

VCHIP CHAMP VDH COVID-19

April 3, 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)

Sharing Practice Strategies – Harry Chen, MD, OnCall for Vermont (Medical Reserve Corps & Surge Planning)

Harry Chen, MD, VDH lead for OnCall for Vermont (Medical Reserve Corps)

In preparation, the State of Vermont is using predictive modeling from Oliver Wyman/Helen Leis, Columbia University and Northeastern University, and we are planning for the higher end of the models. We are focused on assessing potential need for staffed beds, ICU beds, ventilators, and PPE. The current models project the “peak” of cases between mid-to-late April and early May. We recommend reviewing this article in The Atlantic on modeling: <https://www.theatlantic.com/technology/archive/2020/04/coronavirus-models-arent-supposed-be-right/609271/>. At this time, it’s unclear what COVID-19 positive illness means in terms of subsequent infections with other coronaviruses for those who recover from COVID-19 during this pandemic.

In this role, my main task is to understand, if we do go beyond our hospital capacity, what do we do then? If you look at NYC, you will see what will happen. Right now, we are in the calm before the storm. In the worst case scenario, the surge will exceed capacity by 100s of beds, as well as ICU space and ventilators. There is some amount of latitude in increasing ICU and ventilator space. My focus has been to expand bed and staffing capacity both to help the hospitals and also to staff the surge sites. Each of the hospitals have planned to increase capacity as central locations for surge planning. That was our charge to them, to increase capacity. We need to work with hospitals to set up alternative care sites that may be part of the hospital itself, staffed and run by the hospital. If that is still overrun, then these are the alternative sites.

Location	Type	Beds	Med Lead	Support Lead
Essex Junction: Champlain Valley Expo	State	400	VTNG	VTNG
Rutland: Spartan Arena	State	150	RRMC	VTNG
Barre: Barre Civic Center	Regional	50	CVMC	State
St. Albans: Collins Perley	Regional	50	NMC	State
Burlington: UVM Patrick Gymnasium	Regional	150	UVMMC	State
Brattleboro: Brattleboro Memorial	Staged Surge Trailer	50	BMH	State
Windsor: Mt. Ascutney	Staged Surge Trailer	50	MAH	State

+ State has two portable hospital units to be deployed as needed.

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The State is charged with caring for the most vulnerable, including special populations with disabilities or mental illness, the homeless, and those in corrections. We are working hard to provide staffing at the State itself for these populations, as they will require special attention while recovering, but may not require hospitalization.

Surge capacity starts with the hospitals, as they are the ones who will have to take care of the sickest with COVID-19. We want to support them logistically, with staff to the best of our ability, and be cognizant of not taking away staff. Here are points for volunteering. If you work for a hospital, that's where you need to be. We at the State need hospitalists to work at their optimal level for to protect and take care of Vermonters. In terms of the alternate surge sites, we need to figure out where to get the staffing from. In terms of medical staffing, we are looking to FQHCs as potential sources, since they are not associated with hospitals, Medical Reserve Corps, higher education, school nurses, and the National Guard. We are trying to recruit them into our efforts. We are also looking into how we can relax the licensing guidelines to bring people back in, especially those who have recently retired. What I would like to say to healthcare providers, I know all of you are either pediatricians or family medicine physicians, is that Vermont really needs your help in response to COVID-19. Staffing is really going to be the most challenging aspect of the surge efforts in the State. If you work at or have a relationship with a hospital, a home health agency, or a long term care facility, that's where your focus should be. See if they need more help. If you are not associated with them or not needed, I encourage everyone to sign up for the Medical Reserve Corps (MRC). If you are retired, you can also sign up. MRC should be the central clearinghouse to match volunteer providers in Vermont with areas of need. No one will draft you to serve, whether you serve or not is totally voluntary. We are actively working on important issues like liability coverage and even potential payment for these services. We are making the case that if people are working more than an afternoon, and we may need volunteers over a several week period, then I think we should pay them. The Secretary of the Agency of Human Services is in agreement on principle, but needs to find funding. We are trying to send out letters to licensing boards. We are also looking for people with medical background who aren't using it right now due to slowdowns in other industries, like EMTs on ski patrol. The Governor is also concerned with the sustainability of the healthcare system as a whole in the midst of the surge.

Stephanie Winters, AAPVT Executive Director: The sign up link for the MRC went to all AAPVT and VTAFP members yesterday! The State's volunteer website directs these individuals to Vermont's MRC units, community-based groups of volunteers who can supplement local emergency, health care provider staff and public health resources. This is needed because Vermont's existing health care workers are going above and beyond to respond to this challenge as it unfolds, and they are going to need reinforcements.

