Associated Video (00:02:13):

[Music Plays] What is the potential of one strand? Of one person? What do we do when our world is unraveling? How many problems can we solve when we work together? This is what's possible. When we answer the call, The Associated is built from moments like these. You, our donors and volunteers are what bind us. Together, we are the fabric of this community. Thank You.

Marc Terrill (00:11:17):

Good afternoon. I'm Marc Terrill, president of The Associated: Jewish Federation, and on behalf of our board of directors and the eighteen local social service agencies that comprise The Associated network, I'm delighted to welcome everybody to this important information session, underscoring the tremendous quest in desire for credible information. There are hundreds of you who have registered for this event, which we are proud to co-sponsor with LifeBridge health. The content of this forum will include a focus on COVID treatment prevention and the vaccination process. As all of you would probably agree, there is an abundance of information that is floating around, but finding credible discernible information is rather tough to come by. So today our hope is to change that as a matter of housekeeping, all participants will have access on your computer to a chat function where you can submit questions. Now with hundreds of people on the video meeting, it will be hard to answer individual questions. We will curate and bundle questions and present them to the experts to hopefully address and answer those questions. It is now my pleasure to turn over the program to the president of Sinai hospital, Daniel Blum. Daniel,

Dan Blum (00:12:50):

Thank you very much, Marc. My name is Daniel Blum. I'm president of Sinai Hospital of Baltimore and also Grace Medical Center and senior vice president of LifeBridge Health. I've been here since April coming to the community from the greater New York Metro area, Westchester County, New York. Privileged to be here in this role and a privilege to be with you this evening. I want to start off by first, thanking Marc and Michelle for putting this together and partnering with us on this endeavor. I think it's an important opportunity to share information and come together. I want to acknowledge the long, deep and productive relationship that Sinai and LifeBridge have had with The Associated and the sense of common spirit and mission, a common value system that we share. I want to acknowledge John Davidov, who is our board chair and actually the brainchild of this event this evening.

Dan Blum (00:13:52):

And his comments to me were really precious and essentially what he spoke of was the sense of community and the need to come together during a time like this and share information. This is about connections with people ironically, during this COVID period much of what we have learned is that it's hard for us to stay connected other than through these digital virtual platforms. Relationships suffer as a result of what we have all experienced - the need to socially distance and stay apart. Our mission here at Sinai and across life bridge is to educate and promote health and wellbeing, not just to deal with the consequences of ill health, although we are here for you in the event, you need us. At LifeBridge we've undertaken many work streams, Leslie Simmons in particular, we'll talk about some of that this evening.

Dan Blum (00:14:51):

But we've become a manufacturing facility for personal protective equipment. We altered our facility's policies. Some of that was very painful for you and for us things like altering the visitation policy, which was not something that we wanted to do, but was something that we had to do. We have, you

know, started to set up antibody infusion program. We were the first in the state to or in this region I should say to, to initiate testing and had to essentially invent a regimen to test people in our communities. We've served an unprecedented volume of patients who have suffered from the affliction of COVID-19, the coronavirus. On any given day, we have a very significant census of patients who have suffered from COVID. And yet at the same time, I'm very proud that our facility is fully safe.

Dan Blum (00:15:55):

The incidents of spread within the facility has been something that is imperceptible to us where we know that our associates, our colleagues have gotten sick. Generally, we've been able to trace back, through contact tracing, that that has occurred in the community and not from within the facility. So I feel very good coming in here every day, rounding inside the emergency department and in our units. It's a safe environment in a safe place to work and to receive care. We've also been very thoughtful and conscious to maintain continuity of operations for people who have other medical conditions. And I would urge you to maintain constant contact, as you need with, your physicians and to receive care that you might need for your endocrine conditions, cardiac conditions, et cetera. One of the lessons that we have learned through all of this is that people have gone without, at times, and that has created other medical consequence that we've had to deal with.

Dan Blum (00:17:07):

So one of the messages that we want to underscore this evening is to maintain continuity of care. And then I anticipate that a lot of the discussion this evening will be about vaccination. And we've worked hard to vaccinate our staff as well as now, reach out into the community to assure that the public has access to as much vaccine as we've had delivered to us. Again, one of Leslie's principal topics and one of the roles that's consumed so much of her time, and that of my colleagues is you know, trying to grab every bit of vaccine that we possibly can and get that as rapidly as possible into the arms of our community members, not just our workforce. So she'll talk a little bit more about those Herculean efforts this evening. There is a long-term impact to COVID that concerns me greatly.

Dan Blum (00:18:04):

I am very, very concerned for the durability of our healthcare workforce. They have served on the front lines of what we have done. We have a saying at LifeBridge "Care Bravely." I'm not big on, you know, the whole hero thing. When you see day in and day out the nurses, the physicians, the physical therapists, the respiratory therapists - the call to arms when there's an alert here you know, people put themselves into the breach to care for our community. And it is humbling to work in the environment and see that on, on a day to day basis. Now more than ever it's important for us to demonstrate kindness and caring and compassion and our value system. That again, is common among our organizations. And I think you'll hear tonight about some of the very, very impressive scientifically advanced expert kinds of care and consideration that our subject matter experts have. I'm not actually going to introduce each of them. I'm going to leave that for each of them to do so that we can get to actually the important discussion points this evening. So I'm going to kick it off with the next speaker. I believe that's Dr. Schabelman, is that correct?

Dan Blum (00:19:33):

Yeah. So with that, Dr. Este Schabelman.

Esteban Schabelman, MD (00:19:40):

Hello. My name is Este Schabelman, I'm the chief medical officer for Sinai. I'm going to try to compress all of the vaccine knowledge in about seven minutes. Let me share my screen while I get this up and

running. Okay. So it looks like you guys can see my screen, which is good. All right. I'm going to start by just introducing you to coronavirus. I think everyone is familiar with this by now, but we have approximately a hundred million, almost a hundred million cases in the world and that we're getting about 800,000 to a million new cases per day. In the U.S., this is approximately, we've had approximately 25 million cases and we're getting approximately 250,000 cases per day. So it's, it's definitely, it's definitely getting out of control.

Esteban Schabelman, MD (00:20:46):

To get a little more local, you can see Maryland numbers here. So the very bottom state on this far left hand graph is Maryland. You can see we're actually number 26. So for total number of infected. But on a per 100,000 people basis, we're number 43 out of 50. So we are doing pretty well there. So you know, I'll take this opportunity to encourage continued mask wearing and social distancing, because we are doing a pretty good job of it. As you can see our daily infection rates skyrocketed right around early November and has now started to plateau at around 2.5 thousand new cases per day. I'm hoping that this will come down in the near future. So now we need to talk a little about the Moderna, the, the vaccines. I'd like to talk about the Moderna vaccine first.

Esteban Schabelman, MD (00:21:47):

So the first thing to know is a little bit about mRNA vaccines. So mRNA is just delivery platform for a small piece of genetic material that enters the cell. And it uses the cell's machinery to sort of create a protein. And that's a protein that was normally on the virus. In this particular case both of them, both Moderna and the Pfizer vaccine, sort of ask the cell machinery to create the spike protein, the spike protein is what the coronavirus uses to insert itself into a cell. So it makes an obvious target because if you can prevent the coronavirus from entering the cell, you can prevent an infection. So the mRNA enters the cell and asks the cell to essentially create this spike protein. The spike protein is then expressed on the outer coating of the cell.

