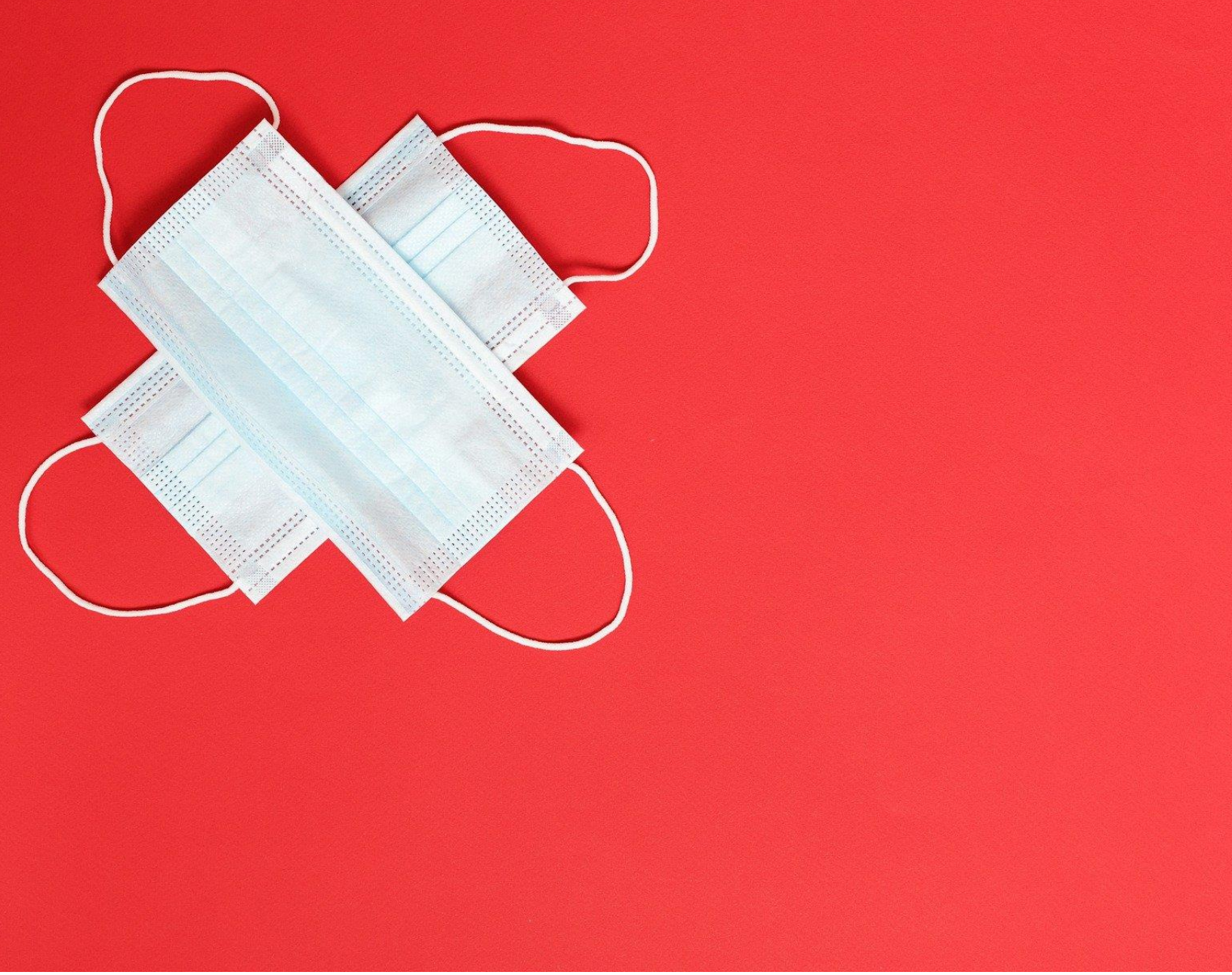

# HHSC: Task Force on Infectious Disease Preparedness and Response, December 8th, 2020

The Task Force on Infectious Disease Preparedness and Response provides expert, evidence-based assessments, protocols, and recommendations related to state responses to infectious diseases and serves as a reliable and transparent source of information and education for Texas leadership and citizens.

Task Force on Infectious Disease Preparedness and Response

- On October 6, 2014, Governor Rick Perry created the Texas Task Force on Infectious Disease Preparedness and Response through Executive Order RP-79. The Task Force was composed of seventeen members, and included representatives from pertinent state agencies, as well as experts in infectious disease, emergency management, and in public health preparedness and response.
- H.B. 2950, 84th Legislature, Regular Session, 2015, codified the Task Force on Infectious Disease Preparedness and Response in Texas Health and Safety Code (HSC) Chapter 81, Subchapter J. The Task Force is required to provide expert, evidence-based assessments, protocols, and recommendations related to state responses to infectious diseases, as well as serve as a source of information and education.
- H.B. 2950 is created as an advisory panel to the Governor, and task force membership is determined by the Governor.
- **Enabling statute:** Health and Safety Code, Chapter 81, Subchapter J
- **Find the Task Force Members at this link.**

**Governor's appointment notice**

**Rapid Assessment Subcommittee Membership**

- John Hellerstedt, M.D.
- Peter Hotez, M.D., Ph.D.
- Nim Kidd
- David Lakey, M.D.
- James LeDuc, Ph.D.
- Dorothy Overman, M.D.
- Gerald Parker, D.V.M., Ph.D.
- Cecile Young

**1.Call to Order & Welcome Remarks**. DSHS Commissioner John Hellerstedt, M.D.

**2. Approval of Meeting Minutes from October 19, 2020**. The minutes were approved with minor corrections.

**3. COVID-19 Situation Update - Dr. Hellerstedt**

Texas COVID-19 Timeline

- January 23: DSHS launched the dshs.texas.gov/coronavirus/ website and prepared #TexasDSHS social media campaigns
- January 31: DSHS activated the State Medical Operations Center (SMOC)



