Adolescent COVID-19 Vaccine Co-Administration Webinar Notes

AUGUST 18, 2021

Recognition of past trauma and abuse

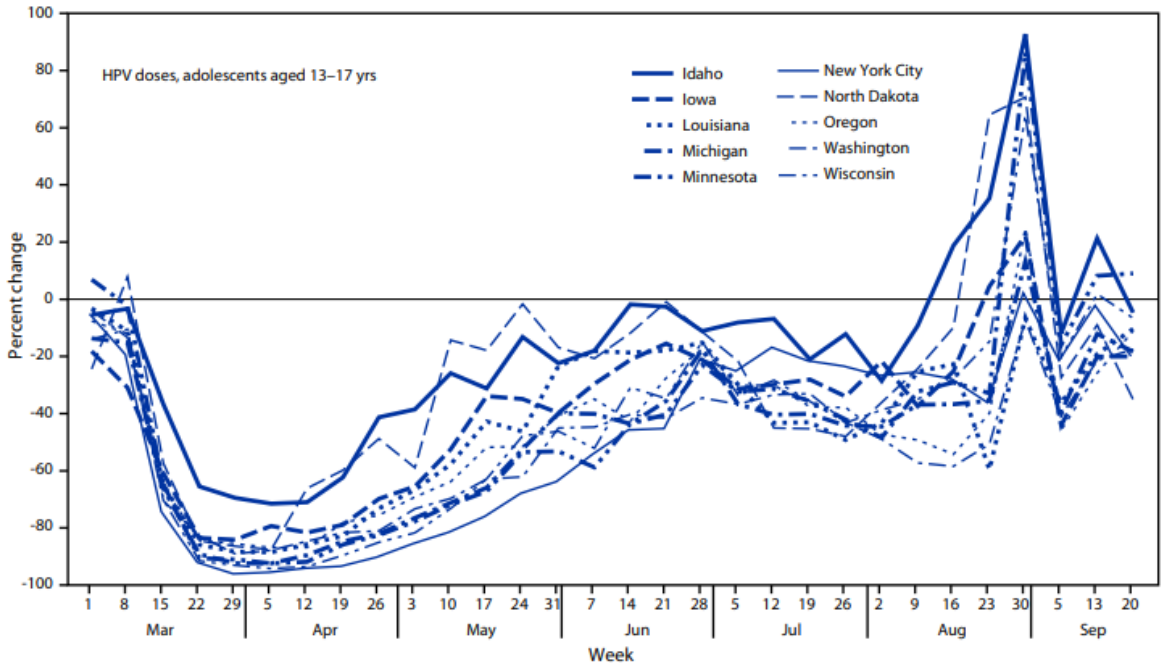
The state of Minnesota and the Department of Health recognize trauma, medical abuse, and discrimination that have happened to our Black, Indigenous, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine and public health.

MDH, local public health, medical providers, and other partners are actively working to rebuild trust with communities and bring community members' voices to the table.

Agenda

- Minnesota adolescent vaccine coverage and COVID-19 case data
- Co-administration recommendations
- ACIP refresher on adolescent immunizations
- Building vaccine confidence
- Co-administration best practices with Dr. Singh
- Questions and answers

Impact of the COVID-19 Pandemic on Administration of Selected Routine Childhood and Adolescent Vaccinations — 10 U.S. Jurisdictions, March–September 2020



Abbreviations: HPV = human papillomavirus; MMR = measles, mumps, and rubella.
* During March–May 2020, eight of the 10 jurisdictions implemented some form of stay-at-home order; no orders were issued in Iowa and North Dakota.

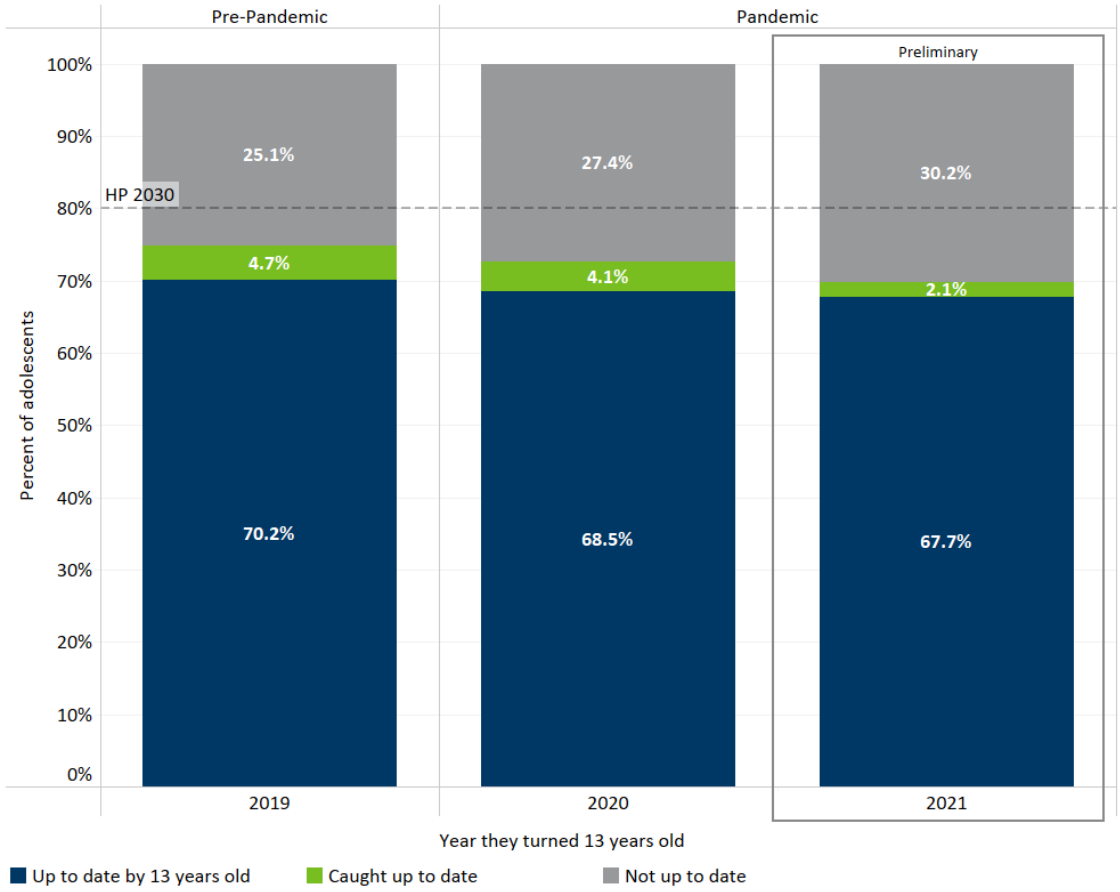
Graph from: MMWR: Impact of the COVID-19 Pandemic on Administration of Selected Routine Childhood and Adolescent Vaccinations — 10 U.S. Jurisdictions, March–September 2020 (www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7023a2-H.pdf)

