VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE

VERMONT
DEPARTMENT OF HEALTH

VCHIP CHAMP VDH COVID-19

April 2, 2020 | 12:15-12:45pm Call Questions and Answers*

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

Testing Site Utilization, Wait Times, and Distance for Travel – Breena Holmes, MD, VDH

Since we are pediatric-focused, we are not seeking to increase the number of children tested. We are still recommending that kids be moderately to severely sick to be tested. This conversation is related primarily to adult patients you are sending to test. We have a map that I will send out that shows how many tests per thousand Vermonters, and there are pockets around the state that don't have very much testing done, in particular White River Junction, Rutland, and Newport. The density differences are quite striking on the maps. We are wondering why more tests are not occurring in those regions by looking at only the data, which doesn't work. We need to hear from physicians as to where you are sending people for testing and why those geographic locations aren't testing as vigorously as the rest of the state. We are trying to move physicians into best practice by encouraging the use of testing sites. Many of our adult colleagues are testing in their offices. Additionally, if a test center has more than a 15-minute wait time, that's not good, and VDH wants to know about that. We don't want to stand up more test centers if they are not needed because it's not a good use of resources.

A: Indra Lovko, MD, CHCRR: In Rutland, testing was available only for inpatients and health care personnel until last Sunday. We now have the capacity to test many more patients and seem to be doing so.
A: Ashley Miller, MD, South Royalton Health Center: Do you think White River Junction practices are sending to DHMC? I know we were told to send to Mt. Ascutney from South Royalton.
A: Wendy Davis, MD, VCHIP: Breena will investigate.
A: Alex Bannach, MD, North Country Pediatrics: NCH hospital now has 2 test sites, one in Newport and one in Island Pond. There is discussion about others in satellite offices, but there is concern regarding increased use of PPE. Both are part-time, currently Newport is 3 days per week and Island Pond is 2 days per week.
A: Kim Aakre, MD, Mt. Ascutney Hospital and Health Center: We were getting referrals from White River Junction to our testing site. Our urgent tests go to DHMC and the "non-urgent" to VDH. I'm not sure how many White River Junction referrals we are actually getting for testing. We are not super busy....oddly.

Sharing Practice Strategies – Rainbow Pediatrics and Pediatric Primary Care, Porter Medical Center

Tawnya Kiernan, MD, FAAP, Rainbow Pediatrics
We are two pediatric practices that work closely together to provide pediatric care in our community, and we also provide routine and emergency care for newborns at Porter Hospital. We are working hard right now to make the necessary adjustments in providing care to newborns both for emergency care and routine newborn inpatient care, as we try to keep providers from going back and forth to the obstetrical unit from our community-based practices. I'll let Monica start with what our new hospitalist model looks like.

Monica Benjamin, APRN, Pediatric Primary Care, Porter Medical Center
Right now we're having one MD every day that is only seeing babies in the nursery, and they're doing telemedicine visits from there as well. That way that provider is not in the office and not coming into contact

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

with anyone that's been sick, unless a parent has been sick and is in the delivery room. We haven't had that situation yet, but we know it's coming. The week before that provider is in the nursery they work from home doing telemedicine visits. They were completely out of the office during this two-week rotation. The provider then goes back in the office after this two-week rotation. This method minimizes as much contact as possible. For nighttime, whoever is on call will get called in for deliveries and may have been in the office that day, but we're really trying to minimize direct nursery-to-office contact and vice versa. On the weekend, we share call between Rainbow and Porter Pediatrics, so one provider is in the office seeing patients and then one provider is just doing the nursery for the weekend. We also divide overnight call for emergency deliveries on the weekend as well. At Porter Pediatrics, for our sick visits, we are seeing non-respiratory acute visits in the office in the afternoons only, and then our other kiddos go to an acute respiratory clinic that was set up as of last week. In this way, we limit the number of pediatric respiratory sick visits we see in the office. Ideally, it's none. So far, we've been pretty successful. That clinic is staffed by our family medicine and internal medicine colleagues. We are available for consults as needed. Another collaboration within the Porter network is that we have arranged for the audiologist to come to the Porter Pediatrics office one day per week for repeat newborn hearing screenings. Now I'll let Tawyna talk about the changes to newborn care.