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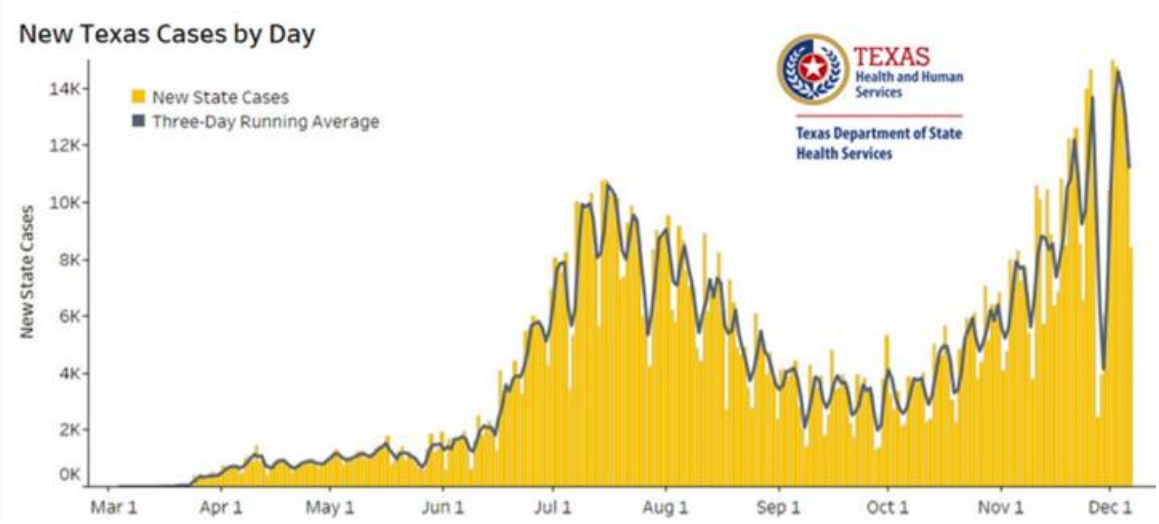
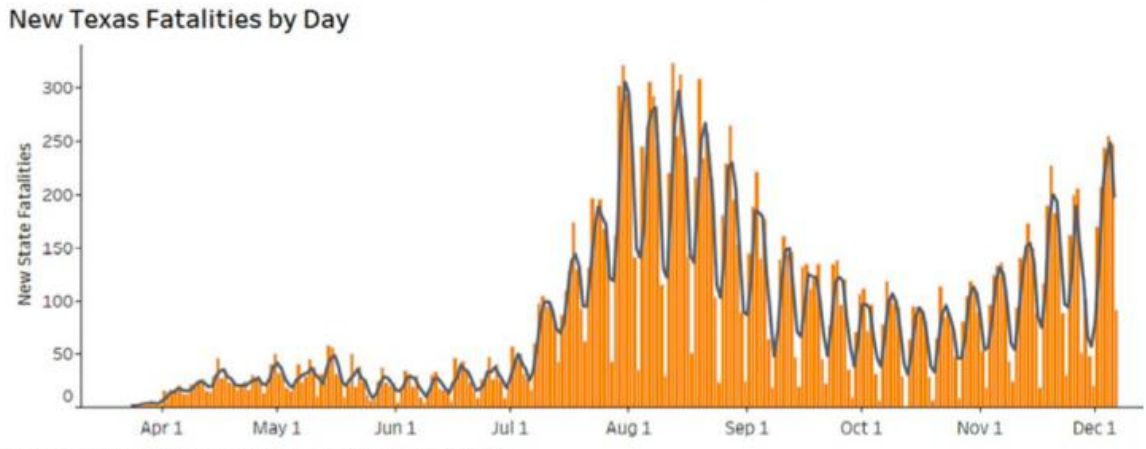
- March 4: DSHS announced the first positive test result for COVID-19 in Texas
- March 13: Governor Greg Abbott declared a State of Disaster for all Texas counties and began issuing Executive Orders and Waivers to mitigate the crisis
- March 17: DSHS announced the first death of a person with lab-confirmed COVID-19
- March 19: DSHS Commissioner Hellerstedt declared a Public Health Disaster for Texas
- December 6: 1,249,323 confirmed COVID-19 cases reported in all 254 Texas counties with 22,594 fatalities




These preliminary data are current as of 1:00pm on 12/6/2020.
Note: As of July 27, DSHS is reporting COVID-19 fatality data based on death certificates. The metric used in these charts reports total newly reported fatalities (as opposed to the date of death).



