VCHIP CHAMP VDH COVID-19

May 8, 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)

Practice Issues – Today's Media Briefing

Breena Holmes, MD, FAAP, VDH

It's going to get really busy between now and fall for pediatricians to advise and inform child care, summer camp, and school openings on best practices and educating childcare providers on how to keep kids safe. I am recruiting a work group of all of you to receive training and hold conversations and meetings in your communities to educate on these issues. Dr. Bill Raszka is going to participate as well.

Practice Issues – Testing Updates (HAN)

Breena Holmes, MD, FAAP, VDH; William Raszka, MD, UVMMC; Benjamin Lee, MD, UVMMC

VDH is initiating several on-site testing opportunities for frontline healthcare workers, first responders and child care providers currently serving essential workers. This is voluntary and not to be used as criterion for return to work. VDH anticipates several additional opportunities next week in Bennington, Brattleboro and Hartford. VDH will continue to identify best process for testing including enhancing the extended test site capacity and hours to test mildly symptomatic patients. There is more information to come on this topic.

William Raszka, MD, UVMMC: We've always had some difficulty in deciding who to test and under what conditions. Testing asymptomatic people is particularly perplexing and vexing. In South Korea, they had an aggressive policy in testing for asymptomatic people. Doing a random group of people who are asymptomatic in sampling is a debatable strategy. It's a very short snapshot in time and only reflects what may have occurred in the past 48-72 hours. I am having difficulty in understanding what information you're going to get from this standup clinic in testing frontline healthcare workers, first responders, and child care providers. I don't routinely recommend testing asymptomatic people unless they've had a true exposure to someone who was positive.

Breena Holmes, MD, VDH: Fom the public health perspective, there is a significant interest in asymptomatic testing in the epidemiological world. When you put individuals into an epidemiologic strategy, you risk things. One of the risks is it gets confused with clearance for employment. There will be plenty of employers who wonder about this. Private employment can set its own guidance on what they require of their employees, which is a slippery slope.

Benjamin Lee, MD, UVMMC: I don't have much to add to what Dr. Raszka said. To reiterate, as part of a comprehensive contact tracing and isolation strategy, if you have identified exposures who are asymptomatic, then it would make sense to test for the purposes of isolating if positive. That's really the context in which most asymptomatic testing has been done in a community. As part of a comprehensive test and isolate strategy, that makes sense. It's much more challenging to know how to approach wide-scale, population-based asymptomatic testing. Without a known exposure, the likelihood of finding folks who are positive is low. If you do find them, it raises the question of where they got it. It really is just a snapshot in time and doesn't have any predictive value. A single test of an asymptomatic person without a known exposure doesn't really say much other than they were negative at that period of time. Interpretation and knowing what to do with those results is a little limited in the absence of a known exposure. Another scenario where asymptomatic testing has been discussed quite frequently and there is rationale for it is for

pre-procedural or pre-surgery testing. If they are going into surgery, there's a significant risk of exposure to the healthcare workers.

Breena Holmes, MD, VDH: I am not the decider on who gets tested. I am encouraging the testing task force to work closer with clinical people (i.e. Drs. Raszka and Lee) to figure out what makes sense. Starting tomorrow, there will be this pop-up testing site and then 3 or 4 more which gets us to May 15. Our original intent of healthcare worker screening was to test those who are going to be part of elective procedures in the very near future as we inch of reopening and restarting. It's getting inflated, hard to message and a little bit out of my control. We hope the governor and his team work more closely with the medical center. We want to add more guardrails to this. I'm all for more tests, but I'm grateful for your input. Let's see what happens tomorrow.

Wendy Davis, MD, VCHIP: PCPs would be notified and prepared with all of this information to be able to have an informed discussion with their patients. It is important to understand there is not clear direction. This group is trying to use science and balance with the larger context. The larger context is a political context here and there are many different interests being served when these complicated and challenging policies come out. There was also a question about criteria in regards to a patient being seen at UVMMC ER who had a fever but was not tested. Dave Nelson (at ER) says policy is to test anyone who is indicated and will look into it. Ashley said sometimes testing is offered and parents decline. Despite assurances to contrary from the State, there are concerns and confusion about employers requiring testing.

Breena Holmes, MD, VDH: We need to keep asking ourselves what is the goal and what are we doing. The serology work group is keeping tabs on the accuracy and reliability of those tests. My epidemiology team is saying short-term testing is the better strategy for restart. That's the political and economic strategy right now. Test, test, test, pluck and isolate those who are ill, move forward. What should we do about healthcare workers? If Dr. Lee or Dr. Raszka could dig around and figure out the impetus behind testing asymptomatic healthcare workers, that would be helpful.

William Raszka, MD, UVMMC: This is a very fluid process. There has been discussion about testing healthcare workers in UVMMC system but he is not sure who exactly or what the ultimate decision will be at this time.