- After the March 2020 declaration of the COVID-19 pandemic in the United States, an analysis of provider ordering data from the federally funded Vaccines for Children program found a substantial decrease in routine pediatric vaccine ordering.
- Follow-up analysis published in June of this year looked at nine state and New York City's immunization registries and found that fewer administered doses of routine childhood and adolescent vaccines were recorded in all 10 jurisdictions during March–September 2020 compared with those recorded during the same period in 2018 and 2019. The number of vaccine doses administered substantially declined across all vaccines looked at during March–May 2020, when many jurisdictions enacted stay-at-home orders. After many jurisdictions lifted these orders, the number of vaccine doses administered during June–September 2020 approached pre-pandemic baseline levels, but did not increase to the level that would have been necessary to catch up children who did not receive routine vaccinations on time.
- The graphs shows that among adolescents aged 13–17 years, HPV doses administered declined a median of 71.3% during March–May 2020 compared with doses administered during the same period in 2018 and 2019. During June-Sept, among adolescents aged 13–17 years, administration of HPV vaccine decreased a median of 28.1%, when compared to 2018 & 2019.

- Same was seen with Tdap, doses administered during this period in 2020 decreased a median of 61.4% among adolescents aged 13–17 years during March–May 2020 compared with doses administered during the same period in 2018 and 2019. During June-Sept, among adolescents aged 13–17 years, administration of Tdap vaccine decreased a median of 30.0%, when compared to 2018 & 2019

Adolescent routinely recommended vaccine coverage gaps due to the pandemic

Current Tdap/MenACWY vaccination status of 13-year-old children in Minnesota



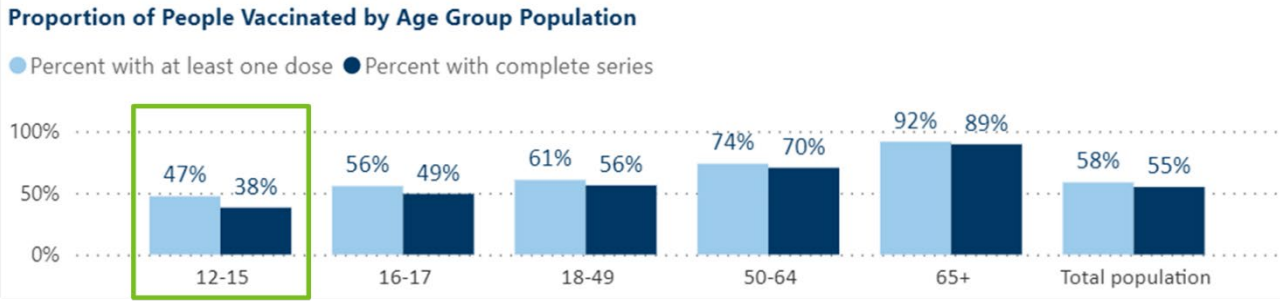
Notes:

- Data are for children who turned 13 years old between 1/1/2019-8/6/2021.
- Tdap/MenACWY: 1+Tdap, 1+ MenACWY.
- Up to date by 13 years: Received Tdap/MenACWY s prior to 13th birthday.
- Caught up to date: Received Tdap/MenACWY as of 8/9/2021.
- HP 2030: Represents Health People 2030 measure for adolescent vaccinations.

- Up to date (UTD) by 13 years rates decreased by 1.7 (2019-2020) and 2.5 (2019-2021) percentage points and the caught UTD rates decreased by 0.6 percentage points from the 2019 to the 2020 cohort.

Adolescent COVID-19 vaccination coverage

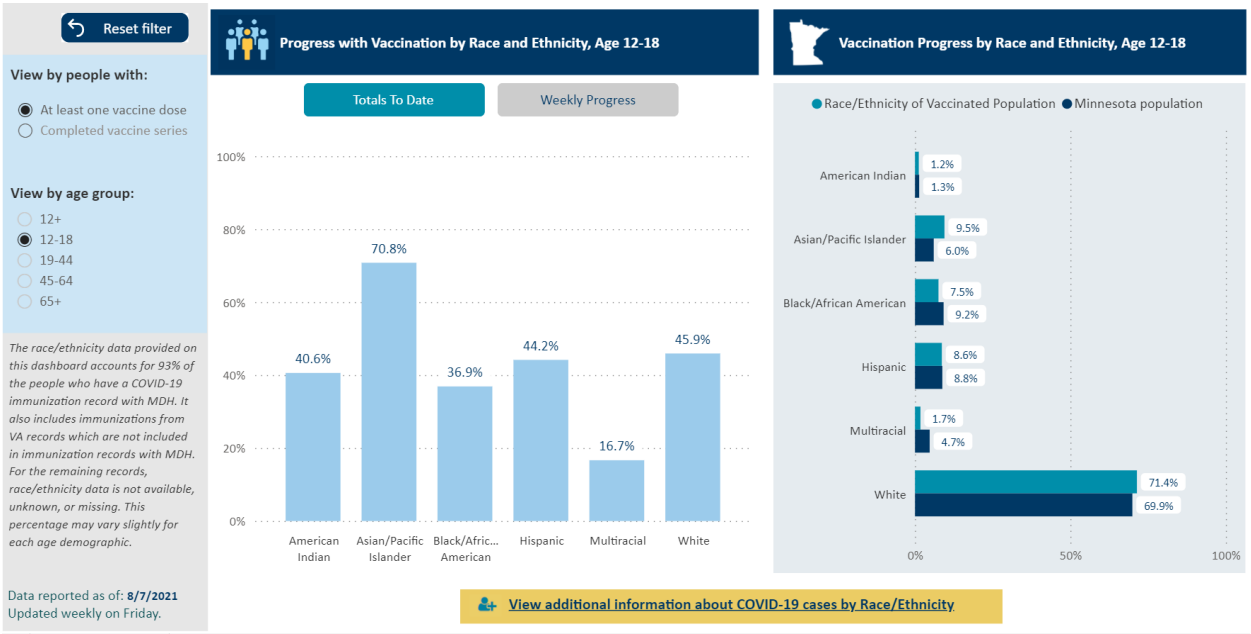
Age group	People with at least one vaccine dose	People with completed vaccine series
12-15	142,411	113,336
16-17	81,591	71,852
18-49	1,416,611	1,307,331
50-64	819,399	780,865
65+	793,795	774,117
Unknown/missing	212	74
Total	**3,254,019**	**3,047,575**



Data updated as of 8/15/2021 and pulled from the Vaccine Data (mn.gov/covid19/vaccine/data/index.jsp) dashboard on 8/18/2021 at 10:30 a.m.

