

## COVID-19 Dramatizes the Value of Rediscovering the Power of House Calls



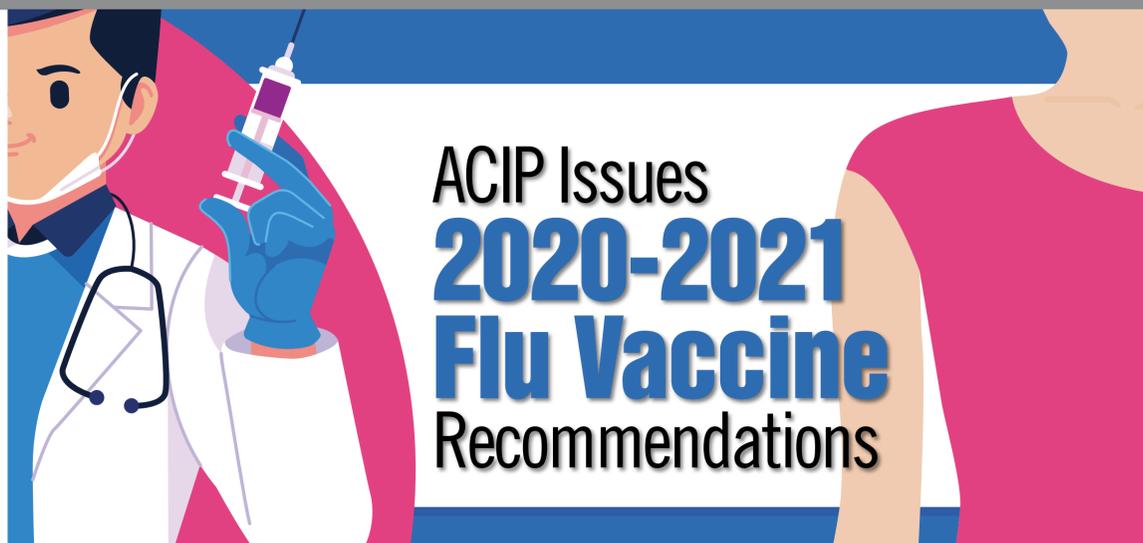
Written by  
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I work with a practice called Housecall Doctors P.C. in Highland, IN, which has treated more than 6,500 homebound patients over the last decade. We're an interdisciplinary care team that goes beyond primary care to ensure access to specialty treatments. As a team, we deliver care where it is often unavailable, and the results have been remarkable. Within a 12-month period ending last August, we treated more than 1,000 patients, reduced emergency department usage by 77%, and cut hospital readmissions by 50%. Moreover, patient satisfaction scores increased from 17% to 84% after implementation of the program.

COVID-19 has caused some physicians, insurance companies, and even the federal government to take special notice of the power of care models that reach out to patients. CMS issued new rules at the onset of the pandemic to allow home health agencies (HHAs) to provide services to Medicare beneficiaries through telehealth and to treat patients in their homes who are suspected of contracting COVID-19 or who have a condition that makes them more susceptible to the virus. They also allow for more flexibility on who is eligible to receive home healthcare and which clinicians are allowed to deliver care.

This crisis could have a silver lining if it prompts us to create a smarter model: while hospitals treat the most acute cases, more sick patients could be treated in their homes, where they recover better and quicker. With buy-in from CMS and a growing number of insurance companies, I am optimistic that more practices like ours will open. My hope is that with the new CMS rules, and the innovation being spurred by this pandemic, more physicians will take up this powerful model of care in their own areas.

All it takes is a team of clinicians working together to get it started in your community. COVID-19 will undoubtedly change how we deliver care. I hope that we can take this as an opportunity to form new partnerships, cross specialty lines, and, in a sense, rediscover our roots in bringing care into people's homes. ■



## ACIP Issues 2020-2021 Flu Vaccine Recommendations

As the 2020-2021 flu season looms in the midst of the ongoing COVID-19 pandemic, the CDC's Advisory Committee on Immunization Practices (ACIP) has released updates to its recommendations for using seasonal influenza vaccines.

