

VCHIP CHAMP VDH COVID-19

July 20, 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)

VDH Updates

Manchester Medical Center

35 of the 63 people with a positive antigen test for COVID-19 reported to VDH by MMC since July 10 have had a PCR test. 33 of those 35 PCR tests were negative, and two (2) were positive. VDH has contacted 56 of the 63 individuals with positive antigen tests as of July 18, and most are symptomatic with no link to other cases. So far, VDH finds no indication of COVID-19 spreading in the community.

Weekly data summary (7/17/20)

Weekly Spotlight – County Profiles: detailed data for every county in Vermont:

https://www.healthvermont.gov/sites/default/files/documents/pdf/DataTeam_WeeklySummary_7.17.20.pdf

Testing

Information on when and how to get testing can now be found at:

<https://www.healthvermont.gov/response/coronavirus-covid-19/testing-covid-19>

Publications and Media Articles

MMWR: *Absence of Apparent Transmission of SARS-CoV-2 from Two Stylists After Exposure at a Hair Salon with a Universal Face Covering Policy* — Springfield, Missouri, May 2020

MMWR: *Factors Associated with Cloth Face Covering Use Among Adults During the COVID-19 Pandemic* — United States, April and May 2020

Health Affairs: *Community Use of Face Masks And COVID-19: Evidence from A Natural Experiment of State Mandates in The US* (July 2020)

Recap of Friday (7/17/20) media briefing and follow up (Raszka & Lee): <https://vtdigger.org/2020/07/19/qa-a-uvm-researcher-on-covids-impact-on-kids-and-the-implications-for-schools/>

Emerging Infectious Diseases (early release): *Contact Tracing during Coronavirus Disease Outbreak, South Korea, 2020*. From NYT & AAP Daily Briefing: “children younger than 10 transmit [the coronavirus] to others much less often than adults do, but the risk is not zero.” Furthermore, “those between the ages of 10 and 19 can spread the virus at least as well as adults do.” Several experts have cautioned that “the findings suggest that as schools reopen, communities will see clusters of infection take root that include children of all ages.”

“Trump Administration Strips C.D.C. of Control of Coronavirus Data” (NYT 7/14/20 re: hospitals ordered to bypass CDC & send all patient information to a central database in Washington). MoveOn.org petition:

https://sign.moveon.org/petitions/cdc-data-bypass-2?share=8cbd97f7-9879-4395-a313-9e9aa09a0c99&source=email-share-button&utm_medium=&utm_source=email

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NEW reports (TX & FL) of pediatric testing data (including infants < 1 y.o. positive)

CDC Resources for Young Adults

Factsheets for Young Adults

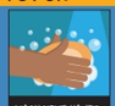
CDC has produced a series of factsheets for young adults, ages 15-21. The factsheets cover a variety of topics, including what test results mean, how to stay safe at the pool or beach, how to wear a face covering and other preventive measures.

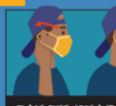
- [Wear a Cloth Face Covering to Protect You and Your Friends](#) [1 MB, PDF]
- [Help Protect Yourself and Others from COVID-19](#) [1 MB, PDF]
- [What Your Test Results Mean](#) [1 MB, PDF]
- [Slow the Spread of COVID-19](#) [1 MB, PDF]
- [Do it for Yourself and Your Friends](#) [1 MB, PDF]
- [Stay Safe at the Pool/Beach](#) [1 MB, PDF]


More Info

Wear a Cloth Face Covering to Protect You and Your Friends


PUT ON



WASH YOUR HANDS

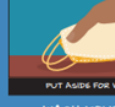

PLACE OVER NOSE AND MOUTH



MAKE SURE YOU CAN BREATHE EASILY

TAKE OFF



TAKE OFF YOUR FACE COVERING


FOLD OUTSIDE CORNERS TOGETHER


PUT ASIDE FOR WASHING


WASH YOUR HANDS

WASH YOUR HANDS OFTEN, WEAR A MASK, AND STAY 6 FEET FROM OTHERS.


cdc.gov/coronavirus

Cloth Face Covering: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/Young-Mitigation-recommendations-resources-toolkit.pdf>

