

VCHIP CHAMP VDH COVID-19

March 30, 2020 | 12:15-12:45pm Call Questions and Answers*

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Practice Implementation Strategies – David Rettew, MD, Update on Mental Health Services from DMH

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Major preparations for COVID-19 surge across the state:

At DMH, we are doing contingency planning for mental health services statewide. Woodside is in the process of being converted to an adult inpatient psychiatric unit for COVID-19 positive patients. The youth have been moved out, and it will be staffed by UVM/UVMMC psychiatry staff. The Brattleboro Retreat offers a large campus with auxiliary buildings, which will be used for children and youth who test positive for COVID-19 and require inpatient psychiatry services.

Preparations and changes are also taking place with children in residential programs. While the recommendation for positive COVID-19 cases involves isolation in rooms, for children with behavioral challenges or developmental problems, it's not always possible. Goddard College near Montpelier is being converted into a COVID-19+ residential facility. Some designated agencies (DAs) have their own plans locally. For example, the Howard Center is sending COVID-19+ adults, and possibly children, to Rock Point (an alternative school campus in Burlington). DMH and DCF also discharged youth from residential units who were moving toward discharge, and they are now back in the community. Residential units are experiencing severe staffing shortages as well.

Community mental health centers (Designated Agencies, or DAs) are also experiencing staffing shortages, including many staff members calling out due to COVID-19. The DAs have been retraining staff whose regular work assignments were disrupted. For example, if staff members primarily worked in schools, they are now being retrained for priority areas, such as crisis. As many services as possible are being provided via telemedicine.

For voluntary inpatient admissions, DMH also put processes in place to try to keep youth out of the ED. Hospitals are relaxing some of the labs requested for medical clearance. Many youth can now be cleared in outpatient settings. The number of kids in mental health crisis is dropping right now, so there are not a lot coming to EDs or other places.

Mental Health Resources:

DMH posted mental health resources in response to COVID-19 at <https://mentalhealth.vermont.gov/coronavirus-and-our-mental-health>. Including SAMHSA's national TalkWithUs hotline for people experiencing stress due to COVID-19 or other natural or human-caused disasters. Additional local resources include calling designated agencies, 2-1-1, and a new program in

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Chittenden County called Partners for Access, which offers a central clearing house for private therapists and is intended to save families from making multiple phone calls.

UVM child psychiatry remains open, but has transitioned to telepsychiatry. Many UVM child psychiatrists will be staffing the Woodside unit. In addition, some child psychiatry fellows will be spending time on Baird 5 to support pediatric staff on the units during this time. The consultation line remains open for primary care consultation. Call 802.847.4563 or email eliza.pillard@uvmhealth.org. Many private therapists are still open and seeing clients via telemedicine/phone. At this point, there seems to be availability.

Suggestions for coping during the pandemic:

These are the general coping strategies we commonly offer. They are intended to help families currently juggling telecommuting, homeschooling, and living in close quarters. It's possible these circumstances may lead to conflict and possibly abuse. Physical activity for children is really important, especially since they will be spending more time on screens. Slacking of limits is okay in times of crisis, but it can get excessive if families not following through on lesson plans. Parents should try to wake kids up at a decent hour, have them get dressed, and adhere to a regular school routine as much as possible. It's touch dichotomy between how hard some people, like healthcare professionals, are working, while others are being told to stay home. Encourage your families to contribute and think of ways they can help other people, either by donating money or doing things to help others in the community. This mentality shifts us away from individualistic behaviors like hoarding.

Questions/Discussion

Q: Any suggestions about cloth (homemade masks) vs disposable surgical masks? For HCP and patient use?

A: William Raszka, MD, UVMMC: A very hot topic and one that is brought up each day here at the hospital. We have a PPE committee working on that issue now. Currently, UVMMC is not using homemade masks but things are quite fluid.

A: Ashley Miller, MD, South Royalton Health Center: Several articles on homemade masks if you search Pubmed.

