VCHIP CHAMP VDH COVID-19

October 23, 2020 | 12:15-12:45pm Call Questions and Answers*

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School/Higher Education News (national and Vermont)

Wendy Davis, MD, VCHIP: There's been lots of news over the last couple of days.

New York Times article: *Schoolchildren Seem Unlikely to Fuel Coronavirus Surges, Scientists Say* (10/22/20):

- https://www.nytimes.com/2020/10/22/health/coronavirus-schools-children.html
- https://policylab.chop.edu/reports-and-tools/policy-review-evidence-and-guidance-in-person-schooling-during-covid-19-pandemic

Boston public schools moved to fully remote this week (until they experience 2 straight weeks of falling rates)

Union Elementary School (Montpelier) moving is on remote learning today because of some increased case activity there.

- No connections of new case to other community members. A new positive case in the other school buildings. School officials will meet with VDH today.
- Two positive cases last week, and four more anticipated. Monday (all in same classroom); at least some cases connected to hockey-associated outbreak.

St. Michael's College moved to all remote (6 new cases; 8 total)

From the CDC

Wendy Davis, MD, VCHIP: This week's regular MMWR morbidity and mortality weekly reporting to the CDC had a number of articles related to COVID-19, so those may be of interest, for you baseball fans, the one about the outbreak among Major League ballplayers. They also report on the vaccination coverage by age 24 months among children born in 2016 and 2017 from the National Immunization Survey (NIS). We're going to hear more about NIS data on Monday from Christine Finley from the immunization program.

- MMWR this week (10/23/20 – selected contents)
  https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6942-H.pdf
  - Vaccination Coverage by Age 24 Months Among Children Born in 2016 & 2017 — National Immunization Survey-Child, United States, 2017–2019
  - Mitigating COVID-19 Outbreak Among Major League Baseball Players United States 2020
  - Race, Ethnicity, and Age Trends in Persons Who Died from COVID-19 — United States, May–August 2020
  - Excess Deaths Associated with COVID-19, by Age and Race and Ethnicity — United States, January 26–October 3, 2020
  - Association Between Social Vulnerability and a County's Risk for Becoming a COVID-19 Hotspot — United States, June 1–July 25, 2020

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On October 21, two days ago, the MMWR issued an early release entitled COVID-19 in a Correctional Facility Employee Following Multiple Brief Exposures to Persons with COVID-19, which occurred right here in Vermont between July and August of 2020. As you likely recall from the news, a Department of Corrections officer was infected after several brief interactions with incarcerated individuals who had COVID-19. None of the individual interactions were greater than 15 minutes, which has been our threshold for identifying a close contact, but the total amount of time of exposure over a longer period of time was greater than 15 minutes.

- MMWR (early release 10/21/20): COVID-19 in a Correctional Facility Employee Following Multiple Brief Exposures to Persons with COVID-19 -Vermont, July–August 2020
    - VT DOC officer infected after several brief interactions with incarcerated people with COVID-19. No individual interactions > 15 mins.; total amount over time > 15 mins. (based upon video footage review)
    - Transmission can occur during multiple brief exposures with an infected person.
    - VDH: "contributes to national understanding of COVID-19 transmission." https://www.healthvermont.gov/media/newsroom/Vermont-investigation-contributes-national-understanding-COVID-19-transmission-October-22-2020

This information really likely has contributed to the national understanding of COVID-19 transmission, and in fact, we then heard over the past few days about the revision of the CDC case definition of a close contact, now reading to be within 6 feet of an infected person for a cumulative total equal to or greater than 15 minutes over a 24-hour period: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html.

Impact on Vermont of this change in CDC Close Contact Definition – from VDH:

- Vermont will be moving forward with the change in close contact definition.
- Do not anticipate that this change will have a huge impact. It has already been implemented in some facilities and in some situations.
- VDH is working on appropriate revisions to the website and other guidance documents

We do wonder how this change might increase the volume of close contacts identified through contact tracing.

Governor's Media Briefing – COVID-19 Vaccine Preparation

Breena Holmes, MD, VDH & VCHIP: Governor Scott launched with the COVID vaccine plan submitted to the CDC last week. He then thanked Vermonters and emphasized continued vigilance is needed. Commissioner Levine gave more detail about the COVID interim vaccine plan on the VDH website. He wants to make sure we know it is an interim plan, because it is an ever evolving story. Vermont has an advisory committee with equity at the center to ensure equitable access to the COVID-19 Vaccine. He did note that the National Advisory for COVID-19 immunization practices did meet, and they are going to describe the priority populations, which won't be of any surprise to us. It will be health care workers, elderly populations, etc. There's a massive push nationally with great partnerships with pharmacies to be part of the administering of the vaccine. Providers must be enrolled with VDH immunization program to administer the COVID vaccine,

which will require two doses. Commissioner Levine emphasized that safety and effectiveness are the only priorities when it comes to bringing the vaccine to this state.

