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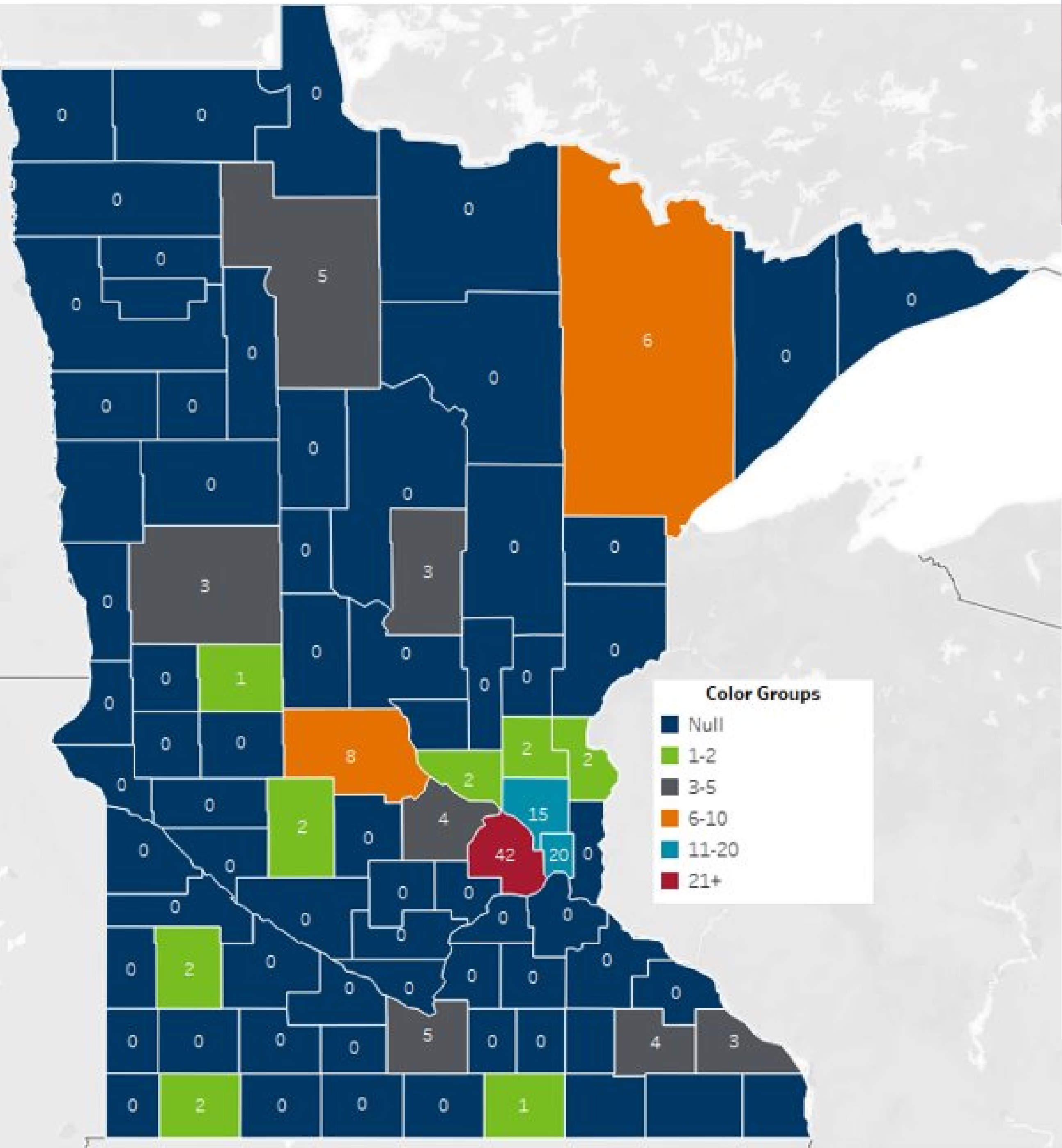
MDH Update: COVID-19 Flexible Response Funds and Monoclonal Antibody Treatment

