

**MNCYN Regional Perinatal & Paediatric
COVID-19 Update
February 2, 2022**

1500-1600
WebEx

Moderator: Kerri Hannon (MNCYN)

Present: Gwen Peterek (MNCYN), Kristine Fraser (MNCYN), Crystal Turner (Stratford), Andrea McPherson, Angela Stuyt, Cailin McMeekin (Owen Sound), Lynanne Mason (LHSC), Heather Christie (Owen Sound), Kelly Barzsa (Cambridge), Lindsey Rae (Thunder Bay), Michelle Barton-Forbes (LHSC ID), Stacy Laureano Steele (LHSC), Jackie Mitchell (St. Thomas), Katie Forbes (Thunder Bay), Kirsten Blaine (Stratford), Michelle Basacco (LHSC), Teresa Bruni (Thunder Bay), Sharon Johnson (Walkerton), Angela ?? (Tillsonburg), Anita Bunnie (MNCYN), Sheila Johnston, 2 unidentified people on the phone.

Item #1: Welcome/Regional Updates, COVID-19 Cases (Kerri Hannon)

Welcome to everyone attending today. It's been a month since our last connect. In terms of the agenda today, we're going to change it up a bit and ask for someone at each hospital site to share what challenges they're seeing and also if there are any plans or discussions underway for COVID recovery.

MNCYN Work Plan – our Team has been working on an updated MNCYN work plan for fiscal 2022-23 year, with COVID planning and COVID recovery being the focus of the work plan. We have come through almost 3 years since COVID began and some things have been pushed to the back burner and can probably use some attention now. We have cleared our agenda and are looking at how best we can serve the region. A poll was sent out recently asking for your input on identifying your most pressing education needs. In many cases, where there are issues with basic standards of care, or different hospitals are at different stages of progress, it is useful to go back to basics. Please reach out if we can assist as we are able.

Ontario Health West (OHW) Paediatric Escalation Group – you will have been receiving communications from me (Kerri). We are now heading into the 3rd week since children returned to school. Usually, we look at trends occurring 3 weeks post school, as that is when illnesses tend to show up. We are following our school age children and basing data on inpatient stats. Things are looking good across the region in terms of access and flow, but 1 more week's data will be more useful.

We are looking at the dashboard that we rolled out, via CritiCall and PRHS data. We have been looking at other ways to poll this data in a more efficient way, rather than gathering it manually. To that end, we have reached out to CritiCall to see what can be put in place. Every year we see a surge with Paediatric admissions, so this system will be useful gathering this data even after COVID.

Provincial rollouts – The Safe Administration of Oxytocin toolkit was released and a webinar is

planned. We hope to offer some education sessions as well. A Webinar is planned for March 7th from 12-1pm to outline the toolkit and its use.

- **Health / Human Resources** - Lots of discussions are taking place at Level I centres, in particular re Health and Human Resource services. We need to ensure adequate capacity for all levels of care. Provincial Council raised this and has taken it to the MOH. They are inundated with HHR issues across all sectors, but we don't want to lose sight of this discussion. One of the key points will be looking at all of the education and how to bring education under one umbrella and ways to make it more robust and more available.

Kelly Barzsa (Cambridge) – like everyone else, we are experiencing staffing issues, difficulty with base staff, with lots of staff job openings. We have worked on how can we move forward with a plan for the day. One solution was to have an evening huddle in pm to plan for the daytime shift. In other changes, we removed a tub room that was not being used and turned it into a Triage room to help with flow in the Triage dept. We are now working on an alternative model of care.

Item # 2 COVID Recovery – Round Table question: Where are people at with COVID recovery planning?