- And although much of the discussion about vaccinating adolescents has been on COVID-19 vaccination rates, overall, we still have a way to go to get our teens protected, especially as they prepare to return to in-person school, sports and social activities.

Adolescent COVID-19 vaccination coverage



Race/ethnicity data from the [Vaccine Data (mn.gov/covid19/vaccine/data/index.jsp).]

- And within our adolescent vaccination rates, we see racial disparities that mirror those we have seen in adults, with Black and American Indian (AI) teens notably less likely to have been vaccinated to date.

Minnesota pediatric COVID-19 stats

- 82,212 cases in ages 0-16
- 749 hospitalizations
- 3 deaths

Q1 SVI (high vulnerability)

Indicator	Number	Percent
COVID-19 Cases	23,645	29%
COVID-19 Hospitalizations	313	42%
COVID-19 Deaths	1	33%
Total Population	340,630	29%

Q2 SVI

Indicator	Number	Percent
COVID-19 Cases	16,938	21%
COVID-19 Hospitalizations	163	22%

Indicator	Number	Percent
COVID-19 Deaths	2	67%
Total Population	237,011	22%

Q3 SVI

Indicator	Number	Percent
COVID-19 Cases	17,994	22%
COVID-19 Hospitalizations	128	17%
COVID-19 Deaths	0	0%
Total Population	245,389	22%

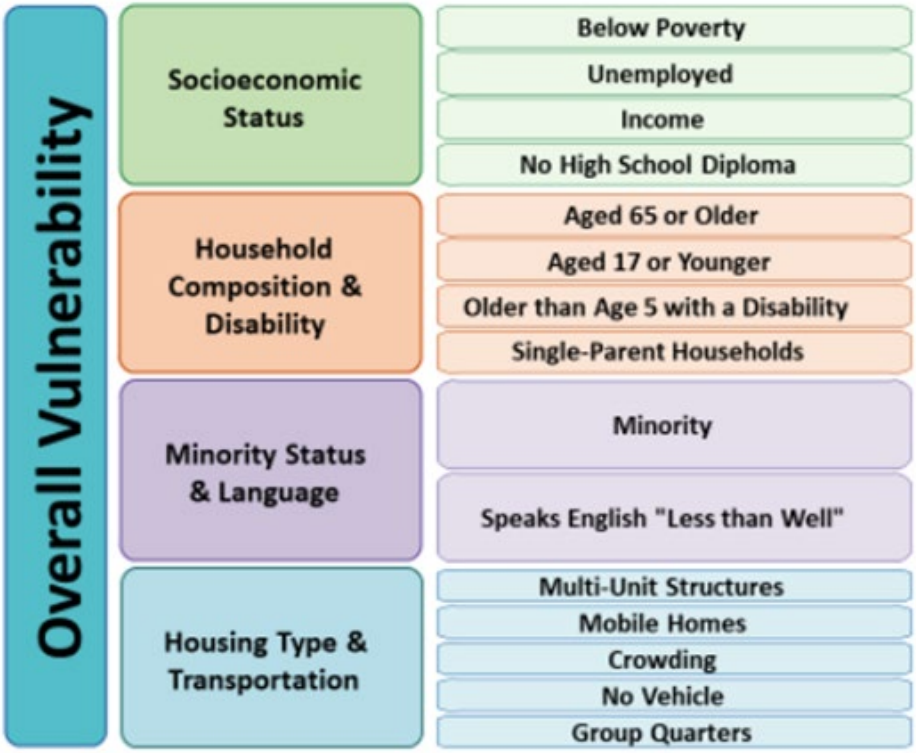
Q4 SVI (low vulnerability)

Indicator	Number	Percent
COVID-19 Cases	23,635	29%
COVID-19 Hospitalizations	145	19%
COVID-19 Deaths	0	0%
Total Population	326,386	26%

Data as of August 10, 2021 - Excluding Long Term Care Residents. Table should be interpreted as N of Y population (X% of Y population lives in respective vulnerability quartile). Data source: 2015-2019 ACS Estimate.

- COVID-19 has and continues to significantly impact the health of our children.
- And when we look at how COVID-19 has impacted our children using our place-based equity metric, the CDC's SVI, we see that the impact has been greatest among children who live in high risk SVI ZIP codes, with children younger than age 17 who live in high SVI ZIP codes in Minnesota experiencing 42% of all COVID-19 hospitalizations to date in their age group.

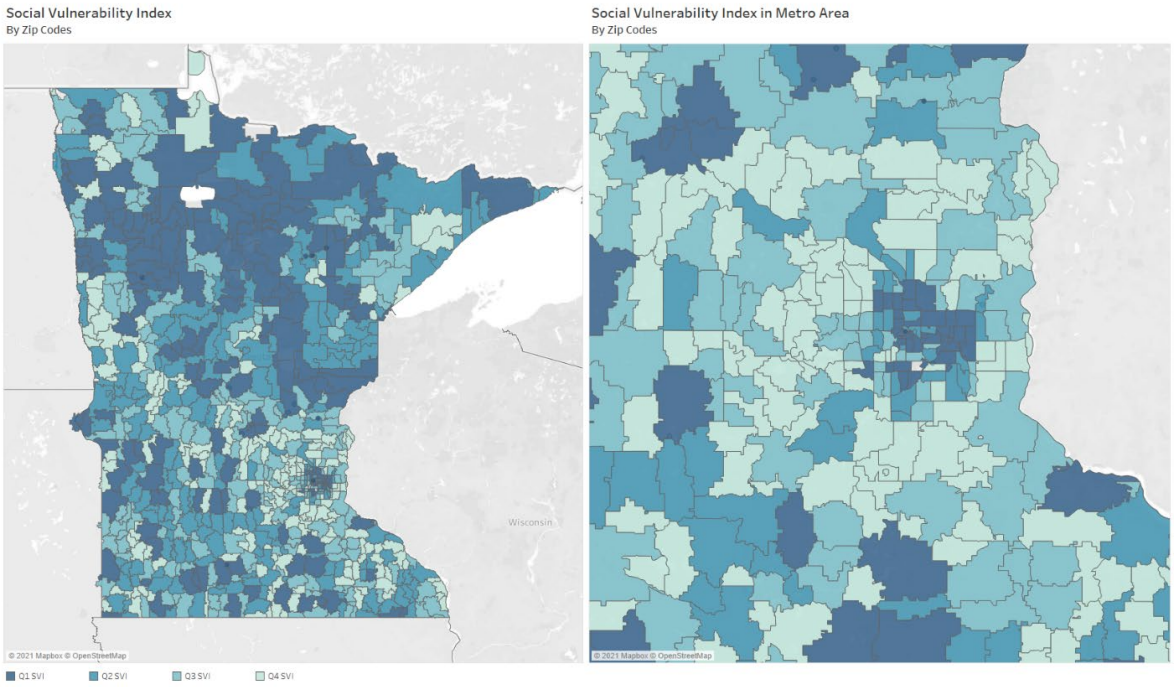
The Social Vulnerability Index (SVI)



