VCHIP CHAMP VDH COVID-19

January 11, 2021 | 12:15-12:45pm Call Questions and Answers*

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COVID-19 & Schools

Breena Holmes, MD, VCHIP, VDH: I realized we could do more educating of all of us together on what's available to you as community resources for schools and reassure you the process by which a school handles a case is now really well worked out. Early on, we asked schools to develop line lists and to figure out a list of people that may have been exposed when there was a positive case. Then, we get on the call with them and go through the exposure criteria to determine who among that list is actually a close contact, and then the schools alert those people and tell them what their day zero and day seven are and how to quarantine. The reason that's important is it helps us get out ahead of the slower timeline if we were to put the school cases into the bigger epidemiological list (sometimes 200 cases a day). VDH still talks to the person with COVID-19, but it puts the schools in the center of the communication with folks (both staff and students) who have been asked to quarantine as close contacts.

We were busy this weekend. It's certainly not a spike but my hope that maybe we have fewer cases in schools in January was disproven by the weekend. That being said, 0.17% of the teacher surveillance test came back positive last week, which is extraordinary. Dr. Davis also noted we are interested in creating a shared PowerPoint with you to catalyze dialogue in your communities as they continue to move toward this goal of all in-person learning. So, I'm excited for that.

In the News

Wendy Davis, MD, VCHIP: A great opinion piece was published in *The Boston Globe* this morning about vaccinating the youngest folks first (available at: https://www.bostonglobe.com/2021/01/11/opinion/vaccinate-youngest-first/).

Breena Holmes, MD, VCHIP, VDH: This group has been so helpful and trying to have this hard conversation. We obviously understand the mortality, and in some cases, morbidity, of the virus itself tracks with age. However, this editorial speaks to the ongoing needs of asymptomatic spread, kids needing to get back to their lives and the long term impact of this pandemic on younger people. It's just opinion, but I like sharing thoughts from different good thinkers. It certainly would be better if there was just more supply and this idea that we have to pit groups against each other doesn't feel great.

Practice Issues: *COVID-19 Vaccine: VDH Immunization Program Update* by *Christine Finley, APRN MPH – VDH Immunization Program Mgr. & Merideth Plumpton, RN – Nurse Program Coordinator*

Wendy Davis, MD, VCHIP: As we mentioned on Friday, the Vermont Vaccine Implementation Advisory Committee met on Friday. Stephanie Winters is our consistent attendee and often sends the information to us before it comes out formally. Of note, the group began to look at high risk conditions, including national statistics uncovered in these populations and continuing to think about our BIPOC community. A small work group out of this committee will be convening to discuss which conditions to include here in Vermont. That implementation will perhaps take place after the age banding to age 40. Editorially, I would like to say the

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logistics of this ongoing vaccine allocation rollout are exceedingly complex and require not only federal and state coordination, but really a tremendous amount of coordination among multiple state agencies and community groups here in Vermont.

Christine Finley, APRN MPH, VDH: I think I'll start my comments with just saying yes, there's a lot going on. There's public health. There's politics. There's the press. There are many challenges on top of that. I don't think we've had a day go by where something hasn't changed with CDC based on what we were expecting. There are a lot of challenges, but I think we need to improve our communication not only to the public, but to the professionals. I believe something is actually going up this hour to primary care colleagues. I think everybody is okay with 1a being health care workers and long term care facility staff and residents. Although, I can tell you a day doesn't go by that we don't get 20 questions asking us to define what a health care worker is, so we're still working to address many parts of that.

Based on national data from COVID-NET, risk for in-hospital death among adults hospitalized with COVID-19 increases with age. There's been an incredible focus on age and some people question if it is overemphasized. I've heard all sorts of numbers of who is in which age groups, so I wanted to share the breakdown of age groups. If we're looking at vaccinating folks ages 75 and up, we estimate there's just under 50,000 eligible in Vermont. The thought is that we would begin to vaccinate ages 75 and older and then go to the next five year grouping, ages 70 to 74, and then ages 65 to 69. After that, my understanding is we would look at chronic disease for those 40 years and older.