A: Michelle Shepard, MD, PhD, UVMMC: Check this out:

<https://bmjopen.bmj.com/content/5/4/e006577?fbclid=IwAR3S8DoFO8gT4ipc5PGrnIXqYGjB-pTQsM5k-D-N3E88ec9nc17-kR-qvso>

A: Colleen Moran, MD, Northwestern Pediatrics: Thanks Michelle-- looking for clear references as ways to conserve seeing an increase in cloth masks.

A: Molly Rideout, MD, UVMMC: I think that the Vietnam study was sponsored by 3M.

A: Michelle Shepard, MD, PhD, UVMMC: It sounds like 3M gave masks for testing filtration but their products were not used in the study. "Acknowledged the support of 3M for testing of filtration of the facemasks. 3M was industry partner in the ARC linkage project grant; however they were not involved in study design, data collection or analysis. The 3M products were not used in this study."

Q: I've had some people ask if there are any recovered patients in VT yet?

A: William Raszka, MD, UVMMC: 36 patients have recovered.

Q: I missed the call last week but reviewed the handouts. Is there any evidence to use PPE for ALL patients - symptoms or not? I'm talking both outpatient and inpatient and nursery.

A: William Raszka, MD, UVMMC: So, pediatrics is quite different from adult medicine. Seattle Children's does NOT recommend universal use. BCH has been (but they are part of Partners). Generally, if screening on the phone and outside the office suggests that the patient and adult are totally well, I do not generally recommend masking for the patient, parent or HCW.

A: Meghan Gunn, MD, Southwestern Vermont Health Care: Thanks Bill. Does that apply for nursery too?

A: William Raszka, MD, UVMMC: My comments deal with primary care and the NBN – not the ED, etc.

A: Ashley Miller, MD, South Royalton Health Center: I will say as a one pediatrician practice, I am masking and goggling for all patients, and putting masks on patients and parents because if I get knocked out, there goes my practice/livelihood, and we are only seeing a few patients a day.

Q: Should small hospitals send suspicious cases to central testing centers since we have limited PPE supplies?

A: William Raszka, MD, UVMMC: Yes; conserve PPE and send to central testing sites.

A: Wendy Davis, MD, VCHIP: Yes, that's what we're trying to encourage, and the state is trying to encourage being efficient, streamlined, and knowing where testing is occurring, as well as to conserve PPE.

Q: I'm interested in the recommendation to test more adults and only side reference to testing kids. Should we not recommend testing children with minor manifestations? Is that simply to minimize uncomfortable procedures in children?

A: Breena Holmes, MD, VDH: We added a special line in HAN about pediatric patients. We are not going from limited testing to universal testing. We are not going to be able to test every mildly symptomatic child. Tell us how these recommendations feel as the voices of community practices getting calls from parents. We thought it was important to set limits on the testing of children. VDH really wants to get at what's happening around adults who are positive and continue to trace close contacts. The tests are still limited. For pediatrics, it would make sense to use centralized testing centers, unless there is situational anxiety for kids at testing centers. These recommendations are primarily for maintaining supply of PPE. It's complicated, especially for providers in practice by themselves. We want to do more testing and still have recommendations for really sick kids to get tested. We also recommend testing kids in residential programs (Lund, DCF, etc.), even if they are mildly symptomatic due to the group setting. We found out what other states are doing. There is no protocol for universal testing of children right now, mostly due to limits of test kits.

A: Benjamin Lee, MD, UVMMC: It is not only that, but also due to the fact that in general the epidemiology suggests that children in general are very low risk for COVID. So we should not be testing children with minor manifestations now as they are very unlikely to be positive.

Q: I have a child who had a low grade temp for a day, and is otherwise now fine. Dad works in corrections. Test or not test? Dad is totally fine. This has spiraled into a huge discussion...thoughts?

A: Meghan Gunn, MD, FAAP, Southwestern Vermont Health Care: We are getting lots of questions about children of health care workers or other parents that have potential for high exposure - kids have fever, cough - test or not to test? Also, at our hospital, the HCW has to be out until the test is back which has big impact.

