

## VCHIP CHAMP VDH COVID-19

August 7, 2020 | 12:15-12:45pm Call Questions and Answers\*

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### **Publications and Media Articles**

- Washington Post: On Parenting/Perspective – Back to school in a pandemic: A guide to all the factors keeping parents and educators up at night, Vermont’s Jessica Lahey & Tim Lahey: [https://www.washingtonpost.com/lifestyle/on-parenting/back-to-school-in-a-pandemic-a-guide-to-all-the-factors-keeping-parents-and-educators-up-at-night/2020/08/05/479542b4-d740-11ea-aff6-220dd3a14741\\_story.html](https://www.washingtonpost.com/lifestyle/on-parenting/back-to-school-in-a-pandemic-a-guide-to-all-the-factors-keeping-parents-and-educators-up-at-night/2020/08/05/479542b4-d740-11ea-aff6-220dd3a14741_story.html)
- Michelle Obama’s podcast on her own mental health in the context of COVID-19
- Dr. Becca Bell did an interview on school reopening that is now posted on NPR: <https://www.vpr.org/post/poll-finds-vermonters-split-over-reopening-public-schools-fall#stream/0>
- Melissa Kaufold – The CDC just issued new guidance for immigrants arriving in Vermont (mostly Chittenden County) from other countries.

### **Practice Issues: DRAFT COVID-19 in Pediatric Patients: Triage, Evaluation, Testing and Return to School**

*Wendy Davis, MD, VCHIP:* We tried to incorporate your feedback and sent another DRAFT out this morning that some you have already responded to. In this latest version, we clarified some of the notes. We provided context for why we are using pre-test probability. We clarified the definitions of exposure and travel based on the Vermont definitions. We also borrowed language from the Vermont childcare and school guidance about inclusions, such as known allergies and well-controlled asthma, which does not require clearance notes from physicians.

*Breana Holmes, MD, VDH:* Many of you on the call have stepped up and spoken to schools and parents. Hearing from all of you has helped a lot. All of you are out there trying to listen and respond. Dr. Leah Costello produced a great hour-long video with the COVID-19 coordinator from CVSD (<https://www.youtube.com/watch?v=K2t2HYrn5d0&feature=youtu.be&fbclid=IwAR3U-NCVeP1DWWekn4dJhJxwyqh1q-3U9dZKcgYw1cdzwPRSYAjXbrmoQjg>). Dr. Judy Orton also stepped up and spoke to multiple schools in the Bennington area. Bennington is moving towards everyone in-person in school by October, Getting started and then bringing more and more kids into school as the plans work is a good approach. Almost every state is opting for a binary, with the option to either leave school and get a test or leave school and stay home for 10 days. Few besides Vermont are trying to define clinical guidance for when kids could return to school in under 10 days without a test.

*Leah Costello, MD, Timber Lane Pediatrics:* I did that video with a UVMHC Hospitalist (and good friend) and the COVID health and safety coordinator for CVSD, the very smart Jocelyn Bouyea. We were answering questions from the school union representatives to CVSD. The video was intended for teachers, but the district decided to share it publicly. We have received some good feedback and >1000 views in the last couple of days, so share it widely for parents and teachers. Dr. Elizabeth Hunt is also actively involved and shaped a lot of our answers as well. She was not available the day we did the video. Many of the teacher’s questions were about their own health and risks, so I thought an internist would be most helpful at answering those questions.

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

*Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics:* We put these symptoms into three buckets. For students with exposure to or symptoms similar to COVID-19, then we want them to test or stay home for 10 days. If a student only has solitary symptoms and no exposure to a COVID-19 patient, then we do not recommend testing, but do want the student to stay home until 24 hours after symptoms have resolved. If we had a lot of capacity, then the easiest thing to do would be to just test students in the event of any symptoms. However, we are concerned about testing capacity. We built this algorithm based on the assumption that we wouldn't have a lot of testing capacity and would need to make good clinical judgements.

*Breana Holmes, MD, VDH:* It's important to get this right as the return to school is upon us. We need feedback on whether we need this algorithm for the littlest kids. Childcare providers often call about kids with persistent runny nose whose parents want to send them back. Schools are different because we really want school nurses and medical homes and parents have more dialogue together about symptoms and return to the school. We don't have test supplies enough to do every runny nose.