- Heather Christie (Owen Sound – Level II) – we are a mixed unit, L&D, Gyn/Surgery, Paeds. We are just trying to get through the staffing issues. Haven't worked through yet any recovery plans. One thing that seems to be trending is that some nurses have taken up travel nursing, thus, giving up their full time lines, but also aware that there will be positions available for them when they want to return.
- Crystal Turner (Stratford – Level II). Not COVID related, but our new Sensory Room is being installed, so that's exciting. At the end of March we had an increase of beds, so we moved our paeds unit and we're currently planning for what we want to see with that. We moved the Triage area as well into a 3-bed ward space, but we haven't felt that loss as yet. The existing Triage room was turned into a resuscitation room, and this change will be helpful for flow.
- Leanne Paton (Woodstock – Level I) – we're just trying to get through the day today; dealing with staffing issues all day. The biggest news here is that we have hired a new Chief of Paediatrics, Dr. Hasan El-Shabanah. We have also recruited another Paediatrician, who is also a Neonatologist, who will, hopefully, assist with outpatient clinics. We still have to decide what day and where the clinic will be, but for now, it will be 1 day/week. We continue to recruit more paediatricians, but we are so happy and very much looking forward to a paediatrics program.
- Katie Forbes (Thunder Bay – Level II) – We don't have any data on current numbers, but something new at Thunder Bay involves a few staff resignations. They are leaving acute care and we suspect there will be more. Regarding Paediatric status, we are having a bit of a surge right now, with several respiratory patients, including 5-6 COVID positive children. We are reviewing work flow daily. It remains challenging, but we are striving to work through it. Post COVID planning – there haven't been any discussions just yet. We have become comfortable with the current day-to-day situation and it is our belief that some of these processes and structures will be staying with us long term.

Dr. Teresa Bruni (Thunder Bay) Our outpatient department has been spacing out a bit,

but still surging. Lots of RSV and other viruses. We function as a unit with flow of staff. I think the lull is not yet on our radar.

- Jackie Mitchell (St. Thomas – Level II) – We haven't yet started post COVID planning. We are currently dealing with the need for NRP instructors. We received funding to purchase obstetrics mannequins, so we will be planning obstetric emergency workshops.
- Stacy Laureano Steele (LHSC-Level II-III) – some projects that had been paused are now being looked at to begin again. This will be good for staff morale; it gives people hope that there is more than just day-to-day drama.
- Lynanne Mason (LHSC Children's -Level II-III) – This is very different from other waves, because the Master plan has to continue that initial work, in addition to COVID plans. Paeds surgery will start to build again. We are still working mostly day-to-day staffing. There has been a rise in the COVID patient population in the past few months. There is also concern about the long term fall out, so we've been working with ID team for those patients that will require longer term support. We are also leveraging virtual care as much as possible where it can be supported.
- Angela (Tillsonburg – ED only)– We don't have inpatient paediatrics or Mat/newborn, but we like to participate in these sessions to have an understanding about what is going on in the region. We do reach out mostly to London for RSV and Emerg department patients.
- Sharon Johnson (Walkerton – Level I) Primary obstetric barriers are our staffing issues ie. not being able to fill base staffing at times. Overall, we are just starting to open up services in lab and DI departments.

Discussion: Update of Current COVID-19 Cases Within the Region

Michelle Barton-Forbes (LHSC - ID) Currently, we are seeing a lot of children with respiratory issues and children with co-morbidities. Though we say OMICRON is mild, some otherwise healthy people are getting sick with it and some children are very sick. Some have advanced into ICU and challenges to treatment options. There is competition for treatment, heavy load in terms of adults, but when you have a sick child there are challenges as to who is priority for treatment. If we don't manage our sick children well, this will spill over into the news. We want to manage them as well as possible and have the best outcomes. We are thankful for all the physician and nursing players who are making this possible. We are learning on the go in regards to manifestations that we haven't seen, so we are learning more from Omicron that we didn't see with the initial virus. We are seeing more central nervous system complications with Omicron with paediatric patients. Paediatric patients with underlying seizure disorders are presenting with febrile seizures and encephalitis (not generally seen in adults). We are seeing about 25% in the infant population. We don't want to assume a bacterial infection; it could be bacterial and viral infections simultaneously. Some centres have required COVID treatment as their conditions worsened. Awareness of the understanding of the management, time is of the essence in terms of drug management (ie. if parents are desensitized to the seriousness and wait to bring the child in). When talking to families, we were told that they did seek care sooner, but were told that it was okay. Kids who are mild don't need intervention, but you might need guidance from ID. Once you get to moderate and the child needs oxygen, the child will need Dexamethasone, and this is approved. There are biologics approved, but that is for ICU cases. They may require

Dexamethasone and antivirals.

