VCHIP CHAMP VDH COVID-19

March 27, 2020 | 12:15-12:45pm Call Questions and Answers*

Wendy Davis, MD, FAAP, Vermont Child Health Improvement Program, UVM; Breena Holmes, MD, FAAPS, Director of Maternal & Child Health, Vermont Department of Health (VDH)

Planned Parenthood – Updates

Breena Holmes, MD, VDH: Planned Parenthood has been working for years to do more telephonic support, especially with adolescents and young adults. They amped that up significantly in the last week. If patients in your practice need contraception and reproductive health services, Planned Parenthood can now provide these services over the phone, including prescribing.

Practice Implementation Strategies – UVM Children's Hospital Pediatric Inpatient Admissions Process

Karen Leonard, MD, FAAP, Pediatric Hospitalist, Medical Director of Inpatient Pediatrics

Goals: 1) Avoid unnecessary visits to ER for both patients and providers and 2) Identify patients who can be admitted directly to the inpatient floor.

Our ability to take more patients directly without going through the ER has advanced since capacity and workflow at the hospital has changed over the last week, so we can take a wider variety of patients. We have always been able to take some admits directly without going through the ER, but we have enhanced our service quite a bit due to the changes related to COVID-19.

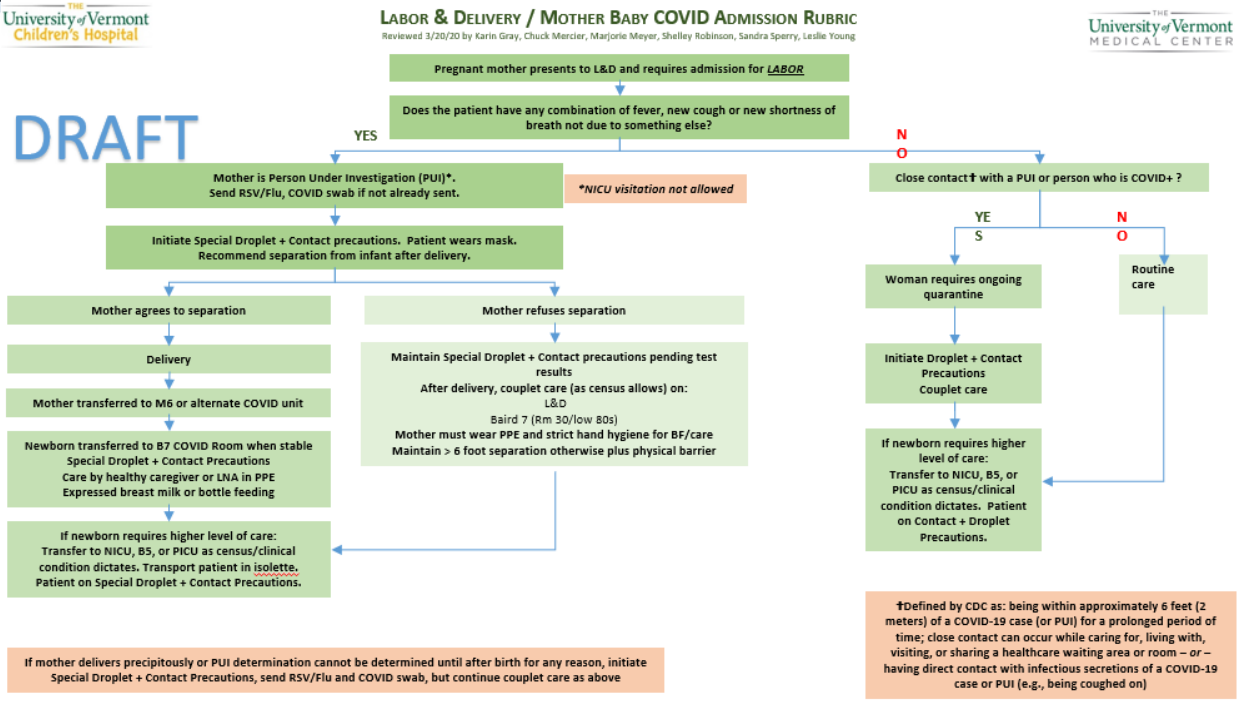
In terms of the process, if a provider identifies a patient as potentially needed admission at an outpatient clinic, telemedicine visit, or emergency room visit, call the Regional Transfer Center (1-866-648-4886) and ask for the pediatric hospitalist on call. We will discuss the case with you and together determine the safest disposition for the patient. We aim to bring an intensivist or subspecialists onto the call. Please consider calling us for patients you are "on the fence" about before sending the patient to the ER for evaluation. We may be able to help avoid the ER by admitting the patient directly or by offering a telephone consultation.