According to CDC estimates, during the most recent flu season from October 1, 2019 to April 4, 2020, there were 39 million to 56 million cases of the flu, 18 million to 26 million flu-related medical visits, 410,000-740,000 flu-related hospitalizations, and 24,000-62,000 flu-related deaths. And this year, the US has to contend with the ongoing COVID-19 pandemic, which we've learned can present with symptoms similar to the flu and is set to place an additional strain on the nation's healthcare infrastructure.

In its new recommendations, published in *Morbidity and Mortality Weekly Report*, Lisa A. Grohskopf, MD, of the Influenza Division at the National Center for Immunization and Respiratory Disease at the CDC, and colleagues outlined the composition of this year's flu vaccines. "For the 2020-21 season, US egg-based influenza vaccines (ie, vaccines other than ccIV4 and RIV4) will contain hemagglutinin (HA) derived from an influenza A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like virus, an influenza A/Hong Kong/2671/2019 (H3N2)-like virus, an influenza B/Washington/02/2019 (Victoria lineage)-like virus, and (for quadrivalent egg-based vaccines) an influenza B/Phuket/3073/2013 (Yamagata lineage)-like virus," they wrote. "US cell culture-based inactivated (ccIV4) and recombinant (RIV4) influenza vaccines will contain HA derived

from an influenza A/Hawaii/70/2019 (H1N1)pdm09-like virus, an influenza A/Hong Kong/45/2019 (H3N2)-like virus, an influenza B/Washington/02/2019 (Victoria lineage)-like virus, and an influenza B/Phuket/3073/2013 (Yamagata lineage)-like virus."

### New Vaccines, New Contraindications

Notably, ACIP pointed out two new flu vaccines that will be available this flu season. The first, Fluzone High-Dose Quadrivalent (HD-IIV4), gained FDA approval in November 2019 and is expected to replace the trivalent formulation of Fluzone High-Dose that was available in previous years; HD-IIV4 contains four times the amount of HA per vaccine virus in each dose compared with standard-dose inactivated influenza vaccines (60µg per virus vs. 15µg in standard-dose IIVs), ACIP noted. The second new vaccine, Fluaad Quadrivalent (aIIV4), was FDA-approved in February 2020 and, like its trivalent predecessor, contains the adjuvant MF59. Both the quadrivalent and the trivalent formulation of Fluaad are expected to be available for the 2020-2021 flu season. Both of these vaccines, ACIP noted, are indicated for patients aged 65 and older.

New contraindications for patients receiving a quadrivalent live attenuated influenza vaccine (LAIV4) have also been added to the recommendations. As of this update, LAIV4 vaccines should not be given to patients with anatomic and functional asplenia; patients with active communication between the cerebrospinal fluid (CSF) and oropharynx, nasopharynx, nose, or ear or any other cranial CSF leak; and patients with cochlear implant, due to the potential for CSF leak. Also,

ACIP's recommendations for persons with a history of egg allergy were updated to state that "additional measures for those with a history of severe allergic reaction to egg (ie, vaccination in a medical setting supervised by a healthcare provider who is able to recognize and manage severe allergic reactions) are needed only if a vaccine other than [quadrivalent cell culture-based inactivated influenza vaccine] ccIV4 or [quadrivalent recombinant influenza vaccine] RIV4 is used."

### Who Should Get Vaccinated & When

As in previous years, ACIP recommended that all persons aged 6 months and older who do not have contraindications receive a flu vaccine. When vaccine supplies are limited, efforts should focus on delivering vaccination to the following high-risk populations (Figure).

ACIP suggested offering vaccines to patients by the end of October. Children aged 6 months to 8 years who need to receive two vaccine doses "should receive their first dose as soon as possible after the vaccine becomes available to allow the second dose (which must be administered ≥4 weeks later) to be received by the end of October," ACIP wrote. "Community vaccination programs should balance maximizing the likelihood of persistence of vaccine-induced protection through the season with avoiding missed opportunities to vaccinate or vaccinating after onset of influenza circulation occurs."