Item #3: MNCYN Perinatal Updates (Gwen Peterek):

PCMCH: COVID Vaccine Information Page:

- Provides a list of resources to help patients and health care providers in the decision-making process related to COVID vaccines
- Among a variety of resources, the Info. Page includes ...

A) Patient Brochure for Pregnant / Breastfeeding Women entitled “I am Pregnant or Breastfeeding: Should I get the COVID -19 vaccine?”

[PCMCH: I am pregnant or breastfeeding. Should I get the COVID-19 vaccine? v. 5 25.01.2022 \(PDF\)](#)

- The information sheet was last updated on January 25, 2022 to reflect the current situation with the Omicron Variant
- It provides basic information to support the safety and efficacy of COVID-19 vaccination during pregnancy and while breastfeeding.
- PCMCH also provides a link for anonymous feedback on the Information Sheet
- PCMCH is collaborating with the Department of Obstetrics and Gynaecology at McMaster University and will use the feedback to determine how many people in Ontario have used the tool, if they were satisfied with its content and/or if it has made an impact on their decision whether or not to get the COVID-19 vaccine.
- Posted on PCMCH website and under MNCYN Vaccination: Patient information tab

B) Link to Provincial Online Vaccine Booking System

- Allows ready access for people to book their COVID vaccine / booster

SOGC:

[MONTREAL | News: Montreal hospital delivers baby to unvaccinated mother with COVID-19, who is now on life support 30.01.2022](#)

- An article from Montreal was recently published citing a case where an unvaccinated pregnant woman at 30 wks. developed COVID required a CS and is now on ECMO.
- It cites Dr. Isabelle Boucoiran, OB/GYN from Montreal who is also a member of the infectious diseases committee of the SOGC
- Emphasizes the need to get across the message promoting vaccination to each pregnant woman who walks through the door
- She states that latest Canadian surveillance data to be published within the next couple of weeks indicates that compared to women of the same age, pregnant women are at six times higher risk of being admitted to the ICU.

CBC News:

[CBC News: Babies admitted to hospital with COVID-19 had unvaccinated mothers 05.01.2022 \(PDF\)](#)

- Six babies under 12 months were admitted at 2 Ontario hospitals since mid-December
- Pediatric hospitals across Ontario are urging pregnant people to get vaccinated because they're seeing an increase in infants hospitalized with COVID-19.
- Since mid-December, CHEO, eastern Ontario's children's hospital in Ottawa, and Hamilton's McMaster Children's Hospital have admitted a total of 6 babies under the age of 12 mo. with COVID. Previously this was a rare event.

- News release came from the two children's hospitals along with SickKids in Toronto and the Kingston Health Sciences Centre.
- Vaccinated mothers can transfer antibodies to their unborn children during the third trimester, offering the child some level of protection during the first six months of life.
- Recommend the pregnant woman and all people living with her should also get vaccinated

Ontario Ministry of Health:

- On Jan. 13, 2022 the province of Ontario widened access to free PCR COVID-19 testing for pregnant people, select unvaccinated adults over the age of 70, and first responders.
- The new guidance from the MOH offers all of these groups, as well as household contacts of essential health care and congregate care workers, a free PCR test if they show symptoms consistent with COVID-19.
- [CTV News: Ontario expands eligibility for COVID-19 testing to include pregnant people, first responders and unvaccinated seniors 13.01.2022 \(PDF\)](#)

National Advisory Committee on Immunization (NACI):

- Public Health Agency of Canada (PHAC) released updated guidance from NACI related to vaccination following myocarditis and pericarditis on Jan. 14, 2022
- It's recommended that until more information is available, further doses of mRNA COVID-19 vaccines should be deferred among people who experienced myocarditis (with or without pericarditis) within 6 weeks of receiving a previous dose of an mRNA COVID-19 vaccine.
- Those with a history compatible with pericarditis and who either had no cardiac workup or had normal cardiac investigations, can receive the next dose of vaccine once they are symptom free and at least 90 days has passed the previous dose.
- Some people with confirmed myocarditis (with or without pericarditis) vaccination may choose to receive another dose of vaccine. In this case, it's recommended that the subsequent dose be Pfizer-BioNTech due to a lower reported rate of myocarditis and/or pericarditis compared to the Moderna.

