VCHIP / CHAMP / VDH COVID-19 UPDATES

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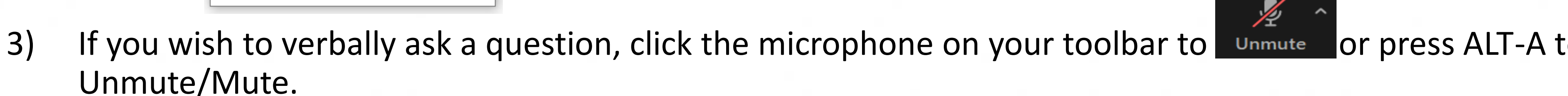
February 2, 2022

Technology Notes – *"Welcome to Zoom!"*

1) **All participants will be muted upon joining the call.**

2) **Presenters**: Please avoid the use of speakerphone and make sure your computer speaker is muted if you dialed in via phone.

3) To ask or respond to a question using the ***Chat*** box, click Chat on your toolbar, type your question and press the *Enter* key on your keyboard to send.



3) If you wish to verbally ask a question, click the microphone on your toolbar to Unmute or press ALT-A to Unmute/Mute.
4) If you have technology questions, please directly message **Allison Koneczny**, **Angela Zinno** or **Ginny Cincotta**.
5) Calls are RECORDED and posted on VCHIP web site for asynchronous review.

Overview

https://www.astate.edu/news/black-history-month-observance-2022-highlights-we-strive-we-thrive-theme

2/2/22!

- Celebrating ***Black History Month***
  - Theme: Black Health and Wellness https://www.npr.org/2022/02/01/1075623826/why-is-february-black-history-month
- ***Happy Lunar New Year!*** The Year of the Tiger
- ***Groundhog Day***: Phil saw his shadow – 6 more weeks of winter!
- Reminder – weekly event schedule:
  - **February VCHIP-VDH call calendar** (see slide 5)**;** Gov. Media Briefings generally ***Tuesdays only***; VMS calls with Dr. Levine 1st & 3rd Thursdays
- Practice Issues: ***Updated IZ Info & "Return to Play" Guidance***
- Q & A/Discussion

[Please note: the COVID-19 situation continues to evolve – so the information we're providing today may change]

Black History Month Education Resources (Families/Teachers)

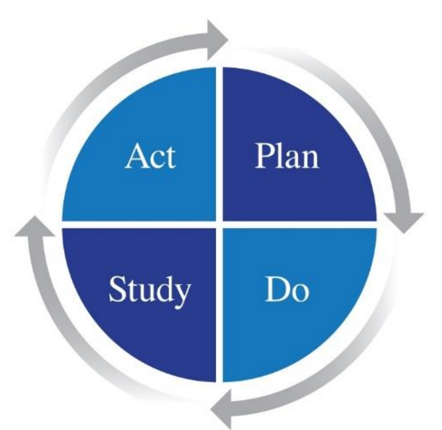
- *Thank you, Melissa Kaufold!* https://www.vermontpbs.org/kids-education/?ct=t(BLACK-HISTORY-MONTH-PROGRAMMING-20220201)
- VPR & Vermont PBS: films, activities & lessons to deepen children's understanding of Black history. Free to families and teachers; support at-home or classroom learning for children of all ages.
- Young children: includes the "I have a dream" vision board activity from PBS Parents and PBS Learning Media.
- Middle school: VPR's *Timeline* podcast (Great Migration to Chicago/Harlem). 2/17 VT PBS to broadcast *Legacy of Love* (MLK & Coretta Scott's formative years in 1950's Boston).
- HS students/adults: 2/8 VT PBS to broadcast *Marian Anderson: The Whole World in Her Hands*. 2/10 Made Here will air *The Price of Safety*, which explores conversations of over-policing & racial bias in Vergennes, VT. 2/15 *The American Diplomat*: how three Black diplomats broke racial barriers at the U.S. State Dept. during the Cold War.

VCHIP-VDH COVID-19 calls – *2022!*

February calls – currently all *Wednesdays*:

- **2/2, 2/9, 2/16, 2/23/22**
- We recognize that February school vacation weeks may affect your ability to participate!
- **Continuing via Zoom!**
- Schedule **subject to change** at any time if circumstances warrant!
- *Please continue to send your feedback re: schedule/topics to* vchip.champ@med.uvm.edu
- VMS calls w/VDH Comm. Levine now 1st/3rd Thursdays

And now for something completely different…



In the spirit of continuous quality improvement, we are continuing our ***NEW CALL FORMAT*** – our own PDSA cycle

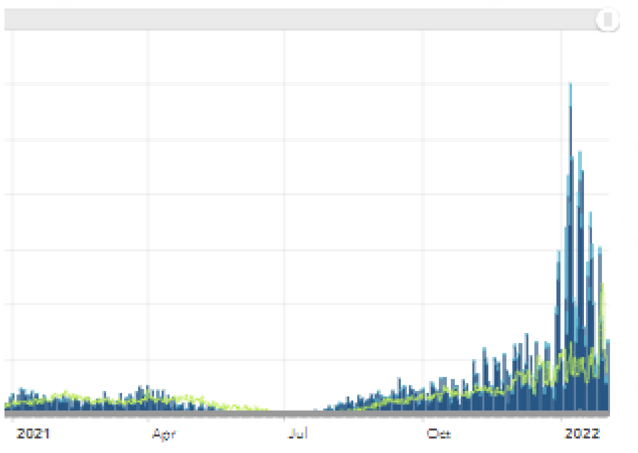
- Responding to your comments and feedback – thank you!
  - Desire to be able to focus on content but not miss Q & A from chat; avoid duplication of responses that may be included in presentation
- Content presentation for ~20-25 minutes
- Chat will be monitored, BUT – both verbal and written feedback will occur ***AFTER*** the presentation
- REMINDER: Chat Q & A is (re)organized, streamlined and made available following the call each day.

VMS *COVID Convos* with Health Commissioner Levine

- ***New Schedule for 2022***
- **Calls with VDH Commissioner Levine now 1st and 3rd Thursdays**
- **Next VMS COVID Convo with VDH Commissioner Levine is 2/3/21**
- Summary: VMS calls are held the first and third Thursdays of the month from **12:30 to 1:00 p.m.**
  - Join Zoom Meeting: https://us02web.zoom.us/j/86726253105?pwd=VkVuNTJ1ZFQ2R3diSVdqdlJ2ZG4yQT09
  - **Meeting ID**: 867 2625 3105 **Password**: 540684 **Dial In**: 1-646-876-9923

Situation update

New Cases
677
105,569 Total
Currently Hospitalized
88
Hospitalized in ICU
23
Percent Positive 7-day Avg.
9.2%
New Tests
12,362
3,230,817 Total
Deaths
545
0.5% of Cases
Last Updated: 2/2/2022, 11:22:45 AM



The Case Dashboard is updated every day, typically by 1:00 p.m.

Case information reflects counts as of the end of the previous weekday. All data are compiled by the Health Department and are preliminary and subject to change.

https://www.healthvermont.gov/covid-19/current-activity/vermont-dashboard

- One year ago: 12,329 **VT** total cases; 129 new/52 hosp.
- U.S. **75.2 million+** cases; **889,522 deaths**
  - https://www.nytimes.com/interactive/2021/us/covid-cases.html (updated 2/2/22)
  - Past week: av. 424,077 cases/day (14d. change **-44%)**
  - **5.68 million+ deaths worldwide; 381.6 million+ cases** (+38% & +7% 14-day change respectively)
- VDH **Data Summary** now q.o.week. **1/21/22: NO Weekly Spotlight topic**
  - **Table of Contents:** Overview of COVID-19 in Vermont; Clinical Course; Vaccine Breakthrough.
  - **Vaccine breakthrough cases = 29,993** since Jan. 2021 (~6.3% of fully vaccinated). Find previous summaries at: https://www.healthvermont.gov/covid-19/current-activity/weekly-data-summary2

Situation update

Cases by Age Group if Known *

Age group	Cases
0-9	12,550
10-19	16,640
20-29	19,609
30-39	16,123
40-49	12,948
50-59	12,388
60-69	8,707
70-79	4,129
80+	2,471

Cases by Sex *

Cases by Ethnicity if Known *

Cases by Race if Known *

Case Demographics

https://www.healthvermont.gov/covid-19/current-activity/vermont-dashboard

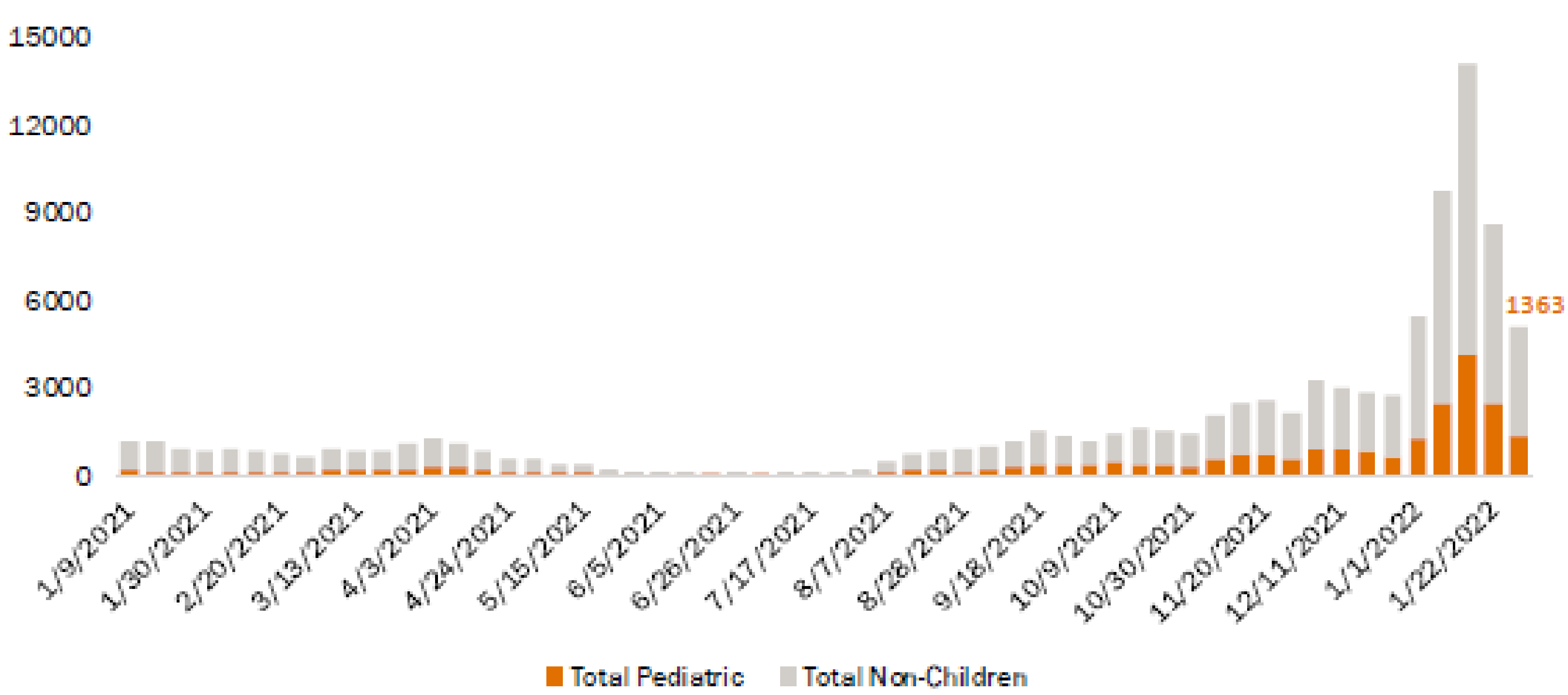
February 2, 2022

VCHIP Vermont Child Health Improvement Program University of Vermont Larner College of Medicine

COVID-19 Pediatric Cases

Jan 31, 2022

This brief reflects data as of January 29, 2022 (the last complete MMWR week). All rates are calculated per 10,000 people. Data is preliminary and subject to change.