Commissioner Jan Malcolm

Senate HHS Finance and Policy—February 7, 2022

MDH Emergency Staffing Pool for Hospitals, $40M

PROPOSAL	• Procure emergency staffing support for hospitals.
PROBLEM	• The omicron surge further compromised the ability of hospitals to provide patient care because of higher need for hospital-level care and increased numbers of providers out due to illness or quarantine or isolation. • There is an urgent need for additional nursing, respiratory therapy, and other clinical providers who can supplement existing hospital teams during what is anticipated to be a steep rise in hospitalizations over the coming weeks.
APPROACH	• A contracted vendor is supplying 199 RNs, 20 RTs as emergency support • Staff work 60 hours/week for 60 days (~330 FTEs) • Regional allocation, coordinated by regional coalitions • 25% hospital cost share
STATUS	• Contract executed on 1/15/22 • 140 providers on the ground, providing care



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- Regional Distribution of Emergency Staff

MDH/DHS Emergency Staffing Hospital Decompression, $7.49M

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PROPOSAL	• Continue and expand the hospital decompression program with selected nursing facilities
PROBLEM	• There is an urgent need for additional support to increase availability of post-acute care capacity for patients who no longer require hospital-level care
APPROACH	• Private vendors provide RNs and CNAs • MN National Guard provide initial CNA/TNA support • Focus on lower-acuity patients
STATUS	• Vendors have provided 80+ FTEs • National Guard soldiers no longer supporting initial 4 sites • New National Guard-only, 4-week site began operating on 1/31 for COVID-recovering patients • Total of 116 new beds available; 303 admissions to date • Transitioning to accept more higher-acuity patients for remainder of program • Exploring expansion to homecare support, for at-home care to COVID-recovering and complex patients no longer needing hospital-level care • Decompression sites will continue to operate through Spring 2022

Hospital decompression metrics

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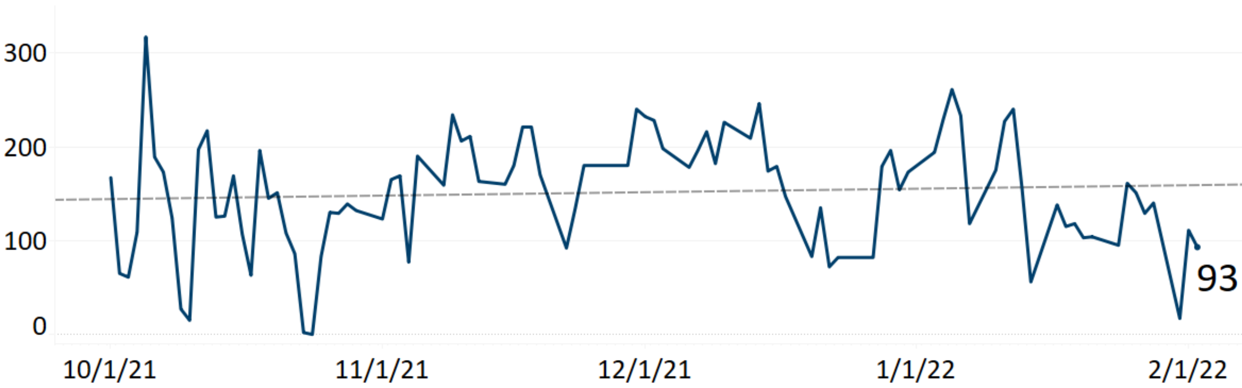
Patients in ED waiting 4+ hours for Admission for ICU or MedSurg

