Increase patient outreach efforts to recommend, encourage, and offer COVID-19 vaccination and boosters.
- Recommend that all healthcare personnel who are immunocompromised continue to practice all prevention measures to protect themselves against COVID-19 even if they have received all COVID-19 vaccines, additional and booster doses as recommended by CDC.
- When spending time in community settings, take all recommended steps to protect yourself and others from SARS-CoV-2 infection to decrease the risk of introducing new transmission into the healthcare setting.

Recommendations for Healthcare Facilities and Systems and Nursing Homes

- Implement new CDC guidance for contingency and crisis conditions to shorten duration of work restrictions for healthcare personnel with SARS-CoV-2 infection and those who had a higher-risk exposure to SARS-CoV-2, when needed to alleviate healthcare staffing shortages and maintain a safe environment for patients, visitors, and healthcare personnel.
- Recommend and offer COVID-19 vaccine and boosters to your staff and employees and establish policies to encourage uptake such as time off to get COVID-19 vaccinations and boosters. See resources at Workplace COVID-19 Vaccine Toolkit.
- Provide resources and support to assist healthcare personnel with stress and physical demands.
- Ensure that SARS-CoV-2 testing is performed with a test that can detect SARS-CoV-2 considering currently circulating variants. For more information, see SARS-CoV-2 Viral Mutations: Impact on COVID-19 Tests | FDA.

For More Information

- Omicron Variant: What You Need to Know | CDC
- Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC
- CDC COVID Data Tracker

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The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

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Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Staff Updates - 09/27/21

Court Witschey <cwitschey@athenspublichealth.org>

Mon 9/27/2021 1:20 PM

To: **all users <allusers@athenspublichealth.org>**; Briana Karl-Berkel <bkarl.berkel@athenspublichealth.org>; Ward Bryson <comcorpsathenshealth@gmail.com>

Good morning,

1. **Please refer to Jack's email regarding who is eligible for the Pfizer booster.** In alignment with the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA), booster doses of the Pfizer/Comirnaty COVID-19 vaccine are now available for the following populations at least six months after completion of the primary Pfizer series, meaning at least six months after the second dose was administered:

- People 65 years and older or residents in long-term care settings SHOULD receive a booster shot.
- People ages 50 to 64 with certain underlying medical conditions SHOULD receive a booster shot.
- People ages 18 to 49 with certain underlying medical conditions MAY receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient, but those eligible are encouraged to talk to their healthcare providers if they have any questions.
- People aged 18 and older who are at increased risk for COVID-19 exposure and transmission because of their job or living in an institutional setting MAY receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient.

2. **If someone is unable to schedule a booster vaccine by themselves through https://gettheshot.coronavirus.ohio.gov/, confirm the information below prior to scheduling them through VMS.**

- They fit in one of the eligible categories
- It has been 6 months since their 2nd dose.
- Their previous doses were Pfizer

3. **The new county wellness program has started, effective 8/14/21-8/12/22.**

- The new program year is kicking off with a blood draw in the Commissioners' Meeting Room on Friday, October 22 form 7:30-10:30 AM.
- There will also be a Fall Walk-Thru Health Fair on Saturday, October 23 at 510 Union Street form 8:00-11:00 AM.
- The portal is open for registration now, but the "new and improved" portal design has not yet occurred.

4. **COVID vaccination clinic this Friday at Heritage Hall from 8:30-11:30. (PROCESS CHANGES BELOW)**

- At the Health Check station, volunteers will confirm which vaccine the person is requesting (only Pfizer boosters right now) and that they have their COVID vaccine cards with them.
- Anyone without a COVID vaccine card will be directed to a Vaccine Verification station immediately next to the Health Check station. At this station, staff will use IMPACT (Ohio's vaccination database) to verify vaccine status for individuals that do not have their COVID vaccine cards. Staff will fill-out a new COVID vaccine card for the individual prior to directing them to the Vaccination station.

5. **Call volume remains high. Continue to fill-in per the Continuity of Operations (COOP) document I sent out on 9/16. Duties include:**

- Answering phones and responding to questions that you can answer. Forwarding calls that you cannot answer to the appropriate person.
- Checking in with Jack to see if any Isolation letters need to be sent out.
- Checking in with Crystal or Morgan to see if any data entry can be completed.

Thank you!

Court Witschey
Director of Policy & Planning
Athens City-County Health Department
278 West Union Street • Athens, OH 45701
740-592-4431, ext: 5911 • 740-594-2370 (fax)
cwitschey@athenspublichealth.org • www.athenspublichealth.org• Check us out on Facebook!

Health Advisory 453: COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths...

Ohio Health Alert Network <5942d340-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Wed 9/29/2021 1:07 PM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

September 29, 2021, 12:00 PM ET

CDCHAN-00453

COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19

Summary

The Centers for Disease Control and Prevention (CDC) recommends urgent action to increase Coronavirus Disease 2019 (COVID-19) vaccination among people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future. CDC strongly recommends COVID-19 vaccination either before or during pregnancy because the benefits of vaccination outweigh known or potential risks. As of September 27, 2021, more than 125,000 laboratory-confirmed COVID-19 cases have been reported in pregnant people, including more than 22,000 hospitalized cases and 161 deaths.1 The highest number of COVID-19-related deaths in pregnant people (n=22) in a single month of the pandemicwas reported in August 2021. Data from the COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) in 2021 indicate that approximately 97% of pregnant people hospitalized (either for illness or for labor and delivery) with confirmed SARS-CoV-2 infection were unvaccinated.2 In addition to the risks of severe illness and death for pregnant and recently pregnant people, there is an increased risk for adverse pregnancy and neonatal outcomes, including preterm birth and admission of their neonate(s) to an intensive care unit (ICU). Other adverse pregnancy outcomes, such as stillbirth, have been reported. Despite the known risks of COVID-19, as of September 18, 2021, 31.0% of pregnant people were fully vaccinated before or during their pregnancy.3 In addition, there are racial and ethnic disparities in vaccination coverage for pregnant people. Healthcare providers should communicate the risks of COVID-19, the benefits of vaccination, and information on the safety and effectiveness of COVID-19 vaccination in pregnancy. Healthcare providers should strongly recommend that people who are pregnant, recently pregnant (including those who are lactating), who are trying to become

pregnant now, or who might become pregnant in the future receive one of the authorized or approved COVID-19 vaccines as soon as possible.

Background

COVID-19 vaccination is recommended for pregnant people. CDC recommends COVID-19 vaccination for all people aged 12 years and older, including people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.4CDC recommendations align with those from professional medical organizations serving people who are pregnant, including the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. Accumulating data provide evidence of both the safety and effectiveness of COVID-19 vaccination in pregnancy. CDC strongly recommends COVID-19 vaccination either before or during pregnancy, because the benefits of vaccination for both pregnant persons and their fetus/infant outweigh known or potential risks. Getting a COVID-19 vaccine can prevent severe illness, death, and pregnancy complications related to COVID-19.

COVID-19 vaccination coverage for pregnant people remains low. Despite recommendations for vaccination, uptake of COVID-19 vaccination by pregnant people has been lower than that of non-pregnant people.5 In addition, vaccination coverage for pregnant people differs by race and ethnicity, with vaccination coverage being lowest for non-Hispanic Black pregnant people (15.6%) as of September 18, 2021.3 Although the proportion of fully vaccinated pregnant people has increased to 31.0% (as of September 18, 2021), the majority of pregnant people remain unprotected against COVID-19, and significant disparities exist in vaccination coverage by race and ethnicity.

Pregnant and recently pregnant people with COVID-19 are at increased risk of severe illness, death, and pregnancy complications. Pregnant and recently pregnant people with COVID-19 are at increased risk for severe illness when compared with non-pregnant people. Severe illness includes illness that requires hospitalization, intensive care unit (ICU) admission, mechanical ventilation, or extracorporeal membrane oxygenation (ECMO), or illness that results in death. Although the absolute risk is low, compared with non-pregnant symptomatic people, symptomatic pregnant people have more than a two-fold increased risk of requiring ICU admission, invasive ventilation, and ECMO, and a 70% increased risk of death.6 Pregnant people with COVID-19 are also at increased risk for preterm birth and some data suggest an increased risk for other adverse pregnancy complications and outcomes, such as preeclampsia, coagulopathy, and stillbirth, compared with pregnant people without COVID-19.7-10 Neonates born to people with COVID-19 are also at increased risk for admission to the neonatal ICU.9-11 In addition, although rare, pregnant people with COVID-19 can transmit infection to their neonates; among neonates born to women with COVID-19 during pregnancy, 1–4% of neonates tested were positive by rRT-PCR.12,13

Recommendations

CDC recommends urgent action to help protect pregnant people and their fetuses/infants. CDC recommends urgent action to accelerate primary vaccination for people who are pregnant, recently

pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. Efforts should specifically address populations with lower vaccination coverage and use approaches to reduce racial and ethnic disparities. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits. In addition, pregnant people should continue to follow all recommended prevention measures and should seek care immediately for any symptoms of COVID-19. Healthcare providers should have a low threshold for increased monitoring during pregnancy due to the risk of severe illness.

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Leverage resources to promote vaccine equity: COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups.
    - Include focused efforts to increase vaccination coverage in pregnancy among people from racial and ethnic minority groups.
- Encourage healthcare providers to offer and recommend COVID-19 vaccination to their patients and community members who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Work with community partners and employers to make vaccination easily accessible for unvaccinated populations, including those who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Continue to implement additional prevention strategies where SARS-CoV-2 transmission is high and vaccination coverage is low, including in groups at increased risk, such as pregnant people.
- Continue to monitor community transmission and vaccination coverage levels and focus vaccine efforts on populations with low coverage.
- Disseminate and communicate information to key partners about vaccination coverage, risks posed by the highly transmissible Delta variant, and local transmission levels. Partner and share messaging with programs serving pregnant and recently pregnant people.
- Communicate accurate information about COVID-19 vaccines, respond to gaps in information, and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.

Recommendations for Healthcare Providers

- Ensure all clinical staff are aware of the recommendation for vaccination of people before and during pregnancy and the serious risks of COVID-19 to pregnant and recently pregnant people and their fetuses/infants.
- Increase outreach efforts to encourage, recommend, and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. A strong recommendation from a healthcare provider is a critical factor in COVID-19 vaccine acceptance and can make a meaningful difference to protect the health of pregnant and recently pregnant people and their fetuses/infants from COVID-19.

- For healthcare providers who see patients who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future:
    - Review patients' COVID-19 vaccination status at each pre- and post-natal visit and discuss COVID-19 vaccination with those who are unvaccinated.
    - Reach out to your patients with messages encouraging and recommending the critical need for vaccination.
    - Remind patients that vaccination is recommended even for those with prior COVID-19 infections. Studies have shown that vaccination provides increased protection in people who have recovered from COVID-19.
    - Support efforts to ensure people receiving the first dose of an mRNA COVID-19 vaccine (i.e., Pfizer-BioNTech, Moderna) return for their second dose to complete the series as close as possible to the recommended interval.
        - Consider a booster dose in eligible pregnant persons.4
    - Communicate accurate information about COVID-19 vaccines and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.
- Become a COVID-19 vaccine provider and vaccinate patients during their visit. More information can be found at How to Enroll as a COVID-19 Vaccination Provider.

For More Information

- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States
- COVID-19 Vaccines While Pregnant or Breastfeeding
- COVID-19 Vaccines for People Who Would Like to Have a Baby
- COVID-19 among Pregnant and Recently Pregnant People
- COVID Data Tracker
    - Vaccination Among Pregnant People
    - Data on COVID-19 during Pregnancy: Severity of Maternal Illness
- Toolkit for Pregnant People and New Parents
- Building Confidence in COVID-19 Vaccines

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, epidemiologists, HAN coordinators, and clinician organizations##

Sent by:

Christopher Zukoski, ODH

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
September 29, 2021, 12:00 PM ET
CDCHAN-00453

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Summary
The Centers for Disease Control and Prevention (CDC) recommends urgent action to increase Coronavirus Disease 2019 (COVID-19) vaccination among people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future. CDC strongly recommends COVID-19 vaccination either before or during pregnancy because the benefits of vaccination outweigh known or potential risks. As of September 27, 2021, more than 125,000 laboratory-confirmed COVID-19 cases have been reported in pregnant people, including more than 22,000 hospitalized cases and 161 deaths.[1] The highest number of COVID-19-related deaths in pregnant people (n=22) in a single month of the pandemic was reported in August 2021. Data from the COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) in 2021 indicate that approximately 97% of pregnant people hospitalized (either for illness or for labor and delivery) with confirmed SARS-CoV-2 infection were unvaccinated.[2] In addition to the risks of severe illness and death for pregnant and recently pregnant people, there is an increased risk for adverse pregnancy and neonatal outcomes, including preterm birth and admission of their neonate(s) to an intensive care unit (ICU). Other adverse pregnancy outcomes, such as stillbirth, have been reported. Despite the known risks of COVID-19, as of September 18, 2021, 31.0% of pregnant people were fully vaccinated before or during their pregnancy.[3] In addition, there are racial and ethnic disparities in vaccination coverage for pregnant people. Healthcare providers should communicate the risks of COVID-19, the benefits of vaccination, and information on the safety and effectiveness of COVID-19 vaccination in pregnancy. Healthcare providers should strongly recommend that people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future receive one of the authorized or approved COVID-19 vaccines as soon as possible.

Background
COVID-19 vaccination is recommended for pregnant people. CDC recommends COVID-19 vaccination for all people aged 12 years and older, including people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.[4] CDC recommendations align with those from professional medical organizations serving people who are pregnant, including the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. Accumulating data provide evidence of both the safety and effectiveness of COVID-19 vaccination in pregnancy. CDC strongly recommends COVID-19 vaccination either before or during pregnancy, because the benefits of vaccination for both pregnant persons and their fetus/infant outweigh known or potential risks. Getting a COVID-19 vaccine can prevent severe illness, death, and pregnancy complications related to COVID-19.

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Recommendations

CDC recommends urgent action to help protect pregnant people and their fetuses/infants. CDC recommends urgent action to accelerate primary vaccination for people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. Efforts should specifically address populations with lower vaccination coverage and use approaches to reduce racial and ethnic disparities. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits. In addition, pregnant people should continue to follow all recommended prevention measures and should seek care immediately for any symptoms of COVID-19. Healthcare providers should have a low threshold for increased monitoring during pregnancy due to the risk of severe illness.

Recommendations for Public Health Jurisdictions

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- Leverage resources to promote vaccine equity: COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups.
    - Include focused efforts to increase vaccination coverage in pregnancy among people from racial and ethnic minority groups.
- Encourage healthcare providers to offer and recommend COVID-19 vaccination to their patients and community members who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Work with community partners and employers to make vaccination easily accessible for unvaccinated populations, including those who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Continue to implement additional prevention strategies where SARS-CoV-2 transmission is high and vaccination coverage is low, including in groups at increased risk, such as pregnant people.
- Continue to monitor community transmission and vaccination coverage levels and focus vaccine efforts on populations with low coverage.
- Disseminate and communicate information to key partners about vaccination coverage, risks posed by the highly transmissible Delta variant, and local transmission levels. Partner and share messaging with programs serving pregnant and recently pregnant people.

- Communicate accurate information about COVID-19 vaccines, respond to gaps in information, and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.

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- For healthcare providers who see patients who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future:
    - Review patients' COVID-19 vaccination status at each pre- and post-natal visit and discuss COVID-19 vaccination with those who are unvaccinated.
    - Reach out to your patients with messages encouraging and recommending the critical need for vaccination.
    - Remind patients that vaccination is recommended even for those with prior COVID-19 infections. Studies have shown that vaccination provides increased protection in people who have recovered from COVID-19.
    - Support efforts to ensure people receiving the first dose of an mRNA COVID-19 vaccine (i.e., Pfizer-BioNTech, Moderna) return for their second dose to complete the series as close as possible to the recommended interval.
        - Consider a booster dose in eligible pregnant persons.[4]
    - Communicate accurate information about COVID-19 vaccines and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.
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    - Data on COVID-19 during Pregnancy: Severity of Maternal Illness
- Toolkit for Pregnant People and New Parents
- Building Confidence in COVID-19 Vaccines

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4. CDC Interim Clinical Considerations for Use of COVID-19 Vaccines. (accessed September 27, 2021)
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##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, epidemiologists, HAN coordinators, and clinician organizations##

FW: Medical-Grade PPE Face Shields - Over 50 Million sold

jojo@hlpklearfold.com <jojo@hlpklearfold.com>

Mon 9/27/2021 2:31 PM

To: jojo@hlpklearfold.com <jojo@hlpklearfold.com>

HLP Medical is a very significant manufacturer of high-quality face shields for use by healthcare and other essential workers. We have the capacity to make 600,000 face shields per day, and we have supplied over 60 million to medical and government agencies in North America, Europe and Asia. We keep significant inventories in both West Coast and East Coast warehouses.

Our face shields are economical, lightweight, and fit over eye glasses and masks, and have been treated for anti-fog. They have been third-party certified to satisfy U.S. ANSI Z87.1-2015 and European EN 166:2001 standards for eye protection from droplets and splash, CE health, safety and environmental protection standards, and ISO 13485 quality management system standards for the design and manufacture of medical devices.

Our face shields are Class I medical devices. Our manufacturing facility is FDA registered, and our face shields have been both FDA registered and listed. To learn more about the three styles of face shields we offer, please visit:

https://www.hlpmedicalsupplies.com/

If you would like to receive samples or if you would like more information about our face shields, please contact us at info@hlpklearfold.com or +1 888 457-7225.

Thank you for your consideration.

Jo Jo

HLP Klearfold
VISUALIZE

RE: Additional question

Ruth Dudding <rdudding@athenspublichealth.org>

Fri 7/16/2021 1:20 PM

To: Jack Pepper <jpepper@athenspublichealth.org>; James Gaskell <jgaskell@athenspublichealth.org>; Court Witschey <cwitschey@athenspublichealth.org>

Court and I would prefer [redacted]

From: Jack Pepper <jpepper@athenspublichealth.org>
Sent: Friday, July 16, 2021 1:12 PM
To: James Gaskell <jgaskell@athenspublichealth.org>; Ruth Dudding <rdudding@athenspublichealth.org>; Court Witschey <cwitschey@athenspublichealth.org>
Subject: Fw: Additional question

See below.

From: [redacted]
Sent: Friday, July 16, 2021 1:10 PM
To: Jack Pepper <jpepper@athenspublichealth.org>
Subject: Re: Additional question

Jack,

At this time, I believe the COVID vaccine should not be a requirement until it has gone through rigorous testing with known long-term effects and meets FDA approval. As you mentioned in the interview, if COVID had a higher death rate, many would see it in a different perspective, including myself, and I would understand the rush to receive the vaccine. At my age, I do not feel comfortable receiving the vaccine when comparing the risks of getting COVID. I would abide by any mask mandate or other requirements for safety and consideration of others, but if the vaccine is a condition of employment, I would remove my name.

Thank you!

On Fri, Jul 16, 2021 at 12:30 PM Jack Pepper <jpepper@athenspublichealth.org> wrote:

> [redacted]
>
> Thanks again for applying for our PHEP coordinator position. During the interview you mentioned that you were currently not COVID vaccinated. Will you be removing your name from consideration if the COVID vaccine is a condition of employment?
>
> Thanks
> Jack Pepper
> Administrator
> ACCHD

COVID Literature

Jack Pepper <jpepper@athenspublichealth.org>

Wed 9/1/2021 10:41 AM

To: **all users <allusers@athenspublichealth.org>**

Please see the attached literature reviews regarding COVID vaccines. There is some great stuff here that might help with some of the questions you are fielding.

Jack

Summary Document for Interim Clinical Considerations

for Use of COVID-19 Vaccines Currently Authorized in the United States

	Pfizer-BioNTech	Moderna	Janssen
Vaccine type	mRNA	mRNA	Replication-incompetent adenovirus type 26 vector
Authorized age groups	≥12 years	≥18 years	≥18 years
Dose	30 µg	100 µg	5×10^{10} viral particles
Dose volume	0.3 ml	0.5 ml	0.5 ml
Number of doses in series	2*	2*	1
Interval between doses	3 weeks (21 days)	1 month (28 days)	N/A
All currently authorized COVID-19 vaccines			
Interchangeability of vaccines	■ Vaccines are not interchangeable. However, in exceptional situations, such as a contraindication to a second dose of mRNA vaccine, interchangeability may be allowed.†		
Coadministration with other vaccines	■ COVID-19 vaccine and other vaccines may be administered on the same day, as well as any interval without respect to timing. When deciding whether to administer COVID-19 vaccine and other vaccines, providers should consider whether the patient is behind or at risk of becoming behind on recommended vaccines, their risk of vaccine-preventable diseases (e.g., during an outbreak), and the reactogenicity profile of the vaccines.		
Persons with prior or current COVID-19	■ COVID-19 vaccines can be given safely to people with prior SARS-CoV-2 infection ■ Defer vaccination until person has recovered from the acute illness and criteria have been met for them to discontinue isolation		
Women aged <50 years	■ Can receive any FDA-authorized vaccine but should be informed of risk of thrombosis with thrombocytopenia syndrome (TTS) after receipt of Janssen (Johnson & Johnson) COVID-19 Vaccine and the availability of other COVID-19 vaccine options		
Persons who received monoclonal antibodies or convalescent plasma for COVID-19 treatment	■ Defer vaccination for at least 90 days		
Persons with a known SARS-CoV-2 exposure	■ People in community or outpatient setting should defer vaccination until quarantine period has ended ■ Residents or patients in congregate settings may be vaccinated if they do not have symptoms consistent with COVID-19		
History of heparin-induced thrombocytopenia (HIT)	■ If within 90 days of illness, offer an mRNA vaccine, after 90 days vaccinate with any FDA-authorized COVID-19 vaccine		

Summary Document for Interim Clinical Considerations

for Use of COVID-19 Vaccines Currently Authorized in the United States

All currently authorized COVID-19 vaccines	
Persons with underlying conditions	■ May receive COVID-19 vaccine
Persons with moderate to severe immune compromise	■ Can receive any FDA-authorized COVID-19 vaccine • 1 dose Janssen COVID-19 Vaccine; currently no recommendation for an additional dose, or • 2-doses of an mRNA COVID-19 vaccine; consider an additional dose at least 28 days after completion of the primary 2-dose series
Persons with a history of Guillain-Barré Syndrome	■ Can receive any FDA-authorized COVID-19 vaccine, however, discuss the availability of mRNA vaccines to offer protection against COVID-19
Pregnant or breastfeeding people or people trying to get pregnant	■ Are recommended to receive a COVID-19 vaccine, inform of risk of TTS after receipt of Janssen (Johnson & Johnson) COVID-19 Vaccine and the availability of other options
Adolescents	■ Adolescents aged 12-17 are ONLY eligible for Pfizer-BioNTech COVID-19 Vaccine ■ Adolescents aged 18 years and older are eligible for all COVID-19 vaccines
Persons vaccinated outside the United States	■ Received all recommended doses of an FDA-authorized COVID-19 vaccine, do not need additional doses ■ Received a non FDA-authorized vaccine • If vaccine is listed for emergency use by the World Health Organization (WHO) and received all recommended doses, do not need any additional doses with an FDA-authorized vaccine • If vaccine is listed for emergency use by WHO, but has not received all recommended doses, may be offered a complete FDA-authorized series • If vaccine is not listed for emergency use by WHO, may be offered a complete FDA-authorized COVID-19 vaccine series
Contraindications	■ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to component of the COVID-19 vaccine ■ Immediate (within 4 hours of exposure) allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine
Precaution	■ Immediate allergic reaction to any other vaccine or injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines or therapies [excluding subcutaneous immunotherapy for allergies, i.e., "allergy shots"])
Post-vaccination observation periods	■ **30 minutes:** persons with a precaution to vaccination (i.e., history of an immediate allergic reaction of any severity to a vaccine or injectable therapy) and persons with a history of anaphylaxis due to any cause ■ **15 minutes:** all other persons
SARS-CoV-2 antibody testing	■ Antibody testing not recommended for vaccine decision-making or to assess immunity following vaccination

*Consider an additional dose at least 28 days after the initial 2-dose primary series for people with moderate to severe immune compromise.

†Although CDC provides considerations for a mixed series in exceptional circumstances, this is still considered an administration error that requires VAERS reporting

COVID-19 Vaccine FAQs for Healthcare Professionals

Below are answers to commonly asked clinical questions that apply to all authorized COVID-19 vaccines.

For clinical questions on the following specific COVID-19 vaccines, see:

Janssen COVID-19 Vaccine (Johnson & Johnson) FAQs

Moderna COVID-19 Vaccine FAQs

Pfizer-BioNTech COVID-19 Vaccine FAQs

About Vaccines

We have new staff members who are not familiar with vaccines. Are there training materials CDC recommends for them? +

All staff supporting COVID-19 vaccination efforts should receive ongoing training as new COVID-19 vaccines become available and recommendations evolve. Review and complete training and core competencies by professional qualification. Additionally, for healthcare professionals new to vaccination, the COVID-19 Vaccination Training Programs and Reference Materials for Healthcare Professionals provide a comprehensive list of suggested training and reference materials.

For more immunization training resources, see Resources for Health Care Providers and Immunization Education and Training.

Vaccination Schedule and Use

My patient cannot remember which vaccine they received for the first dose. What do I do? +

COVID-19 vaccines are **not** interchangeable. The safety and effectiveness of a mixed-product series have not been evaluated. Every effort should be made to determine which vaccine product was administered as the first dose to ensure completion of the vaccine series with the same product. **In exceptional situations:**

- When the vaccine product given for the first dose cannot be determined or is no longer available, you may administer any available mRNA COVID-19 vaccine, with a minimum of 28 days between doses. If two different mRNA COVID-19 vaccine products are administered, no additional doses of either product are recommended at this time.
- If a patient received the first dose of an mRNA COVID-19 vaccine but is unable to complete the series with either the same or a different mRNA COVID-19 vaccine (e.g., due to contraindication), you may consider administering a single dose of Janssen COVID-19 Vaccine, with a minimum of 28 days between doses. See contraindications and precautions for more information on use of Janssen COVID-19 Vaccine and additional precautions in people with a contraindication to mRNA COVID-19 vaccines.

Implement the following strategies to help ensure patients receive the second dose with the appropriate product and interval between doses:

- Provide a COVID-19 vaccination record card to every vaccine recipient. Ask recipients to bring their card to their appointment for the second dose. Encourage them to make a backup copy (e.g., by taking a picture of the card with their phone).

- Encourage vaccine recipients to enroll in v-safe, a free smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins as well as second-dose reminders.
- Encourage vaccine recipients to enroll in VaxTextSM, a free text-message-based platform, to receive reminders to get their second dose of COVID-19 vaccine.
- Record each recipient's vaccination in the immunization information system (IIS).
- Record vaccine administration information in the patient's medical record.
- Make an appointment for the second dose before the vaccine recipient leaves to increase the likelihood that patients will return to the same vaccination provider site for the second dose. Make sure that the recipient has a reminder for the second appointment.

Is there a minimum interval between administering routine vaccines and COVID-19 vaccines? −

No. You may administer COVID-19 vaccine and other vaccines without regard to timing. This includes simultaneous administration of COVID-19 vaccine and other vaccines (including live, attenuated vaccines such as the measles-mumps-rubella [MMR] vaccine) on the same day, as well as coadministration at any time interval. It is unknown whether reactogenicity of COVID-19 vaccine is increased with coadministration, including with other vaccines known to be more reactogenic, such as adjuvanted vaccines or live vaccines.

When deciding whether to coadminister another vaccine(s) with COVID-19 vaccine, consider:

- Whether the patient is behind or at risk of becoming behind on recommended vaccines
- The patient's risk of vaccine-preventable disease (e.g., during an outbreak or occupational exposures)
- The reactogenicity profile of the vaccines

Learn more about coadministration with other vaccines.

Can you administer COVID-19 vaccines with immune-based tests for tuberculosis (TB) infection, such as the tuberculin skin test (TST) and interferon-gamma release assay (IGRA)? +

Yes. Testing for TB infection with one of the immune-based methods, either the TST or an IGRA, can be done before or during the same encounter as COVID-19 vaccination. It is recommended that the TST be placed or blood drawn for the IGRA before administration of the COVID-19 vaccination. If it is not possible to test with TST or IGRA at the same time as COVID-19 vaccination, these tests should be delayed ≥4 weeks after the completion of COVID-19 vaccination with either the 2-dose mRNA COVID-19 vaccines (Pfizer-BioNTech and Moderna) or single dose viral vector COVID-19 vaccine (Janssen). However, the decision whether a TST or IGRA that is being done for medical diagnosis of latent TB infection (for example, during a contact investigation after exposure to contagious TB disease) should be delayed for 4 weeks after completion of COVID-19 vaccination is at the discretion of the responsible medical provider and local tuberculosis program overseeing the contact investigation.

The reliability of a positive TST or IGRA result after COVID-19 vaccination is expected to be the same as without the vaccination. COVID-19 vaccination is not expected to cause false positive results from a TB test that is done at the same encounter as or after COVID-19 vaccination. It should be noted that the reliability of a negative TST or IGRA result after COVID-19 vaccination has not been studied. If these tests cannot be done at the time of COVID-19 vaccine administration or delayed until ≥4 weeks after administration, a false negative TST or IGRA cannot be excluded, and consideration should be given to repeating negative TST or IGRA tests at least 4 weeks after the completion of COVID-19 vaccination. For more information, please refer to the CDC's Division of Tuberculosis Elimination "Dear Colleague" Letter.

Patients who have active TB disease or an illness that is being evaluated as active TB disease can receive a COVID-19 vaccine (note: the presence of a moderate or severe acute illness is a precaution to administration of all vaccines).

Do patients need to wait to schedule a routine screening mammogram after receiving a COVID-19 vaccine? +

People who have received a COVID-19 vaccine can have axillary lymphadenopathy, which may cause a false reading on a mammogram. If it is not possible to schedule the mammogram before COVID-19 vaccination, some experts recommend waiting 4 to 6 weeks after COVID-19 vaccination to schedule the mammogram.

Are booster doses needed after the series is completed?