Sharing Practice Strategies – James Metz, MD, FAAP, UVM Children's Hospital

James Metz, MD, FAAP, UVM Children's Hospital and UVM LCOM Department of Pediatrics

I want to talk about what we are seeing in child abuse admits during this pandemic and come up with strategies to try to recognize abuse while children are in households more and not being seen daily by teachers or other adults who are mandatory reporters. April is child abuse prevention and awareness month. We had planned to put on talks around the state and were pre-empted by the pandemic. If we can do some things now in time to help children, it will be really important. During the recession, rates of child abuse went up considerably. With this pandemic, reporting has gone down by 50% from last year at this

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Time in Vermont. We know reporting has gone down in New England and nationally as well. There have been significant increases in cases of abuse with head trauma, reported in Texas. We expect more cases with come to light.

Locally, we are engaged in an ongoing discussions of how to allow visitation safely between biological parents and their children currently in foster care. The majority of families have agreed to alternative ways to have visitation by phone or videoconference. In rare cases of pushback, we have looked at those cases individually and tried to come up with a rubric to determine when those children would be allowed to go with their biological families.

We have been working with VDH and DCF on getting a message out in front of families and children about how to report and how to deal with family stress. I am looking for recommendations on how we can get this messaging more in front of children and families directly, whether it be on a banner on Google or Facebook or Snapchat. I think that would be really important. Families are dealing with a lot of stress, and domestic violence and child abuse are going to be big issues. From DCF, because teachers have been the bulk of mandated reporters in the past, how do we make up for that when children are not being seen outside of the home? We are thinking beyond mandated reporters to folks exposed to children who see children and may also report, like mail carriers and sanitation workers.

For determinations of when to report, we recommend that any child with signs of physical abuse and their contacts need to be seen by a medical provider as soon as possible. They can start with primary care and then be triaged to the ED, if necessary. If you have concerns about abuse in a child under two years of age, that child will likely need a skeletal survey, which can only be done at UVMMMC, DHMC, or Albany. If you have concerns about abuse in a child less than six months of age, they will likely need head imaging. For bruising, we recommend using the TEN-4 decision rule. Any patterned bruises are concerning. For unexplained bruising or no confirmed accident in a public setting that accounts for bruising, we recommend making a report for child abuse if you see any bruise on a child less than four months of age or bruising present in the TEN (torso, ears, neck) region of a child 4 months to 4 years of age. (In many cases, bruising over the spine is not child abuse – “The Spring is Fine.” The TEN-4 decision rule has 97% sensitivity and 84% specificity for predicting abuse.

For concerns of sexual abuse, UVMMMC has 24/7 coverage by pediatric forensic nurse examiners (PEDI FNEs) all over the state. They are always available for questions through PAS (847-2700), which will connect you with the Child Safe Program. If you have significant concern of an acute event occurring within 120 hours, then the patient needs to go to an ED for forensic collection. SWMC and North Country have telehealth programs in place. CVMC ED and Primary Care Pediatrics are collaborating (Loretta Charles, FNP, and Kathleen Bryant, FNP, can see patients in the office, if appropriate, or respond to the ED). If the concern is chronic and the child is safe, you can make a referral to Child Safe, and we will contact the family. Advocacy programs through the Vermont Network for domestic violence are messaging about availability and connecting by phone. You can submit consult request to the Child Safe Program at any stage based on the information you have available to you.

Please do not hesitate to call me through the hospital operator. I am always available to help or be of assistance whenever I can. Consult Child Safe whenever you have a question. You can email childprotectionteam@uvmhealth.org, which we monitor all the time, or you can call 802-847-2700 and have Dr. Metz paged.

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Questions/Discussion

Q: I would still like to hear about testing sites in the southern parts of the state. I heard Springfield has a site. I would also like to hear what Dartmouth is doing.

A: Meghan Gunn, MD, FAAP, Southwestern Vermont Health Care: We have some testing here at SVMC in Bennington, but it's very limited.

A: Judy K. Orton, MD, Green Mountain Pediatrics: SVMC has drive through testing with an appointment - couple hours/day.

A: Carolyn Lorenz-Greenberg, MD, CVMC: CVMC has a pop-up site.

A: Cindy Howes, CPNP, Brattleboro Memorial Hospital: BMH has an off-campus site with clinician order.

A: Ashley Miller, MD, South Royalton Health Center: Dartmouth testing is only for physicians or patients with COVID+ exposure or hospital admission. At the main hospital near the ED, there are signs to direct you. You need to call ahead first to get permission. My friend thinks it's only NH residents but she says call ahead and check, it's changing daily.

Q: Can we use the AAP grant, Stephanie?

A: Stephanie Winters, AAPVT: We can't use grant funds for direct service.

Q: Is it still one positive child out of 160-ish?