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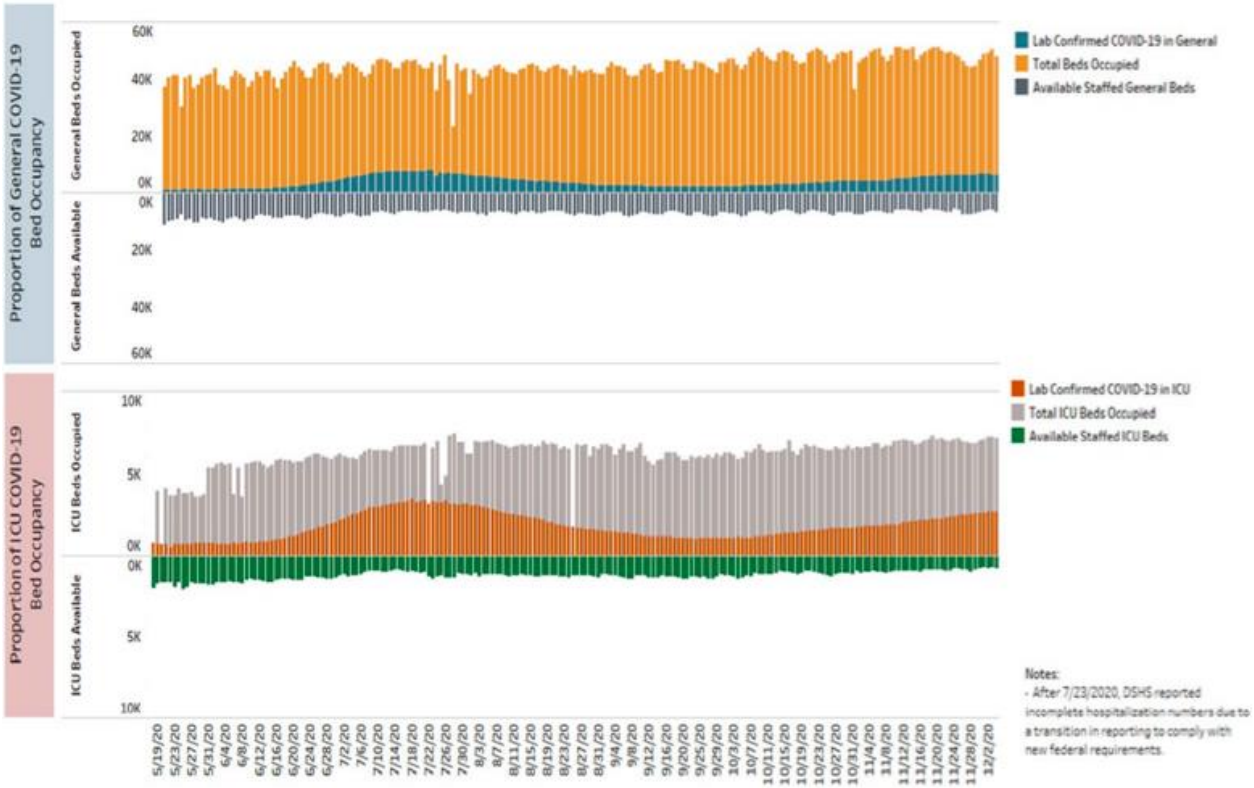
## Hospitalizations Over Time

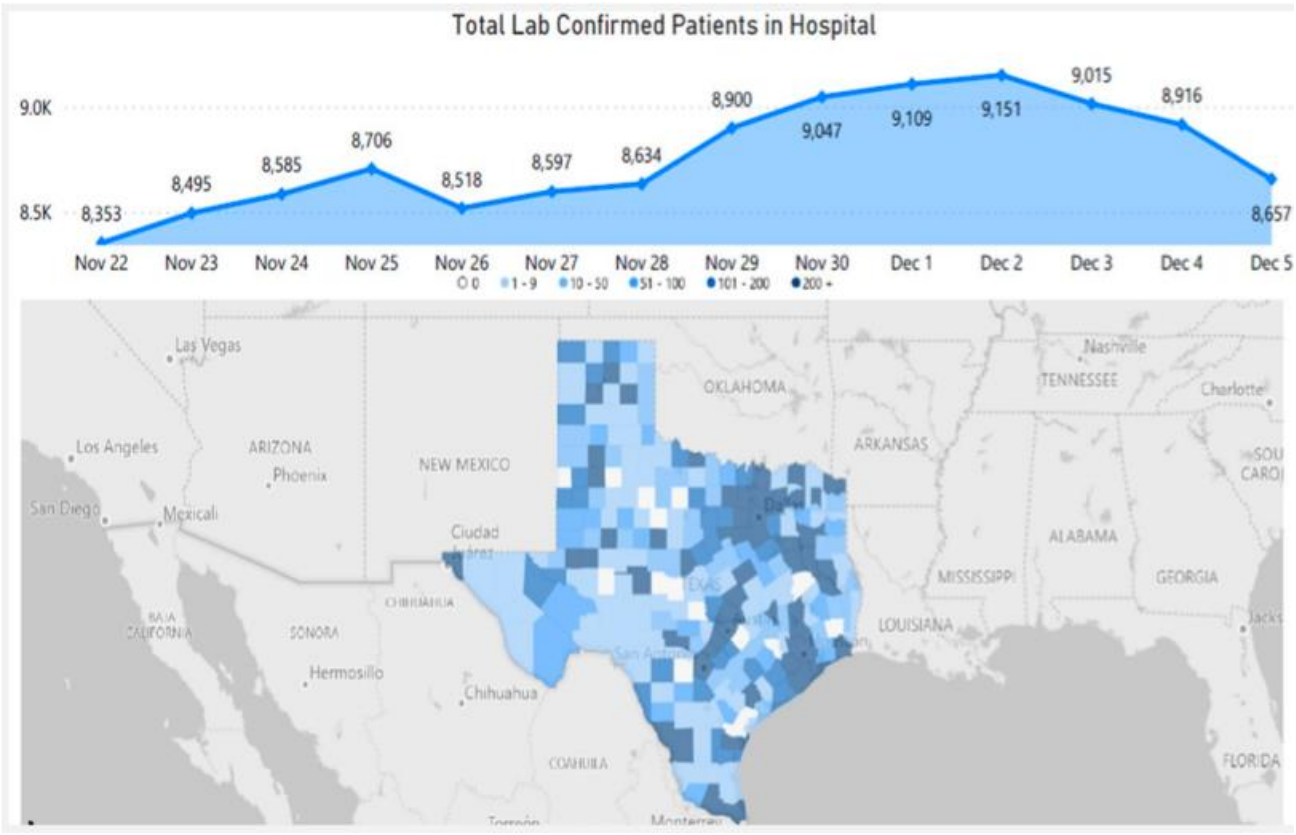
Total Texas Proportion of Lab-Confirmed COVID-19 Occupancy of General and ICU Beds out of Total Hospital Beds as of:
Saturday, December 5, 2020

TEXAS Health and Human Services
Texas Department of State Health Services




Notes:
- After 7/23/2020, DSHS reported incomplete hospitalization numbers due to a transition in reporting to comply with new federal requirements.