- What is SVI?
  - Consistent with MDH's broader equity strategy and Minnesota's FEMA site.
  - LPH used SVI to determine funding for disaster preparedness pre-pandemic.
  - During COVID-19, MDH has used SVI for their weighting formula for COVID-19 funding across the state.
  - Uses 15 different characteries in census tracts – all factors of social vulnerability in an area.

SVI in Minnesota

- ZIP code level SVI selected as equity metric.
  - 65 counties have at least one zip code categorized as Q1 SVI.
  - 52% of Minnesotans in Q1 zip codes are in the 7-county metro.
  - 48% of Minnesotans in Q1 zip codes are in Greater MN.



- In Minnesota, we used SVI for ZIP codes to see how we're doing to reach people.

Demographics of MN SVI ZIP code quartiles, age <17

Race/ethnicity	Q1 SVI (High)	Q2 SVI	Q3 SVI	Q4 SVI (Low)
American Indian or Alaska Native	58%	15%	7%	6%
Black or African American	57%	21%	11%	11%
Hispanic or Latinx	50%	20%	15%	15%
Asian or Pacific Islander	48%	17%	13%	22%
White	22%	21%	24%	33%
Multiple	36%	22%	17%	25%
Other	57%	20%	13%	9%

Demographics of MN SVI ZIP code quartiles, all ages

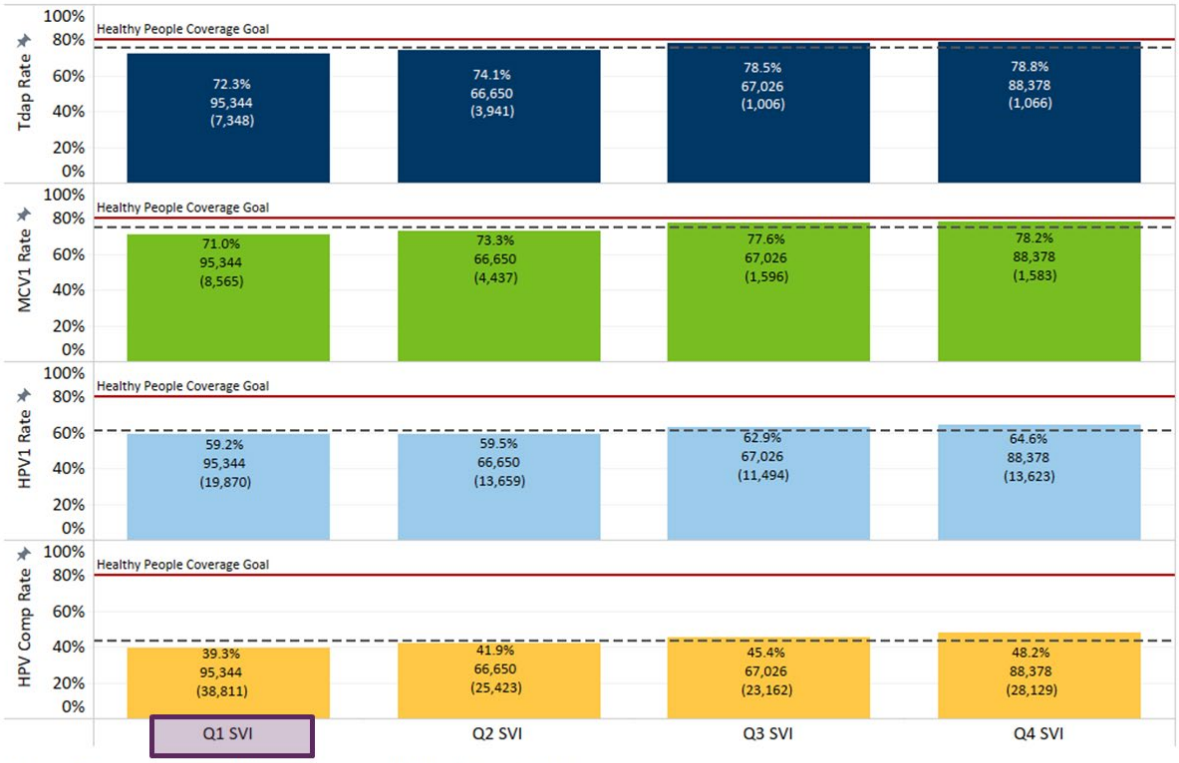
Race/Ethnicity	Q1 SVI (High/most vulnerable)	Q2 SVI	Q3 SVI	Q4 SVI (Low/least vulnerable)
American Indian or Alaska Native	54%	17%	8%	7%
Asian or Pacific Islander	24%	22%	22%	26%
Black or African American	53%	20%	11%	9%
Hispanic or Latinx	47%	22%	17%	14%
White	24%	22%	22%	26%
Multiple Races	35%	23%	16%	20%
Other	39%	24%	14%	20%

Other characteristics	Q1 SVI (High/most vulnerable)	Q2 SVI	Q3 SVI	Q4 SVI (Low/least vulnerable)
Limited english proficiency	59%	17%	9%	9%
Living with disabilities	34%	23%	19%	18%
MN Medicaid/MNCare enrollees	43%	23%	17%	17%
Total % of MN population	29%	22%	22%	26%

Data Source: 2015-2019 ACS Estimate.