Protect Yourself and Others: https://www.cdc.gov/coronavirus/2019-ncov/downloads/Young_Mitigation_recommendations_and_resources_toolkit_01.pdf

What Test Results Mean: https://www.cdc.gov/coronavirus/2019-ncov/downloads/Young_Mitigation_recommendations_and_resources_toolkit_02_HS.pdf;
https://www.cdc.gov/coronavirus/2019-ncov/downloads/Young_Mitigation_recommendations_and_resources_toolkit_02_COL.pdf

Slow the Spread: https://www.cdc.gov/coronavirus/2019-ncov/downloads/Young_Mitigation_recommendations_and_resources_toolkit_03_HS.pdf

Do It for Yourself and Friends: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/Young-Mitigation-recommendations-resources-toolkit-HS.pdf>; <https://www.cdc.gov/coronavirus/2019-ncov/downloads/Young-Mitigation-recommendations-resources-toolkit-COL.pdf>

Stay Safe at the Pool/Beach: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/FS-stay-safe-pool-beach-HS.pdf>; <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/FS-stay-safe-pool-beach-college.pdf>

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Practice Issues: COVID Clinical Conundrums – Breena Holmes, MD, VDH and Benjamin Lee, MD, and William Raszka, MD, Pediatric Infectious Disease Specialists

Wendy Davis, MD, VCHIP: We will begin to address some of these clinical conundrums that you have been bringing to us. We pulled out some of the scenarios that you were hearing about in practice and how to respond. We will present the scenarios as they were presented to us, talk a little bit about the guidance that we think is responsive, and then entertain from you any additional feedback, questions, or comments about these different scenarios.

Breena Holmes, MD, VDH: This is a great of example of how we really want to hear very specific questions from you so that we can get the right information to as many of you as possible. Here is the first question:

- What if a teacher or their child (at same school) fails screening at the door?
 - Scenario 1: Teacher is fine, but child is mildly symptomatic and needs to go home. Does the parent-teacher need to go home too? **No.** The kids go home, but the teacher is still fine. We don't send the whole family out of the system for one symptomatic or positive health screen.
 - Scenario 2: Teacher is symptomatic and needs to go home. Does their child also automatically have to go home if they are asymptomatic? **No. The teacher will be asked to go home, but the child is able to say stay in school. If the teacher is tested and has COVID-19, then the child (will be a close contact and) goes home.**

We need to slow down enough to ask ourselves “what is the purpose of a health screen?”, and the health screen is really about individuals. Here is the guidance that supports our response to this scenario: Refer to VDH – VT AOE “[A Strong and Healthy Start: Safety and Health Guidance for Reopening Schools, Fall 2020](#)”

Stay Home When Sick: Exclusion/Inclusion Policies – Students and staff will be excluded from in-person school activities, if they:

- Show symptoms of COVID-19, such as a cough, shortness of breath, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell
- Have been in close contact with someone with COVID-19 in the last 14 days
- Have a fever (temperature higher than 100.4°F)
- Have a significant new rash, particularly when other symptoms are present
- Have large amounts of nasal discharge in the absence of allergy diagnosis

If above signs and symptoms begin while at school, the student (or staff member) must be sent home as soon as possible. Keep sick students separate from well students and limit staff contact as much as reasonably possible, while ensuring the safety and supervision of the sick student(s) until they leave. Students and staff should be excluded from school until they are no longer considered contagious. Students and staff with fever greater than 100.4°F and no specific diagnosis should remain at home until they have had no fever for 24 hours without the use of fever-reducing medications (e.g., Advil, Tylenol). Materials, toys & furniture touched by the student should be thoroughly cleaned & disinfected. Healthy students and staff with the following symptoms/conditions are not excluded from in-person school activities:

- Allergy symptoms (with no fever) that cause coughing and clear runny nose may stay if they have medically diagnosed allergies and follow medical treatment plans.
- Well-controlled asthma

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Breana Holmes, MD, VDH: One of the most interesting parts of COVID is the symptom list. As you know, from the beginning it was fever, cough, and shortness of breath, and then all sorts of observations were being made about COVID-19 and many, many other symptoms. The list just got longer and longer. Somewhat interestingly, if you go on the VDH website or any sort of adult screening list for businesses and other places where people are receiving health screens, the list of symptoms is longer than this. When we developed the school guidance with Bill and Ben's help, we took diarrhea off the list. We removed diarrhea because so many kids have diarrhea. We felt like it was going to create a lot of confusion out in the world.