Breena Holmes, MD, VDH: I'd like to remind you colleagues and peers that you will all be in these dialogues with families. We can't make public health decisions about what private employers do. We are not using test-based strategies for employment clearance, including testing children for parent employment clearance. Every time we suggest testing, it will not create reassurance for the future. All testing does is eliminate positive people from moving about during the time when they test positive and are contagious. A negative test doesn't tell you anything beyond today.

Wendy Davis, MD, VCHIP: There were questions on serotology testing. Some of the private labs are offering in anticipation of parents asking. We generally accept a negative result with low prevalence in Vermont and low pre-test probability. Dr. Lee reminded us that children will have low pre-test probability anyway.

Breena Holmes, MD, VDH: A week ago, I was promoting all testing should be done at physician's orders so that you all knew the results. I got pushback and it turns out that's a big burden on primary care to receive phone calls from asymptomatic patients wanting a referral for a test. The public health physician on record will now be the ordering physician with the primary care physician listed in case results come back positive for notification purposes.

Practice Issues – Friday Potpourri
Wendy Davis, MD, FAAP, VCHIP

Business Impact on Pediatric Practice

Dr. Ashley Miller brought to our attention that primary care providers have to charge for masks/gowns/googles based upon agreement with insurers. PCPS can charge for supplies that are over and above of what they normally would use because of COVID. This raised some questions for us about implementation. With help from Stephanie Winters, we are seeking clarification from VT payers. 99070 and COVID CPT code are being used for these visits. Dr. Miller also raised a possible issue related to malpractice coverage because there have been some agreements in place about relief from COVID-19 related cases. There were some concern about how broadly that would be apply depending on clinical scenario. One thing that was shared was the specific wording people are using as documentation for their telehealth visits (i.e. describing how the visit was conducted, limitations on that visit, and the risks and benefits described to the parents, and verbal consent being obtained). We'll try to get more clarification.

Other Clinical Issues

Lactation consultation service delivery

Kristen Bird, lactation consultant, had shared with us previously on how to safely deliver lactation consultation services and was doing some through telehealth. Kristen had recently raised a question about being able to safely do that now going back to home-based service delivery and some of the informal discussion as identifying that as a necessary service.

Decreasing immunization rates

There will be an early release of MMWR today with data showing troubling decreases in ordering and administering of childhood vaccines during the beginning of 2020 due to COVID-19 outbreak.

Questions/Discussion

Q: Is tomorrow's onsite testing opportunity in Colchester advertised in other ways or dependent upon word of mouth?
A: Breena Holmes, MD, VDH: This has been sent through the usual channels, professional groups, etc. We are hopeful that it came through HHA.

Q: How will those who self-register for testing be notified of results, and will their PCPs be notified?
A: Breena Holmes, MD, VDH: VDH collects the PCP's information and shares the results with the medical home.

Q: Will they be using an NP test for the pop-up testing center?
A: Breena Holmes, MD, VDH: They are planning on an NP for tomorrow, but they are planning to move swiftly to the anterior nares with full PPE.

Q: Not sure if anyone from UVM MC ER is online, but I am curious what criteria UVM MC ER is using in terms of who to test. On Wednesday night, I had a child with a fever seen in the ER who was not tested.
A: David Nelson, MD, UVM Pediatrics ED: I wasn't in the ED on Wednesday, but we can test anyone we want. Not sure why that child wasn't tested.
A: Ashley Miller, MD, South Royalton Health Center: Did the parents decline? I just had parents of a 2-year-old decline because it wouldn't change management and they considered it to be invasive.

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

A: Alicia Veit, MD, Timber Lane Pediatrics: I will touch base with Dr. Nelson about it later. I'm not sure why it wasn't done. The note did not report that the parents refused and when I had originally called the ER, they had stated that testing would be done. But, yes, parents may have declined.
A: David Nelson, MD, UVM Pediatrics ED: Please email me with some details at david.nelson@uvmhealth.org

Q: Will VDH have recommendations for routinely testing health care workers who are seeing patients for procedures, elective surgeries, or more in-office visits?
A: Breena Holmes, MD, VDH: We are encouraging the testing task force to work closely with medical providers. This pop-up testing will get us to May 15th (reopening). I thought the testing was just for the elective surgery teams, but it seems to be for all.

Q: Drs. Lee and Raszka, do you know what adult infectious disease is thinking? Are they aligned with you?
A: William Raszka, MD, UVM Children's Hospital & Larner COM Department of Pediatrics: I do not know if they were involved. Historically, we have not recommended testing asymptomatic people unless they are part of contact tracing.

Q: If the asymptomatic incidence in the population is what we are looking for, would serology make more sense?
A: Breena Holmes, MD, VDH: We want serology testing to be more accurate and yes, for long-term, that is a good tool. For short-term, the testing is better for restarting to understand the current burden.
A: William Raszka, MD, UVM Children's Hospital & Larner COM Department of Pediatrics: We are waiting for better serologic tests.