COVID-19 Pediatric Cases

Rates by Week by Age Category

400
350
300
250
200
150
100
50
0

1/9/2021, 2/9/2021, 3/9/2021, 4/9/2021, 5/9/2021, 6/9/2021, 7/9/2021, 8/9/2021, 9/9/2021, 10/9/2021, 11/9/2021, 12/9/2021, 1/9/2022

119.4
117.3
99.4

Ages 0-5 | Ages 6-11 | Ages 12-18

All rates are calculated per 10,000 people. Data is preliminary and subject to change.

Vermont Educational COVID-19 Data

- ***NOTE***: VT AOE has ***ceased*** data collection for "COVID-19 Cases in VT K-12 Learning Communities While Infectious"
  - Find previous files at: https://www.healthvermont.gov/sites/default/files/documents/pdf/COVID19-Transmission-Schools.pdf
- VT College & University dashboards:
  - **UVM update** (week of 1/24/-1/30/22): 71 pos. tests off campus; 82 on campus; 1 faculty; 13 staff.
  - **Bennington College** (as of 1/31/22): 2 total active/0 new active cases.
  - **Middlebury College** (as of 1/31/22): 15 new cases; 15 total active (11 students/4 employees)

Fig 6. United States: Number of Child COVID-19 Cases Added in Past Week*

4.23.20 to 1.27.22

Number of child cases added

1,200,000
1,150,000
1,100,000
1,050,000
1,000,000
950,000
900,000
850,000
800,000
750,000
700,000
650,000
600,000
550,000
500,000
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0

6,651
50,695
211,466
88,497
8,447
251,781
100,630
131,828
164,289
198,551
325,340
580,247
981,488
1,150,543
808,013

Week ending in

* Note: 5 states changed their definition of child cases: AL as of 8/13/20, HI as of 8/27/20, RI as of 9/10/20, MO as of 10/1/20, WV as of 8/12/21
On 1/14/22, TX released new data that is NOT included in cumulative case counts or figures but located here and in Appendix 3B of this report (774,083 cumulative child cases as of 1/20/22);
TX previously reported age for only a small proportion of total cases each week (eg, 2-20%); these cumulative cases through 8/26/21 are included (7,754)
As of 6/30/21, NE COVID-19 dashboard is no longer available; NE cumulative cases through 6/24/21
Due to available data and changes made to dashboard, AL cumulative cases through 7/29/21
Due to available data and calculations required to obtain MA child cases, weekly estimates fluctuate (eg, on 1/27/22 there were 2,718 fewer cumulative child cases)
On 1/27/22, due to available data, DC cumulative child cases and HI cumulative child cases and total cases through 1/13/22
On 1/27/22, due to available data, VA cumulative child cases and GU cumulative child and total cases through 1/20/22
See detail in Appendix: Data from 49 states, NYC, DC, PR and GU
All data reported by state/local health departments are preliminary and subject to change; Analysis by American Academy of Pediatrics and Children's Hospital Association

https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/

Fig 7. United States: Child COVID-19 Cases Added in Past Week, by Region*

Midwest | Northeast | South | West

4.23.20 to 1.27.22

Cases added in past week

Week ending in

Note: Regions are the US Census Regions
5 states changed their definition of child cases: AL as of 8/13/20, HI as of 8/27/20, RI as of 9/10/20, MO as of 10/1/20, WV as of 8/12/21
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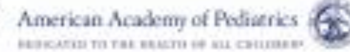

Fig 8. United States: Number of COVID-19 Cases Added in Past Week for Children and Adults*

Adult cases
Child cases

22.8%
child cases

4.23.20 to 1.27.22

4,000,000
2,000,000
0

Number of cases added

2.6%
child cases

Week ending in

* Note: 5 states changed their definition of child cases: AL as of 8/13/20, HI as of 8/27/20, RI as of 9/10/20, MO as of 10/1/20, WV as of 8/12/21;
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https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/

VDH COVID-19 Vaccine Registration & Sites

GETTING THE COVID-19 VACCINE

Find out about vaccines for children ages 5 to 11

GET THE MOST PROTECTION WITH A BOOSTER SHOT!

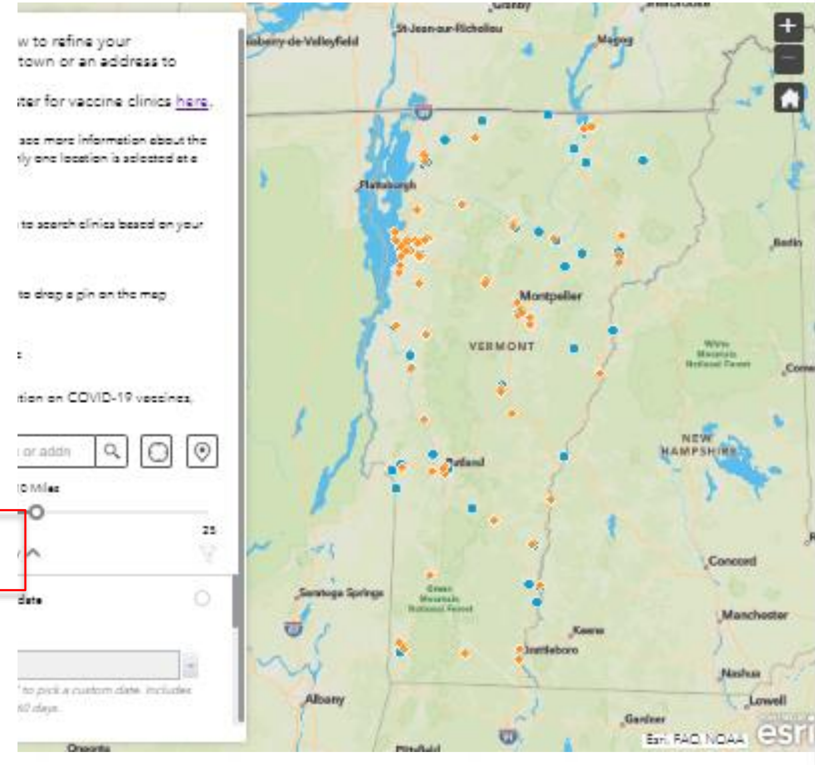
You should get a booster if you are 12 or older and you received:

- your Johnson & Johnson vaccine **at least two months ago** or
- your second dose of Pfizer or Moderna vaccine **at least five months ago**

If you are age 18 or older, your booster can be the vaccine type of your choice: Pfizer, Moderna or Johnson & Johnson, no matter which vaccine you got originally. For youth 12 - 17 the booster must be Pfizer.

See Frequently Asked Questions about boosters

WHERE TO GET YOUR BOOSTER SHOT, FIRST OR SECOND DOSE



https://www.healthvermont.gov/covid-19/vaccine/getting-covid-19-vaccine

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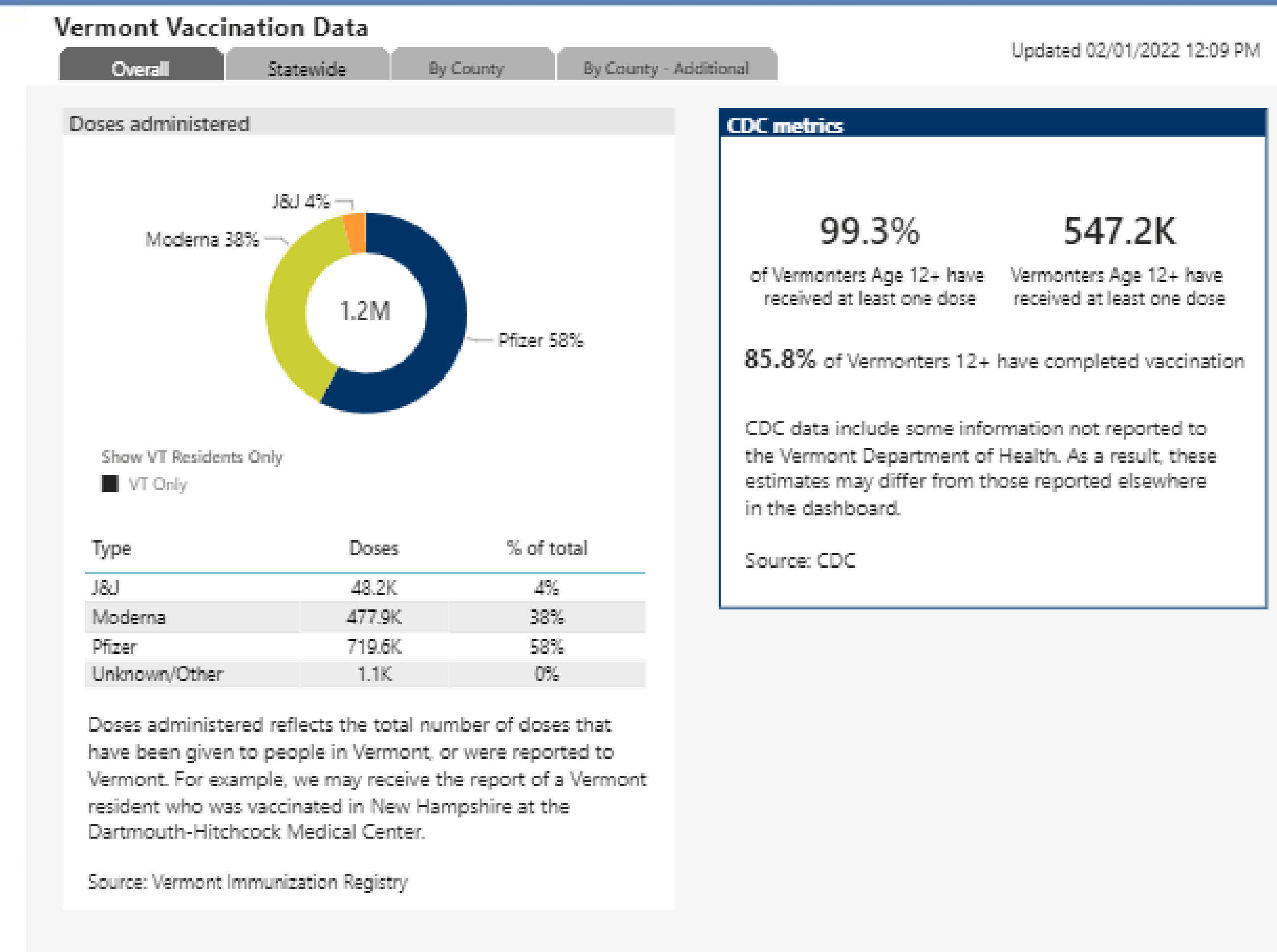
VDH COVID-19 Vaccine Dashboard (“Overall” view: 2/1/22)

- Daily updates Tuesday thru Sat.
- Data = counts reported by end previous day; subject to change.
- [https://www.healthvermont.gov/covid-19/ vaccine/ covid-19-vaccine-dashboard](https://www.healthvermont.gov/covid-19/vaccine/covid-19-vaccine-dashboard)
- ***Notes:* Vermont Forward percentages** use data from CDC, which includes some data not reported to VDH; these estimates may differ from those reported elsewhere in the dashboard.