The minute we released the school guidance, we got a ton of questions about that, which then led to childcare and summer camp questions. Everyone likes alignment during COVID-19. My VDH colleagues were saying "why do you have a different list of symptoms than adult guidance on the website?" I'm calling that out. We have a whole group of people here who thought this through together. I am wondering what your experience is. I'm going to ask Dr. Raszka to address the symptom list for this group and where we might want to go from here for including diarrhea or not.

William Raszka, MD, UVMCH: As you know, children rarely present with cough or shortness of breath, maybe 20%, or they have very mild symptoms. I have been extremely hesitant to simply use diarrhea as a sign and symptom that would necessitate testing for COVID-19. I think so many children have loose stools that we would have difficulty trying to even define diarrhea. How many loose stools over what period of time? Is a single bowel movement enough to define diarrhea? I think that puts so much pressure on the physicians. If you have diarrhea and other symptoms, like malaise, then sure, but simply diarrhea, I am happy not to use that as a diagnostic criterion for COVID-19 in the pediatric population.

Wendy Davis, MD, VCHIP: It's important for us to go back to our basic rules about infectious illnesses in children and school and childcare attendance. We should apply that lens as well.

Breana Holmes, MD, VDH: You are all so important to this mission critical experience in the month of August in getting schools open in some capacity for in-person learning. One of the ways we are going to get kids back into some level of in-person instruction will be for you all to become experts in contact tracing and the public health response to COVID-19 so that you can slow everybody down. There is a journey that's well worked out that we're really good at. If someone develops signs and symptoms at school, they go home, and then a whole decision algorithm needs to ensue. Are the symptoms consistent with COVID-19? Does the child need testing? Or is it run-of-the-mill pediatric illness?

You are going to need to get involved. I think one of the things that I say too much is team-based care because I need the school nurses, you, and parents to talk together about symptomatology and about the decision of who should be tested, who needs to stay home for a couple of days, and who needs to go right back the next day because it was really something mild. In terms of the whole notion of contagion, return to school after 24 hours with no fever is very much rooted in this notion for almost every virus or infection. I want to think this through and recognize the burden ahead for all of you, though maybe you don't perceive it as a burden. Maybe it's your - the primary care medical home's - role in keeping some of our in-person activities rolling.

Allergy and asthma have been topics since the very beginning. I've asked childcares and summer camps not to request medical clearance letters from you, but I still hear from all of you that that's glitchy. It's not completely clearing up in my discussions with childcare providers in big settings and also our childcare

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advisory group and our child development division. It's possibly going to need more of the community-based, team-based care where someone in your office outreaches to childcare providers. You can do that through your Building Bright Futures council or through your MCH coordinators in the districts. Have a conversation about when kids have allergies and asthma, and you think they're okay to attend care or school. How does that get communicated if it's not verbal? I actually thought it could be verbal, but people are still really nervous about that.

William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Asthma is crystal clear now. Only people with moderate or severe asthma may be at increased risk.

Wendy Davis, MD, VCHIP: We are entertaining whether there is anything we can put into a one-pager where we recap and summarize in a succinct way the guidance. Is there anything we can put out that would be helpful to practices? Something where you could point to it and say, "You need clearance? Here's what I've got for you."

Breana Holmes, MD, VDH: One of the things we know you need is a handout for parents that says what to expect. we have one for childcare in camp, but we'd like one for school. In that, I'd like to empower parents to go to childcare or schools and say "Here's the letter. Here is the what to expect, and it does not involve medical clearance. My doctor did say this is well-controlled asthma" that kind of thing. If a specific letter that you could send to all of the childcare providers in your community would be helpful, then we have some avenues for that as well. I really have tried, but I think we need to keep trying.