Tawnya Kiernan, MD, FAAP, Rainbow Pediatrics
Right now, I am only providing emergency nighttime newborn care. I am no longer seeing my babies that would be coming to Rainbow Pediatrics in the morning. I haven't had my turn as the hospitalist yet. Newborns may be coming out of the hospital at 24 hours of life or younger, and they are losing our Porter Care Connection visit that we've had established for moms and babies for years now. It's a post-discharge visit for moms and babies coming out of the hospital between 24 and 48 hours of life to follow-up on feeding problems, weight, jaundice, and any issues the moms are having. It's a really good way to catch problems early. We've had to make necessary adjustments regarding how that Porter Care visit works. We want to decrease babies and moms coming back to the hospital. There is a new algorithm for nurses at the nursery for calling and checking in. They may be using Zoom with families shortly as well. We need to make decisions at discharge about when that baby might have to follow-up. Most of us are now trying to make a workflow that sees a baby anywhere between 3 and 7 days of life, depending on the circumstance. We are making sure that if they have been discharged before 24 hours of life that they still need a newborn screening. We are getting tools in our office to monitor for elevated bilirubin and being able to draw a serum of bilirubin. In collaboration with Porter Women's Health, when babies come in within that first week of life, if that mom needs a blood pressure taken, then we can take it for the obstetrical doctors and let them know what the mother's blood pressure is to try to decrease the amount of back and forth of these mom and baby units. That's still being worked out. Something that we plan to see more of but haven't seen too much of yet is moms coming from out of state and seeking obstetrical care in Vermont. Nobody has presented to the birth center yet as a person under investigation (PUI) or as a COVID-19 positive patient. The obstetricians are fielding a lot of calls from people wanting to transition obstetrical care to Vermont upon moving to the area. They are having a hard time talking to these moms and are requesting 14 days in quarantine before initiating care, unless there is an obstetrical emergency. We are trying to prepare at Porter for births with moms who are already infected with COVID-19. If the infant needs resuscitation, where are we doing that? Who's helping us? If the mom needs an emergency C-section, how are we getting them back to the OB unit where we have all our tools? All of these are rubrics and algorithms that are in draft form, and we are working hard with the incident team to firm up these algorithms.

Questions/Discussion

Q: Has there been any progress in having BCBS and Medicaid cover telemedicine well child checks for infants? This will be key to our long term finances.
A: Breena Holmes, MD, VDH: I do not think infant WCC will be paid for telemedicine. We discussed this at the beginning of the outbreak and determined that the infants need physical exams.
A: Denise Aronzon, MD, Timber Lane: What about a model where the history is done by telemedicine and the exam is done in person? It would decrease exposure time for providers and still accomplish key points of WCC.
A: Breena Holmes, MD, VDH: Currently, providers are not able to get paid for partial home and partial in-office.
A: Ashley Miller, MD, South Royalton Health Center: We are basically doing that. We are talking to them on the phone while they are in the car/parking lot to get all the history. They then come into the office to get their vitals and physical exam, have a quick Q&A (if longer we would send them back to the parking lot to talk on the phone), getting vaccinations (already drawn up), and then off they go.
A: Freyda Neyman, MD, CVMC: Even 9 month visits are not covered via telemedicine since they are not getting their immunizations?
A: Breena Holmes, MD, VDH: Freyda, I will find out, but BC/BS is clear about under age 2 needing to be in-person. We will keep talking with BC/BS and Medicaid about this.
A: Paul Parker, MD, Richmond Pediatric and Adolescent Medicine: It seems that doing the history remotely, but still bringing the child into the office for a physical exam and immunizations doesn't really mitigate the risk of exposure significantly. I'm just doing the whole thing in the office, but scheduling such that there is only one family in the office at a time and we have time to clean between patients.
A: Rebecca Collman, MD, Collman Pediatrics: My approach is the same as Paul's.
A: Debra Hartswick, MD, Timber Lane: We are doing something similar to Paul and Becky, but asking for a single well adult in a mask and scheduling the youngest infants first in the morning.
A: Ashley Miller, MD, South Royalton Health Center: Given the CDC guidance that prolonged contact makes a difference, we can get them in and out of the office in about 10-15mins, where a full visit takes 45 mins.

Q: Since we had Planned Parenthood on yesterday, my friend who works for them in CA is being told she cannot wear a mask. Even if she brings her own and wears it, she will be fired because it is "against protocol." Not sure if we can ask Donna for insight?
A: Breena Holmes, MD, VDH: Donna would be happy to answer that.