VDH COVID-19 Vaccine Dashboard ("Statewide" view)

- Daily updates Tuesday thru Saturday
- Data = counts reported by end prev. day; subject to change.
- [https://www.healthvermont.gov/ covid-19/ vaccine/ covid-19-vaccine-dashboard](https://www.healthvermont.gov/covid-19/vaccine/covid-19-vaccine-dashboard)
- By Age – Statewide (≥ 1 dose):
  - 5-11 = 59% (58% on 1/24/22)
  - 12-17 = 76% (76% on 1/24/22)
  - 18-29 = 69% (69% on 1/24/22)
  - **VT Age 5+ = 87%** (86% on 1/24/22)

Vermont Vaccination Data

Overall | Statewide | By County | By County - Additional

Updated 02/01/2022 12:09 PM

People vaccinated

At least one dose | Completed | Additional dose

514.7K
At least one dose

87%
% of Vermonters age 5+ who have received at least one vaccine

J&J 8%
Moderna 36%
Pfizer 56%

Show VT Residents Only
VT Only

Percent of the statewide population **age 5+ of each subgroup that has received at least one dose of vaccine**

Age	%
5 - 11	59%
12 - 17	76%
18 - 29	69%
30 - 39	92%
40 - 49	89%
50 - 59	88%
60 - 64	95%
65 - 69	100%
70 - 74	100%
75+	100%

Race	%
Asian	79%
Black or African American	83%
Native American, Indigenous, or First Nation	28%
Pacific Islander	27%
Two or more races	83%
White	85%

Ethnicity	%
Hispanic	100%
Not Hispanic	83%

Sex	%
Female	88%
Male	84%

Race*	5-11	12-30	31-64	65+	Age 5+
BIPOC	58%	79%	97%	100%	86%
Non-Hispanic White	56%	67%	86%	100%	83%

Source: Vermont Immunization Registry, VDH Population Estimates (2019)

Data notes

Statewide numbers and percentages are capped at 100%. To protect the identity of individuals, data is suppressed when there are fewer than six people vaccinated in a subgroup.

Race information is not reported for 3% of people vaccinated.

Race/ethnicity information is not reported for 4% of people vaccinated.

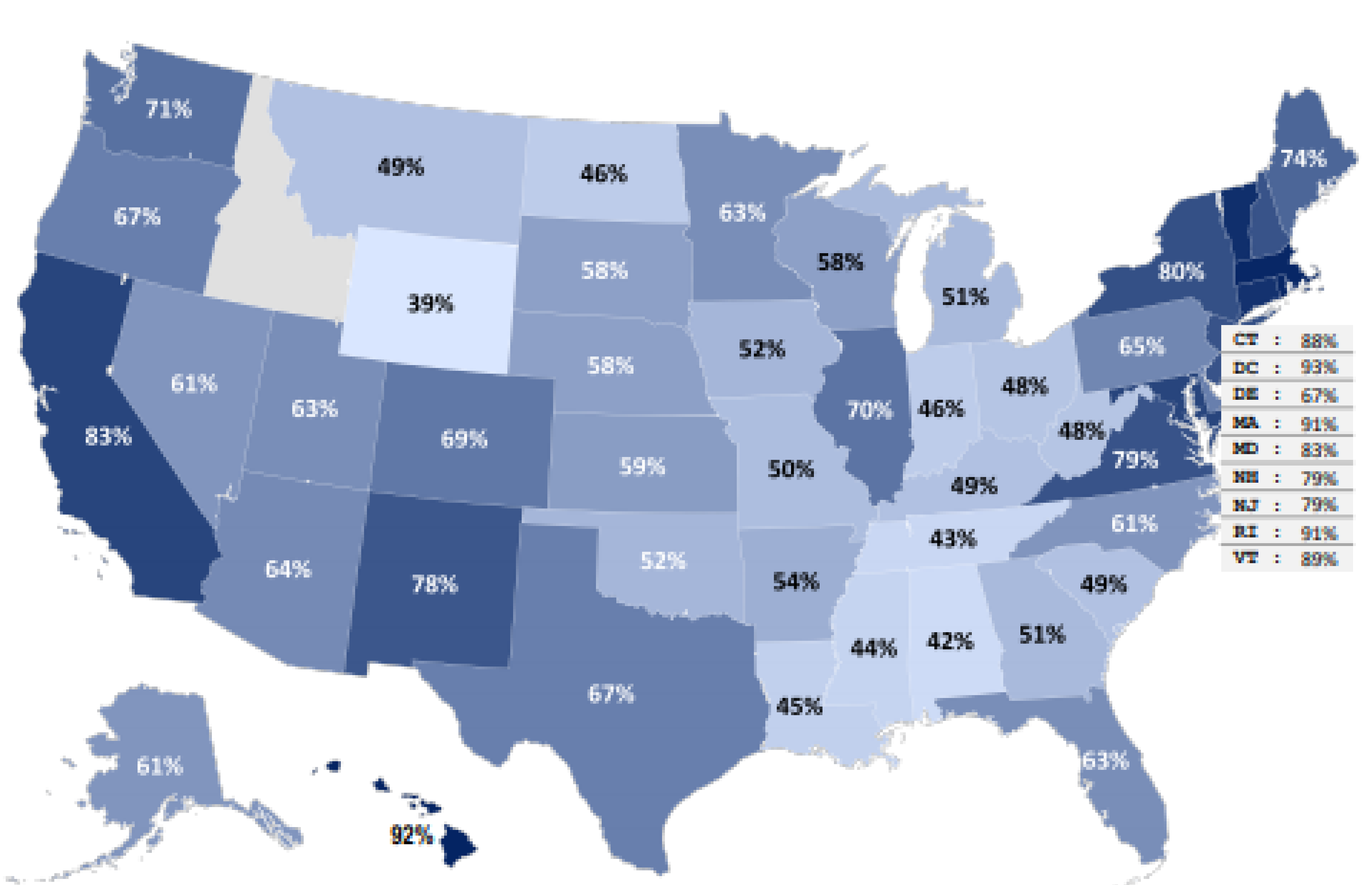
Ethnicity information is not reported for 4% of people vaccinated.

BIPOC refers to Black, Indigenous, and people of color.

Sex information is not reported for 555 people vaccinated. The categorization of **male/female** for some people is based on sex assignment at birth, while for others, it is based on gender. This is due to the varying sources and ways the information is reported.
Sex not reported may mean the provider did not collect that information, the patient did not provide it, or the provider or the patient selected a category other than male or female.

Data on this page is sourced from the Vermont Immunization Registry and therefore may differ from data reported

Proportion of Eligible US Children Ages 12-17 Who Received the Initial Dose of the COVID-19 Vaccine, by State of Residence



Source: AAP analysis of data series titled "COVID -19 Vaccinations in the United States, Jurisdiction". CDC COVID -19 Data Tracker (URL: https://data.cdc.gov/Vaccinations/COVID-19-Vaccinations-in-the-United-States-Jurisdi/unsk-b7fc). Idaho information not available. Check state's web sites for additional or more recent information

Proportion of Eligible US Children Ages 5-11 Who Received the Initial Dose of the COVID-19 Vaccine, by State of Residence

Received Initial Dose 13% – 62%

as of 1.26.2022

35%
35%
23%
21%
39%
45%
26%
15%
30%
26%
38%
37%
20%
30%
37%
27%
25%
32%
39%
20%
23%
17%
41%
27%
22%
20%
27%
37%
17%
16%
27%
20%
18%
13%
13%
18%
26%
13%
21%
27%
41%

CT	:	44%
DC	:	43%
DE	:	29%
MA	:	54%
MD	:	42%
NH	:	38%
NJ	:	37%
RI	:	52%
VT	:	62%

Source: AAP analysis of data series titled "COVID -19 Vaccinations in the United States, Jurisdiction". CDC COVID -19 Data Tracker (URL: https://data.cdc.gov/Vaccinations/COVID-19-Vaccinations-in-the-United-States-Jurisdi/unsk-b7fc). Idaho information not available. Check state's web sites for additional or more recent information

From the CDC Vaccine Tracker

Total Doses Administered Reported to the CDC by State/Territory and for Select Federal Entities per 100,000 of the Total Population

No Data | 0 | 1 - 170,000 | 170,001 - 180,000 | 180,001 - 190,000 | 190,001 - 200,000 | 200,001 +

NOTE: ***new*** color key for doses/100K population

Daily Change in Number of COVID-19 Vaccinations in the United States Reported to CDC

7-Day moving average

Doses: 5M, 4M, 3M, 2M, 1M, 0

Dec 14, '20 | Feb 21, '21 | May 1, '21 | Jul 9, '21 | Sep 16, '21 | Nov 24, '21 | Jan 27, '22

Date of CDC Report

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

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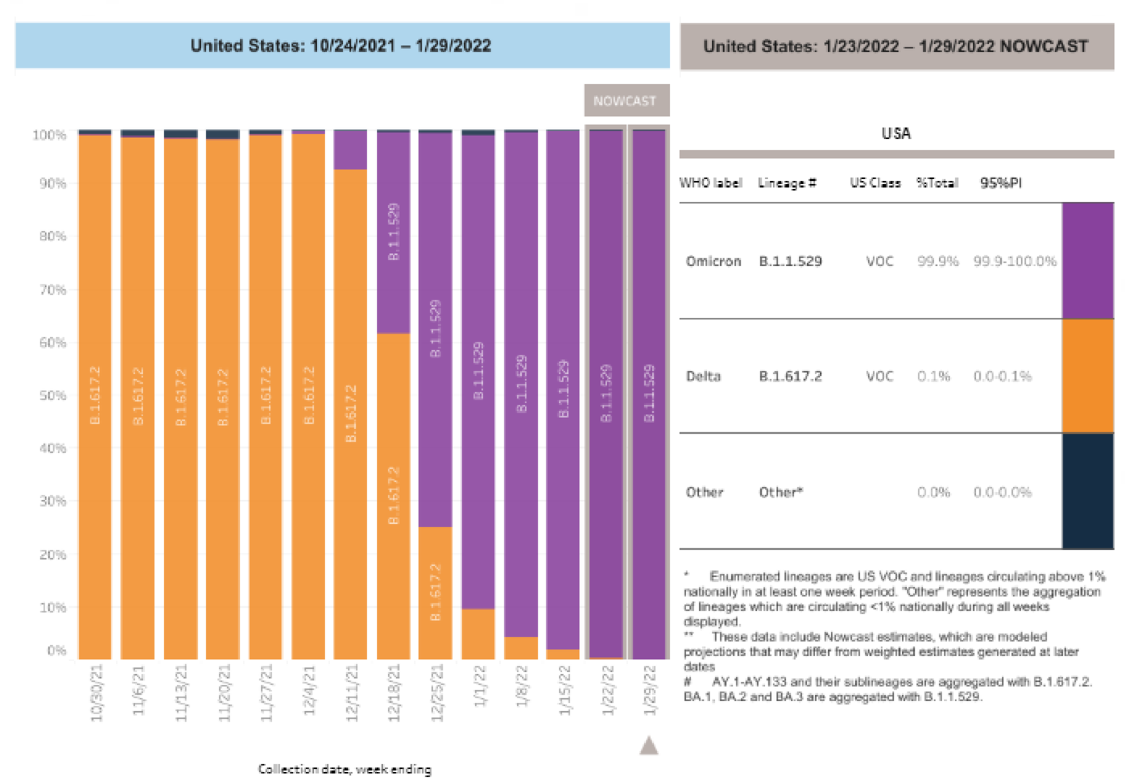
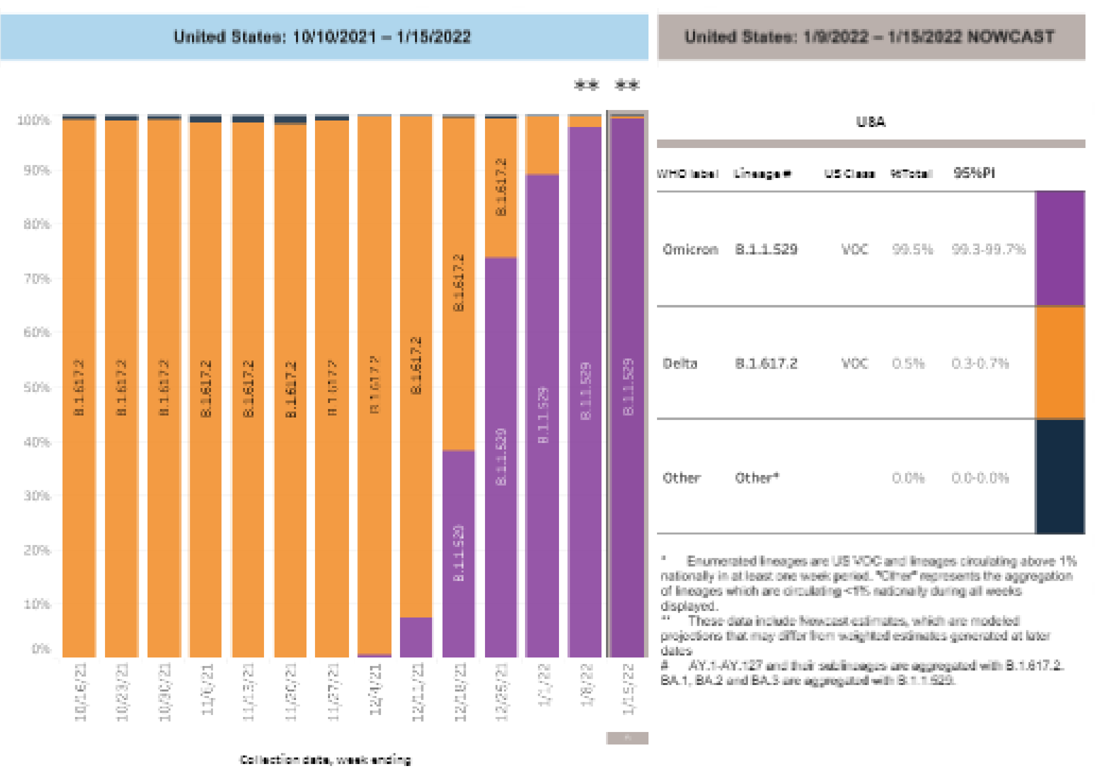
https://covid.cdc.gov/covid-data-tracker/#vaccinations