A patient is considered fully vaccinated ≥2 weeks after a 2-dose mRNA COVID-19 vaccine series or ≥2 weeks after a single dose of Janssen COVID-19 Vaccine. The need for and timing of COVID-19 booster doses have not been established. No additional doses are recommended at this time.

Vaccine Indications

My patient is asking for an antibody test to inform the decision to vaccinate (or revaccinate). What do antibody tests tell us about immunity, and should these tests influence the decision to vaccinate or revaccinate?

Antibody tests for COVID-19 look for the presence of antibodies made in response to a previous infection or vaccination. They are an indicator of the body's efforts to fight off the SARS-CoV-2 virus. None of the currently authorized SARS-CoV-2 antibody tests have been validated to evaluate specific immunity or protection from SARS-CoV-2 infection.

Antibody testing is **NOT** currently recommended to assess

- Immunity to COVID-19 following COVID-19 vaccination
- The need for vaccination in an unvaccinated person

There are several issues to consider when interpreting an antibody test for SARS-CoV-2 infection:

- **Scientists have not yet established a serologic correlate of protection**, which is the measurable threshold above which a person is protected against SARS-CoV-2 infection. This makes it difficult to interpret how laboratory results might translate to clinical protection.
- **Antibody testing does not evaluate the cellular immune response,** which may also play a role in vaccine-mediated protection.
- **Vaccines trigger antibodies to specific viral protein targets**. Currently authorized COVID-19 vaccines induce antibodies to the **spike protein** but not to the **nucleocapsid protein**, which is likely detected only after a natural infection with SARS-CoV-2. Therefore, COVID-19-vaccinated people who have not had previous natural infection will receive a negative antibody test result if the antibody test is designed to detect nucleocapsid protein.
- **Antibody tests have different levels of sensitivity** (i.e., the true positive rate, or ability to identify people with antibodies to SARS-CoV-2) and specificity (i.e., the true negative rate, or ability to identify those without antibodies to SARS-CoV-2).

For assistance with patient counseling and education related to COVID-19 testing and vaccination, please see:

- Test for Past Infection **[CDC]**
- Using Antibody Tests for COVID-19: *Information for Patients and Consumers* [**CDC**]
- Antibody (Serology) Testing for COVID-19: *Information for Patients and Consumers* [**FDA**]

For more detailed information, please see:

- Interim Guidelines for COVID-19 Antibody Testing [**CDC**]
- Serology/Antibody Tests: *FAQs on Testing for SARS-CoV-2* [**FDA**]
- Antibody Testing Is Not Currently Recommended to Assess Immunity After COVID-19 Vaccination: *FDA Safety Communication* **[FDA]**

Can I vaccinate patients with underlying medical conditions?

Yes, you may administer any currently authorized COVID-19 vaccine to people with underlying medical conditions; the Advisory Committee on Immunization Practices (ACIP) does not state a product preference. This includes people with:

- Immunocompromising conditions or people who take immunosuppressive medication or therapies

- Autoimmune conditions
- A history of Guillain-Barré syndrome
- A history of Bell's palsy
- A history of dermal filler use

Learn more about vaccinating patients with underlying medical conditions.

Can I vaccinate patients with a history of heparin-induced thrombocytopenia (HIT)? +

People with a history of an episode of immune-mediated syndrome characterized by thrombosis and thrombocytopenia (e.g., heparin-induced thrombocytopenia) should be offered Moderna COVID-19 Vaccine or Pfizer-BioNTech COVID-19 Vaccine if it has been 90 days or less since their illness resolved. After 90 days, patients may be vaccinated with any FDA-authorized COVID-19 vaccine.

More information is available at: Clinical Care Considerations for COVID-19 Vaccination

Are there special considerations for vaccinating immunocompromised patients or timing immunosuppressive therapy? +

Immunocompromised patients can receive any currently authorized COVID-19 vaccine; however, you should consider counseling them and timing immunosuppressive therapies.

Counsel immunocompromised patients about the:

- Unknown vaccine safety profile and effectiveness in immunocompromised populations
- Potential for reduced immune responses
- Need to continue to follow current guidance to protect themselves against COVID-19

Data are currently insufficient to inform optimal timing of COVID-19 vaccination and receipt of immunosuppressive therapies. However, based on general best practices for vaccination of immunocompromised people, ideally **COVID-19 vaccination should be completed at least 2 weeks before initiation of immunosuppressive therapies**. When it is not possible to administer a complete COVID-19 vaccine series (i.e., 2 doses of an mRNA vaccine or a single dose of Janssen COVID-19 Vaccine) in advance, you may still vaccinate patients receiving immunosuppressive therapy. Decisions to delay immunosuppressive therapy to complete COVID-19 vaccination should consider the patient's risks related to their underlying condition.

At this time, revaccination is not recommended after patients regain immune competence. Recommendations on revaccination or additional doses of COVID-19 vaccines may be updated when more information is available.

Learn more about vaccinating patients with underlying medical conditions.

Can pregnant or lactating people be vaccinated? +

Yes. COVID-19 vaccination is recommended for all people 12 years and older, including people who are pregnant, breastfeeding, trying to get pregnant now, or might become pregnant in the future. Pregnant or lactating people can receive any of the currently authorized COVID-19 vaccines; the Advisory Committee on Immunization Practices (ACIP) does not state a product preference.

However, if a woman younger than 50 years chooses to receive the J&J/Janssen COVID-19 vaccine, you should talk to her about:

- The very low but increased risk of thrombosis with thrombocytopenia syndrome (TTS) after receipt of this vaccine
- The availability of other FDA-authorized COVID-19 vaccines (i.e., mRNA vaccines) for which the risk of TTS has not been observed

Increasing data on the safety and effectiveness of COVID-19 vaccination indicate that the benefits of vaccination outweigh any known or potential risks of COVID-19 vaccine during pregnancy. When making a decision about vaccination, you and your pregnant patient should consider the following:

- Known and potential benefits of vaccination
- Vaccine effectiveness
- Vaccine side effects
- Limited but growing evidence about the safety of COVID-19 vaccination during pregnancy
- Level of COVID-19 community transmission
- Patient's personal risk of contracting COVID-19
- Risks of COVID-19 to the patient and potential risks to the fetus

Encourage pregnant people who choose to be vaccinated to enroll in v-safe, a smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins after COVID-19 vaccination. A v-safe pregnancy registry has been established to follow outcomes among pregnant people who are vaccinated.

Learn more about vaccination of pregnant or lactating people and considerations for use of the J&J/Janssen COVID-19

Do COVID-19 vaccines impact fertility? Should patients planning pregnancy be concerned about receiving COVID-19 vaccines? +

No. There is no evidence that any of the COVID-19 vaccines impact menstrual cycles or future fertility. Those who are trying to become pregnant do not need to avoid pregnancy after COVID-19 vaccination. There is no recommendation for routine pregnancy testing before receipt of a COVID-19 vaccine. For more information, please visit Myths and Facts about COVID-19 Vaccines.

Can people with a prior or current SARS-CoV-2 infection be vaccinated? What if they received passive antibody therapy for COVID-19 treatment? +

Recommendations for vaccination depend on when a person has or had SARS-CoV-2 infection and when they received treatment.

People with a history of infection: Offer vaccination regardless of history of prior symptomatic or asymptomatic SARS-CoV-2 infection, including to people with prolonged post-COVID-19 symptoms.

While there is no recommended minimum interval between infection and vaccination, current evidence suggests that the risk of SARS-CoV-2 reinfection is low in the months after initial infection but may increase with time due to waning immunity.

People with a history of multisystem inflammatory syndrome in children (MIS-C) or adults (MIS-A): These people may choose to be vaccinated but should consider delaying vaccination until they have recovered from their illness and for 90 days after the date of diagnosis. Considerations for vaccination may include:

- Clinical recovery from MIS-C or MIS-A, including return to normal cardiac function
- Personal risk of severe acute COVID-19 (e.g., age, underlying conditions)
- Level of COVID-19 community transmission and personal risk of reinfection
- Lack of safety data of COVID-19 vaccines following these illnesses
- Timing of any immunomodulatory therapies

People with a current infection: Defer vaccination of people with known current SARS-CoV-2 infection until the person has recovered from acute illness (if the person has symptoms) and until criteria have been met for them to discontinue isolation. This recommendation applies to any vaccine, including the first and second doses of COVID-19 vaccine.

People who previously received passive antibody therapy as part of COVID-19 treatment: Defer vaccination for at least 90 days after receipt of passive antibody therapy (monoclonal antibodies or convalescent plasma). This recommendation applies to people who receive passive antibody therapy before receiving any COVID-19 vaccine dose and to those who

receive passive antibody therapy after the first dose of an mRNA COVID-19 vaccine but before the second dose, in which case the second dose should be deferred for at least 90 days following receipt of the antibody therapy.

My patient is receiving intravenous immunoglobulin. Do they have to wait 90 days before receiving COVID-19 vaccine? +

No, your patient may be vaccinated. Although people who have received passive antibody therapy as treatment for COVID-19 should wait at least 90 days before vaccination, there is **no minimum interval** between antibody therapies not specific to COVID-19 treatment and COVID-19 vaccination.

My patient has shingles. Can they receive COVID-19 vaccine? +

As with other vaccines, a moderate or severe illness is a precaution to receiving any currently authorized COVID-19 vaccine. It is not considered a contraindication. Generally, vaccination should be delayed until the acute illness has improved. However, if you and your patient feel the potential benefits of vaccination outweigh the potential risks, they may receive COVID-19 vaccine.

The following considerations can be used to help the provider conduct a risk assessment for COVID-19 vaccination:

- Risk of exposure to SARS-CoV-2 (e.g., living in a congregate setting, such as a long-term care facility; occupation)
- Risk of severe disease or death due to COVID-19 (e.g., because of age or underlying medical conditions)
- Whether the patient has previously been infected with SARS-CoV-2 and, if so, how long ago
    - Note: Vaccination is recommended for people with a history of COVID-19. However, because the risk of reinfection is low in the months after initial infection, people with a precaution to vaccination and recent COVID-19 may choose to delay vaccination.

Vaccine Storage and Handling

What type of temperature monitoring device (TMD) should be used to monitor storage unit temperatures? +

CDC requires vaccination providers participating in the COVID-19 Vaccination Program to use a specific type of TMD called a "digital data logger" (DDL) to monitor temperatures. A DDL provides the most accurate storage unit temperature information, including details on how long a unit has been operating outside the recommended temperature range (referred to as a "temperature excursion"). DDLs using a buffered temperature probe provide the most accurate way to measure actual vaccine temperatures. Always use DDLs with a current and valid Certificate of Calibration Testing.

Note that not all DDLs can measure ultra-cold temperatures. For accurate ultra-cold temperature monitoring, it is essential to use an air-probe or a probe designed specifically for ultra-cold temperatures with the DDL.

For the Pfizer-BioNTech COVID-19 vaccine, there are additional considerations for using a TMD with the thermal shipping container. Refer to the Pfizer-BioNTech COVID-19 Vaccine Storage and Handling Summary and Pfizer-BioNTech COVID-19 Vaccine web page for more information.

Whom can I contact about a problem with COVID-19 vaccine (e.g., temperature excursion, damaged vaccine)? +

If the vaccine experienced problems during shipment (for example, damage or temperature excursion), contact:

- Directly distributed vaccine (Pfizer): Contact Pfizer at 800-666-7248 (option 8) or CVGovernment@Pfizer.com.
- Centrally distributed vaccine (for example, Moderna): Contact McKesson Specialty Customer Service at (833) 343-2703, Monday–Friday, 8 AM–8 PM Eastern Time.

If the vaccine experienced problems after it was received and placed into storage, contact the vaccine manufacturer for guidance on improper storage and handling.

For temperature excursions (out-of-range temperatures), take immediate action:

- Label the vaccine "Do Not Use" and store at the recommended temperature range until you receive manufacturer guidance.
- Document the date and length of time of the excursion, storage unit temperature, room temperature, and inventory affected.
- Record any other relevant information.
- Contact the manufacturer for guidance on whether to use affected vaccines and whether patients need to be recalled for revaccination.
- Document the event and action taken for record-keeping requirements.

Vaccine Administration

What is the proper route and site for vaccine administration?

Intramuscular injection is the recommended route for all COVID-19 vaccines.

The recommended site to administer an intramuscular injection to adolescents and adults is the deltoid muscle. When coadministering vaccines, more than one vaccine may be injected into the deltoid muscle. Separate injection sites by 1 inch. If administering COVID-19 vaccine with vaccines that tend to be locally reactogenic (e.g., tetanus-toxoid–containing vaccines, vaccines with adjuvants), administer vaccine in separate limbs, if feasible. You may use the vastus lateralis muscle of the anterolateral thigh as an alternate site. Refer to the following job aids for identifying administration sites:

- Vaccine Administration: Intramuscular (IM) Injection Adults 19 years of age and older
- Vaccine Administration: Intramuscular (IM) Injection Children 7 through 18 years of age
- HCP Vaccine Administration Resource Library (includes demonstration videos for intramuscular injections)
- ACIP Vaccine Administration Guidelines for Immunization

We don't want to waste vaccine and can get more doses if we combine vaccine from multiple vials. Is it acceptable to combine or "pool" vaccine from more than one vial?

No. CDC recommends following these practices:

- **Never** combine or "pool" partial doses from two or more vials to obtain one or more doses of vaccine.
- Withdraw only the number of doses authorized for the specific vaccine.
- Discard the vaccine vial and remaining vaccine if the amount of vaccine left in the vial is not a full dose.

Although no one wants to waste vaccine, it is crucial for infection control and patient safety to administer vaccine properly. Combining vaccine doses from multiple vials can result in cross-contamination, potentially causing bacterial infection in patients.

I have a patient seeking vaccination at the end of the clinic day, but I would have to puncture a new vaccine vial. I am concerned I will have to waste doses of vaccine. Should I ask the person to return another time for vaccination?

No. While it is important to try to use every dose of vaccine possible, that should not be at the expense of missing an opportunity to vaccinate every eligible person when they are ready to get vaccinated. Strategies to ensure providers do not miss an opportunity to vaccinate every eligible persons and limit wastage can be found here: Identification, Disposal, and Reporting of COVID-19 Vaccine Wastage .

My patient does not want an injection in either deltoid muscle because of a previous double mastectomy and increased risk of lymphedema. Is there an alternate site for intramuscular injection?

The deltoid muscle of the arm is the preferred site for intramuscular injection . If the deltoid muscle cannot be used or accessed, the vastus lateralis muscle of the anterolateral thigh can be used.

Should I use the Z-track method to administer vaccine intramuscularly?

No. The Z-track injection technique is more commonly used for irritating medication (e.g., iron preparation). It is not recommended for vaccine administration. CDC recommends expelling the air when drawing vaccine from a vial into a regular syringe because the amount of air drawn into the syringe may be larger than the amount in a manufacturer-filled syringe. Expelling the air is part of general medication guidelines for drawing medication into a syringe. To avoid loss of vaccine, leave the needle in the vial while expelling air.

What needle length and gauge should I use?

Needle gauge and length recommendations vary for adolescents based on age, and for adults based on age, gender, and weight. Use CDC's Vaccine Administration: Needle Gauge and Length job aid to help you determine the appropriate gauge and length. A discussion of vaccine administration best practices can be found in the "Vaccine Administration" chapter of *Epidemiology and Prevention of Vaccine-Preventable Diseases* (Pink Book).

Why are needles for vaccine administration in the ancillary supply kit different lengths? Why aren't they all 1-inch needles?

COVID-19 vaccines are administered by intramuscular injection. For all intramuscular injections, the needle should be long enough to reach the muscle mass and prevent vaccine from seeping into subcutaneous tissue. Ensuring the vaccine is given in the muscle is important to optimize immunogenicity and minimize adverse reactions at the injection site. If vaccine is given subcutaneously with the incorrect needle length, patients may experience more pain, irritation, and redness at the injection site.

Needle gauge and length recommendations vary for adolescents based on age, and for adults based on age, gender, and weight. CDC's needle gauge and length chart , included in the ancillary kits, outlines ACIP's recommendations for needle length. Other vaccine administration and injection resources can be found in CDC's Vaccine Administration Resource Library.

Do I have to aspirate before giving COVID-19 vaccine?

No. You should not aspirate before giving any vaccine, including COVID-19 vaccines. Aspiration can increase pain because of the combined effects of a longer needle-dwelling time in the tissues and shearing action (wiggling) of the needle. A discussion of vaccine administration best practices can be found in the "Vaccine Administration" chapter of *Epidemiology and Prevention of Vaccine-Preventable Diseases* (Pink Book).

Is it acceptable to use a spike (sometimes called a dispensing pen) or leave a needle inserted in the septum of the vial to withdraw multiple doses of vaccine?

No. These devices or a needle should not be left inserted into a medication vial septum for multiple uses. This provides a direct route for microorganisms to enter the vial and contaminate the fluid in these devices. Additional injection safety information can be found here: Information for Providers | Injection Safety | CDC.

Is there general guidance for what we should do when vaccine administration errors occur?

Interim recommendations for COVID-19 vaccine administration errors differ from ACIP's general best practice guidelines. Review vaccine administration errors and deviations for COVID-19 vaccines to learn about the interim recommendation for each type of error.

For all vaccine administration errors:

- Inform the recipient of the vaccine administration error.
- Consult with the state immunization program or immunization information system (IIS) to determine how the dose should be entered into the IIS, both as an administered dose and to account for inventory.

- Report the error to the Vaccine Adverse Event Reporting System (VAERS) unless otherwise indicated in the Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States. Providers are required to report all COVID-19 vaccine administration errors—even those not associated with an adverse event—to VAERS .
- Determine how the error occurred and implement strategies to prevent it from happening again. A discussion on strategies to prevent errors can be found in the "Vaccine Administration" chapter of *Epidemiology and Prevention of Vaccine-Preventable Diseases* (Pink Book). Additional resources can be found on CDC's vaccine administration web page, including a job aid for preventing errors.

How do I dispose of COVID-19 vaccine vials and packaging? +

To reduce the risk of fake or counterfeit vaccines, dispose of vials and packaging as medical waste by placing vials in a sharps container and packaging in a red medical waste bag. If medical waste containers are in short supply, deface or safely crush packaging materials so they cannot be reintroduced or reproduced. After the products are sufficiently defaced or destroyed, dispose with regular waste.

The disposal process for unused COVID-19 vaccine and diluent may be different. For guidance, contact your jurisdiction's immunization program. If advised to dispose of the vaccine, properly dispose of the vaccine as biohazard waste. Never return unused or expired vaccines with the shipping containers back to the manufacturer. Additionally, promptly report any expired or unused vaccine. This helps CDC accurately monitor the amount of vaccine in the field. Keep in mind that there are no negative consequences for reporting waste, and it will not negatively impact future allocations. CDC recognizes that unused expired vaccine is a normal part of any vaccination program, especially one of this scope and size.

Vaccination Documentation

What are the documentation and reporting requirements for COVID-19 vaccination? +

Vaccination providers enrolled in the COVID-19 Vaccination Program are required to:

- Document vaccine administration in their medical record systems within 24 hours of administration.
- Report administration data to the relevant system (i.e., IIS) for the jurisdiction as soon as practicable and no later than 72 hours after administration. See data reporting requirements.
- Report inventory daily using Vaccines.gov. In some jurisdictions, providers may report vaccine inventory to the jurisdiction's IIS for the jurisdiction to upload into Vaccines.gov. If you have questions about the process for your jurisdiction, please contact your jurisdiction's immunization program.
- Report the following to VAERS :
  - Vaccine administration errors
  - Serious adverse events
  - Multisystem inflammatory syndrome
  - Cases of COVID-19 that result in hospitalization or death after the recipient has received COVID-19 vaccine

There are additional requirements for COVID-19 vaccination providers besides documentation (e.g., providing the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers to vaccine recipients). Please refer to your COVID-19 vaccination provider agreement for all provider requirements.

I have patients who have been partially or fully vaccinated with a COVID-19 vaccine that is not authorized in the United States. Are these vaccinations valid? +

Some people may have received a COVID-19 vaccine outside of the United States. Consider the following for these patients:

- People who received an FDA-authorized COVID-19 vaccine and have received all the recommended doses **do not need** any additional doses. People who received the first dose of an FDA-authorized COVID-19 vaccine that requires two doses do not need to restart the vaccine series in the United States but should receive the second dose as close to the recommended time as possible.

- People who have received all recommended doses of a COVID-19 vaccine listed for emergency use by the World Health Organization (WHO) **do not need** any additional doses with an FDA-authorized COVID-19 vaccine. See Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States for a list of WHO vaccines listed for emergency use.
- People who have not received all the recommended doses of a COVID-19 vaccine listed for emergency use by WHO may be offered a complete FDA-authorized COVID-19 vaccine series. Wait at least 28 days after the last dose of the non-FDA-authorized vaccine before administering an FDA-authorized COVID-19 vaccine.

People who received all or some of the recommended doses of a COVID-19 vaccine not listed for emergency use by WHO and not authorized by FDA may be offered a complete FDA-authorized COVID-19 vaccine series. Wait at least 28 days

Is there a vaccine information statement (VIS) for COVID-19 vaccine? +

No. VISs are only available for certain licensed vaccines. Under an EUA, there is not a VIS for an authorized vaccine. Instead, providers are legally required to provide the FDA-authorized EUA Fact Sheet for Recipients and Caregivers to vaccine recipients or their guardians. The Fact Sheet for Recipients and Caregivers includes:

- Basic information on COVID-19, symptoms, and what to discuss with a healthcare provider before vaccination
- Who should and should not receive the vaccine
- A statement that recipients have the choice to receive the vaccine
- Vaccine series information
- Potential and known risks and benefits of the vaccine, including common side effects
- Information on reporting side effects to VAERS
- An explanation of what an EUA is and why it is issued
- Any approved available alternatives for preventing COVID-19
- Additional resources

Am I required to document that the EUA Fact Sheet for Recipients and Caregivers was provided to the recipient or their caregiver? +

Although you are required to provide the vaccine-specific Fact Sheet for Recipients and Caregivers to vaccine recipients or their caregivers, you are not required to document that you did so. However, to help facilitate such documentation in electronic medical records/immunization information systems for vaccination providers who choose to do so, CDC is leveraging the existing vaccine information statement (VIS) Code Set infrastructure, barcoding, and URLs to provide the information needed for various systems. This is similar to the electronic system and workflow documentation of the VIS. The barcode at the bottom of the last page of the EUA Fact Sheet for Recipients and Caregivers may be scanned to capture in electronic medical records/immunization information systems that the fact sheet was provided to the vaccine recipient or caregiver.

We understand written, dated records may be required for proof of COVID-19 vaccination by different public and private sector entities. Where can these be found for patients who misplaced or lost their COVID-19 vaccination record card? +

COVID-19 vaccine providers are required by law to report vaccination to a state IIS. Providers or patients can contact the appropriate immunization information system (IIS) to obtain documentation. Contact the appropriate state or local IIS or immunization program for information on obtaining vaccination record information.

Please note CDC does not have vaccination record information for individuals.

Vaccine Safety and Efficacy

Where should I report adverse events that occur after COVID-19 vaccination? +

Adverse events that occur in a recipient following COVID-19 vaccination should be reported to the Vaccine Adverse Event

Adverse events that occur in a recipient following COVID-19 vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS). Vaccination providers are required by the FDA to report:

- Vaccine administration errors
- Serious adverse events
- Cases of multisystem inflammatory syndrome
- Cases of COVID-19 that result in hospitalization or death following COVID-19 vaccination under an EUA

Reporting is encouraged for any other clinically significant adverse event, even if it is uncertain whether the vaccine caused the event. Also, vaccine recipients can report adverse events that occur after vaccination. Information on how to submit a report to VAERS is available at https://vaers.hhs.gov or by calling 1-800-822-7967. For more information on VAERS, please refer to the VAERS FAQs.

Am I required to report vaccine administration errors to VAERS? I thought it was optional to report these errors. +

The VAERS reporting requirements for COVID-19 vaccines (under Emergency Use Authorization) are different from those for routine vaccines licensed in the United States. Healthcare providers are strongly encouraged to report vaccine administration errors involving any licensed vaccine. However, healthcare providers are **required** to report COVID-19 vaccine administration errors to VAERS.

What side effects might occur following vaccination? +

Before vaccination, counsel patients about expected local and systemic side effects.

Common side effects include:

Local reactions:

- Pain
- Redness
- Swelling

Systemic reactions:

- Tiredness
- Headache
- Muscle pain
- Chills
- Fever
- Nausea

If receiving Janssen COVID-19 Vaccine, women younger than 50 years old should be made aware of the rare but increased risk of blood clots with low platelets following vaccination and the availability of other COVID-19 vaccines where this risk has not been observed. Provide recipients or caregivers (as applicable) the EUA Fact Sheet for Recipients and Caregivers.

Can a person who has received COVID-19 vaccine still spread COVID-19? +

Recent studies show that the mRNA vaccines (Pfizer-BioNTech, Moderna) help keep people from spreading the virus that causes COVID-19, and studies are underway to learn more about the benefits of Johnson & Johnson's Janssen vaccine. Guidance for fully vaccinated people is available and will continue to be updated as more information becomes available.

What actions can I take to minimize exposure to COVID-19? +

The potential for asymptomatic transmission of the virus that causes COVID-19 underscores the importance of applying infection prevention practices to encounters with all patients while in a healthcare facility. These include physical distancing, respiratory and hand hygiene, surface decontamination, and source control. Vaccination providers should

distancing, respiratory and hand hygiene, surface decontamination, and source control. Vaccination providers should refer to the guidance developed to prevent the spread of COVID-19 in healthcare settings, including outpatient and ambulatory care settings.

General practices for the safe delivery of vaccination services is available in the Interim Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic.

Off-Site Clinics

Can I predraw vaccine?

CDC does not recommend predrawing vaccine. If vaccine must be predrawn:

- Set up a separate administration station for each vaccine type to prevent medication errors.
- Draw up vaccines only after arriving at the clinic site or mass vaccination event.
- Each person administering vaccines should draw up no more than one multidose vial or 10 doses* at one time.
- Monitor patient flow to avoid drawing up unnecessary doses.
- Predraw reconstituted vaccine into a syringe only when ready for administration.
- If predrawn vaccine is not used within 30 minutes of being reconstituted, follow manufacturer guidance for storage conditions and time limits.

*You may withdraw a total of 12 doses (2 multidose vials) of Pfizer-BioNTech COVID-19 Vaccine. This applies only to Pfizer-BioNTech COVID-19 Vaccine.

See CDC's *Vaccine Storage and Handling Toolkit* for more information.

Can I transport vaccine in a syringe?

CDC recommends transporting vaccine in vials. However, there may be instances when the only option is to transport predrawn vaccine in a syringe. U.S. Pharmacopeia includes guidance for transporting predrawn vaccine in syringes in the USP COVID-19 Vaccine Toolkit: Operational Considerations for Healthcare Practitioners.

Off-Label Use

Can I offer my patients who do not have certain kinds of immunocompromise their booster early?

No. Off label use of the COMIRNATY/Pfizer-BioNTech COVID-19 Vaccine is not authorized at this time. The Administration is preparing systems and logistics to be able to offer COVID-19 booster shots to fully vaccinated adults this fall. The regulatory and clinical details of this booster plan are contingent on FDA conducting an independent evaluation and determination of the safety and effectiveness of a third dose of the mRNA vaccines (Pfizer and Moderna) and CDC's Advisory Committee on Immunization Practices (ACIP) issuing recommendations based on a thorough review of the evidence when those recommendations are adopted by the CDC Director.

An additional dose for individuals beyond those with certain conditions associated with immunocompromise would be an off-label use at this time. Administration of the product off label may not be covered under the PREP Act or the PREP Act declaration; therefore, providers may not have immunity from claims. Individuals who receive a third dose may not be eligible for compensation after a possible adverse event. Such use also would be in violation of the CDC COVID-19 Vaccination Program provider agreement and therefore may not be reimbursable, and may impact the ability of a provider to remain in the CDC Program, in addition to other potential sanctions. Administration fees for off-label doses may not be reimbursed by payers.

Can I offer the vaccine to patients under 12 as part of off-label use?

No. At this time, clinical trials in this age group are still ongoing and no product has been authorized or approved for this age group yet. Children under age 12 likely will require a different dose of the vaccine than older individuals, and the safety and effectiveness of Pfizer-BioNTech's product COMIRNATY (COVID 19 Vaccine, mRNA) in children under 12 remains yet to be determined. Pfizer has stated publicly that it plans to submit a request to amend the EUA to include children 5 through 11 years of age by the end of September, following the completion of their clinical trial.

Further, any off-label use of the COMIRNATY/Pfizer-BioNTech COVID-19 Vaccine, including administration of the vaccine in children under 12, is not authorized at this time.
Administration of the off-label product may not be covered under the PREP Act or the PREP Act declaration; therefore, providers may not have immunity from claims. Individuals who receive a third dose may not be eligible for compensation after a possible adverse event. Such use would be in violation of the CDC COVID-19 Vaccination Program provider agreement and therefore may not be reimbursable, and may impact the ability of a provider to remain in the CDC Program, in addition to other potential sanctions. Administration fees for off-label doses may not be reimbursed by payers.

Because the Pfizer vaccine is now approved by FDA, does it change how I administer it? +

No. Vaccine providers should continue to administer all COVID-19 vaccines in accordance with the current BLA/EUAs and the CDC COVID-19 Vaccination Program provider agreement. The FDA-approved Pfizer-BioNTech product COMIRNATY (COVID-19 Vaccine, mRNA) and the FDA-authorized Pfizer-BioNTech COVID-19 Vaccine under EUA have the same formulation and can be used interchangeably to provide the COVID-19 vaccination series without presenting any safety or effectiveness concerns. Providers should continue to use the vaccine on their shelves that was provided under EUA.

Other

I have further questions about whether my patient can receive a COVID-19 vaccine. Who can I contact at CDC for assistance with specific questions related to vaccination decision making for patients with complex medical histories?
Please contact CDC-INFO for further questions on COVID-19 vaccines.