These preliminary data are current as of 1:00pm on 12/6/2020.




**DSHS Roles during the Pandemic**

- Coordination of local and state public health efforts
- Statewide management and provision of lab testing and capacity
- Data collection, analysis, and reporting
- Health care system support and deployment of medical staffing to hospitals and nursing facilities
- Statewide public awareness
- Public health guidance for individuals and businesses, and consultation with local elected leaders
- Sourcing and allocating medications, medical supplies, and personal protective equipment
- Developing the infrastructure to safely and appropriately disseminate vaccine

**Estimated COVID-19 Pandemic Expenditures**
**Category Amount Obligated**

- Medical Surge Staffing: $1.7 Billion
- Local Response: $113.4 Million
- Disease Surveillance: $77.8 Million

- Local Contracts: $71.1 Million
- Lab Costs: $30.6 Million
- Repatriation: $5.4 Million
- Other Costs: $0.5 Million

**Total: $1.97 Billion**

**DSHS Outputs as of Late November**

Health system support

- 2,447 State of Texas Assistance Requests (STARs) filled
- 10,016 Staff assigned to support hospitals
- 850 Alternate care beds secured
- 850+ Oxygen concentrators distributed
- 980+ Ventilators distributed

Call Center

- 29,410 calls and 26,727 emails received

Contact Tracing

- 3,058 State and local contact tracers active
- 51 Local health entities voluntarily participating in Texas Health Trace

**Thanksgiving news release**

• Steps people can take to reduce spreading COVID -19

• DSHS Shares Advice for a Safe, Healthy Thanksgiving (texas.gov)


**#HealthyTexas Holiday Communications Toolkit**

• Includes animated videos, social media graphics, and radio spots in English and Spanish

• #HealthyTexas Holiday Communication Tools

COVID-19 Prevention

- Use face coverings in public
- Limit contact with others, maintain a physical distance, and avoid crowds
- Stay home, especially when sick
- Personal hygiene: wash hands, cover coughs, disinfect surfaces and objects
- Businesses and activities follow the minimum standard protocols and Executive Orders:

**Influenza Update as of Late November**
Texas Vaccines for Children (TVFC) and Adult Influenza Vaccine Initiative (AIVI) vaccine doses

- 2,894,680 Total Ordered
- 1,857,210 Total Received
- 1,326,580 or 71% Total Shipped
- 390,222 Flu vaccine current season doses reported to ImmTrac2

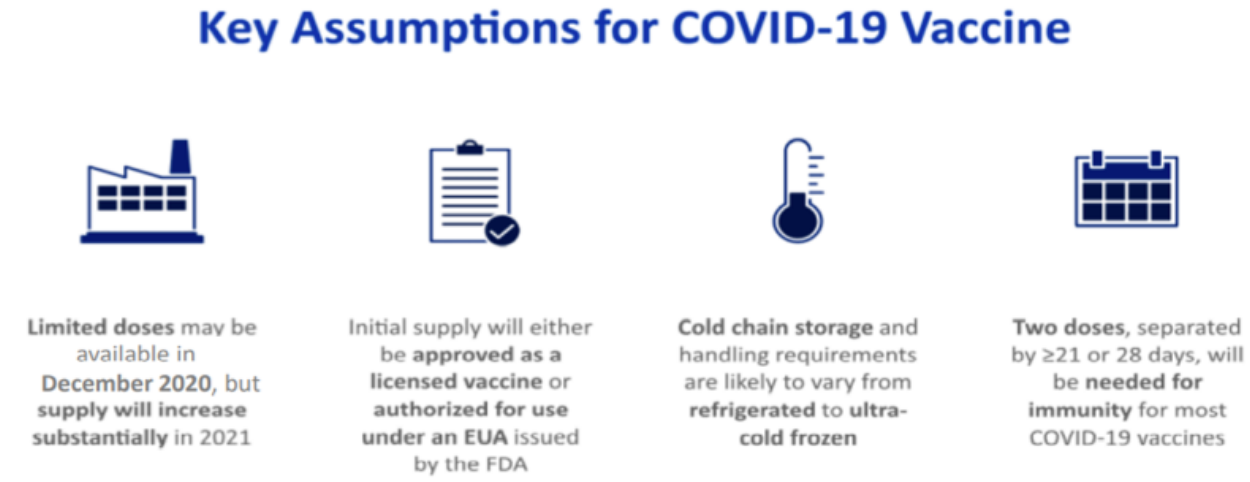
Disease activity

- 1.81 % Current Season Week 48 ILI (influenza-like illness)
- 0 % Current Season Week 48 Positivity Public Health Labs

**Questions/Answers/Comments**
Is there any indication that mortality has been forced down with the interventions? There do appear to be improvements with steroids and positioning.

There is a disconnect between getting a test and seeing a professional. Many people get tests and then go home. People are being told to go home and treat it like the flu. There is a role for DSHS in messaging to patients. Dr. Hellerstedt stated that we never appear to be able to provide end-to-end solutions. There were issues in PPE, overwhelming labs, etc. The last mile to make the connection is an excellent point.