Esteban Schabelman, MD (00:22:48):

The immune system attacks it as if it were an invader. And then in a normal immune system, you create a memory to that, so that the next time your immune system is exposed to it, you are able to fight off the infection. That's the way most vaccines work. The mRNA acts the actual messenger. Of note, And just to debunk some, some, some misinformation before we get there, the mRNA in these vaccines never actually enter the nucleus of the cell. That's the, sort of the, the, the powerhouse of the cell where the DNA lives. It's not, it doesn't enter that. So it doesn't interact with the DNA. Doesn't change. The DNA doesn't affect the DNA in any way. It just essentially co-ops the cells machinery to create the protein. So the Moderna vaccine it had a phase three trial with 30,000 volunteers.

Esteban Schabelman, MD (00:23:41):

That's a very large phase three trial. Just to orient you on that phase one trial tests, whether or not a drug is safe, a phase two trial tests whether or not it works, and a phase three trial is one of those randomized placebo controlled trials, that you guys hear about, that tests whether or not the intervention works compared to something else. In this particular case it's compared to placebo. But you could, for example, if you developed a new flu vaccine compared to the old flu vaccine. So in this particular case, they compared it to a fake shot and they had 30,000 volunteers and they found 95 cases of COVID in those 30,000 volunteers. And those 95 cases of COVID, 90 of them occurred in the placebo. That means they never got the vaccine.

Esteban Schabelman, MD (00:24:40):

And only five of them occurred in the vaccinated group, sort of approximately half the people were in the the intervention group. So out of 15,000 people who got the vaccine five, got COVID out of it, and none of those cases were severe. So this gives them, this gives the vaccine efficacy of about 94%. And one important thing to note about the Moderna vaccine is they are essentially advertising that it had a hundred percent effectiveness at preventing severe COVID-19. And it did in those 50,000 people. The advantage of the Moderna vaccine is the logistics. It stores for six months at -20 degrees Celsius, which is a sort of industry standard. And it can stay up to 30 days at normal refrigerator temperatures. It's not anything special about how it's stored. The Pfizer vaccine targets the exact same protein spike as a Moderna vaccine.

Esteban Schabelman, MD (00:25:38):

Again, it's a, it's a very rational target because it prevents the infection. And they enrolled 43,000 participants. And this vaccine was 95% effective against COVID-19. Again, starting 28 days after the first dose. They had 170 cases of COVID. And only eight of those were in people who got the vaccine. The disadvantage to this is logistics. It has to be stored at -70 degrees Celsius. Pfizer is working on a more durable version of this, it's called [inadubible]. And it would be able to be kept at normal refrigerator temperatures but we don't think that'll be ready until 2022.

Esteban Schabelman, MD (00:26:19):

The other one that you might've heard about is the AstraZeneca Oxford vaccine. This, instead of using mRNA as the, as the sort of entryway into the cell, it actually uses a common-cold causing virus. It's called an [inaudible] virus. And that cold virus obviously already has the machinery for getting into the cell because that's how it infects you. And so they essentially take out all of the all of the infective material from the [inaudible] virus and insert the data that your cell would need in order to create also a protein spike. And so the adenovirus enters your cell the way it normal adenovirus does. It would normally ask your cells to replicate itself, but since all of that material has been taken out of it, it now asks the cell to replicate the protein spike, which is then expressed in the same way.

Esteban Schabelman, MD (00:27:11):

This trial was a little weirder. They, they found it it's a two, two dose vaccine just like the other vaccinations, but they found an overall effectiveness of 70%. Okay. And they had 131 cases of COVID 19 and 11,000 participants. Now the problem is that that 70% was averaged amongst two groups, that they had. One group where they received the full dose followed by the full dose as dose two, and the other group received a half dose and a full dose at the second time. And that half those followed by the full dose was more effective. It was 90% effective versus the full dose followed by the full dose which was 62% effective. So the average up to 70, but the half dose plus full dose regimen was better. That being said, they didn't do enough of that half dose full dose regimen because that half, those full dose regimen was not planned.

Esteban Schabelman, MD (00:28:12):

It was a mistake. It's one of those sort of scientific curiosities that it, it just happened to work better. So we're hoping that this vaccine is 90% effective when done in that half dose full dose manner, but we're still waiting for the larger trial to prove that out. So that's ongoing right now. So some, some notes on mRNA vaccines. The, the first questions we get, and I just want to head off questions in advance. Cause we, we got these questions all the time. So the first question we get is 'why was this so fast?' Okay. and the answer is, you know, a lot of the research was already done for generic coronavirus vaccines. Coronaviruses are what cause the common cold. And so we've been targeting that for years. So this is not research that started from scratch. Funding. These, these vaccines, essentially had guaranteed funding either from the federal government or just because it's coronavirus and it was

essentially an open market for purchase. So they didn't have to justify revenues to the company at every step. And lastly, they did do parallel research. So normally phase one is complete and then phase two and then phase three. And they didn't do that here. They did those trials at the same time. Now that does increase the risk slightly to the participants. But once the data is out, the risk is same to the general public because it doesn't really matter what order you do that. And the other question we got a lot is what about these mRNA vaccines? I mean, they're, they're new. Should we be worried about them? And you know, again, this is technology that's been around for a long time. It's actually been in development for the last 20 years or so it's not new.

Esteban Schabelman, MD (00:30:03):

The only real problem is that most of the easy targets were already taken by another vaccine. So if you wanted to use an mRNA vaccine against the flu then you would have to prove that your vaccine is better than the flu vaccine, which is a, a bigger hurdle to surmount than proving that your vaccine is better than nothing. So the other thing that, that made the mRNA vaccines less sort of desirable for mass vaccination is the whole cold custody chain that we talked about, the -20 degrees [Celsius] and -70 degree [Celsius] cold chain. And so you know, that's not so great when you want to vaccinate 300 million people like you do with the flu vaccine. That being said, one of the advantages is that they are very quick and easy to develop. And again, I'm just going to head off a question at the pass.

Esteban Schabelman, MD (00:30:57):

You know, we, we've heard about these new COVID variants coming out of South Africa and the UK. And while we think that the current vaccines will work against them, at least they do in a test tube and in animal studies, we don't know a hundred percent for sure. However, because these mRNA vaccines are so easy to produce we could potentially get one to market within about six weeks. Assuming that the approval process was similar to that for the flu vaccine where each year they don't have to get a new approval, they just get a sort of modified approval for whatever the flu season is. So what's the risks of this speedy development? So we only know that the vaccine is effective out a few months. You know, the trial is still ongoing. And so as the trial progresses, we'll know how effective it is on a month to month basis.

Esteban Schabelman, MD (00:31:49):

You know, we know that it's effective right now, at least up to four or five months. That being said, even if it, if that's all it did, if it only protected you for four or five months, it still be worth it as an interim measure until you got a vaccine that lasted longer, we don't think it lasts four or five months. We think it'll provide a longer-term immunity, but we don't know yet. Similarly, we don't know about long-term side effects because again, the full trial is still ongoing. Again, there's no reason to think that there'll be any long-term side effects and COVID-19 definitely has some long-term side effects. And so the goal isn't to be a hundred percent safe, the goal is to be safer than getting COVID, which this definitely is. The other risk of going this fast is we, we like data on secondary end points.

