VCHIP CHAMP VDH COVID-19

August 14, 2020 | 12:15-12:45pm Call Questions and Answers*

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AAP Updates

The headline for me here was the recommendation for universal use of cloth facial coverings by children two years of age and older and the adults with whom they interact. I would say they were not quite as descriptive as we've tried to be with the childcare and school guidance, but there is a lot of good language included. AAP tried to put out guidance that could be generally applicable knowing that a lot of us will provide more detailed guidance on the local level.

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

Wendy Davis, MD, VCHIP: This document is still in draft form. We have several notes at the top that are now numbered about pre-test probability. We also added a link to the ACCD travel map and instructions.

Breena Holmes, MD, VDH: We have school liaisons in district offices who are willing and able to pull together family medicine physicians and pediatricians to review this grid and ask how we want to communicate about these pathways. It is a large burden on your medical homes to tell every disposition to the school, but this is a pandemic. School nurses cannot be put in a position of a kid walking into school with some symptomatology without clear communication from the medical home about the disposition. If we start with the goal that we want to get kids safely back to school after an illness, then how we communicate about that becomes paramount. I wanted to get this draft out to you today, but then I found an item that needs clarification. Please don't distribute this widely yet, as it is still being perfected. We want to get it as good as possible before it becomes a community document.

Wendy Davis, MD, VCHIP: One new addition to the grid is the new box at the top for individuals with a known exposure to a COVID-19 patient or relevant travel history. It would be helpful if these patients didn't arrive at school having been screened and these situations are not okay. We just wanted to bring awareness to these issues. We have switched from asterisks to numbers for our footnotes.

Breena Holmes, MD, VDH: It expect it will be easier for this group to digest this document over the next few days. Vermont is trying to do something that other states are not attempting. It's a clinical space where alternative diagnosis will be important, as will testing capacity and your access to those tests.

Wendy Davis, MD, VCHIP: If some of you have sick patients this weekend, we would love to have you pilot this grid. While piloting, pretend schools are back in session, pretend you are trying to communicate with a school nurse, and test it out. Let us know what you think and how it works.

Breena Holmes, MD, VDH: We added this first page to emphasize that if you have been exposed, then this is what you do in general for a close contact. It's a little bit of a style with this. Do we lead with this or bury it? This is really the current standard. The remaining 3 pages are really the innovative stuff – symptomatology and alternate diagnoses. It's more about slowing down and talking through with all of these public health principles, as well as a shared agreement between you and your public health colleagues. Who should be seen? Who should be tested? Who should just wait it out?

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Wendy Davis, MD, VCHIP: The first grid is exposure history. The second grid is high pre-test probability. The third grid is moderate pre-test probability. The fourth grid is low pre-test probability. The caveat on all of this is that you can undertake clinical decision making in customized circumstances when deciding whether to test for COVID-19 or not.

Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: In patients with known exposure or high-risk travel, then a negative test does not apply. They still need to quarantine for the full 14 days. We have a couple of little details to clean up and then, hopefully, it will be intuitive for folks.

Breena Holmes, MD, VDH: I encourage you to call VDH in real-time for any very specific clinical scenarios.

Questions/Discussion

Q: Yesterday's call with Dr. Levine, there was a recommendation to wait 3-5 days for testing after symptoms, not on day 1 of symptoms. Wonder if you could speak to this? The thought was Dr. Levine was referring to the fact that you could wait a few days. I take that as monitor the child, not that there is a problem with the testing.
A: Wendy Davis, MD, VCHIP: You are exactly right about what he said. It was in response to a specific question and I wonder, personally, if he was just trying to, instead of making a strong recommendation, give people context of how to think about that.
A: Breena Holmes, MD, VDH: I had the same reaction. I tell people, if you're symptomatic, you can get the test any day. But I think he was saying you could wait it out a couple of days as more of a clinical observation.
A: Ashley Miller, MD, South Royalton Health Center: My understanding was that we thought anterior nares would be most accurate early on as the virus migrates down the respiratory tract, and it wasn't like strep that you had to increase proteins to get positive rapid, so waiting 24-48 hours made sense.
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: We know that lower respiratory tract samples remain positive for longer. I'm not sure if there is much of a difference early on between anterior nares and nasopharyngeal. I didn't hear Dr. Levine's comments, so not sure I can comment as to the rationale.

Q: Should anterior nares/NP be done earlier, i.e., first 48-hours, or is 72-hours+ still likely to be positive?
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: I think that if there is suspicion for COVID, by the time of symptom onset, testing should be positive. The longer the symptoms progress, I think there is a possibility that false negatives may increase.

Q: Regarding contact tracing, I am doing another video with the CVSD district next week with a contact tracer to explain what it is and how that works within a school. I am sure we will release that publically, too, just like the last one we did.
A: Breena Holmes, MD, VDH: Monica Ogelby is the contact tracer, right?

Re: Children masking/not masking in childcare
C: Becca (Rebecca) Bell, MD, UVMCH PICU: My anecdotal experience is that there are essentially no kids in my children's daycare that are masking. This is primarily due to the kids' inability to independently take off and put on their mask. They eat three times per day, they go outside twice a day, and nap once a day. All require removal of their mask. Even if my kids start off with their masks on, they don't end up going back on. I really don't think teachers should be putting masks on the kid's face. I'm not sure what the right thing

to do is but the guidance saying that kids need to be able to put on and take off and not play with it makes it challenging in this age group.

