

VCHIP CHAMP VDH COVID-19

March 26, 2020 | 12:15-12:45pm Call Questions and Answers*

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Practice Implementation Strategies – South Royalton Health Center

Ashley Miller, MD, FAAP, South Royalton Health Center (Member, AAPVT Executive Board)

Our waiting room is now void of all chairs, toys, and everything else, since we're not using it right now. We had a furnace explosion in our office last night as my staff was leaving, so we are now truly practicing out-of-office care. We are all working from home right now, which made us up our abilities on telehealth and coordinating with everyone being off-site.

Prior to that, we are a small practice. We've got about 1,000 patients on our panel. We've got about 1.2 to 1.5 FTE providers: myself and a nurse practitioner. We also have co-located mental health and a care coordinator. To maintain our social distancing in the office, we luckily had enough space to move into all separate offices. Our front desk person was alone, even though she's now checking patients in over the phone once they get to our parking lot and give her a call. I provided everyone with hand sanitizers for their desks and cars in hopes of keeping germs down and out of the office as much as possible.

Our front door is locked and has a sign on it that says, "Due to coronavirus, please call from the parking lot." They call and check in. From there, the phone call is transferred to our RN who does the initial history taking that she would normally do in the room over the phone. She then meets them with masks for the parent and the patient at the door. She's also wearing goggles and a mask, and they are brought immediately to the appropriate room. Our rooms are pretty bare now, no toys in there either, no pictures on the walls. All the stuff off the desk, so it can be easy to wipe down. We're lucky that we do have two hallways, and we can use two entrances if we need to. We can use the back door staff entrance as a well entrance if we get to that point. We have one hallway that has two rooms in it that we're using as a sick room and a sort of sick room, so that anyone who comes in with a URI goes into the sick room. Anyone coming in for a follow-up well visit that has some symptoms goes in the other room. In the other hallway, we have our well-visit room where we're doing kids under 2 for their well visits, 4-year-olds for their well visits, and any follow-ups (mental health, asthma, etc.). The mental health counselor's room is in that same hallway. The counselor is wearing a mask and having her patients and parents wear masks as well while she's doing any in-person therapy. We are asking parents who aren't directly involved in counseling or whose children can do the visits on their own to wait in their cars to decrease the amount of interaction.

Phones are running the same as usual, except all sick visits are being triaged through the nurse now, whereas before our scheduler could also do that. To keep even more social distance, we're seeing our well visits from 9 to 10 am in the morning. That's when we do all the little babies, all the immunizations. We have another block of well visits from 2 to 3 pm in the afternoon. Those tend to be teens who can't figure out how to get up for 9 am. They appreciate having later visits. We close the office from 12 to 2 pm to get some airing out. With the two separate hallways, we feel comfortable having well visits from 2 to 3 pm. We've started doing well visits in the parking lot if the parent requests, including vaccines. Based on information learned on this call, we got landlord to give long extension chord to do nebs in the car, if we need to, by running the chord out to the sidewalk.

*Note: This is a paraphrased synopsis of the call and is not a word-for-word transcription.

We're all wearing what PPE we have. For all visits, we wear a mask and goggles or safety glasses, based on Table 1 I mentioned from CDC about exposure. If a provider wearing safety glasses or goggles and a mask, if exposed to patient who not wearing a mask, covered for quarantine aspects, and by adding a mask to the patient as well, we're doubly covering ourselves. We did have to buy our goggles and safety glasses from the local hardware store. We are reusing our masks for the day, unless they get contaminated or wet to preserve the PPE that we have. We wipe down goggles between each visit. State did send us the supplies we requested: N95, gowns, face shields. We set up a station for them and have all practiced donning and doffing appropriately so as not to contaminate ourselves. Our goal is to keep as many kids as we can out of UrgentCares and the ERs, so that's why we're still doing sick visits.

Otherwise, we're doing telephone visits for anyone who seems reasonable. We're asking parents to get a weight and a height if they can at home. Some parents even have blood pressure cuffs. We ask for temps if appropriate. We document that these vitals were taken by the parents in the chart. I set up doxy.me. It took a little figuring out – issues with service connectability and turning the mic and the camera on through my computer, but did my first visit at 10 am today. It worked really well.

After the call with Kate McIntosh yesterday, we pulled our list of phone calls since March 13 to try to bill the G codes that she talked about. We did 101 calls in total and about 75% turned out to be billable. Not sure how the money will come in from all of the insurances, but moving forward with billing all calls that come in that are appropriate. I also ran panel of patients under 2 who are not up to date on immunizations, and our staff is calling them in for well visits and emphasizing importance of immunizations to protect everyone from what we can protect them from. Next week, we will go through the rest of our panel. Practice-wide communication to all patients to keep them up to date on what practice is doing, how to schedule appointments, and encouraging them to watch our FaceBook page to make sure they have the most up-to-date information. We also encourage them to use the portal rather than the phones. I'm happy to talk offline with other small business owners about what we're doing and to try to make payroll and all of that. Wendy can connect us by email for any questions.