*William Raszka, MD, UVMCH & LCOM Dept. of Pediatrics:* For older children who can self-administer a test, then it's worth doing that because PPE can be preserved to rule out ambiguity.

*Breana Holmes, MD, VDH:* Dr. Lee met with adult infectious disease doctors to discuss the importance of adult primary care providers having information and shared decision making when holding conversations with all adult patients, but specifically teachers due to the time sensitivity. Stephanie Winters and VMS will distribute talking points to adult primary care to include general information about the virus and how to go about decision-making processes with the teachers. In many cases, it's going to be a pro-con discussion.

*Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics:* The challenge is that in the pediatric community we are lucky to have this forum and venue for getting everyone together as a community. There isn't a similar platform among adult primary care providers. We are proposing that Tim Lahey on the adult side come up with some kind of brief guidance document with input from me and Dr. Raszka. We then need to figure out how to disseminate that. It's going to be important to get ahead of the volume of inquiries from adult teachers as schools re-open.

*Breana Holmes, MD, VDH:* In moderate pre-test probability, there needs to be either a test or clinical decision-making as to why the test isn't necessary, such as strep throat or another alternate diagnosis. The other thing I want to note for high pre-test probability is the timing of when the test was done matters if kids have an exposure or have symptoms and then get a negative test back. The best time to test is 7 days after your exposure. If symptoms persist, then good infectious disease principles should still be observed, 7 days symptom-free before sending these students back to school. A negative test doesn't send students back if they are still symptomatic.

*Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics:* When we look at testing, if a person has a low- or moderate-pre-test probability, how do we define that? In this situation, we are comfortable with a negative test. If someone had a high pre-test probability, then we would question and have concerns about a negative result in that scenario. I hope we do not run into that situation too often.

*Breana Holmes, MD, VDH:* We need to get this grid and algorithm as correct as possible ahead of time, and then test and use it when schools re-open and see how it goes. Teachers need to know that sick kids aren't going to be in their midst. School nurses need to know they don't have to make these decisions without the

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backup of medical homes. Medical homes have to admit this situation puts a lot of pressure on pediatric primary care provider offices. I've heard some disappointing stories from school nurses who reached out to medical homes and received a response indicating the medical homes do not have the bandwidth to deal with more volume. I want to encourage you all to engage with school nurses and your local public health nurses can assist with this connection. We need to get an algorithm in place for families who need to be seen.

*Wendy Davis, MD, VCHIP:* I wondered if the Health Commissioner was turning us in the direction of possible issues with testing capacity by talking about stockpiling supplies as demand increases.

*Breana Holmes, MD, VDH:* Everyone knows that schools reopening means more testing and symptomatic testing, so that's a good start. We are shifting away from pre-procedural and asymptomatic testing ([https://www.healthvermont.gov/sites/default/files/documents/pdf/COVID-19-HAN-Pre-ProcedureTesting.final\\_.pdf](https://www.healthvermont.gov/sites/default/files/documents/pdf/COVID-19-HAN-Pre-ProcedureTesting.final_.pdf)). We have plenty of anterior nares test kits now. We need to get test kits out there, and I stipulated each practice needed at least 50. Please also have conversations with your health systems about increased volume and how these kids should be tested if not in your offices. I also want to reiterate this algorithm is in draft form and it would be problematic if teachers and parents started seeing a grid that isn't final. It's really intended as a communication device between schools and primary care. Maybe we should think about the language used and if it's valuable to adapt the language and disseminate it more widely.

### Questions/Discussion

#### **Re: reopening school plans**

*C: Stephanie Winters, Vermont Medical Society:* <https://www.vpr.org/post/poll-finds-vermonters-split-over-reopening-public-schools-fall#stream/0>

*C: Leah 2: Last night's MAUSD school district staff meeting still has the social distancing as 6 feet, not 3-6 feet. MAUSD also said even though they have small schools and could open them fully because the numbers are small and could space out appropriately, they will not do this sighting education equality.*

*C: Leah Costello, MD, Timber Lane Pediatrics:* CVSD is not revising their plan but is starting to say that they will quickly reassess within weeks after starting schools and could change plans if appropriate. Fingers crossed. No promises.

*C: Breana Holmes, MD, VDH:* I just heard from AOE that release of revision to guidance is early next week...sigh.