Esteban Schabelman, MD (00:32:37):

So there are potentially some small subpopulations of people that the vaccine might not work so well in. It might not work well in say a racial group, an ethnic group. It might not work so well. We don't know if it works in kids or in pregnant women because it wasn't tested that way. Again, we think it does, but those kinds of trials weren't performed due to the speed that we did this. And and then some notes on safety. So are they safe? That's another question we get a lot. And again, these are huge phase three trials. Normally phase three trials are not 30-40,000 people like these were there, they're 10 times smaller than that. So in these huge phase three trials, they had a 10-15% side effect ratio. And these side effects were mild, like pain, headache, things like that. Muscle aches. About 2% of

people had fever. And again, those are the most common side effects are pain at the injection site and and fever. Both these tend to be worse after the second injection. Again, they didn't discover any serious side effects such such as, you know, anaphylaxis and things like that did not occur on the trial.

Esteban Schabelman, MD (00:33:57):

So how's the vaccination process going? Again, like we said, this is a little bit of a logistics thing. So in the United States here in this top left-hand graph you can see that [inaudible] Pfizer vaccines given and about 10 million Moderna vaccines given. In Maryland, we're getting about 72,000 vaccines per week, and we've administered about 338,000 so far. And at LifeBridge Health we've gotten 13,425 first doses. We've given 8,000 -sorry- 8,700 of them. And all of the rest are accounted for and scheduled. We're about one week from from fulfilling those orders. We've also we've also received 12,500 2nd doses. And remember those doses can't be used for the first people, because you have to guarantee that the people who get the first vaccine have a second vaccine. So those are essentially in waiting for people who got the first vaccine.

Esteban Schabelman, MD (00:35:06):

So again, our backlogs about a week and the limiting factor is supply of the vaccine. Again, a week is about what we expect because we don't release. We don't release spots until we have the vaccine on hand because our receipt of the vaccine has been variable anywhere between zero and almost 3000 per week is what you can get in our experience. So hopefully that gives you an update on the vaccine. I guess the last question is will I get it? And the answer is yes, I've already gotten both doses. Yes, I had some arm pain, and I, I think that's better than COVID. So the next speaker is Dr. Unguru. Dr. Unguru is our chief ethicist here at Sinai. And in addition he is an excellent pediatrician.

Yoram Unguru, MD (00:35:59):

Thank you, Este, good evening. Este, could you just give me a thumbs up if you see my screen? Thank you. Good evening everybody apologies for my attire. Everybody looks so much better than me. I ran over from clinic but I'm very happy to be here. Thank you all for zooming in and Este really did a great job laying the groundwork. My focus is going to be on some of the ethical issues that relate to prioritizing the COVID-19 vaccine in general. And I'll briefly highlight some of the things that come up here at LifeBridge. So how does the vaccine rollout work? Well, it seems very straightforward. There's a federal allocation. The government distributes to save primarily based on population, and States, in turn decide how to distribute to local hospitals and health systems, who, in turn, will roll it out to their individuals.

Yoram Unguru, MD (00:36:53):

Again, seems straightforward, but we'll come back to this in just a moment. So although our focus today is on shortages of COVID-19 vaccines. It's important to appreciate that shortage of medications and other essential resources have a longstanding history. One of the first large-scale drug shortages was insulin in the 1920s, and this was followed by penicillin in the 1940s that affected far greater numbers of patients. And like the COVID vaccines shortages that we see now, both insulin and penicillin shortages were due to an inability to manufacture adequate supply. Now beyond their important historical perspective, what's really critical is understanding the manner in which they were allocated. When it comes to insulin, Dr. Frederick Banting, who was one of the co-discoverers of insulin, he was responsible for prioritization. And Bantings allocation decisions were arbitrary and biased influenced by personal, emotional political appeals. What that meant was that the politically well-connected acquaintances were prioritized over others.

Yoram Unguru, MD (00:37:53):

Penicillin on the other hand was preferentially allocated to U.S. Soldiers and not civilians. And at the time it caused a huge uproar because the population was not told about the allocation process. And let's think about, again, what's happening now with COVID. Same time that there were shortages of penicillin or shortages of food on the U.S. home front during the second world war. Fast forward to the 1960s, some of you with some more gray hair may remember the so-called Seattle God committee. This was the group of individuals who decided who would get dialysis and who wouldn't. And in addition to focusing on health status, prognosis, the committee also focused on so-called social worth. So people who were married were prioritized over those who were single. People who were, who went to church, were prioritized over those who didn't and here the limited constraint was ability to pay for this expensive new technology. I remember the 1970s standing in line for shortages of gasoline. And the more recent examples of shortages are things like seasonal H1N1 influenza vaccine, medications -We've had shortages of medication for years- and PPE.

Yoram Unguru, MD (00:39:00):

So arguably the examples that I just mentioned should serve as a cautionary tale of sorts and really support the need for having an ethical framework for how to allocate these vaccines. But shortly after the vaccine started rolling out a series of concerning stories started to break in media outlets across the country. And that really serves, I think, as a Clarion call and a reminder of the importance that we have a transparent public and defensible vaccine distribution framework. And here's one example from what happened at New York hospitals. Here's another story about some academic medical centers and what led to this seeming free-for-all well, although there's federal guidance, that's exactly what it is. It's guidance. And as all of you know, guidelines are meant to be followed. They're not written in stone and each State interprets these, the federal guidance, a little bit differently. That, along with the slow rollout of the vaccines, has placed immense pressure on States and health systems to sometimes loosen the criteria, distribute the vaccine as widely as possible.

Yoram Unguru, MD (00:40:08):

And this is not just confined to academic medical centers. This is happening at hospitals across the health system, across the country. And some of these health systems don't have as many checks and balances in place. And so that makes it even easier for some of these very bombastic quotes that you see here to kind of service. And importantly, these problems aren't just limited to hospitals, take a look at what's happened in Florida. So as many of you I'm sure know, Florida was one of the first States to prioritize larger segments of the population. And that really illustrates the challenges, I think, of expanding a vaccine rollout and program that's developing as it's being built in real-time and with limited federal assistance. And so this is what ends up happening. And these are the types of things that really, when we think about how can we make sure that we're not getting some of this bad media coverage and the optics that nobody wants to see, again, to me as somebody who's worried about bioethics and let alone good clinical care, it really is a wake up call.

Yoram Unguru, MD (00:41:15):

This is a quotation from my colleague, Ruth Faden. Ruth is one of the premier bioethicists out there. And really, I think it's, it's worth, it's worth hearing out loud. So forgive me. I'm going to read it for you guys. 'Cronyism and connections have no place in the rollout of the vaccine. If we don't do this right, the consequences could be quite catastrophic. So it's really critical that people be hypersensitive to the rules of the game here.' So Ruth talks about the rules of the game. Well, what are the rules of the game? When it comes to rationing prioritization allocation, we need to distinguish between equitable and inequitable rationing. And what I like to use is the pizza example. My colleagues here have heard

me say this before, but most of us like pizza, if it's a low carb version, I'll eat it too. And so equitable distribution or rationing happens when you're about to sit down with your family of 4 to eat pizza.