I also wanted to show you the case fatality rate of COVID-19 in Vermont by age bracket. There rate among those 75 and older is clearly high. This has been a big concern for many people involved in the decision-making process. The Governor's senior leadership group is where all final policy decisions are being made. So there's been a lot of talk on the Vermont Vaccine Implementation Advisory Committee about looking at prioritizing adults of any age with high risk conditions, based on the CDC's list. We tried to get additional clarity from the CDC on some of the high risk conditions. In response, CDC reminded us the response to this virus just started a year ago and the data we have on identifying risk factors is not as much as we would want to make informed decisions. There is a lot of ongoing research. In addressing those that are known to have high risk, there's a real sense that we can decrease some of the morbidity and mortality associated with the disease.

There are a few points I would like to address with regard to allocations. We're receiving week to week allocation, which is no way to run a program. I can't tell you how difficult that is. We find out on Tuesday morning what our allocation is and our order needs to go in on Thursday night. At this point, we've enrolled hospitals, district offices, and we have to provide a certain amount of vaccine to cover what we owe for the long term care facilities through federal pharmacy partners. Each week, a portion of our vaccine has been coming off the top to ensure the three pharmacies doing the outreach and vaccinating in long term care facilities have an adequate amount of vaccines. However, that does come out of our allocation of 8,000-8,800 a week that we've been getting. We will be done with that soon if we continue on what we're planning, we'd be done in two weeks. We may be able to extend it a little more, but that's one of the challenges. The way we've been doing it is there's been a conversation each week with a hospital pharmacist to identify what they believe they need and what clinics they have scheduled. We try to meet their needs. This process is not going to be scalable, so we'll be transitioning to using the vaccine inventory management system, where people have to reconcile what they have on hand every week. In the meantime, we'll be doing there are multiple conversations going on at a lot of levels as to the best way to reach folks

ages 75 and over. There's probably not one best way, but we're considering the potential role of hospitals, district offices and retail pharmacies based on the limited vaccine doses we have available. At this point, there are a lot of planning discussions taking place, but there's a recognition that we want to begin providing vaccines to those beyond just the health care workers in Phase 1a. Ideally, this expansion would have started next week, but given some of allocation challenges, it may be the week of the 25th or later.

Questions/Discussion:

Q: Just saw a report that the B.1.1.7 variant of COVID-19 may yield more false negatives on testing if using tests targeting a smaller portion of the genome vs. larger portion. With this variant in several nearby states wondering what type of PCR test is used in VT?
A: Breena Holmes, MD, VCHIP, VDH: I'd like to hear from Ben. I have not that alert yet. I've heard the VT interpretation of that or if we're going to do anything differently.
A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: I believe what you're referring to with the B116 variant is if when we go back and in one of the clues that was first raised when they noticed this in the UK or one of the helpful sort of characteristics of this variant, is that one of the mutations happens to sit right at the priming site for one of the PCR primers. So what that means is in in the UK, they used a combination of three different PCR reactions to identify a positive result. If you remember, going way back, the original CDC test, it was sort of based on the same principle. You needed three separate targets to come up positive, and the reason the tests didn't work was that there was a manufacturing flaw or contamination in one of those components. So with this test, you could get a false negative if you're only looking at that specific primer site. I don't know if there are other mutations that they've since discovered that could also affect the positivity rate of PCR, but I believe the question raised that that's really what that is referring to. I'll confess in in terms of the UVMMC lab or the Department of Health Lab, I don't know the specifics of what exact primers they are using. I believe they're mainly using those CDC primers at the three locations. If somebody from the health lab is on and can weigh in or correct me, then certainly do so. What it could mean is that not necessarily false negatives, but if you're not positive at all of the sites, I believe a lot of places will report those as indeterminate, and so there is a theoretical possibility that we could have more indeterminate depending on which lab is doing the PCR if they're only looking at that one site, which I think would be pretty unlikely for any of the public health labs to do that. The bigger challenge is that, and this has been pretty well articulated in the press and the scientific media, nobody is just doing enough of surveillance sequencing and so here, in the United States, there's hardly any routine surveillance sequencing, and an honestly in order to really get a handle on what type of variants are out there, that that's what would be needed, but it's just not something that's on a national level we're really set up to do, which is sort of one of the other flaws and sort of our basic public health … raised is really we should be doing more surveillance sequencing across the board, and it's just not happening. Hopefully I was able to answer that question without just making things more confusing. Further details--the CDC SARS-CoV-2 PCR reaction looks at N (nucleocapsid) genes, while the mutations that led to negative PCR results in the UK were based on the double deletion in the spike protein--so we shouldn't have the same issue with detection as the UK did, although in full disclosure I have not investigated whether the B1.1.1.7 mutations also has alterations in any of the N gene sites targeted. FYI, additionally, the UVMMC platforms do not target spike, so we should be good for tests run here as well.