- Demographics – gives us a proxy of if we are focusing on these areas, giving more resources to those disadvantaged pops.
- Similar trend when we look broadly at all ages.
- 29% of children live in Q1 SVI but have experienced 42% of hospitalizations.

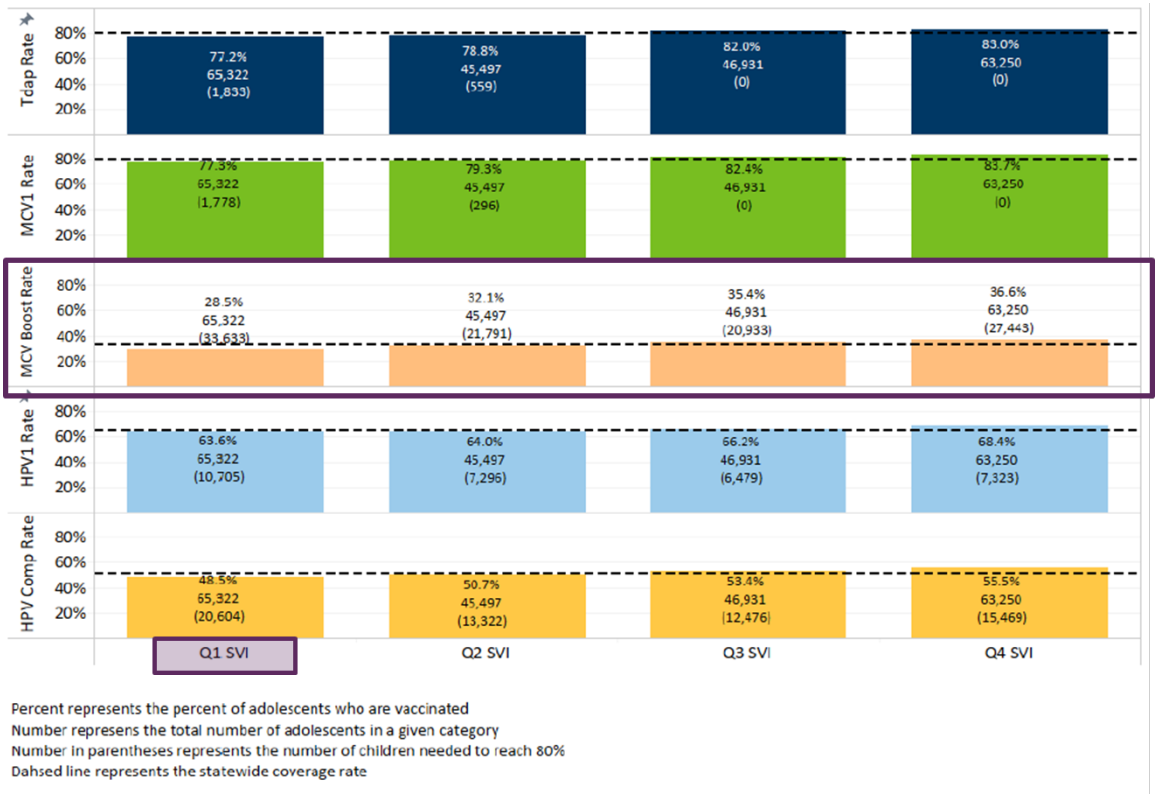
Adolescent vaccine coverage by SVI quartiles (13-15-year-olds)



Reference line represents the adolescent coverage goal for healthy people 2030
Percent represents the percent of adolescents who are vaccinated
Number represens the total number of adolescents in a given category
Number in parentheses represents the number of children needed to reach 80%
Dahsed line represents the statewide coverage rate

- When we look at routine immunization rates for 13-15-year-olds, we see notable gaps in rates along lines of SVI.
- For every immunization, Q1 rates are lower than the statewide average (the dashed line) and notably below Q4.
  - 6.5% lower for Tdap
  - 7.2% lower for MCV1
  - 5.4% lower for HPV1
  - 8.9% lower for HPV complete

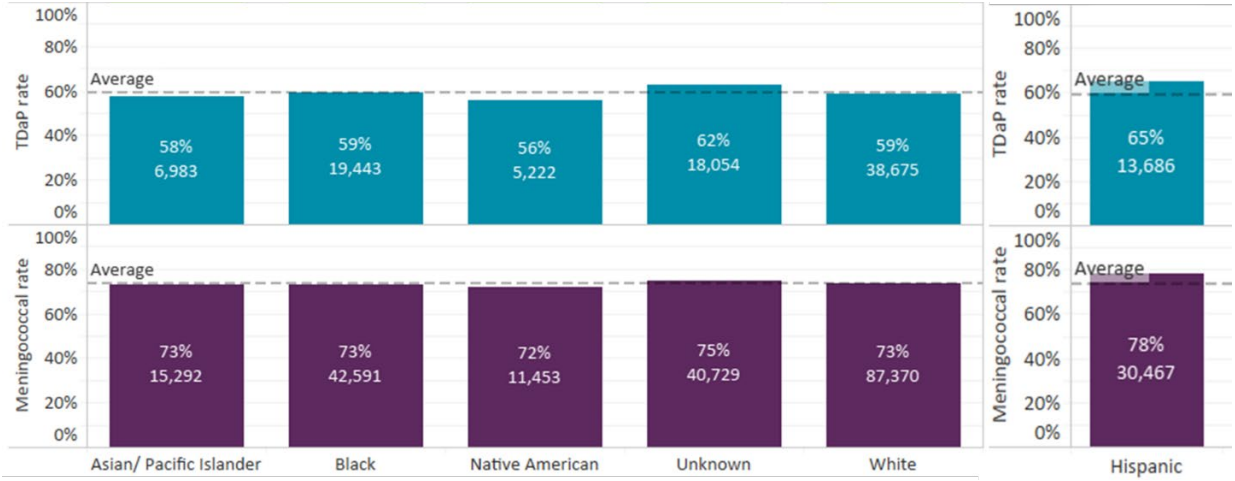
Adolescent vaccine coverage by SVI quartiles (16-17-year-olds)



- We see the same pattern for 16-17-year-olds, although the gaps are narrower.
  - 5.8% lower for Tdap
  - 6.4% lower for MCV1
  - - 8.1% lower for MCV booster (low across all quartiles)
  - 4.8% lower for HPV1
  - 7.0% lower for HPV complete