Updated February 2, 2022

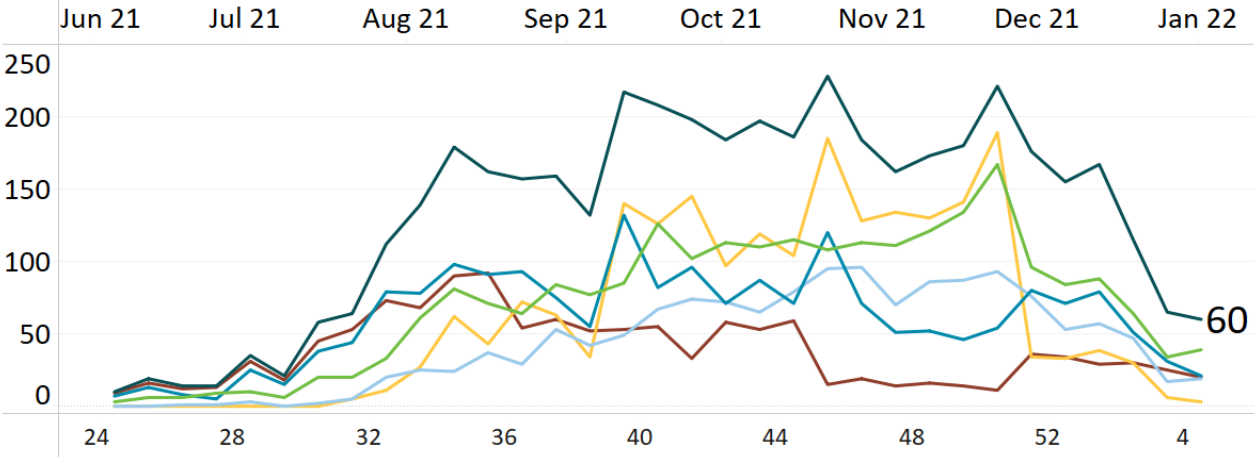
Since 1/3/2022, on average **146** people waited 4+ hours in the ED for a hospital or ICU bed each day.



Number of people waiting to be placed: Weekly C4 Data

Updated January 31, 2022

Total Reqs | ICU Reqs | MedSurg Reqs | COVID+ Reqs | In-Place Care | Total Placements



Increased Access to Tests—Federal Funding

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$40 million appropriated to continue expanding COVID-19 testing resources:

- Funds to be used for purchasing COVID-19 rapid tests and distributing them to Minnesotans.
- Working with testing manufactures to increase supply of rapid testing in the weeks and months ahead.
- Combined with HHS's expanded testing operation, this will increase testing access for communities disproportionately affected by COVID-19.

Testing Resources

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- **New Federal Test Site**: Jan. 26 - Feb. 14 in St. Paul, daily capacity of 1,000 tests.
- **21 Community Test Sites** across the state offering mix of rapid and PCR tests:
  - Expanded capacity in the fall/December to meet demand of Delta and Omicron surges
    - Additional Community Sites opened in Anoka, Cottage Grove, North Branch.
    - Expanded capacity at Inver Grove Heights, Stillwater, St. Paul test sites.
  - Monitoring use and will right-size footprint to meet testing demand
- 150,000 at home rapid **tests distributed to vulnerable communities** through community partners in January
- 1.8 million at home **rapid tests for school districts** for use spring semester.
- 450,000 at home **rapid tests secured for child care** in spring semester