A: Breena Holmes, MD, VDH: We are not doing real-time pediatric analysis. On 3/31, 1 child under 15 and 6 from 15 to 24 were positive. We can't ask the epidemiology staff to do the breakdown daily. Thanks to Ben and Bill for that.

A: Freyda Neyman, MD, CVMC: I find that data regarding COVID+ kids helps to reassure frantic parents.

A: Breena Holmes, MD, VDH: I completely agree.

Q: We are getting calls here asking us to "clear" kids with any URI symptoms at all to be allowed to go to daycare.

A: Heather Link, MD, UVMMC: Yes, we had a request for documentation of COVID-negative so a young adult could return to work. We provided it, but felt like it was violation of his privacy.

A: Alex Bannach, MD, North Country Pediatrics: I agree. That's a big topic. Due to isolation recommendations for basically any URI symptoms and school closures, many parents who might still have a job need to stay home when their kids have URI symptoms of febrile illness and are calling us to get a note for work. These are not kids ill enough to need a visit or testing but are not welcome by other caregivers (grandparents, etc.), which poses a very difficult situation.

A: Breena Holmes, MD, VDH: Our childcare guidance is clear...no sick kids can go, even if you are sure it is mild URI. We can't risk exposure even though it may be super low risk.

A: Meghan Gunn, MD, FAAP, Southwestern Vermont Health Care: Yes, I agree but the childcares are directing parents to call us so they must have confusion.

A: Breena Holmes, MD, VDH: Ok good to know. I am doing another webinar with the childcare work force next Tuesday and will address this directly.

A: Alex Bannach, MD, North Country Pediatrics: Under "normal" circumstances we would not write excuse notes for patients we have not seen, but as everything else, this is in flux.

A: Paul Parker, MD, Richmond Pediatric and Adolescent Medicine: How about simply sending them for drive-by COVID testing?

A: Alex Bannach, MD, North Country Pediatrics: With the ongoing limitations to testing, we don't test the kids.

A: Leah Flore, FNP, Timber Lane: I did not think they want us testing kids in general.

A: Meghan Gunn, MD, FAAP, Southwestern Vermont Health Care: We can't test kids here unless they're super high risk or hospitalized.

A: Breena Holmes, MD, VDH: That's right. Don't test kids unless moderate to severely ill and you're thinking about hospitalizing them.

A: Ashley Miller, MD, South Royalton Health Center: You could do a televisit for these kids and then write a note and get paid for your work!

A: Alex Bannach, MD, North Country Pediatrics: Ashley, I like your idea!

A: Breena Holmes, MD, VDH: Remember Seattle data (which VT appears to be confirming) showed a 0.7 percent positive rate.

A: William Raszka, MD, UVMMC: The data in Seattle was in symptomatic children (as it was here).

Q: I've tested several symptomatic kids whose parents are emergency responders or physicians and have had no problem getting them tested (other than long turn-around times for results). Is that ill-advised or a misuse of tests?

A: Meghan Gunn, MD, FAAP, Southwestern Vermont Health Care: My understanding is to only test them if they're symptomatic AND if the HCW is symptomatic too.

A: Alex Bannach, MD, North Country Pediatrics: Meghan, and then we would check the HCW rather than the kid anyways, right?

A: Benjamin Lee, MD, UVMMC: As with all testing, one can use discretion and clinical judgement. We are not saying testing is forbidden in children, but rather we discourage testing of children as routine.

Q: Any thoughts to liberating the MDI's at "school nurses" offices to be delivered back to families via the lunch delivery buses?

A: Breena Holmes, MD, VDH: It has not come up, and it's a great thought. Dr. Chen outreached to the state board of nursing and is talking to the school nurse state association to activate nurses outside of their current scope of work. They're feeling underutilized in general, so we're hoping to hear where they can be utilized. If you have local needs, please reach out.

A: Leah Flore, FNP, Timber Lane: At the school I work at, the nurses are doing essential child care screening.

A: Alex Bannach, MD, North Country Pediatrics: We called the school nurses when school closures started asking them to dispense both the controlled medicines as well as inhalers to families.

A: Suzanne Picard, RN, CVMC: I think activating the school nurses is great, we have a per-diem who is a school nurse and isn't allowed to help at the practice right now.

A: Leah Flore, FNP, Timber Lane: Some of the school nurses have multiple jobs, so they are feeling very busy.

A: Alex Bannach, MD, North Country Pediatrics: Also, it's a good idea to be prescribing nebulizers rather than inhalers for at home therapy if there is a shortage.

A: L.E. Faricy, MD, UVMMC: Also, keep in mind that albuterol MDI reportedly has a shortage, but no shortage has been reported for xopenex (levalbuterol) or possibly other brands of albuterol (i.e. Proventil).