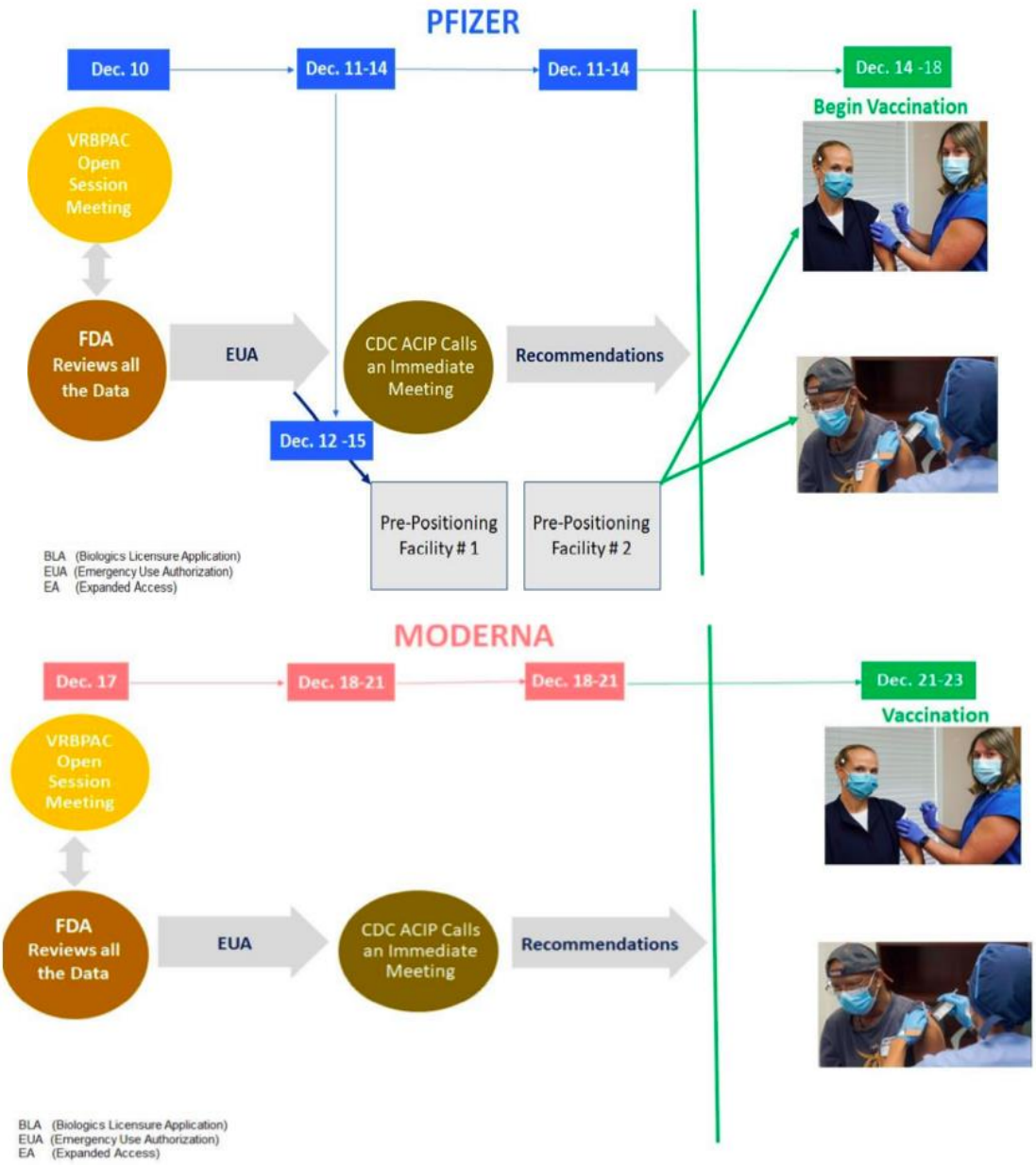
**4.** **COVID-19 Vaccine Update - Saroj Rai, Ph.D.** Information is rapidly evolving and can change. There are six vaccines under consideration but only four are in stage three.



## COVID-19 Vaccine Updates

| Phase III Vaccine Candidates | Technology Platform | Storage & Handling | Dose (Intramuscular Injection) |
|---|---|---|---|
| Pfizer | m-RNA | Ultra-low frozen: 6mos<br>Refrigerated: 5 days | 2<br>(0, 21 days) |
| moderna | m-RNA | Frozen: 6mos<br>Refrigerated: 30 days | 2<br>(0, 28 days) |
| AstraZeneca / Oxford | Viral Vector<br>(Non-Replicating) | Refrigerated: 6mos | 2<br>(0, 28 days) |
| janssen | Viral Vector<br>(Non-Replicating) | Refrigerated: 6mos | 1 |

| Phase III Vaccine Candidates | Technology Platform | Efficacy & Safety | | | Regulatory Status |
|---|---|---|---|---|---|
| | | Study Design | Interim Analysis | Completion of Primary Endpoint | |
| Pfizer | m-RNA | • N=44,000<br>• ≥ 12 yrs<br>• Randomization (1:1)<br>• Placebo vs. Vaccine<br>• (Saline vs. 30 µg)<br>• 2 doses (0, 21 days) | • 90% effectiveness (94 cases) | • **95%** vaccine efficacy (162 placebo vs. 8 vaccine)<br>- 30 severe case (30 placebo vs. 0 vaccine)<br>• Consistent efficacy across age, gender, race/ethnicity<br>• No serious adverse reported to date | EUA Filed |
| moderna | m-RNA | • N=30,000<br>• ≥ 18 yrs<br>• Randomization (1:1)<br>• Placebo vs. Vaccine<br>• (Saline vs. 100 µg)<br>• 2 doses (0, 28 days) | • **94.5%** vaccine efficacy (90 placebo vs. 5 vaccine)<br>- 11 severe case (11 placebo vs. 0 vaccine)<br>- 16% adults ages >65 yrs<br>- 21% diverse population<br>• No serious adverse reported to date Grade 3 (>2%): Fatigue, myalgia, arthralgia, headache, pain, & redness at injection site | • **94.1%** vaccine efficacy (185 cases in placebo vs. 11 vaccine)<br>- 11 severe case (11 placebo vs. 0 vaccine)<br>- 17% adults ages >65 yrs<br>- 21% diverse population<br>• 1 death in the placebo group | EUA Filed |
| AstraZeneca / Oxford | Viral Vector<br>(Non-Replicating) | **UK Study**<br>• N=12,390<br>• ≥ 18 yrs<br>• 1 Dose vs. 2 Doses vs. MenACWY<br>**Brazil Study**<br>• N=10,300<br>• ≥ 18 yrs<br>• 2 does vaccine vs. MenACWY/Saline | • **90%** vaccine efficacy (half dose/full dose ($5x10^{10}$ vp) with n=2,741<br>• **62%** vaccine efficacy (full dose/full dose (n=8,895)<br>• Combined efficacy of **70% (131 COVID-19 cases)**<br>• No serious adverse events have been reported thus far | | |
| janssen | Viral Vector<br>(Non-Replicating) | • N=60,000<br>• ≥ 18 yrs<br>• Randomization (1:1)<br>• Placebo vs. Vaccine (Saline vs. $5×10^{10}$ vp)<br>• 1 doses | | | |