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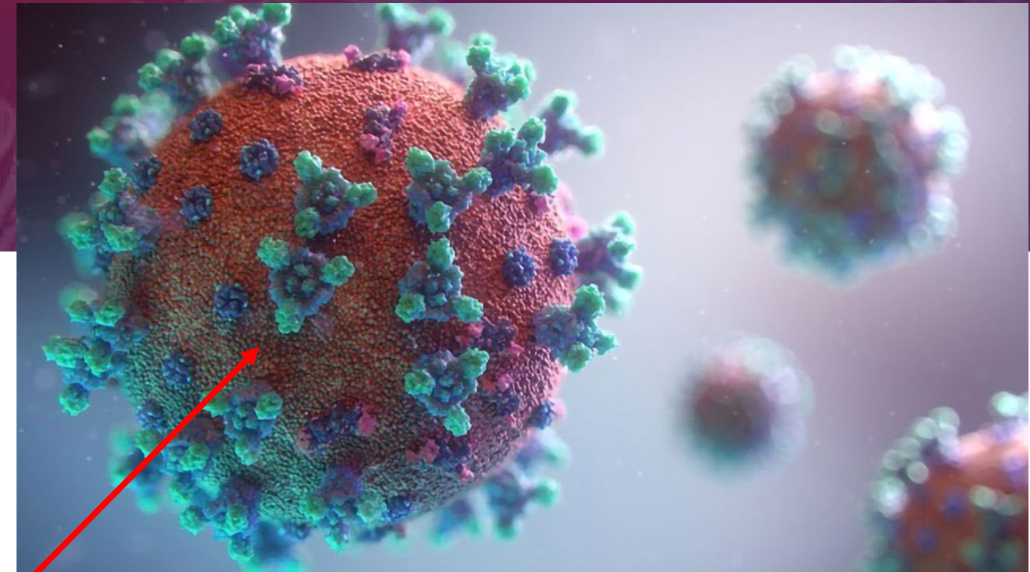
Monoclonal Antibodies