Other questions

Vaccine Administration Management System (VAMS)

Preparing for COVID-19 vaccination at long-term care facilities

Federal Retail Pharmacy Partnership Program

V-safe after vaccination health checker

Page last reviewed: August 26, 2021

FW: Governor DeWine Issues Statement on Pfizer/Comirnaty COVID-19 Vaccine Booster Doses

Jack Pepper <jpepper@athenspublichealth.org>

Fri 9/24/2021 9:46 AM

To: **all users <allusers@athenspublichealth.org>**

From: local.support@odh.ohio.gov <local.support@odh.ohio.gov>
Sent: Friday, September 24, 2021 9:45 AM
Subject: Governor DeWine Issues Statement on Pfizer/Comirnaty COVID-19 Vaccine Booster Doses

Dear Local Partners—

Please see the news release from last night. Thank you for your partnership.

Ohio | Department of Health

News Release

www.odh.ohio.gov

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

FOR IMMEDIATE RELEASE **Sept. 23, 2021**
Contact: ODH Office of Communications 614-644-8562

Governor DeWine Issues Statement on Pfizer/Comirnaty COVID-19 Vaccine Booster Doses

Following CDC Action, Booster Doses to be Available in Ohio

COLUMBUS – Ohio Governor Mike DeWine and the Ohio Department of Health have announced that eligible Ohioans will be able to receive a booster dose of the Pfizer/Comirnaty COVID-19 vaccine as soon as practical, following final action by the Centers for Disease Control and Prevention (CDC).

Last night, the U.S. Food and Drug Administration (FDA) amended the emergency use authorization (EUA) for the Pfizer COVID-19 vaccine to allow for use of a single booster dose, to be administered at least six months after completion of the primary series to specific groups. Today, the CDC's Advisory Committee on Immunization Practices (ACIP) further refined that recommendation.

"We have been closely following the discussions and developments on COVID-19 vaccine booster doses. The experts have stressed that those at risk for the most severe outcomes from COVID-19 should be eligible for booster doses of the Pfizer COVID-19 vaccine," said Governor DeWine. "Ohioans should rest assured that they will be able get their booster dose. As we have said since the beginning of the pandemic, our goal is to save lives. In alignment with federal partners, prioritization of specific high-risk groups will allow us to continue to save lives as we work toward getting the COVID-19 pandemic under control."

"We have been diligently working with our vaccine providers to ensure that there are abundant opportunities to receive COVID-19 vaccine boosters in Ohio," explained Ohio Department of Health Director

Dr. Bruce Vanderhoff. “There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Following final action by the CDC, Ohio’s many providers will be able to begin administering booster doses of the Pfizer vaccine in pharmacies, federally qualified health centers, doctor’s offices, community vaccination sites, and local health departments.”

At this time, the Ohio Department of Health is awaiting final action of the CDC, including the release of a Morbidity and Mortality Weekly Report (MMWR) with detailed guidance. Once the CDC issues final approval of the recommendation, Ohio’s more than 3,500 enrolled COVID-19 vaccine providers can begin to offer boosters to eligible Ohioans.

After all necessary approvals are received, Ohioans will be able to check gettheshot.coronavirus.ohio.gov or call 1-833-427-5634 for the latest eligibility information and to find a vaccine provider near them. Eligible booster recipients will be asked to attest they have one of the qualifying conditions, but specific proof will not be required. Eligible Ohioans should allow 2-3 weeks to get their booster dose, with many opportunities to be vaccinated in their local community, whether they walk in to get their third dose or make an appointment with a nearby provider.

COVID-19 vaccines are widely available throughout the state. Many providers offer walk-in appointments, or Ohioans can schedule a vaccination appointment at gettheshot.coronavirus.ohio.gov. Ohioans who want to learn more about the safety, efficacy, and side effects of COVID-19 vaccines should talk to their doctor, nurse, or pharmacist, or visit coronavirus.ohio.gov/vaccine to learn more.

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About the Ohio Department of Health

The Ohio Department of Health’s mission is advancing the health and well-being of all Ohioans by transforming the state’s public health system through unique partnerships and funding streams; addressing the community conditions and inequities that lead to disparities in health outcomes; and implementing data-driven, evidence-based solutions.

Office of Performance and Innovation

Local Support Services
Ohio Department of Health
246 North High Street
Columbus, Ohio 43215
www.odh.ohio.gov

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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Ohio | Department of Health

News Release

www.odh.ohio.gov

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

FOR IMMEDIATE RELEASE **Sept. 23, 2021**

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"We have been closely following the discussions and developments on COVID-19 vaccine booster doses. The experts have stressed that those at risk for the most severe outcomes from COVID-19 should be eligible for booster doses of the Pfizer COVID-19 vaccine," said Governor DeWine. "Ohioans should rest assured that they will be able get their booster dose. As we have said since the beginning of the pandemic, our goal is to save lives. In alignment with federal partners, prioritization of specific high-risk groups will allow us to continue to save lives as we work toward getting the COVID-19 pandemic under control."

"We have been diligently working with our vaccine providers to ensure that there are abundant opportunities to receive COVID-19 vaccine boosters in Ohio," explained Ohio Department of Health Director Dr. Bruce Vanderhoff. "There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Following final action by the CDC, Ohio's many providers will be able to begin administering booster doses of the Pfizer vaccine in pharmacies, federally qualified health centers, doctor's offices, community vaccination sites, and local health departments."

At this time, the Ohio Department of Health is awaiting final action of the CDC, including the release of a Morbidity and Mortality Weekly Report (MMWR) with detailed guidance. Once the CDC issues final approval of the recommendation, Ohio's more than 3,500 enrolled COVID-19 vaccine providers can begin to offer boosters to eligible Ohioans.

After all necessary approvals are received, Ohioans will be able to check gettheshot.coronavirus.ohio.gov or call 1-833-427-5634 for the latest eligibility information and to find a vaccine provider near them. Eligible booster recipients will be asked to attest they have one of the qualifying conditions, but specific proof will not be required. Eligible Ohioans should allow 2-3 weeks to get their booster dose, with many opportunities to be vaccinated in their local community, whether they walk in to get their third dose or make an appointment with a nearby provider.

COVID-19 vaccines are widely available throughout the state. Many providers offer walk-in appointments, or Ohioans can schedule a vaccination appointment at gettheshot.coronavirus.ohio.gov. Ohioans who want to learn more about the safety, efficacy, and side effects of COVID-19 vaccines should talk to their doctor, nurse, or pharmacist, or visit coronavirus.ohio.gov/vaccine to learn more.

XXX

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FW: Ohio Department of Health Releases Guidance on COVID-19 Vaccine Booster Doses

Jack Pepper <jpepper@athenspublichealth.org>

Mon 9/27/2021 7:00 AM

To: **all users <allusers@athenspublichealth.org>**

From: local.support@odh.ohio.gov <local.support@odh.ohio.gov>
Sent: Saturday, September 25, 2021 4:23 PM
Subject: Ohio Department of Health Releases Guidance on COVID-19 Vaccine Booster Doses

Dear Local Partners—

Please see the attached documents for booster guidance and a media advisory. Thank you for your continued partnership.

Ohio | Department of Health

Media Advisory

www.odh.ohio.gov

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

FOR IMMEDIATE RELEASE **Sept. 25, 2021**
Contact: Office of Communications (614) 644-8562

Ohio Department of Health Releases Guidance on COVID-19 Vaccine Booster Doses

COLUMBUS – The Ohio Department of Health has issued guidance to the more than 3,500 COVID-19 vaccine providers statewide to ensure they have access to the latest information on administering booster doses of the Pfizer/Comirnaty COVID-19 vaccines. In addition, Ohioans can get information about the booster doses from the following recently released resources:

- Fact Sheet COVID-19 Vaccine Booster Doses
- Frequently Asked Questions COVID-19 Vaccine Booster Doses

In alignment with the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA), booster doses of the Pfizer/Comirnaty COVID-19 vaccine are now available for the following populations at least six months after completion of the primary Pfizer series, meaning at least six months after the second dose was administered:

- **People 65 years and older or residents in long-term care settings SHOULD** receive a booster shot.
- **People ages 50 to 64 with certain underlying medical conditions SHOULD** receive a booster shot.
- **People ages 18 to 49 with certain underlying medical conditions MAY** receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient, but those eligible are encouraged to talk to their healthcare providers if they have any questions.
- **People age 18 and older who are at increased risk for COVID-19 exposure and transmission because of their job or living in an institutional setting MAY** receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient.

There are many opportunities in Ohio to be vaccinated, including walk-in and scheduled appointments statewide at pharmacies, federally qualified health centers, doctor's offices, community vaccination sites, and local health

departments. There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Ohioans will be able to check gettheshot.coronavirus.ohio.gov or call 1-833-427-5634 for the latest eligibility information and to find a vaccine provider near them.

Eligible booster recipients will be asked to attest they have one of the qualifying conditions, but specific proof will not be required. Eligible Ohioans should allow 2-3 weeks to get their booster dose, with many opportunities to be vaccinated in their local community.

COVID-19 vaccines are widely available throughout the state. Many providers offer walk-in appointments, or Ohioans can schedule a vaccination appointment at gettheshot.coronavirus.ohio.gov. Ohioans who want to learn more about the safety, efficacy, and side effects of COVID-19 vaccines should talk to their doctor, nurse, or pharmacist, or visit coronavirus.ohio.gov/vaccine to learn more.

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Office of Performance and Innovation

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Ohio | Department of Health

Media Advisory

www.odh.ohio.gov

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

FOR IMMEDIATE RELEASE **Sept. 25, 2021**

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There are many opportunities in Ohio to be vaccinated, including walk-in and scheduled appointments statewide at pharmacies, federally qualified health centers, doctor's offices, community vaccination sites, and local health departments. There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Ohioans will be able to check gettheshot.coronavirus.ohio.gov or call 1-833-427-5634 for the latest eligibility information and to find a vaccine provider near them.

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COVID-19 Vaccine Program
Guidance for Vaccine Providers for Administering Booster Doses

COVID-19 vaccine booster doses have been authorized for certain recipients of the Pfizer-BioNTech/Comirnaty vaccine to prevent serious outcomes from COVID-19 illness. Eligibility for booster doses is currently limited to individuals at the highest risk for severe COVID-19 based upon their age, certain underlying medical conditions, or occupational/institutional settings as outlined below. A booster dose is recommended at least six months following completion of the original Pfizer-BioNTech/Comirnaty vaccine series.

Following required actions by the U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC), Ohio's more than 3,500 enrolled COVID-19 vaccine providers can begin administering booster doses to eligible individuals as outlined below. It is important to note that the FDA will review data and determine if and when booster doses are needed by vaccine product. Right now, recipients of the Moderna and Johnson & Johnson (Janssen) vaccines do not need booster doses, but evaluation of safety, effectiveness, and immunity will continue and recommendations will be updated as needed.

As booster dose administration begins, it's important to note the top priority for vaccine providers should be continued vaccination of unvaccinated individuals to protect against serious illness, hospitalization and death from COVID-19.

Booster doses can be given immediately. It is important to note that the CDC is expected to share additional guidance and resources for providers on booster dose administration in its Interim Clinical Considerations for Use of the COVID-19 Vaccines, and its Morbidity and Mortality Weekly Report (MMWR).

PROOF OF ELIGIBILITY

BOOSTER DOSE ELIGIBILITY REQUIREMENTS

A single booster dose for the **Pfizer-BioNTech/Comirnaty COVID-19 vaccine** can be given to the following populations at least six months or more after completion of the primary vaccine series:

- **People 65 years and older or residents in long-term care settings SHOULD** receive a booster shot.
- **People ages 50 to 64 with certain underlying medical conditions SHOULD** receive a booster shot.
- **People ages 18 to 49 with certain underlying medical conditions MAY** receive a booster shot based on their individual benefits and risks.
- **People age 18 and older who are at increased risk for COVID-19 exposure and transmission because of their job or living in an institutional setting MAY** receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination to be made by the vaccine recipient.

At this time, booster doses are authorized only for the Pfizer vaccine and the defined populations above. Eligibility criteria for Pfizer recipients could be expanded in the future following further evaluation.

View the CDC's list of applicable underlying medical conditions: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

IDENTIFICATION REQUIREMENTS

- Providers should ask to see identification that proves name, age, and identity.
    - Ask for identification to verify only the patient's identity, name, and age. Patients do not need to show proof of citizenship or residency status. Identification should still be accepted if it is expired or from another state or country.
    - Acceptable forms of identification are listed below:
        - Driver's license or any photo ID, regardless of expiration date or place of origin.
        - Active/retired military ID.
        - Physician statement (including shot records).
        - Census records.
        - Adoption records.
        - Naturalization certificate.
        - Birth certificate: Birth record, either original or certified copy.
        - Consulate ID or matricula consular.
        - Passport or a passport card.
        - Certificate of citizenship.
        - Permanent resident card.
        - Application for replacement naturalization/citizenship document.
        - Department of State forms.
            - Military service records (DD-214)
            - Certification of Birth Abroad of a Citizen of the United States (FS-545)
            - Certification of Report of Birth Abroad of a United States Citizen (DS-1350)
            - Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)
            - Employment Authorization Document (I-766/EAD)
            - Transportation letter (I-797F)

PROOF OF ELIGIBILITY

Eligible booster recipients will be asked to attest they meet one of the eligibility requirements, but specific proof will not be required. Individuals ages 18 to 49 with certain underlying medical conditions or who live/work in high-risk institutional or occupational settings are encouraged to discuss the benefits and risks of getting a booster dose with their healthcare providers.

VACCINE CARDS

Eligible Ohioans are encouraged to bring their COVID-19 vaccine card to their booster appointment. If they cannot find their vaccine card, they should first contact their original vaccine provider to see if their records can be located. If the original vaccine provider is unable to assist, they should contact their local health department. The final available option is to review this information on how to mail a request for your vaccination records to the Ohio Department of Health. Replacement vaccine cards are not available from the Ohio Department of Health. If a vaccine recipient does not have their original vaccine card, that should not be a barrier to prevent them from being vaccinated.

BOOSTER DOSE AVAILABILITY

Eligible Ohioans will have many opportunities to receive a booster dose, including at pharmacies, federally qualified health centers, doctor's offices, community vaccination sites, and local health departments. While it will be important for providers to administer booster doses to eligible Ohioans, there are still many Ohioans who have not yet received their first dose of vaccine. Please continue to prioritize vaccination for new vaccine recipients while administering booster doses.

VACCINE MANAGEMENT SOLUTION: GETTHESHOT.CORONAVIRUS.OHIO.GOV

Eligible Ohioans will be able to determine their eligibility for booster doses and, if determined to be eligible, schedule an appointment at gettheshot.coronavirus.ohio.gov. Providers may continue to offer walk-in availability as appropriate.

Providers can start programming appointment availability in VMS now. For those providers who are scheduling appointments and whose schedulers can accommodate, please open schedulers at least three weeks out for future appointments if possible.

65 AND OLDER, ELIGIBLE INDIVIDUALS WITH CERTAIN UNDERLYING MEDICAL CONDITIONS AND THOSE WHO LIVE OR WORK IN HIGH-RISK OCCUPATIONAL OR INSTITUTIONAL SETTINGS NOT LISTED SEPARATELY BELOW

Eligible Ohioans can find a provider and schedule an appointment online at gettheshot.coronavirus.ohio.gov or by calling 1-833-427-5634.

- Most retail and independent pharmacies will offer either walk-in or scheduled appointments.
- Local health departments in some of our largest cities will offer special community vaccination sites, and health departments in virtually every county are prepared to offer booster doses, including to homebound individuals.
- Community health centers and participating primary care providers will also offer booster doses.
- Affordable senior housing communities will work with local partners to host special vaccination opportunities for booster doses. Ohio will have ample supply of vaccine for boosters and for first and second doses. It may take 2-3 weeks, or more, for every eligible person who wants a booster to receive one.

LONG-TERM CARE FACILITIES

Participating long-term care facilities will offer doses of the Pfizer vaccine to residents through Ohio's COVID-19 Vaccine Maintenance Program, and state agencies and state-owned veterans homes will vaccinate eligible staff and residents.

DIRECT ORDERING

There will be no changes to the standard ordering process as a result of the start of booster dose administration. Vaccine providers should factor booster dose supply into current ordering cadences. All Ohio COVID-19 Vaccine Providers are responsible for placing vaccine orders through the ImpactSIIS Vaccine Ordering Management System (VOMS). VOMS is open for providers to place orders 24 hours a day, 7 days a week. Providers can order COVID-19 vaccine at their convenience. ODH is committed to getting COVID-19 vaccines to our providers as quickly as possible.

To ensure adequate inventory levels, providers should anticipate a window of 7 days from the date your order is entered into VOMS to the date the vaccine is delivered to your facility. Orders for products that are shipped directly from the manufacturer will be approved and processed Monday through Friday.

MINIMUM ORDER/SHIPPING QUANTITIES

- Minimum order quantity for direct shipment from the manufacturer is 1,170 doses, available in increments of 1,170 doses.
- The ODH Receipt, Store, and Stage (RSS) warehouse will break down Pfizer shipments into smaller sizes.
    - Minimum order quantity is 120 doses, available in increments of 120.
    - In rare cases, smaller increments of 30 doses are available for small providers such as pediatric practices or primary care providers with special approval.

COVID-19 orders processed through the ODH RSS Warehouse will be delivered Tuesdays, Thursdays, and Fridays. The Friday delivery option is only available to pharmacies. These products are available for distribution from the ODH RSS Warehouse:

- Federal holidays that occur on weekdays may interrupt the delivery schedule.

Ancillary kits – containing needles, syringes, alcohol pads, vaccination cards and surgical masks/face shields for vaccinators – are shipped separately.

VACCINE ADMINISTRATION

- **Timing of booster doses:** Booster doses can be administered 6 months or longer after completion of the primary series. Immunity wanes gradually over time, therefore a booster may be given at an interval greater than 6 months.
- **Coadministration:** Booster doses may be given with other vaccines without regard to timing. This includes simultaneous administration of COVID-19 and other vaccines on the same day. Best practices for administering more than one vaccine, including COVID-19 vaccines and influenza vaccines, include:
    - When preparing more than one vaccine, label each with the name and dosage (amount) of vaccine, lot number, the initials of the preparer, and the exact beyond-use time, if applicable.
    - Always inject vaccines into different injection sites.
    - Separate injection sites by 1 inch or more, if possible, so that any local reactions can be differentiated. Each muscle (deltoid, vastus lateralis) has multiple injection sites.
    - If administered at the same time, COVID-19 vaccines and vaccines that might be more likely to cause a local injection site reaction (for example, high-dose and adjuvanted inactivated influenza vaccines) should be administered in different arms (or legs), if possible.
- Data on the safety and efficacy of a mixed-product series are limited. Both doses of the primary series and any additional or booster doses should be completed with the same product.
- Contraindications and precautions for a booster dose are the same as for the primary series.
- For individuals who had myocarditis and myopericarditis, it is recommended to defer a subsequent dose until myocarditis and myopericarditis has completely resolved.

View the CDC's Interim Clinical Considerations for use of COVID-19 vaccines for more detailed guidance for vaccine providers.

DATA REPORTING

The Ohio Department of Health (ODH) is committed to releasing data to inform the public in the midst of the COVID-19 crisis while also protecting the privacy rights of Ohioans. ODH has developed several online data dashboards reflecting information from multiple sources, including vaccination data provided by all enrolled providers.

VACCINE ADMINISTRATION DATA

The COVID-19 Vaccination Dashboard at coronavirus.ohio.gov displays the most recent data reported to the Ohio Department of Health (ODH) regarding the number of individuals that have started and completed the COVID-19 vaccination series by various demographics and county of residence.

To ensure timely data reporting and sharing, all COVID-19 vaccine providers must report all vaccinations within 24 hours through the Ohio Impact Statewide Immunization Information System (ImpactSIIS). **This includes the reporting of booster doses.**

VACCINE ADMINISTRATION ERRORS AND ADVERSE EVENTS

As part of essential ongoing vaccine safety monitoring efforts, vaccine providers are required to report any adverse events, including vaccine administration errors, to the Vaccine Adverse Event Reporting System.

VAERS is the nation's early warning system that monitors the safety of vaccines after they are authorized or licensed for use by the U.S. Food and Drug Administration (FDA). VAERS is part of the larger vaccine safety system in the United States that helps make sure vaccines are safe. The system is co-managed by the Centers for Disease Control and Prevention (CDC) and FDA.

VAERS accepts and analyzes reports of possible health problems — also called "adverse events" — after vaccination. If VAERS detects a pattern of adverse events following vaccination, other vaccine safety monitoring systems conduct follow-up studies.

Visit VAERS for a complete listing of requirements and step-by-step instructions on how to submit a report.

MESSAGING

Primary care providers are asked to recommend booster doses to eligible patients to boost their immunity to help prevent severe outcomes from COVID-19, including hospitalization or death.

Please specify that eligibility, at this time, is only for individuals who received the Pfizer primary vaccine series.

KEY MESSAGES

- With the Delta variant surging and cases of COVID-19 increasing significantly, a booster dose will help provide continued protection against severe disease in these populations who are especially at risk for severe COVID-19. For example:
    - Because residents in long-term care (LTC) settings live closely together in group settings and are often older adults and/or have underlying medical conditions, they are at increased risk of infection and severe illness from COVID-19.
    - The risk of severe illness from COVID-19 increases with age, and can also increase for adults of any age with certain underlying medical conditions. This is why CDC recommends that individuals 50 to 64 with underlying medical conditions receive a Pfizer-BioNTech booster shot. Individuals 18-49 with underlying medical conditions may also receive a booster if they determine the personal benefits outweigh the risks.
    - And while COVID-19 vaccine effectiveness against severe disease remains high for healthcare personnel and other essential workers, those with even mild illness often cannot work. In addition, some individuals may care for or live with at-risk people, such as the immunocompromised, and others may live in a congregate setting such as a homeless shelter or correctional facility where there is higher risk for transmission. For these reasons – as well as continued strain on the U.S. healthcare infrastructure due to the widely circulating Delta variant – CDC recommends that adults at high risk of disease from occupational and institutional exposures to COVID-19 get the Pfizer booster based on their individual benefits and risks.
    - The COVID-19 vaccines approved and authorized in the United States continue to be effective in reducing risk of severe disease, hospitalization, and death, even against the widely circulating Delta variant.

PATIENT REMINDER MESSAGE TEMPLATE

COVID-19 boosters are now available for select Ohioans who completed the Pfizer vaccine series. Vaccine booster doses have been authorized for those 65+,those with underlying medical conditions, or those live or work in a setting that puts them at risk for exposure. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

[Provider name] is now offering #COVID19 booster doses to eligible Ohioans. If you received the Pfizer vaccine series and are either 65 or older, have underlying medical conditions, or live or work in a setting that puts you at risk for exposure, you can get a booster dose six months after you completed the series. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

SOCIAL MEDIA POSTS

We are now offering #COVID19 booster doses to eligible Ohioans. If you received the Pfizer vaccine series and are either 65 or older, or have underlying conditions, or live or work in a setting that puts you at risk for exposure, you can get a booster dose 6 months after your second dose. [Call to action, such as "Walk-in appointments available every day from 8 a.m. to 6 p.m." or "Call XXX-XXX-XXXX or visit www.ourwebsite.com to make an appointment."]

Did you get the Pfizer #COVID19 vaccine series? Ohioans age 65+, those with underlying conditions, or those live or work in a setting that puts them at risk for exposure, are now eligible for booster doses, six months following their second dose. Check eligibility and find a shot near you at https://gettheshot.coronavirus.ohio.gov, or call 1-833-427-5634.

EMAIL OR WEBSITE ARTICLE

The following groups of Ohioans who originally received the Pfizer COVID-19 vaccine series are now eligible to receive a single booster dose, to be administered at least six months after completion of the primary series in:

- People 65 years or older or residents in long-term care settings should receive a booster shot.
- People ages 50 to 64 with certain underlying medical conditions should receive a booster shot.
- People ages 18 to 49 with certain underlying medical conditions may receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient.
- People age 18 and older who are at increased risk for COVID-19 exposure and transmission because of their job or living in an institutional setting may receive a booster shot based on their individual benefits and risks. The CDC has indicated that this is a determination made by the vaccine recipient.

There is ample supply of vaccine for boosters, as well as first and second doses, for Ohioans. Vaccinations are available at [Provider name] either by making an appointment or by walking in [insert details including days of the week and start time and end time]. While you do not have to get your booster dose at the same location where you received your first and second doses, you are welcome to continue to visit [Provider name] for your COVID-19 vaccine needs. You are encouraged to bring your COVID-19 vaccine card, and if you cannot find your vaccine card, please review this fact sheet from the Ohio Department of Health for options to access to your vaccination records. In short, you should first contact your original vaccine provider to see if they can locate your records. If they are unable to assist, please contact your local health department. If they are unable to assist, please review this information on how to mail a request for your vaccination records to the Ohio Department of Health.

Eligible Ohioans should allow 2-3 weeks to get their booster dose, with many opportunities to be vaccinated in their local community, whether they walk in to get their third dose or make an appointment with a nearby provider.

Created Sept. 24, 2021.

For additional information, visit coronavirus.ohio.gov.

The Ohio Department of Health COVID-19 Provider website is a hub for a variety of resources for vaccine providers. Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

COVID VACCINE UPDATES

Jack Pepper <jpepper@athenspublichealth.org>

Wed 10/20/2021 10:33 AM

To: **all users <allusers@athenspublichealth.org>**

Good Morning All.

Putting this out there with the hopes of providing some clarification around vaccine planning and availability…

As of this morning the FDA has recommended approval of boosters for both Moderna and J&J, the ACIP is meeting tomorrow to discuss " COVID vaccines" which we are assuming are the two vaccine boosters as well as the possibility of co-mingling vaccine brands. It is plausible that a recommendation for those vaccines could come from the ACIP tomorrow which means that ODH will then issue their guidance documents within a day or two. The ODH guidance document is truly our green light to administer vaccine.

We have really heard nothing but speculation surrounding the 5-11 Pfizer vaccine. Yes the FDA has made their approval but it appears that the ACIP is moving just a little slower on their recommendation. ODH **is** frontloading the vaccine to local public health so that when the green light happens we can immediately began to offer. Everything we are currently hearing is that we should expect an approval to vaccinate around November 1, 2021. We are currently working with all of the superintendents to better understand the best way to deliver the vaccine to this age group; overwhelmingly they all want onsite clinics and we agree. As you all know many of the families in our county struggle with transportation and limiting access to only Heritage Hall does not fit with our equitable access to care for all philosophy. As we hear more for the superintendents we will identify dates to go to the elementary schools in the county to offer vaccine, I will be asking the superintendents tomorrow to send home information regarding the vaccine this week. If all goes as planned we should have a firm idea on possible dates and numbers by Wednesday of next week; all staff should be prepared to participate in the offsite clinics.

The only mass vax clinic that we have left on our schedule is this Friday, the 22nd with tentative dates on the 29th and possibly the 12th of November. We all are in agreement that it seems that our need for mass vaccination may once again be waning and we can comfortably move our operations back to the ACCHD.

Hopefully this provides at least a bit of clarity, I wish I could provide firm dates and times, but at this moment it is still very much a moving target. Thanks for all you do.

Jack

Fw: PIO Email: COVID-19 Boosters/"Mask to Stay" and "Mask to Play" Additional School Quarantine Options/Creating Health Equity in Ohio/New Flu Toolkit/Playlist of Previous Press Conferences/Training Opportunity on Addiction

Jack Pepper <jpepper@athenspublichealth.org>

Tue 10/26/2021 1:21 PM

To: **all users <allusers@athenspublichealth.org>**

FYI

From: local.support@odh.ohio.gov <local.support@odh.ohio.gov>
Sent: Tuesday, October 26, 2021 9:35 AM
Subject: PIO Email: COVID-19 Boosters/"Mask to Stay" and "Mask to Play" Additional School Quarantine Options/Creating Health Equity in Ohio/New Flu Toolkit/Playlist of Previous Press Conferences/Training Opportunity on Addiction

Good Morning Local Health Department Partners—

We hope that you had a wonderful weekend. Today's email has some important updates about: COVID-19 boosters, K-12 quarantine guidance, a new flu toolkit, and a training opportunity on addiction.

Creating Health Equity in Ohio, Tuesday, Oct. 26
Please be sure to join us for our next webinar, "Creating Health Equity in Ohio" during our regular PIO call time **today at 3:30 p.m.** Our speaker will be Jamie Carmichael, chief health opportunity officer at the Ohio Department of Health. Please see the attached for more details. The link to use will be our regular Microsoft Teams link, but it will be sent out to you again soon. We look forward to having you participate in this insightful presentation!

COVID-19 Boosters
Last week, the U.S. Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) announced they have authorized a single booster dose for the three COVID-19 vaccines available in the United States (Pfizer/Comirnaty, Moderna, and Johnson & Johnson/Janssen) to increase protection against COVID-19. Guidance from ODH was sent to vaccine providers. Please reference and share this guidance: https://coronavirus.ohio.gov/static/vaccine/guidance-vaccine-providers-admin-booster-doses.pdf. We also have a new vaccine booster chart graphic to share with you. It is attached and is available at https://coronavirus.ohio.gov/static/vaccine/booster-chart-2021.pdf.

"Mask to Stay" and "Test to Play" Additional School Quarantine Options
During a press conference this morning, Dr. Vanderhoff announced additional quarantine options, "Mask to Stay" and "Mask to Play," for school districts and local health departments. The proposed changes incorporate mask-wearing and testing to reduce the chance of spread of COVID-19 within structured school settings and provide a safe alternative to out-of-school quarantine. These options only apply to direct contacts in a school environment – those individuals who are identified as being directly exposed to COVID-19 by a positive case in a classroom or other school setting. COVID-19 is spread through sneezing, coughing, talking, and breathing. The best practices for distancing are 3 feet with everyone masked, 6 feet if not masked. Tests can be either PCR or antigen tests, but they must be proctored or observed.

"Mask To Stay"
Direct contacts in a school environment, regardless of vaccination or masking status, may remain in the classroom environment if they:

1. Wear a mask for 14 days after their last date of exposure.

2. Self-monitor, or parent-monitor, for symptoms of COVID-19.
3. Isolate and get tested if they start to experience symptoms associated with COVID-19 (regardless of level of severity).
4. Consistent with guidance for others quarantining in lower-risk environments, students and staff may discontinue these quarantine procedures after seven days — if they meet two basic criteria: one – they don't develop symptoms, and two – they test negative between days 5-7.

While parents and students are responsible for symptom monitoring, if school staff or school nurses see a child exhibiting symptoms they should act accordingly.