A: William Raszka, MD, UVMMC: So, the guidelines are for testing for ill children. However, my impression is that physicians can use judgement. We always wrestle with these special cases. The guidelines do not say MD cannot order tests. Use your judgement :)

Q: Can you share the Seattle data on testing kids?

A: William Raszka, MD, UVMMC: Seattle tested almost a thousand symptomatic children. The positive rate was less than 1% in that group.

A: Benjamin Lee, MD, UVMMC: The Seattle data that Andrea is referencing is the fact that at Seattle Children's, they tested almost 1,000 symptomatic children and rate of positivity was <1%

Q: Debra Hartswick, MD, Timber Lane: What about testing of symptomatic children of healthcare workers? This comes up often for us.

A: Benjamin Lee, MD, UVMMC: I've been trying to answer the chat questions to the best of my ability. This is clearly a hot topic right now. Epidemiology suggests that children are at low risk for having COVID-19, mostly based on the Seattle data. They hosted a public grand rounds. I will try to find a link and send it around to discuss their experience. They had the most pediatric testing available in the area with high incidence. They tested 1,000 children with symptoms similar to COVID-19, and around .6% of the children tested were positive, which is pretty reassuring. In the absence of a child having an adult in the house who clearly also has respiratory illness, the likelihood of the child in the house having COVID-19 is very low; even as a child of a healthcare worker, if the adult is fine. If the child is fine or has respiratory symptoms, the likelihood that it's COVID-19 is very low, so that's why they are not a high priority for testing. This thinking could change as testing capacity ramps up, but given the current capacity, it is not high priority.

A: William Raszka, MD, UVMMC: Here is the link to Seattle Children's

<https://www.seattlechildrens.org/healthcare-professionals/education/grand-rounds/provider/>

A: Wendy Davis, MD, VCHIP: Thank you, Ben. This is as clear as we can be at the moment.

A: Breena Holmes, MD, VDH: I've been working on standing up a healthy childcare environment for emergency workers. Many childcare providers were asking if kids could be tested before coming for care. For now, the answer is no. If you test a kid today and they are negative, what about a couple of days from now? It gives a false sense of security. The VDH Commissioner indicates that asymptomatic people being tested creates concerns about false negatives as well. Your dialogue with families is key now. We can provide talking points for you as needed.

A: Mort Wasserman, MD: False reassurance is a downside of widespread testing

A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: I'm discouraging knee-jerk testing because recommendations don't really change based on results-- still recommending self isolation for foreseeable weeks to come.

A: Benjamin Lee, MD, UVMMC: Paul, agree

A: Alex Bannach, MD, North Country Pediatrics: Agree with Paul, same approach here. I feel that often we would test more for parent's comfort than to guide care. HCW kids are tricky.

A: William Raszka, MD, UVMMC: We wrestle with that every single day:)

A: Benjamin Lee, MD, UVMMC: In general, the likelihood that a child with symptoms in a household where all the adults are well has COVID is very, very low

A: Jill Rinehart, MD, UVMMC: It meant a lot to me to learn that children don't give this to adults as much as the other way around

A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: Very happy that kids are not as susceptible to infection or complications, but WHY? (fascinating)

A: William Raszka, MD, UVMMC: We do not know why they seem to have low incidence of severe disease. Could be receptor mediated but unclear.

A: Shannon Hogan, DO, UVMMC: I think for a lot of families that I talked to, they are worried as schools were closed and think that means that kids get others sick. I think it is important for us to educate our families of this data.

A: William Raszka, MD, UVMMC: It turns out that it is easier to close schools than most other interventions

A: Meghan Gunn, MD, FAAP, Southwestern Vermont Health Care: That is helpful to pass on to our ER (re testing children of HCW)

A: Shannon Hogan, DO, UVMMC: I completely agree re: schools, but it is important for us to educate parents why this happens. My 11-year-old is educating his peers about the chance of kids getting infected.

Q: Any thought to add loss of smell/taste to general screening questions? We have had positive with only this history.

A: William Raszka, MD, UVMMC: We hear more and more often about anosmia being a common finding. Loss of taste too.