Governor's Media Briefing – School Cases

Breena Holmes, MD, VDH & VCHIP: From AOE Secretary Dan French's perspective, he acknowledged that there are more cases in schools, but from his perspective, schools continue to operate pretty well. He spoke about the student voice on the State School Board. They met this week, and that students were able to describe comfort in routine. He wants us to remember that one measure success is the ability to establish routines and connections among Vermont's schoolchildren. He praised our beloved school nurses as pragmatic and resourceful, calling out Louisa Driscoll as School Nurse of the Year. Our task force revisions for school guidance will be published soon and implemented in mid-November to allow time for the full implementation of some of the changes by the school administrators.

We are now asking schools to do travel screening with their growing observation that people's movement is a factor in our increased cases. We added Grade 6 to the distancing changes for 3-feet between students, and we are no longer allowing Plexiglas to reduce distancing requirements. We describe requirements for distancing in cafeterias, and the need for open windows on school buses. Music continues to present significant challenge due to risk in indoor spaces. There is new guidance that allows individuals to sing or play woodwinds alone, but not in groups. The sports guidance is anticipated next week.

Commissioner Levine then agreed with Secretary French, saying we should listen to our students and children because they are wise. School nurses are pivotal and amazing, and travel screening is important.

Commissioner Levine then covered several situations:

- Ice sports Outbreak in Central VT
- 2 colleges (6 cases)
- 7 schools (12 cases)
- 7 work places (12 cases)
- 2 hospitals (2 cases)
- 43 cases total and hundreds of close contacts

These are real people, and please respect their privacy. The 28 new cases were expected, but also concerning (50 % of cases are ice sports, wedding, and St Michael's College). He's wondering about foliage travel, encroachment from bordering states, and increased indoor time. There is an increase in close contacts from two to three in the spring to six to seven or more now.

Commissioner Levine gave a shout out to the VDH team who published in the MMWR about Corrections Officer contracting virus after multiple brief interactions with infected people. These findings led to the CDC change in definition in close contact. Now someone who is within 6 feet with CUMULATIVE time of 15 minutes over 24 hours is considered a close contact. He is very proud of our team, expressed a commitment to following the science, and the need for Vermonters to make hard but important choices. He focused on avoiding large gatherings and crowds now that we are indoors.

Practice Issues: Friday Potpourri – Specific School Issues and a Clinical Scenario

Breena Holmes, MD, VDH & VCHIP:

Infants seen with classic bronchiolitis

- Patients < one year of age
- No travel or COVID exposure history
- Typical presentation for common respiratory viral infection prevalent this time of year
- To test or not to test?

Helpful guidance for symptomatic patients

- UVMMC "Testing for Influenza-Like Illnesses" – do not test for flu, RSV in healthy outpatients without risk for severe disease "unless compelling clinical reasons"
- AAP: COVID-19 Testing Guidance https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-testing-guidance/

Wendy Davis, MD, VCHIP: Are you now seeing patients with increased respiratory illness? Are you aware of when you should be testing and for which viruses? The UVMMC document covers Indications for SARS Co V2 testing, influenza and RSV testing, and then some additional information about what's available in their laboratory.

Breena Holmes, MD, VDH & VCHIP: There is a HAN on "please don't test for flu and RSV." https://www.healthvermont.gov/sites/default/files/documents/pdf/COVID-19-HAN-RespiratoryViruses-Testing-Chemoprophylaxis.pdf

Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: The HAN that was written regarding the need for RSV testing that had intentionally really been intended for the purposes that you need to test somebody for RSV if they're being admitted with clinical bronchiolitis. That was the reason for it and the original context. The background of trying to be as judicious as we can with any form of respiratory virus testing this winter to make sure that we have enough supply and capacity to be able to test anybody for SARS-CoV-2 who really needs it with a focus on those being hospitalized for respiratory illness. The challenge with RSV compared with bronchiolitis is that we don't really have any data yet about how often or how frequently co-infections with RSV and SARS-CoV-2 really might be occurring and if COVID-19 alone can cause classic bronchiolitis. We know from the other seasonal coronaviruses that that they can, but they're very, you know, they're very rare for coronavirus alone to cause as a sole cause of bronchiolitis. It's not zero, but it's pretty rare. More likely is a co-infection probably driving the bronchiolitis. In terms of testing the patients themselves, there may not be as much of a need. However, the challenge comes in terms of what to do then about siblings and household contact etc. So that's really the challenge that we're facing. I think this is a discussion that we're going to engage in as we get into our sequencing in terms of what you want everybody to do is. Most of the time we're going to be talking about daycare-age children, and usually for the most part, children who are school age are less likely to have true clinical bronchiolitis. This is the background, and I'd be interested to hear from the community about what's going on now and how to move forward.