The COVID-19 pandemic, however, may complicate things. It is currently anticipated that SARS-CoV-2 and influenza virus will both be active during the upcoming flu season; to account for this, flu vaccination programs might need to work around stay-at-home orders and social distancing measures by starting vaccination campaigns sooner.

### Covid-19 & Flu Vaccination

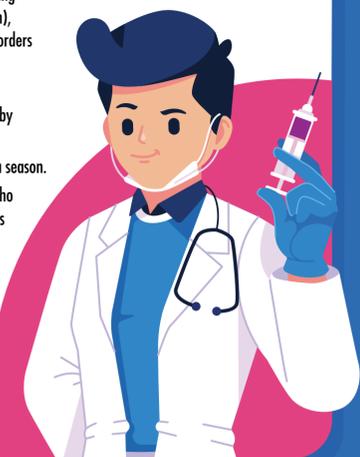
ACIP noted that COVID-19 infections might place a substantial burden on the nation's healthcare infrastructure this flu season without proper precautions. "The extent to which SARS-CoV-2 will circulate over the course of the 2020-21 influenza season is unknown," ACIP wrote. "However, during the continued or recurrent circulation of SARS-CoV-2 concurrently with influenza viruses during the upcoming fall and winter, influenza vaccination of persons aged ≥6 months can reduce prevalence of illness caused by influenza, and can also reduce symptoms that might be confused with those of COVID-19."

ACIP noted that clinical experience with flu vaccination of people with COVID-19 is extremely limited. Therefore, physicians should consider delaying influenza vaccination until these patients are no longer acutely ill, and patients should be reminded to return and receive a flu vaccine once they are recovered. ■

Figure.

- Children aged 6-59 months.
- People aged 50 and older.
- Adults and children who have chronic pulmonary (including asthma), cardiovascular (excluding isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus).
- People who are immunocompromised due to any cause (including but not limited to immunosuppression caused by medications or HIV infection).
- Women who are or will be pregnant during the influenza season.
- Children and adolescents (aged 6 months to 18 years) who are receiving aspirin- or salicylate-containing medications and who might be at risk for experiencing Reye syndrome upon influenza infection.
- Nursing home and other long-term care facility residents
- American Indians/Alaska Natives.
- People who are extremely obese (BMI ≥40 for adults).

## WHO SHOULD GET VACCINATED



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MEDPAGE TODAY'S

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## To Wear a Mask Is to Be Brave. To Trust Your Doctors Is to Be Brave

By Abubakr Chaudhry, MD

The pandemic is a lie. I will not wear someone else's fear. This is all fake news. It is remarkable to see these statements littered across the news and social media. Individuals with a fairly decent level of understanding and intelligence pandering to these ideas just go to show how strong anti-science culture has become.

On January 19, the first American would test positive for the novel coronavirus. By early February, the hysteria would start to set in and social media would start increasing speculative reporting. By late February, the stress and arguments about who should take responsibility began to boil over. Then there was the increase in fear among healthcare exposure rates, conflicting case fatality reports, and frustrations with the CDC on the flip-flopping in guidelines.

We became tired of the complaining, fear, and misinformation, so we decided to pen a guideline for our hospital. Georgia went on lockdown April 3. Throughout March and April, the world seemed to trust us as the scientific community to lead them through this crisis.

By April, we saw our algorithms were working, and we had some of the best outcomes in the state. People were adhering to the guidelines by staying home. Businesses had shut down, the spread was contained, and we could see the light at the end of the proverbial tunnel. Then, on April 24—with 892 deaths and 22,147 infected in GA—the lockdown restrictions were eased in our state. We were one of the last to close but the first to reopen. We knew the world needed to open; we just didn't know our world would open like this. I remember wondering why we couldn't mandate masks, contact tracing, and social distancing when we reopened. The virus became political.

