

## Crisis Standards of Care ended statewide

Yesterday, IDHW [deactivated Crisis Standards of Care](#) (CSC) in the Panhandle Health District. Case counts remain high in the northern counties, but the surge is no longer exceeding available healthcare resources. CSC was originally implemented in the northern counties on September 6 and for the rest of the state on September 16. CSC was ended for all health districts, with the exception of the Panhandle Health District, on November 22.

While the entire state is now out of CSC, hospitals may still be using contingency care strategies due to high patient census and/or staffing availability. In addition, many are working through backlogs of delayed procedures and treatments.

## Reimbursement & Policy

### [Vaccines ~ fact sheets, confidence, and success](#)

This week, the FDA issued updated fact sheets for [providers](#) and [recipients and caregivers](#) for the Johnson & Johnson vaccine. The revisions outline a contraindication for those with histories of thrombosis with thrombocytopenia following vaccination. Women ages 30-49 have experienced the highest reporting rate – approximately one case per 100,000 administered doses.

However, the vaccine news is not all grim. A [study](#) by the Commonwealth Fund shows that in the first year of available vaccines, over 1 million deaths and 10.3 million hospitalizations – nearly 5 times more than occurred – were averted. In addition, the CDC's recent [survey](#) shows an increase in vaccine confidence when vaccinations are recommended by a health care provider.

### [Data reporting during the holidays](#)

Last week, HHS notified all hospitals of flexibilities put in place for the upcoming holidays. For federal data reported via TeleTracking, the following may be observed:

- Friday, December 24 - Sunday, December 26, facilities may submit their data for each of those days on Monday, December 27, dated-back to the appropriate date.
- Friday, December 31 - Sunday, January 2, facilities may submit their data for each of those days on Monday, January 3, dated-back to the appropriate date.

## Resources & Information

### [Idaho ranked high for pandemic response](#)

A new [Pandemic Scorecard](#) by Politico shows Idaho ranking #4 overall in handling the pandemic. Education, economy, health, and social impacts were considered when ranking each state. Idaho ranked high for education and the economy, with strong GSP growth, low unemployment, and job growth, as well as education.

## A closer look at Omicron

On November 24, nearly 24 months after the first case was officially identified in China, South African scientists reported another variant of concern (VOC) to the World Health Organization: B.1.1.529, or the Omicron variant. This novel VOC was identified from biological specimens collected in South Africa and Botswana more than two weeks prior to the reporting date. In the US, between December 1st and today, [48 of 59 U.S. jurisdictions have reported at least one case of Omicron](#) and many of these cases are linked to community transmission.

These developments underscore how SARS-CoV-2 continues to outpace our collective ability to anticipate the behavior of this virus and successfully end the pandemic. At every turn, political calculations and social hubris have undercut real gains towards reducing community transmission and ending the pandemic, leaving healthcare workers exhausted, the general public exasperated, and the virus at an advantage.

Information is still emerging about the Omicron variant, but results of genomic sequencing are concerning. Along with genetic changes elsewhere in the genome, Omicron has ["30 amino acid changes, three small deletions and one small insertion in the spike protein"](#) compared to SARS-CoV-2 alpha; 15 of these changes are in the spike protein binding domain, and may have direct implications for increased transmissibility, and "immune escape" – i.e. reinfection post-illness or reduced vaccine efficacy. Early data from South Africa and the United Kingdom demonstrate that it is more transmissible than the Delta variant that was largely responsible for the most recent and severe wave in Idaho, which led to Crisis Standards of Care being activated.

European Union modeling data estimate that Omicron will become the dominant variant in Europe during the first two months of 2022. The United States seems to be following suit. In the US as of December 14th, [approximately 13% of sequenced cases were caused by Omicron in New York and New Jersey](#) and 2.9% of sequenced cases in the US overall – a change from 0% at the beginning of December. These figures are boosted in part by using S-gene target failure (SGTF) screening by PCR to selectively refer likely Omicron specimens for whole genome sequencing, but are nevertheless concerning. In New York, Omicron contributed to the state setting incidence case records for four days in a row through December 19. For the week ending in 12/18/21, CDC modeling data estimate that [~73% of U.S. cases are attributable to Omicron – a nearly six-fold increase from the prior week](#).