Practice Implementation Strategies – UVM Children's Hospital Labor & Delivery Mother/Baby COVID-19 Admissions Rubric

Karin Gray, MD, FAAP, UVMMC

Karin reviewed the following rubric/flowcharts for determining labor and delivery admission procedures for pregnant mothers and when to recommend separation between mother and newborn due to COVID-19 concerns.

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



LABOR & DELIVERY / MOTHER BABY COVID ADMISSION RUBRIC
Reviewed 3/20/20 by Karin Gray, Chuck Mercier, Marjorie Meyer, Shelley Robinson, Sandra Sperry, Leslie Young

Discharge instructions if separated:
For COVID +: Continue separation until 7 days from symptom onset AND 72 hours after resolution of symptoms
For COVID test pending at discharge: Separation as above until results known, if negative, discontinue isolation

Discharge instructions if not separated:
For COVID+: Self-isolate together, monitor for symptoms in infant
For COVID test pending at discharge: Monitor for symptoms until results known
Asymptomatic but exposed to known positive: Continue self-quarantine together and isolation from contact

Questions/Discussion

Q: How should we be getting kids tested?

A: Wendy Davis, MD, VCHIP: Leah - please stay tuned - we don't have all details yet but hope to have them later today. Please watch e-mail.

A: Breena Holmes, MD, VDH: We're trying to get 2-3 sites ready to roll with full staffing over the weekend. We have adequate collection kits, so we're trying to get them to all of the sites. It's still important to prioritize testing based on risk. We don't want you to feel pressured to test kids you know have flu or RSV.

A: Leah Flore, FNP, Timber Lane: I guess we have been NOT encouraging test in general.

A: Jill Rinehart, MD, UVMMC: Even if they have COVID--if they aren't in distress, we shouldn't be testing them.

A: Wendy Davis, MD, VCHIP: We try to provide the best guidance from VDH – all the details may not be related to children in the initial communication. Anything we can get out to this group in the next 48-72 hours, we will get out. What's going to be needed is how, if at all, to change the strategy around testing. I would not change the fact that we're not encouraging testing right now.

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

A: William Raszka, MD, UVMMC: Influenza testing is still problematic. We can order some, but there's not a lot of swabs kicking around the UVMMC system.
A: Benjamin Lee, MD, UVMMC: I would encourage that, to the extent possible, testing should be referred to centralized centers rather than having each practice attempt to collect their own specimens, as this will help preserve PPE. This may be different pending the new guidance coming out today.

Q: A couple of organizations have reached out to me offering both supplies (gloves and surgical masks) and personnel (dental hygienists). Is there someone I could refer them to to contribute?
A: William Raszka, MD, UVMMC: Kenneth Jensen at UVMMC has coordinated the donations.
A: Leah Costello, MD, Timber Lane: Meredith Monahan asked me about borrowing PPE since their order was delayed. Essex Pediatrics could really use some, as they are testing in their office.
A: Jill Rinehart, MD, UVMMC: Leah, I will refer over to Essex Pediatrics.