Practice Implementation Strategies – UVM Children's Hospital and CSHN/High Risk Populations

Keith Robinson, MD FAAP, Vice-Chair for Quality Improvement & Population Health, The University of Vermont Children's Hospital

I wanted to answer any questions about how the University of Vermont Children's Hospital and the Children's Specialty Center can help out. If there's any questions about that, please let me know. Over the last couple of weeks, we've done a lot of work, like you all have, to reinvent the healthcare system, which is not an easy task. We are implementing new systems and improving, really strong opportunity to rethink how we do population health.

I've asked the specialists to identify high-risk patient populations and then reach out to the families to make sure that we have care goals in mind, modes of communication (whether telemedicine, phone, or inpatient visits worked out). Right now, we are trying to build up outreach to primary care offices to partner more intently on how to manage either sick visits and/or check-ins for kids with medical complexity as we move through this situation. There's going to be a lot of different ways to do this. Whenever possible, we'd like to see kids in clinic. At times, we will need to partner with primary care locations using telemedicine. We are getting up to speed on it now and looking at it as a big opportunity in the coming weeks to months.

Questions/Discussion

Q: The following question just came up: anyone? the state? have pedi masks?

A: William Raszka, MD, UVMMC: Yes

Q: Ashley Miller, MD, South Royalton Health Center: Can we access them? We are out and HS canceled our order without telling us.

Q: Will the HAN give guidance on more testing (or testing beyond those we have identified at high risk)?

A: Breena Holmes, MD, VDH: Such a good question. Probably the speedy thing is to use different swaps because there's a limitation on swabs even for high-risk patients because of supply. I'm guessing the HAN this afternoon is just about the swab.

Q: Not sure how more testing is going to make a big difference at this point given community spread and the Governor's order for everyone to stay home until mid-April. More testing might just creat more opportunity for more people to get exposed. Any thoughts?

A: Breena Holmes, MD, VDH: It is important to have a broader set of data to show that staying home is helping to put guardrails on spread. Many of our positive cases now have NEGATIVE household contacts which is hopeful. We also just haven't done enough testing.

A: Wendy Davis, MD, VCHIP: One thought about this question is that it may help us understand how our mitigation strategies are working.

Q: What about expanding testing people in cars? Would that be the safest way to limit exposure and get the incidence data we need as a state?

A: William Raszka, MD, UVMMC: I would hope that testing would not increase risk of transmission. Drive through testing has been used by many programs, states, and countries. We would have to be a bit careful. Is the goal to test every single person in one community (which was done in some Italian communities) vs. children with sort of risk or symtom complex?

A: Breena Holmes, MD, VDH: There is definitely no plan to test everyone.

A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: Yes, car testing would serve that purpose but what of preserving PPE that is in short supply? Seems like a less than ideal expenditure of those scarce resources since it isn't going to inform our treatment recommendations.

A: Jody Brakeley, MD, Middlebury Pediatric and Adolescent Medicine: The ability to expand testing is good to know. I hear from our early childhood educators that they would experience less stress if there was some testing of the children in care. This is especially true for children in unfamiliar childcare programs.

A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: I'm just concerned that word will get out and I'll have parents demanding that their children be tested (which will likely happen). Currently my parents are very understanding of the current policy regarding testing. No demands at all once I explain the rationale and situation.

A: Wendy Davis, MD, VCHIP: Thanks. That's thoughtful guidance for VDH as they continue to address testing.

A: Breena Holmes, MD, VDH: We will be very clear on the messaging about testing. Perhaps i should not have shared without the reassuring information behind it.

A: William Raszka, MD, UVMMC: No worries. It lets us hash it out here before implementation.

A: Judy K. Orton, MD, Green Mountain Pediatrics: Yes, what Paul said. I worry that even with car testing that contamination and spread occurs particularly if a practice only ends up 1 or 2/day or less. You would also end up going through an awful lot of PPE. Drive thru testing at a central location in a community seems like the safest and best utilization of PPE resources.

A: William Raszka, MD, UVMMC: When I think of drive thru testing, I think of a centralized location. I would not recommend each practice doing their own drive thru testing.

A: Elizabeth Hunt, MD, Timber Lane: I find that most families understand why we are recommending having their children with fever and/or cough stay home and not get tested. They don't want to leave the house and if no respiratory distress and no chronic health issues, they are OK with just staying in contact with us. Children of healthcare providers are also getting sick but that often leads to testing the healthcare provider if they are symptomatic. Thanks for that. Dr. Raszka, the existing test sites are doing a great job and have access to large amounts of PPE. We are not testing at Timber Lane Pediatrics.

Q: Is everyone keeping all their staff working or are some being laid off?

A: Colleen Moran, MD, Northwestern Pediatrics: There have been pay decreases and furlough at some offices. The federal assistance is not immediately available.

Q: Do you place masks on all patients and parents or only on sick patients? It seems like a lot of masks...

A: Ashley Miller, MD, South Royalton Health Center: We are doing every patient due to the concern of asymptomatic shedding, since we are only seeing 4-5 patients a day, it's working right now.