Q: What was the positivity rate amongst teachers?
A: Susan Sykas DNP, Appleseed Pediatrics: 0.17%

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Q: *Lancet* article referenced in 1/9/21 *NYT* regarding long term COVID-19 symptoms, 6 months out from Wuhan (available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32656-8/fulltext).
A: Susan Sykas DNP, Appleseed Pediatrics: I haven't read the article, who were the younger people, since it is not tested in children yet? Were they referring to the 18- 29 year olds?
A: Breena Holmes, MD, VCHIP, VDH: Young adults, since the vaccines are approved over 18 for Moderna and 16 for Pfizer.

Q: I just want to make sure I have this right. Do we recommend that those with prior anaphylactic reaction to vaccines wait to be vaccinated or any history at all of anaphylaxis?
A: Merideth Plumpton, RN, VDH: There is guidance. I will post it here: CDC's Interim clinical considerations for mRNA COVID-19 vaccine: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html. VDH website with COVID-19 eligibility https://www.healthvermont.gov/covid-19/vaccine/about-covid-19-vaccines-vermont

Q: Have there been any pediatric admissions in VT for COVID-19 since 3/2020?
A: Breena Holmes, MD, VCHIP, VDH: No one under 18 has been admitted with COVID-19 in VT.
A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: To my knowledge there have been NO pediatric admissions for COVID-19.

Q: Any word on when the VHD points of distribution clinics will be up & running at the VDH offices?
A: Merideth Plumpton, RN, VDH: Once we go to the next priority groups for vaccination, the plan is for PODs to start.
A: Breena Holmes, MD, VCHIP, VDH: Folks who have offered to help with vaccine clinics, I have offered your services (along with several school nurses who have offered), so stay tuned.
A: Ellen Gnaedinger, APRN, South Royalton Health Center: Also, those of us in the MRC have been asked to provide days we are available through the end of Jan.
A: Merideth Plumpton, RN, VDH: Yes, the state is reaching out to the MRC now to begin planning. Medical Reserve Corps: https://rms.vermont.gov/.

Q: I heard that closed PODs are not being pursued anymore, is that accurate?
A: Merideth Plumpton: Closed POD's might be used in later planning.
A: Alex Bannach: There will need to be official guidance on that for hospital administration.

Q: I just found out that the architect from my housing development who doesn't meet priority criteria got vaccinated while many health care workers in the state have not been given a vaccine. Why is that?
A: Breena Holmes, MD, VCHIP, VDH: My hypothesis is that in some settings they had extra vials that were going to be needed to be utilized and somebody was there, but that's just my strength-based approach.
A: Halle Davis: Could he have been in the right place at the right time for doses needing to be used?

C: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: There is a support group for COVID-19 patients with chronic symptoms, run by Frymoyer Community Health Resource Center, contact is Kristine Buck, kristine.buck@uvmhealth.org. She stated it is currently just for adults but it may be appropriate for teens, and would be open to considering programs for younger kids if there is a need/demand.

Q: Any thoughts of starting trials here for 12 plus, as we cannot go to Worcester?
A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: There has been some discussion about whether UVM could become a site for pediatric trials, but nothing definitive is being planned. If so, it might

run through ECHO/IdEA network run by Kelly Cowan. Ultimately it will be more up to the sponsors/networks than us.

Q: How is the state planning on prioritizing BIPOC Vermonters? It seems like prioritizing essential workers, a group in which BIPOC folks are overrepresented, would have been a bit more straightforward and less politically charged.
A: Merideth Plumpton, RN, VDH: We have a group meeting to discuss this topic.

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