"Test to Play"
Asymptomatic contacts in a school environment may continue to participate in extracurricular activities if they:

1. Wear a mask when able. This includes wearing a mask during transportation, such as traveling on a team bus to and from games; while in locker rooms; while sitting or standing on the sidelines; and any time the mask will not interfere with breathing, the activity in which they are participating, or create a safety hazard.
2. Test on initial notification of exposure to COVID-19.
3. Test again between days 5-7 following exposure to COVID-19. If they are negative at this time, they will test out of quarantine after day 7 and can resume normal activities.

School districts are also encouraged to consider same-day testing for athletic competitions where there is the potential of school-to-school exposure.

Those who are fully vaccinated, as well as those who consistently wear masks in school, can already remain in the classroom if exposed to COVID-19 in a school setting.

The full guidance is available at https://coronavirus.ohio.gov/static/responsible/schools/k-12-schools-quarantine-alternative.pdf. The recording of the press conference can be watched at https://www.youtube.com/watch?v=bBDhjLtuDJg&list=PL0gaHgzgaSNcaArRSL_0XZHwaJotZ17eM&index=14.

Lead Awareness Week
We launched a public awareness campaign this week in recognition of National Lead Awareness Week. Attached are some social media graphics for you to use to help spread the message on lead awareness.

2021-22 Flu Toolkit
As we mentioned during last week's PIO call, we have developed a 2021-22 flu toolkit (attached) for your use. Please help us by using this toolkit to ensure we all are sharing the same message.

Playlist of Previous Press Conferences
A playlist of previous press conferences is available for your reference at https://www.youtube.com/playlist?list=PL0gaHgzgaSNcaArRSL_0XZHwaJotZ17eM.

Training Opportunity on Addiction
Recovery Ohio is asking Ohio's local health departments to share information on enCompass, a training opportunity on addiction. enCompass is open to any Ohioan who wants to learn more about navigating the ins and outs of addiction. It is a free, day long, virtual training, that will cover many topics in the addiction space. A partner toolkit is available for you to use that includes sample social media posts, newsletter blurbs, flyers, and images. Additionally, the direct link to the registration page is available at https://recovery-ohio.brand.live/statewide-encompass-training.

Have a great week!

Arundi

Office of Performance and Innovation
Local Support Services
Ohio Department of Health
246 North High Street
Columbus, Ohio 43215
www.odh.ohio.gov

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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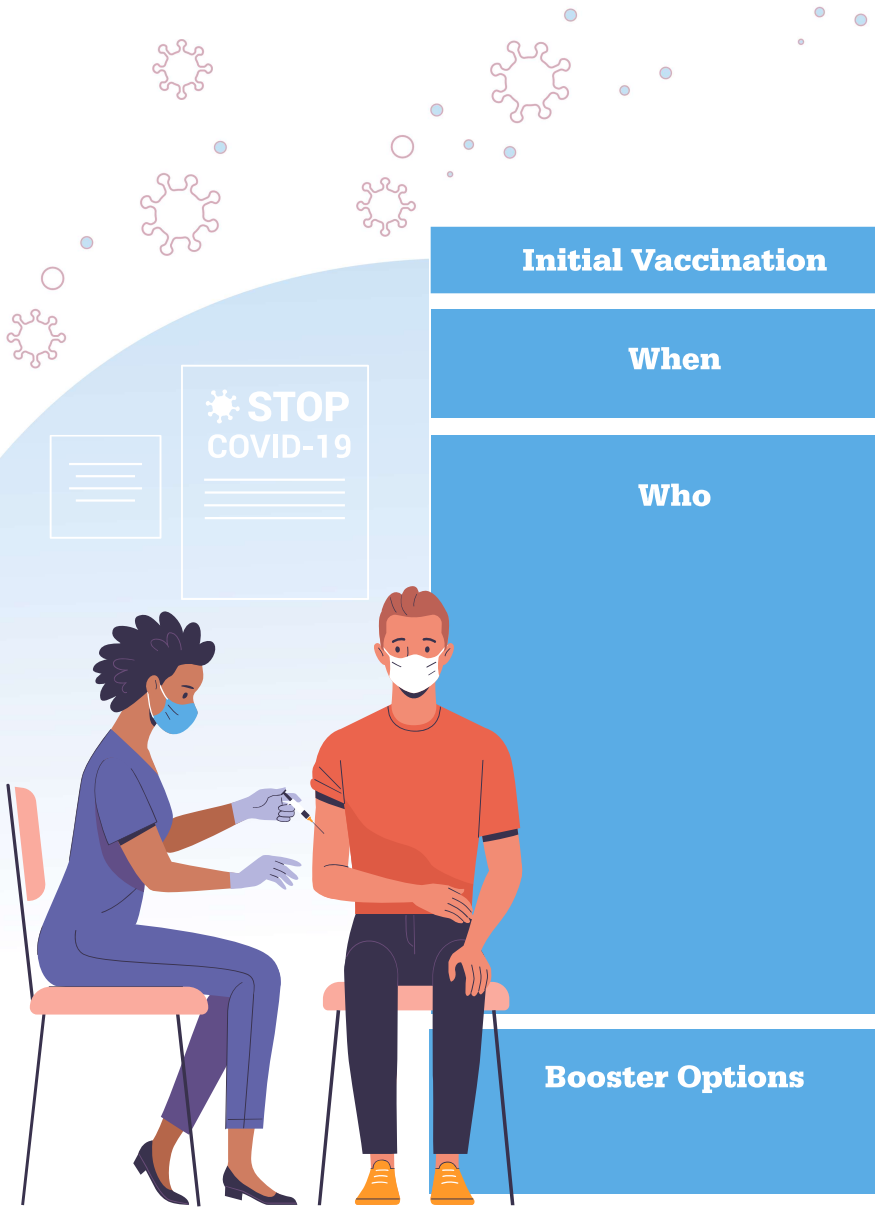
COVID-19 Vaccine Booster Shots

If you have been vaccinated against COVID-19, you may be eligible for a booster dose. Check below to find out if you qualify.

Initial Vaccination	Johnson & Johnson	Moderna or Pfizer/Comirnaty
When	Two months after single dose.	Six months after second dose.
Who	• 18 or older.	• 65 or older. • 18 or older with **underlying health condition.** • 18 or older living in **long-term care setting** (such as a nursing home). • 18 or older **living in a high-risk setting** (such as a group home, jail, or homeless shelter). • 18 or older **working in a high-risk setting.**
Booster Options	**If you're eligible, you can choose which vaccine you receive as a booster dose. Some people may prefer the vaccine type that they originally received and others may prefer to get a different booster.**	



Note: If you have received a third/additional dose of the Moderna or Pfizer/Comirnaty vaccine because you are immunocompromised, you should NOT get a booster dose. No one should receive more than three doses of these vaccines at this time.

Help prevent the spread of COVID-19.

Schedule an appointment: gettheshot.coronavirus.ohio.gov
More info: coronavirus.ohio.gov/vaccine

Ohio Department of Health

FW: CDC issues updated standing orders for all three COVID-19 vaccines

Jack Pepper <jpepper@athenspublichealth.org>
Fri 10/29/2021 2:02 PM
To: **all users <allusers@athenspublichealth.org>**
FYI

From: local.support@odh.ohio.gov <local.support@odh.ohio.gov>
Sent: Friday, October 29, 2021 1:58 PM
Subject: CDC issues updated standing orders for all three COVID-19 vaccines

To All Enrolled COVID-19 Vaccine Providers,

The Centers for Disease Control and Prevention (CDC) has issued updated Standing Orders with guidance on administering vaccines to include language about all booster doses.

The updated information is available at:

- Moderna Standing Orders for Administering COVID-19 Vaccine
- Johnson & Johnson/Janssen Standing Orders for Administering COVID-19 Vaccine
- Pfizer-BioNTech Standing Orders for Administering COVID-19 Vaccine
- Quick Reference Guide

Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

Ohio COVID-19 Vaccine Provider Relations Team

Office of Performance and Innovation

Local Support Services
Ohio Department of Health
246 North High Street
Columbus, Ohio 43215
www.odh.ohio.gov

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Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt.Governor

Bruce Vanderhoff, MD, MBA, Director

Oct. 28, 2021

To All Enrolled COVID-19 Vaccine Providers,

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Sincerely,

Ohio COVID-19 Vaccine Provider Relations Team

FW: CDC backs Pfizer COVID-19 Vaccine for Ages 5-11; Updated Resources for Providers

Jack Pepper <jpepper@athenspublichealth.org>

Wed 11/3/2021 6:58 AM

To: **all users <allusers@athenspublichealth.org>**

FYI

From: local.support@odh.ohio.gov <local.support@odh.ohio.gov>
Sent: Tuesday, November 2, 2021 10:08 PM
Subject: CDC backs Pfizer COVID-19 Vaccine for Ages 5-11; Updated Resources for Providers

Nov. 2, 2021

To All Enrolled COVID-19 Vaccine Providers,

COVID-19 vaccinations for children ages 5-11 can begin as quickly as possible now that the federal review and authorization process is complete.

Today, the Centers for Disease Control and Prevention (CDC) recommended use of the Pfizer-BioNTech COVID-19 vaccine pediatric formulation for children ages 5-11 following a thorough review of the vaccine's safety and effectiveness.

On Friday, the U.S. Food and Drug Administration granted an emergency use authorization for the Pfizer-BioNTech COVID-19 vaccine for children ages 5-11. The FDA has published emergency use authorization fact sheets for the Pfizer-BioNTech COVID-19 vaccine pediatric formulation for healthcare providers and for vaccine recipients and caregivers.

"Today is a day that many children and numerous adults — parents, guardians, grandparents, aunts, uncles, pediatricians, teachers, and coaches — have long awaited," said Ohio Department of Health Director Bruce Vanderhoff, MD, MBA. "The authorization of this COVID-19 vaccine for younger Ohioans is yet another crucial turning point in this pandemic, allowing us to better protect young children from severe complications from COVID-19. This deadly virus has killed more than 24,000 Ohioans, and has caused nearly 206,000 pediatric infections among those ages 17 and younger."

The Pfizer-BioNTech COVID-19 vaccine for children ages 5-11 is administered as a two-dose primary series, three weeks apart, but is a **lower dose (10 micrograms)** than that used for individuals 12 years of age and older (30 micrograms). The Pfizer-BioNTech COVID-19 vaccine pediatric formulation is a new product configuration with new packaging, new preparation, and a new national drug code (NDC). **The current Pfizer/Comirnaty product for adults and adolescents should not be used in children younger than 12.**

The Ohio Department of Health (ODH) is sharing updated **Provider Guidance for Pfizer-BioNTech COVID-19 Vaccines for Children Ages 5-11.**

This guidance document includes preliminary information about:

- Packaging and dosage.
- Storage and Handling.
- Pediatric considerations.
- Ordering.
- Data Reporting.
- Messaging.

The CDC is expected to publish complete clinical guidance in the near future. We will share those resources as soon as they are available.

Providers can now order the Pfizer-BioNTech COVID-19 vaccine pediatric formulation. Providers can request vaccine through the Vaccine Ordering Management System (VOMS) in the Impact Statewide Immunization Information System (ImpactSIIS). VOMS is open for providers to place orders 24 hours a day, 7 days a week. Details for ordering in the coming days are included below:

- Large quantities of Pfizer COVID-19 vaccine formulation shipped directly by the manufacturer:
  - The minimum order is 300 doses, and the maximum order is 600 doses.
  - Ordering is available in the "COVID-19-Pfizer" order set in VOMS.
  - Orders placed the week of Nov. 1 are expected to arrive late the following week, after Nov. 10.
  - In the near future, the direct shipment minimum will be reduced to 100 doses.
- Small quantities of Pfizer COVID-19 vaccine formulation will be repackaged and shipped by the RSS warehouse:
  - The order quantity is 50 doses.
  - Ordering is available in the "COVID-19-Pfizer 30" or "COVID-19-Pfizer RSS" order sets in VOMS.
  - Delivery will begin Tuesday, Nov. 9, for orders placed by Thursday, Nov. 4, at 6 p.m. In the future, orders will follow the standard Tuesday/Thursday/Friday RSS delivery cadence.

The Ohio Department of Health COVID-19 Provider website is a hub for a variety of resources for vaccine providers. Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

COVID-19 Vaccine Provider Relations Team

Office of Performance and Innovation

Local Support Services
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Ohio | Department of Health

Mike DeWine, Governor
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Bruce Vanderhoff, MD, MBA, Director

Nov. 2, 2021

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- Messaging.

The CDC is expected to publish complete clinical guidance in the near future. We will share those resources as soon as they are available.

Providers can now order the Pfizer-BioNTech COVID-19 vaccine pediatric formulation. Providers can request vaccine through the Vaccine Ordering Management System (VOMS) in the Impact Statewide Immunization Information System (ImpactSIIS). VOMS is open for providers to place orders 24 hours a day, 7 days a week. Details for ordering in the coming days are included below:

- Large quantities of Pfizer COVID-19 vaccine formulation shipped directly by the manufacturer:
    - The minimum order is 300 doses, and the maximum order is 600 doses.
    - Ordering is available in the "COVID-19-Pfizer" order set in VOMS.
    - Orders placed the week of Nov. 1 are expected to arrive late the following week, after Nov. 10.
    - In the near future, the direct shipment minimum will be reduced to 100 doses.
- Small quantities of Pfizer COVID-19 vaccine formulation will be repackaged and shipped by the RSS warehouse:
    - The order quantity is 50 doses.
    - Ordering is available in the "COVID-19-Pfizer 30" or "COVID-19- Pfizer RSS" order sets in VOMS.
    - Delivery will begin Tuesday, Nov. 9, for orders placed by Thursday, Nov. 4, at 6 p.m. In the future, orders will follow the standard Tuesday/Thursday/Friday RSS delivery cadence.

The Ohio Department of Health COVID-19 Provider website is a hub for a variety of resources for vaccine providers. Vaccine providers with questions may call the ODH Provider Call Center at 1-844-9ODHVAX (1-844-963-4829) between 8 a.m. and 7 p.m. Mondays through Fridays or email COVIDVACCINE@odh.ohio.gov.

Sincerely,

COVID-19 Vaccine Provider Relations Team

FW: COVID-19 Booster Shot

jsikorski@athensoh.org <jsikorski@athensoh.org>

Thu 10/14/2021 3:55 PM

To: all@athensoh.org <all@athensoh.org>

FYI

From: melissa@athens911.com <melissa@athens911.com>
Sent: Thursday, September 30, 2021 12:56 PM
To: 911@athens911.com
Cc: JoAnn Rockhold - Clerk <jsikorski@athensoh.org>
Subject: COVID-19 Booster Shot

If you previously got 2 doses of the Pfizer-BioNTech COVID-19 vaccine, you can get a booster shot of the Pfizer-BioNTech COVID-19 vaccine if you fall into one of these groups:

***65 years or older,**
***You're 18+ and have certain underlying medical conditions, (See CDC website)**
Or
***You're 18+ and work or live in a high-risk setting**. (**First Responders)** (and other – see CDC website).

You can get your booster shot at least 6 months after you complete your second does of Pfizer vaccine. The booster shot can help strengthen and prolong your protection against COVID-19. Currently, the Athens Hocking Health Department is giving the booster.

Call the Health Department to schedule your vaccine.

Regards,

Melissa Fowler-Dixon
Administrative Assistant
Athens County 911
13 West Washington Street
Athens, Ohio 45701
Phone: 740.592.3273
Fax: 740.592.5370
melissa@athens911.com
www.athens911.com

September CHC Coalition Mtg. Follow Ups

Kari Boyle <kboyle@athenspublichealth.org>

Thu 9/9/2021 2:35 PM

To: Vana Cesta-Miller <Vana.Cesta-Miller@hopewellhealth.org>; Alisha Swiney <alisha.swiney@hapcap.org>; Amanda Sawvel <amanda.sawvel@hapcap.org>; Autumn Brown <abrown@athenscbdd.org>; Bailey, Karen <baileyk@ohio.edu>; Bob Fedyski <bfedyski@yahoo.com>; Bond, Caitlin A <Caitlin.Bond@ohiohealth.com>; Borovicka, Lauren <borovick@ohio.edu>; Bryce Lemaster <bbail@athenspublichealth.org>; Bryce Lemaster (comcorpsathenshealth@gmail.com) <comcorpsathenshealth@gmail.com>; Cadmus, Annie <cadmus@ohio.edu>; Carole Merckle (mercklec@ohio.edu) <mercklec@ohio.edu>; Carrie Carson <carrieellencarson@gmail.com>; Celestia Hathhorn (hathhornC@gmail.com) <hathhornC@gmail.com>; Christopher Parsons <christopher@livehealthyappalachia.org>; Ciara Martin (cmartin@rosscountyhealth.org) <cmartin@rosscountyhealth.org>; Court Witschey <cwitschey@athenspublichealth.org>; Diane Pfaff <Diane@ahv317.co.athens.oh.us>; Eric Long <longe@ohio.edu>; Erin Helms <ehelms@ci.athens.oh.us>

Hi friends,

Thanks for participating in today's CHC Coalition meeting. As always, I enjoy seeing everyone's faces and the conversations we have. As promised, I am following up with various things that were shared during the meeting. I will follow up with meeting minutes in another email sometime soon.

- The AFAC survey is also now available at various locations in the community as well: https://ohio.qualtrics.com/jfe/form/SV_249Sm6I9G7Hj37g
- Vaccine Clinics offered by OU schedule is here: https://www.ohio.edu/coronavirus/vaccine/distribution
- Integrate Athens Webpage has been updated, check it out: http://integrate.athenscbdd.org/
- Ohio University's Community Engagement Fair tomorrow from 11:30am-2:30pm on campus. For anyone interested in touring 29 Park Place or reserving the space, please feel free to contact Mary Nally!
- Please take the broadband survey via HAPCAP, as well. For more information on local broadband resources (and the survey) in Southeast Ohio, visit HAPCAP's Web page (https://hapcap.org/utility-services/broadband/) includes internet service providers, affordability options, and a speed test.
- AmeriCorps is funding a new Public Health Corps program, if anyone wants to learn more about the new CDC/AmeriCorps initiative, here is registration info for today's 2 pm webinar: https://americorps.zoomgov.com/meeting/register/vJItcuCrrzIsHwTaQ6fXl_ubC9XnSdfjyOw
- September 17th is World Hunger Action Day
- Per our conversation on COVID-19 tests, I've attached a resource that might help further explain the differences. I would also recommend checking out this resource: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html If you have further questions, you are welcome to call us at the health department. However, I do recommend an email at this time, to Ruth or myself as we will probably be quicker at responding.

Our next coalition will be Thursday, October 14th at 12pm. We will virtually celebrate Apple Crunch Day! I will send meeting details closer to the date.

Thanks everyone!

Kari Boyle, CHES
Health Educator
Creating Healthy Communities Coordinator
Athens City-County Health Department
278 West Union Street • Athens, OH 45701
740-592-4431, ext: 5913 • 740-594-2370 (fax)
kboyle@athenspublichealth.org • www.athenspublichealth.org • Check us out on Facebook!

FDA U.S. FOOD & DRUG ADMINISTRATION

Coronavirus Disease 2019 Testing Basics

You've probably heard a lot about coronavirus disease (COVID-19) testing. If you think you have COVID-19 and need a test, contact your health care provider or local health department immediately. You can also find a community testing site in your state, or buy an FDA-authorized at-home test. Some FDA-authorized at-home tests give you results within minutes. Others require you to mail the sample to a lab for analysis.

There are two different types of tests – diagnostic tests and antibody tests.

Diagnostic tests can show if you have an active Covid-19 infection and need to take steps to quarantine or isolate yourself from others. **Molecular** and **antigen tests** are types of diagnostic tests than can detect if you have an active COVID-19 infection. Samples for diagnostic tests are typically collected with a nasal or throat swab, or saliva collected by spitting into a tube.

Antibody tests look for antibodies in your immune system produced in response to SARS-CoV-2, the virus that causes COVID-19. **Antibody tests should not be used to diagnose an active COVID-19 infection.** Antibodies can take several days or weeks to develop after you have an infection and may stay in your blood for several weeks or more after recovery. Samples for antibody tests are typically blood from a finger stick, or blood drawn by your doctor or other medical personnel.

	MOLECULAR TEST	ANTIGEN TEST	ANTIBODY TEST
Also known as...	Diagnostic test, viral test, molecular test, nucleic acid amplification test (NAAT), RT-PCR test, LAMP test	Diagnostic test, viral test, rapid test	Serological test, serology, blood test, serology test
How the sample is taken...	Nasal swabs, either shallow or deep (most tests). Saliva (some tests)	Nasal or nasopharyngeal swab (most tests)	Blood from a fingerstick or vein
How long it takes to get results...	Less than an hour (at-home tests and some point-of-care locations), same day (some point-of-care locations) or 1-3 days (tests sent to a lab for processing). Some tests may take longer in some locations, depending on testing capacity.	Some may be very fast (15–30 minutes), depending on the test	Same day (some point-of-care locations) or 1-3 days (tests sent to a laboratory for processing)
Is another test needed...	Not usually. This type of test is typically highly accurate andmusually does not need to be repeated. Some may indicate the need to re-test in certain circumstances.	Maybe. Positive results are usually highly accurate, but false positives can happen, especially in areas where very few people have the virus. Negative results may need to be confirmed with a molecular test.	Sometimes a second antibody test is needed for accurate results.
What it shows...	Diagnoses active COVID-19 infection. (Some tests may also diagnose influenza or other respiratory viruses)	Diagnoses active COVID-19 infection. (Some tests may also diagnose influenza or other respiratory viruses)	Shows if you've been infected by the virus that causes COVID-19 in the past
What it can't do...	It cannot show if you ever had COVID-19 or were infected with the virus that causes COVID-19 in the past	It may not detect an early COVID-19 infection. Your health care provider may order a molecular test if your antigen test shows a negative result, but you have symptoms of COVID-19. It also cannot show if you ever had COVID-19 or were	It cannot diagnose COVID-19 at the time of the test or show that you do not have COVID-19

Diagnostic Tests with Alternative Options

Diagnostic tests are now available with alternative methods and benefits.

- **Rapid, point-of-care** diagnostic tests use a mucus sample from the nose or throat but can be analyzed at the doctor's office or clinic where the sample is collected and results may be available in minutes. These may be molecular or antigen tests.

- **Combination tests** can test for the flu and the coronavirus at the same time. Some can test for many different types of respiratory viruses, including the one that causes COVID-19.

- **Home Collection Test:** sample is collected at home but analyzed in a laboratory
- **Direct to Consumer (DTC) Test:** home collection tests available without a prescription, but the sample is analyzed in a laboratory
- **At-home Testing:** consumer completes sample collection and testing at home
- **Over the Counter (OTC) Test:** consumer completes sample collection and testing at home, without a prescription

- **Saliva tests** allow a patient to spit into a tube rather than get their nose or throat swabbed. Saliva tests may be more comfortable for some people and may be safer for health care workers who can be farther away during the sample collection.

Ordering a Test

Many tests, including some home collection and at-home tests, require a prescription or order from a health care provider.

Prescription Tests – Health care providers can determine whether you need a test, and ensure you get the most appropriate test and that you know what the results mean. For example, certain tests are authorized only for people suspected of having COVID-19 or for people with COVID-19 symptoms that started within a certain number of days. A health care provider can help determine which test is best for your situation. Prescription-only home collection and at-home tests may require you to answer some questions online so that a health care provider can determine whether to prescribe or order a specific test.

Non-Prescription Tests – Some tests are available without a prescription. Home collection and at-home tests available without a prescription may be called "direct-to-consumer" (DTC) or "over-the-counter" (OTC). DTC and OTC tests may be available to purchase at a pharmacy or online, but they may not be available everywhere.

We do not know how long antibodies stay in the body following infection with the virus that causes COVID-19. We do not know if antibodies give you protective immunity against the virus, so results from a serology test should not be used to find out if you have immunity from the virus. The FDA cautions patients against using the results from any serology test as an indication that they can stop taking steps to protect themselves and others, such as stopping social distancing or discontinuing wearing masks.

Report Adverse Events

The FDA encourages health care professionals and patients to report adverse events or side effects related to the use of COVID-19 tests or other medical products to the FDA's MedWatch Safety Information and Adverse Event Reporting Program:

- Complete and submit the **report online** through the FDA's MedWatch website.
- **Download the form** or call 1-800-332-1088 to request a form, then complete and return to the address on the form or submit by fax to 1-800-FDA-0178.

UPDATE: CDC Health Alert Network (HAN) Health Advisory 445 - Recall of LeadCare Blood Lead Tests

Ohio Health Alert Network <56382698-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Tue 7/6/2021 5:52 PM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

Distributed via the CDC Health Alert Network
July 06, 2021, 12:00 PM ET
CDCHAN-00445

Recall of LeadCare® Blood Lead Tests Due to Risk of Falsely Low Results

Summary

Magellan Diagnostics, Inc. and the U.S. Food and Drug Administration (FDA) have issued a recall notice concerning the use of some LeadCare® Blood Lead Tests (certain LeadCare II, LeadCare Plus, and LeadCare Ultra test kit lots). These lots were distributed between October 27, 2020, and June 15, 2021. The use of these devices may cause serious injuries because they might underestimate blood lead levels. The FDA has identified this as a Class I recall, the most serious type of recall.

The purpose of this Centers for Disease Control and Prevention (CDC) Health Alert Network (HAN) Health Advisory is to notify healthcare providers and state and local health departments about this recall notice and to recommend appropriate follow-up actions.

Background

Magellan Diagnostics, Inc. is recalling its LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests due to a significant risk of falsely low blood lead level results. The FDA has concerns that the falsely low results may contribute to health risks in special populations such as young children and pregnant individuals. A pregnant or lactating individual's exposure to lead is concerning because it may cause health problems for the parent and the developing baby. Obtaining falsely low blood lead level results may lead to inappropriate follow-up assessments, which may result in patient harm, including delayed puberty, reduced postnatal growth, decreased IQ, and inattention and behavior problems in children.

The FDA notified CDC on June 24 that some Magellan Diagnostics blood lead test kits were undergoing a voluntary recall by the manufacturer. The FDA is now recommending that Magellan

Diagnostics customers discontinue the use of all affected test kit lots identified as part of the recall and quarantine remaining inventory.

Recommendations

- Discontinue use of all affected test kit lots identified as part of the recall.
- Retest children who were tested with the recalled LeadCare test kits whose results were less than 5 µg/dL, the current CDC-recommended blood lead reference value. Retesting should be done with a venous blood sample analyzed with higher complexity testing.
- Retest children who were previously tested with a LeadCare test kit if the lot number of the initial test kit is unknown and the test was done between October 27, 2020, and July 6, 2021, the date of this health advisory.
- Priority for retesting should be given to—
    - Children where there is clinical concern that symptoms or developmental problems may be related to lead exposure,
    - Populations at higher risk of elevated blood lead levels, such as children tested due to Medicaid-required screening or due to other state or local requirements, and
    - Individuals who are pregnant or breastfeeding.
- If retesting indicates blood lead levels in excess of the current CDC Blood Level Reference Values (BLRV) or state or local action level, the healthcare provider or public health official should refer to CDC guidelines or state/local guidelines for appropriate follow-up action.
- Discuss the recall and retesting recommendations with a parent and/or caregiver of children who meet the retesting criteria.

Per CDC guidance, children with blood lead levels at or greater than 5 µg/dL should have had a subsequent test with a venous blood sample for confirmation. LeadCare instruments are currently approved for use only with capillary or finger/heel stick samples. Venous blood confirmation levels are performed with higher complexity testing such as inductively coupled plasma mass spectrometry (ICP-MS) or graphite furnace atomic absorption spectroscopy (GFAAS) and are generally considered more accurate.

More information about blood lead testing can be found by visiting—

- CDC's Lead Poisoning Prevention Program
- CDC's Lead and Multi-element Proficiency Program

More information about the recall can be found by visiting—

- Magellan Diagnostics Recalls LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests Due to Risk of Falsely Low Results

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on

critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert - Requires immediate action or attention; highest level of importance

Health Advisory - May not require immediate action; provides important information for a specific incident or situation

Health Update - Unlikely to require immediate action; provides updated information regarding an incident or situation

HAN Info Service - Does not require immediate action; provides general public health information

---------- **Original Message** ----------
"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

July 6, 2021, 12:00 PM ET

CDCHAN-00445

Recall of LeadCare® Blood Lead Tests Due to Risk of Falsely Low Results

Summary

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The FDA notified CDC on June 24 that some Magellan Diagnostics blood lead test kits were undergoing a voluntary recall by the manufacturer. The FDA is now recommending that Magellan Diagnostics customers discontinue the use of all affected test kit lots identified as part of the recall and quarantine remaining inventory.

Recommendations

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Per CDC guidance, children with blood lead levels at or greater than 5 µg/dL should have had a subsequent test with a venous blood sample for confirmation. LeadCare instruments are currently approved for use only with capillary or finger/heel stick samples. Venous blood confirmation levels are performed with higher complexity testing such as inductively coupled plasma mass spectrometry (ICP-MS) or graphite furnace atomic absorption spectroscopy (GFAAS) and are generally considered more accurate.

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- CDC's Lead Poisoning Prevention Program
- CDC's Lead and Multi-element Proficiency Program

More information about the recall can be found by visiting—

- Magellan Diagnostics Recalls LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests Due to Risk of Falsely Low Results

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Health Advisory May not require immediate action; provides important information for a specific incident or situation

Health Update Unlikely to require immediate action; provides updated information regarding an incident or situation

HAN Info Service Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Ryan Morrison, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

Statewide LHD Leadership

Statewide LHD-Group

Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
July 6, 2021, 12:00 PM ET
CDCHAN-00445

Recall of LeadCare® Blood Lead Tests Due to Risk of Falsely Low Results

Summary
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##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Health Advisory 446: Potential Exposure to Person with Confirmed Human Monkeypox Infection

Ohio Health Alert Network <569cca29-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Mon 7/19/2021 9:46 AM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

July 17, 2021, 5:00 PM ET

CDCHAN-00446

Potential Exposure to Person with Confirmed Human Monkeypox Infection — United States, 2021

Summary

The Centers for Disease Control and Prevention (CDC), in collaboration with the Texas Department of State Health Services and Dallas County Health and Human Services, is investigating a single case of monkeypox virus infection in a U.S. citizen who resides in the United States and recently returned from travel to Nigeria. The patient traveled to Dallas from Lagos, Nigeria, via Atlanta on two separate flights during July 8-9, 2021. The patient presented to an emergency department in Dallas, Texas on July 13 for complaints of a rash that began on July 7, one day prior to travel. Testing at Dallas County and CDC confirmed the presence of monkeypox virus. CDC is working with the airlines to share information with state and local health officials to contact airline passengers and others who may have been in contact with the patient during two flights: Lagos, Nigeria, to Atlanta on July 8, with arrival on July 9; and Atlanta to Dallas on July 9. CDC is issuing this health advisory to ask clinicians to consider a diagnosis of monkeypox in people who present with a febrile prodrome followed by rash and who may have had direct or indirect contact with the patient.