**COVID-19 Vaccine Safety Monitoring**

- Vaccine Adverse Event Reporting System (VAERS)
- V-safe


**v-safe | after vaccination health checker**

- V-safe is a smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins after someone receives a COVID-19 vaccination.
- Vaccine recipients can quickly tell the CDC if they have any side effects. The CDC may follow up with them by phone to get more information.
- V-safe will also remind them to get their second COVID-19 vaccine dose, if needed.

V-Safe. The COVID-19 vaccine is not yet available, but once it arrives in the U.S., the Centers for Disease Control and Prevention plans to follow up on the health of those who receive it with a new program called V-SAFE.

According to a September CDC presentation, V-SAFE, or vaccine safety assessment for essential workers, is "a smartphone-based text-to-web survey, and email-to-web survey active surveillance program for early vaccine recipients."

Explore Reports: COVID-19 immunity can last for months
The program uses phone numbers from those who went through the registration process for the COVID-19 vaccination. Those workers amounted to more than 20 million in the initial months of a vaccination program. V-SAFE will perform health checks on vaccine recipients through text messages and email for two periods after vaccination. In the first week after vaccination, check-ins will occur daily. After that time, weekly check-ins will occur for six weeks following vaccination.

Should adverse effects be reported by a recipient, the system will offer a telephone follow-up. CNN reported the system will aid with sending a report to Vaccine Adverse Event Reporting System or VAERS, which is co-managed by the CDC and the Food and Drug Administration.

How long do v-safe check-ins last?

- During the first week after you get your vaccine, v-safe will send you a text message each day to ask how you are doing.
- Then you will get check-in messages once a week for up to 5 weeks.
- The questions v-safe asks should take less than 5 minutes to answer.
- If you need a second dose of vaccine, v-safe will provide a new 6-week check-in process so you can share your second-dose vaccine experience as well.
- You'll also receive check-ins 3, 6, and 12 months after your final dose of vaccine.

***The information presented today is based on CDC's recent guidance and MAY change***.

**5. COVID-19 Vaccine Distribution Plan Update - Imelda Garcia, MPH (Phased approach to vaccination)**

Phase 0 (October 2020 - November 2020)

- Provider recruitment and registration into ImmTrac2 and new web-based portal.

Phase 1 (December 2020 – January 2021): Limited supply of COVID-19 vaccine doses available.

- Vaccines will be direct-shipped to registered providers serving healthcare workers and other select populations based upon the DSHS Commissioner's approval in accordance with CDC/ACIP recommendations.
- Occupational healthcare settings will be the primary administrators of vaccines.
- Some large chains enrolled directly by CDC to serve some targeted populations (long-term care facilities).
- Continue ongoing provider recruitment and registration to ensure access to vaccination.

Phase 2 (February 2021-July 2021): Increased number of vaccine doses available.

- Emphasis on ensuring access to vaccine for members of Phase 1 critical populations who were not yet vaccinated as well as for the additional populations; expand provider network.
- Texas will use specialized vaccine teams, as needed, to vaccinate identified critical groups lacking access to the vaccine (e.g., rural communities).

Phase 3 (July 2021 -October 2021): Sufficient supply of vaccine doses for entire population.

- DSHS will focus on ensuring equitable vaccination access across the entire population. Monitor vaccine uptake and coverage; reassess strategy to increase uptake in populations or communities with low coverage.
- May consider extending the use of vaccine teams depending on the uptake and coverage received thus far, especially to ensure second doses are administered from the end of Phase 2.

Phase 4 (October 2021 and forward): Sufficient supply of vaccine with a decreased need due to most of the population being vaccinated already.

- May include boosters or annual vaccines, if required.
- Vaccine availability open throughout private providers. Population able to visit provider of choice.

**CDC Critical Populations for COVID-19**

| Groups and individuals may fall into multiple categories. Prioritization recommendations among and within groups are in development. | |
|---|---|
| **Category** | **Includes:** |
| **Essential workers** | • Healthcare personnel (i.e. EMS, hospital staff, vaccinators, pharmacy and long-term care staff)<br>• Other essential workers (i.e. first responders, education, others with critical roles who cannot easily socially distance) |
| **People at increased risk for severe COVID-19 illness** | • People 65 years of age and older<br>• LTCF residents (i.e., nursing home, assisted living, others)<br>• People with underlying medical conditions that are risk factors for severe COVID-19 illness |
| **People at increased risk of acquiring or transmitting COVID-19** | • People from racial and ethnic minority groups<br>• People from tribal communities<br>• People who are incarcerated/detained in correctional facilities<br>• People experiencing homelessness/living in shelters<br>• People attending colleges/universities<br>• People living in other congregate settings |
| **People with limited access to routine vaccination services** | • People living in rural communities<br>• People with disabilities<br>• People who are under- or un-insured |

**COVID-19 Expert Vaccination Allocation Panel (EVAP)**

Texas has convened a team of appointed external and internal subject-matter experts (SME) into the COVID-19 Expert Vaccine Allocation Panel (EVAP) to develop vaccine allocation strategies as recommendations to the Texas Commissioner of Health. The panel will develop and apply guiding principles in their recommendations. The recommendations from the EVAP will be sent to the Texas Commissioner of Health for final approval. EVAP voting members https://www.dshs.texas.gov/coronavirus/immunize/evap.aspx