Q: Do we send for testing if they are very ill and if typical illness, assume they don't have COVID-19?
A: *Benjamin Lee, MD, UVMMC: I will try to address a couple questions--first, at this time, testing in children is still dependent on risk factors and severity. If the child is ill enough for hospitalization, they will be tested, but if they're appropriate for home care, we are discouraging testing, unless they meet certain high-risk criteria (e.g. immunocompromised).*

Q: Just to clarify: "any swab" relates to testing site, correct? We still need viral test media? Or can we use the same culturette we use for strep swabs/cultures?
A: Breena Holmes, MD, VDH: The CDC has updated its recommendations for respiratory sampling to diagnose COVID. This update is based on data presented to FDA that prompted FDA to change its guidance (https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2-troubleobtainingviraltransport). The new recommendations allow for sampling of anterior nares, mid turbinate or oropharynx (OP); they also allow for "on-site" (i.e., under the supervision of healthcare professionals) of these samples. We believe this will greatly reduce the need for PPE when collecting specimens and also reduce the need for nasopharyngeal (NP) swab-collection devices. FDA guidance states the NP swabs are still the best option when possible. However, given the nationwide shortage of PPE and NP swab-collection devices, we anticipate that most sites will switch immediately to the alternate sampling options (i.e., on-site nasal, mid-turbinate, or oral).
A: Wendy Davis, MD, VCHIP: We shared this guidance in last night's email and it is now posted on the VCHIP website.

Q: Is there any information (probably not yet) about the effects of COVID-19 on neonates?
A: Jill Rinehart, MD, UVMMC: I'll defer to Bill, but The Pediatrics Journal article released last week says thr highest risk of complications are in children under 1 year and the second highest risk is children 1-5 years.
A: Benjamin Lee, MD, UVMMC: There are some data starting to come out regarding neonates.
A: Michelle Shepard, MD, PhD, UVMMC: New article in JAMA Pediatrics: https://jamanetwork.com/journals/jamapediatrics/fullarticle/2763787?guestAccessKey=a0c06290-a39e-4c3f-aae8-b3dee269e844&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jamapediatrics&utm_content=olf&utm_term=032620.
A: Michelle Shepard, MD, PhD, UVMMC: Results "Thirty-three neonates born to mothers with COVID-19, including 3 neonates with COVID-19, were identified (Table). The most common symptom was shortness of breath (4 of 33 neonates). Radiographic findings were nonspecific. No deaths were reported."

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

A: Benjamin Lee, MD, UVMMC: As of now, there are some reports that some neonates have developed symptoms of illness, but it is still unclear if any of those illnesses are due to COVID or if they are due to other newborn issues (e.g. respiratory distress in preemies).
A: Carolyn Lorenz-Greenberg, MD, CVMC: No, but if an exposed infant developed a fever in the first month of life, it would need a full septic work up and likely admission. I haven't seen any guidance that suggests otherwise.
A: Karen Leonard, MD, UVMMC: We would definitely admit, workup and test such an infant at UVMMC.
A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: I agree – the usual sepsis work-up + COVID/ Influenza testing would be appropriate.
A: Benjamin Lee, MD, UVMMC: I agree with your responses on febrile exposed neonates.
A: Carolyn Lorenz-Greenberg, MD, CVMC: I feel like febrile neonate risk needs to be included in discussing risk/benefits of separation.

Q: While I appreciate this approach might work for the hospital, it is really unlikely that mothers and babies are going to remain apart in the community, especially if they aren't very sick, correct?
A: Jill Rinehart, MD, UVMMC: It is possible that the COVID test on the mom may not even be back before the newborn is ready to go home.
A: Wendy Davis, MD, VCHIP: We can only provide the best guidance we can provide.
A: Karin Gray, MD, UVMMC: We are doing the best care we can. We can certainly give the CDC recommendations, but it is up to families on whether they choose to follow those or not. Even if they go home, do good hand hygiene, and minimize the amount of time around the baby when COVID positive, that's really the best they can do.