We could send out letters more widely, if that's helpful. We are getting stronger in our language about asymptomatic testing is not a thing. We don't encourage it for return to work or school, though colleges will be doing a ton of asymptomatic testing. Schools really need to be told by local pediatricians as well as public health that the decision to test or not will be made at the PCP level. I love that we are in this community of practice together because this is not a normal time, but you have all the clinical backup, each other, your colleagues, and Drs. Lee and Raszka to go case-by-case .

Here is the second scenario:

- Grade school age child at daycare discloses "I had diarrhea". Sent home with no other symptoms & normal stool at home the same day. Daycare requested PCP clearance to return.

Benjamin Lee, MD, UVMCH: One day or one episode of loose stools or diarrhea by itself really isn't in my mind cause for concern. That child would be perfectly fine to go back to school when their symptoms have already resolved. There were no symptoms that were concerning for COVID-19. This one is pretty cut and dried. It happens all the time in kids. They may have just had too much juice that morning. Even if widespread agreement that not cause for concern, the daycares are still requesting PCP clearance to return. As Dr. Holmes said, everything you can do as far as outreach in getting the message out to daycare centers that for a single episode of diarrhea you don't need to keep the child out of care.

Breana Holmes, MD, VDH: When you have a school-age child with these complexities, then you have a school nurse to talk to, which is different than childcare. Any time a clearance letter is requested, you have several choices. You can whip off something quick, which is not ideal. You can find someone in your office who can be your childcare liaison. Call VDH or call your regional Building Bright Futures coordinator. I can get you these phone numbers. Try to work it out at the systems level to say that this is not a requirement,

and the parent has the information they need to tell you that we're not concerned and the child may return to care or school. I want to try to get this to the community level. Reminding people that you don't need a clearance note from my perch, which is meeting with childcare leadership, a childcare advisory group, and the Building Bright Futures state group isn't working. I have to hand it back to you now to do some sort of team-based care in your communities. I do think our district health offices can help with that.

Here is the third scenario:

- Preschool-age child with clear runny nose X few days: PCP feels potential allergy symptoms based on history but no formal testing. Daycare requests clearance/note.

That's up to you to empower the parent to say, "I believe this is allergies." We're certainly not requiring testing, as we're not engaging in any way in your clinical judgment.

Here is the fourth scenario:

- Preschool-age child (w/known chronic OME) brought to ER with symptoms of purulent ear drainage & no other symptoms. Started on drops and ER provided note saying he could go back to daycare. Family called next day saying daycare would not allow return w/o medical clearance from PCP.

That's again surprising to us and not remotely OK. ER clinicians are just as able to work through the COVID returns as primary care. these local scenarios need a lot of education.

Here is the fifth scenario:

- 6-month-old in DCF custody coughing X 4 months after bronchiolitis-like illness. Seen by pulmonology: "likely post viral or asthma-like condition." Some improvement with asthma care plan, but constant concern from daycare about cough. Dilemma: is increase in cough new illness or exacerbation of underlying condition?

William Raszka, MD, UVMCH: If someone has a persistent complaint like cough, I think that is an underlying condition. I would only exclude that person if that person had something now quite different about the cough. Does he have fever? Is the cough now associated with shortness of breath? If this is still consistent with his underlying illness, then I would not exclude them from childcare.

Breena Holmes, MD, VDH: This is where you guys know your families. If it's this specific and truly a kid coughing in childcare, this scenario might require a note. I don't want to be so black and white that I miss an opportunity to really relieve a childcare system of high stress. A cough is stressful to be witnessing without a little bit of back up. For some of the other stuff, I think the clearance could be verbal and should be verbal. If it's someone that's been quite ill for a prolonged period, I would appreciate some written communication for that scenario.