**Texas Vaccine Allocation Guiding Principles**

Texas will allocate COVID-19 vaccines that are in limited supply based on:

- Protecting healthcare workers who fill a critical role in caring for and preserving the lives of COVID-19 patients and maintaining the healthcare infrastructure for all who need it.
- Protecting front-line workers who are at greater risk of contracting COVID-19 due to the nature of their work providing critical services and preserving the economy.
- Protecting vulnerable populations who are at greater risk of severe disease and death if they contract COVID-19.
- Mitigating heath inequities due to factors such as demographics, poverty, insurance status, and geography.
- Data-driven allocations using the best available scientific evidence and epidemiology at the time, allowing for flexibility for local conditions.
- Geographic diversity through a balanced approach that considers access in urban and rural communities and in affected ZIP codes.
- Transparency through sharing allocations with the public and seeking public feedback.

**COVID-19 Critical Population Update Phase 1A Healthcare Workers Definition – First Tier**

1. Hospital staff working directly with patients who are positive or at high risk for COVID19. Includes:

    a. Physicians, nurses, respiratory therapists, and other support staff (custodial staff, etc.)

    b. Additional clinical staff providing supporting laboratory, pharmacy, diagnostic, and/or rehabilitation services

2. Long-term care staff working directly with vulnerable residents. Includes: a. Direct care providers at nursing homes, assisted living facilities, and state supported living centers b. Physicians, nurses, personal care assistants, custodial, food service staff

3. EMS providers who engage in 9-1-1 emergency services like pre-hospital care and transport

4. Home health care workers, including hospice care, who directly interface with vulnerable and high-risk patients

5. Residents of long-term care facilities

**COVID-19 Critical Population Update Phase 1A Healthcare Workers Definition – Second Tier**

1. Staff in outpatient care offices who interact with symptomatic patients. Includes:



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- Physicians, nurses, respiratory therapists, and other support staff (custodial staff, etc.).
- Clinical staff providing diagnostic, laboratory, and/or rehabilitation services c. Non-91-1 transportation for routine care

2. Direct care staff in freestanding emergency medical care facilities and urgent care clinics.

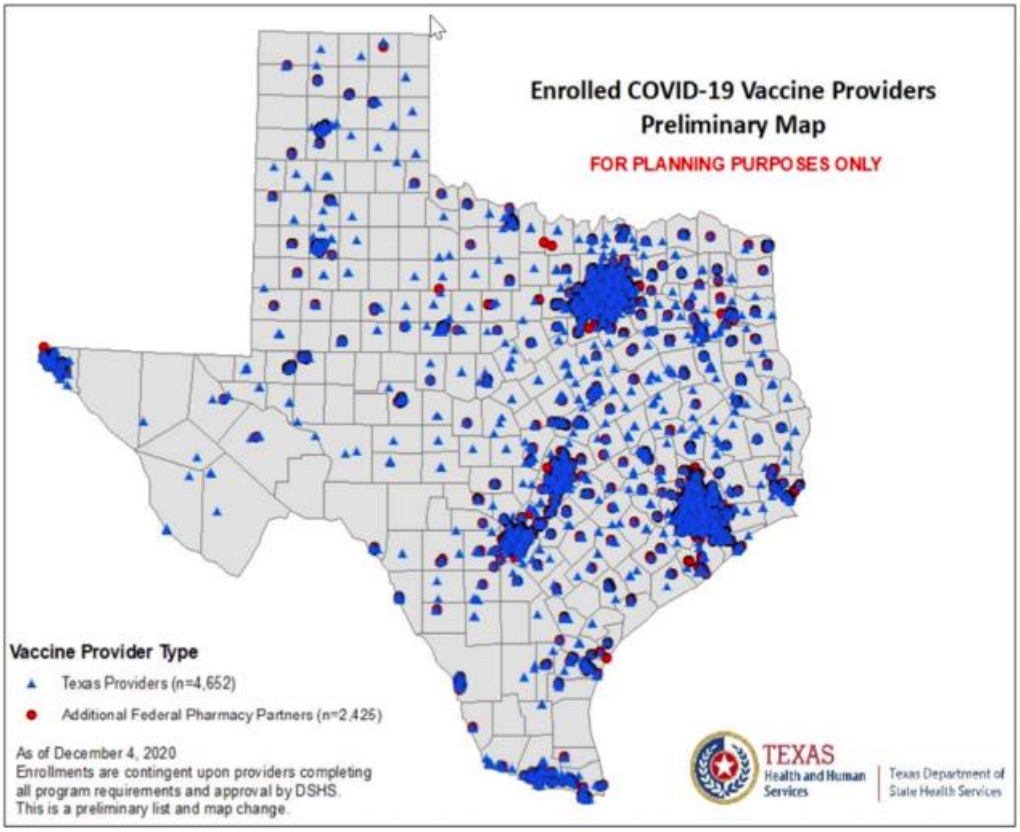
3. Community pharmacy staff who may provide direct services to clients, including vaccination or testing for individuals who may have COVID-19.