February 2, 2022

21

From the CDC: SARS-CoV-2 Variants in the U.S.



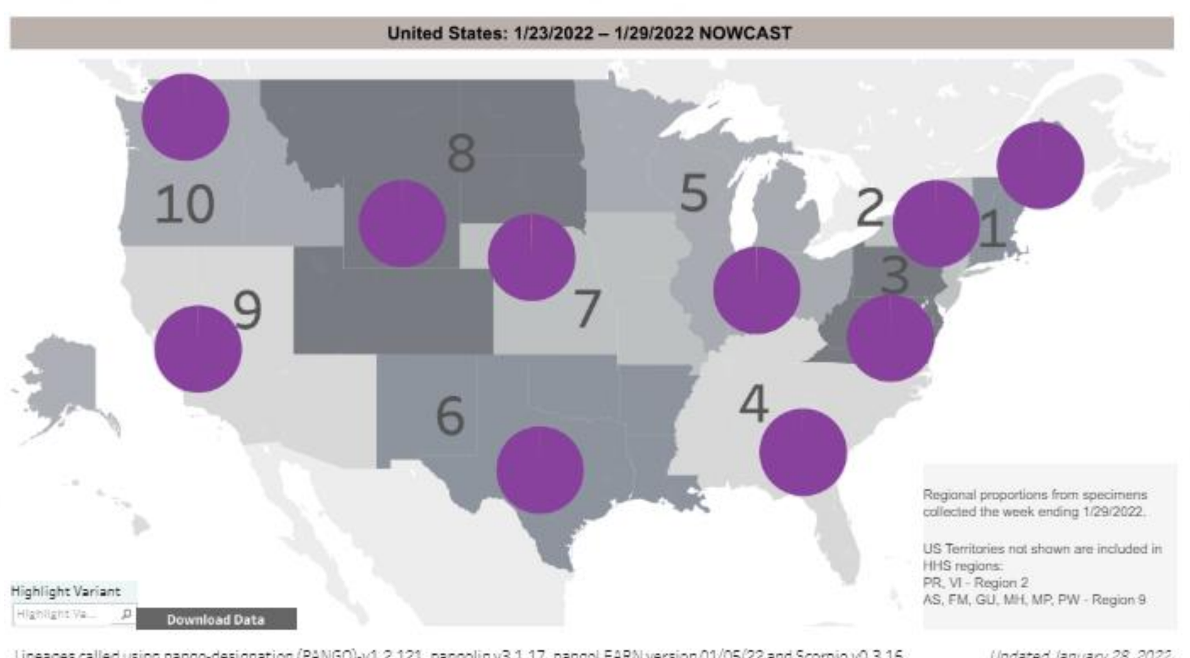


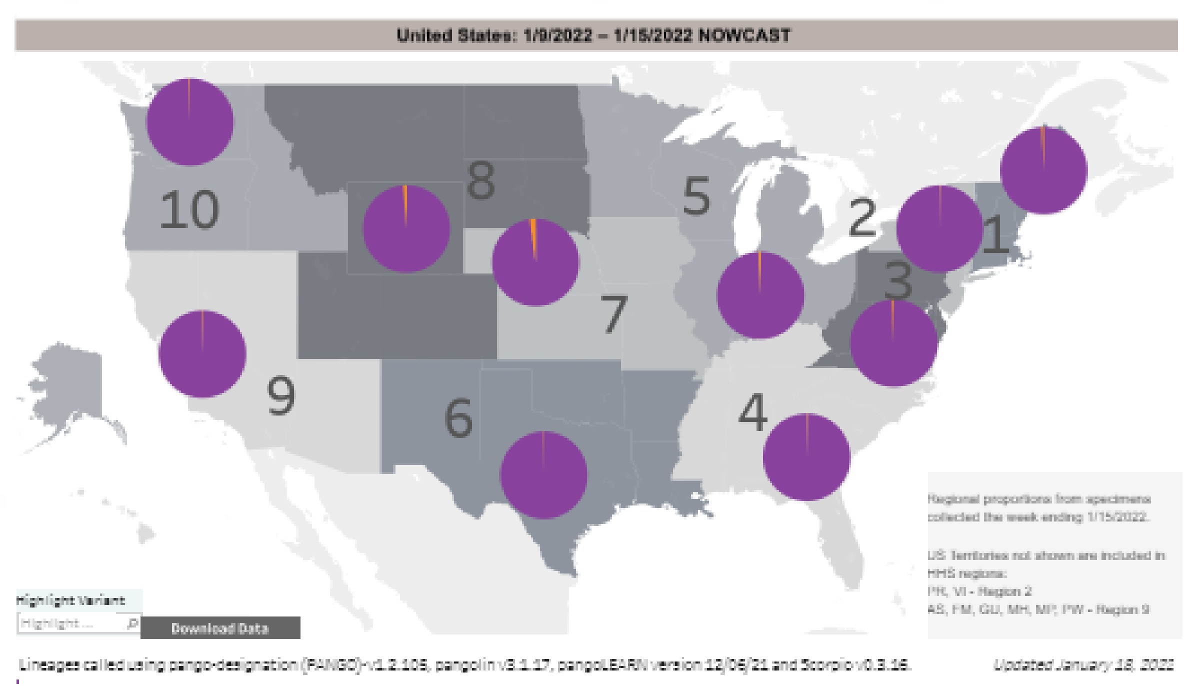
Note: week-to-week comparison in Omicron variant proportion (purple): far right bar in graph on left is week ending 1/29/22.

https://covid.cdc.gov/covid-data-tracker/#variant-proportions

February 2, 2022

From the CDC: SARS-CoV-2 Variants in the U.S.



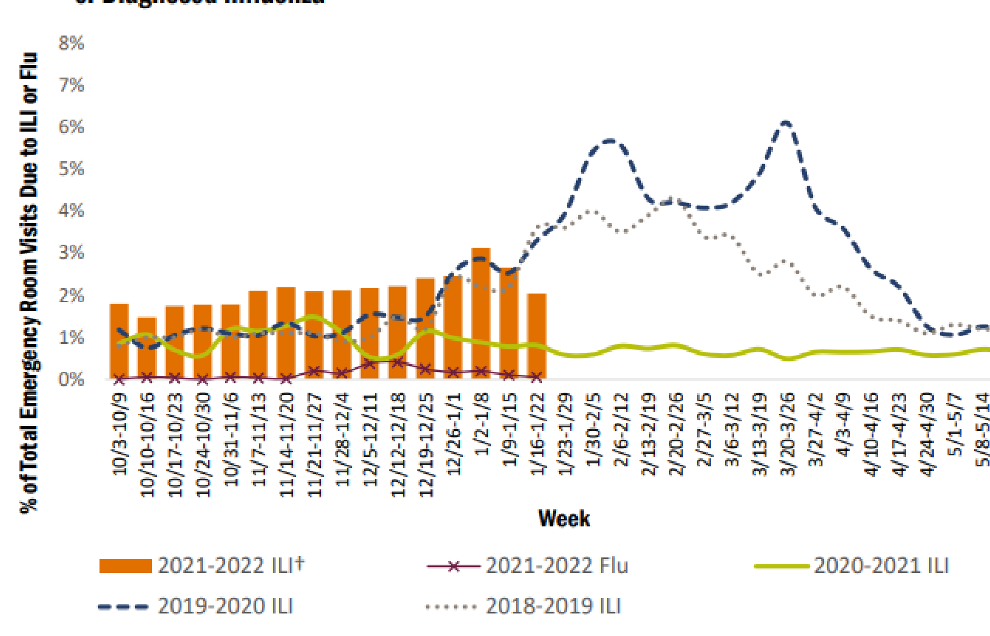


Note: week-to-week comparison in Omicron variant proportion (purple). Map on left is week ending 1/29/22.

https://covid.cdc.gov/covid-data-tracker/#variant-proportions

Don't Forget Influenza!

- Current Influenza-like Illness (ILI) activity level remains **MINIMAL** in Vermont
- **5** pediatric flu **deaths** this season
  - U.S. flu activity decreasing in recent wks. but remains elevated above baseline activity. While influenza activity is difficult to predict, the CDC expects it to continue for several more weeks.
  - Majority = influenza A(H3N2)
- Link to weekly surveillance:



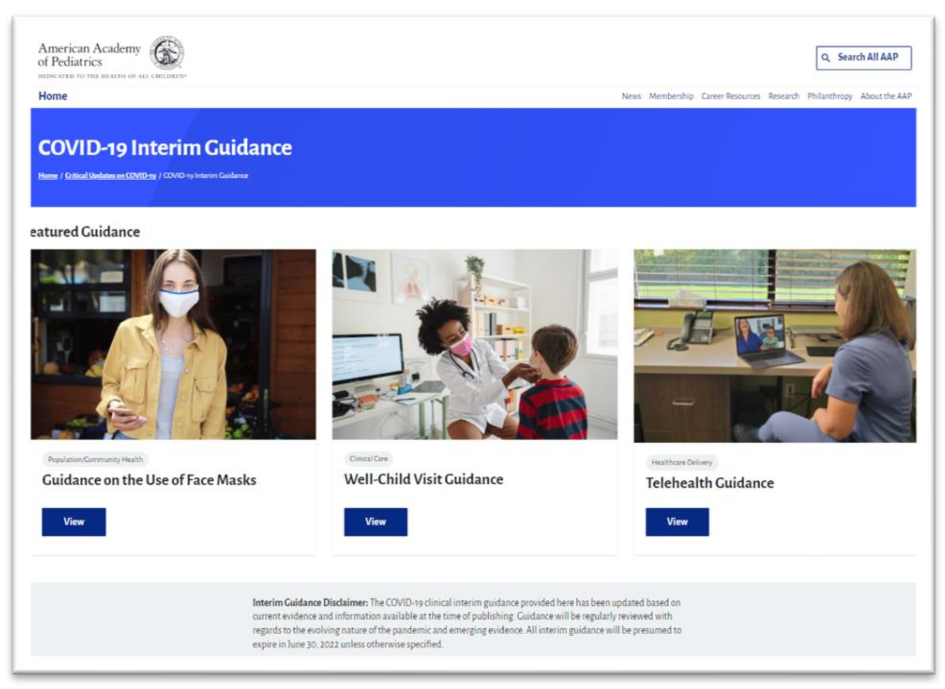
https://www.healthvermont.gov/sites/default/files/documents/pdf/2021-2022-Flu-WeeklyReport-Week-03.pdf