*C: Judy K. Orton, MD, Green Mountain Pediatrics:* BRSU (Manchester, Dorset, Mt Tabor, Londonderry) schools are doing a blended plan. Starting 9/8, 10 - 20% of high needs K-5 students will be full time, gradually adding other students, physically with 50% attending Monday/Tuesday, other 50% Thursday/Friday, with the hopes of everyone being fulltime by sometime in October.

**Q: Should we say, with the positive test, somewhere that it DOES NOT require a negative test to come back?**

**Q: How would you define CAP v. COVID? I think of CAP as fever +cough + lung findings on PE or low O2 sat. I feel like I would need to COVID test to determine these symptoms aren't from COVID, am I missing something?**

*A: Barbara Kennedy, MD, Timber Lane Pediatrics:* We were going to take out CAP as allowing us to not need a COVID test. I think our group decided that CAP can look too much like COVID and should get tested.

**Q: In the high v. moderate table, high says fever + cough or runny nose you should test, but moderate says fever +1 other symptom. It does not specify that we are now talking other symptoms that do not include cough or runny nose. I think mistakes could be made here.**

**Q: Where does vomiting without other symptoms fit? Where does HA fit? In the low table, should we say 24-hour resolution of symptoms without intervention?**

**Q: What about the kids that have rhinitis/congestion all winter?**

*A: Leah Costello, MD, Timber Lane Pediatrics: Parents are going to demand testing, honestly. 10 days is very limiting.*

*A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: I agree this is the challenge, but it will depend on testing capacity as well.*

**Q: For the possible moderate folks, do we see and then write a note they have a cold and then they can go back to school?**

**Q: Wait, if we think not COVID but has a "cold", it gets them back to school when fever resolves?**

*A: Heather: I think the reality is, that we would need a concrete alternate diagnosis: Strep, influenza, parainfluenza, RSV.*

*A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: That is true but testing for other viruses this winter will also be problematic because those tests utilize the same resources as COVID tests.*

**Q: Does this (cover pre-school/daycare ages as well? Or only school age?**

*A: Wendy Davis, MD, VCHIP: There's some language in childcare guidance that speaks to some narrow aspects of this but, Breena, do you want to say your thought on this?*

*A: Breena Holmes, MD, VDH: It's mission critical to get this out there for schools as it is 80,000 kids. I feel some urgency there. This is almost right for little kids. I think we'll have to have some conversations about recognizing that little kids even have less pretest probability. I do think we need this and if you all could tell me if you need this same type of decision making for kids under 5 or 3, I would love that.*

**Q: So, the essential daycare this summer for moderate things, they only had to stay out of school 3 days, are we not doing that anymore?**

**Q: It looks like if they have a fever and cough and a negative COVID test, it is still recommended that they be out of school until 7 days from onset of symptoms? Am I reading that correctly?**

*A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: If they have a negative COVID test, return is based on resolution of symptoms (24 hours), the 10 days only applies to confirmed COVID or if no test is performed.*

**Q: Most kids with URI will have cough AND congestion, which would put them from low probability into the moderate pretest probability table and keep them out of school x 10 days even in an area with extremely low numbers, like our area. This seems very restrictive and a huge burden on parents/families.**

*A: Breena Holmes, MD, VDH: That's not what we're trying to say. What we're saying is in moderate pretest probability, there has to be a pathway where there's clinical decision making saying it's not COVID, it doesn't need a test, you can go back before 10 days. Thank you for bringing this up.*

*A: Monica Fiorenza, MD, Timber Lane Pediatrics: So many URIs will last for 7+ days.*

*A: Leah Costello, MD, Timber Lane Pediatrics: I think parents are going to say I want the testing, even if that gets my kid back in 2 days earlier.*

*A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: We are trying to walk a tightrope between overburdening families and medical homes but also making everyone feel safe in the school environment. Admittedly, there is no easy solution, from any perspective.*

*A: Karen Nelson, RN, VDH: Remind parents that testing is also not treatment.*

**Q: So, the Vermont Agency of Education rules are that kids who have diarrhea, vomiting, fever, strep, eye discharge, have to stay out of school for 24 hours fever free. Is this form/draft going to change that for the School Nurses?**

*A: Alex Bannach, MD, North Country Pediatrics: It gets them from low into moderate.*

*A: Karen Nelson, RN, VDH: Fevers do not belong in school. School nurses will get that I think.*