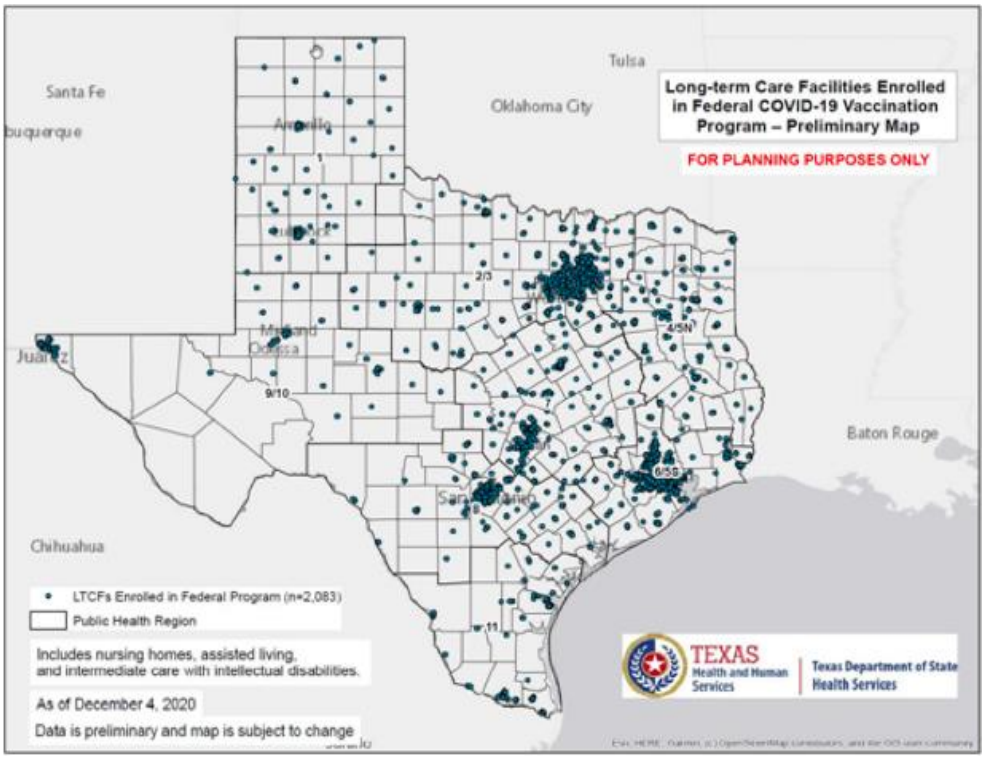
4. Public health and emergency response staff directly involved in administration of COVID-19 testing and vaccinations.

5. Last responders who provide mortuary or death services to decedents with COVID19. Includes:

- Embalmers and funeral home workers who have direct contact with decedents
- Medical examiners and other medical certifiers who have direct contact with decedents

6. School nurses who provide health care to students and teachers.


Enrolled COVID-19 Vaccine Providers
Preliminary Map
FOR PLANNING PURPOSES ONLY
Vaccine Provider Type
Texas Providers (n=4,652)
Additional Federal Pharmacy Partners (n=2,425)
As of December 4, 2020
Enrollments are contingent upon providers completing all program requirements and approval by DSHS.
This is a preliminary list and map change.
TEXAS
Health and Human Services
Texas Department of State Health Services




**Texas COVID-19 Vaccine Allocation & Distribution Timeline**

The First Vaccine Allocation

- 12/02/2020-12/03/2020 - Vaccine doses allocated to 109 hospitals across the state
- 12/04/2020 - Providers accepted allocations and DSHS submitted orders to the CDC
- 12/14/2020 – 12/18/2020 – Vaccine shipment & delivery to hospitals, depending on the date(s) of the EUA issuance/ACIP recommendations

Subsequent Vaccine Allocations

- Weekly allocations, depending on vaccine availability
- Allocations are made ~2 weeks in advance of shipment/delivery
- Vaccine delivery Monday - Friday

Website for Providers: www.dshs.texas.gov/coronavirus/immunize/provider-information.aspx

DSHS COVID-19 Vaccine Provider hotline: (877) 835-7750, 8 a.m. to 5 p.m., Monday through Friday or Email: COVID19VacEnroll@dshs.texas.gov

Website to enroll as a COVID-19 provider: Syntropi - IDx Management System (texas.gov)

General Questions: Email: COVIDvaccineQs@dshs.texas.gov

**Questions/Answers/Comments**

Other countries had the virus before we did; are they working on a vaccine? Some countries have developed vaccines. There are more than two hundred vaccines at various stages of development. Pfizer and Moderna have signed shipment agreements with other countries.

The time for development was shortened by taking away the risk of roll-out and tracking effectiveness.

Most employers do not want to mandate vaccinations related to employment. There is vaccine hesitancy and there are some who do not want it. There are many who do want the vaccine. Public health has to explain to people the importance of receiving the vaccine.

Early assessment of the preclinical development and experience inside and outside the US built a base of a critical amount of work. This allowed for large quantities of vaccine to be developed (Messenger RNA). The steps normally done in sequence were actually done simultaneously.

Post-vaccine masks would still be recommended. The vaccine is not perfect.

How long will the vaccine last? This is unknown at the moment since vaccinated people are still being followed.

Following the vaccinated will be complicated, especially for people with unrelated illnesses. DSHS stated that this will of course occur, and the problem is— you do not have to tell the truth for people to believe you. The federal government should take a credible and active stance in reporting and following cases dispelling misinformation.

Should people who have had COVID-19 get the vaccine? All should be vaccinated when the vaccine is made available.

**6. Public Comment.**

**Written Testimony Summary from the Texas Dental Association**

- Dentistry is important for systemic health
- Dentists are high exposure risks
- They follow infection protocols
- They should be high in the vaccination lists

**Oral Testimony**

**Sandra Batton, PACSTX** (long term care providers), stated that it is unclear where congregate settings for IDD fall in the prioritization. People with IDD are twice as likely to die from COVID-19 than the general population.

**Questions were posed in the Q and A Tab.**

DSHS stated that the recommendations will be made more firm as the process evolves, using the vaccine allocation panel guidance. It will depend on the vaccines the state receives.

Imelda Garcia will address questions about allocations to different hospitals. It can go to the email address EVAT@DSHS.Tx.Gov

**7. Planning and Discussion of Future Meeting Topics.** Status report on each item discussed today.

**8. Adjourn**. There being no further business, the meeting was adjourned.

***