Reminder: AAP COVID-19 Town Halls

- Next Town Hall **Thursday, February 3, 2022 – 8 pm Eastern**
- Session will address the latest related to the COVID-19 pandemic and its impact on children, adolescents, and families – hear from leading experts and connect with your peers
- Expert Panelists: Susannah “Suz” Briskin, MD FAAP (AAP Council on Sports Medicine/Fitness, CWRU/RB & C); Sarah Risen, MD FAAP (Ped. Neurology, TX Children’s Hospital/Baylor COM); José R. Romero, MD FAAP (AAP COID, Immed. Past Chair CDC ACIP, AR Secretary of Health, Peds ID U. of AR)
- Find previous recordings on AAP COVID-19 Town Hall webpage:

https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/connecting-with-the-experts/

AAP Interim Guidance Updates



Recently Released

- Return to Sports
- Safe Schools
- Caring for Patients During Episodes of Surge

In Revision

- Testing
- Therapeutics
- Acute Illness

Pediatric COVID-19 Vaccine

- AAP **national** response to news re: vaccine for younger children
  - https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-statement-on-covid-19-vaccine-for-children-under-5/
  - https://www.nytimes.com/live/2022/02/01/world/covid-19-cases-vaccine
- Invitation to join ***VT Immunization Advisory Council*** public meeting: to discuss the school immunization schedule
- Tuesday, 2/8/22, 10-11 a.m. Microsoft Teams meeting [will share call invite]
  - **Join on your computer or mobile app:** Click here to join the meeting
  - **Or call in (audio only)**: +1 802-552-8456,,334379155# United States, Montpelier
  - Phone Conference ID: 334 379 155#

NEW from VDH MCH School Health Team

***Thank you, Kaitlyn Kodzis* – January School Nurse Bulletin:** Contents

- Vermont COVID-19 Information
- Test at Home Protocol
- COVID-19 Prevention & Mitigation Measures Winter 2022
- COVID-19 School Testing Program FAQs
- Mental Health Resources
- Publications
- Nurses in the News

(***SEE tonight's email***)

NEW from VDH Oral Health Office

- Newly updated *2021 Guide to Fluoride Levels in Public Water Systems*; enables health care professionals to determine level of fluoride in patient's public water system before Rx for fluoride supplements. Does NOT include fluoride levels of private wells or springs; DOES include info re: private water source testing. Hard copies may be requested for practices.
- **VDH recommends Vermonters w/private wells or springs test water for fluoride levels before getting Rx for fluoride supplements.**
  - Impt. to test since exposure can occur through mixing tap water w/infant formula & drinking well or spring water.
  - Well Water Testing Program offers free fluoride testing for families with children < 5 yo w/private wells. Guide includes. well water testing form (pls make copies for office use).
- Testing Program tracks # of requests vs. # of wells tested; many more kits are given out then are returned/processed by the lab (risks funding loss).

Thank you, OH Director Robin Miller: **Robin.n.miller@vermont.gov**

Tuesday Media Briefing (2/1/22)

Governor Phil Scott

- Favorable trends continue – *"not much for me to say re: COVID."*
- February is Career & Technology Education Month – we desperately need to focus work force efforts here.
- Trades are just as impressive as 4-year degree. Launching 1.4m. Campaign: half to upgrade CTE centers. As we spend billions of ARPA funds, we need trained work force to do these things.
- Yesterday (1/31) was Mental Health Advocacy Day – attended event with advocates, providers, stakeholders, community. Due to pandemic, MH needs more important than ever. Thank all MH professionals who have worked so hard over past 2 years & stepped up during extremely tough conditions to help keep folks safe across Vermont.

Tuesday Media Briefing (2/1/22)

VT DFR Commissioner Mike Pieciak

- U.S. & Northeast – trends now pretty much favorable for much of country.
- U.S. cases down 36%; hosps. down 10.5%; deaths up 9%
- New England cases down 44%, hosps. 20%
- VT: cases down 40% past week; > 50% past 14d.; down across all geographic areas & age groups. 5K cases this week down fr. ~3300 last week. Averaging just >600 cases/d.
- PCR tests down 21% - may impact case #s but less circulating virus means less need to seek test. Positivity rate coming down.
- VT trends similar to New England, NY, NJ.
- College campuses –most tests w/fewest cases this sem. LTCFs not seeing improvement yet – active outbreaks and cases are up.

Tuesday Media Briefing (2/1/22)

VT DFR Commissioner Mike Pieciak

- Forecast: expect cases down throughout Feb. & solid improvement next few wks.
- New hospital admissions: started to trend down 2 weeks ago & down ~10% past wk. (will favorably impact total census)
- Bed availability: stable for general hospital; increasing on ICU side.
- Fatalities: total = 542; 62 in Jan. (few more may be added); tied w/Dec. Hosp trends consistent – case fatality ratio 70-79 yo = 2.4% ; >80 yo >7%. Other ages <1%. Expect improvement in fatalities during February.
- Booster #s: VT near or at top in all categories. Added ~5500 new this week.

Tuesday Media Briefing (cont'd.)

VT AOE Secretary Dan French

- Many questions re: test kit supply management, esp. from school nurses. AOE published FAQs.
- Past week looking at "***presumptive contacts***" (no more contact tracing in schools). **PCs** = shared classroom w/student w/pos. test; casts a wider net (vs. previous contact def. = w/in 3-6 ft of case >15 mins.). Esp. in elementary schools was resulting in entire classroom in quarantine.
- Now doing ***Test at Home***: allows real time decision-making.
- FAQs this week: students on bus or eating lunch together are ***NOT*** **PCs** for Test at Home. Changes based on risk assessment – our real-world experience says these are not areas of concern.
- Generally if seeing cases in schools, it's related to cases in communities.

Tuesday Media Briefing (cont'd.)

VT AOE Secretary Dan French

- Since Jan. 1 VT & U.S. have struggled w/Omicron. VT especially successful in keeping schools open thanks to dedicated teachers/school staff.
- Good vaccine progress: some schools >80% – 6 applications for incentive grant program (public & independent schools). Amount is based on total enrollment. Congrats to: Crosset Brook 87%; Harwood Union HS 87%; Green Mtn. Valley School 100%; Open Field school 89%. Expect more schools eligible in coming wks. Working w/VDH re: vax rates by school – hope to share soon.
- Guidance has helped to significantly reduce health risks – now need more emphasis on educational risks – "call to urgency to address them." Plan to pivot towards end of February.

VERMONT
DEPARTMENT OF HEALTH

Tuesday Media Briefing (cont'd.)

VT AHS Interim Secretary Jenney Samuelson

- Non-COVID impact of pandemic: VTers protected – but came at a cost.
- Increased mental health & substance use disorder concerns across all age groups; suicide & overdoses increased in 2020 & 2021.
- MH will be front & center as we turn to recovery.
- Working to make it easier for all to become up to date on vaccine.

Tuesday Media Briefing (cont'd.)

VDH Commissioner Mark Levine:

- Now even more data re: critical role of boosters, per CDC study. Case & mortality rates lower. Mortality rate w/booster 1/m., & w/o booster 6/m.; unvax 78/m.
- Need for booster does NOT mean initial series didn't work – COVID requires more doses for full protection. Science continues to evolve & different decisions made w/new knowledge. CDC study & literature from Israel reinforce reality of vaccine impact. Israeli studies demonstrate 90-95% against severe disease/death. *"You are not fully vaxed, protected or 'up to date' if w/o booster."*
- VT's comparatively higher vax rates making a difference – health care system/ capacity never became overwhelmed.
- Emerging from surge: our future w/COVID – may seem like we've been stuck in movie [*Groundhog Day*] – repeating the same day over & over X past 2 years.

Tuesday Media Briefing (cont'd.)

VDH Commissioner Mark Levine:

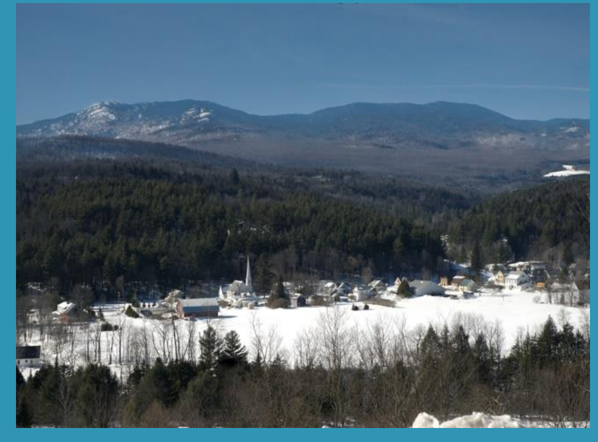
- Planning for new phase in post-pandemic era.
- COVID may be permanent but milder, less disruptive.
- Not unlike flu – requires regular vaccines & good preventive practices.
- Public Health strategies: transition away from contact tracing & surveillance testing. Goals: protect those at highest risk for worst outcomes & health care system.
  - Reliance on metrics like daily case counts no longer of much value. But surveillance of wastewater, genomic sequencing, etc., will help us monitor.
  - Requires civility, empathy, equity, compassion, & respect.
- Now look to focus across society on ***recovery***, including improving social-emotional well-being; focus on substance use & mental health, food insecurity (rise in eating disorders). Assess long term impact on health behaviors – what I call "***health debt***." E.g., worsening chronic illness. Critical issues can no longer remain on back burner.

VCHIP

Tuesday Media Briefing (cont'd.)

VDH Commissioner Mark Levine:

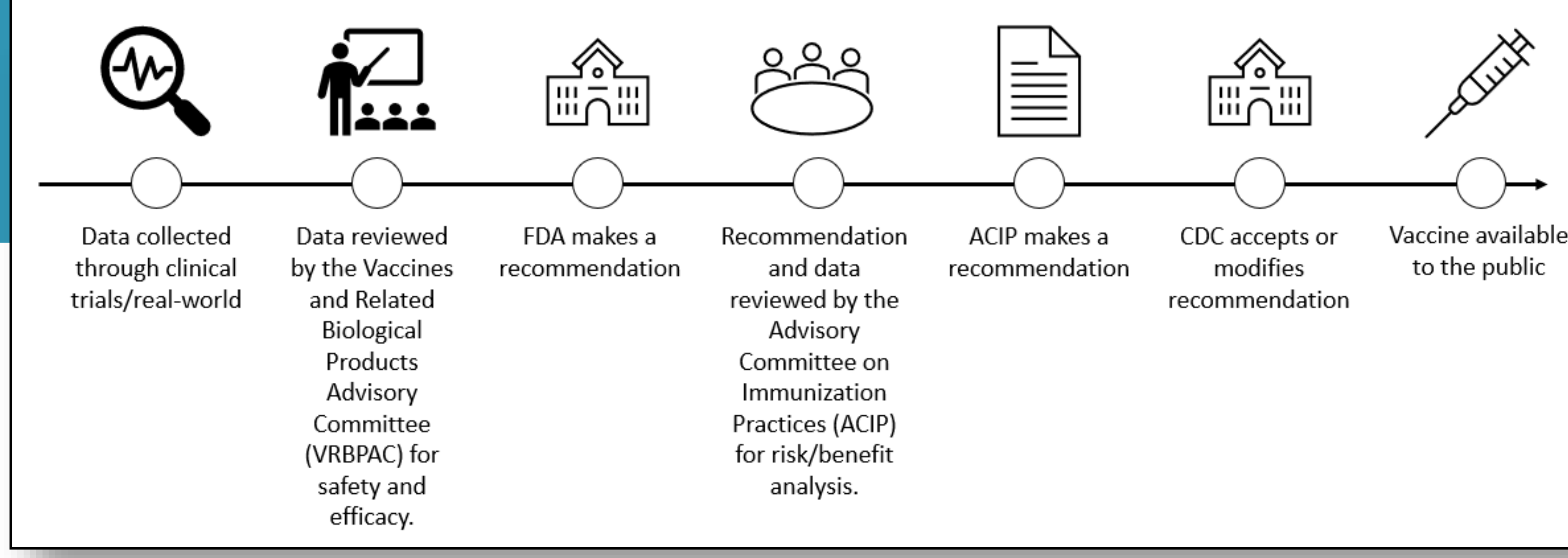
- We will continue same deliberate approach as ***Vermont Forward***.
- As part of evolving pandemic response, VDH will update case dashboard only M-F.
- All weekend data will be available Monday (have already been doing this w/holidays). Data Team has worked incredibly hard, nearly non-stop, for almost 2 years.
- News reports re: sub-variant Omicron BA.2. Have identified in one VT specimen.
- Not new variant but more transmissible version of Omicron. Spreads more quickly but (to date) no other traits of concern.
- Yesterday (1/31/22): Moderna vaccine received full approval for 18+ yo; means even more data proving that it works & is safe.