Clinical Issues Arising in Vermont Schools Supporting ESL families regarding symptom screening, exclusion, etc. – how are you helping to solve those issues?

- PCPs not being called by families when advised by school nurse

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- Concerns regarding "essential travel" (people working immediately after returning from out of state in this context)
- Accuracy of no touch thermometers: for example, indoor reading of 97 in patient with fever of 102 by aural thermometer. We are monitoring cases to continue to inform the utility of temperature checks at school.
- Challenges with failure to return disposition forms
- Frequency of rhinorrhea/congestion as symptoms
- Necessity to assess multiple children in isolation rooms at one time—concerns about running out of space
- Are you seeing these – and what else?

Summary: School Guidance Changes

Highlights and incorporation of supplemental guidance as prev. published in AOE FAQs:

- Clarifications and emphasis on quarantine guidance for out-of-state travel
    - Added the requirement of a daily travel screen for staff and students
- Clarity around return-to-school after illness, including links to the return-to-school algorithm and parent guidance
- Clarification on cleaning schedule when an individual is sent to the isolation room, as well as cleaning of the isolation room
- Clarification on factors the Health Department will use in making recommendations when there is a case of COVID in school
- Added winter weather considerations for buses and transportation
- Added recommendations for seating charts in the school bus and cafeteria, along with classrooms
- Added link to guidance on mask exemptions
- Clarified guidance on cleaning and disinfecting, including accidental large volume spills or body fluids.
- Added guidance on the use of Plexiglas/plastic barriers
- Clarified guidance on shared materials and lockers
- Younger students for the purposes of physical distancing requirements is now defined as students in PreK through Grade 6
- Clarified guidance on minimum physical distancing requirements for younger and older students
- Clarified guidance on performance arts
- Added new guidance on physical education
- Added new guidance on driver education (as published in the AOE FAQ)
- Added new guidance on the public use of school facilities (as published in the AOE FAQ)
- Added new guidance on indoor field trips
- Clarifications on isolation space
- Additional guidance on HVAC requirements
- Additional guidance on the use of cafeterias in Step III
- Explanation on the use of 6-feet to determine close contacts for the purposes of contact tracing, as well as additional instruction for schools for contact tracing
- Additional resources for schools from the Health Department and CDC

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Questions/Discussion

Q: A question for pediatric providers: Does anyone have a good CPT code for completing Asthma Action Plans?
A: Nathaniel Waite, RN, VDH: I emailed Karen Casper in our VDH asthma program. She's looking now.
A: Ashley Miller, MD, South Royalton Health Center: g9001. 94664 can be used for mdi teaching.
A: Nathaniel Waite, RN, VDH: G9001 - yearly care plan for chronic condition. I'll be sharing some more detailed coding information for Asthma Action plans with you to include in your notes tonight. Karen is updating a document right now.

Q: Communication to school RN's FAQ document that came out this week states that "cold" is considered an alternative dx from a provider and is ok to readmit without testing. School RN's are feeling very uncomfortable with this, as am I. Those of us on the call will know to test, but there are providers in my area who aren't unless the school RN pushes back. Unfortunately, the "FAQ" seems to support the rogue (https://www.healthvermont.gov/sites/default/files/documents/pdf/CYF_COVID-SchoolNurse-DesignatedPersonnel-Guide-10.4.20.pdf. See bottom of page 24.)
A: Breena Holmes, MD, VCHIP, VDH: Remember your great school liaisons. If there are providers making nurses and other providers uncomfortable with alternative diagnoses, then I would encourage you to contact school liaisons to get meetings together with these physicians. I'd like to get ahead of rogue colleagues. I will have Sharonlee Trefry and Nate Waite remove that confusing part of that document. Thanks for pointing it out.
Nathaniel Waite, RN, VDH: I shared the concern with Sharonlee who isn't on the call right now.

Q: Many are around extended family and friends now without masks and don't think of it as a risk factor, so I have been asking, "Who are you around besides people that live in your house?"
A: Breena Holmes, MD, VCHIP, VDH: Good thinking. The lessons of the week are relaxed. Vermont has relaxed, maybe due to travel and foliage, maybe becoming complacent. Let's get everyone back in masks and in smaller groups.

Q: We are getting calls from families that have been "exposed to a positive COVID across the river in NH. Do you have any information on VT working with neighboring states for contact tracing?
A: Breena Holmes, MD, VCHIP, VDH: Yes, NH works with VT on contact tracing. We are hearing that NH is under water with contact tracing. I think we need to further find out how NH lets VT know.