MINNESOTA

How Monoclonal Antibodies Work against SARS-CoV-2



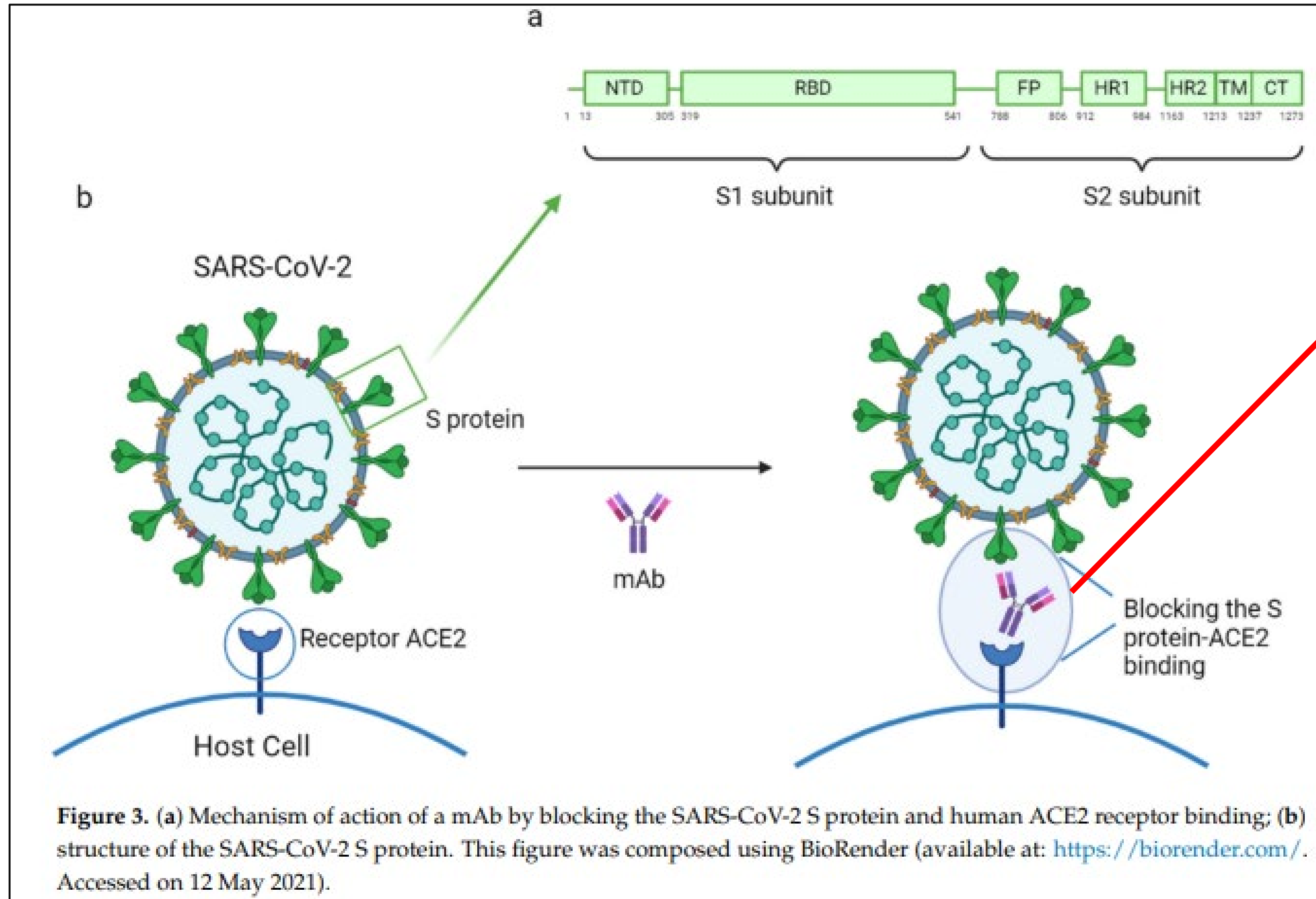


Figure 3. (a) Mechanism of action of a mAb by blocking the SARS-CoV-2 S protein and human ACE2 receptor binding; (b) structure of the SARS-CoV-2 S protein. This figure was composed using BioRender (available at: https://biorender.com/. Accessed on 12 May 2021).

- These mAbs are tailored to identify and bind to specific parts of the spike protein on the outer viral membrane
- This prevents attachment to and entry into human cells

Torrente-Lopez A, et al; Vaccines. 2021,9,557. https://doi.org/ 10.3390/vaccines9060557 s

COVID-19: Outpatient Treatment of Infection

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Monoclonal Antibody	% Reduction in hospitalization/death	Effective against Omicron?	Patient Population
Bamlanivimab/etesevimab	70%	NO	Adults and children including infants
Casirivimab/imdevimab	70%	NO	Adults and children 12 and older
Sotrovimab	85%	SOME	Adults and children 12 and older
Oral Antiviral	**% Reduction in hospitalization/death**	**Effective against Omicron?**	**Patient Population**
Molnupiravir	30%	LIKELY YES	Adults EXCEPT in pregnancy
Paxlovid	89/88%	LIKELY YES	Adults and children 12 and older
IV Antiviral	**% Reduction in hospitalization/death**	**Effective against Omicron?**	**Patient Population**
Remdesivir	87%	LIKELY YES	Adults and children 12 and older (FULL APPROVAL), under 12s (EUA)