Vermont Department of Health –Immunization Program

Monica Ogelby, MSN, RN – *Immunization Program Manager*
Merideth Plumpton, RN - *Nurse Program Coordinator*

COVID-19 Vaccine for those under 5



- VRPAC scheduled on 2/15
- ACIP will meet shortly after
- No confirmation on what ages will be approved
- Manufacturing of vaccine (Maroon cap) has started
- SOONEST available is the week of February 21
- No information on allocation amount but we will have thresholds on initial orders
- Immunization Program will conduct training when more information is available

We want to hear from you!

Vermont administration plan for under 5

- There will be a heavy dependency on the Medical Home for administration
  - Start thinking about how you want to vaccinate this population.
  - Immunization Program will contact practices that see a large number of kids in this age group.
  - Please reach out to us if you are concerned.
- The state efforts will prioritize Equity Clinics and vaccine to those historically underserved and disproportionately impacted by COVID
  - Exploring ways to integrate COVID-19 vaccines into existing public health work (i.e., WIC clinics)

Take-aways from offices with the 5-11 highest rates

- Leaned on state clinics, especially early on. Many attributed high rates to availability of these clinics and a motivation on the part of their patients.
- Not every office held clinics, but almost all offices expanded hours
  - Added an extra nurse on vaccination days
  - Stayed open an hour later or opened an hour early
  - Providers available on weekends to administer vaccinations
- For those offices who utilized the AAP grant for COVID clinics, it was almost exclusively used to pay for additional staff time.
- Office clinics and state run clinics were advertised through Facebook pages, websites, e-mail/text message blasts, and phone call referrals.
- 15-minute wait time was accommodated through
  - a dedicated exam room
  - dedicated corner of the waiting room
  - asking patients to wait in the car where office personnel could see them
  - Assessing COVID-19 vaccination intention at the beginning of a well-child visit

Other COVID-19 vaccine news

- Sunsetting Janssen vaccine
- FDA approved vaccines (Comirnaty or Spikevax) will not be available any time soon
  - Single dose presentation will not be available soon either
- Novavax – we won’t hear anything until Q3/Q4 – This vaccine may not be available under EUA in the US. May be used in other parts of the world.
- ACIP meeting on 2/4 to talk about Moderna.

Mailing from Immunization Program

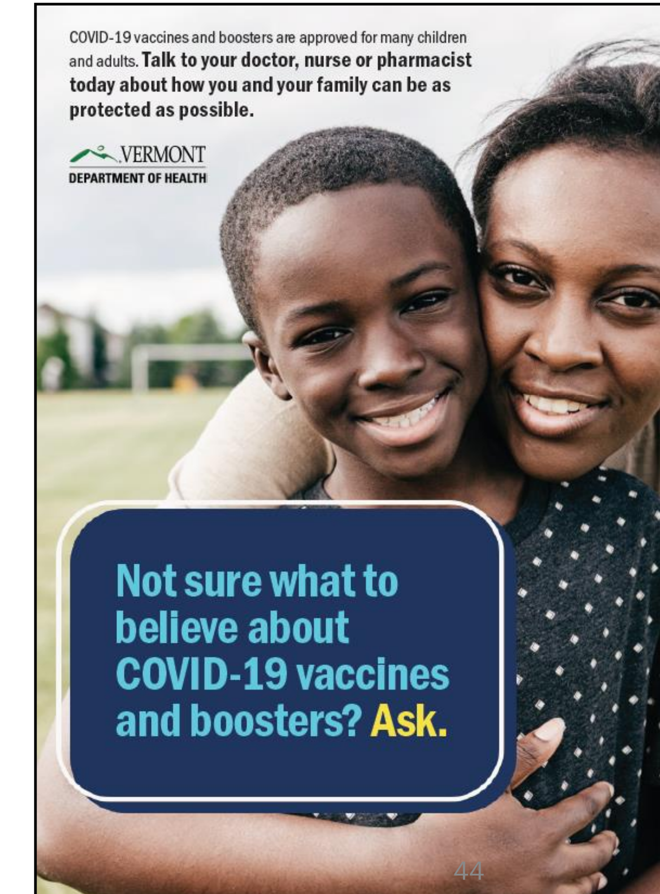
Vermont Chapter
INCORPORATED IN VERMONT

What Families with Children Should Know About COVID-19 Vaccines

Every VAVP/VCVP enrolled office will receive a mailing in the coming weeks.

- One or two large posters for placement in your entrance or waiting room to every office. COVID19-AskVaccinePoster11x17
- A batch of handouts designed for parents and caregivers who may be hesitant for their child to receive the vaccine (VCVP enrolled only). COVID-19 Vaccine in Children - Parent Handout

Translated links to both documents will be available on the COVID-19 Translations | Vermont Department of Health webpage



AAP Grant Extension!

- Extension of monetary cap per practice up to $10,000 (from $5,000)
- Will apply to COVID-19 or Flu clinics held through the end of 2022
- More information is coming and will be communicated broadly!
- http://www.aapvt.org/news/aapvt-chapter-still-accepting-grant-applications-flu-and-covid-19-vaccines
- If would like to apply for the grant, please complete the application (either in word or pdf form) and email back to Birdie Pauley at BPauley@vtmd.org

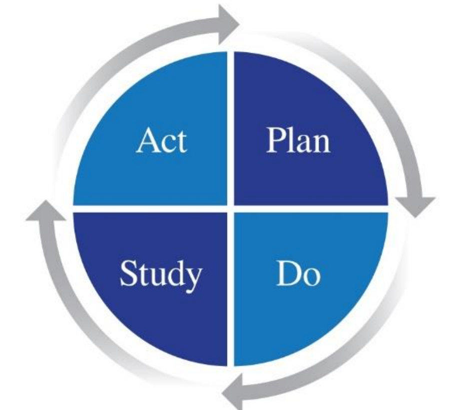
Immunization Communication

- Ordering guidance comes from AHS.VDHCovidVaxDistribution@vermont.gov prior to ordering on Wednesday.

- January Vermont Vaccine Update is available:
  - https://mailchi.mp/2f30f3ba745b/vermont-vaccine-program-updated-january-2022 for the direct link
  - or go to our website: Vaccine Information for Health Care Professionals | Vermont Department of Health

- Immunization Program 01/25/2022 Provider Call
  - Video: https://youtu.be/7z-XOckRuAQ
  - Slide deck: www.healthvermont.gov/sites/default/files/documents/pdf/HS-IZ-VVP-OfficeHours-01.25.2022.pdf

And now for something completely different…



In the spirit of continuous quality improvement, ***NEW CALL FORMAT*** today – our own PDSA cycle!

- Responding to your comments and feedback – thank you!
  - Desire to be able to focus on content but not miss Q & A from chat; avoid duplication of responses that may be included in presentation
- Content presentation for ~20-25 minutes
- Chat will be monitored, BUT – both verbal and written feedback will occur ***AFTER*** the presentation
- REMINDER: Chat Q & A is (re)organized, streamlined and made available following the call each day.

Practice Issues

Updated "Return to Play" Guidance

Dr. Jonathan Flyer – Division Chief Pediatric Cardiology, UVM Children's Hospital

Kristen Connolly, MD FAAP – Timber Lane Pediatrics

Return to Play: Why is this important?

A **sample** of your recent questions:

- *Our practice just started receiving forms requiring clearance with EKGs for even preschoolers to return to gym after COVID infection. Is this now expected? If it is, we are not going to be able to meet that need.*
- *I have a grade school (southern VT) now requiring students (under 12) do your Return to Play form before they can participate in PE class. I can't quite believe that VCHIP wants every child who has tested positive for COVID to come in for a full cardiac exam before they can be in gym class. I thought I would get a response from you before I speak to this particular principal.*
- *I'd suggest that we recommend testing for symptomatic kids and adults to determine treatment plans & would push for making tests for exposed, but asymptomatic kids optional. Put the focus on prevention and managing illness, mental health and other needs. Keep the masks.*

VCHIP

February 2, 2022

THE University of Vermont Children's Hospital

Responding to Changes in CDC Isolation/Quarantine Criteria after COVID19: General Practice AAP Guidance Updates for Safe "Return to Play"

Jonathan Flyer MD FAAP FAAC
Associate Professor of Pediatrics
Division Chief, Pediatric Cardiology
University of Vermont

Kristen Connolly MD FAAP
Timber Lane Pediatrics

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN

1. COVID-19 Interim Guidance: Return to Sports and Physical Activity (aap.org)
2. 2022-01-21 RTP algorithm.pdf (aap.org)

Home News

COVID-19 Interim Guidance: Return to Sports and Physical Activity

Home / Critical Updates on COVID-19 / COVID-19 Interim Guidance / COVID-19 Interim Guidance: Return to Sports and Physical Activity

- ***Over the past year, the AAP has provided quarterly updates– and now after recent CDC isolation changes.***
- ***Rates of myocarditis due to COVID remain low (0.5-3%).***

General Teamwork Reminder: RTP

The Return-to-Play protocols based upon national recommendations to increase safety and minimize risk. *Return-to-Play does not impact a student's ability to return to school. Return-to-Play should be a teams-based discussion between the parent and medical provider. Return-to-Play is not the responsibility of the school nurse.*

Continued team-based care between school nurses and pediatric medical homes is encouraged. *School nurses should advocate for families of students post-COVID-19 infection to communicate with their medical home before returning to activity.*

AAP Algorithm

Severity of symptoms

Asymptomatic or mild

<4 days of fever >100.4, <1 week of myalgia, chills, or lethargy

Assessment by Primary Care Physician (PCP) (phone, telemedicine, or in-person consultation)

During assessment:
1. Guidance re: duration of isolation
2. Do not exercise while in isolation
3. AHA 14-element screening evaluation, with special emphasis on symptoms of myocarditis (incidence: 0.5-3%): **chest pain, shortness of breath (SOB) out of proportion to upper respiratory infection (URI) symptoms, new-onset-palpitations, or syncope**

Negative AHA screen

Cleared to begin return to play (Box A)

Positive AHA screen

In-office visit with complete physical exam (PE) (post-isolation). In patients with symptoms that may involve the cardiac system, such as; chest pain, shortness of breath with exercise (not related to pulmonary issues), syncope, the PCP should have electrocardiogram (EKG) done and interpreted prior to clearance to return. Refer to pediatric cardiologist for abnormal EKG. Exclude from physical activity until cleared by cardiology then return to play (Box A)

Moderate

≥4 days of fever >100.4°F, ≥1 week of myalgia, chills, or lethargy, or a non-ICU hospital stay and no evidence of multisystem inflammatory syndrome in children (MIS-C).