C: Here is the link to the UVM MC Viral Testing document
https://uvmhn.s3.amazonaws.com/www.uvmhealth.org/assets/2020-10/covid-fmp-cg-guidance-uvmmc-providers-regarding-influenza-like-illness.pdf

Q: Is there data linking classic croup caused by coronavirus?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: I have not seen reports of croup with COVID, but have with bronchiolitis. Will check more.
A: Michelle Perron, MD, Timber Lane Pediatrics: I have seen some children with croup and did consider it an alternative diagnosis.
A: Kari McKinley, NP, Timber Lane Pediatrics: I did see this Medscape article about limited cases of croup and COVID-19
https://www.medscape.com/viewarticle/938000?nlid=137572_5142&src=WNL_mdplsfeat_200929_mscpedit_peds&uac=214538EK&spon=9&impID=2594451&faf=1

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A: Carolyn Lorenz-Greenberg, MD, CVMC, Pediatric Primary Care: Case series of croup with COVID in AJEM - PMID 32980228.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: I had not seen the article. Thanks. It would appear that any coronavirus can cause any URI or LRTI illness.
A: Alicia Veit, MD, Timber Lane Pediatrics: My gut says, at least for the first few months, until we have better national information on the bronchiolitis/croup comorbities that I would probably test.
A: Keith Robinson, MD, UVCH: From a pathophysiology perspective, any respiratory virus could cause croup. The subglottic mucosa is loosely attached and prone to inflammation to yield croup presentation.
Breena Holmes, MD, VCHIP, VDH: That's definitely true.

Q: Regarding the school document, if URI is a diagnosis which they could have and the data says they are likely not to have COVID? Then should we use that diagnosis or do you want us to test everyone?
A: Breena Holmes, MD, VCHIP, VDH: For upper respiratory infection, it's really case by case. Uncomplicated congestion without fever or a cough, does not need a test, but if it presents with a fever or a cough, then that does indicate testing.

Q: I'm still a bit confused. Is clinical diagnosis acceptable with bronchiolitis?
A: Breena Holmes, MD, VCHIP, VDH: We can't make that decision in a policy. We can't say every kid with bronchiolitis is free to move about. That child may need a test for COVID-19. There's no great answer. It's so much harder than before COVID.
A: Ashley Miller, MD, South Royalton Health Center: For bronchiolitis, I am testing with my rapid RSV test in office, and if negative, testing for COVID.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Dr. Lee and I actually talked about this this morning. This is not straight forward at all. There are cases reported of children with COVID-19 who have bronchiolitis. Often times there are people hospitalized with COVID-19 who go on to develop bronchiolitis. We are actually looking for some guidance from the community because there's no easy answer. The algorithm suggests if you have a child with fever and cough, you might test. It would put them in the higher pretest probability. Many children with bronchiolitis will have fever and cough. The cases we experience, the children didn't have to go back to daycare. Technically, if you have bronchiolitis, you can't go back to daycare immediately. We're looking for some different approaches. Testing children with bronchiolitis for SARS-C0V-2 has implications for daycare. It is not an issue for schools. The implications for the family are also significant. We can we assume that they do not have COVID-19. The pathway would suggest testing. That makes things challenging. The most important issue is whether to test infants with bronchiolitis for COVID.
A: Alicia Veit, MD, Timber Lane Pediatrics: We do not test for RSV at TLP.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: This is precisely the question we are trying to clarify, should we consider clinical bronchiolitis an alternative diagnosis that does not requires SARS-CoV-2 testing? We have not come to a consensus on this yet.
A: Breena Holmes, MD, VCHIP, VDH: There is no consensus. Maybe we can build it together.

Q: In MAUSD school district, I have also heard from the nurses that PCPs have not contacted the families when communication forms are sent and have advised this by school nurse.
A: Breena Holmes, MD, VCHIP, VDH: I would just keep pushing team-based care. Don't forget your school liaison.

Q: With all of the traveling and lax in social distancing/masking, we probably need to err on the side of caution and test?
A: Breena Holmes, MD, VCHIP, VDH: I've been feeling that way, too.

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Q: Do we still feel comfortable telling a family that when one child is awaiting a test that the other kids who are asymptomatic can go to school? Or are the cases going up enough that we should have the whole family stay home until that test returns?
A: Breena Holmes, MD, VCHIP, VDH: Yes, we are. Not yet on your second question. We did have 28 cases yesterday, but we are still in low prevalence. There is no need to change policies yet.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: For now, we are still okay for those siblings to still go to school.

Q: Should that sick child be isolating from everyone? Obviously that is not practical in a family.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: To the extent possible, yes, that child should try to isolate until test results are back.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Anyone tested should try to isolate if possible.

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