As has been true in other phases of the pandemic, a more transmissible but similarly or less virulent version can still have significant consequences for population health and hospital capacity. As noted above, higher rates of transmission have been noted with Omicron; currently available data are, however, insufficient to establish its virulence. Although data from South Africa indicate higher numbers of hospitalizations and deaths during the period when Omicron began to predominate, these increases are commensurate with case counts, and more related to higher transmission rates than higher virulence. Additionally, data on vaccination status of hospitalized cases has been difficult to determine in South Africa and the United Kingdom. For example, in Norway, an outbreak at a Christmas party reinforced how highly transmissible Omicron is, but cases in the 30- to 50-year-old and largely vaccinated group were relatively mild (at publication, no hospitalizations, no deaths).

In the United States, a recent [MMWR report](#) indicated that among the 43 reported cases with initial follow-up, 79% had completed their primary vaccination series ≥ 14 days prior to symptom onset; approximately 41% of these had also received a booster dose (5 < 14 days prior to symptom onset). Six of the 43 Omicron cases had a previous infection. Symptoms were generally mild, with the exception of one vaccinated patient who was hospitalized. No deaths have been reported to date. Drawing inference about the severity of Omicron infection from these limited data is difficult, and currently available data should be interpreted with consideration of the limitations. Perhaps the most important limitation pertaining to Idaho is the unknown severity of disease among unvaccinated individuals, for which Idaho has the highest percentage in the nation.

In terms of treatment, data are still too limited to determine if monoclonal antibody therapies will remain efficacious. Data from other variants indicate that some therapies will remain efficacious while others will be less effective against this variant. [Data from a pre-print article posted December 17th indicate that several monoclonal antibody therapies will be less efficacious against Omicron](#). Spike protein receptor binding domain mutations – of which this variant has 15 – are the most concerning for the three monoclonal antibody therapies currently in use: Sotrovimabexternal, Bamlanivimab and Etesevimabexternal, and REGEN-COVexternal. Single mutations to the binding site may not result in a loss in efficacy, which is why specific data describing the relationship between Omicron and monoclonal antibody therapy efficacy are critical to inform clinical guidelines.

In the absence of a more definitive understanding, the precautionary principle has been embraced by both the European Union and CDC. CDC recommendations concerning this new and potentially impactful VOC include:

#### [Guidance for travelers \(domestic and international\)](#)

- All travelers should get a COVID-19 viral test 3-5 days after arrival.
- Travelers who are not fully vaccinated should self-quarantine for 7 days, even if their test is negative.
- Travelers should self-isolate if they test positive or develop COVID-19 symptoms.

[Vaccination](#) - Vaccination remains the best possible protection for serious illness and death attributable to COVID-19. Vaccination also helps limit the spread of SARS-CoV-2 and prevents new variants from arising. All eligible persons should consider vaccination and boosters as appropriate. As of December 16th, CDC endorsed the Advisory Committee on Immunization Practices' recommendation that individuals receive an mRNA COVID-19 vaccine over the Janssen COVID-19 vaccine. ACIP did, however, stress that any vaccine is better than being unvaccinated.

[Layered prevention strategies](#) - Although vaccination, testing, and isolation/quarantine are effective in reducing the spread of SARS-CoV-2 and the emergence of new variants, these strategies will not be entirely effective in stopping transmission of SARS-CoV-2 and in particular may be less effective in the presence of Omicron or other/future variants. This is especially true in Idaho, which is dead last among US states in the proportion of the adult population with a completed COVID-19 vaccination series. Mitigation measures such as wearing a face mask indoors or in crowded environments, improving ventilation of indoor spaces, physical distancing, and testing and handwashing remain critical in slowing SARS-COV-2 transmission. Currently, CDC recommends that everyone ≥ 2 years of age – including vaccinated individuals – wear masks in indoor places in areas of substantial or high transmission, e.g. Idaho.

For the latest data on Omicron in Idaho and the US, visit the [CDC's Variant Monitoring page](#).

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