Refer to "[A Strong and Healthy Start: Safety and Health Guidance for Reopening Schools, Fall 2020](#)" and "[Health Guidance for Childcare Programs, Summer Programs and Afterschool Programs](#)" (latter rev. 7/13/20)

Stay Home When Sick: Exclusion/Inclusion Policies – Children and staff will be excluded from in-person activities, if they:

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- Show symptoms of COVID-19, such as a cough, shortness of breath, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell
- Have been in close contact with someone with COVID-19 in the last 14 days
- Have a fever (temperature higher than 100.4°F)
- Have a significant new rash, particularly when other symptoms are present
- Have large amounts of nasal discharge in the absence of allergy diagnosis If above signs and symptoms begin while in care or in your program, the child (or staff member) must be sent home as soon as possible.

Separate sick and well children & limit staff contact as much as reasonably possible, while ensuring safety & supervision of the sick child(ren) until they leave.

If a family childcare provider has any of the above signs and symptoms, she/he must arrange for children to be picked-up as soon as possible and keep as much a distance from children while waiting for children to be picked-up as possible.

Consult with the child's healthcare provider. Based on clinical judgment, the child's HCP will be able to help the family determine what medical course to take (e.g. whether or not they think COVID-19 testing may be necessary). ***A medical note is not required for anyone to return to care in cases in which COVID-19 is suspected.***

Children and staff with a fever greater than 100.4°F, no specific diagnosis, and COVID-19 is not suspected by the HCP must remain at home until they have had no fever for a minimum of 24 hours without the use of fever-reducing medications (e.g., Advil, Tylenol).

A family childcare provider who has a fever greater than 100.4°F, no specific diagnosis, and COVID-19 is not suspected by the healthcare provider should remain closed until they have had no fever for a minimum of 24 hours without the use of fever-reducing medications.

Materials, toys, and furniture touched by children or staff who are sent home should be thoroughly cleaned and disinfected [NOTE: additional guidance provided here.]

Healthy children, family childcare providers, and/or staff with the following symptoms/ conditions are not excluded from in-person activities:

- Allergy symptoms (with no fever) that cause coughing and clear runny nose may stay if they have medically diagnosed allergies and follow medical treatment plans.
- Well-controlled asthma

This inclusion does NOT require a medical clearance note from a healthcare provider when the child's allergy and/or asthma condition was known by the childcare program/provider prior to COVID-19. A new diagnosis does require written confirmation from the child's healthcare provider.

Note: If a parent/caregiver or staff member reports symptoms of COVID-19, encourage them to have a conversation with their healthcare provider to see if they should be tested for COVID-19. The parent/caregiver or staff member can contact 2-1-1 for information on where to access a healthcare provider if they do not have one. Families who do not have insurance can contact Vermont Health Connect for information about affordable insurance options. This also applies to family childcare providers who have symptoms of COVID-19.

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Wendy Davis, MD, VCHIP: We've really gotten to the crux of the issue today. Use good judgment to identify the kids who we need to be worried about and consider testing. There's been some chat about the availability of testing. Timing of testing is also a question. This really seems to be to me kind of the defining issue right now, and it's likely only to get worse as we open schools

Breana Holmes, MD, VDH: I agree with Dr. Davis. We need more local conversations between healthcare providers, or at least the office staff, and childcare/schools about clearance notes. We need to try a little bit harder locally. You also need hand-outs for parents that says, "here is how we're going to handle illness if your child is sent home from school or childcare." Testing is its own topic. There will be times clinically when you're interested in knowing if a child has COVID-19 or not. I will always have your back if that's a clinical decision. It's not a return to care, school, or work decision. That part I think we got to reasonably, but again it requires more availability on your part when kids are sent home to think it through Together and decide who needs testing.

Here is the sixth scenario:

- What is the best timing to test children exposed at camp – 7 days from 1st exposure or 7 days from positive test? Optimal testing time if 7 days after last exposure to last contact w/known positive case?

Breana Holmes, MD, VDH: The best timing to test children exposed at camp is 7 days from the child's exposure to the person who got the positive test results.

Here is the seventh scenario:

Common scenario now: patient with no COVID contacts & fever without localizing signs, COVID test ordered but can't be done for 3-4 days & child then fever-free/asymptomatic for the 3 days after initial visit? Proceed with test? Families may or may not be able to observe at home while waiting.

- Redefine who needs testing? Continue if pre-test probability is very low?
- Why is there a 3-day delay in testing?