[Summary of the National Advisory Committee on Immunization \(NACI\) advice on vaccination with COVID-19 vaccines following myocarditis \(with or without pericarditis\) 2022.01.14](#)

Simulation Canada:

- Website that provides links to a variety of Canadian and Australian COVID simulation scenarios including paediatric and obstetrical scenarios
- Link posted under MNCYN COVID website under Simulation Tab

[Simulation Canada: COVID-19 related Education Simulations](#)

Item #4: & MNCYN Paediatric Updates (Kristine Fraser)

1. Morbidity & Mortality Weekly Report from the CDC, January 14, 2022

Risk for Newly Diagnosed Diabetes >30 Days After SARS-CoV-2 Infection Among Persons Aged <18 Years — United States, March 1, 2020–June 28, 2021

<https://www.cdc.gov/mmwr/volumes/71/wr/mm7102e2.htm>

- People <18 years of age with COVID-19 are more likely to receive a new diabetes diagnosis >30 days after infection than those without COVID-19 or those with a pre-pandemic acute

respiratory infection. Non COVID-19 respiratory infections are not associated with an increased risk of diabetes.

- Public health messaging highlights the risks associated with COVID-19 among the paediatric population & are especially important to inform clinicians & parents about possible sequelae (cqwella) of COVID-19. Health care providers should be aware of long-term consequences & monitor persons aged <18 years in the months following a COVID-19 infection for new onset diabetes.

2. National Advisory Committee on Immunization (NACI) Updates

NACI Guidance on the use of COVID-19 booster vaccines for children aged 12-17 years

<https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/guidance-use-booster-covid-19-vaccines-adolescents-12-17-years-age.pdf>

- **On January 24, 2022**, NACI approved their recommendations on the use of booster doses of COVID-19 vaccines in adolescents 12-17 years of age who may be at higher risk of severe COVID-19 disease due to biological risk factors, social risk factors and/or experience systemic barriers to accessing health care.
- Adolescents at increased risk for severe outcomes may include (but is not limited to) those who are: obese, medically fragile/medical complexities (complex chronic conditions, functional limitations, high health care utilization and/or a high need for caregiving, 1 or more comorbidities, neurological disorders, Down Syndrome, and immune dysregulation associated with immunocompromising conditions.

PHAC: Summary of the NACI Statement on January 25, 2022: Updated recommendations on the use of COVID vaccines in children 5 to 11 years of age

<https://www.canada.ca/content/dam/phac-aspc/documents/services/immunization/national-advisory-committee-on-immunization-naci/summary.pdf>

- **January 25, 2022:** NACI's guidance also "strengthened" its previous recommendation for children 5-11 years of age: Now the NACI recommend a complete series with the Pfizer vaccine (10 mcg) **should** be offered to children 5 to 11 years of age who do not have contraindications to the vaccine, with a dosing interval of at least 8 weeks between the first and second doses.
- **NACI now also recommends** Children 5-11 years of age who are moderately to severely immunocompromised should be offered a three dose primary series of the Pfizer vaccine (10 mcg), using an interval of 4 to 8 weeks between each dose.

3. Children's Healthcare Canada Immunizing Children with Confidence Conference, January 27, 2022 Speaker: Fatima Tokhmafshan: Geneticist, Director of Community Outreach Lead

COVID-19 <https://www.childrenshealthcarecanada.ca/vaccination-conversations-program>