NIH COVID-19 Treatment Guidelines: Statement on Therapies for High Risk Patients

Sotrovimab remains in short supply

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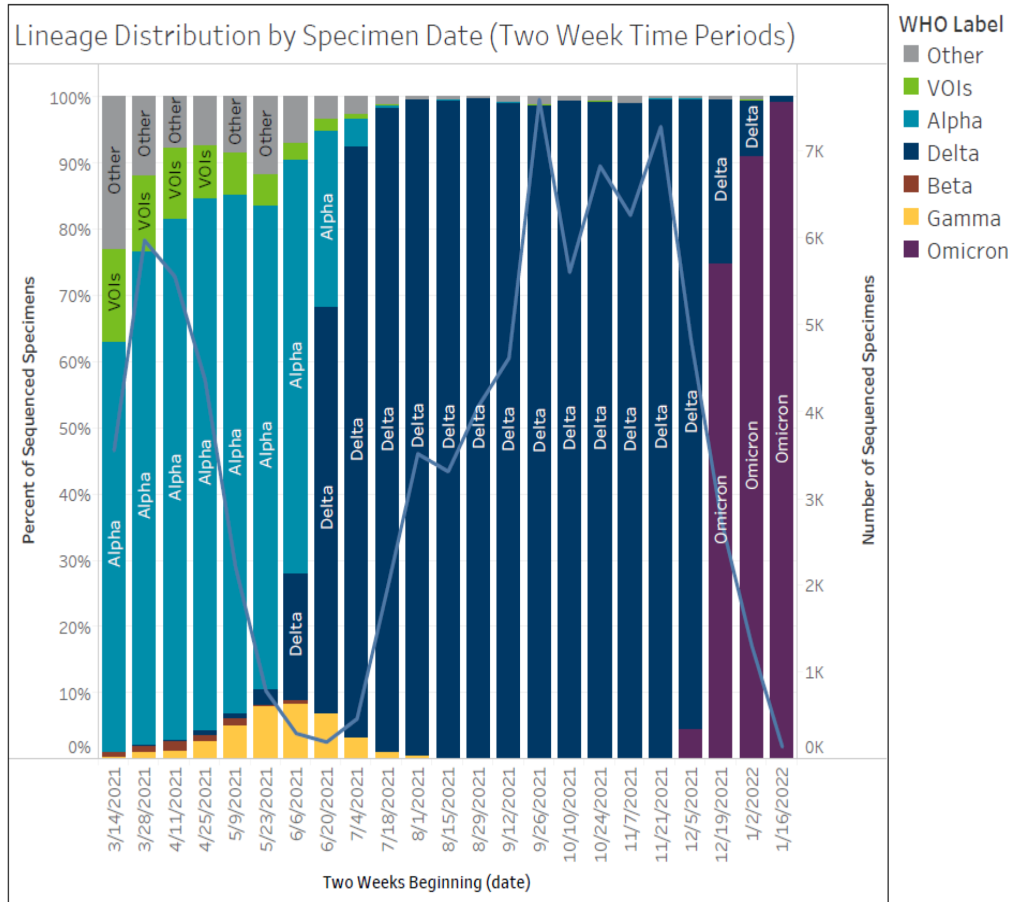

MN Allocation of mAbs from HHS for Treatment* (occurring weekly)

Date	Sotrovimab	Bam/Ete	Cas/Imdevi	Total Active Product
15-Nov-21	1356	2020	3396	6772
29-Nov-21	0	3480	4056	7536
08-Dec-21	0	0	0	0
17-Dec-21	1374	2870	3480	1374/6350**
27-Dec-21	714	590	708	714
03-Jan-22	552	530	648	552
10-Jan-22	462	410	504	462
17-Jan-22	594	530	660	594
24-Jan-22	792	0	0	792
31-Jan-22	960	0	0	960

*does not include Evusheld

**transition period for spread of Omicron

Allocation of Monoclonal Antibodies

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Stage 1

Sufficient supply for all

- Enough treatment capacity for **all eligible patients**
- Eligibility based on criteria listed in EUA (high-risk medical conditions that increase risk of progression to severe COVID-19)[1]
- Must fulfil all other eligibility criteria per EUA (within 10 days of onset of symptoms, mild-mod illness, not hospitalized)

Stage 2

Clinical prioritization

- Not enough capacity for **all** eligible patients from Stage 1
- Prioritize those at higher risk based on M-MASS score[2] and pregnancy
- Increasing cut-off as scarcity deepens (e.g., M-MASS 1+, then 2+, then 3+)
- Prioritize treatment over PEP when in scarcity

Stage 3

Weighted randomization

- Not enough capacity for all with M-MASS scores of 4 or above OR pregnant
- 4 chosen as cut-off as this is associated with a >10% risk of hospitalization
- Weighted random selection, with M-MASS 7+ or pregnancy receiving higher chances based on highest risk
- MNRAP system used to operate in opted in sites

1. FDA: Provider fact sheet for sotrovimab: https://www.fda.gov/media/149534/download
2. Razonable et al, Mayo Clin Proceed Jan 2022: Elsevier BV. https://doi.org/10.1016/j.mayocp.2021.11.017

Questions?