I do want to continue to ask why it would take three to four days to get a test. If that's a community conversation you're having, then I don't get that exactly, but maybe I'm missing something. You as the clinicians have to decide what to do here. We're not going to tell you that kid now has to have a test if his symptoms resolved because originally you thought you might want it. I'd rather find out why you can't get a test the day that you as the clinician want it.

The school guidance went out a month ago. School districts have been having their own journeys on how they've been meeting, whether they've been reaching out to pediatricians, and what to do about their district plan. We've been hearing for about a week now that plans are coming out. Many of you get them because you're parents. Some of you are partnering up with your school districts and are part of the plan creation process, which is ideal. As those plans start to come out, we're starting to see some decisions that may not feel like they're based in the science or what Bill and Ben and all the articles are teaching us. I just wanted to acknowledge that's how school districts are choosing to move forward. Some of them are slowing down and bringing in pediatricians in deciding how they want to set it up for the reopening. They will likely morph and continue to roll out over the weeks ahead.

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If you get plans in your inbox and you want to send them along, we're kind of grabbing them right now. We're hearing where it's already been set and where there are still opportunities for pediatric input. To me, that's a big role for this group: to continue to think about our local roles with the school reopening plans. We just want you all to know that this is just the tip of the iceberg. Please send more questions about process, about illness scenarios, and cases. It's time to get the dialogue going among us that there's a lot of news coverage about transmission in older kids. Texas and Florida are reporting high numbers of cases in pediatrics. Bill and Ben are looking at those numerators and denominators and helping us understand. It would be helpful to get your thoughts, not just as physicians and medical professionals, but as parents and citizens. I bet you're hearing a lot from your families.

We are also still looking for volunteers for PSAs.

It's a good reminder to think about the volume of patients needing to be seen in pediatric primary care setting is of great concern to our colleagues. I hear you on that. We should probably think together. I get a lot of questions from school nurses about best practices for illness because in the olden days pre-COVID19, I think school nurses would say, "You don't have to be seen by the doctor. Go ahead and go home for a couple days, get well, and then come back to school." There is an increased demand for physicians and healthcare professionals in these scenarios. Are we interested in some of these conversations occurring via telehealth? I feel like that might be a practice topic for a call ahead. How do you increase your volume without breaking your back?

Questions/Discussion

Q: What about diarrhea and sore throat?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: My bias is that two or more is much more concerning.

Q: So, students/staff don't need to stay home for 3-days s/p fever of 100.4?

A: Breena Holmes, MD, VDH: That changed, so in the early days of childcare guidance in April, we said 72 hours to line up if you had COVID. Then, through revisions and creating a process, it's back to 24 hours return because if a kid has COVID, we're on a different part of the algorithm. Schools just published on June 17th said 24 hours, so we have aligned childcare with our revision this last Thursday.

Q: Breena Holmes, MD, VDH: How does asthma and allergy clearance get communicated if not verbal, because I actually thought it could be verbal?

A: Michelle Shepard, MD, UVMCH Pediatric Primary Care & VCHIP: Yes, I got paged yesterday at 4:30 PM to write a letter to return to daycare.

A: Wendy Davis, MD, VCHIP: Is there anything we could put out for practices, like a 1-pager, recapping or summarizing in a succinct way that would be helpful?

A: Breena Holmes, MD, VDH: That's part of being with you today. Shari Levine, on the call, is pulling up what you need. We know you need a handout for parents that says what to expect (for school). I'd like to empower parents to go to their childcare and say here's what to expect and hand them the paper and say that it (asthma/allergy) doesn't include medical clearance. If a specific letter would be helpful, we have some avenues for that.

A: Colleen Moran, MD, Appleseed Pediatrics: Daycare and camps arxe requesting PCP clearance as well as parents to return to work.

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A: Kristen Connolly, MD, Timber Lane Pediatrics: They often request clearance even PRIOR to COVID so this just increases the demand.

Q: What is the K-12 testing strategy?