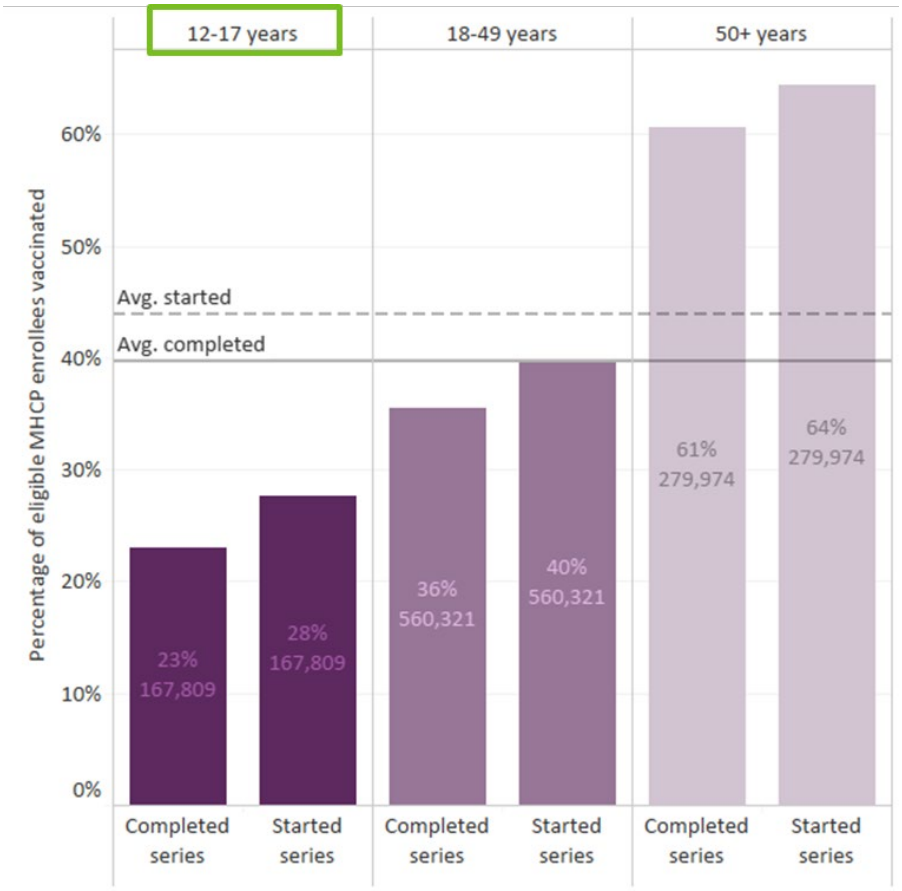
Adolescent vaccine coverage for Medicaid/CHIP enrollees by race/ethnicity

Ages reported here are 11-13 years for TDaP and 11-17 years for Meningococcal



- Because we know families on Medicaid face additional challenges in accessing care and have had a drop in well child care during the pandemic, we also looked at our rates in our adolescents enrolled in MHCPs.
- We see that:
  - MHCP Tdap average is ~59%
  - MCV is ~74%
  - Of note, missing 20% of racial demographic data but only 2% of ethnicity data.
- Statewide data comparison as of 6/30/21:
  - 11-17 yo MenACWY statewide coverage is 67.7%.
  - 11-13 yo Tdap statewide coverage is 56.7%.
  - For TDaP, only children of an unknown race had rates above the statewide MHCP average. Native American and Asian/Pacific Islander children each had below-average rates. Rates for Black and White children did not differ significantly from the average. Overall racial disparities were small.
- Meningococcal vaccination rates were below average for Native American children and above average for children of an unknown race.
- Hispanic enrollees were more likely to be vaccinated than enrollees who were non-Hispanic or missing ethnicity data.

Adolescent COVID-19 vaccine coverage for Medicaid/CHIP



- Similarly, we have looked at COVID vaccination among enrollees as of June 30th. When we look at 12–17-year-olds on Medicaid we see that 28% complete/23% started, while statewide rates on 6/30 for 12-17-year-olds were 41.5% complete/35.2% started.

Be prepared to address COVID-19 vaccine questions

Hopefully, all providers have started talking to parents about getting their own COVID-19 vaccinations to help protect their children. Now that it is their children's turn, many of the same concerns may linger as they weigh the pros and cons of vaccination. People are looking for information from community members they trust.

- MDH has put together What You Should Know About COVID-19 Vaccines (www.health.state.mn.us/diseases/coronavirus/vaccine/vaxtruths.pdf) with answers to common myths and misconceptions about COVID-19 vaccination.
- Consider hosting or participating in information sessions with parents and young teens to address questions and concerns and promote the safety and efficacy of COVID-19 vaccines.
- Offer early morning, evening, or weekend appointments for caregivers to bring in children for COVID-19 vaccination.

- Consider working with schools, other local community organizations, or mobile vaccination units to help facilitate community vaccination drives specifically for children and families from areas with high social vulnerability factors.
- Prioritize those in high-risk ZIP codes for offers of assistance in arranging transportation to the appointment via their medical benefits/health insurance.
  - The user guidance for this function can be found at Client Follow-Up (www.health.state.mn.us/people/immunize/miic/train/followup.html).
  - Identify families that will benefit from interpreter services to schedule and be present at their appointment.
- Reach out to highly impacted communities.
  - Black, Indigenous, Hispanic, and Asian Pacific Islander communities.
  - Children with disabilities.
  - Children with other medical comorbidities per CDC guidance: People with Certain Medical Conditions (www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html).
  - Children from households where the language spoken is not English (e.g., Somali, Spanish, etc.).
  - Children on Medicaid/Minnesota Health Care Programs.

Learn more at Pediatric COVID-19 Vaccination (www.health.state.mn.us/diseases/coronavirus/vaccine/peds.html), under "Reaching the most disadvantaged adolescents."