Yoram Unguru, MD (00:42:11):

And that means everybody gets two slices of pie. But let's imagine that your neighbors knock on the door in pre COVID times, and we don't have to worry about social distancing, and they want to partake too. Now, if you believe in equitable rationing, that means that everybody gets one slice, but nobody goes hungry. And that's what we need to strive for. Okay. Making sure that everybody has a piece of the pie. Well, so what's happening here locally in Maryland, but in particular in the Baltimore region, we're fortunate that here at LifeBridge, we from the outset of the pandemic, got together with other health systems, Hopkins, Maryland, MedStar, Luminous, and LifeBridge. And we have come up with equitable, ethical and transparent frameworks for all sorts of allocation of scarce resources, medicines, beds, vents, vaccines, and each one of his systems has really tried to adhere to the same guidance.

Yoram Unguru, MD (00:43:08):

And each one of our systems, including here LifeBridge we have what we call scarce resource allocation or triage teams. And that's how we make some of these difficult decisions. And it's important to keep in mind that yes, we have a shortage of vaccines, but also ultimately everybody will get a vaccine who wants one. Now, having an ethically sound allocation framework is important, but it's only the first step. I'd argue that the second, and more important step, really is that whatever framework we're using is perceived by the public as being fair and equitable. And language is important. You know, Noam, Chomsky said, words had meaning and so many other important, you know, impressive people. What do I mean by that? So if you look at the frameworks that have been published by the National Academy, CDC, et cetera, you'll see words like phases and groups. And that suggests that we have a successive deployment, what you don't see, but what was seen in some of the earlier drafts, words like tiering. Tiers or tiering suggested there's a hierarchy.

Yoram Unguru, MD (00:44:12):

And that would suggest that my wife is more important than me, which is true, but you know, I won't admit that right here. And we want to make sure that we're not distinguishing in that way. And it's really important along those same lines that we recognize that within each phase, phase 1A phase 1B phase 1C, no one person is more important than the other. And if you think about that, practically, it makes sense. So for me, as a pediatric hematologist oncologist to do my job, I need the transporter to take my patient to radiology. I need the radiology technician to do the scan. I need the food services person to feed my patient. So we're all in this together. And I'll talk just a second about what that looks like here at LifeBridge and then language again is important. Remember as Este so, so well-stated, these are safe and effective vaccines, but we don't have long-term data.

Yoram Unguru, MD (00:45:01):

So the federal government has said, we're authorizing these under the emergency use authorization. We're not yet approving them. And so that goes to the transparency part. So how did we develop our framework? Well, we looked at what smart people have done. We have the National Academy's recommendations. We have the CDC and other important bodies. And so here's what the National Academy says. The National Academy says that these are the ethical principles, primarily focusing initially on maximum benefit that we need to be mindful for. And if the National Academy is appreciated for any vaccine rollout to be successful, it directly rates to engaging the public, being a fair process and making sure that we're transparent. And again, go back to the insulin and penicillin

shortages of yesteryear. Remember how frustrated and upset the population was. And if we want to avoid that, we need to share what we're doing, which was one of the reasons we're doing today's talk.

Yoram Unguru, MD (00:45:56):

Here's what the CDC says about how to roll out a vaccine. And again, you can see, maximize benefits and minimize harms. So this is what the National Academies of Medicine framework looks out. And you'll notice here that it talks about phase one, two, three, four, and you can see what the breakdown is now what the National Academy did was, in coming up with this recommendation, they looked at 31 different countries across the globe and their own individual frameworks. And every single one talked about first, we should vaccinate high-risk healthcare workers and first responders. So there is some process behind this. Well, here's, what's happening in Maryland. And forgive me for the microfont. I don't mean for this to be an eye test for you. I wanted to capture everything. So you can see that, as of yesterday, we started phase 1C, and this is a little bit different, this kind of rollout than what the National Academy did.

Yoram Unguru, MD (00:46:52):

And again, this goes back to what I was trying to state earlier that every state interprets these guidelines a little bit differently. There is some room for nuance, if you will. And this is just another picture of what where we're at right now. And as I'm wrapping up, I want to drive home a couple of points for you. So this comes from our state and you can see here, vaccine supply is dependent on the government's allocation to Maryland, and is subject to change. Take a look at this, the state estimates that we're going to need 3 million doses just to get through the first phase one. Okay. 1A, 1B and 1C and Este told us 72,000 vaccines a week or 288,000 vaccines a month is what the state gets. It's going to take a little bit of time for us to get there, which is why it's super important that we have a nuanced and transparent process and how we do that.

Yoram Unguru, MD (00:47:44):

So at LifeBridge I told you, what do we do? Well, we don't distinguish between somebody who delivers care or somebody who supports care they're equally important. And if you're in that class, you were in our first phase of the rollout. And when we don't have enough vaccine, when vaccine demand outpaces vaccine supply, we rely on a lottery because the lottery is the only true ethical way to make sure that it's random, contrary to what happens with first come first serve. And if in the Q&A there's time and interest, I'm happy to go into that. And so that's a real key component of what we do. Este noted, we have to be able to commit to people that we have two vaccines. If we give you the first vaccine, we better be able to back it up. And that in turn depends on what we get from the state and from the, from the government.

Yoram Unguru, MD (00:48:30):

Messaging is key. It's really important that not only we're transparent, but that we don't game the system. So I always like to use the kind of analogy, the son of the hospital CEO and the son of the hospital environmental services worker are of equal standing. Okay. And if you participated in a COVID trial, if you had prior, COVID, it doesn't matter. You're still eligible and should get the vaccine. And I just want to wrap up with this: vaccines are good. It's great if you have vaccines, but you know what's even better? Getting the vaccination. We still have a lot of work to do nationally, locally in drumming up support for the vaccine, because there is a vaccine hesitancy, and this is one model that the World Health Organization talks about, about how to overcome that. And so with that, I will leave you guys. I want to thank you for giving me the opportunity for speaking with you and look forward to the Q&A, and I will stop sharing my screen now. Thank you.

Dan Blum (00:49:30):
I believe Dr. Poffenroth is next.

Yoram Unguru, MD (00:49:32):
Sorry, Matt. Matt, forgive me. Thank you.

Matt Poffenroth, MD (00:49:37):
That's fine. Thanks. thanks very much, Yoram and thanks, Este. So my name is Dr. Matt Poffenroth chief physician executive with LifeBridge Health. Internal medicine provider is my background. And I, I don't have a slide presentation for you as Este and Yoram did, and I'm going to keep my remarks relatively short because Leslie Simmons is after me. And she's going to be speaking about kind of the next phases of, of the rollout of the vaccinations to the general public. And I suspect that from looking at the questions that many of you submitted, there's a lot of, a lot of eagerness to know when when the general public will be have access to vaccination. Those are appropriate questions. So I was asked us to make some general comments on you know, so now we've had our, you know, what happens next.