A: Benjamin Lee, MD, UVMMC: Good question, wouldn't be unreasonable. In the adult data, this keeps popping up as a significant complaint in a significant fraction of patients (but not all).

A: Is there any data on resolution vs persistence of anosmia?

A: Benjamin Lee, MD, UVMMC: I'm not aware of any firm data on this although in full disclosure, haven't been looking.

A: Barbara Kennedy, MD, Timber Lane: The few cases of loss of taste/smell that I am aware of had resolving symptoms.

A: William Raszka, MD, UVMMC: What we hear from Europe and locally that loss of taste/smell is an early finding.

Q: Do we know sensitivity and specificity of tests?

A: William Raszka, MD, UVMMC: No public facing data on test characteristics on any of diagnostic tests!

Q: Are MOC requirements waived this year?

A: Alex Bannach, MD, North Country Pediatrics: I have had direct contact with ABP as my MOC cycle ends this year and they confirmed that MOC requirements for this year are waived (I only asked about PIP points)

[Note: following our call, Dr. Bannach shared the following e-mail response that she received from Dr. Keith Mann, VP for Continuing Certification at the ABP (Alex advised that we could share it with you-thank you, Alex!):

We will not require any submission of your QI work in order to complete your cycle that ends this year. We are working out the details, but essentially the points will just show up. Our goal was to make this as easy as possible so you can focus on patient care and whatever else is most important to you. You will still have to enroll before December 17th into your next cycle, but the points will be taken care of and you have plenty of time to worry about that.

Once you enroll in your next cycle, you will be able to start MOCA-Peds in January 2021. There is a lot more information on our [website](#) about this new option that replaces the old, proctored exam (should you wish to go this route).

Thank you again for the care you are providing, the obvious passion you have for pediatrics, and for reaching out to share that with us in the midst of these unprecedented times. If there is ever anything I can do to help now or in the future please don't hesitate to ask.]

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Q: If only .6% of symptomatic pediatric patients are positive if parents are not sick, what are the implications of PPE for seeing those patients?

A: William Raszka, MD, UVMMC: That is a key point and one reason why in healthy children with healthy adults in the primary care setting, I have not routinely recommended universal masking for HCW or patients.

A Benjamin Lee, MD, UVMMC: This would suggest that PPE should be conserved for more compelling clinical situations and not used if children and parents are completely well.

Q: What if parents are well, but pre-symptomatic?

A: Judy K. Orton, MD, Green Mountain Pediatrics: My thought is that the kids probably won't give me COVID but the parents might. We are masking with face shields for all patients, gowns for those with respiratory symptoms (or if parents have respiratory symptoms plus the patient/parent get masked). I'm like Ashley, I'm solo so taking extra precautions.

Q: For sick kids who have fever and/or cough with well parents, how much PPE do we need?

A: Benjamin Lee, MD, UVMMC: If the child has clear respiratory symptoms, it still remains reasonable to use droplet/contact precautions as one would typically do anyway—remember, even if not COVID, the child with respiratory symptoms probably has some other type of respiratory virus.

A: Meghan Gunn, MD, FAAP, Southwestern Vermont Health Care: I respect the data but it still just feels really risky to not wear PPE when we are in a closed room with a patient and parent. We can't always trust people to tell us the correct answer about cough/fever/SOB (at least here at my practice, we've already seen this multiple times).

A: Lisa Gannon, MD, Timber Lane: Re: PPE, RNs in Denver are steaming their masks for 3 mins. and allowing to dry for re-use (nephew is critical care nurse there.)

A: Jill Rinehart, MD, UVMMC: Some are using UV Box to re-use masks also.

A: William Raszka, MD, UVMMC: We hope to address many of these issues (as best we can) during Grand Rounds. And yes, ironing homemade cloth masks is an effective way to sterilize the mask.

A: William Raszka, MD, UVMMC: It is possible that PPE production will ramp up very quickly in the US. IF that is the case, things will be much easier. Right now, most protocols are built on a PPE shortage philosophy. Partners are re-evaluating their policy as the burn rate of masks is high. PPE is probably the hottest topic in the US right now.