A: William Raszka, MD, UVMMC: Very generally speaking, the likelihood of a totally asymptomatic child without ill adult contacts spreading disease is remarkably low.

A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: I use masks only for those with ANY viral symptoms (and old enough to keep one on). I'm only wearing a mask when I see sick patients. I think the risk of contracting the virus via airborne droplets is probably very low from someone who is asymptomatic and not coughing/ sneezing. Of course, surface cleaning and good handwashing continues to be imperative.

A: Ashley Miller, MD, South Royalton Health Center: I think by masking everyone, even though the risk is low, people feel better about coming in for well visits, and I think the feeling is we really don't have enough population data to say it's not a risk at all.

A: William Raszka, MD, UVMMC: In Seattle, only 1% of children tested positive.

A: Ashley Miller, MD, South Royalton Health Center: Also, if you look at the CDC table 1 about quarantine, if you are exposed to a patient that ends up testing positive, it is at least 7 days out, if not 14, and as a small practice, if we get quarantined, we will be done. We don't have a back up team.

A: Ashley Miller, MD, South Royalton Health Center: Epidemiological Characteristics of 2143 Pediatric Patients With 2019 Coronavirus Disease in China:

<https://pediatrics.aappublications.org/content/pediatrics/early/2020/03/16/peds.2020-0702.full.pdf>

A: William Raszka, MD, UVMMC: Thanks for sharing the article. The issue with that article is that a) all those children had intense adult exposure and b) it is unclear if they were the end result of a chain of transmission. We will never be able to totally resolve this issue.

A: Alex Bannach, MD, North Country Pediatrics: We are only seeing healthy kids in office, staff wears goggles and masks for all visits, same for shots. We have done some shots in the car but for infants nursing says that can require some yoga skills.

Q: Gowns too or not?

A: Alex Bannach, MD, North Country Pediatrics: We use gowns and gloves only when seeing sick kids in their car, as gown supplies are extremely limited. This works well unless it's too windy.

Q: Barbara Kennedy, MD, Timber Lane: Anyone have guidance on the use of NSAIDS with possibility of COVID-19?

A: Wendy Davis, MD, VCHIP: There was some early chatter out in the blogosphere about not using NSAIDS, but we're not finding strict evidence of that.

A: William Raszka, MD, UVMMC: Part of the NSAID data has to do with whether to use NSAIDS at all in critically ill patients. To the best of my knowledge, there is still no CDC guidance not to use ibuprofen for fever in children with respiratory complaints.

Q: Debra Hartswick, MD, Timber Lane: Keith, could you comment on our children with RAD and use concerns with steroids/ their regular ICS if they have exacerbation?

A: Keith Robinson, MD, UVMMC: There's concern about using more systemic steroids with COVID for sure. There's been no clear recommendation to absolutely increase use of steroids for kids with RAD or asthma at this point. With the rate of co-infection out there too, I would treat any symptoms that you're seeing as you normally would. In the absence of really good data, it's hard to recommend a whole practice change. I would still continue to treat kids as expected with beta agonists as front-line therapy for hyperreactivity. If you feel like there is a clinical response and elements of poor asthma control, whether that be exercise intolerance or nocturnal cough, then I would have a lower threshold to increase inhaled corticosteroid therapy.

Q: Debra Hartswick, MD, Timber Lane: Are all subspecialists at UVMMC offering telemed visits? We have been trying to get someone "seen" by Urology?

A: Keith Robinson, MD, UVMMC: We are trying to get all subspecialists hooked up with telemedicine. There's a lot of IT barriers, as one would imagine. If there is a specific need, let Keith know. The goal is that as many of those subspecialists as possible will have access as soon as possible to support primary care. If not, then they will do individual visits with the families they feel are high-risk or complex.

A: Colleen Moran, MD, Northwestern Pediatrics: It sounds like it is a work in process like everyone else's practice changes. Keith, just let us know what the best ways to communicate with providers and families. Assuming in the next couple weeks the clear communication lines will be more clear. I love the idea of using PCP office for telemedicine- we could get vitals, etc. in our office and then connect with subspecialist.

A: L.E. Faricy, MD, UVMMC: I think developing a PMD/subspecialist telemed visit would be most useful or obviously our on-call physician is available by phone too.

A: Shannon Hogan, DO, UVMMC: Dr. Hollander who is on line is seeing telehealth and phone visits for pediatric rheumatology.

A: L.E. Faricy, MD, UVMMC: So far I think the infrastructure with pediatric pulmonology is here to start whenever.

A: Ashley Miller, MD, South Royalton Health Center: Doxyme is very easy, do we just need insurances to agree to pay speciality codes?

Q: Could you comment on the beta agonist question about use of MDI versus nebulizer? Also, beta agonist question about MDI vs. nebulizer?

A: Keith Robinson, MD, UVMMC: UVMMC developed a pathway strongly recommending MDIs whenever possible. On the inpatient side, for anyone who's doing inpatient or ER treatment, trying Albuterol with a nebulizer first with appropriate PPE and then switching to MDIs if there's a clinical response. Local resources will drive that decision.