Matt Poffenroth, MD (00:50:31):
First and foremost it doesn't mean you can start running around without a mask on and having parties and all that sort of stuff. So the masks, the hand washing, social distancing that is probably our number one line of defense against any virus. And that's not going to go away anytime soon. So even though you receive the vaccine we don't know for sure, but there's still a possibility that you could that an individual could be a carrier of the virus and could potentially transmit it to another individual. And, and that's why we wear masks, right, is to protect other people, not so much ourselves. So even though we might feel protected because we have we've been immunized we may still be at risk or pose a risk to others. So masks are going to be around for a while.

Matt Poffenroth, MD (00:51:20):
Quite frankly, I'm kind of happy about that because I have to shave less often, which is great. And I haven't had a cold in like a year. I haven't had a sniffle it's, it's phenomenal. So there's, you know, there's a little bit of positive stuff from all this. So side effects, Este commented on this, you know, we have not seen a lot of with our own experience and certainly in the trials have serious side effects. That's definitely a sore arm, I think after you get your second dose, more people have sort of the, the aches and, and you know, fatigue and delays for a day or so after the second dose. But we haven't had a lot of people like calling out sick or anything like that. So the side effects are relatively mild, probably more so than a flu shot, but certainly more mild than getting getting COVID for sure.

Matt Poffenroth, MD (00:52:11):
Duration of immunity. Again, that's an unknown question at this point. The longer we go into this pandemic and, and we get more experience with the vaccinations we'll know more. We certainly know that it's a least good for three or four or five months. There is some science that outside of the trials are just based on the type of immune response that it provokes. That's some scientists that are a lot smarter than me think that the immunity could last for a few years. The unknown of course, or another unknown is what does the virus do? So it is these mutations that we're hearing about now that that seemed to make some strains a little bit more infectious, easier to to catch. They still seem to be susceptible to our vaccines, but, you know, g-d forbid there could be a more major mutation that that happens that makes the vaccines less effective.

Matt Poffenroth, MD (00:53:06):

We just don't know if that's going to happen. So the sooner we can really, you know, get to what's known as herd immunity. That was another question that came out is when do we consider this over? But the sooner we can get to a point where we really quieted down the virus the better, because it gives the virus less opportunity to, to to mutate. That herd immunity, I think you've probably, you know, we, we are pretty used to hearing Dr. Fauci on the news and he talks about, you know, at the point where 70-85% of the population has an immunity to the vaccine or to the virus. We get to this point of what what's called herd immunity, which basically means there's not, you know, people are we're hosts for the virus or the virus needs a person to, to live in, to reproduce them.

Matt Poffenroth, MD (00:53:58):

And so if enough people are immune, the virus can't can't live and it starts to kind of die out. Not a lot of people think it will ever go away. It'll probably always be around to some level, but again, if we get to that 70 to 80% population immunity, then the incidents of COVID will be substantially low to the point where we can start getting back to more normal life. I think the hope is that that could be by the fall. But again, there's, there's unknowns with what, what does the virus do and, and how many people actually get the vaccine. So just a couple of other questions that came in and I'll comment on, and then I'll pass it over to Leslie. There was at least three or four questions I saw about, you know, if I have a food allergy or my child's got a peanut allergy, can I get the vaccine?

Matt Poffenroth, MD (00:54:54):

And the only people where we're recommending that if you do not get vaccinated, is if they've had a true, you know, anaphylactic reaction to a vaccine in the past. You know, anaphylaxis is where your body goes essentially into shock, right? It's not just some swelling of the lips, but it's, you know, your blood pressure drops and your pulse rate goes up and you need to be admitted to the hospital, and it's a near death experience, and it can be an actual fatal experience. So unless you've had an anaphylactic reaction to a to a vaccine in the past, then then it's, that's, as far as we know, it's safe to get the vaccine. And so that's a very rare instance. There's a couple of questions about, you know, I just got my shingles vaccine, can I get the COVID vaccine? And, and the timing with this is, you know, the recommendations are not to have either this vaccine or another vaccine within about two weeks of each other. So so I think that's kind of the key sort of clinical questions I saw, again, a lot of questions about when can I get my vaccine and that's what Leslie Simmons is going to talk about, I believe.

Dan Blum (00:55:59):

And Dr. Poffenroth before we go there, I guess it, they're saying that for people who have sort of personal questions about their individual medical conditions, probably the best thing for them to do is to seek advice from the physician who provides their, their continuity of care, their internist or general practitioner, because that's, who will know them best. And I know you've done a lot to prepare our medical practices, including trying to secure vaccine through those practices for, for the patients who use those practices. So as Leslie talks about our strategy around vaccination, that that certainly bears discussion, I guess I'd also say that unlike you, haven't had a sniffle since March, you know, I'm probably more like many other people on this call where if I cough once, I'm convinced that, you know, I'm I'm the next victim. So it's interesting how we all personalize, you know what, what may or may not be going on. So with that, I'll, I'll move on to Leslie Simmons, who again, has been very hard at work, trying to strategize our vaccination plan for LifeBridge.

Leslie Simmons (00:57:20):

All right. Thank you, Dan. And good evening, everyone. My name is Leslie Simmons. I'm the executive vice president and chief operating officer at LifeBridge. And I have the privilege of leading the COVID response with a bunch of amazing talented individuals to help us weather through. And I think Dan

had some really compelling comments at the beginning of our talk, and that was around the healthcare workers and the great focus and sacrifice they have made. I'm a nurse by background, and I've only had just a, a brief encounter of being in that N-100 mask for 12 hours and understanding what they go through. So I'm just exceedingly proud of, of our whole team. But tonight I really appreciate John Davidov and Marc and Michelle, and the way they envisioned this town hall. And thanks to all of you who have dialed in to participate.

Leslie Simmons (00:58:16):

So when can you get the vaccine? That is absolutely the compelling question. So let me take you back a little bit. When we first started vaccinating people, our directive was simply to vaccinate all your healthcare workers as quickly as you can. Dr. Unguru went through that prioritization for you, and you know what? It was a pretty amazing task. We set up very urgently, three vaccination clinics, one at Sinai, Northwest and Carroll Hospital. Also some clinics at Grace Medical and, you know, we had to ramp up really quickly and get shots in the arm. And we had sort of a captive audience in which to do that. I think one of the biggest challenges, where unlike the flu vaccine, these vaccines aren't mandatory first time around, and instead of one shot, it's two. There's a very particular procedure you have to go through to get the vaccines prepared to administer.

Leslie Simmons (00:59:16):

So we quickly learned that it wasn't as easy as the shot in the arm. It really more the preparation and the approval process and making sure we were following the governor's prioritization plan. We also have to enter all that information into an electronic system that's monitored and tracked to make sure that we're not vaccinating outside of that prioritization. So we started with those vaccinations and did a pretty good job. And then things started to slow down a little bit, and we realized we had some leftover vaccine and we started asking, could we go beyond our healthcare workers and vaccinate some of the public? And so, you know, how they say be careful what you wish for? Well, that definitely happened because the moment, literally the moment we were able to open up a link to share with the public, to begin to sign up, the website started just blowing up with requests, leading us to the point today, we currently have 27,400 people sitting in a queue waiting to be vaccinated.