- Very good ways to engage parents who believe they should just allow their child to get COVID (natural immunity), often stating “infections are mild anyway, not a lot of kids end up in hospital, etc.”
- **Infection-generated or natural immunity versus vaccine-generated immunity:**
 - Vaccine generated immunity is like using a smoke spray to test your fire alarm while infection-generated immunity is like setting fire to your couch to test your fire alarm system!
 - Infection can cause a cytokine storm that is synonymous with the downstream effects of the virus that are triggered in the body. The scale of using the smoke spray is not even comparable in nature.
 - Vaccine-generated immunity offers a more standard & predictable immunity among everyone. Protection from an infection varies greatly & depends on how much virus you are exposed to, how the body reacts to it & how sick you feel after.
 - **Relatable analogy:** Viral infection is similar to giving students different materials to study for the same test: some kids may receive a single page, others may receive a blank page and others may receive an entire textbook. Vaccines on the other hand, provide a standard dose which is like giving all students the same amount of material to study for the same test.
- Fatima suggests using a hook line such as: ‘Did you know the molecule the virus needs to enter cells can be found in a number of different organs and it can cause a lot of different complications, many of which are not visible right away’ (Diabetes)
- Infection & disease are not natural states, we have seen this impact by a number of emerging studies monitoring post-acute infection & symptoms of acute infection (Long-COVID) & how people of different ages are fairing. We do see COVID-long haulers with kids. The most common S&S being cough, sleep disturbances, rash, abdominal pain, chest pain, body aches, decreased appetite & weight loss – sometimes seen for weeks & even months after infection
- When asked about newly emerging information about Diabetes & COVID, Fatima stated Omicron mutations have changed the biology of the virus: Strongly binds to the ACE2 receptors, and there are plenty of ACE2 receptors in the pancreas, so it’s not surprising it can induce Type 1 diabetes. The amount it can was a bit of a shock, it isn’t good news! HCP should be aware of it and have it in their minds, especially if the child has a history of prediabetes, important to do the proper checks.
- **Another argument anti-vaxers make is:** vaccines do not stop transmission & therefore they are not useful so what is the point of them.
 - Though the vaccine doesn’t stop transmission, they do in fact reduce the disease symptoms, so you will not cough or sneeze as much, therefore the number of particles you are exuding is less.
 - As the virus gets integrated, you have your virus specific T-cells & other immune molecules that come in and interfere with the virus’s ability to copy itself.
 - In fact, we see vaccinated people infected with ancestral virus shed fewer viral particles.

- **Side Effects of Vaccinations:** Vaccines cause myocarditis is another claim
 - Recent data shows that the likelihood of myocarditis post COVID infection is 30x higher than post-vaccination. To put into context: chances of head injury without a helmet are 150/100,000 versus <0.3-5/100,000 with a helmet.
 - Risk of MIS-C post-infection is approx. 150x higher than the risk of post-vaccination hyper-inflammatory syndrome. Number of data sets coming out showing the vaccine decreased the chances of MIS-C by 91%. Recent study from Israel shows vaccination is associated with lower frequency & shorter term effects of long-COVID symptoms.

There are several resources available debunking many of the myths & false information that is spreading about the vaccine and COVID-19 in general.

One of the most common false claims anti-vaxers or COVID deniers use is 'there are more vaccinated people in the hospital with COVID-19 than unvaccinated'. The Eastern Ontario Health Unit produced a short video on the concept - called Base Rate Fallacy. We have posted this link on the MNCYN website along with many other resources: <http://ow.ly/wpsk50HJnfJ>

Another excellent resource is the ScienceUpFirst Twitter feed which is a group of Canadian researchers & health care experts sharing good science to stop misinformation.

https://twitter.com/ScienceUpFirst/status/1488214801641840647?ref_src=twsrc%5Etfw%7Ctwcamp%5Etweetembed%7Ctwterm%5E1488214801641840647%7Ctwgr%5E%7Ctwcon%5Es1_&ref_url=https%3A%2F%2Fwww.scienceupfirst.com%2Fproject%2Fare-you-getting-the-full-picture%2F

Discussion: Michelle Barton-Forbes (LHSC ID): as soon as the child is no longer infectious, you can get the vaccine, but we are now saying 4-6 weeks after infection. So, there is no rush to do it 10-days after, as that will be a suboptimal boost and will have a longer sustained antibody rate. We need to get the word out to wait the 4-6 weeks. Just had approval for a publication on CMHC that is coming out shortly, which will show what happens with each variant that will be useful and will support pushing the vaccine.

Item #5: Paediatric Regional Q & A and Open Discussion

Will meet in another month, unless there is a need to meet sooner in order to disseminate updates based on new updates.

Adjourned: 1600 hrs.