Q: I still think that the risk of contracting virus from a non- (or pre-) symptomatic adult via respiratory droplet is very low. Good surface cleaning and hand-washing should be sufficient to prevent contracting or spreading...I don't wear a mask unless someone at the visit is sick. Am I being too cavalier?

A: Benjamin Lee, MD, UVMMC: I think that is a very reasonable approach.

A: William Raszka, MD, UVMMC: Hand washing and cleaning surfaces remains a critical part of protection. That is great and I agree your approach is very reasonable.

A: Benjamin Lee, MD, UVMMC: With all the discussion of PPE, one part that we forget to emphasize is the critical importance of good hand hygiene and surface cleaning.

Q: Are there any new data about neonates in Seattle/elsewhere?

A: Benjamin Lee, MD, UVMHC: Michelle, the current online JAMA had a number of additional articles on the topic, along with an editorial by David Kimberlin and a second author (whose name I am blanking on). The upshot is that there are still very few data. There were a handful of cases reported of newborns testing positive, but all with detection of actual virus were symptomatic. It is still unclear still whether this represents vertical transmission or not. More data is still needed...

Q: Also, if I'm not using PPE in the office and then I'm going over to the newborn nursery, are there any potential before symptomatic spreading virus there?

A: Monica Benjamin, APRN, Porter Medical Center: We are keeping one provider per day only doing telemed to be the nursery person.

Q: Our hospital is now providing ozone water for some disinfectant purposes. Any thoughts on that?

A: Benjamin Lee, MD, UVMHC: Unfortunately I am unable to comment. I am not familiar with that strategy.

A: William Raszka, MD, UVMHC: I have heard about ozone water but have not seen much data published about it. In theory, it sounds attractive but I really need to see if someone has officially tested it against surfaces contaminated with sars-cov2.

A: Alex Bannach, MD, North Country Pediatrics: I agree! My concern is that if we are using it and it does not work we make things worse.

A: Anna Zuckerman, MD, UVMHC: I have also heard about ozonators (airborne ozone generators) to clean surfaces, but I'm not sure if this is something there is any data on...

Q: Is there an update on the letter that was going to the Supreme Court about child visitation in foster care?

A: Breena Holmes, MD, VDH: The letter to the Supreme Court went with recommendations on visitation during the pandemic. Only a handful of families are pushing for in-person visitation.

A: Lisa Gannon, MD, Timber Lane: See also Vermont Family Network's current newsletter for many pertinent links, resources, and a general survey for families and professionals on what do people need for info.

A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: They must all be in my practice because I've had multiple calls about children back and forth between two homes -- encouraging divorced parents to discuss and agree (right!).

Q: With having Dr. Rettew on, are there recommendations on how to screen for safety when on telemed/zoom as it is not easy in with social distancing?

A: David Rettew, MD, UVM, DMH: If it's possible, talk to both the parent and the children. It will help you assess how much of a safety risk there actually is. If you have concerns, have a low threshold for having them call crisis services for the DA to do a more thorough assessment via telemedicine.

Follow-up Needed

- (Benjamin Lee, MD, UVMHC) Wendy to distribute the following link to the 3/27/20 Seattle Children's Hospital Grand Rounds: <https://www.seattlechildrens.org/healthcare-professionals/education/grand-rounds/online/covid-19-the-seattle-childrens-experience/>
- Breena to send VDH Commissioner information indicating that asymptomatic people being tested creates concerns about false negatives to Wendy for distribution
- (Andrea Green, MD, UVMHC) Wendy to distribute the following link to the 3/30/20 AAP Webinar on Telehealth and billing: <https://www.cvt.org/COVID-19-resources>

- Q: *Matthew Hollander, MD, UVMMC*: Tangential topic guidance state \$ for kids of HCWs?
- Q: *Deborah Jerard, MD, UVMMC*: What about contact tracing? Anything new on that? Last week you had indicated that not much of that was happening.
- Q: *Valerie A. Rooney, MD, Brattleboro Memorial Hospital*: It would help to know if there are any different PPE recommendations for physicians who have health conditions that put them at risk?