Background

Monkeypox is endemic to several Central and West African nations. Recent cases outside of Africa either reported recent travel to one of these countries or contact with a person with confirmed

monkeypox.

Symptoms of monkeypox most often begin with a prodrome of fever and other non-specific symptoms such as malaise, headache, and muscle aches following an average incubation period of 5-13 days. After the prodrome, which lasts approximately one to three days, a generalized rash appears. Nearly all patients with monkeypox have had fever early in illness onset and prior to the rash onset. Although lesions often begin on the face before spreading to other parts of the body, there has been at least one report of lesions beginning in the groin region. Lesions progress through specific stages—macules, papules, vesicles, and pustules—before scabbing and falling off1. The rash appearance of monkeypox is very similar to that of smallpox, including a centrifugal distribution and lesions on the palms and soles. Monkeypox can occur concurrently with other rash illnesses, including varicella-zoster virus and herpes simplex virus infections. Case fatality ranges between 1 and 10%. Laboratory confirmation of monkeypox is performed using real-time polymerase chain reaction (PCR) on lesion material.

A person is considered infectious beginning five days prior to rash onset and is presumed to remain infectious until lesions have crusted, those crusts have separated, and a fresh layer of skin has formed underneath. Human-to-human transmission is thought to occur primarily through large respiratory droplets. Respiratory droplets generally cannot travel more than a few feet, so prolonged face-to-face contact is required. Transmission can also occur by direct contact with body fluids or lesion material. Indirect contact with lesion material through fomites has also been documented. Animal-to-human transmission may occur through a bite or scratch, preparation of wild game, and direct or indirect contact with body fluids or lesion material.

There is no specific treatment for monkeypox virus infection, although antivirals developed for use in patients with smallpox may prove beneficial2. Persons with direct contact (i.e., exposure to the skin, crusts, bodily fluids, or other materials) or indirect contact (e.g., presence within a 6-foot radius in the absence of an N95 or filtering respiratory for ≥ 3 hours) with a monkeypox patient should be monitored by health departments; some persons may be candidates for post-exposure prophylaxis with smallpox vaccine after consultation with public health authorities.

Recommendations for Clinicians

- If clinicians identify patients with a constellation of signs and symptoms that could be monkeypox, a travel history should be solicited. Monkeypox should be considered in patients with unexplained onset of fever, chills, new rash, or new lymphadenopathy, and a history of 1) air travel from Lagos Murtala Muhammed International Airport, Nigeria, to Hartsfield-Jackson Atlanta International Airport on July 8 with arrival on July 9, 2) air travel from Atlanta to Dallas Love Field Airport on July 9, or 3) presence in those airports on July 8-9.
- Patients with suspected monkeypox should be isolated in a negative pressure room, and all personnel should wear personal protective equipment (PPE) in accordance with recommendations for standard, contact, and airborne precautions3. All healthcare workers (e.g., clinical staff and environmental staff) caring for a patient with suspect or confirmed monkeypox

should be communicated the importance of maintaining proper isolation precautions so that infection is not transmitted to them or others.
- Clinicians should consult their state health department or CDC's monkeypox call center through the CDC Emergency Operations Center (770-488-7100) as soon as monkeypox is suspected.

Recommendations for Health Departments

- If monkeypox is suspected by the health department, then CDC should be consulted through the CDC Emergency Operations Center (770-488-7100).
    - After consultation with CDC, samples can be sent to CDC or an appropriate Laboratory Response Network for confirmatory testing by PCR4.
    - Send all specimens through the state/territorial public health department, unless authorized to send directly to CDC.
- Ideal specimens for laboratory testing include lesion fluid, lesion roof, scabs, and crusts. Serum and whole blood can also be collected. Best practices are to collect multiple specimens from different locations on the body. Detailed specimen submission instructions are available at CDC's monkeypox website5.

Recommendations for the Public

- Individuals who may have had contact with a suspect or confirmed monkeypox case should contact their health department for a risk assessment.

For More Information

- Contact your local health department if you have any questions or suspect a patient may have monkeypox.
- **CDC**
    - CDC-INFO or 1-800-232-4636
    - CDC 24/7 Emergency Operations Center (EOC): 770-488-7100

References

1 Clinical Recognition of Monkeypox

2 Antivirals

3 Infection Control Measures in Hospitals

4 U.S. Laboratory Response Network

5 Preparation and Collection of Specimens

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert Requires immediate action or attention; highest level of importance

Health Advisory May not require immediate action; provides important information for a specific incident or situation

Health Update Unlikely to require immediate action; provides updated information regarding an incident or situation

HAN Info Service Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Christopher Zukoski, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

Statewide LHD Leadership

Statewide LHD-Group

Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

Ohio HAN: COVID-19 Vaccine Breakthrough Cases Reminder

Ohio Health Alert Network <569f4852-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Mon 7/19/2021 2:31 PM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

Health Advisory: COVID-19 Vaccine Breakthrough Cases

Ohio Department of Health, Monday, July 19, 2021

Action Steps

- Identify and report any cases of hospitalizations for COVID-19 or deaths from COVID-19 among fully vaccinated persons.
- Coordinate sequencing of retained PCR/RNA specimens through local and state public health.

COVID-19 Vaccine Breakthrough Cases Surveillance:

Despite the high level of COVID-19 vaccine efficacy, thousands of symptomatic COVID-19 vaccine breakthrough cases will occur nationally, even though the vaccines against the disease are working as expected. In accordance with Centers for Disease Control and Prevention (CDC) guidelines, a vaccine breakthrough infection is defined as the detection of SARS-CoV-2 RNA or antigen in a respiratory specimen collected 14 or more days after completion of the series of an FDA-authorized COVID-19 vaccine. Ohio has adopted the CDC surveillance strategy for vaccine breakthrough infections to focus on ***identifying and investigating only COVID-19 vaccine breakthrough cases that result in hospitalization or death***. These investigations are aimed at identifying trends or clustering in patient characteristics, geographic location, time since vaccination, the administered vaccine, or the infecting virus strain.

COVID-19 Vaccine Breakthrough Reporting:

If a COVID-19 vaccine breakthrough case resulting in hospitalization or death is suspected or identified, the case should be reported to the appropriate Local Health Department (LHD) based on the patient's home address. Click here for a comprehensive search tool, to locate LHD by patient address.

LHDs should report suspected or identified vaccine breakthrough cases to the Vaccine-Preventable Disease (VPD) Epidemiology Program at (614) 995- 5599.

For surveillance purposes, the following criteria must be met for a report to be classified as a COVID-19 vaccine breakthrough case:

- *COVID-19-related hospitalization or death (new criteria)*
- U.S. Resident
- Completed full primary series of an FDA-authorized COVID-19 vaccine
- SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected 14 or more days *after* completing the primary series of an FDA-authorized COVID-19 vaccine
- No known positive test for SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected less than 45 days before the most recent positive test

Sequencing for COVID-19 Vaccine Breakthrough Cases:

Submission of RNA specimens to ODH Laboratory for viral sequencing are encouraged; however ***approval through the VPD Epidemiology program must be obtained prior to shipment***. Healthcare facilities should coordinate submission through the appropriate LHD.

The attached guidance document entitled “COVID-19 Vaccine Breakthrough Specimen Submissions” provides additional instructions for specimen submissions. LHDs are asked to ensure that vaccine module and clinical fields in the Ohio Disease Reporting System (ODRS) are complete for all COVID-19 vaccine breakthrough cases.

For questions, please contact the ODH Bureau of Infectious Diseases VPD Epidemiology Program at (614) 995-5599.

Attachments: 1

Sent by: Laurie Billing, Ohio Department of Health

Recipients:

ODH Senior Leadership

Statewide Environmental Health

Statewide Epi-Surveillance

Statewide HAN Notification

Statewide Hospital IP

Statewide LHD Leadership

Statewide Nursing-Physician-Medical

Statewide OPHCS Coordinator

To reply, click the appropriate response from the list of options below.

Option# Response:

1. Click here to confirm receipt.

Thank you,
Ohio Health Alert Network

COVID-19 Vaccine Breakthrough Specimen Submissions

Jurisdictions are asked to investigate SARS-CoV-2 infections among fully vaccinated persons to identify trends or clustering in patient characteristics, the administered vaccine, or the infecting virus. The Centers for Disease Control and Prevention (CDC) has asked states to supplement these investigations with RNA sequencing of respiratory specimens from COVID-19 vaccine breakthrough cases to assess the frequency of SARS-CoV-2 variantstrains. This sequencing may be performed at a local or regional laboratory with that capability or by specimen submission to the Ohio Department of Health laboratory (ODHL).

Criteria for COVID-19 Vaccine Breakthrough Case Investigations:

- COVID-19-related hospitalization or death
- U.S. resident.
- Completed full primary series of an FDA-authorized COVID-19 vaccine.
- SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected at least 14 days after completing the primary series of an FDA-authorized COVID-19 vaccine.
- No known positive test for SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected less than 45days before the most recent positive test.

Obtaining Approval for Breakthrough Specimen Sequencing at Ohio Department of Health Laboratory (ODHL)

When a vaccine breakthrough case is suspected or identified, local jurisdictions should contact the ODH Vaccine-Preventable Disease (VPD) Epidemiology Program at 614-995-5599 during normal business hours to approve and coordinate RNA specimen submissions to the ODHL for viral sequencing. Specimens sent to ODHL are sequenced for public health surveillance purposes only – there is no diagnostic value to these tests, and it is recommended that they are not used for that purpose. Once approval is obtained, local jurisdictions should promptly contact the diagnostic laboratory and request the specimen be saved and frozen.

Specimen Submission Criteria

- Approved by VPD Epidemiology Program team.
- Adequate – a minimum volume of 500ul of the original specimen is required for evaluation.
- Accompanied by appropriate paperwork – a completed SARS-CoV-2 Specimen Submission Form for **each specimen.** Access the form at https://electroniclabsubmission.odh.ohio.gov/.
    - Ensure all patient and submitter information fields are filled out, as well as collection dateand specimen site.
    - Please indicate in the comments section of the ODHL SARS-CoV-2 Specimen Submission Form that the specimen is being sent to ODHL for “WGS – Vaccine Breakthrough.”

Last updated May 3, 2021.

    - Once web fields are entered, you can click the "Generate PDF" button for printing.
- Labeled in a specimen tube that contains **at least** two **identifiers –** name and DOB are preferred**. Identifiers on tube must match identifiers on paperwork.**
- ***Frozen*** *– Freeze the specimen immediately and ensure it is shipped overnight on dry ice so it arrives at the laboratory frozen. If the specimen arrives at refrigerated or room temperature, it will not be viable for testing.* If specimens will be driven to the ODH lab, they may be transported on ice packs.
- Sealed in a bag – please keep the specimen separate from the paperwork and do not put any ice packor water in the bag with the specimen.

Packaging and Labeling Specimens

Specimens must be packed as Category B biological specimens. This means that specimens should be placed in aprimary receptacle, and there should be secondary packaging and a rigid outer packaging with adequate absorbent material as needed. Packages containing Biological Substance, Category B must be clearly marked "Biological Substance, Category B" with the characters being at least 6 mm high. The package must also be marked with theidentification number "UN3373" in a square-on-point configuration (diamond shaped) with each side being a minimum of 50 mm (or 2 inches) in length with the UN337. A Saf-T-Pak Checklist is provided on the last page of this document to aid in ensuring appropriate packaging and labeling. Completed form(s) should be included in the shipping container within a sealed (zip-lock) plastic bag, separate from the specimen and separate from the cold pack.

Shipping Specimens

- Ship the specimen to:

  Erica Leasure
  Special Microbiology
  Ohio Department of Health Laboratory
  8995 E. Main St.
  Building 22
  Reynoldsburg, OH 43068

Last updated May 3, 2021.

SAF-T-PAK
A Cantel Medical Company

Packaging Checklist

Use this checklist to ensure your package has been properly prepared. Check the box as you complete each step.

	Category A	Category B	Genetically modified organisms	Exempt patient specimens
Manufacturer's instructions followed	☐	☐	☐	☐
Good quality packaging	☐	☐	☐	☐
Primary receptacles sealed and leakproof	☐	☐	☐	☐
Primary receptacle closures secured with secondary means	☐	Optional	Optional	Optional
Multiple fragile primaries wrapped individually	☐	☐	☐	☐
Sufficient absorbent inside each secondary	☐	☐	☐	☐
Secondary packaging properly sealed and leakproof	☐	☐	☐	☐
Primary or secondary receptacle 95 kPa pressure compliant	☐	☐	N/A	N/A
Itemized list of contents between secondary and outer packaging	☐	☐	N/A	N/A
Outer package displays UN specification mark	☐	N/A	N/A	N/A
In Canada, package displays TC-125-1A	☐	N/A	N/A	N/A
In Canada, package displays TC-125-1B	N/A	☐	N/A	N/A
Rigid outer packaging	☐	☐	☐	N/A
Check minimum external dimensions of outer packaging	☐ All dimensions at least 100 mm	☐ One surface at least 100 mm x 100 mm	☐ All dimensions at least 100 mm	☐ One surface at least 100 mm x 100 mm

This checklist may be copied without permission.

Last updated May 3, 2021.

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
July 6, 2021, 12:00 PM ET
CDCHAN-00445

Recall of LeadCare® Blood Lead Tests Due to Risk of Falsely Low Results

Summary
Magellan Diagnostics, Inc. and the U.S. Food and Drug Administration (FDA) have issued a recall notice concerning the use of some LeadCare® Blood Lead Tests (certain LeadCare II, LeadCare Plus, and LeadCare Ultra test kit lots). These lots were distributed between October 27, 2020, and June 15, 2021. The use of these devices may cause serious injuries because they might underestimate blood lead levels. The FDA has identified this as a Class I recall, the most serious type of recall.

The purpose of this Centers for Disease Control and Prevention (CDC) Health Alert Network (HAN) Health Advisory is to notify healthcare providers and state and local health departments about this recall notice and to recommend appropriate follow-up actions.

Background
Magellan Diagnostics, Inc. is recalling its LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests due to a significant risk of falsely low blood lead level results. The FDA has concerns that the falsely low results may contribute to health risks in special populations such as young children and pregnant individuals. A pregnant or lactating individual's exposure to lead is concerning because it may cause health problems for the parent and the developing baby. Obtaining falsely low blood lead level results may lead to inappropriate follow-up assessments, which may result in patient harm, including delayed puberty, reduced postnatal growth, decreased IQ, and inattention and behavior problems in children.

The FDA notified CDC on June 24 that some Magellan Diagnostics blood lead test kits were undergoing a voluntary recall by the manufacturer. The FDA is now recommending that Magellan Diagnostics customers discontinue the use of all affected test kit lots identified as part of the recall and quarantine remaining inventory.

Recommendations
- Discontinue use of all affected test kit lots identified as part of the recall.
- Retest children who were tested with the recalled LeadCare test kits whose results were less than 5 µg/dL, the current CDC-recommended blood lead reference value. Retesting should be done with a venous blood sample analyzed with higher complexity testing.
- Retest children who were previously tested with a LeadCare test kit if the lot number of the initial test kit is unknown and the test was done between October 27, 2020, and June 15, 2021.
- Priority for retesting should be given to—
    - Children where there is clinical concern that symptoms or developmental problems may be related to lead exposure,
    - Populations at higher risk of elevated blood lead levels, such as children tested due to Medicaid-required screening or due to other state or local requirements, and
    - Individuals who are pregnant or breastfeeding.
- If retesting indicates blood lead levels in excess of the current CDC Blood Level Reference Values (BLRV) or state or local action level, the healthcare provider or public health official should refer to CDC guidelines or state/local guidelines for appropriate follow-up action.
- Discuss the recall and retesting recommendations with a parent and/or caregiver of children who meet the retesting criteria.

Per CDC guidance, children with blood lead levels at or greater than 5 µg/dL should have had a subsequent test with a venous blood sample for confirmation. LeadCare instruments are currently approved for use only with capillary or finger/heel stick samples. Venous blood confirmation levels are performed with higher complexity testing such as inductively coupled plasma mass spectrometry (ICP-MS) or graphite furnace atomic absorption spectroscopy (GFAAS) and are generally considered more accurate.

More information about blood lead testing can be found by visiting—

- CDC's Lead Poisoning Prevention Program
- CDC's Lead and Multi-element Proficiency Program

More information about the recall can be found by visiting—

- Magellan Diagnostics Recalls LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests Due to Risk of Falsely Low Results

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Categories of Health Alert Network messages:

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Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Health Advisory 447 - Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants

Ohio Health Alert Network <56e7d453-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Tue 7/27/2021 5:39 PM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

July 27, 2021, 4:00 PM ET

CDCHAN-00447

Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021

Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network Health Advisory to notify public health practitioners and clinicians about the urgent need to increase COVID-19 vaccination coverage (i.e., the percentage of the population fully vaccinated) across the United States to prevent surges in new infections that could increase COVID-19 related morbidity and mortality, overwhelm healthcare capacity, and widen existing COVID-19-related health disparities. Increasing vaccination coverage is especially urgent in areas where current coverage is low. Unvaccinated persons account for the majority of new COVID-19 infections, hospitalizations, and deaths. Currently circulating SARS-CoV-2 variants of concern, especially the highly infectious Delta variant (B.1.617.2), are accelerating spread of infection. Unvaccinated and partially vaccinated people need to practice all recommended prevention measures until fully vaccinated. In areas with substantial and high transmission, CDC recommends that fully vaccinated individuals wear a mask in public indoor settings to help prevent the spread of Delta and protect others.

Background

COVID-19 case rates are rising again after a period of decline: COVID-19 cases have increased over 300% nationally from June 19 to July 23, 2021, along with parallel increases in hospitalizations and deaths driven by the highly transmissible B.1.617.2 (Delta) variant. While significant progress has been made to make COVID-19 vaccine widely available, disparities in vaccination coverage persist across population groups and geographic areas. As of July 23, 2021, 1,856 (63.0%) of the 2,945 counties with available vaccination data have particularly low vaccination coverage, defined here as <40% of the population being fully vaccinated. As of July 23, 2021, among the counties with vaccine coverage <40%, 36.0% (N = 668) have COVID-19 incidence rates in the high burden level (≥100 cases/100,000 over the last seven days) (see figure below, and further data at COVID Tracker).

Overall, the majority (81.4%) of counties with high COVID-19 incidence rates are found in communities with low vaccination coverage. As COVID-19 case counts continue to rise nationally, areas with lower vaccination coverage are at especially high risk for a surge in cases.

Most cases of COVID-19 and hospitalizations are in unvaccinated individuals: While COVID-19 vaccines authorized in the United States remain effective against SARS-CoV-2 infection and severe disease, some infections among vaccinated persons (i.e., breakthrough infections) are anticipated and have been reported. However, the majority of COVID-19 cases and hospitalizations are occurring among individuals who are not fully vaccinated. From January through May 2021, of the more than 32,000 laboratory-confirmed COVID-19-associated hospitalizations in adults ≥18 years of age for whom vaccination status is known, <3% of hospitalizations occurred in fully vaccinated persons.

The COVID-19 Delta variant is widely prevalent and more infectious than prior strains: The COVID-19 Delta variant currently accounts for more than 80% of all COVID-19 cases in the United States. This variant is significantly more infectious than prior SARS-CoV-2 variants and has led to a rapid rise in COVID-19 cases in other countries, including the United Kingdom and Israel. Emerging evidence suggests that fully vaccinated people who do become infected with the Delta variant are at risk for transmitting it to others.

COVID-19 vaccination is our most effective strategy to prevent infection and severe disease: Vaccination is a priority national strategy to interrupt SARS-CoV-2 transmission, protect personal and public health, and preserve healthcare system capacity. COVID-19 vaccines are safe and recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Immunologic data support the role of Food and Drug Administration (FDA)-authorized COVID-19 vaccines in offering protection against the known currently circulating variants. By limiting viral spread, vaccination also minimizes opportunities for the introduction of more infectious variants through random mutation. Mutations could produce future variants that are more virulent and capable of evading diagnostic and therapeutic tools or overcoming vaccine-induced immunity.

COVID-19 vaccination coverage at skilled nursing facilities (SNF) helps prevent infection: Nursing home residents have been severely impacted by COVID-19 and are disproportionately represented in overall burden of COVID-19-related morbidity and mortality in the United States. While there has been significant progress in vaccinating SNF residents, vaccination coverage of staff at many

facilities remains low. Preliminary data from CDC's National Healthcare Safety Network (NHSN) indicate residents of SNFs in which vaccination coverage of staff is 75% or lower experience higher crude rates of preventable COVID infection.

CDC recommends urgent action by all: CDC recommends continued efforts to accelerate primary vaccination efforts, especially in areas with lower vaccination coverage. Individuals who are not fully vaccinated need to maintain all recommended prevention measures. People who are immunocompromised should be counseled about the potential for reduced immune responses to COVID-19 vaccines and to follow current prevention measures to protect themselves against COVID-19 until advised otherwise by their healthcare provider. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits (see vaccine equity resources below).

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination. Co-lead the conversation by participating in community education and outreach events.
- Leverage resources to promote vaccine equity.
- Encourage clinicians to offer and recommend COVID-19 vaccination to their patients and community members.
- Work with community partners to make vaccination easily accessible for unvaccinated populations.
- Implement additional prevention strategies when transmission is high and vaccination coverage is low (*MMWR*).
- Continue to monitor community transmission levels, variant, and vaccination coverage levels, and focus vaccine efforts on populations with low coverage.
- Communicate vaccination coverage, variant, and transmission levels to key partners, including the key information on risk associated with the B.1.617.2 (Delta) variant.

Recommendations for Clinicians

- If you are a clinical provider and are not fully vaccinated, get vaccinated as soon as possible to protect yourself, your family, and your patients.
- Increase patient outreach efforts to encourage, recommend, and offer COVID-19 vaccination.
- Remind patients that vaccination is recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Follow trusted sources carefully for any new recommendations and changes in vaccine guidance.
- Support efforts to ensure people receiving a first dose of a COVID-19 mRNA vaccine (i.e., Pfizer-BioNTech or Moderna) return for their second dose to complete the series.
- Communicate with unvaccinated staff, patients, and other individuals to increase confidence in vaccination. CDC has many resources for providers to help increase vaccine confidence.
- Recommend that fully vaccinated patients who are immunocompromised continue to practice all recommended prevention measures for unvaccinated persons.

Recommendations for Healthcare Facilities and Systems, Nursing Homes, and Businesses

- Recommend and offer COVID-19 vaccine to your staff and employees and establish policies to encourage uptake such as time off to receive the vaccine.
- Consider offering COVID-19 vaccine at your workplace (Workplace COVID-19 Vaccine Toolkit).
- Evaluate whether your facility can implement vaccine requirements or vaccine incentives.

For More Information

- CDCWeekly *Morbidity and Mortality Weekly Report* (*MMWR)* Guidance for Implementing COVID-19 Prevention Strategies in the Context of Varying Community Transmission Levels and Vaccination Coverage
- Interim Public Health Recommendations for Fully Vaccinated People
- COVID Data Tracker

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

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##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Ryan Morrison, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

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Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

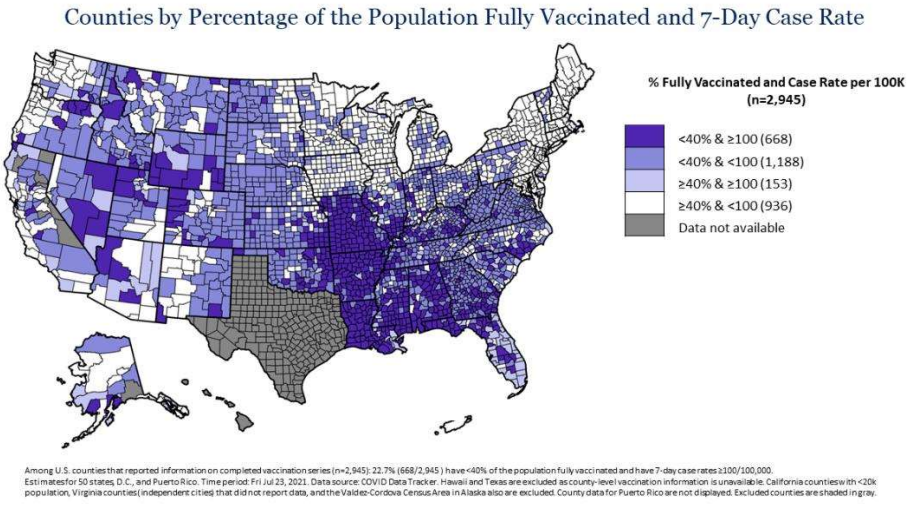
CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
July 27, 2021, 4:00 PM ET
CDCHAN-00447

Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021

Summary
The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network Health Advisory to notify public health practitioners and clinicians about the urgent need to increase COVID-19 vaccination coverage (i.e., the percentage of the population fully vaccinated) across the United States to prevent surges in new infections that could increase COVID-19 related morbidity and mortality, overwhelm healthcare capacity, and widen existing COVID-19-related health disparities. Increasing vaccination coverage is especially urgent in areas where current coverage is low. Unvaccinated persons account for the majority of new COVID-19 infections, hospitalizations, and deaths. Currently circulating SARS-CoV-2 variants of concern, especially the highly infectious Delta variant (B.1.617.2), are accelerating spread of infection. Unvaccinated and partially vaccinated people need to practice all recommended prevention measures until fully vaccinated. In areas with substantial and high transmission, CDC recommends that fully vaccinated individuals wear a mask in public indoor settings to help prevent the spread of Delta and protect others.

Background
COVID-19 case rates are rising again after a period of decline: COVID-19 cases have increased over 300% nationally from June 19 to July 23, 2021, along with parallel increases in hospitalizations and deaths driven by the highly transmissible B.1.617.2 (Delta) variant. While significant progress has been made to make COVID-19 vaccine widely available, disparities in vaccination coverage persist across population groups and geographic areas. As of July 23, 2021, 1,856 (63.0%) of the 2,945 counties with available vaccination data have particularly low vaccination coverage, defined here as <40% of the population being fully vaccinated. As of July 23, 2021, among the counties with vaccine coverage <40%, 36.0% (N = 668) have COVID-19 incidence rates in the high burden level (≥100 cases/100,000 over the last seven days) (see figure below, and further data at COVID Tracker).



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Most cases of COVID-19 and hospitalizations are in unvaccinated individuals: While COVID-19 vaccines authorized in the United States remain effective against SARS-CoV-2 infection and severe disease, some infections among vaccinated persons (i.e., breakthrough infections) are anticipated and have been reported. However, the majority of COVID-19 cases and hospitalizations are occurring among individuals who are not fully vaccinated. From January through May 2021, of the more than 32,000 laboratory-confirmed COVID-19-associated hospitalizations in adults ≥18 years of age for whom vaccination status is known, <3% of hospitalizations occurred in fully vaccinated persons.

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COVID-19 vaccination is our most effective strategy to prevent infection and severe disease: Vaccination is a priority national strategy to interrupt SARS-CoV-2 transmission, protect personal and public health, and preserve healthcare system capacity. COVID-19 vaccines are safe and recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Immunologic data support the role of Food and Drug Administration (FDA)-authorized COVID-19 vaccines in offering protection against the known currently circulating variants. By limiting viral spread, vaccination also minimizes opportunities for the introduction of more infectious variants through random mutation. Mutations could produce future variants that are more virulent and capable of evading diagnostic and therapeutic tools or overcoming vaccine-induced immunity.

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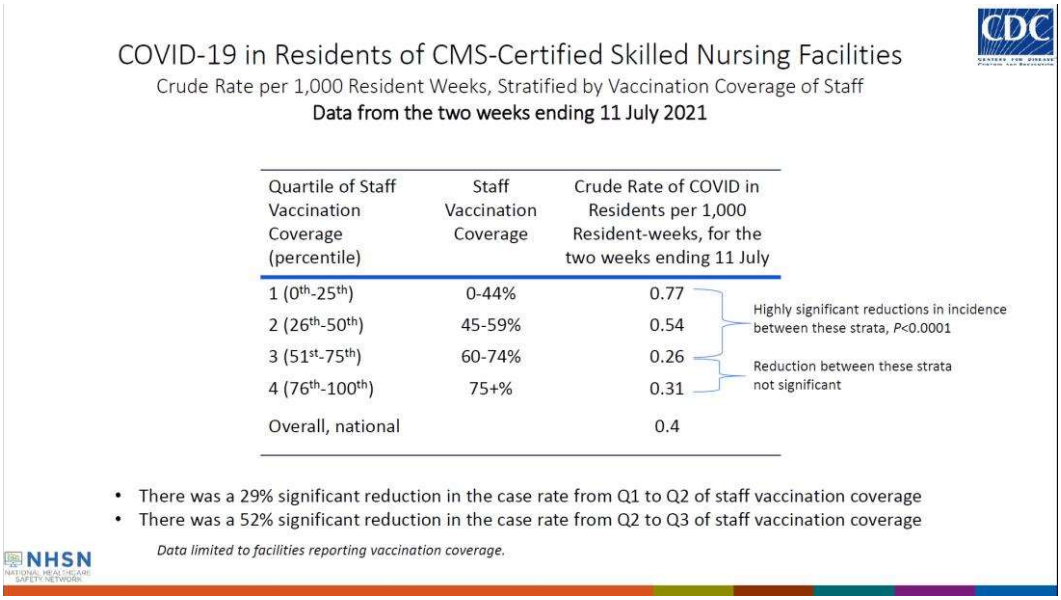

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Recommendations for Public Health Jurisdictions

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- Encourage clinicians to offer and recommend COVID-19 vaccination to their patients and community members.
- Work with community partners to make vaccination easily accessible for unvaccinated populations.
- Implement additional prevention strategies when transmission is high and vaccination coverage is low (*MMWR*).
- Continue to monitor community transmission levels, variant, and vaccination coverage levels, and focus vaccine efforts on populations with low coverage.
- Communicate vaccination coverage, variant, and transmission levels to key partners, including the key information on risk associated with the B.1.617.2 (Delta) variant.