Minnesota adolescent immunization data recap

- Encouraging news that MHCP tetanus avg is higher than statewide avg, as of June 2021
  - Still see gaps across race across Medicaid enrollees, esp black and AI
    - In your practice, you might need to focus more on specific popuatlions
- June 30, 12-17 yr old, see gaps in statewide avg and Medicaid enrolles for COVID vaccine
    - How can we identify pops who are experiencing gaps?
- Overall decrease in immunizations due to the pandemic
- Teens in High SVI communities have the greatest gaps in routine immunization rates
- Children in High SVI communities are experiencing a disproportionate amount of hospitalization due to COVID-19
- We have a ways to go to get our school age COVID-19 community immunity up
  - We see similar racial disparities in adolescents like we do in adults around COVID immunization

  - Also see a gap among adolescents on Medicaid
- Providers can do a lot to decrease barriers to access and proactively address disparities!!
- Similarly we have looked at COVID vaccination among enrollees as of June 30th. When we look at 12-17 year olds on Medicaid we see that… 28/23% while Statewide rates on 6/30 for 12-17 = 41.5/35.2%
- Hopefully, all providers have started talking to parents about getting their own COVID-19 vaccinations to help protect their children. Now that it is their children's turn, many of the same concerns may linger as they weigh the pros and cons of vaccination. People are looking for information from community members they trust.
- Offer early morning, evening, or weekend appointments for caregivers to bring in children for COVID-19 vaccination.

Co-administration recommendations

- CDC recommends adding COVID-19 vaccine as part of regular, on-going vaccination.
- ACIP recommends use of COVID-19 vaccines for everyone ages 12 and older within the scope of the emergency use authorization for the particular vaccine.
- COVID-19 vaccine and other vaccines may be administered on the same day.
- Learn more at CDC Birth-18 Years Immunization Schedule (www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html).
- COVID-19 vaccines and other vaccines may now be administered without regard to timing.
  - Includes simultaneous administration of COVID-19 vaccine and other vaccines on the same day.
    - Or any amount of time between other vaccines. Someone could get a COVID-19 vaccine in the community and then come in to the clinic a few days later for other vaccines.
  - Let people know of potential for increased reactogenicity when receiving vaccines known to be more reactogenic, such as adjuvanted vaccines or live vaccines with COVID-19 vaccines.
  - It is unknown whether the reactogenicity of COVID-19 vaccine is increased with co-administration – new data expected from CDC.
  - There may be significant pain/redness/swelling at the injection site and other systemic reactions.
  - When administering vaccines that may be more likely to cause a local reaction, administer them in different limbs when possible.
  - Learn more at CDC: Interim Clinical Considerations for Use of COVID-19 Vaccines (www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Coadministration).

- Make sure you are using the most current Vaccine Information Statements (VIS), many were updated on August 6, 2021.
  - Find them at CDC Vaccine Information Statement: Current VISs (www.cdc.gov/vaccines/hcp/vis/current-vis.html) or IAC Vaccine Information Statements (www.immunize.org/vis/).
  - Use the EUA fact sheet for recipients and caregivers for the Pfizer COVID-19 vaccine (find it at Comirnaty and Pfizer-BioNTech COVID-19 Vaccine (www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine)).

ACIP refresher on adolescent immunizations

Routine recommendations:

- 11–12-year-olds: Tdap, HPV (2 doses) and MenACWY vaccines.
- 12-year-olds and older: COVID-19 vaccine.
- 16-year-olds: MenACWY vaccine.
- Every year: Flu.
- 16-18-year-olds: offer MenB.
  - Shared clinical decision making for adolescents not at increased risk.
  - Routine for children with increased risk (e.g., asplenia or complement disorders).
  - Refer to the CDC 2021 Recommended Child and Adolescent Immunization Schedule for routine, catch-up and high-risk vaccine recommendations (CDC Birth-18 Years Immunization Schedule (www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html))
  - Also, refer to MDH's Teens Need Vaccine, Too! (www.health.state.mn.us/people/immunize/basics/teens.pdf) document to see which vaccines are required for school in Minnesota.

Adolescent immunization provider resources

- www.wevaxteens.org is a one-stop-shop for adolescent immunization health care providers.
- Has resources to support making a strong recommendation for adolescent immunization, including addressing families' questions and concerns.

Announcement style vaccine recommendation

"Now that Sam is **12**, there are **five vaccines** we give to young people her age. **Today**, she'll get the COVID-19, influenza, meningitis, HPV, and Tdap vaccines. We'll give those at the end of the visit."

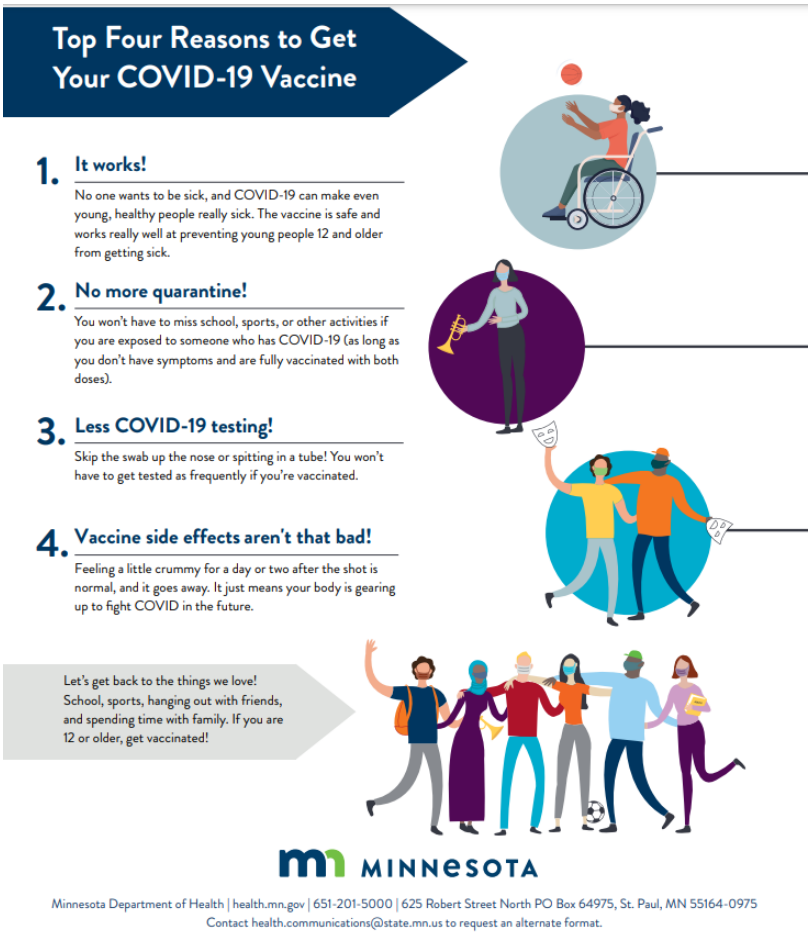
- In an announcement recommendation, you presume the parent will follow your recommendation, which is standard of care.
- Elements to include in this announcement recommendation are:
  - Noting child's age.
  - Announcing the child is due for five vaccines recommended for children this age, placing HPV vaccine in middle of list.
  - Recommending HPV vaccine the same way and with same-day vaccination.
    - Many providers assume parents will be hesitant about HPV vaccination and this assumption may affect how they recommend the vaccine. If the vaccine is recommended differently or in a more conversational style, this invites the parent to question the vaccine.
      - Role playing can be helpful to make sure you are not giving any verbal or non-verbal cues that might elicit a parent to second guess your HPV vaccine recommendation.
  - Moving on with the visit.