In-person evaluation by PCP after symptom resolution and completion of isolation

During in-person evaluation:
1. Do not exercise until cleared by PCP
2. AHA 14-element screening evaluation, with special emphasis on **chest pain, SOB out of proportion to URI symptoms, new-onset-palpitations, or syncope**
3. Complete physical exam
4. EKG

Negative AHA screen, normal exam, and normal EKG

Positive AHA screen, abnormal exam, or abnormal EKG

Refer to cardiology, exclude from physical activity until cleared by cardiology

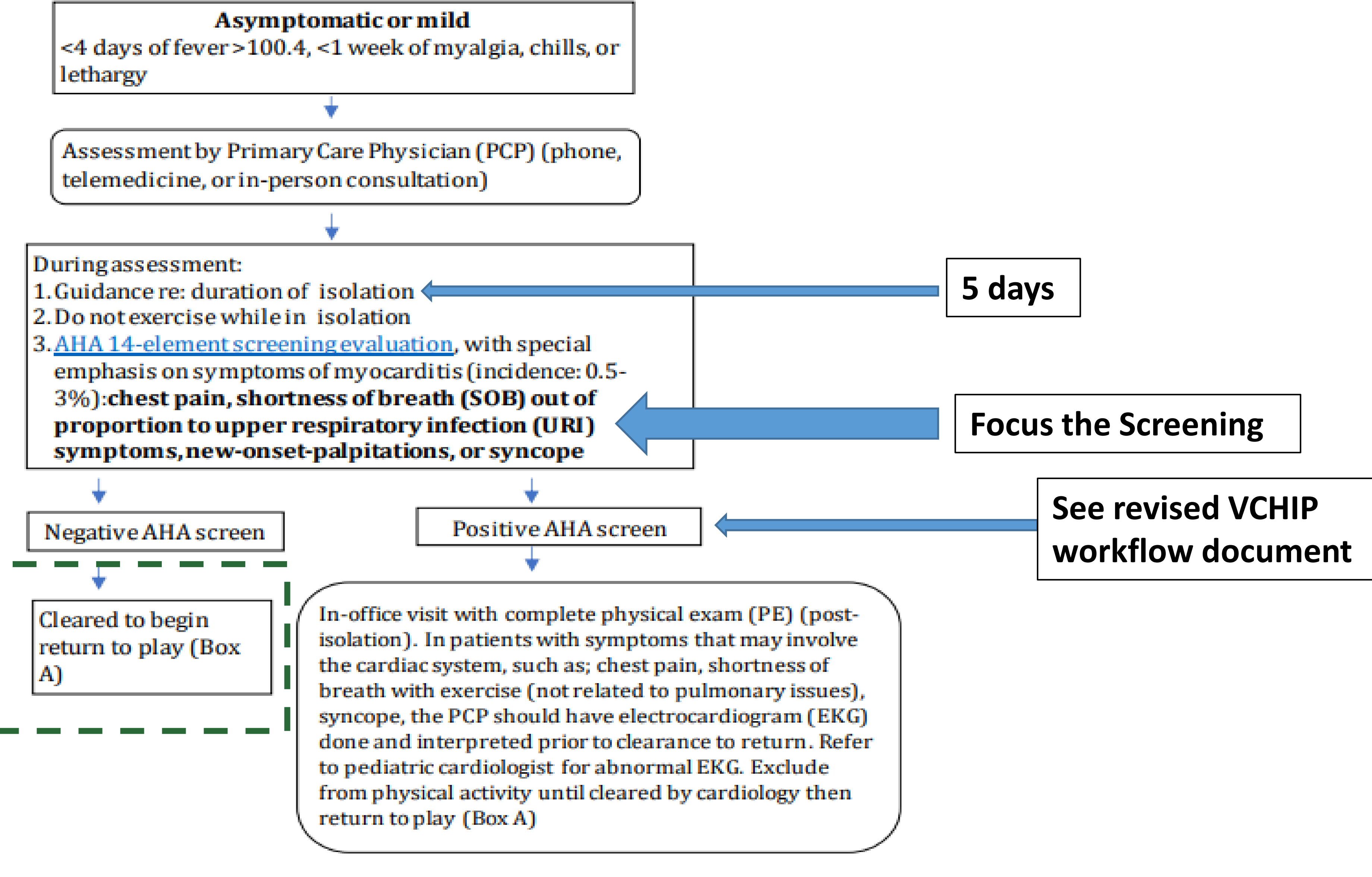
Cleared to begin the return to play (Box A) after 10 days have passed from symptom onset or positive test

Severe

ICU stay and/or intubation, or **MIS-C**

Restrict from exercise for 3-6 months, obtain cardiology clearance prior to resuming training or competition

Asymptomatic/Mild



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Moderate

Moderate
≥4 days of fever >100.4°F, ≥1 week of myalgia, chills, or lethargy, or a non-ICU hospital stay and no evidence of multisystem inflammatory syndrome in children (MIS-C).

In-person evaluation by PCP after symptom resolution and completion of isolation

Can be evaluated after **5 days**

During in-person evaluation:
1. Do not exercise until cleared by PCP
2. AHA 14-element screening evaluation, with special emphasis on **chest pain, SOB out of proportion to URI symptoms, new-onset-palpitations, or syncope**
3. Complete physical exam
4. EKG

Can start RTP after **10 days**

Negative AHA screen, normal exam, and normal EKG

Positive AHA screen, abnormal exam, or abnormal EKG

Refer to cardiology, exclude from physical activity until cleared by cardiology

Cleared to begin the return to play (Box A) after 10 days have passed from symptom onset or positive test

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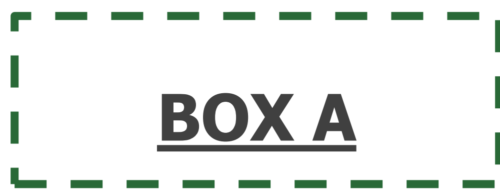
Severe

ICU stay and/or intubation, or **MIS-C**

Restrict from exercise for 3-6 months, obtain cardiology clearance prior to resuming training or competition

Recent AAP Updates



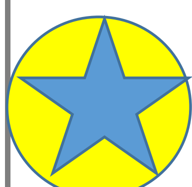
BOX A: Additional Guidance on Returning to Play *(Note: if the patient has already advanced back to physical activity on their own and is without abnormal cardiovascular signs/symptoms, then no further evaluation is necessary. COVID19 disease history should be documented.)*

When should children and adolescents return to play?

1) Completed isolation and minimum amount of symptom free time has passed
2) Can perform all activities of daily living
3) No concerning signs/symptoms
4) Physician clearance has been given, if indicated

At what pace should children and adolescents return to play?

5) <12yo: progress according to own tolerance
6) 12+: gradual return to physical activity



- Asymptomatic / Mild symptoms: Minimum 1 day symptom free (excluding loss of taste / smell), 2 days of increase in physical activity (i.e. one light practice, one normal practice), no games before day 3. A mask is required for ALL physical activity, including games or scrimmages, until 10 full days from + test or symptom onset have passed.
- Moderate symptoms: Minimum 1 day symptom free (excluding loss of taste / smell), and a minimum of 4 days of gradual increase in physical activity (one light cardio workout on own, two light practices, one full practice), no games before day 5. A mask is required for ALL physical activity, including games or scrimmages, until 10 full days from + test or symptom onset have passed.

When should children and adolescents pause return to play?

- If patient develops any chest pain, SOB out of proportion to URI infection, new-onset palpitations, or syncope when returning to exercise, immediately stop and go to PCP for in-person exam and consider referral to Pediatric Cardiology

Goodbye: 7 Day RTP

Goodbye

BOX B: Gradual Return to Play

(Adapted from Elliott N, et al, infographic, British Journal of Sports Medicine, 2020; copied from AAP Policy statement)

Stage 1: Day 1 and Day 2 – (2 Days Minimum) – 15 minutes or less: Light activity (walking, jogging, stationary bike), intensity no greater than 70% of maximum heart rate. NO resistance training.

Stage 2: Day 3 – (1 Day Minimum) – 30 minutes or less: Add simple movement activities (eg. running drills) – intensity no greater than 80% of maximum heart rate.

Stage 3: Day 4 – (1 Day Minimum) – 45 minutes or less: Progress to more complex training – intensity no greater than 80% maximum heart rate. May add light resistance training.

Stage 4: Day 5 and Day 6 – 2 Days Minimum) – 60 minutes: Normal training activity – intensity no greater than 80% maximum heart rate.

Stage 5: Day 7 – Return to full activity/participation (ie, contests/competitions).

2021

RTP CHANGES: BOX A

The 7day RTP recommendation has been removed (Box B).

- ***<12yrs: RTP as tolerated***
- ***≥ 12***

- Asymptomatic/Mild: 2 day RTP

- Moderate: 4 day RTP

Parents/caregivers: Monitor RTP

All children younger than 12 years with COVID-19 may progress back to sports/physical education classes according to their own tolerance once above steps for isolation and clearance have been completed.

Individuals who are 12 years and older should perform the following progression once isolation is completed and physician clearance has been obtained if indicated:

- **Asymptomatic/mild symptoms:** Minimum 1 day symptom free (excluding loss of taste/smell), 2 days of increase in physical activity (ie, one light practice, one normal practice), no games before day 3. A face mask should be worn for ALL physical activity, including games or scrimmages, until 10 full days from positive test or symptom onset have passed.
- **Moderate symptoms:** Minimum 1 day symptom free (excluding loss of taste/smell), and a minimum of 4 days of gradual increase in physical activity (one light cardio workout on own, two light practices, one full practice), no games before day 5. A face mask should be worn for ALL physical activity, including games or scrimmages, until 10 full days from positive test or symptom onset have passed.

All children and adolescents and their parents/caregivers should be educated to monitor for **chest pain, shortness of breath out of proportion for upper respiratory tract infection, new-onset palpitations, or syncope** when returning to exercise. If any of these signs and/or symptoms occur, the AAP recommends immediately stopping exercise and

Recent AAP Updates

Still the Same

1. **If the patient has already advanced to physical activity on their own and is without abnormal cardiovascular signs/symptoms, then no further evaluation is necessary → *this is primarily intended for past illness.***

2. **COVID19 disease history should be documented.**

Quick Hits!