Q: I think there will be difficulty at the schools with a Nurse one day a week. They have a person with little to no medical knowledge the other days of the week.
A: Breena Holmes, MD, VDH: Definitely true, but in COVID, we are promoting school nurse leadership COVID coordination and many schools are building this capacity.
A: Becca (Rebecca) McCray, MSN, RN, VT State School Nurses' Association: The VSSNA leadership has a meeting to talk to Senator Leahy about promoting funds to hire more school nurses in the state so that schools can hire full time nurses for every school.
A: Leah: That's great to know. I work in the School as well as my practice and I had not heard this.
A: Becca (Rebecca) McCray, MSN, RN, VT State School Nurses' Association: NASN sent a letter to congress in March/April asking for funding for 10,000 school nurses to be hired nationwide.
A: Leah: The superintendent at MAUSD said last week he would not be hiring any more Nurses. Nor has he asked the part-time Nurses to work more.

Q: Feedback on the algorithm?
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: The big clarification in this table is that this specific grid refers to people with known contact to a patient or high-risk travel. In that scenario, even with a negative test, these patients are still under quarantine rules for 14 days, so they CANNOT go back to school 24 hours after resolution of symptoms.
C: Leah: When you first look at the chart, it looks like kids with just a symptom have to stay out for days...unless testing.
C: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: This refers only to those with an epidemiologic link to COVID, so the highest risk/pre-test probability. There is a second grid that refers to patients without known contact with a COVID patient or travel history.
C: Ashley Miller, MD, South Royalton Health Center: I think it's good to know about the exposed group, but the other tables are what the school nurses will need.

Q: So, known contacts, symptomatic or not, are quarantining for 14-days, or can they test at day 7 and come out early?
A: Breena Holmes, MD, VDH: You cannot come out early if you've been exposed because you have to wait out the 14-days. Symptomatic people stay home until they meet the criteria.
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: Only if asymptomatic. The day 7 test strategy only applies to asymptomatic people.
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: What Dr. Davis eluded to earlier is correct, there's a separate set of grids depending on the condition. I just want to point out, to caution the fact that, in the box that states "test result negative", I want to make sure we clarify. In patients who've had a known exposure to a COVID positive patient or high risk travel, then the quarantine rules apply regardless of what the testing result is. If it's negative, they're still under quarantine. At UVM MC, the guidance everyone is getting is that if someone in the household is being ruled out for COVID-19, then the healthcare worker is being asked to stay home and not come to work until that person is cleared. That doesn't mean it will be the guidance going forward indefinitely. For now, we have enough low prevalence that can spare these healthcare workers from the work site currently. That's what drove that change, and it may change again as conditions on the ground change.

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Q: I think these tables are very detailed and nicely walk you through the decision making, thank you! I wonder, if anyone could address the question what to do with other household members (sorry, if I missed that earlier)?
A: Breena Holmes, MD, VDH: We're really trying to guide people to the regular close contact guidance. If you're talking about household contact of people who have COVID, everyone's on the same path, which is you quarantine for 14-days or you're testing at day 7 in the asymptomatic lane and if you've got symptoms, it's really a case-by-case.
A: Stan Weinberger, MD, UVMCH Pediatric Primary Care: Agreed. I really like the tables and also wondering about Betsy's question.
A: Ashley Miller, MD, South Royalton Health Center: I agree this is an ongoing question for my practice.

Q: Quarantine can end early if negative test at or after day 7 though, right?
A: Breena Holmes, MD, VDH: Yes for asymptomatic people.
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: Only if the person is asymptomatic.

Q: What do you do while waiting for the test to come back in household contacts?

Q: Just confirming; what if the parents don't want to test the kid, and they quarantine the kid for 14 days. Does the family need to quarantine, too? (I've been saying yes.)
A: Breena Holmes, MD, VDH: This is what they call at the CDC a presumptive positive, but in Vermont, it's very unlikely that the kid has COVID-19. I'm not sure what to do about that.
A: Breena Holmes, MD, VDH: Why would the kid be quarantine? Exposed to someone with COVID? Then household contacts would also be close contacts.
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: That would be one alternative, to simply quarantine for 14 days following an exposure.
A: Ashley Miller, MD, South Royalton Health Center: The whole family, correct?

Q: So the issue with healthcare worker home contact, waiting 48-72 hours to get results back is very hard in a solo practice. Is there any way to have that turn around faster for health care workers home contacts?
A: Heather Link, MD, UVMCH Pediatric Primary Care: Our family just went through waiting for results with two physicians in the family, and a full week of work missed.

Q: A kid with symptoms that could be COVID, the family doesn't want to test, so we've been having the family treat it as if COVID is positive?
A: Breena Holmes, MD, VDH: During time of low prevalence, we wouldn't consider that child a presumptive positive. We don't really do this in VT.

Q: So a kid is symptomatic and exposed, then symptoms resolve, negative test after sx resolved and on at least day 7 of exposure, can then return to school after asymptomatic x 24 hours?
A: Breena Holmes, MD, VDH: Yes.
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: Sorry, to clarify, for the person who was exposed? If only one person was exposed, contacts of an exposure but not confirmed positive are not under quarantine restrictions.

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Q: The employee health rule has been a problem for colleagues whose kids are in daycare and rhinovirus, etc. is going around but they need COVID testing. Lots of missed work with 2-3-day turnaround time. So hoping this can be re-evaluated.
A: Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: I agree!

Q: So the issue with the kid that parents won't test, if we are saying very unlikely it is COVID in the kid, then why are we testing any of them?
A: Breena Holmes, MD, VDH: Sounds like a rare and specific example, so, yes, they should all quarantine, if you really think COVID.
A: Ashley Miller, MD, South Royalton Health Center: I'm saying they hit yes for fever, and yes for symptoms, in that table that recommends testing.

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