"COVID-19 Vaccine Safety, Distribution, and Considerations for Patients," Q&A from Dec. 22, 2020

1. Who will be keeping track of which Vermonters have been vaccinated?
    a. Vaccines input into the Immunization Registry

2. To what extent are physicians being asked to proactively reach out to their patients to urge them to get a vaccine? Or will it be entirely up to patients to take the initiative to obtain the vaccine?
    a. Physicians should discuss the vaccine with patients and post their own vaccination #OurShotVT. While vaccine supply is so limited and we are still working through the prioritization we should educate not encourage.
    b. Doses that went to hospitals is 18,075

3. Will the Department of Health (or any other State government agencies) be contacting Vermonters directly with information about how to sign up for getting the vaccine?
    a. There will be a campaign to let people know when, where/how.
    b. I think the PCPs feel the most anxious and the hospitals are doing it and they will have it done and sorry for the frustration. I think everyone is really eager to hear when we get it. It is really important for physicians to tell the patients they should be getting the vaccine – we should be highlighting the positive and be leaders like that.

4. What criteria should physicians refer to in prioritizing the order in which their patients receive the vaccine? Or will this be dictated by the DOH or other officials?
    a. It is a bit of a relay race – State first and then each practitioner is going to want to encourage each person that fits that criteria to come in and get a vaccination. While the vaccine is limited and while identifying those at risk – the vaccine will not go to every PCP – we know chronically ill like to go to the PCP but how do we look at best way to do it – looking at pharmacies and open clinics

5. Q: Have any persons who had Covid-19 disease subsequently received a Covid vaccine and if so were their reactions to it more severe?

6. Also, should these currently scarce vaccines only be given to persons who have not had the disease as those who have been ill may be naturally immune?
    a. We know people have antibodies for 90 days. There is some wording to consider waiting until 3 months after infection.

7. Q: What is the incidence of reactions to the vaccines 1st dose vs. second.?
    a. Arm pain – the other tangential side-effect is fatigue and chills and that can happen in second dose.

8. A personal question that might also apply to others. I'm 72 now and still doing my solo practice as well as doing Occ Med work at Concentra. Wondering when I might be able to get the vaccine, where and when? I have significant patient contact in both venues. TYVM for any information provided.

9. how is a covid case defined in the studies?
    a. The studies used symptoms and PCR positive to define cases

10. When can primary care offices expect to receive the vaccine (for vaccinating office staff and practitioners)?
    a. Community practices should expect to hear from your local hospital no later than Jan 4 regarding scheduling you or your staff for vaccination.

11. can you describe vaccine efficacy in layman's terms?
    a. Vaccine efficacy is the difference in rate of infection of COVID in those vaccinated vs. those not (placebo).
    VE: If you have 100 cases of COVID in unvaccinated/placebo people and 5 in vaccinated then your VE is: 100-5/100=95%
12. where do inmates of prisons fall in the distribution scheme?
    a. Inmates and others in prison settings are more highly exposed, more likely to transmit, and low to moderate risk of severe disease and corrections of course important to societal function. Adding that up, not as highly prioritized as health care workers or the highest risk community members but I suspect will be prioritized above general public. In VT those later tiers in prioritization are still in discussion so we'll see what the details show...

13. How do you recommend approaching a community hospital that is not appearing to follow these ethical guidelines - keeping doses for themselves rather than sharing with non-hospital-affiliated practices?
    a. Hospitals also received directives from Dept of Health to offer only to hospital staff, EMS and home health in weeks 1&2 - starting community providers in week. We know this is causing confusion and frustration.
    b. @Dayna: Ethical guidance around COVID vaccines is being passed from national to state to institutional leaders so there will of course be some shifts from step to step. No central body can police adherence to those approaches at an institutional level but good dialog can help people and institutions steer true. Very importantly, we'll have to expect people not to leap to conclusions. I've heard from folks who developed grave concerns about some institution's approach based on an anecdote or two when in fact those were exceptions. We'll try to get this right, at light speed, there will be dialog, and we'll all understand that faster distribution is more important than perfect prioritization, i.e. pragmatic decisions about how to distribute efficiently will influence who gets a shot first

14. Do you think that for the benefit of the general population those who have had the covid-19 illness be delayed regarding immunization?
    a. We still do not have good data regarding duration of immunity, other than a general consensus that risk is very low within 3 months of infection. There is an allowance for people to defer vaccination who have had COVID within the past 3 months, but beyond that there is not a general recommendation that people should defer vaccination if otherwise eligible.

15. Can you explain the higher efficacy with lower antigen dose in Astrazeneca trials?
    a. It is a little unclear still how robust those data are. The sample size was small so it could have been an issue of statistical power that will not bear out with greater numbers. That arm also only included people <55 years of age, so again it is unclear if the higher efficacy will be sustained with larger numbers in older patients as well. However, immunologically there is a rationale for why this could happen. It is possible that people could develop an immune response to the adenovirus vector, and that a larger (full) dose of the vector initially might stimulate more immunity against it so that the second dose is less effective. This is an interesting question that will require further study.

16. How long should we wait to vaccinate after shingles episode?
    a. Try to do it two weeks apart – ultimately maybe it will fine – 2 weeks pretty safe window

17. Do vaccines need to be administered exactly 21 (or 28) days apart? Or is this a minimum (and if so, is there a maximum?)?
    a. there is a four-day window for the second dose. I do not know if there is a maximum. I think we have not limited that - but we have yet to give a second dose!

18. Should patients on long term steroid (prednisone) therapy receive the mRNA vaccines?
    a. @Gene: if the benefit>risk, then recommended for all patients with no specific limitations for comorbidities
    b. Thanks Beth, but is there any concern that the vaccine won't be effective in patients on prednisone or other immunosuppressant meds?
    c. we always tell immunocompromised patients that we vaccinate that their immune response to the vaccine may not be as robust or protective. Still, we do not exclude them from non-live vaccines.
    d. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

19. Can patients who are actively ill with SARS Co-V 2 get the vaccine?
    a. Patients who have active COVID-19 should not get the vaccine, they should wait. CDC - "Current evidence suggests reinfection is uncommon in the 90 days after

initial infection, and persons with documented acute infection in the preceding 90 days may defer vaccination until the end of this period, if desired.

20. The allergic reactions in the UK was there one component that seems to be the most likely cause of those responses? How would someone know if they were allergic to a component?