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- If you are a clinical provider and are not fully vaccinated, get vaccinated as soon as possible to protect yourself, your family, and your patients.
- Increase patient outreach efforts to encourage, recommend, and offer COVID-19 vaccination.
- Remind patients that vaccination is recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Follow trusted sources carefully for any new recommendations and changes in vaccine guidance.
- Support efforts to ensure people receiving a first dose of a COVID-19 mRNA vaccine (i.e., Pfizer-BioNTech or Moderna) return for their second dose to complete the series.
- Communicate with unvaccinated staff, patients, and other individuals to increase confidence in vaccination. CDC has many resources for providers to help increase vaccine confidence.
- Recommend that fully vaccinated patients who are immunocompromised continue to practice all recommended prevention measures for unvaccinated persons.

Recommendations for Healthcare Facilities and Systems, Nursing Homes, and Businesses

- Recommend and offer COVID-19 vaccine to your staff and employees and establish policies to encourage uptake such as time off to receive the vaccine.
- Consider offering COVID-19 vaccine at your workplace (Workplace COVID-19 Vaccine Toolkit).
- Evaluate whether your facility can implement vaccine requirements or vaccine incentives.

For More Information

- CDC Weekly *Morbidity and Mortality Weekly Report* (*MMWR*) Guidance for Implementing COVID-19 Prevention Strategies in the Context of Varying Community Transmission Levels and Vaccination Coverage
- Interim Public Health Recommendations for Fully Vaccinated People
- COVID Data Tracker

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Health Alert	Requires immediate action or attention, highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

CDC Releases Updated STI Treatment Guidelines

Ohio Health Alert Network <578c71c2-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Fri 8/13/2021 8:29 AM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

Health Alert

CDC Releases Updated STI Treatment Guidelines

Dear Colleagues,

CDC has released Sexually Transmitted Infections Treatment Guidelines, 2021**.** This document provides current evidence-based diagnostic, management, and treatment recommendations, and serves as a source of clinical guidance for managing sexually transmitted infections (STIs).

The new guidelines include notable updates from the previous 2015 guidance, including:

- Updated treatment recommendations for chlamydia, trichomoniasis, and pelvic inflammatory disease.
- Updated treatment recommendations for uncomplicated gonorrhea in neonates, children, and other specific clinical situations (e.g., proctitis, epididymitis, sexual assault), which builds on broader treatment changes published in Morbidity and Mortality Weekly Report late last year.
- Information on FDA-cleared diagnostic tests for *Mycoplasma genitalium* and rectal and pharyngeal chlamydia and gonorrhea.
- Expanded risk factors for syphilis testing among pregnant patients.
- Recommended two-step serologic testing for diagnosing genital herpes simplex virus.
- Harmonized recommendations for human papillomavirus vaccination with the Advisory Committee on Immunization Practices.
- Recommended universal hepatitis C testing in alignment with CDC's 2020 hepatitis C testing recommendations.

STIs are common and costly to the nation's health and economy. With 26 million new STIs occurring each year, totaling nearly $16 billion in medical costs, evidence-based prevention, diagnostic, and treatment recommendations are critical to halting continued increases.

The new recommendations come at a pivotal moment in our field's history. As many of you know all too well, the COVID-19 pandemic caused decreased clinic capacity, as well as drug and diagnostic test kit shortages. Along the way, CDC provided guidance for the disruption of STD clinical services, focusing on syndromic management and STI screening approaches to maximize the number of people with STIs identified and treated, while prioritizing those most likely to experience complications. However, most drug and testing kit shortages have since resolved and many health care providers are returning to normal clinical practices, which includes conducting STI evaluation and management in accordance with CDC Sexually Transmitted Infections Treatment Guidelines, 2021.

You can stay informed on the latest STI recommendations and clinical guidance with CDC's online and print resources, which include:

- **An updated wall chart and pocket guide** summarizing the current treatment and screening recommendations. A limited number of free copies will be available for order through CDC-INFO On Demand in the coming weeks, as well as the MMWR itself. PDFs are available online in the meantime.
- **An updated STI Treatment Guidelines mobile app** is in development and is expected to launch in the coming months. **NOTE**: The 2015 STD Treatment Guidelines app will be retired at the end of July 2021. CDC is finalizing an interim, mobile-friendly solution – please visit STI Treatment Guidelines (cdc.gov) where we will post information, as it becomes available.
- **A customizable letter** is also available for colleagues looking to promote the updated guidelines.

CDC partners offer an array of additional resources. The National Network of STD Clinical Prevention Training Centers provides training and technical assistance. Providers also can access STD clinical consultation services through the latest STD Clinical Consultation Network.

For questions about the updated 2021 STI Treatment Guidelines, email the Clinical Team in CDC's Division of STD Prevention at stitxguidelines@cdc.gov.

The road to these updated guidelines would not be possible without the expertise and on-the-ground work of everyone committed to STI prevention and control. Together, we will continue to advance the field of STI prevention.

Best regards,

Raul Romaguera, DMD, MPH

Acting Director, Division of STD Prevention

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

US Centers for Disease Control and Prevention

Recipients:

ODH Senior Leadership

Statewide Epi-Surveillance

Statewide HAN Notification

Statewide Hospital IP

Statewide LHD Leadership

Statewide Nursing-Physician-Medical

Statewide OPHCS Coordinator

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Click here to confirm receipt.

Thank you,
Ohio Health Alert Network

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

July 22, 2021

Dear Colleagues,

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Best regards,

/Raul A. Romaguera/
Raul Romaguera, DMD, MPH
Acting Director, Division of STD Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
US Centers for Disease Control and Prevention

Health Advisory 449 - Rapid Increase in Ivermectin Prescriptions and Reports of Severe Illness

Ohio Health Alert Network <5800676f-0005-3002-80c0-fceb55463ffe@notify.mir3.com>
Thu 8/26/2021 12:31 PM
To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

August 26, 2021, 11:40 AM ET

CDCHAN-00449

Rapid Increase in Ivermectin Prescriptions and Reports of Severe Illness Associated with Use of Products Containing Ivermectin to Prevent or Treat COVID-19

Summary

Ivermectin is a U.S. Food and Drug Administration (FDA)-approved prescription medication used to treat certain infections caused by internal and external parasites. When used as prescribed for approved indications, it is generally safe and well tolerated.

During the COVID-19 pandemic, ivermectin dispensing by retail pharmacies has increased, as has use of veterinary formulations available over the counter but not intended for human use. FDA has cautioned about the potential risks of use for prevention or treatment of COVID-19.

Ivermectin is not authorized or approved by FDA for prevention or treatment of COVID-19. The National Institutes of Health's (NIH) COVID-19 Treatment Guidelines Panel has also determined that there are currently insufficient data to recommend ivermectin for treatment of COVID-19. ClinicalTrials.gov has listings of ongoing clinical trials that might provide more information about these hypothesized uses in the future.

Adverse effects associated with ivermectin misuse and overdose are increasing, as shown by a rise in calls to poison control centers reporting overdoses and more people experiencing adverse effects.

Background

The Centers for Disease Control and Prevention (CDC) confirmed with the American Association of Poison Control Centers (AAPCC) that human exposures and adverse effects associated with ivermectin reported to poison control centers have increased in 2021 compared to the pre-pandemic baseline. These reports include increased use of veterinary products not meant for human consumption.

Ivermectin is a medication that is approved by FDA in oral formulations to treat onchocerciasis (river blindness) and intestinal strongyloidiasis. Topical formulations are used to treat head lice and rosacea. Ivermectin is also used in veterinary applications to prevent or treat internal and external parasitic infections in animals. When used in appropriate doses for approved indications, ivermectin is generally well tolerated.

Clinical trials and observational studies to evaluate the use of ivermectin to prevent and treat COVID-19 in humans have yielded insufficient evidence for the NIH COVID-19 Treatment Guidelines Panel to recommend its use. Data from adequately sized, well-designed, and well-conducted clinical trials are needed to provide more specific, evidence-based guidance on the role of ivermectin in the treatment of COVID-19.

A recent study examining trends in ivermectin dispensing from outpatient retail pharmacies in the United States during the COVID-19 pandemic showed an increase from an average of 3,600 prescriptions per week at the pre-pandemic baseline (March 16, 2019–March 13, 2020) to a peak of 39,000 prescriptions in the week ending on January 8, 2021.1 Since early July 2021, outpatient ivermectin dispensing has again begun to rapidly increase, reaching more than 88,000 prescriptions in the week ending August 13, 2021. This represents a 24-fold increase from the pre-pandemic baseline. (**Figure**)

Figure: Estimated number of outpatient ivermectin prescriptions dispensed from retail pharmacies — United States, March 16, 2019–August 13, 2021*

*Data are from the IQVIA National Prescription Audit Weekly (NPA Weekly) database. NPA Weekly collects data from a sample of approximately 48,900 U.S. retail pharmacies, representing 92% of all retail prescription activity. Ivermectin dispensed by mail order and long-term care pharmacies, prescriptions by veterinarians, and non-oral formulations were not included.

In 2021, poison control centers across the U.S. received a three-fold increase in the number of calls for human exposures to ivermectin in January 2021 compared to the pre-pandemic baseline.

In July 2021, ivermectin calls have continued to sharply increase, to a five-fold increase from baseline. These reports are also associated with increased frequency of adverse effects and emergency department/hospital visits.

In some cases, people have ingested ivermectin-containing products purchased without a prescription, including topical formulations and veterinary products. Veterinary formulations intended for use in large animals such as horses, sheep, and cattle (e.g., "sheep drench," injection formulations, and "pour-on" products for cattle) can be highly concentrated and result in overdoses when used by humans. Animal products may also contain inactive ingredients that have not been evaluated for use in humans. People who take inappropriately high doses of ivermectin above FDA-recommended dosing may experience toxic effects.

Clinical effects of ivermectin overdose include gastrointestinal symptoms such as nausea, vomiting, and diarrhea. Overdoses are associated with hypotension and neurologic effects such as decreased consciousness, confusion, hallucinations, seizures, coma, and death. Ivermectin may potentiate the effects of other drugs that cause central nervous system depression such as benzodiazepines and barbiturates.

Examples of recent significant adverse effects reported to U.S. poison control centers include the following:

- An adult drank an injectable ivermectin formulation intended for use in cattle in an attempt to prevent COVID-19 infection. This patient presented to a hospital with confusion, drowsiness, visual hallucinations, tachypnea, and tremors. The patient recovered after being hospitalized for nine days.
- An adult patient presented with altered mental status after taking ivermectin tablets of unknown strength purchased on the internet. The patient reportedly took five tablets a day for five days to treat COVID-19. The patient was disoriented and had difficulty answering questions and following commands. Symptoms improved with discontinuation of ivermectin after hospital admission.

Recommendations for Clinicians and Public Health Practitioners

- Be aware that ivermectin is not currently authorized or approved by FDA for treatment of COVID-19. NIH has also determined that there are currently insufficient data to recommend ivermectin for treatment of COVID-19.
- Educate patients about the risks of using ivermectin without a prescription, or ingesting ivermectin formulations that are meant for external use or ivermectin-containing products formulated for veterinary use.
- Advise patients to immediately seek medical treatment if they have taken any ivermectin or ivermectin-containing products and are experiencing symptoms. Signs and symptoms of ivermectin toxicity include gastrointestinal effects (nausea, vomiting, abdominal pain, and diarrhea), headache, blurred vision, dizziness, tachycardia, hypotension, visual hallucinations,

altered mental status, confusion, loss of coordination and balance, central nervous system depression, and seizures. Ivermectin may increase sedative effects of other medications such as benzodiazepines and barbiturates. Call the poison control center hotline (1-800-222-1222) for medical management advice.
- Educate patients and the public to get vaccinated against COVID-19. COVID-19 vaccination is safe and the most effective means to prevent infection and protect against severe disease and death from SARS-CoV-2, the virus that causes COVID-19, including the Delta variant.
- Educate patients and the public to use COVID-19 prevention measures including wearing masks in indoor public places, physical distancing by staying at least six feet from other people who don't live in the same household, avoiding crowds and poorly ventilated spaces, and frequent handwashing and use of hand sanitizer that contains at least 60 percent alcohol.

Recommendations for the Public

- Be aware that currently, ivermectin has not been proven as a way to prevent or treat COVID-19.
- Do not swallow ivermectin products that should be used on skin (e.g., lotions and creams) or are not meant for human use, such as veterinary ivermectin products.
- Seek immediate medical attention or call the poison control center hotline (1-800-222-1222) for advice if you have taken ivermectin or a product that contains ivermectin and are having symptoms. Signs and symptoms include gastrointestinal effects (nausea, vomiting, abdominal pain, and diarrhea), headache, blurred vision, dizziness, fast heart rate, and low blood pressure. Other severe nervous system effects have been reported, including tremors, seizures, hallucinations, confusion, loss of coordination and balance, decreased alertness, and coma.
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- Protect yourself and others from getting sick with COVID-19. In addition to vaccination, wear masks in indoor public places, practice staying at least six feet from other people who don't live in your household, avoid crowds and poorly ventilated spaces, and wash your hands often or use hand sanitizer that has at least 60 percent alcohol.

For More Information

NIH COVID-19 Treatment Ivermectin Guidelines

FDA Consumer Alert on Use of Ivermectin to Treat or Prevent COVID-19

FDA MedWatch Adverse Event Reporting program

CDC Coronavirus (COVID-19) website

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American Association of Poison Control Centers

Press Release: American College of Medical Toxicology Reports Data on Adverse Effects and Toxicity from Unapproved Use of Ivermectin for the Prevention or Treatment of COVID-19

Treatments Your Healthcare Provider Might Recommend if You Are Sick

References

1 Lind JN, Lovegrove MC, Geller AI, Uyeki TM, Datta SD, Budnitz DS. Increase in Outpatient Ivermectin Dispensing in the US During the COVID-19 Pandemic: A Cross-Sectional Analysis. J Gen Intern Med. 2021 Jun 18:1–3. doi: 10.1007/s11606-021-06948-6.

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Sent by:

Christopher Zukoski, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

Statewide LHD Leadership

Statewide LHD-Group

Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

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Distributed via the CDC Health Alert Network
August 26, 2021, 11:40 AM ET
CDCHAN-00449

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Summary
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Ivermectin is not authorized or approved by FDA for prevention or treatment of COVID-19. The National Institutes of Health's (NIH) COVID-19 Treatment Guidelines Panel has also determined that there are currently insufficient data to recommend ivermectin for treatment of COVID-19. ClinicalTrials.gov has listings of ongoing clinical trials that might provide more information about these hypothesized uses in the future.

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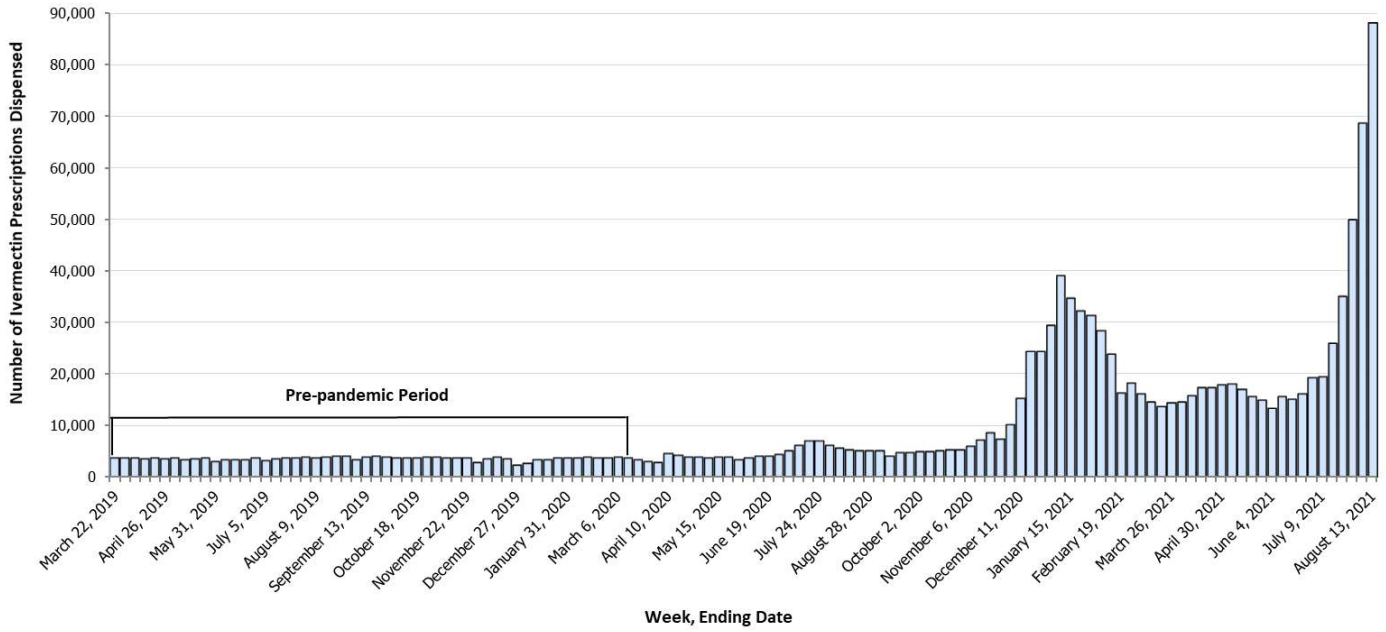

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Health Advisory 451: Increases in Availability of Cannabis Products Containing Delta-8 THC

Ohio Health Alert Network <58baadd9-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Tue 9/14/2021 12:05 PM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

September 14, 2021, 10:00 AM ET

CDCHAN-00451

Increases in Availability of Cannabis Products Containing Delta-8 THC and Reported Cases of Adverse Events

Summary

The purpose of this Health Alert Network (HAN) Health Advisory is to alert public health departments, healthcare professionals, first responders, poison control centers, laboratories, and the public to the increased availability of cannabis products containing delta-8 tetrahydrocannabinol (THC) and the potential for adverse events due to insufficient labeling of products containing THC and cannabidiol (CBD).

Background

Marijuana, which can also be called weed, pot, or dope, refers to all parts of the plant *Cannabis sativa L.*, including flower, seeds, and extracts with more than 0.3% delta-9 tetrahydrocannabinol (THC) by dry weight. Any part of the cannabis plant containing 0.3% or less THC by dry weight is defined as hemp.1 The cannabis plant contains more than 100 cannabinoids, including THC, which is psychoactive (i.e., impairing or mind-altering) and causes a "high".2 CBD is another active cannabinoid found in the cannabis plant that is not psychoactive and does not cause a "high".

The term THC most often refers to the delta-9 THC isomer, which is the most prominently occurring THC isomer in cannabis. However, THC has several other isomers that occur in the cannabis plant, including delta-8 THC. Delta-8 THC exists naturally in the cannabis plant in only small quantities and is estimated to be about 50-75% as psychoactive as delta-9 THC.3,4

CBD can be synthetically converted into delta-8 THC, as well as delta-9 THC and other THC isomers, with a solvent, acid, and heat to produce higher concentrations of delta-8 THC than those found naturally in the cannabis plant.5 This conversion process, used to produce some marketed products, may create harmful by-products that presently are not well-characterized.

Delta-8 THC products are increasingly appearing in both marijuana and hemp marketplaces, some of which operate legally under state, territorial, or tribal laws.6 Most states and territories permit full or restricted hemp marketplaces that sell hemp and hemp-derived CBD products.7 Products sold as concentrated delta-8 THC are also available online. Delta-8 THC products are sometimes marketed as "weed light" or "diet weed."

The health effects of delta-8 THC have not yet been researched extensively and are not well-understood. However, delta-8 THC is psychoactive and may have similar risks of impairment as delta-9 THC.4 As such, products that contain delta-8 THC but are labeled with only delta-9 THC content rather than with total THC content likely underestimate the psychoactive potential of these products for consumers. In addition, the sale of delta-8 THC products is not limited to regulated marijuana dispensaries in states, territories, or tribal nations where marketplaces operate under law. Rather, delta-8 THC products are sold by a wide range of businesses that sell hemp. As a result, delta-8 THC products may also have the potential to be confused with hemp or CBD products that are not intoxicating. Consumers who use these products may therefore experience unexpected or increased THC intoxication.

A wide variety of delta-8 THC-containing products have entered the marketplace, including, but not limited to, vapes, smokable hemp sprayed with delta-8 THC extract, distillates, tinctures, gummies, chocolates, and infused beverages. In addition, because testing methods for products like synthetically derived delta-8 THC are still being developed, delta-8 THC products may not be tested systematically for contaminants such as heavy metals, solvents, or pesticides that may have adverse health effects.8

Recent increases in delta-8 THC-involved adverse events

In March 2021, the West Virginia Poison Control Center9 reported two cases of adverse events related to use of delta-8 THC products in adults. In both instances, individuals mistook the products containing delta-8 THC for CBD-like products. These exposures led to symptoms consistent with cannabis intoxication. The Michigan Poison Control Center10 also reported two cases of severe adverse events to delta-8 THC in two children who ingested a parent's delta-8 THC-infused gummies purchased from a vape shop. Both children experienced deep sedation and slowed breathing with

initial increased heart rate progressing to slowed heart rate and decreased blood pressure. The children were admitted to the intensive care unit for further monitoring and oxygen supplementation.

In 2021, The American Association of Poison Control Centers (AAPCC) introduced a product code specific to delta-8 THC into its National Poison Data System (NPDS), allowing for the monitoring of delta-8 THC adverse events*. From January 1 to July 31, 2021, 660 delta-8 THC exposures were recorded with the new product code, and one additional case was recoded as a delta-8 THC exposure from October 2020. Eighteen percent of exposures (119 of 661 cases) required hospitalization, and 39% (258 of 661 cases) involved pediatric patients less than 18 years of age.

Syndromic surveillance data from emergency departments participating in the CDC's National Syndromic Surveillance Program (NSSP) show an increase in visits with a mention of delta-8 THC or some variation in the chief complaint text in recent months. More than 4,400 active emergency facilities that represent portions of 49 states and Washington, DC contribute data to NSSP, accounting for approximately 71% of all U.S. non-federal emergency departments. The first suspected visit associated with delta-8 THC in NSSP was observed in September 2020, with three additional visits observed through the end of 2020. Suspected visits have generally increased monthly in 2021 (three suspected visits were observed in January; six in February; 16 in March; 11 in April; 29 in May; 32 in June; and 48 in July 2021). The majority of these visits (73%, 109 of 149 visits) occurred in the Department of Health and Human Services' Regions 4 and 6, which are composed primarily of Southern states that have not passed state laws to allow non-medical adult cannabis use.11 These numbers are likely an underestimate due to the potential for inaccurate and incomplete information about products used by consumers.

Several factors can influence both the type and severity of cannabis-related adverse events, including the type of cannabinoid ingested, concentration, route of exposure, and the individual characteristics of the person who consumed the cannabinoid such as their age, weight, and sex. Delta-8 THC intoxication can cause adverse effects similar to those observed during delta-9 THC intoxication10,12, and may include—

- Lethargy
- Uncoordinated movements and decreased psychomotor activity
- Slurred speech
- Increased heart rate progressing to slowed heart rate
- Low blood pressure
- Difficulty breathing
- Sedation
- Coma

Summary

The rise in delta-8 THC products in marijuana and hemp marketplaces has increased the availability of psychoactive cannabis products, even in states, territories, and tribal nations where non-medical adult cannabis use is not permitted under law. Variations in product content, manufacturing practices, labeling, and potential misunderstanding of the psychoactive properties of delta-8 THC may lead to unexpected effects among consumers. Adverse event reports involving products that contain delta-8 THC that resulted in consumers' hospital or emergency department treatment have been described. Increased reports of adverse events related to delta-8 THC, as well as preliminary reports of the emergence of other similarly produced products derived from cannabis warrant the continued monitoring and tracking of adverse events related to THC.

Recommendations for the Public and Consumers

- Consumers should be aware of possible limitations in the labeling of products containing THC and CBD even from approved marijuana and hemp retailers. Products reporting only delta-9 THC concentration, but not total THC may underestimate the psychoactive potential for consumers.
- Consumers should be aware that products labeled as hemp or CBD may contain delta-8 THC, and that products containing delta-8 THC can result in psychoactive effects. Delta-8 THC products are currently being sold in many states, territories, and tribal nations where non-medical adult cannabis use is not permitted by law. In addition, retailers may sell products outside of regulated dispensaries in states, territories, and tribal nations where cannabis use is permitted by law. This may provide consumers with a false sense of safety, as delta-8 THC products may be labeled as hemp or CBD, which consumers may not associate with psychoactive ingredients.
- Parents who consume edibles and other products that contain THC and CBD should store them safely away from children. Children may mistake some edibles that contain THC and CBD (e.g., fruit-flavored gummies containing delta-8 THC) as candy.
- If consumers experience adverse effects of THC- or CBD-containing products that are an immediate danger to their health, they should call their local or regional poison control center at 1-800-222-1222 or 911 or seek medical attention at their local emergency room and report the ingredients of ingested products to healthcare providers. Consumers are also encouraged to report adverse events to MedWatch.
- Consumers should be aware that the cannabis marketplace continues to evolve. Other cannabis-derived products of potential concern have emerged recently, such as those containing delta-10 THC and THC-O acetate. More research is needed to understand the health effects of products containing these compounds.

Recommendations for Public Health Departments and Poison Control Centers, including those in locations where laws only permit hemp marketplaces

- Release information to healthcare providers and the public about the psychoactive qualities and the potential health implications of using products containing delta-8 THC and that products labeled as hemp or CBD may contain delta-8 THC.

- Poison control centers have a new code available to identify delta-8 THC exposures. For patients or providers reporting delta-8 THC consumption, poison control centers should use the

American Association of Poison Control Centers code 310146 or product code 8297130 to indicate delta-8 THC exposure and aid in the continued surveillance of these exposures.
- States, territories, and tribal nations that have passed laws allowing non-medical use of adult cannabis or that may allow such use in the future may consider requiring the reporting of total THC content, including ingredients like delta-8 THC and other compounds that may be synthetically produced, on product labeling.
- Community-based organizations, such as Drug-Free Communities coalitions, can use information from this report to raise awareness in their communities about the potential negative health effects associated with use of delta-8 THC-containing products, as well as the emergence of other cannabis-derived products of potential concern.

Recommendations for Retailers Selling Cannabis Products

- Retailers selling cannabis products should provide information to consumers about the psychoactive qualities of delta-8 THC.
- Retailers selling cannabis products should report total THC content on product labeling, including ingredients like delta-8 THC that may be synthetically produced to create a psychoactive effect.

Recommendations for Healthcare Providers

- Healthcare providers should be vigilant in observing patients presenting with THC-like intoxication symptoms who do not report an exposure to marijuana or history of use. Symptomatic patients should be questioned about their use of CBD or delta-8 THC products.
- There is no specific antidote for THC intoxication. Treatment is largely symptomatic and supportive care. The ability to detect delta-8 THC with laboratory tests that hospitals use to detect delta-9 THC currently is not fully characterized. Consult with your hospital's medical toxicologist or local poison control center for toxicology consultations on treatment.

For More Information

- CDC Marijuana homepage: "Marijuana and Public Health"
- FDA Delta-8 THC Consumer Update: "5 Things to Know about Delta-8 Tetrahydrocannabinol"
- Visit CDC-INFO or call CDC-INFO at 1-800-232-4636
- CDC 24/7 Emergency Operations Center (EOC) 770-488-7100

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1. Agriculture Improvement Act of 2018. H.R.2, 115th Cong. (2017-2018).

2. Rosenberg EC, Tsien RW, Whalley BJ, Devinsky O. Cannabinoids and epilepsy. Neurotherapeutics, 12 (2015), pp. 747-768.

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4. Hollister LE, Gillespie HK. Delta-8- and delta-9-tetrahydrocannabinol comparison in man by oral and intravenous administration. Clin Pharmacol Ther. 1973 May-Jun;14(3):353-7

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6. Brightfield Group. What's the Fate of Delta-8? Consumer, Product, and Regulatory Trends. Published 2021. Accessed August 31, 2021.

7. National Conference of State Legislatures (2020, April 16). *State Industrial Hemp Statutes*.

8. Delta-8-THC, HB 3000, 2021 Oregon State Legislature Regular Session. Testimony of Steven Crowley.

9. West Virginia Substance Abuse Early Warning Network. Alert #WV003. Reported Cases of Adverse Reactions to Delta-8 THC Products in West Virginia. March 10, 2021.

10. Michigan Poison Center. Fact Sheet: Emerging Public Health Concern: Delta-8 THC. April 23, 2021.

11. National Conference of State Legislatures (2021, July 14). *State Medical Marijuana Laws*.

12. Grotenhermen F. Pharmacokinetics and pharmacodynamics of cannabinoids. Clin Pharmacokinet.2003;42(4):327-60.

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Christopher Zukoski, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

Statewide LHD Leadership

Statewide LHD-Group

Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# *Response*:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
September 14, 2021, 10:00 AM ET
CDCHAN-00451

Increases in Availability of Cannabis Products Containing Delta-8 THC and Reported Cases of Adverse Events

Summary
The purpose of this Health Alert Network (HAN) Health Advisory is to alert public health departments, healthcare professionals, first responders, poison control centers, laboratories, and the public to the increased availability of cannabis products containing delta-8 tetrahydrocannabinol (THC) and the potential for adverse events due to insufficient labeling of products containing THC and cannabidiol (CBD).

Background
Marijuana, which can also be called weed, pot, or dope, refers to all parts of the plant *Cannabis sativa L.*, including flower, seeds, and extracts with more than 0.3% delta-9 tetrahydrocannabinol (THC) by dry weight. Any part of the cannabis plant containing 0.3% or less THC by dry weight is defined as hemp.[1] The cannabis plant contains more than 100 cannabinoids, including THC, which is psychoactive (i.e., impairing or mind-altering) and causes a "high".[2] CBD is another active cannabinoid found in the cannabis plant that is not psychoactive and does not cause a "high".