Q: Is it best for mothers and babies to be apart?
A: Shannon Hogan, DO, UVMMC: I second this question. I worry about the maternal/infant bonding.
A: Wendy Davis, MD, VCHIP: We are all worried about the maternal/infant bonding. We are balancing the longer-term risks against short-term disruption. We won't know the full impact until later.
A: Paul Parker, MD, Richmond Pediatrics & Adolescent Medicine: I think separating COVID19+ mothers and babies is exercising the utmost caution without any science backing that recommendation.
A: Jill Rinehart, MD, UVMMC: I'm with you, Paul.
A: Benjamin Lee, MD, UVMMC: The general approach to mother and infant separation is the same that CDC has been advocating for influenza for years.
A: Karin Gray, MD, UVMMC: I do believe the CDC recommendations allow for the flexibility, and I certainly appreciate the role of the primary provider in balancing this.
A: Benjamin Lee, MD, UVMMC: For safety of the infant, it is generally recommended, but should be determined on a case-to-case basis in discussion with families and providers.
A: Jill Rinehart, MD, UVMMC: I'll of course recommend this, but it doesn't feel right. Parents with influenza are typically very sick and child bearing age women may not be that ill with COVID.
A: Benjamin Lee, MD, UVMMC: I agree that mother-infant bonding is an issue and obviously very, very important.

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

Q: Is asthma considered a high-risk criteria for kids?
A: L.E. Faricy, MD, UVMMC: I haven't seen specific data re: asthmatics being higher risk, but I would assume that viral-triggered asthma and COVID19 would be a risk for an exacerbation similar to influenza. This is a great time to remind patients to stay on their prescribed controllers.

Q: So would a child having mild persistent asthma merit testing? Or only if ill enough for admission?
A: L.E. Faricy, MD, UVMMC: I think if the patient requires admission, they need testing. Otherwise, treating supportively at home with scheduled albuterol as you would in the yellow zone of asthma action plan would be recommended. I would probably err on the side of caution if a kid has a known history of hospitalization for asthma.
A: William Raszka, MD, UVMMC: I do not routinely recommend testing in mild persistent asthma unless they need hospitalization.

Q: We have had families calling about offering that family members from higher risk areas come to stay with family in VT. I'm assuming there would be 2 weeks of self-isolation on arrival, similar to when college kids are coming home. Any specific guidance with a newborn at home?
A: William Raszka, MD, UVMMC: We formally recommend 14 days of self-quarantine from NYC. For other cities with widespread community transmission, this is reasonable. Nothing specific for newborns and a visitor from NYC.

Q: Does UVM allow a support person during labor?
A: Karin Gray, MD, UVMMC: Yes, one support person (typically the other parent).
A: Shannon Hogan, DO, UVMMC: Apparently Baystate in Massachusetts doesn't allow any support person.
A: William Raszka, MD, UVMMC: Pediatric patients can have an adult visitor if they're admitted at Baird 5 even if PUI.
A: Leah Costello, MD, Timber Lane: The visitor can be a PUI?
A: David Nelson, MD, UVMMC: Same in ED at UVMMC.
A: William Raszka, MD, UVMMC: ED visitor cannot be PUI. UVMMC has implemented environmental controls so that all employees and visitors are screened for cough and have a temperature check.

Q: Are pregnant women with COVID more likely to be very ill like they were with H1N1?
A: Benjamin Lee, MD, UVMMC: I think the question of illness severity in pregnant mothers is still not resolved.
A: William Raszka, MD, UVMMC: To date, we are not seeing unexpected findings in pregnant women. Any viral illness in pregnant women can be more severe. I don't think there is something unique (to date) about COVID + mothers.

Q: I would appreciate any pressure on BCBS regarding their pushing their own telehealth "amhealth" rather than connecting with patients' own medical home. BCBS is waving the copays for their calls, but not our calls - this is WRONG and undermines our relationship with our patients!
A: Leah Costello, MD, Timber Lane: I received an email from BCBS saying that if patients use their telehealth services, they do not need to pay towards their deductible. Essentially that is a free visit for the patient if they're using the BCBS telehealth services.
A: Breena Holmes, MD, VDH: I asked Kate McIntosh to work with this team and that she get looped in to these situations to prevent impact on primary care practices.

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