Addressing vaccine questions and concerns

- Most parents will accept an announcement style recommendation for all the recommended vaccines.
- Asking questions does not mean vaccine hesitancy or refusal. Do not assume that asking questions about the vaccine means the parent is vaccine hesitant or will refuse vaccination.
- Many parents want you to listen to their concerns and provide reassurance.
- If a parent refuses, use a vaccine hesitancy communication model like C.A.S.E. (**C**orroborate, **A**bout Me, **S**cience, **E**xplain/Advise).
  - And remember, minds can change as parents and patients learn more about the vaccine so never assume a refusal means they will never vaccinate.
- Continue to recommend vaccines at subsequent visits.
- Most parents will accept the bundled recommendation without questions or concerns.
- Important to listen and try to identify parents' main questions or concerns.
- Many parents just want additional reassurance from their child's physician that you think this vaccine is necessary.

Vaccine confidence

- Top Four Reasons to Get Your COVID-19 Vaccine (www.health.state.mn.us/diseases/coronavirus/vaccine/vaxteen.pdf) speaks to youth's desires and why they might want to get vaccinated.



- Find more resources for patients at [About COVID-19 Vaccine (www.health.state.mn.us/diseases/coronavirus/vaccine/basics.html)](www.health.state.mn.us/diseases/coronavirus/vaccine/basics.html).

Co-administration discussion with Dr. Singh

- A bit about Dr. Singh: Dr. Andrea Singh, MD has been a pediatrician at Park Nicollet Health Services since 2005. She has been Chair of the Park Nicollet Pediatrics Department and Co-Chair of the Children's Health Initiative for HealthPartners since 2017. She is a past Clinical Medical Director and currently a Medical Advisory Board member for virtuwell, as well as a medical advisor for Make-A-Wish of Minnesota. She currently serves on the Board of Directors for the MN American Academy of Pediatrics and also as an appointed member of Governor Walz's Children's Cabinet Advisory Council.
- She grew up in Minnesota, attended the University of Minnesota for both undergrad as well as medical school and completed her pediatric residency in the Bronx, New York.
- She is the mom of two fully vaccinated boys and currently has her clinical practice at the Park Nicollet clinic in Lakeville.

Three simple things we can do to support co-administration

Make it easy

- Process really matters. Whether you are in a health system or a community pop up clinic
  - How can it be seamless for parent and child? From the moment they step in, to getting their questions answers, to getting the dose, to setting up a second appointment.
- Parents' of adolescents lives are filled with competing priorities, no matter the SVI.
- Ask yourself: How can we minimize wait time? How can we prep them for side effects? How can we get them the biggest bang for their buck in terms of health care (offer other things at the same time of the visit)?
- How can we overcome the barriers that some families face? Such as transportation, language, cost (making it clear that no insurance is necessary for COVID-19 vaccine), and/or literacy (how can we explain them in a way that is understandable? Medical information is hard to understand for a lot of people.
- Network with operational teams, think beyond just what the clinician/provider is doing.

Make it relevant

- Good to focus on what is important to the adolescent. Many are very self-centric – how will this affect me? It's good to go through the info with them (like the youth COVID-19 vaccine flyer linked aboove). Help them understand the impact of them getting vaccinated, such as how they will protect little siblings (this is a big motivator), no quarantine, no testing, etc.
  - Try to hit on motivations that often drive their clinical decision making (especially when you know the family).
- Ultimately it is the parent's decision, but it is important to have buy in from both. Buy in from the adolescent can help move a parent who is on the fence.

Make it clear

- Really important as the expert/clinician that ***you*** recommend COVID-19 vaccines and co-administration with other vaccines.
- Also really important to help people understand what their particular fears *are* (such as for HPV or COVID-19 vaccine).
  - People will come in and just say "I'm not sure. I've read some stuff. I've seen it on social media."
    - Ask them, what have you heard? What is making you nervous?
- Parents want the best for their kids. They don't want to make mistakes that adversely affect their kids. It can be really scary when things are newer. Parents need to know that the decision they're making is the right one, and it is backed by science.

  - And you can address those concerns/questions head on.
- Fertility is a big concern, especially with young girls. You can be upfront about the lack of data; talk about where the myth came from; talk about people who have gotten pregnant after being vaccinated, who were pregnant and vaccinated, and all the positive health/birth outcomes thus far.
- Kids think, it's not really necessary. Or that side effects are worse if you've had it. Have the data/information ready to share with them on why it *is* important to get vaccinated.
- Success story: A family that Dr. Singh has known for a long time came in. Son is 12 years old; sister is under 12 years. They asked a lot of question (remember, doesn't mean they aren't going to get vaccinated!). After talking, Dad said "sounds great, let's do it. Can I get it too?" The dad is offering moral support to his son and both were able to get it at the same time, even though the dad didn't have an appointment, they fit him into the schedule.
- Now is a huge opportunity to capitalize on momentum as people are more interested in the vaccine right now. Kids can be advocates by telling their friends getting the shot wasn't that bad.
- It's doable, worth it, and an important part of our practice/work!

Outreach strategies/ideas

- For addressing overdue vaccines: can use Epic/HER to know when a health maintenance is overdue.
- Centralized outreach to address overdue vaccine is another great strategy. Think about what method will work best. Such as phone calls, texts, etc. Also think about where there are resources/manpower in the clinic to execute something.
  - Dr. Singh's practice has found a lot of success in targeted outreach for folks that are overdue.
  - Reminder resources have also been really helpful.
- Another thing to leverage in vaccine outreach: Leverage other pieces of the care system to identify when kids are due – it doesn't all have to live in primary care. For example, work with dental partners – people go in for six-month dental appointment but won't go in for second HPV shot, for example. Urgent care partners are another great idea.
- Partner with local schools.

Minnesota Department of Health
Immunization program
www.health.state.mn.us/immunize

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