Illness Category

- **Asymptomatic/mild:**
  - Does not need in person visit
  - Can be medically evaluated after 5 days of isolation
  - RTP is shorter (now 2 days instead of 7) and modified

- **Moderate:**
  - Can be medically evaluated after 5 days of isolation, + in person exam and EKG
  - RTP progression can start after 10 days
  - RTP is shorter (now 4 days instead of 7) and modified (see Box A)

Age Category

- ***<12yrs: RTP as tolerated***
- ***≥ 12***
  - ***Asymptomatic/Mild: 2 day RTP***
  - ***Moderate: 4 day RTP***

Parents/caregivers: Monitor RTP

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1. COVID-19 Interim Guidance: Return to Sports and Physical Activity (aap.org)
2. 2022-01-21 RTP algorithm.pdf (aap.org)

Medical Home: Workflow

Tools

1. **AAP Algorithm**
2. **AHA 14-point Checklist**
3. **VCHIP Medical Guideline Form for Return to Play**
   - Completed by the medical home & share with patients/families

General Practice

1 Document → Age Based

1. Guidance
2. Screening

↓ Paperwork ↑ Workflow

Current as of February 1, 2022

MEDICAL GUIDELINE FOR RETURN-TO-PLAY AFTER COVID-19 INFECTION

Patient Name:____________________ DOB: ____________________

Date of Positive COVID Test: __________
Date of Symptom Onset: __________ N/A if asymptomatic: ☐
Date of Last Symptoms: __________ N/A if asymptomatic: ☐

☐ **<12yo ASYMPTOMATIC/MILD or MODERATE symptoms:**

GUIDANCE	☐ No exercise while in isolation
SCREENING	☐ AHA 14-element screen reviewed and negative

☐ RETURN TO PLAY:
- May progress physical activity according to own tolerance once out of isolation
- Mask required for ALL activity until 10 full days from +test or symptom onset has passed
- Immediately stop activity and have in-person medical evaluation for any chest pain, shortness of breath out of proportion with symptoms, new-onset palpitations, or syncope with return to exercise

☐ **≥12yo ASYMPTOMATIC/MILD symptoms**
(<4 days fever >100.4F, <1 week myalgia, chills, or lethargy)

GUIDANCE	☐ No exercise while in isolation
SCREENING	☐ AHA 14-element screen reviewed and negative ☐ Out of isolation and ≥1 day symptom-free (excluding loss of taste/smell)

☐ RETURN TO PLAY:
- Minimum 2 days of increase in physical activity (ie. one light practice, one normal practice)
- No games before day 3
- Mask required for ALL activity until 10 full days from +test or symptom onset has passed
- Immediately stop activity and have in-person medical evaluation for any chest pain, shortness of breath out of proportion with symptoms, new-onset palpitations, or syncope with return to exercise

☐ **≥12yo MODERATE symptoms**
(≥4 days fever >100.4, ≥1 week of myalgia, chills, or lethargy, or non-ICU hospital stay without evidence of MIS-C)

GUIDANCE	☐ No exercise while in isolation ☐ No exercise until cleared by PCP
SCREENING	☐ In-person evaluation by PCP after symptoms resolved and out of isolation ☐ Normal physical exam, AHA 14-element screen, and EKG ☐ ≥10 days have passed since symptom onset or positive test

☐ RETURN TO PLAY:
- Minimum 4 days of gradual increase in physical activity (ie. one light cardio workout, two light practices, one full practice)
- No games before day 5
- Mask required for ALL activity until 10 full days from +test or symptom onset has passed
- Immediately stop activity and have in-person medical evaluation for any chest pain, shortness of breath out of proportion with symptoms, new-onset palpitations, or syncope with return to exercise

Clinician:____________________ Office Phone number: ____________________

Guidelines are based on national recommendations (https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-interim-guidance-return-to-sports/) to increase safety and minimize risk. Return to play should be a teams-based discussion between patient/caregiver and medical provider with continued teams-based care encouraged between school nurses and medical homes. This does not impact ability to return to school and is not the responsibility of the school nurse.

Current as of February 1, 2022

MEDICAL GUIDELINE FOR RETURN-TO-PLAY AFTER COVID-19 INFECTION

Patient Name:______________________________ DOB: ______________________________

Date of Positive COVID Test: ____________

Date of Symptom Onset: ____________ N/A if asymptomatic: ☐

Date of Last Symptoms: ____________ N/A if asymptomatic: ☐

☐ **<12yo ASYMPTOMATIC/MILD or MODERATE symptoms:**

GUIDANCE	☐ No exercise while in isolation
SCREENING	☐ AHA 14-element screen reviewed and negative

☐ RETURN TO PLAY:

- May progress physical activity according to own tolerance once out of isolation
- Mask required for ALL activity until 10 full days from +test or symptom onset has passed
- Immediately stop activity and have in-person medical evaluation for any chest pain, shortness of breath out of proportion with symptoms, new-onset palpitations, or syncope with return to exercise

☐ ≥12yo **ASYMPTOMATIC/MILD symptoms**

(<4 days fever >100.4F, <1 week myalgia, chills, or lethargy)

GUIDANCE	☐ No exercise while in isolation
SCREENING	☐ AHA 14-element screen reviewed and negative ☐ Out of isolation and ≥1 day symptom-free (excluding loss of taste/smell)

☐ RETURN TO PLAY:

- Minimum 2 days of increase in physical activity (ie. one light practice, one normal practice)
- No games before day 3
- Mask required for ALL activity until 10 full days from +test or symptom onset has passed
- Immediately stop activity and have in-person medical evaluation for any chest pain, shortness of breath out of proportion with symptoms, new-onset palpitations, or syncope with return to exercise

☐ ≥12yo **MODERATE symptoms**

(≥4 days fever >100.4, ≥1 week of myalgia, chills, or lethargy, or non-ICU hospital stay without evidence of MIS-C)

GUIDANCE	☐ No exercise while in isolation ☐ No exercise until cleared by PCP
SCREENING	☐ In-person evaluation by PCP after symptoms resolved and out of isolation ☐ Normal physical exam, AHA 14-element screen, and EKG ☐ ≥10 days have passed since symptom onset or positive test

☐ RETURN TO PLAY:

- Minimum 4 days of gradual increase in physical activity
  (ie. one light cardio workout, two light practices, one full practice)
- No games before day 5
- Mask required for ALL activity until 10 full days from +test or symptom onset has passed
- Immediately stop activity and have in-person medical evaluation for any chest pain, shortness of breath out of proportion with symptoms, new-onset palpitations, or syncope with return to exercise

Clinician:__________________________ Office Phone number: __________________________

Guidelines are based on national recommendations (https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-interim-guidance-return-to-sports/) to increase safety and minimize risk. Return to play should be a teams-based discussion between patient/caregiver and medical provider with continued teams-based care encouraged between school nurses and medical homes. This does not impact ability to return to school and is not the responsibility of the school nurse.

Screening

1. **Bolded**
2. **Non-bolded**

14-Element AHA Screening Checklist

Yes	No	
☐	☐	**Chest pain/tightness/pressure related to exertion**
☐	☐	**Unexplained syncope or near-syncope (not including vasovagal cause)**
☐	☐	**Excessive exertional, unexplained shortness of breath/fatigue or new onset palpitations with exercise**
☐	☐	**New heart murmur on exam or persistent tachycardia**
☐	☐	**Abnormal pulses on exam including femoral pulses (to exclude aortic coarctation)**
☐	☐	History of elevated systemic blood pressure
☐	☐	Prior restriction from participation in sports
☐	☐	Prior cardiac testing ordered by a physician
☐	☐	Family history of premature death <50yrs due to heart disease
☐	☐	Disability due to heart disease in a close relative <50yo
☐	☐	Family history of HCM/Dilated cardiomyopathy, long QT/ion channelopathies, Marfan syndrome, significant arrhythmias, or genetic cardiac conditions
☐	☐	History of heart murmur (excluding innocent/resolved murmurs)
☐	☐	Physical stigmata of Marfan Syndrome
☐	☐	Abnormal brachial artery blood pressure in sitting position on exam

14-Element AHA Screening Checklist *adapted from Maron BJ, et al. Journal of the American College of Cardiology, 2014.* AHA 14-element screening to be reviewed with special emphasis on symptoms of myocarditis (incidence 0.5-3%): **chest pain, shortness of breath out of proportion with URI symptoms, new-onset palpitations, or syncope.** *Positive screening on non-bolded elements of the checklist may prompt cardiology referral, however these concerns are unlikely to be related to COVID19.*

THANK YOU

The University of Vermont

LARNER COLLEGE OF MEDICINE

In case you missed it…

FINAL Updated Pediatric Flow Chart

- Posted on VCHIP & AAPVT web sites with live links
- ***Thank you:***
  - Stephanie Winters
  - Rebecca Bell
  - Breena Holmes
  - VDH partners: Kaitlyn Kodzis, Katy Leffel, Molly McClintock, Ilisa Stalberg, Nate Waite

VCHIP
Vermont Child Health Improvement Program
University of Vermont Larner College of Medicine

Vermont Chapter
Incorporated in Vermont
American Academy of Pediatrics
Dedicated to the health of all children

Vermont Department of Health

COVID Pediatric Flowchart
Return to School/Childcare

Close Contact

Follow Vermont Department of Health Guidance on What to do if you are a close contact

Symptomatic

Fever (100.4 °F or higher), Cough, Shortness of breath or difficulty breathing, Chills, Fatigue, Muscle or body aches, Headache, Sore throat, New loss of taste or smell, Congestion or runny nose, Nausea or vomiting, Diarrhea

Stay Home or Go Home

Get tested
- Take 2 antigen tests as close to 24 hours apart as possible; or (If child is under 2 years of age, they must have a PCR/LAMP test. Antigen tests are not approved for this age group)
- Sign up for State of Vermont Run Testing; or
- Primary care clinician may be able to collect or order PCR or LAMP test

Stay Home While Awaiting Results

Negative

The individual may return to the school/childcare program once symptoms are improved*

Unable to Test

Treat as COVID case, follow Vermont Department of Health isolation guidelines

Positive

Child has tested positive for COVID (PCR, LAMP, Antigen)

Stay Home or Go Home

Isolate for 5 days
They can leave their home after day 5 if:
- they have two negative antigen tests performed at least 24 hours apart beginning no earlier than day 4* AND
- they have never had symptoms, or their symptoms have improved and they feel better AND
- they have had no fever for at least 24 hours without the use of medicine that reduces fevers AND
- they wear a mask around others through day 10.

They should notify their close contacts that they have tested positive. If they took an antigen test at home, please encourage them to report positive test results to the Health Department.
*Testing is strongly recommended. If they are unable to get a test and they meet all other requirements they can end isolation after 5 days.

If a child has a disability and is unable to mask
- Reasonable accommodation should be made for students who are unable to wear or have difficulty wearing certain types of masks because of a disability
- Although testing is strongly recommended, a student with a current COVID infection and disability that prevents mask use could still end isolation early and return to school between days 6-10 if the other requirements (symptom improvement/afebrile) are met.

- If a child is between the age of 2-5 and cannot mask consistently they can get out of isolation after day 5 if all other requirements are met
- If a child is under the age of 2 they can leave isolation if they meet all other criteria (besides masking and antigen testing) after Day 5

* schools/childcare may have their own policy related to returning to school after illness. Families and caregivers should be aware of and consult their school/childcare about specific policies

Vermont Child Health Improvement Program
University of Vermont Larner College of Medicine

VCHIP-VDH COVID-19 calls – *2022!*

February calls: currently all *Wednesdays*:

- **2/2, 2/9, 2/16, 2/23/22**
- We recognize that February school vacation weeks may affect your ability to participate!
- **Continuing via Zoom!**
- Schedule **subject to change** at any time if circumstances warrant!
- *Please continue to send your feedback re: schedule/topics to* vchip.champ@med.uvm.edu
- VMS calls w/VDH Comm. Levine now 1st/3rd Thursdays

VCHIP-VDH COVID-19 Update Calls – now via *ZOOM*!

Call login information:

- Topic: *CHAMP VDH COVID-19 Call*
- Join Zoom Meeting
  - https://uvmcom.zoom.us/j/94142791300?pwd=K2N4VUYrSHlMQi9XeGVnc3duNTFmZz09
  - NOTE: password (CHAMP) should be imbedded in link (sharing in case needed for any reason. You will not be prompted to enter PW if using link we provided.
- Meeting ID: 941 4279 1300
- Passcode: CHAMP
- One tap mobile
- +16468769923,,94142791300# US (New York)
- +13017158592,,94142791300# US (Washington DC)

Questions/Discussion

- Q & A Goal: monitor/respond in real time; record/disseminate/revisit later as needed.
- **For additional questions, please e-mail:** vchip.champ@med.uvm.edu
  - **What do *you* need** – how can we be helpful (specific guidance)?
- **VCHIP CHAMP VDH COVID-19 website:** https://www.med.uvm.edu/vchip/projects/vchip_champ_vdh_covid-19_updates
- Next CHAMP call – ***Wednesday, February 9, 2022 12:15 – 1:00 pm*** **VIA ZOOM!**
- Please tune in to VMS COVID-19 call with VDH Commissioner Levine – ***Thursday, February 3 – 12:30-1:00 p.m.***
- **Join VMS *Zoom* Meeting:** https://us02web.zoom.us/j/86726253105?pwd=VkVuNTJ1ZFQ2R3diSVdqdlJ2ZG4yQT09
  - Meeting ID: 867 2625 3105 / Password: 540684
  - One tap mobile - +1 646 876 9923,,86726253105#,,,,0#,,540684#