*A: Leah: Yes, I agree but this form is different, and it seems like kids need to stay out longer for symptoms, i.e. runny nose 10 days? no fever. It looks like from this form that kids can't go back until they do not have a runny nose?*

**Q: As community prevalence increases, how will our approach for the "moderate pre-test probability group" with multiple clinical symptoms be modified to account for the false negative rate? In adults, we would exclude those people 10 days regardless of testing results.**

*A: Sharonlee Trefry, RN, VDH: Great point about existing exclusions prior to COVID-19 as that is all local control so all LEAs are different depending on SN availability (and use of AAP's BF guidelines). The silver in this cloud is that we may be creating the first consistent exclusion guidance.*

**Q: With moderate probability, how much do we trust the negative COVID test? As really, the test is only about when they can return to school, as no treatment indicated.**

*A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: I think we accept negative tests in low to moderate test categories.*

**Q: Would RVPs (Respiratory Viral Panels) have a role as outpatient management this season?**

**Q: What is happening at the state level for increasing testing capacity? The conversation trying to convince people not to test isn't going to hold.**

*A: Kate Goodwin, RN, CPNP, Lakeside Pediatrics: It would be helpful if there was some more public messaging regarding the availability of testing supplies. Right now, it feels like anyone who wants a test for any reason can get one. The pop-ups are part of that. It would be helpful for families to understand that supplies are not unlimited when we say no this fall.*

**Q: When there is a clear alternate diagnosis, return to school once fever-free x24h makes sense, but how on earth are we going to clinically differentiate between "just a cold" and COVID for mildly sick kids with runny nose and cough?**

*A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: I think in general; we are probably not going to have capacity to do a lot of testing for other viruses this winter, unfortunately.*

*A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: This is very hard. Testing is not precluded. We are trying to minimize risk in the school system. We still need to work through the pressure points.*

**Q: A question for the group is this: How granular should this grid be?**



A: Freyda Neyman, MD, CVMC, Pediatric Primary Care: I think as granular as possible, since this is a state-wide issue and consistency between providers (and practices) would be great.

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: This should be a living document, that we probably need updates as we learn more about testing capacity, etc.

A: Alex Bannach, MD, North Country Pediatrics: I agree, also for consistency between pediatric and FP providers.

A: Joe Nasca, MD, Dr. Joe Nasca Pediatric Medicine: I would keep it less granular, since every situation/family dynamic is unique.

A: Freyda Neyman, MD, CVMC, Pediatric Primary Care: I think BECAUSE each family dynamic is unique, a consistent algorithm, with as much objectiveness as possible, is needed so that families don't feel that their neighbor's kid is "triaged" differently than their own, based on family circumstance.

**Q: I am also wondering if Vermont has considered connecting actual case numbers to direct school closures etc., such as Maine is going with red, yellow and green? Predicting certain areas of the state will likely have different case numbers come Fall/Winter.**

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: The State will use a variety of metrics. The anterior nares testing is very, very handy, particularly when self-administered.

A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: I think VDH has intentionally been a bit hesitant to commit to firm metrics because the situation could be so context- and location-specific. I have no inside knowledge, just my observation/opinion.

**Q: If small offices are willing to do the test, how do we get them to the hospital?**

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: I think the issue will be how to get the specimen to the State.

A: Heather: We have a beast of a process that involves wrapping the tube in paper towel, double bag, pack in Styrofoam and then the lab picks up.

A: Alex Bannach, MD, North Country Pediatrics: I would feel very comfortable and interested in doing anterior nares testing in the office. We would then send it to the NCH lab to be shipped out.

A: Colleen Moran, MD, Northwestern Pediatrics: CHSLV plans to coordinate with Copley again and combine RSV/Flu/COVID testing.

**Q: A different issue is the isolation rooms at the schools. One of the big issues with the isolation rooms is the school districts think this is a room only or COVID folks, but the nurses feel this is a room to triage those sick kids.**

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Hopefully, by keeping ill children home, they will not need much space in the school for isolation! We have been working with many to decide the amount of space and how to maximize space.

C: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: No one should be at school with confirmed COVID-19. So, it really should be all triage, but how to create/use the space is the challenge.

**Q: What are requirements v. suggestions?**

A: Karen Nelson, RN, VDH: This is always a problem for school nurses.

**Q: On an easier note, can you please add fever is > or = 100.4F?**

**Q: What is the realistic testing capacity for the state?**