When I started writing this, I was upset at a social media comment I read from a friend that read, "This pandemic is a joke, I will not wear a mask because I will not wear their fear." Now, I see that he was afraid and uninformed. People, in general, are still afraid, if not of the virus, then of loneliness, poverty, or even subjugation. When people exhibit these fears, and if their voices are loud, the politicians must bend to their will. If our politicians are afraid and their voices alleviate our fears, then we bend to their will. My point is, it is OK to be afraid. I am a pulmonary and critical care doctor, my wife is a pediatric intensivist, we have a small child, and we are afraid. But to wear a mask is to be brave. To social distance is to be brave. To trust your doctors is to be brave. To those with doubts, know that you are correct in your feeling that the system is broken. I don't know how to fix it, but I know that it has to be done soon. Help us get through this so we can build a better world: a world built from understanding, not from fear.

Abubakr Chaudhry, MD is a pulmonary and critical care physician.

## In Case You Missed It Ocrelizumab Reduces Immune Response to Certain Vaccines

Responses to selected vaccines in relapsing multiple sclerosis (RMS) patients treated with ocrelizumab (Orevus) suggested an attenuated but potentially helpful response, according to the phase IIIb VELOCE study, published in *Neurology*. In VELOCE, patients with RMS were randomized to ocrelizumab with two 300 mg intravenous infusions separated by 14 days (n=68) or to a control group (n=34, including patients using who either continued interferon-β treatment or received no disease-modifying therapy). All received and were assessed for response to tetanus toxoid (TT)-containing vaccine and 23-PPV (Pneumovax). The primary endpoint, a ≥4-fold increase from pre-vaccination antibody level at 8 weeks after the TT vaccine, was seen in 23.9% of the ocrelizumab group versus 54.5% in controls (treatment difference -30.7%, 95% CI -10.8 to -50.5%). A positive response to ≥5 serotypes in 23-PPV at 4 weeks was 71.6% in the ocrelizumab group and 100% in controls. The ocrelizumab group was further divided into OCR 1 (n=33) and OCR 2 (n=35) at randomization. The OCR 1 group received 13-PCV (Prenar; a booster for 23-PPV) 4 weeks after 23-PPV. The OCR 2 and control groups received influenza vaccine. The 13-PCV booster did not enhance 23-PPV response to pneumococcal serotypes in the OCR 1 group at 4 weeks, with positive response defined as 2-fold or >1 µg/mL increase in serotype-specific antibody titers. Four-week seroprotection against five influenza strains ranged from 55.6-80.0% in the OCR 2 group to 75.0-97.0% in controls.

## In-Hospital Heart Failure Deaths Down With Routine Vaccinations

For patients with heart failure, influenza and pneumococcal vaccinations are associated with lower in-hospital mortality, according to a study presented at the European Society of Cardiology Congress 2020: The Digital Experience. Karthik Gounguntla, MD, from the University of Connecticut in Hartford, and colleagues compared in-hospital mortality for patients with heart failure who received influenza and pneumococcal vaccines and those who did not using data from the National Inpatient Sample Database from 2010 to 2014. Data were included for 587,018 patients with heart failure (mean age, 70.53 years; 60.1% male; 53.2% Caucasian). Only 1.4% of patients in the study had received the influenza vaccine, and 1.4% the pneumococcal vaccine. In-hospital mortality rates in patients with heart failure were 1.3% and 3.6% for those who received the influenza vaccine and those who did not, respectively. Rates of in-hospital mortality were 1.2% and 3.6% for patients receiving and those not receiving the pneumococcal vaccine, respectively. "Pneumonia and flu vaccines are vital to preventing these respiratory infections and protecting patients with heart failure," Dr. Gounguntla said in a statement. "Although many people have rejected common and safe vaccines before COVID-19, I am optimistic that the pandemic has changed perceptions about the role of immunizations in safeguarding our health." ■