Leslie Simmons (01:00:33):

So that's an extraordinary number. And that happened in a very brief period of time. So there is definitely an interest I would like to reiterate that we do believe that everyone that wants the vaccine will get one, but this is going to try our patients. You know, we're used to being able to have almost instant gratification. If we see something, we can order it up on Amazon and get it delivered the next day, right? But it isn't that way with the vaccine. We have a huge demand and a very little supply. And so I think Este shared earlier that Maryland has 6 million people. We only get 72,000 vaccines a week and we, the hospitals, never know what our allocation is going to be until the day or two beforehand. So our ethics committee last night, we were looking to approve people for vaccines.

Leslie Simmons (01:01:35):

And we had an exciting task to do because of those 27,400, we had about 975 vaccines we could approve, you know, so that's sorta just spitting in the wind as they say. But you know what? We take that job very seriously. And so we immediately look to the governor's prioritization for how we do that. It is a very small but ethical team that says, okay, we have to start with our 75 year and older and do about 60% there. And then we go onto our 65 to 74 and do 20% there. And then we have to not forget about the teachers and the police officers. And we try to do 20% there. So as we move down on the prioritization, we adjust that percentage of what we can approve, but the most important thing is to get in the queue. So you're in that waiting line.

Leslie Simmons (01:02:35):

And then we can, as we get vaccine in, approve based on the prioritization. Now, some of you might say, you know, how come a 50 year old teacher got it? And my 72 year old mother is still waiting. Well, it literally is, as Dr. Unguru said a bit of a lottery. So it, obviously when we only can do 20% of the group that is 65 to 74 you know, we, might've only had so many of them we could do in that group, but a lot more who requested it, then we had to move on to the teachers and do a little bit of a prioritization of approval of them. So it, you know, I will tell you, it's, we get excited that we get to approve people and make them happy. And then we get sad for those that we just don't have enough vaccine to give yet.

Leslie Simmons (01:03:32):

I will say this week, our number allocated to us was pretty small, but that was largely because the state was bringing pharmacies online. You may have heard Giant, Walmart, some of the other pharmacies, and so a bigger allocation went to them. So you heard Dan speaking earlier, how we've been able to also bring on some of our physician practices. Dr. Poffenroth has been working to have all of our physician practices, primary care, be able to qualify to receive vaccine. Yet, none of them have received vaccine directly. We have been able to send eight practices within LifeBridge some of the vaccine supply from the hospital over to their practices, in a very small amount, to get them started. So now the good news is you have hospitals, you have health departments, you have pharmacies, you have some physician offices, you have some bigger mass vaccination centers that are all gearing up to give vaccines, but we're all fighting for those 72,000 precious vaccines that are being distributed.

Leslie Simmons (01:04:47):

What we really need to have happen is for the state's allocation to be increased. Certainly the state of Maryland has petitioned the federal government to get our statewide allocation increased, but so have every, every other state, right? We're all in the same boat of just needing more vaccine. So last night, something a little unfortunate happened that I thought I'd proactively address cause perhaps some of you were affected by it. Somehow the back end of our scheduling link got out to the public and was copied on social media. And boy, Oh boy. Talk about how good news, bad news travels fast. Around 10:00 PM last night, we noticed an incredible amount of activity on the back end of the process. And that was very alarming for us because typically you have to register, get in the queue, be approved. When you're approved, you get an email that says you are approved and you get a unique vaccination identifier and a link which, you were provided, to then go register for a scheduled appointment. When that happens in proper order, it means that we have not only one, but two vaccines reserved for you. And we're very careful not to go over that allocation because it would be terrible if you come for your appointment and we don't have your vaccine.

Leslie Simmons (01:06:22):

So what we noticed, at 10 o'clock last night is people were seemingly getting access to that very last portion without going through the other initial steps. And so as quickly as possible, around 11 o'clock, we broke the link. Well guess what, in that short period of time, well over 5,000 people figured out how to schedule themselves for an unapproved appointment, meaning there was no vaccine reserved for them. So if you happen to be on the line and you were, unfortunately one of those people, our deepest apologies, it certainly wasn't anything that LifeBridge did or didn't do. It's just one of those things that happened. And we tried to react as quickly as possible. We did communicate to all of those that were affected because very fortunately for us, you had to give your email. And so we were able to communicate with you and teach you the proper way to get in the queue.

Leslie Simmons (01:07:33):

I will tell you, the easiest thing to do is go to the LifeBridge website and you'll see a large red banner across that website. And if you just click on that, it'll take you to the proper link to register and get in the queue. And then as soon as we have vaccine available, we begin approving that. I will tell you that LifeBridge has very big plans to eventually phase out our three, four hospital-based clinics and transition to a central location where we could potentially give up to 2-3000 vaccines a day, assuming we can get that supply from the state. And that will be a very efficient process. So more to follow when, and if we're able to transition to that. But one of the things that's really important to Neil and Dan Blum and myself is really how we can service the, the homeless and the home bound patients that really no one in the state has solved for. Everyone understands that it's an issue, but everybody's concerned about vaccine stability and a process to be able to reach out to that group.

Leslie Simmons (01:08:44):

So Dan and I are working with a team that really will wrap our heads around that and determine how best we can begin to deliver that. And again, we're hopeful that the state will dedicate vaccine specifically for that purpose. So, you know, a lot more to follow. The nurse in me has to remind you, please don't forget wear your masks, social distance, wash your hands. I believe that's one of the biggest reasons we've had such a low flu season because everybody's doing that. I also know that even with the vaccine as you've heard Dr. Poffenroth and Dr. Schabelman report, that's going to be very effective to helping us beat this thing and just remember a tincture of patients. And we're all gone to get that vaccine, but I'm going to tell you it's going to be a long haul, right? One of the things we know is the general public that doesn't fit one of those high risk prioritization categories probably won't have the vaccine available to us until maybe the middle of spring or early summer.

Leslie Simmons (01:09:51):

We probably won't be through a good 75% of our population until the end of the summer. So that's why we all have to work together and be patient, but we're going to get there. So on behalf of LifeBridge and the entire leadership team, thank you so much for working with us. Get registered, get in the queue and hang in there. You know, we, as, like I said, as we get our allocations we will, we are excited to approve and get you scheduled. So unfortunately, like I said, this week, it was just a little small 975 doses, but we're really hopeful next week to have that allocation be even bigger and better. So with that, I know we're running close to time and we want to get to the Q&a. So Dan, back to you,

Dan Blum (01:10:40):

Thank you, Leslie. Just a couple of quick points. One is we are recording this session this evening. The questions that will come to us will be fielded. Thank goodness by, by Beth who will serve as the MC the questions are come to us privately via chat. So if you have a question you can send it in via chat. I do want to reinforce that one of the concepts that Leslie raised in that is this concept of equity. And as we all know, we are rooted in a faith-based mission here, a healthcare mission that is faith-based, and there's nothing that makes me prouder than seeing that. We serve as an Emissary of care for all. And we do know that there are many people in our community who are fragile, who are underserved and it's our goal to care for everybody and try and assure that nobody is left behind.

