VCHIP VDH COVID-19 Q&A Chat February 2, 2022

FAQ AOE VT SCHOOL TESTING

C: https://education.vermont.gov/covid19/testing/faq-vermont-covid19-school-testing-program
C: I am surprised that he said that as lunch is a high-risk area, as they are not masking while eating. My son got COVID at school lunch and all 6 of the kids sitting together at the lunch table ended up positive. They were all vaccinated and not boosted yet, as they were 13/14.

Q: What is the science behind now having "day 0" be the day school nurses find out about the Covid case vs. when the student is tested Covid positive or day they begin with symptoms? This is a big change from what we have been doing for 20 months. This seems to be an arbitrary AOE decision. Breena response: day 0 has always been symptom onset OR date of positive test if patient is asymptomatic. It is not the day the nurse finds out about the case

VACCINE FOR AGES 2-4

Q: What are the thoughts on giving the 2-4 vax, even though the data we have now shows the response isn't that great, and they may pass the EAU without the 3rd dose data?
*A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics (verbally): **PERSONAL OPINION**: I think it would be a mistake for the FDA to authorize vaccines in 2-4 year olds if the data presented shows that two dose series doesn't stimulate an antibody response. If that is the case, then what is the role of the FDA. This is a much bigger discussion. Personally, I do not think it would be in the interest of public safety and trust for the FDA to authorize vaccination, even though it is desperately desired, based on data that show that the vaccine does not do what it needs to do. Whether they want to approve vaccinations for 6 months to two year olds and carve out that small sub group that is possible if that data are supportive enough.*
A: Wendy Davis, MD, VCHIP: Ben's summary and other chat comments re: vaccine for younger age group is reflected in national AAP's public comments over the past day or so. We will provide some links in tonight's email. AAP continues to follow, provide feedback, and engage in this national discussion.
A: Ben, I agree. I worry that approving this will really hurt our message.

FEEDBACK ON RUNNING VACCINES COMMUNITY CLINICS

C: Community clinics worked really well for 5-11 vaccine, but this younger age group will be smaller and I feel that we will be able to handle that in clinic. Already doing daily boosters for teens and parents and many new pedi vax during routine visits, also continuing special afternoon "vax clinic hours" 2 afternoons a week, but agree with Ashley about wanting more info about data.
C: Merideth Plumpton, RN, Vermont Department of Health: So great to hear that it is working for your office! Thank you for the feedback. We too want to see the data.

TRANSMISSION OF DATA WITH VT IMMUNIZATION REGISTRY

Q: Any updates on timing of when the VT Immunization registry will transmit data to practices EHR? The amount of staff time that is needed to look at the registry to see if patients have had COVID vaccines and boosters has been tremendous. It would be so helpful to have that information directly come to our practice's EHR.
C: Oh I soooo agree!! We are unable to keep up! So we are unable to use our robo calls to call patients who haven't gotten their covid vax yet.
C: Second, third and fourth this 2-way registry communication!
A: Merideth Plumpton, RN, Vermont Department of Health: We haven't seen all the data that was submitted yet. We were told by CDC multiple times that FDA may not approve the entire age range at this time, we will have to wait and see what happens with approval.
A: Merideth Plumpton, RN, Vermont Department of Health: We can ask the IMR team for an update on that functionality.
A: Monica Ogelby, Vermont Department of Health: Re: bidirectional data between IMR and EHRs: Current estimates are that we will be able to start rolling it out around mid-year. That is our goal and we are on target but like all large scale IT projects, there is always the change things are delayed due to unforeseen circumstances.

Q: Will the IMR/EHR bidirectional data sharing include SNAP, the EHR used by most VT school nurses? This would be an amazing help to school nurses!
A: Merideth Plumpton, RN, Vermont Department of Health Re SNAP bidirectional, great question and one I will pass along to the IMR team for an answer.
A: Merideth Plumpton, RN, Vermont Department of Health: IMR team response to the SNAP question - technically it should be feasible and we'll explore it. Great news!

BOOSTERS

Q: Do you think there will be further recommendations for MRA boosters for adults who got J&J? My other question is regarding the intensity of the line on a rapid test - I assume it doesn't mean anything if it is darker or lighter, just like a pregnancy test. But, I just wanted to confirm so I can best counsel patients and friends (really for friends who send me photos thinking their child is less sick because less intense positive line). Thanks for everything.
A: Merideth Plumpton, RN, Vermont Department of Health: We have been asking about additional doses for J&J recipients and haven't been given any additional information yet. We have lots of providers and patients asking!