A: Alex Bannach, MD, North Country Pediatrics: Thanks, good to know.

A: Thomas Moseley, MD, Newport Pediatrics: Remember that some formulary rules require PI for non-generic MDI's.

Q: Ben/Bill - any sense on if CDC is going to recommend masks in public? The media seems to be pushing that possibility.

A: Alex Bannach, MD, North Country Pediatrics: Germany and Austria just started recommending it.

A: William Raszka, MD, UVMMC: There were massive headlines about that last PM but the headlines as of noon did not suggest that has been done that yet. I suspect it is now a hot political topic. I suspect it will come.

A: Benjamin Lee, MD, UVMMC: I don't have any inside info on this. My sense was that CDC was likely going to recommend this but perhaps as a soft and not firm recommendation.

A: Breena Holmes, MD, VDH: I am not Bill/Ben but yes we are heading toward masks in public (and reminder to please stay home). This will have to be done responsibly regarding PPE since masks should be reserved for healthcare frontline personnel.

A: Ashley Miller, MD, South Royalton Health Center: From 2 hrs. ago on masks via C-span: Vermont Governor Phil Scott (R) holds a briefing on the state's response to the coronavirus pandemic. Vermonters are urged to continue social distancing practices, including wearing cloth masks in public, even if they are not symptomatic. <https://www.c-span.org/video/?470931-1/vermont-residents-urged-wear-cloth-masks-public>

A: William Raszka, MD, UVMMC: Many countries do recommend it and some are requiring masks.

A: Lisa Gannon, MD, Timber Lane: Lots of searchable directions on how to make your own cloth mask. This reserves supplies for HCP also.

A: Alex Bannach, MD, North Country Pediatrics: Ideally, those would be primarily homemade fabric masks in order to preserve PPE. Anyone else feeling their BP rise when they see pictures of public with N95 masks on TV?

A: Stephanie Winters, AAPVT: Mark Levine said to wear cloth masks when outside, but that does not replace stay at home, stay safe.

A: Benjamin Lee, MD, UVMMC: Great, thanks for the updates all on cloth masks in VT.

A: David Nelson, MD, UVMMC: At UVM in the ED, we are using a minimum of surgical masks for all patient encounters, N95 for respiratory patients.

A: Benjamin Lee, MD, UVMMC: I think having all parents wear cloth masks when they come into the office would make sense.

Q: I heard Fauci state that COVID-19 can be transmitted by breathing or speaking. Is there any science behind that? If so, I probably need to reconsider wearing masks at all patient encounters.

A: Lisa Gannon, MD, Timber Lane: News on CBS today was related to a blood test for antibodies.

Stephanie Winters, AAPVT: Commissioner Levine also acknowledged that the science is mixed, but expected the CDC to come out with guidelines soon.

A: William Raszka, MD, UVMMC: There is concerning data from a choir group in Washington. There is experimental data that suggests it can be in the air for two hours. Several companies have designed tests for antibodies. The FDA is quite clear that they have allowed that but have not done any validation studies. The results have to come with major disclaimers. I think when there are sufficient masks, HCW have been wearing masks when seeing patients (e.g. a mask for the shift).

Q: Are they going to come out with thoughts on homemade masks and their actual utility, whether they should be putting vacuum filters etc. in them? Ben, I would put on surgical masks, not homemade masks. I am seeing homemade are only 50-60% effective.

A: William Raszka, MD, UVMMC: Homemade masks do not replace surgical masks.

A: Benjamin Lee, MD, UVMMC: For providers who require PPE for a patient encounter, medical-grade PPE should always still be used.

A: William Raszka, MD, UVMMC: There are no standard for homemade masks.

A: Benjamin Lee, MD, UVMMC: The gray zone is what to do with asymptomatic parents in the office, and whether we should "sacrifice" medical-grade PPE to use on them.

Q: Bill/Ben: Is there any good data emerging about asymptomatic "carriage" (not presymptomatic or never symptomatic)?

A: Benjamin Lee, MD, UVMMC: There are data to suggest that some proportion of people can remain asymptomatic, but what is not clear is if they are able to transmit infection, and if so, how efficiently. For example, on the diamond princess cruise ship, if memory serves, 18% of positive cases were truly asymptomatic.

Q: Is anyone having patients wait in their cars and call them when it's time to be seen?

A: Ashley Miller, MD, South Royalton Health Center: Yes.

A: Judy K. Orton, MD, Green Mountain Pediatrics: Yes.

A: Alex Bannach, MD, North Country Pediatrics: Yes, we have been seeing all sick (infectious) visits in their car for the past 3 weeks. This works fine, but there's obviously limited vital signs and exams. Parents, overall, are very understanding.