Dan Blum (01:11:41):

And that is one of the really wonderful tenants about The Associated and the affiliated entities as well. And then finally, one of the things that I want to caution is the concept of flexibility. We know today, for instance, the governor gave something of an impromptu or unanticipated news conference, where there were some announcements. About an hour later, we learned that one of the new variants has made it to the U.S. and while we've been on this call, actually, there's been some breaking news from the federal government about an increase in vaccine production. My point is the information that we

give you this evening is the best that we know as of this moment, and things will continue to change over time. The only predictability is the unpredictability of how this unfolds. So with that Beth, if you could take us through some of the questions and our panel of experts will do their best to provide the answers.

Beth Goldsmith (01:12:46):

Thanks. Thanks so much. I just want to thank everyone who has presented what a wealth of information. And we really do appreciate it. I'm Beth Goldsmith, I'm chair of the board of The Associated, and we couldn't be happier, prouder to be part of this, to partner with LifeBridge and be able to bring this information to the community. Leslie, you covered a lot of the questions to be quite frank people wanting to know when they could expect to hear back. But a big question, and I'm not sure who's going to handle that, that's come in a lot, is about prepping for the vaccine. I know people are telling their friends, Oh, my arm hurts, take an Advil beforehand. Would one of the medical people please like to comment on that? Is there a way to prep? Should we be taking Advil or anything before going for our vaccine?

Esteban Schabelman, MD (01:13:41):

Hi, this is Este Schabelman. So the recommendations right now are, are not to take anything prophylactically. No Tylenol, no Motrin. There are some potential thoughts that, you know, as an anti, as anti-inflammatories could lower the inflammatory response or something you want to happen. That being said, the recommendations are, if you do need to take it once you've gotten the vaccine Tylenol would be our choice, followed by Motrin.

Yoram Unguru, MD (01:14:13):

Drink your mother's matzo ball soup beforehand, that'll help everybody.

Beth Goldsmith (01:14:21):

Okay. Another question. I'm not sure how he answered this one. Why aren't people with underlying conditions in a higher category, for instance, a 60 year old with asthma or cancer?

Matt Poffenroth, MD (01:14:36):

Yeah, so it's not. So I'll take that. So folks in that are under 65 with underlying medical conditions are categorized in 1C I believe so they're categorized higher than those under 65 without underlying health conditions. The fact that a healthy 80 year old is prioritized over a seemingly unhealthy 60 year old is because in general the elderly population has a higher risk for mortality from COVID even more so than the younger ones with other diseases. I can tell you that the state is, and the governor actually directed the secretary of health to convene a group of physicians to put together a list of conditions that would further prioritize folks with specific underlying conditions. So if they're immunocompromised, if they're receiving treatment for cancer, if they were on dialysis, because there's certain conditions that, that we think put people at an extremely high risk, and because we still have limited quantities of vaccine, and we may, for several weeks, we want to get the most vulnerable folks vaccinated as quickly as possible. So that, that may be coming.

Beth Goldsmith (01:15:56):

Thank you. Here's another question. Can you sign up and get in more than one queue from various hospitals and other areas, Leslie, I guess this is for you.

Leslie Simmons (01:16:08):

Yes. actually you can, you know, I will tell you it's a little, it's a little chaotic because it's hard for you to sign up on multiple lists. And then obviously if you get on one, it's important that you try to notify the other ones. That's what I would ask. I do think it's wise though, to sign up on multiple lists, to see who can come through for you first. Cause we all get different allocations. My only ask is to please, if you sign up on multiple lists and one comes through for you to try to cancel yourselves on others, that'd be very helpful.

Dan Blum (01:16:42):

And to be clear why that's so important. If we make the commitment to somebody that we're going to deliver the vaccine, we, we really treat that as a sacred commitment. We reserve the dose and then that makes that dose unavailable for somebody else who has the desire and the need. And then if we don't use the medication after we've brought it to temperature we run the risk of actually having to dispose of that vaccine. So you know, that's that, that reality is very, very concerning to us. So please, for whomever, you know, you, you, with whomever, you make an appointment. If you're not going to keep the appointment, let them know far in advance so that the vaccine does not get wasted and people don't go without.

Beth Goldsmith (01:17:39):

And to that, to do that topic, Dan a lot of people have said, they've heard that at the end of the day, sometimes there are unused doses. Perhaps people didn't show up or perhaps there are actually more doses than you knew. Is there some sort of a wait list where somebody can zip on over to get it?

Leslie Simmons (01:17:58):

So I would say right now there is an internal waitlist because as you can imagine, as Dan alluded to, you have to grab somebody pretty quickly. So generally speaking that waitlist is absorbed by people working in the facility. However, if we exhaust that as we are doing, you know, as we go down the road, we'll make those lists more publicly available because LifeBridge has a strong desire never to see a single dose wasted, not a single dose. So we have developed that framework. We're testing it internally and if we can extend that to the public, we absolutely will do that.

Beth Goldsmith (01:18:40):

That's great to hear, let me ask another question. What about our seniors who may not be tech savvy? What can we do to help them to get registered?

Leslie Simmons (01:18:50):

So one of the biggest things I would advise is to partner up with your seniors. You know, if you know of a senior that you're concerned about being able to help them navigate the link is really essential. You know, we are trying as we can to reach out and offer that support, but sometimes a family member or a friend is the best person to be able to work with that senior, particularly if they're signed up on multiple lists, I will say that we are hearing that the LifeBridge link is pretty user-friendly compared to some others. So that's a, that's a good thing, but I would really say it's almost like adopt-a-senior, you know, if you know that and you can reach out and do that that would be very, very helpful.

Beth Goldsmith (01:19:40):

Thanks. And I want to even take that one step further. For those of us watching who can be helpful seniors need rides as well to get to their appointments. So it's another way we in the community can

be helpful to them. Do you distinguish between city and County residents as to where they are able to get the shot?

Leslie Simmons (01:20:04):

You know what we really don't, it's one, it's it doesn't matter to us where you live. I would suggest though Sinai is our busiest clinic. And so I would encourage you that if you're willing to drive to Carroll or Northwest, if that's not too far of a hike, those appointments are more readily available. And you could be probably quicker to schedule. Sinai is very, very busy, very busy.

Dan Blum (01:20:33):

And this is one of the advantages of having a dynamic health system like this, where, you know, we have a bunch of different methodologies including some mobile services that we're trying to stand up for congregate housing and other frail populations. So part of the benefit of being in this large health system is having resources and alternative approaches.

Beth Goldsmith (01:21:02):

I know we hear about this every day. If we're watching about vaccines on television, but would someone please also address what is the recommended? I know the recommended timeframe, I guess people want to know what's the longest timeframe between doses,

Esteban Schabelman, MD (01:21:19):

Right? So the recommended timeframe is 28 days between doses with the Moderna vaccine, and 21 for the Pfizer vaccine. There's a three-day window on each side of that, that was studied. Anything outside of that is it has not been studied or verified. So my personal preference would be that everyone get vaccinated within that three day window on each side of the 21, 28 days. That being said the federal government put out a document recently that says that in extreme circumstances it could be delayed longer than that and likely to be effective, but we don't know exactly how effective it will be.

Leslie Simmons (01:22:06):

And Beth, if I could just comment on one other thing, I think Dan is trying to address it for me as well. When you make your appointment, remember how I was saying Caroll and Northwest perhaps might have more available ability than Sinai. You get to pick which hospital you would like to receive your vaccine in. So that's purely up to you. You don't have to pick at each one, just pick the one you want and pick your appointment once you've gone through that approval process.