A: Becca (Rebecca) Bell, MD, UVCH PICU: I'm hearing from folks on local school re-opening boards that some districts are going to require COVID testing for any child/teacher with symptoms. I really think whether or not to test should be up to the clinician. I know VDH re-opening does not weigh in on testing but since some school districts are, maybe there needs to be an explicit statement from VDH saying testing is up to the PCP and will be based on pre-test probability, community prevalence, etc.

A: Breena Holmes, MD, VDH: I completely agree and so does the health department. We're trying to figure this out right now as we're getting stronger with our language around asymptomatic testing and that it is not for return to work. We're not encouraging it for return to schools. With colleges, they are doing tons of asymptomatic testing. But this conversation about the sick kids or the sick staff leaving and needing a test. We haven't got there yet. But we know we're not going to require it for return. Schools really need to be told it's going to be a decision made by the primary care offices.

Q: I'm unclear of the role of mild nasal congestion without cough in kids. Does this count as a symptom?

A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: Clear rhinorrhea by itself, without cough, doesn't make the list.

A: Denise Aronzon, MD, Timber Lane Pediatrics: So, if child has diarrhea and mild congestion does this count as 2 COVID symptoms or likely a typical viral illness?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: I agree that there will be many children with typical signs and symptoms of viral illness. I think if there isn't another risk factor (travel, ill contacts, etc.) and if you see the child with classic enter viral disease, I am ok with that. I think changes in cough should be investigated. Presumably, someone with a chronic cough will have been seen and evaluated.

Q: But the crux of the matter seems to be that we cannot (at least I think I cannot) always reliably differentiate COVID from non-COVID viral illnesses and I worry that every parent will demand testing for their child with the most minimal sx, despite our advice and counseling. Will there be sufficient testing capacity for the possible increase in sick children?

A: Colleen Moran, MD, Appleseed Pediatrics: We are already seeing a much-increased request for testing. Will there be increased testing opportunities and quick results?

A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: Capacity, as the fall and winter progresses, is a big issue. For now, my understanding is that we are ok, but conversations are in place already looking towards strategies to ensure good supply. A key component of this will be reducing the burden of unnecessary testing.

Q: Is there any kind of back up/personnel support or simple health department algorithm that could be followed by clinicians and support staff? I am concerned about being able to see all of the kids we need to see/clear, or even have the chance to speak with all of them, given staffing shortages we have recently experienced.

Q: What about the child with no medical home or who can't get an appointment?

Q: What do you say to teachers that think that we are throwing them to the wolves? I have a friend who is terrified to go back to teaching, but she hangs out with her teacher friends with no masks. I don't get it. She's from South Korea and they didn't elaborate.

A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: It is a great point. There is a lot of dissonance, and a lot of people who are separating the school setting as distinct from the community, wanting to shift blame to schools or daycares for things that are going on in the community.

A: Shannon Hogan, DO, UVM Medical Center Pediatric Primary Care, Burlington: I think that they are blaming us, too, as Pediatricians since the AAP came out with their statement. But in my mind, the study confirms what we have been suspecting for a while...younger children are very unlikely to spread, but as the kids get older, the risk increases to the adult level.

Q: Sorry if I had missed this, but what is the discussion on the "new" evidence on kids 10 and older actually being spreaders?

A: Becca (Rebecca) Bell, MD, UVMCH PICU: This is a great review:

<https://emilyoster.substack.com/p/saturday-night-bonus-kid-news>

A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: I believe we may discuss those findings at some point in greater detail.

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: South Korean study suggested that children 10 and older were able to transmit disease in the household as well as adults but did not seem to transmit outside the household as well.

Q: Concerns about capacity come fall?

C: Kristen Connolly, MD, Timber Lane Pediatrics (Milton): I think we are all worried about capacity come fall, especially as office flow may be impacted by risk reduction protocols and PPE.

C: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: We share your concern and are actively looking into how to ensure we have adequate testing capacity and PPE.

C: Colleen Moran, MD, Appleseed Pediatrics: With the small increase with return to daycare and camp with common summer illnesses and that is nothing compared to flu/RSV season.

C: Alex Bannach, MD, North Country Pediatrics: I agree. I already noticed that sick visits with full PPE donning and doffing take a lot longer and unable to schedule at regular intervals due to that which will negatively impact accessibility.