Q: Is there any timeline for when VT DOH and/or UVM will have reliable serology testing available?
A: Breena Holmes, MD, VDH: We are waiting for better accuracy.
A: Denise Aronzon, MD, Timber Lane Pediatrics: Thanks. I hear that some of the private labs (Quest, etc.) are offering serology testing, and so I am anticipating parents starting to ask.

Q: Do we even know that positive serology infers immunity?
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: We do not.

Q: If I was an asymptomatic patient that was having a procedure done and was required to have a COVID test, I would want the health care workers taking care of me to also be tested.
A: Jill Rinehart, MD, UVM MC: All procedures at the hospital that are aerosolizing are requiring COVID testing. Even if they are wearing PPE like in the OR?
A: William Raszka, MD, UVM Children's Hospital & Larner COM Department of Pediatrics*: The patients are tested before procedures primarily if they may need airway management, e.g. they are sedated. We always test before a known aerosol generation procedure.*

Q: How reassured can we be by a negative test in a symptomatic patient? Especially if it takes two days to get the negative result back, they may have become positive during that time!
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: It depends on the clinical scenario and pre-test probability. In general, most children will have low pre-test probability.
A: William Raszka, MD, UVM Children's Hospital & Larner COM Department of Pediatrics: We have a low prevalence rate. If the pre-test probability is low, I accept the negative results.

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Q: What is UVM using currently for criteria for positive HCWs to return to work? For example, 2 negative tests?
A: William Raszka, MD, UVM Children's Hospital & Larner COM Department of Pediatrics: We use a testing strategy in symptomatic HCWs with positive results separated by 24 hours.
A: David Nelson, MD, UVM Pediatrics ED: For UVM employees: 1) You have had no fever for at least the last 72 hours (that means three full days of no fever without the use of fever-reducing medication) AND other symptoms have improved (for example, when your cough or shortness of breath gets better) AND at least 7 days have passed since your symptoms first appeared.
https://www.uvmhealth.org/Pages/Coronavirus/Expert-Advice-and-Resources.aspx
A: William Raszka, MD, UVM Children's Hospital & Larner COM Department of Pediatrics: David, the CDC updated their guidelines and emphasized a test based strategy. That is what Kemp Alsoton is using now.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: David, this is the previous symptom-based strategy, that will need to be updated. It is now 10 days since symptoms first appeared, that is, for community members who are positive.

Q: If the second test is positive, do they need two subsequent negative test results?
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: Yes, 2 negative tests.
A: Breena Holmes, MD, VDH: VDH is not recommending test-based strategy after a positive test. It is too cumbersome and it's not working.

Q: A medical resident I know in Boston is now 30 days past symptoms, asymptomatic and totally well, but is testing positive.
A: Breena Holmes, MD, VDH: Exactly. We had corrections staff who are positive 40 days after the first positive.
A: William Raszka, MD, UVM Children's Hospital & Larner COM Department of Pediatrics: The prolonged detection of viral RNA is a bear using the testing strategy.

Q: Have people discussed how to approach the care of children if they have only have one parent who then gets admitted for COVID?
A: Breena Holmes, MD, VDH: No, this has never come up. Wow, this is super important.
A: Elizabeth Hunt, MD, Timber Lane Pediatrics: I had a family like that and they tapped into family.
A: Melissa Kaufold, Pediatric Palliative Care Program Home Health Agency: This question has come up to us at HHA by a worrying parent.
A: Alicia Veit: It has been talked about on NBN Quality Committee in relationship to newborns.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: This question came up this morning as this was a potential possibility in our ED overnight. I'm not sure what happened.

Q: Are we able to get the immunization numbers for each of our practices? Those are disturbing graphs!
A: Wendy Davis, MD, VCHIP: I would think so through the registry.

Q: Jill Rinehart, MD, UVM MC: On national news last night, VT and MN were highlighted on a map as states that had a high number of new cases identified (50% uptick in new cases). Is this true or is there data delay?

Q: As far as testing prior to surgery and kids needing dental surgery at the hospital, do they need testing?

Q: What is the test sensitivity in symptomatic people? In asymptomatic people?

Q: In the office, and even if we are negative and asymptomatic, how often are we going to get tested?

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Follow-up Needed

- VDH Fact Sheet: Vaccines Administered – the COVID-19 effect
- Great back to the office campaign information from Ashley Miller, MD, South Royalton Health Center: https://forum.pediatricsupport.com/t/louisiana-aap-back-to-the-office-campaign-info/3795
- Day Care During a Pandemic post from Ashley Miller, MD, South Royalton Health Center: https://www.kckidsdoc.com/kc-kids-doc/day-care-covid19-child-care?fbclid=IwAR0rzcPo8BGdbJ1xUNRqnZ4H23g8lFLbWPt_F8r2zaToCa70q1M53ZQ4R3c

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