The term THC most often refers to the delta-9 THC isomer, which is the most prominently occurring THC isomer in cannabis. However, THC has several other isomers that occur in the cannabis plant, including delta-8 THC. Delta-8 THC exists naturally in the cannabis plant in only small quantities and is estimated to be about 50-75% as psychoactive as delta-9 THC.[3,4]

CBD can be synthetically converted into delta-8 THC, as well as delta-9 THC and other THC isomers, with a solvent, acid, and heat to produce higher concentrations of delta-8 THC than those found naturally in the cannabis plant.[5] This conversion process, used to produce some marketed products, may create harmful by-products that presently are not well-characterized.

Delta-8 THC products are increasingly appearing in both marijuana and hemp marketplaces, some of which operate legally under state, territorial, or tribal laws.[6] Most states and territories permit full or restricted hemp marketplaces that sell hemp and hemp-derived CBD products.[7] Products sold as concentrated delta-8 THC are also available online. Delta-8 THC products are sometimes marketed as "weed light" or "diet weed."

The health effects of delta-8 THC have not yet been researched extensively and are not well-understood. However, delta-8 THC is psychoactive and may have similar risks of impairment as delta-9 THC.[4] As such, products that contain delta-8 THC but are labeled with only delta-9 THC content rather than with total THC content likely underestimate the psychoactive potential of these products for consumers. In addition, the sale of delta-8 THC products is not limited to regulated marijuana dispensaries in states, territories, or tribal nations where marketplaces operate under law. Rather, delta-8 THC products are sold by a wide range of businesses that sell hemp. As a result, delta-8 THC products may also have the potential to be confused with hemp or CBD products that are not intoxicating. Consumers who use these products may therefore experience unexpected or increased THC intoxication.

A wide variety of delta-8 THC-containing products have entered the marketplace, including, but not limited to, vapes, smokable hemp sprayed with delta-8 THC extract, distillates, tinctures, gummies,

chocolates, and infused beverages. In addition, because testing methods for products like synthetically derived delta-8 THC are still being developed, delta-8 THC products may not be tested systematically for contaminants such as heavy metals, solvents, or pesticides that may have adverse health effects.[8]

Recent increases in delta-8 THC-involved adverse events

In March 2021, the West Virginia Poison Control Center[9] reported two cases of adverse events related to use of delta-8 THC products in adults. In both instances, individuals mistook the products containing delta-8 THC for CBD-like products. These exposures led to symptoms consistent with cannabis intoxication. The Michigan Poison Control Center[10] also reported two cases of severe adverse events to delta-8 THC in two children who ingested a parent's delta-8 THC-infused gummies purchased from a vape shop. Both children experienced deep sedation and slowed breathing with initial increased heart rate progressing to slowed heart rate and decreased blood pressure. The children were admitted to the intensive care unit for further monitoring and oxygen supplementation.

In 2021, The American Association of Poison Control Centers (AAPCC) introduced a product code specific to delta-8 THC into its National Poison Data System (NPDS), allowing for the monitoring of delta-8 THC adverse events*. From January 1 to July 31, 2021, 660 delta-8 THC exposures were recorded with the new product code, and one additional case was recoded as a delta-8 THC exposure from October 2020. Eighteen percent of exposures (119 of 661 cases) required hospitalization, and 39% (258 of 661 cases) involved pediatric patients less than 18 years of age.

Syndromic surveillance data from emergency departments participating in the CDC's National Syndromic Surveillance Program (NSSP) show an increase in visits with a mention of delta-8 THC or some variation in the chief complaint text in recent months. More than 4,400 active emergency facilities that represent portions of 49 states and Washington, DC contribute data to NSSP, accounting for approximately 71% of all U.S. non-federal emergency departments. The first suspected visit associated with delta-8 THC in NSSP was observed in September 2020, with three additional visits observed through the end of 2020. Suspected visits have generally increased monthly in 2021 (three suspected visits were observed in January; six in February; 16 in March; 11 in April; 29 in May; 32 in June; and 48 in July 2021). The majority of these visits (73%, 109 of 149 visits) occurred in the Department of Health and Human Services' Regions 4 and 6, which are composed primarily of Southern states that have not passed state laws to allow non-medical adult cannabis use.[11] These numbers are likely an underestimate due to the potential for inaccurate and incomplete information about products used by consumers.

Several factors can influence both the type and severity of cannabis-related adverse events, including the type of cannabinoid ingested, concentration, route of exposure, and the individual characteristics of the person who consumed the cannabinoid such as their age, weight, and sex. Delta-8 THC intoxication can cause adverse effects similar to those observed during delta-9 THC intoxication[10,12], and may include—

- Lethargy
- Uncoordinated movements and decreased psychomotor activity
- Slurred speech
- Increased heart rate progressing to slowed heart rate
- Low blood pressure
- Difficulty breathing
- Sedation
- Coma

Summary

The rise in delta-8 THC products in marijuana and hemp marketplaces has increased the availability of psychoactive cannabis products, even in states, territories, and tribal nations where non-medical adult cannabis use is not permitted under law. Variations in product content, manufacturing practices, labeling, and potential misunderstanding of the psychoactive properties of delta-8 THC may lead to unexpected effects among consumers. Adverse event reports involving products that contain delta-8 THC that resulted in consumers' hospital or emergency department treatment have been described. Increased

reports of adverse events related to delta-8 THC, as well as preliminary reports of the emergence of other similarly produced products derived from cannabis warrant the continued monitoring and tracking of adverse events related to THC.

Recommendations for the Public and Consumers

- Consumers should be aware of possible limitations in the labeling of products containing THC and CBD even from approved marijuana and hemp retailers. Products reporting only delta-9 THC concentration, but not total THC may underestimate the psychoactive potential for consumers.
- Consumers should be aware that products labeled as hemp or CBD may contain delta-8 THC, and that products containing delta-8 THC can result in psychoactive effects. Delta-8 THC products are currently being sold in many states, territories, and tribal nations where non-medical adult cannabis use is not permitted by law. In addition, retailers may sell products outside of regulated dispensaries in states, territories, and tribal nations where cannabis use is permitted by law. This may provide consumers with a false sense of safety, as delta-8 THC products may be labeled as hemp or CBD, which consumers may not associate with psychoactive ingredients.
- Parents who consume edibles and other products that contain THC and CBD should store them safely away from children. Children may mistake some edibles that contain THC and CBD (e.g., fruit-flavored gummies containing delta-8 THC) as candy.
- If consumers experience adverse effects of THC- or CBD-containing products that are an immediate danger to their health, they should call their local or regional poison control center at 1-800-222-1222 or 911 or seek medical attention at their local emergency room and report the ingredients of ingested products to healthcare providers. Consumers are also encouraged to report adverse events to MedWatch.
- Consumers should be aware that the cannabis marketplace continues to evolve. Other cannabis-derived products of potential concern have emerged recently, such as those containing delta-10 THC and THC-O acetate. More research is needed to understand the health effects of products containing these compounds.

Recommendations for Public Health Departments and Poison Control Centers, including those in locations where laws only permit hemp marketplaces

- Release information to healthcare providers and the public about the psychoactive qualities and the potential health implications of using products containing delta-8 THC and that products labeled as hemp or CBD may contain delta-8 THC.
- Poison control centers have a new code available to identify delta-8 THC exposures. For patients or providers reporting delta-8 THC consumption, poison control centers should use the American Association of Poison Control Centers code 310146 or product code 8297130 to indicate delta-8 THC exposure and aid in the continued surveillance of these exposures.
- States, territories, and tribal nations that have passed laws allowing non-medical use of adult cannabis or that may allow such use in the future may consider requiring the reporting of total THC content, including ingredients like delta-8 THC and other compounds that may be synthetically produced, on product labeling.
- Community-based organizations, such as Drug-Free Communities coalitions, can use information from this report to raise awareness in their communities about the potential negative health effects associated with use of delta-8 THC-containing products, as well as the emergence of other cannabis-derived products of potential concern.

Recommendations for Retailers Selling Cannabis Products

- Retailers selling cannabis products should provide information to consumers about the psychoactive qualities of delta-8 THC.
- Retailers selling cannabis products should report total THC content on product labeling, including ingredients like delta-8 THC that may be synthetically produced to create a psychoactive effect.

Recommendations for Healthcare Providers

- Healthcare providers should be vigilant in observing patients presenting with THC-like intoxication symptoms who do not report an exposure to marijuana or history of use. Symptomatic patients should be questioned about their use of CBD or delta-8 THC products.
- There is no specific antidote for THC intoxication. Treatment is largely symptomatic and supportive care. The ability to detect delta-8 THC with laboratory tests that hospitals use to detect delta-9 THC currently is not fully characterized. Consult with your hospital's medical toxicologist or local poison control center for toxicology consultations on treatment.

For More Information

- CDC Marijuana homepage: "Marijuana and Public Health"
- FDA Delta-8 THC Consumer Update: "5 Things to Know about Delta-8 Tetrahydrocannabinol"
- Visit CDC-INFO or call CDC-INFO at 1-800-232-4636
- CDC 24/7 Emergency Operations Center (EOC) 770-488-7100

References

1. Agriculture Improvement Act of 2018. H.R.2, 115th Cong. (2017-2018).
2. Rosenberg EC, Tsien RW, Whalley BJ, Devinsky O. Cannabinoids and epilepsy. Neurotherapeutics, 12 (2015), pp. 747-768.
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5. Kiselak TD, Koerber R, Verbeck GF. Synthetic route of sourcing of illicit at home cannabidiol (CBD) isomerization to psychoactive cannabinoids using ion mobility-coupled-LC-MS/MS. Forensic Sci Int 2020; 308:110173.
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7. National Conference of State Legislatures (2020, April 16). *State Industrial Hemp Statutes*.
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11. National Conference of State Legislatures (2021, July 14). *State Medical Marijuana Laws*.
12. Grotenhermen F. Pharmacokinetics and pharmacodynamics of cannabinoids. Clin Pharmacokinet.2003;42(4):327-60.

* *The American Association of Poison Control Centers (AAPCC) maintains the National Poison Data System (NPDS), which houses de-identified case records of self-reported information collected from callers during exposure management and poison information calls managed by the country's poison control centers (PCCs). NPDS data do not reflect the entire universe of exposures to a particular substance as additional exposures may go unreported to PCCs; accordingly, NPDS data should not be construed to represent the complete incidence of U.S. exposures to any substance(s). Exposures do not necessarily represent a poisoning or overdose and AAPCC is not able to completely verify the accuracy of every report. Findings based on NPDS data do not necessarily reflect the opinions of AAPCC.*

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention, highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

VMS Provider Refresh Training (Youth Vaccinations)

COVIDVACCINE@odh.ohio.gov <COVIDVACCINE@odh.ohio.gov>

Wed 10/27/2021 5:36 PM

To: acehealthyproducts11@gmail.com <acehealthyproducts11@gmail.com>; bboldman@adamscountyhealth.org <bboldman@adamscountyhealth.org>; kstauffer@adamscountyhealth.org <kstauffer@adamscountyhealth.org>; lethompson@acrmc.com <lethompson@acrmc.com>; jlblack@acrmc.com <jlblack@acrmc.com>; aldean@acrmc.com <aldean@acrmc.com>; jmmcchesney@acrmc.com <jmmcchesney@acrmc.com>; msbourne@acrmc.com <msbourne@acrmc.com>; rdcummings@acrmc.com <rdcummings@acrmc.com>; ddcropper@acrmc.com <ddcropper@acrmc.com>; tfmabry@acrmc.com <tfmabry@acrmc.com>; shaynes@adena.org <shaynes@adena.org>; fyingling@adena.org <fyingling@adena.org>; jabner@adena.org <jabner@adena.org>; dtippie@adena.org <dtippie@adena.org>; rash@adena.org <rash@adena.org>; edavis@adena.org <edavis@adena.org>; agow.tmm@gmail.com <agow.tmm@gmail.com>; advim@live.com <advim@live.com>; sschroeder@allenhealthdept.org <sschroeder@allenhealthdept.org>

Hello VMS User,

Thank you for your continued support in protecting Ohioans from COVID-19. As we prepare for the anticipated approval of COVID-19 vaccines for children ages 5-11, we would like to encourage you to participate in a one-time tutorial that will review the enhancements made to VMS to include eligibility screening and administration of the Pfizer-BioNTech COVID-19 pediatric vaccine. In order to get providers acquainted with the new features, we are hosting free educational sessions to demo new VMS features and answer any questions.

This one-session tutorial will be available via Microsoft Teams at the following dates/times:

- **Tuesday, Nov. 2 at 2 p.m. EST: Click here to join the meeting**
- **Wednesday, Nov. 3 at 11 a.m. EST: Click here to join the meeting**

To join one of these sessions, **please click the link above to join at your preferred time**. If you are interested in attending one of these sessions but are unable to make either of these times, please send us a message at covidvaccine@odh.ohio.gov, and we will ensure you receive information regarding these updates.

Thank you for your support on this initiative.

The Ohio Department of Health VMS Team

If you have additional questions, please email CovidVaccine@odh.ohio.gov.

For information about COVID-19:
coronavirus.ohio.gov
1-833-4-ASK-ODH

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Health Update 457 - Update: Expansion of Recall of LeadCare Blood Lead Tests Due to Risk of Falsely

Ohio Health Alert Network <5aa1c490-0005-3002-80c0-fceb55463ffe@notify.mir3.com>
Mon 11/8/2021 10:37 AM
To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

This is an official

CDC HEALTH UPDATE

Distributed via the CDC Health Alert Network

November 5, 2021, 10:00 AM ET

CDCHAN-00457

Update: Expansion of Recall of LeadCare Blood Lead Tests Due to Risk of Falsely Low Results

Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Update as an update to HAN Update 454: Expansion of Recall of LeadCare Blood Lead Tests Due to Risk of Falsely Low Results that CDC issued on October 14, 2021. **The purpose of this HAN Update is to clarify options for retesting children who were tested with the recalled LeadCare lead test kits. The information in this HAN Update remains the same as HAN Update 454, except for the new information added below in bold in the *Recommendations for Clinicians* section.**

Magellan Diagnostics, Inc. and the U.S. Food and Drug Administration (FDA) have issued notifications about the expansion of Magellan Diagnostics' recall of LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests, which were distributed from October 27, 2020, to August 19, 2021. Additional LeadCare II product lots, including lots previously reported to be unaffected, were recalled due to a significant risk of falsely low results. The use of these devices may cause serious injuries because they might underestimate blood lead levels. FDA has identified this as a Class I recall, the most serious type of recall.

Background

Magellan Diagnostics, Inc. is recalling LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Test kits due to a significant risk of falsely low blood lead level results. FDA has concerns that the falsely low results may contribute to health risks in special populations such as young children and pregnant individuals. A pregnant or lactating individual's exposure to lead is concerning because it may cause health problems for the parent and the developing baby. Obtaining falsely low blood lead level results may lead to patients not receiving appropriate follow-up assessments, which may result in patient harm, including delayed puberty, reduced postnatal growth, decreased IQ, and attention and behavior problems in children.

FDA initially notified CDC on June 24, 2021, that some Magellan Diagnostics blood lead test kits were undergoing a voluntary recall by the manufacturer. FDA recommended that Magellan Diagnostics customers discontinue using all affected test kit lots identified as part of the recall and quarantine remaining inventory. On August 31, 2021, Magellan Diagnostics began notifying customers that the recall was expanded to include additional LeadCare II product lots. The recall now includes the majority of all test kits distributed since October 27, 2020. Product distribution has been paused until further notice, and replacement product is currently unavailable. It is unknown when replacement product will be available.

Recommendations for Clinicians

- Continue to schedule and perform required blood lead tests for patients. A venous or capillary blood sample analyzed using higher complexity methods such as inductively coupled plasma mass spectrometry (ICP-MS) or graphite furnace atomic absorption spectroscopy (GFAAS) from a CLIA compliant clinical laboratory should be used if LeadCare lead test kits are unavailable.
- Discontinue using all test kit lots identified as part of the recall.
- Retest children who were tested with the recalled LeadCare lead test kits whose results were less than CDC's blood lead reference value.
- Retest children who were previously tested with a LeadCare test kit if the lot number of the initial test kit is unknown and the test was done after October 27, 2020.
- **Retesting should be done by higher complexity testing (ICP-MS or GFAAS) with either a venous or a capillary blood sample. Capillary screening results above the blood lead reference value should be confirmed with blood drawn by venipuncture. Please note that effective October 28, 2021, CDC has updated its blood lead reference value (BLRV) from 5 µg/dL to 3.5 µg/dL in response to the Lead Exposure Prevention and Advisory Committee recommendation made on May 14, 2021.1**
- Prioritize testing for:
    - Children where there is clinical concern that symptoms or developmental problems may be related to lead exposure,
    - Populations at higher risk of elevated blood lead levels, such as children tested due to Medicaid-required screening or due to other state or local requirements,
    - Individuals who are pregnant or breastfeeding, and
    - Children who are immigrants, refugees, or recently adopted from outside of the United States.

- Discuss the recall and retesting recommendations with a parent or caregiver of children who meet the retesting criteria.
- Follow recommendations for best practices when collecting a capillary blood sample for lead testing.

Recommendations for Public Health Professionals

- Work with healthcare providers in their jurisdictions to ensure patients receive their required blood lead tests. This outreach should include making providers aware of the need to conduct a capillary or venous test analyzed using higher complexity methods if LeadCare lead test kits are unavailable.
- Make providers aware that:
    - By delaying blood lead testing for children due to the unavailability of LeadCare lead test kits, children exposed to lead risk are not being identified and receiving necessary treatment and services.
    - If blood lead testing indicates blood lead levels are above the current CDC blood lead reference value or state or local action level, the healthcare provider or public health professional should refer to CDC guidelines or state/local guidelines for appropriate follow-up action.
    - State and public health laboratories may be able to help with additional demands for higher complexity testing.
- Follow recommendations for best practices when collecting a capillary blood sample for lead testing.
- Per CDC guidance, children with blood lead levels at or greater than CDC's blood lead reference value should have had a subsequent test with a venous blood sample for confirmation. LeadCare instruments are currently approved for use only with capillary or finger/heel stick samples.
    - Venous blood confirmation levels are performed with higher complexity testing such as inductively coupled plasma mass spectrometry (ICP-MS) or graphite furnace atomic absorption spectroscopy (GFAAS) and are generally considered more accurate and are available from CLIA-compliant clinical laboratories.

For More Information about Blood Lead Testing

- CDC's Lead Poisoning Prevention Program
- CDC's Lead and Multi-element Proficiency Program

For More Information about the Recall

- Magellan Diagnostics Recalls LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests Due to Risk of Falsely Low Results
- Information on the LeadCare Test Kit "Controls Out of Range-Low" ("COOR-LO") Recall

For More Information about Laboratory-related Resources

- Blood Lead Testing in Public Health Laboratories
- Video: What is the Laboratory Response Network for Chemical Threats (LRN-C)?
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References

1. Ruckart PZ, Jones RL, Courtney JG, et al. Update of the Blood Lead Reference Value — United States, 2021. *MMWR* Morb Mortal Wkly Rep 2021;70:1509–1512. DOI: https://dx.doi.org/10.15585/mmwr.mm7043a4.

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

To reply, click the appropriate response from the list of options below.

Option# Response:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official
CDC HEALTH UPDATE

Distributed via the CDC Health Alert Network
November 5, 2021, 10:00 AM ET
CDCHAN-00457

Update: Expansion of Recall of LeadCare Blood Lead Tests Due to Risk of Falsely Low Results

Summary
The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Update as an update to HAN Update 454: Expansion of Recall of LeadCare Blood Lead Tests Due to Risk of Falsely Low Results that CDC issued on October 14, 2021. **The purpose of this HAN Update is to clarify options for retesting children who were tested with the recalled LeadCare lead test kits. The information in this HAN Update remains the same as HAN Update 454, except for the new information added below in bold in the *Recommendations for Clinicians* section.**

Magellan Diagnostics, Inc. and the U.S. Food and Drug Administration (FDA) have issued notifications about the expansion of Magellan Diagnostics' recall of LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Tests, which were distributed from October 27, 2020, to August 19, 2021. Additional LeadCare II product lots, including lots previously reported to be unaffected, were recalled due to a significant risk of falsely low results. The use of these devices may cause serious injuries because they might underestimate blood lead levels. FDA has identified this as a Class I recall, the most serious type of recall.

Background
Magellan Diagnostics, Inc. is recalling LeadCare II, LeadCare Plus, and LeadCare Ultra Blood Lead Test kits due to a significant risk of falsely low blood lead level results. FDA has concerns that the falsely low results may contribute to health risks in special populations such as young children and pregnant individuals. A pregnant or lactating individual's exposure to lead is concerning because it may cause health problems for the parent and the developing baby. Obtaining falsely low blood lead level results may lead to patients not receiving appropriate follow-up assessments, which may result in patient harm, including delayed puberty, reduced postnatal growth, decreased IQ, and attention and behavior problems in children.

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- Continue to schedule and perform required blood lead tests for patients. A venous or capillary blood sample analyzed using higher complexity methods such as inductively coupled plasma mass spectrometry (ICP-MS) or graphite furnace atomic absorption spectroscopy (GFAAS) from a CLIA compliant clinical laboratory should be used if LeadCare lead test kits are unavailable.
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- Discuss the recall and retesting recommendations with a parent or caregiver of children who meet the retesting criteria.
- Follow recommendations for best practices when collecting a capillary blood sample for lead testing.

Recommendations for Public Health Professionals

- Work with healthcare providers in their jurisdictions to ensure patients receive their required blood lead tests. This outreach should include making providers aware of the need to conduct a capillary or venous test analyzed using higher complexity methods if LeadCare lead test kits are unavailable.
- Make providers aware that:
    - By delaying blood lead testing for children due to the unavailability of LeadCare lead test kits, children exposed to lead risk are not being identified and receiving necessary treatment and services.
    - If blood lead testing indicates blood lead levels are above the current CDC blood lead reference value or state or local action level, the healthcare provider or public health professional should refer to CDC guidelines or state/local guidelines for appropriate follow-up action.
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- Per CDC guidance, children with blood lead levels at or greater than CDC's blood lead reference value should have had a subsequent test with a venous blood sample for confirmation. LeadCare instruments are currently approved for use only with capillary or finger/heel stick samples.
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References

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Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention, highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Health Advisory 458: Increasing Seasonal Influenza A (H3N2) Activity, Especially Among Young Adults

Ohio Health Alert Network <5b4f7e6b-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Mon 11/29/2021 11:25 AM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

November 24, 2021, 11:00 AM ET

CDCHAN-00458

Increasing Seasonal Influenza A (H3N2) Activity, Especially Among Young Adults and in College and University Settings, During SARS-CoV-2 Circulation

Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory about increased influenza A(H3N2) activity that could mark the beginning of the 2021-2022 influenza season. The purpose of this HAN Health Advisory is to

1. Remind public health practitioners and clinicians to recommend and offer the current seasonal influenza vaccine to all eligible personsaged six months and older (Flu vaccine and COVID-19 vaccine can be given at the same visit).
2. Remind clinicians to consider testing for both influenza virus and SARS-CoV-2 in patients with influenza-like illness (ILI).
3. Advise clinicians that antiviral treatment is recommended as early as possible for any patient with confirmed or suspected influenza who is: a) hospitalized; b) at higher risk for influenza complications; or c) developing progressive illness. In patients with suspected influenza, decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza, however COVID-19 should be excluded if a rapid assay is available.
4. Remind public health practitioners and clinicians to consider mitigation measures including antiviral post-exposure prophylaxis during influenza outbreaks in institutions (e.g., long-term care facilities, university dormitories) in the setting of co-circulation of SARS-CoV-2.

5. Remind the public to use non-pharmaceutical interventions (NPI) or everyday preventive actions, in addition to getting a flu vaccine. Everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing hands often.

Background

Recent increases in influenza activity in many places in the United States could mark the beginning of the 2021-2022 influenza season in the United States. While influenza activity is still low overall nationally, an increase of influenza A(H3N2) viruses has been detected in recent weeks, with most of these infections occurring in young adults. CDC also is aware of influenza outbreaks in colleges and universities in several states. Influenza vaccination coverage is still low and there is still time this season to benefit from getting an annual influenza vaccine.

Available seasonal influenza vaccines in the United States provide protection against four different influenza viruses: A(H1N1)pdm09, A(H3N2), B/Victoria lineage, and B/Yamagata lineage viruses. In the past, influenza A(H3N2) virus-predominant seasons were associated with more hospitalizations and deaths in persons aged 65 years and older than other age groups than other influenza viruses. Influenza A(H3N2) viruses evolve more rapidly to escape human immunity. The influenza A(H3N2) component of this season's vaccines was recently updated in response to the evolution of a new group of viruses called 2a (i.e., 3C.2a1b.2a) that did not circulate widely last year and were not included in last season's H3N2 vaccine component.1 Most H3N2 viruses that have been analyzed in the United States so far are genetically closely related to the current vaccine's H3N2 component. However, this emerging group has continued to evolve, and there are now two subgroups (2a.1 and 2a.2) that are genetically closely related to each other, but do have some antigenic differences from each other (i.e., post-infection ferretantibodies from one virus might not efficiently bind the other virus).2 CDC virus surveillance data shows that most of the A(H3N2) viruses recently identified in the United States (October–November 2021) are in the 2a.2 group that is related to but distinguishable from the vaccine component (i.e., 2a.1). It is not known what impact the differences in the circulating viruses and the vaccine viruses may have on vaccine effectiveness. However, influenza vaccine effectiveness in general has been lower against A(H3N2) viruses than against the other three influenza viruses that could circulate [influenza A(H1N1)pdm09 or influenza B viruses].3 Influenza activity during the 2020–2021 season was low throughout the United States and the timing and intensity of the upcoming 2021–2022 influenza season is uncertain. Because influenza activity was low last season, we are anticipating a lower level of community protection that we rely on year after year to reduce the risk of a severe influenza season. Thus, CDC is anticipating an increase of influenza illness this winter, and both A(H3N2) and B-Victoria viruses are already co-circulating. Moreover, as SARS-CoV-2 continues to circulate in the United States, illnesses associated with both viruses might stress healthcare systems. A growing body of scientific studies suggest that even when vaccination does not prevent infection it can reduce the severity of influenza illness, helping to avert serious outcomes including hospitalization and death.

CDC recommends that healthcare providers continue to recommend and offer influenza vaccination to persons aged six months and older because influenza activity is ongoing. Vaccination protects against four different viruses and is likely to reduce hospitalization and death associated with currently circulating influenza viruses and other influenza viruses that might circulate later in the season. Influenza antiviral medications are an important adjunct that should be used in addition to influenza

vaccination. While vaccination is the primary means for preventing influenza, antiviral medications are a second line of defense used to treat influenza after infection has occurred. Early treatment with influenza antiviral medications is the most effective way to treat influenza and reduce complications.4-8

Influenza antivirals also can be used for post-exposure prophylaxis (PEP) to prevent infection.4,5,9 This can reduce the risk of influenza among persons who are exposed to someone who has influenza. Influenza antivirals have historically been used for PEP among residents in institutional settings, such as long-term care facilities, to help control influenza outbreaks. In the context of SARS-CoV-2 co-circulation, influenza antiviral treatment and PEP could also be considered in other communal settings (e.g., shelters, university dormitories, prisons) to reduce strain on healthcare services in these institutions during influenza outbreaks. In general, CDC recommends initiating influenza antiviral PEP within 48 hours of contact with someone who has influenza.

Recommendations for Clinicians and Public Health Practitioners

1**. Recommend and offer influenza vaccination for all eligible persons aged six months and older**

Anyone who has not received an influenza vaccine this season should get vaccinated now. For 2021-2022, CDC recommends using any licensed, age-appropriate influenza vaccine as an option for vaccination this season.10 Vaccination coverage is lower this season as of the week ending November 6, 2021 in certain groups at higher risk of severe influenza illness, such as pregnant persons and children, compared with the same period in 2020.11 Vaccination is the best way to reduce the spread of influenza and reduce influenza illness and complications that can result in hospitalization and death. Both influenza and COVID-19 vaccines can be administered at the same visit, without regard to timing. If a patient is due for both vaccines, providers are encouraged to offer both vaccines at the same visit.

2**. Treat patients with suspected or confirmed influenza who meet clinical criteria with influenza antivirals**

CDC recommends influenza antiviral medications to treat influenza as an important adjunct to vaccination. Treatment with influenza antivirals has been shown to be safe. Influenza antivirals benefit clinical and public health by reducing illness and severe outcomes of influenza based on evidence from observational studies, randomized controlled trials, and meta-analyses of randomized controlled trials.4-8,12

- CDC recommends influenza antiviral treatment **as soon as possible** for patients with suspected or confirmed influenza who are:
    - Hospitalized
    - Outpatients at increased risk for complications9
    - Outpatients with progressive disease 9

- Influenza antiviral treatment may be offered to patients with uncomplicated influenza based on clinician judgment to shorten their illness duration or lessen symptoms. The use of antiviral treatment in patients with uncomplicated influenza might help lessen the stress on healthcare systems when both influenza and SARS-CoV-2 are co-circulating.
- Antivirals are most effective when started **within two days after the beginning of illness**. It is also possible that antiviral treatment started after 48 hours may offer some benefit.4,8,12
- Potential also exists for co-infection of influenza and SARS-CoV-2 viruses. In such situations, influenza antivirals can be given for influenza illness.
- Because of the importance of early treatment, **decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza.** However, COVID-19 should be excluded with a rapid diagnostic assay if one is available.

There are two oral influenza antiviral medications approved by the U.S. Food and Drug Administration (FDA) **commonly available by prescription** to treat influenza virus infection that can also be used for PEP following influenza exposure.9These include *oseltamivir* (trade name Tamiflu), and *baloxavir marboxil* (trade name Xofluza) (Table 1). *Inhaled zanamivir and intravenous peramivir* **antiviral medications are used less frequently**.9 Additional information on these influenza antiviral medications is available here.