Beth Goldsmith (01:22:41):

Great. Great. I, I think I have another question coming in right now, so I'm going to wait one more sec. I can ask, I know a number of people did write in about allergies and is there a special way perhaps that happens during your intake information for somebody to know advance and, and be prepared and, and know that the people who are about to get the vaccine are prepared, if you have a nut allergy or, you know, allergies that may not be specific to the vaccine itself, is there a way to acknowledge that in advance?

Matt Poffenroth, MD (01:23:24):

We, so when we register, yeah, we, that part of the form does ask what allergies and the way we're administering it now is is individuals are, are it's recommended that you wait for 15 minutes or up to

30 minutes, we have space to do that. Some people choose to, others don't, but certainly if you have a history of allergies or you're anxious or whatnot, then by all means please wait there. You know, the hope is my hope is, is that as, as this rolls out from the hospitals and more into the community, whether it's primary care clinics or urgent cares or, or whatnot, that again, they're, they're going to be very adaptive monitoring patients after receiving the vaccines. So, but again, back to Dan's point earlier, if you have, you know, if you've had any specific kind of bad allergic reactions in the, in the past I would just, you know, just speak with your primary care physician before getting the vaccine and for any additional advice that you may want.

Beth Goldsmith (01:24:28):

I know a lot of people are wondering once they've gone through the correct process, Leslie, what a nightmare that must have been. But once you have gone through the correct process, how long once you filled out that form, is there a guesstimate on how long I wait until I expect to hear back from you?

Leslie Simmons (01:24:47):

I am so sorry to say, I can't give you an exact time because it depends on the allocation. As you can imagine, there's 27,400 people. Now I will say there's all ages in there. So people are just getting in the queue, understanding that if they're way down on the priority list, they're not going to be approved anytime soon. But if we get a big allocation, it's conceivable that you may only be on the list for a week, right? It's as we, especially, if you're one of those high priority groups, if we get small allocations, it could be much longer. So that's why it's so hard to exactly pinpoint a time. But certainly the wait for the high priority groups is much less than people that are much lower on the priority list.

Beth Goldsmith (01:25:39):

A general question about other vaccines, Johnson and Johnson, other companies talking about vaccines. Would anyone like to comment on what, know what we think about the rollout and, and their efficacy?

Esteban Schabelman, MD (01:26:09):

So I think what we're limited in right now is there are other vaccines coming in the pipeline, Johnson, Johnson being one of them. But those trials are a little bit further behind clearly Moderna, Pfizer and AstraZeneca. And so we don't have a good sense of how effective they are. We do know that the sort of review process for these vaccines is working well. For example, recently Merc abandoned its vaccination program because it just wasn't found to be as effective as what was on the market. So you know, our hope is that the vaccines that are currently still in development are equally as effective as the ones that are currently out. And I will take note to say that 95% effectiveness for a vaccine is incredible. It's much, much higher, almost double the effectiveness of the flu vaccine.

Yoram Unguru, MD (01:26:57):

Beth, if I may just dovetail, Este said something that really deserves to be driven home, it's so important that we not only have vaccines, but we have safe and effective vaccines. And so a negative result is still important. It's not what we want that shows that the process works, that shows that at the same time that we're benefiting our patients, we're also protecting them from harm. And so this speaks to whatever each one of us has been saying about, as hard as it is to be patient, we have to continue to do this because we will get there. But it's critical that we allow the process to march forward in the manner that is built.

New Speaker (01:27:42):

[Cross Talk]

Dan Blum (01:27:43):

I would also underscore when prognosticating, the other manufacturers we're not qualified to give any stock-taking advice here.

Beth Goldsmith (01:27:54):

So that really leads to another question. And I think Este did a wonderful job of talking about both Moderna and Pfizer earlier in this program, but people are wondering, do I want one over the other? How will I know which one I'm going I'm signing up for? And should I be concerned about that?

Esteban Schabelman, MD (01:28:12):

So currently if you sign up that so currently, you know, the limiting factor is the negative 70 degree freezer for the Pfizer vaccine. And so right now that's being dispensed at Sinai. Whereas the Moderna vaccine is at Northwest and Carroll. That being said, there isn't there, it does not appear to be any distinguishing factor between them. I would take them all the same. The only difference would be the Moderna vaccine is 28 days between the doses and the Pfizer vaccine is 21, but otherwise they appear to be equally as effective.

Beth Goldsmith (01:28:48):

Thanks. Okay. I think this is going to be the last question we actually have time for tonight, but I do want to remind everybody before I give that question that this is not end obviously of the discussion. We will be continuing to push out information. You can visit associated.org or LifeBridgehealth.org for more information. And the question really was people from various professions, teachers, community non-profit workers, and many other professions are really feeling that they just don't know when and how they will be privileged to get a vaccine. So there is one benefit to being older. I've already had one of my shots. So the information does seem to be slow coming out. I think you've all explained why that is what would be a final recommendation for those who are anxious to get a notice.

Leslie Simmons (01:29:50):

I would say, get yourself on a lot of lists and watch the maryland.gov site as well, because that also has that governor's prioritization and that's what LifeBridge is very carefully following. So as that prioritization changes, LifeBridge will react accordingly along with our vaccine supply. So multiple list and stay on that maryland.gov website and know that LifeBridge will follow suit as vaccine becomes available.

Beth Goldsmith (01:30:27):

Thank you, Leslie. Thank you all so much. I'm going to turn it back to Dan to close it up again on behalf of The Associated thank you all for joining us and please tell your friends that this will be available if they weren't able to view it live tonight. It will be available for viewing later on. Dan, back to you.

Dan Blum (01:30:46):

Thank you, Beth. You did a great job that was not easy to feel those questions. You know, I want to thank everybody for joining in tonight. I think knowledge is power. The sense of community is palpable. The benefit of staying engaged, I think is very, very important. I'm not thinking that this is the last time that we do this. I think, you know, there's a great opportunity to come back and share once again over the coming months. With 400,000 Americans dead, as a result of COVID-19 over

400,000 and many, many, many millions sickened, an economy that's ravaged, relationships that are fractured. The, the impact of this illness is, is frankly unbelievable and we're not done yet. It is incredibly important. And as Dr. Poffenroth added even after you've been vaccinated to practice social distancing use a mask appropriately, wash your hands and certainly get vaccinated and others to do to do so, as soon as you can.

Dan Blum (01:32:03):

With all of that said, I look for signs of optimism. I can tell you that over the last week, the COVID surge that we have been experiencing now for you know, well over a month seems to be declining. Some of the leading indicators that we look at, like the positivity rate in the community, it appears to be going down and that's a leading indicator. So we remain very hopeful. We're hopeful that more vaccine will be on its way. And I can tell you that we are laser focused and dedicated on getting whatever vaccine comes to us into the arms of the public. And I'm hopeful that around the second half of this year things will start to look a lot better. I want to say thank you again for joining us. Thanks. Thanks to The Associated for hosting this, putting this together with us and thank you to tonight's expert panel. These are people who work literally seven days a week, starting at daybreak and ending well after dark each and every day. So thank you for taking your time this evening to meet the community on its terms. Thank you all, stay, stay safe.