RETURN TO PLAY

Q: My concern with the 14 pt AHA screen includes physical exam findings, and I worry by saying it needs to be negative, and not doing the PE that sets up for liability if something is missed, is it possible to word it such that the PE pieces are removed?
Q: What if the AHA 14-element screen is positive due to family history or past medical history (congenital heart disease) - but the symptoms are mild and they are not having SOB/CP, new-onset palpitations, etc. Do they need EKG?
C: Good question and then you cannot check AHA screen normal...

C: For the AHA form, even if we could put a sentence in the mild box stating something like "it is understood that a telehealth visit will not include the physical exam components" and is still adequate

A: Jonathan Flyer, MD, UVM Medical Center, Pediatric Cardiology (verbally): What is bold is what you should focus on. If you're doing this by telemedicine, I would interpret this as you're not examining the patient, you're not held responsible for checking their femoral pulses. We're doing a lot of telemedicine these days. A history of elevated systemic blood pressure in the family or someone having premature death, this is not a reason for our pediatric cardiology service to evaluate someone right now. This is a reason perhaps for a consultation separately but trying to focus on what's COVID related. The AAP did not get rid of the 14=-point AHA screening checklist because this is just the standard for evaluating people clearing for athletic performance.

Q: Also, many patients are feeling fatigued for more than a week, is that moderate disease? They otherwise have mild symptoms that resolve quickly…

Q: Please clarify -under 5yo kids do not need cardiac clearance period; thinking about public pre k 3 and 4 year olds.
A: Breena Holmes, MD, VCHIP (verbally): That is not true. There is no differentiation. Now it is all kids under 12. They just return when they feel better and as tolerated.
Breena clarified on review- I now recall that the original return to play guidance did not include children under 5.
A: Kristen Connolly, MD, Timber Lane Pediatrics (Milton) (verbally): At diagnosis, what we have been doing is giving this guidance. Here is what you need to look for. Sharing this information with families preemptively or you can do it afterwards. I think there are multiple ways you can approach this clinically. It's more about anticipatory guidance in terms of the asymptomatic mild category, under 12 in particular.

Q: Do schoolchildren of any age (say a 7 year old who does not play a sport, but is involved in PE) need this screening? I've seen very few elementary school aged kids requesting that this form needs completed
A: Breena Holmes, MD, VCHIP (verbally): Return to Play was supposed to be done for PE for children, but this has lightened it up now that kids can return when they feel better. The form is a communication tool that is optional because the pathway is between the medical home and parents and teaming with school

nurses to make sure everyone is on the same page. We're trying to deemphasize that the form is a requirement.
A: Kristen Connolly, MD, Timber Lane Pediatrics (Milton) (verbally): That is why I listed a clinician at the bottom really more as a communication tool so if parents choose to share this with the coach or choose to share this with a school so that everyone is in communication. I think that is an individual decision for the family. I think standardizing this across the board and making this a requisite form is really challenging, but I think it's an excellent opportunity for parents to have this form and be able to share it with schools, coaches, and teams. And to keep track of this clinically for our patients to make sure we are screening appropriately and having these conversations and documenting that we've had these conversations.

Q: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics (verbally): Was there any discussion when formulating these revisions with AAP and sports medicine people and the adult cardiology people? The challenge that I'm facing now is the NCAA guidance for return for college athletes is less restrictive than what we're asking pediatricians to do for elementary school kids. There are two competing sets of guidelines, one for college athletes, and one for young kids and the one for kids is far more challenging to implement. I'm not sure what to tell parents when they ask why their college athlete can return to D1 team without doing any of this but their 5th grader has to do x, y, or z.
A: Kristen Connolly, MD, Timber Lane Pediatrics (Milton) (verbally): The good news now is that the 5th grader right now doesn't have to do x, y, or z. At this point, if they are 12 and up, and have had moderate illness, it is a couple of days, very straight forward. The cut off is challenging.
A: Jonathan Flyer, MD, UVM Medical Center, Pediatric Cardiology (verbally): If you could send me the information, I would be happy to look at that. I reached out to the committee and they didn't say who had revised the policy. It was a writing group and it was approved by the AAP executive board.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics:
https://www.amssm.org/Content/pdf-files/COVID19/NCAA_COVID-19_1-13-2022.pdf

Q: Clarification: asymptomatic/mild of any age can start exercise after 5 days (isolation completed, sx resolved)?
A: Yes.

Q: Many patients are still having SOB/cough for weeks after infection. Any tips on how to distinguish whether this is "excessive"?
A: Perhaps impact on daily activities? Agree it is subjective word and decision