Table 1: Summary of most common antiviral medications for treatment and post-exposure prophylaxis of influenza9

	Oseltamivir (Tamiflu)	**Baloxavir (Xofluza)**
Approved by FDA	1999	2018
Mechanism	Neuraminidase inhibitor	Cap-dependent endonuclease inhibitor
Route of administration	**Oral**	**Oral**
Treatment dosing	**Daily dosing for 5 days** • Adults: 75 mg **twice daily** • Children: varies by age/weight9	**Single dose only** • 80 kg: 80 mg
Post-exposure prophylaxis dosing	**Daily dosing for 7 days** • Adults: 75 mg **once daily** • Children: varies by age/weight9	**Single dose only** • 80 kg: 80 mg
Age	**Treatment**: any age for treatment	**Treatment or PEP**: 12 years

	PEP: 3 months	
Contraindications	Known hypersensitivity	Known hypersensitivity

3**. Use of influenza antivirals for post-exposure prophylaxis (PEP)**

Both oseltamivir and baloxavir are FDA-approved for influenza PEP. The efficacy of PEP in reducing virus acquisition to uninfected household contacts is high for oseltamivir (68%-89%)13 and baloxavir (86%).5 In general, before the COVID-19 pandemic, CDC did not recommend widespread or routine use of influenza antiviral medications for PEP in the community.9 However, PEP has been recommended previously in closed settings such as long-term care facilities or crowded group settings such as refugee resettlement facilities. In these situations, CDC has recommended using clinical judgment for antiviral PEP for certain exposed non-ill close contacts of persons with suspected or confirmed influenza. Given the unique considerations of influenza outbreaks in various settings in the context of co-circulation with SARS-CoV-2, influenza antiviral PEP might be considered for persons

- Who have had recent close contact with a person with influenza (e.g., roommates)
- In confined quarters (e.g., dormitories, shelters, prisons) with increasing incidence of influenza
- Who are at increased risk for severe illness from influenza14
- Who have had recent close contact with a person with influenza and will be traveling for the holidays to reduce transmission during travel as well as to reduce transmission to family members or friends who may be at higher risk for influenza complications14

Considerations for choice of PEP antivirals (Table 1):

- A key difference between the drugs relates to the longer half-life of baloxavir (days) vs. the shorter half-life of oseltamivir (hours). Thus, for PEP, **baloxavir can be administered as a single dose** while **oseltamivir requires daily dosing for seven days**.
- **Dosing:** Treatment and prophylaxis (prevention) dosing is the same for baloxavir, but for oseltamivir, treatment dosing is twice daily, and prophylaxis is once daily.

- **Timing of PEP***:* CDC recommends initiating PEP within 48 hours of contact with an influenza case, if PEP is provided. In general, PEP for oseltamivir should not be started >48 hours after exposure due to concerns about resistance with lower PEP dose in persons with active influenza.
- **Duration of PEP:** Antiviral medications are effective as PEP only if a person takes them the entire time they are around another person who has influenza.
- Rates of oseltamivir and baloxavir resistance among circulating influenza A viruses remain low. However, additional monitoring is necessary, especially with baloxavir, which has had limited use compared to oseltamivir.

4**. Influenza testing**

Information to assist clinicians about influenza testing decisions, including in the context of SARS-CoV-2 co-circulation, is available here. The most accurate influenza tests (high sensitivity and specificity) are molecular assays. Molecular assays are recommended for hospitalized patients with suspected influenza. Information on influenza molecular assays is available here.

1. **Non-pharmaceutical interventions**

Because no single intervention can provide complete protection against influenza virus transmission, emphasis should be placed on multiple strategies, including pharmaceutical (e.g., influenza vaccines and antiviral medications) and non-pharmaceutical interventions. Measures that are used for COVID-19 might also provide protection against influenza. Non-pharmaceutical interventions may include

- Community measures (e.g., physical distancing, masking)
- Environmental measures (e.g., routine surface cleaning)
- Advising and encouraging symptomatic persons to stay home and use frequent hand hygiene, and proper cough etiquette

Recommendations for the Public

1. **Get a flu vaccine as soon as possible.** There's still time to protect yourself from flu this season. You can get a flu vaccine and a COVID-19 vaccine at the same time. Vaccines are the best tool for preventing influenza and can reduce the risk of severe illness and death associated with influenza.
2. **Take everyday preventive actions that can help reduce the spread of germs, like flu.**

· These everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing your hands often. While CDC does not recommend wearing a face mask to protect you from getting flu, wearing a face mask is recommended to protect you and others against COVID-19 at this time.

1. If you develop flu symptoms (which can be similar to symptoms of other respiratory viruses), reach out to your healthcare provider who may test you to determine if your sickness is due to flu or another virus that has similar symptoms, such as COVID-19.
2. **Take antiviral drugs if prescribed by your healthcare provider.**

- It's important to remember that there also are drugs that can be used to treat flu illness.
- Antiviral drugs are not meant to replace flu vaccine. A flu vaccine is the best way to help prevent seasonal flu and its potentially serious complications. Antiviral drugs are a second line of defense that can be used to treat flu if you do get sick.
- Flu antiviral drugs work best when started within two days of a person getting sick.
- CDC recommends that people who are very sick or who are at higher risk of developing serious flu complications get antiviral treatment as early as possible without waiting for test results.
- Many patients might not be aware that drugs to treat influenza illness are available. A fact sheet for patients is available here.

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Sent by:

Chris Zukoski, ODH

Recipients:

ODH Leadership

Office of Health Preparedness

Statewide Environmental Health

Statewide Epi-Surveillence

Statewide HAN Notification

Statewide Hospital IP

Statewide Hospital IP-Group

Statewide Hospital Preparedness-Group

Statewide Hospital Public Information

Statewide LHD Leadership

Statewide LHD-Group

Statewide Nursing-Physicians

Statewide OPHCS Coordinators

Statewide Public Health Preparedness

Statewide Regional Healthcare Coordinators

Statewide Regional PHEP Coordinators

To reply, click the appropriate response from the list of options below.

Option# Response:

1. Message Received.

Thank you,
Ohio Health Alert Network

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
November 24, 2021, 11:00 AM ET
CDCHAN-00458

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Summary
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1. Remind public health practitioners and clinicians to recommend and offer the current seasonal influenza vaccine to all eligible persons aged six months and older (Flu vaccine and COVID-19 vaccine can be given at the same visit).
2. Remind clinicians to consider testing for both influenza virus and SARS-CoV-2 in patients with influenza-like illness (ILI).
3. Advise clinicians that antiviral treatment is recommended as early as possible for any patient with confirmed or suspected influenza who is: a) hospitalized; b) at higher risk for influenza complications; or c) developing progressive illness. In patients with suspected influenza, decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza, however COVID-19 should be excluded if a rapid assay is available.
4. Remind public health practitioners and clinicians to consider mitigation measures including antiviral post-exposure prophylaxis during influenza outbreaks in institutions (e.g., long-term care facilities, university dormitories) in the setting of co-circulation of SARS-CoV-2.
5. Remind the public to use non-pharmaceutical interventions (NPI) or everyday preventive actions, in addition to getting a flu vaccine. Everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing hands often.

Background
Recent increases in influenza activity in many places in the United States could mark the beginning of the 2021-2022 influenza season in the United States. While influenza activity is still low overall nationally, an increase of influenza A(H3N2) viruses has been detected in recent weeks, with most of these infections occurring in young adults. CDC also is aware of influenza outbreaks in colleges and universities in several states. Influenza vaccination coverage is still low and there is still time this season to benefit from getting an annual influenza vaccine.

Available seasonal influenza vaccines in the United States provide protection against four different influenza viruses: A(H1N1)pdm09, A(H3N2), B/Victoria lineage, and B/Yamagata lineage viruses. In the past, influenza A(H3N2) virus-predominant seasons were associated with more hospitalizations and deaths in persons aged 65 years and older than other age groups than other influenza viruses. Influenza A(H3N2) viruses evolve more rapidly to escape human immunity. The influenza A(H3N2) component of this season's vaccines was recently updated in response to the evolution of a new group of viruses called 2a (i.e., 3C.2a1b.2a) that did not circulate widely last year and were not included in last season's H3N2 vaccine component.[1] Most H3N2 viruses that have been analyzed in the United States so far are genetically closely related to the current vaccine's H3N2 component. However, this emerging group has continued to evolve, and there are now two subgroups (2a.1 and 2a.2) that are genetically closely related to each other, but do have some antigenic differences from each other (i.e., post-infection ferret

antibodies from one virus might not efficiently bind the other virus).[2] CDC virus surveillance data shows that most of the A(H3N2) viruses recently identified in the United States (October–November 2021) are in the 2a.2 group that is related to but distinguishable from the vaccine component (i.e., 2a.1). It is not known what impact the differences in the circulating viruses and the vaccine viruses may have on vaccine effectiveness. However, influenza vaccine effectiveness in general has been lower against A(H3N2) viruses than against the other three influenza viruses that could circulate [influenza A(H1N1)pdm09 or influenza B viruses].[3] Influenza activity during the 2020–2021 season was low throughout the United States and the timing and intensity of the upcoming 2021–2022 influenza season is uncertain. Because influenza activity was low last season, we are anticipating a lower level of community protection that we rely on year after year to reduce the risk of a severe influenza season. Thus, CDC is anticipating an increase of influenza illness this winter, and both A(H3N2) and B-Victoria viruses are already co-circulating. Moreover, as SARS-CoV-2 continues to circulate in the United States, illnesses associated with both viruses might stress healthcare systems. A growing body of scientific studies suggest that even when vaccination does not prevent infection it can reduce the severity of influenza illness, helping to avert serious outcomes including hospitalization and death.

CDC recommends that healthcare providers continue to recommend and offer influenza vaccination to persons aged six months and older because influenza activity is ongoing. Vaccination protects against four different viruses and is likely to reduce hospitalization and death associated with currently circulating influenza viruses and other influenza viruses that might circulate later in the season. Influenza antiviral medications are an important adjunct that should be used in addition to influenza vaccination. While vaccination is the primary means for preventing influenza, antiviral medications are a second line of defense used to treat influenza after infection has occurred. Early treatment with influenza antiviral medications is the most effective way to treat influenza and reduce complications.[4-8]

Influenza antivirals also can be used for post-exposure prophylaxis (PEP) to prevent infection.[4,5,9] This can reduce the risk of influenza among persons who are exposed to someone who has influenza. Influenza antivirals have historically been used for PEP among residents in institutional settings, such as long-term care facilities, to help control influenza outbreaks. In the context of SARS-CoV-2 co-circulation, influenza antiviral treatment and PEP could also be considered in other communal settings (e.g., shelters, university dormitories, prisons) to reduce strain on healthcare services in these institutions during influenza outbreaks. In general, CDC recommends initiating influenza antiviral PEP within 48 hours of contact with someone who has influenza.

Recommendations for Clinicians and Public Health Practitioners

1**. Recommend and offer influenza vaccination for all eligible persons aged six months and older**

Anyone who has not received an influenza vaccine this season should get vaccinated now. For 2021-2022, CDC recommends using any licensed, age-appropriate influenza vaccine as an option for vaccination this season.[10] Vaccination coverage is lower this season as of the week ending November 6, 2021 in certain groups at higher risk of severe influenza illness, such as pregnant persons and children, compared with the same period in 2020.[11] Vaccination is the best way to reduce the spread of influenza and reduce influenza illness and complications that can result in hospitalization and death. Both influenza and COVID-19 vaccines can be administered at the same visit, without regard to timing. If a patient is due for both vaccines, providers are encouraged to offer both vaccines at the same visit.

2**. Treat patients with suspected or confirmed influenza who meet clinical criteria with influenza antivirals**

CDC recommends influenza antiviral medications to treat influenza as an important adjunct to vaccination. Treatment with influenza antivirals has been shown to be safe. Influenza antivirals benefit clinical and public health by reducing illness and severe outcomes of influenza based on evidence from observational studies, randomized controlled trials, and meta-analyses of randomized controlled trials.[4-8,12]

- CDC recommends influenza antiviral treatment **as soon as possible** for patients with suspected or confirmed influenza who are:
    - Hospitalized

    - Outpatients at increased risk for complications[9]
    - Outpatients with progressive disease [9]
- Influenza antiviral treatment may be offered to patients with uncomplicated influenza based on clinician judgment to shorten their illness duration or lessen symptoms. The use of antiviral treatment in patients with uncomplicated influenza might help lessen the stress on healthcare systems when both influenza and SARS-CoV-2 are co-circulating.
- Antivirals are most effective when started **within two days after the beginning of illness**. It is also possible that antiviral treatment started after 48 hours may offer some benefit.[4,8,12]
- Potential also exists for co-infection of influenza and SARS-CoV-2 viruses. In such situations, influenza antivirals can be given for influenza illness.
- Because of the importance of early treatment, **decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza.** However, COVID-19 should be excluded with a rapid diagnostic assay if one is available.

There are two oral influenza antiviral medications approved by the U.S. Food and Drug Administration (FDA) **commonly available by prescription** to treat influenza virus infection that can also be used for PEP following influenza exposure.[9] These include *oseltamivir* (trade name Tamiflu®), and *baloxavir marboxil* (trade name Xofluza®) (Table 1). *Inhaled zanamivir and intravenous peramivir* **antiviral medications are used less frequently**.[9] Additional information on these influenza antiviral medications is available here.

Table 1: Summary of most common antiviral medications for treatment and post-exposure prophylaxis of influenza[9]

Drug	Oseltamivir (Tamiflu®)	Baloxavir (Xofluza®)
Approved by FDA	1999	2018
Mechanism	Neuraminidase inhibitor	Cap-dependent endonuclease inhibitor
Route of administration	**Oral**	**Oral**
Treatment dosing	**Daily dosing for 5 days** • Adults: 75 mg **twice daily** • Children: varies by age/weight[9]	**Single dose only** • <80 kg: 40 mg • ≥80 kg: 80 mg
Post-exposure prophylaxis dosing	**Daily dosing for 7 days** • Adults: 75 mg **once daily** • Children: varies by age/weight[9]	**Single dose only** • <80 kg: 40 mg • ≥80 kg: 80 mg
Age	**Treatment**: any age for treatment **PEP**: ≥3 months	**Treatment or PEP**: ≥12 years
Contraindications	Known hypersensitivity	Known hypersensitivity

3. **Use of influenza antivirals for post-exposure prophylaxis (PEP)**

Both oseltamivir and baloxavir are FDA-approved for influenza PEP. The efficacy of PEP in reducing virus acquisition to uninfected household contacts is high for oseltamivir (68%-89%)[13] and baloxavir (86%).[5] In general, before the COVID-19 pandemic, CDC did not recommend widespread or routine use of influenza antiviral medications for PEP in the community.[9] However, PEP has been recommended previously in closed settings such as long-term care facilities or crowded group settings such as refugee resettlement facilities. In these situations, CDC has recommended using clinical judgment for antiviral PEP for certain exposed non-ill close contacts of persons with suspected or confirmed influenza. Given the unique considerations of influenza outbreaks in various settings in the context of co-circulation with SARS-CoV-2, influenza antiviral PEP might be considered for persons

- Who have had recent close contact with a person with influenza (e.g., roommates)
- In confined quarters (e.g., dormitories, shelters, prisons) with increasing incidence of influenza

- Who are at increased risk for severe illness from influenza[14]
- Who have had recent close contact with a person with influenza and will be traveling for the holidays to reduce transmission during travel as well as to reduce transmission to family members or friends who may be at higher risk for influenza complications[14]

Considerations for choice of PEP antivirals (Table 1):

- A key difference between the drugs relates to the longer half-life of baloxavir (days) vs. the shorter half-life of oseltamivir (hours). Thus, for PEP, **baloxavir can be administered as a single dose** while **oseltamivir requires daily dosing for seven days**.
- **Dosing:** Treatment and prophylaxis (prevention) dosing is the same for baloxavir, but for oseltamivir, treatment dosing is twice daily, and prophylaxis is once daily.
- **Timing of PEP***:* CDC recommends initiating PEP within 48 hours of contact with an influenza case, if PEP is provided. In general, PEP for oseltamivir should not be started >48 hours after exposure due to concerns about resistance with lower PEP dose in persons with active influenza.
- **Duration of PEP:** Antiviral medications are effective as PEP only if a person takes them the entire time they are around another person who has influenza.
- Rates of oseltamivir and baloxavir resistance among circulating influenza A viruses remain low. However, additional monitoring is necessary, especially with baloxavir, which has had limited use compared to oseltamivir.

4**. Influenza testing**
Information to assist clinicians about influenza testing decisions, including in the context of SARS-CoV-2 co-circulation, is available here. The most accurate influenza tests (high sensitivity and specificity) are molecular assays. Molecular assays are recommended for hospitalized patients with suspected influenza. Information on influenza molecular assays is available here.

5. Non-pharmaceutical interventions
Because no single intervention can provide complete protection against influenza virus transmission, emphasis should be placed on multiple strategies, including pharmaceutical (e.g., influenza vaccines and antiviral medications) and non-pharmaceutical interventions. Measures that are used for COVID-19 might also provide protection against influenza. Non-pharmaceutical interventions may include

- Community measures (e.g., physical distancing, masking)
- Environmental measures (e.g., routine surface cleaning)
- Advising and encouraging symptomatic persons to stay home and use frequent hand hygiene, and proper cough etiquette

Recommendations for the Public

1. **Get a flu vaccine as soon as possible.** There's still time to protect yourself from flu this season. You can get a flu vaccine and a COVID-19 vaccine at the same time. Vaccines are the best tool for preventing influenza and can reduce the risk of severe illness and death associated with influenza.
2. **Take everyday preventive actions that can help reduce the spread of germs, like flu.**
    - These everyday preventive actions include staying home when sick, covering coughs and sneezes, and washing your hands often. While CDC does not recommend wearing a face mask to protect you from getting flu, wearing a face mask is recommended to protect you and others against COVID-19 at this time.
3. If you develop flu symptoms (which can be similar to symptoms of other respiratory viruses), reach out to your healthcare provider who may test you to determine if your sickness is due to flu or another virus that has similar symptoms, such as COVID-19.
4. **Take antiviral drugs if prescribed by your healthcare provider.**
    - It's important to remember that there also are drugs that can be used to treat flu illness.
    - Antiviral drugs are not meant to replace flu vaccine. A flu vaccine is the best way to help prevent seasonal flu and its potentially serious complications. Antiviral drugs are a second line of defense that can be used to treat flu if you do get sick.

- Flu antiviral drugs work best when started within two days of a person getting sick.
- CDC recommends that people who are very sick or who are at higher risk of developing serious flu complications get antiviral treatment as early as possible without waiting for test results.
- Many patients might not be aware that drugs to treat influenza illness are available. A fact sheet for patients is available here.

For More Information
CDC Tracking Flu in Young Adults
Healthy Habits to Help Protect Against Flu

Additional Resources for Clinicians:
- Summary of Influenza Antiviral Treatment Recommendations for Clinicians
- Clinical Description and Lab Diagnosis of Influenza
- Interim Guidance for Influenza Outbreak Management in Long-Term and Post-Acute Care Facilities
  Influenza Virus Testing in Investigational Outbreaks in Institutional or Other Closed Settings

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Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

Health Advisory 460: Rapid Increase of Omicron Variant Infections in the United States

Ohio Health Alert Network <5c710a4d-0005-3002-80c0-fceb55463ffe@notify.mir3.com>

Mon 12/27/2021 8:11 AM

To: Court Witschey <cwitschey@athenspublichealth.org>

Court Witschey,

"This is an ALERT"

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network

Friday, December 24, 2021, 7:00 ET PM

CDCHAN-00460

Rapid Increase of Omicron Variant Infections in the United States: Management of Healthcare Personnel with

SARS-CoV-2 Infection or Exposure

Summary

Due to the increased transmissibility of the SARS-CoV-2 Omicron variant and concerns about potential impacts on the healthcare system, the Centers for Disease Control and Prevention (CDC) is updating recommendations to enhance protection for healthcare personnel, patients, and visitors, and ensure adequate staffing in healthcare facilities. The guidance is based on the limited information currently available about the Omicron variant and will be updated as needed as new information becomes available.

Background

On November 24, 2021, a new variant of SARS-CoV-2, B.1.1.529 (Omicron), was reported to the World Health Organization (WHO). Current COVID-19 vaccines are expected to protect against severe illness, hospitalizations, and deaths from infection with the Omicron variant. Omicron might cause more

breakthrough infections than prior variants, and some studies have found lower effectiveness of the primary series of vaccines against infection (1-3).

On December 1, 2021, the first case attributed to Omicron was reported in the United States. Omicron has now been reported in all 50 states. CDC has been working with state and local public health officials to monitor the spread of Omicron in the United States and has identified a rapid increase in infections consistent with what has been observed in other countries. Multiple large clusters of Omicron variant cases have demonstrated the rapid spread of the virus. Holiday-related travel and gatherings may further accelerate these trends. Plausible scenarios include steep epidemic trajectories that would require prompt public health action to prevent severe impacts on the health of individuals and healthcare systems.

The clinical severity profile of Omicron infection will strongly influence its impact on U.S. hospitalizations and deaths. Early data suggest Omicron infection might be less severe than infection with prior variants (3,4); however, reliable data on clinical severity remain limited (5). Even if the proportion of infections associated with severe outcomes is lower than with previous variants, a rapid, large increase in the number of infections could still result in many people with severe outcomes requiring medical care and hospitalization in a short period. Demand for ambulatory care, supportive care for treatment of mild cases, and staffing shortages resulting from work restriction of healthcare personnel with SARS-CoV-2 infection or with higher-risk exposures could also stress the healthcare system.

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel and safe patient care. CDC's mitigation strategies offer a continuum of options for addressing healthcare staffing shortages and are meant to be implemented sequentially. These strategies were updated on December 23, 2021. If conventional strategies cannot be sustained during a surge in cases, facilities may consider implementing contingency strategies, then crisis strategies, in an incremental manner. Facilities are best positioned to evaluate their own needs as to whether conventional, contingency, or crisis strategies are most appropriate at a given time.

Consider options to address a healthcare surge by shortening the duration of work restrictions.

When staffing shortages are anticipated, healthcare facilities and employers should plan and prepare to address these shortages in collaboration with staff leadership, human resources, and occupational health services. This can include adjusting staff schedules, hiring additional healthcare personnel, and rotating personnel to positions that support patient care activities. It can also include modifications in practices for work restrictions of healthcare personnel who have had higher-risk exposures to SARS-CoV-2 or who have been infected with SARS-CoV-2, as described below. Conventional, contingency, and crisis strategies to mitigate staffing shortages are described in CDC guidance and are intended to allow flexibility to maintain adequate staffing for safe and effective patient care while minimizing the risk of SARS-CoV-2 transmission in healthcare facilities. Protecting the health and safety of healthcare

personnel remains critical and includes ensuring the recommended personal protective equipment (PPE) is available and that healthcare personnel are trained to use it properly.

Healthcare personnel with higher-risk exposure

- *Personnel who have received all COVID-19 vaccine and booster doses as recommended by CDC.* Under conventional strategies, asymptomatic healthcare personnel who have received all COVID-19 vaccine and booster doses as recommended by CDC do not need to be restricted from work if they have had a higher-risk exposure but do not have symptoms. They should follow all recommended infection prevention and control practices and isolate immediately if they develop symptoms. Under conventional strategies, such personnel should be tested for SARS-CoV-2, per CDC guidance. Under contingency or crisis strategies, testing is not required, and the duration of quarantine may be shortened.

- *Personnel who have not received all COVID-19 vaccine and booster doses as recommended by CDC.* Under conventional conditions, asymptomatic healthcare personnel who have not received all COVID-19 vaccine and booster doses as recommended by CDC, and who have had a higher-risk exposure to SARS-CoV-2, can return to the workplace after day ten without testing, or facilities can limit the duration of work restriction under certain circumstances as outlined in CDC guidance. Under contingency conditions such personnel can continue to work using a "test-to-stay" strategy under certain circumstances. Under crisis conditions, such personnel can continue to work without testing as long as they remain asymptomatic.

- Healthcare personnel who are exposed should use well-fitting respiratory source control all times while in the facility and follow all conventional, contingency, and crisis strategies and follow all recommended infection prevention and control practices.

Healthcare personnel with SARS-CoV-2 infection

Under conventional conditions, healthcare facilities can allow asymptomatic healthcare personnel with SARS-CoV-2 infection, regardless of vaccination status, to return to work after seven days and a negative test in accordance with CDC guidance. For healthcare personnel who were symptomatic, fever should have resolved without medications, as detailed in Return to Work Criteria. Under contingency conditions, healthcare personnel with SARS-CoV-2 infection can return to work at five days, if asymptomatic, with facilities having the option to include a negative viral test in the criteria to return to work. Under crisis conditions, such personnel can remain at work or can return to work at less than five days, if asymptomatic or mildly symptomatic, as a last resort, without testing. These healthcare personnel should wear a respirator or well-fitting facemask even when they are in non-patient care areas. Facilities should consider assigning these healthcare personnel to duties that do not include care of immunocompromised patients.

Conventional work restrictions for healthcare personnel should not be shortened under certain circumstances. This includes healthcare personnel who are moderately to severely immunocompromised. Also, in the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to using more stringent work restriction for healthcare personnel with higher-risk exposures. There might be other circumstances for which a jurisdiction's public health authority recommends these and additional precautions for directing healthcare personnel to follow work restrictions.

Recommendations for Healthcare Personnel

- Get all doses of COVID-19 vaccines, including additional and booster doses as recommended by CDC as well as influenza vaccine to protect yourself, your family, and your patients.
- Increase patient outreach efforts to recommend, encourage, and offer COVID-19 vaccination and boosters.
- Recommend that all healthcare personnel who are immunocompromised continue to practice all prevention measures to protect themselves against COVID-19 even if they have received all COVID-19 vaccines, additional and booster doses as recommended by CDC.
- When spending time in community settings, take all recommended steps to protect yourself and others from SARS-CoV-2 infection to decrease the risk of introducing new transmission into the healthcare setting.

Recommendations for Healthcare Facilities and Systems and Nursing Homes

- Implement new CDC guidance for contingency and crisis conditions to shorten duration of work restrictions for healthcare personnel with SARS-CoV-2 infection and those who had a higher-risk exposure to SARS-CoV-2, when needed to alleviate healthcare staffing shortages and maintain a safe environment for patients, visitors, and healthcare personnel.
- Recommend and offer COVID-19 vaccine and boosters to your staff and employees and establish policies to encourage uptake such as time off to get COVID-19 vaccinations and boosters. See resources at Workplace COVID-19 Vaccine Toolkit.
- Provide resources and support to assist healthcare personnel with stress and physical demands.
- Ensure that SARS-CoV-2 testing is performed with a test that can detect SARS-CoV-2 considering currently circulating variants. For more information, see SARS-CoV-2 Viral Mutations: Impact on COVID-19 Tests | FDA.

For More Information

- Omicron Variant: What You Need to Know | CDC
- Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC
- CDC COVID Data Tracker

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Sent by:

Christopher Zukoski, ODH

Recipients:

ODH Leadership

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Statewide Epi-Surveillence

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Statewide Hospital IP-Group

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Option# *Response*:

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Ohio Health Alert Network

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- Healthcare personnel who are exposed should use well-fitting respiratory source control all times while in the facility and follow all conventional, contingency, and crisis strategies and follow all recommended infection prevention and control practices.

Healthcare personnel with SARS-CoV-2 infection

Under conventional conditions, healthcare facilities can allow asymptomatic healthcare personnel with SARS-CoV-2 infection, regardless of vaccination status, to return to work after seven days and a negative test in accordance with CDC guidance. For healthcare personnel who were symptomatic, fever should have resolved without medications, as detailed in Return to Work Criteria. Under contingency conditions, healthcare personnel with SARS-CoV-2 infection can return to work at five days, if asymptomatic, with facilities having the option to include a negative viral test in the criteria to return to work. Under crisis conditions, such personnel can remain at work or can return to work at less than five days, if asymptomatic or mildly symptomatic, as a last resort, without testing. These healthcare personnel should wear a respirator or well-fitting facemask even when they are in non-patient care areas. Facilities should consider assigning these healthcare personnel to duties that do not include care of immunocompromised patients.

Conventional work restrictions for healthcare personnel should not be shortened under certain circumstances. This includes healthcare personnel who are moderately to severely immunocompromised. Also, in the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to using more stringent work restriction for

healthcare personnel with higher-risk exposures. There might be other circumstances for which a jurisdiction's public health authority recommends these and additional precautions for directing healthcare personnel to follow work restrictions.

Recommendations for Healthcare Personnel

- Get all doses of COVID-19 vaccines, including additional and booster doses as recommended by CDC as well as influenza vaccine to protect yourself, your family, and your patients.
- Increase patient outreach efforts to recommend, encourage, and offer COVID-19 vaccination and boosters.
- Recommend that all healthcare personnel who are immunocompromised continue to practice all prevention measures to protect themselves against COVID-19 even if they have received all COVID-19 vaccines, additional and booster doses as recommended by CDC.
- When spending time in community settings, take all recommended steps to protect yourself and others from SARS-CoV-2 infection to decrease the risk of introducing new transmission into the healthcare setting.

Recommendations for Healthcare Facilities and Systems and Nursing Homes

- Implement new CDC guidance for contingency and crisis conditions to shorten duration of work restrictions for healthcare personnel with SARS-CoV-2 infection and those who had a higher-risk exposure to SARS-CoV-2, when needed to alleviate healthcare staffing shortages and maintain a safe environment for patients, visitors, and healthcare personnel.
- Recommend and offer COVID-19 vaccine and boosters to your staff and employees and establish policies to encourage uptake such as time off to get COVID-19 vaccinations and boosters. See resources at Workplace COVID-19 Vaccine Toolkit.
- Provide resources and support to assist healthcare personnel with stress and physical demands.
- Ensure that SARS-CoV-2 testing is performed with a test that can detect SARS-CoV-2 considering currently circulating variants. For more information, see SARS-CoV-2 Viral Mutations: Impact on COVID-19 Tests | FDA.

For More Information

- Omicron Variant: What You Need to Know | CDC
- Strategies to Mitigate Healthcare Personnel Staffing Shortages | CDC
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
- Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC
- CDC COVID Data Tracker

References

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5. Abdool Karim SS, Abdool Karim Q. Omicron SARS-CoV-2 variant: A new chapter in the COVID-19 pandemic. *Lancet* 2021; 398:2126-2128. https://doi.org/10.1016/S0140-6736(21)02758-6

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention, highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##