VCHIP CHAMP VDH COVID-19

August 17, 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)

NEW: Shared Decision-Making on Return-to-Work Decisions for School-Based Personnel

Wendy Davis, MD, VCHIP: The document on shared decision-making on return-to-work decisions for school-based personnel was developed through a collaboration between VMS, VDH, VCHIP, AAP-VT, with special thanks to Tim Lahey, MD MMSc, UVM MC Adult ID/Bioethics. This document is directed specifically at patients of primary care clinicians, emphasizes key concepts from the pediatric reopening guidance and calls out special considerations including the following: local epidemiology; personal medical risk; personal safety measures; family medical risk; school risk mitigation measures; personal/household capacity for alternate plans. We will continue to try to address concerns from our families, teachers and school nurse communities as they arise.

VDH Updates

Wendy Davis, MD, VCHIP: The Updated COVID-19 Testing Guidance and Collection Kit Ordering Information released on August 12, 2020 clarifies the need for partnerships with practices in terms of test ordering and where to order tests depending on your hospital affiliation. We also mentioned the updated HAN related to quarantine recommendations for congregate care settings (Updated Novel Coronavirus 2019 (COVID-19)-Related Quarantine Recommendations for Congregate Care Staff and Residents 8/14/20). We clarified this does **NOT** apply to colleges/boarding schools.

Breena Holmes, MD, VDH: I'd like to continue to figure out which practices want to do testing on-site. The videos released by local colleges seem to confirm to me that kids can do their own anterior nares testing while observed by their clinicians.

What You May be Reading & Hearing

- ☐ From The Atlantic: "We Flattened the Curve. Our Kids Belong in School."
  - ◘ https://www.theatlantic.com/ideas/archive/2020/08/our-city-flattened-the-curve-our-kids-belong-in-school/615274/
  - ◘ "Communities that worked hard to beat the coronavirus should reap the benefits of doing so." (8/14/20 – by Boston pediatrician/child psychiatrist Dr. Elizabeth Pinsky – thank you, Becca Bell!)
  - ◘ "To focus only on the downside of reopening is to ignore the significant risks of staying closed: mental illness, hunger, physical inactivity, undetected child abuse, the trauma that results from witnessing violence."

Practice Issues: Monday Potpourri (including continued discussion DRAFT COVID-19 in Pediatric Patients: Triage, Evaluation, Testing and Return to School)

Wendy Davis, MD, VCHIP: We asked you to think about testing out the algorithm over the weekend. We received a request for guidance for moderate pre-test probability for adults to be incorporated into the

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student guidance or as an accompanying document. We also received feedback regarding the challenges of testing infants and then quarantining from the rest of the family pending the test and result.

Breena Holmes, MD, VDH: I think the adult primary care world needs this type of forum to discuss the nuances of symptomology with infectious disease colleagues, but the request was mostly with regards to testing for return-to-work. The turnaround time for testing results is also a significant barrier on the adult side.

William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: The adult infectious disease service was somewhat reluctant to get into the nitty gritty of signs/symptoms and they do not have this same type of forum to discuss the issues.

Questions/Discussion

Q: I've been hearing for several people they used oral swabs. Is this something we will be seeing as well? It seemed that college students had been sent kits for oral/sputum samples.
A: Breena Holmes, MD, VDH: Do you mean posterior pharynx? That is a big part of the current approach, back of the throat, or front of the nose, or back of the nose. I just don't know if it's in the outpatient setting. I haven't heard much about that.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: We have not used back of the throat much. I think it had to do with our UVMMC platforms for testing. VDH in theory could run these.
A: Michelle Shepard, MD, Pediatric Primary Care, UVM Medical Center (Williston) & VCHIP: It would be nice to use OP swab, particularly when already getting strep/pharyngeal culture in some patients.
A: Alex Bannach, MD, North Country Pediatrics: Personally, just from experience with strep swabs, the gagging and spitting with those would make me not want to do them and stick with anterior nares if I really am worried about COVID.
A: Breena Holmes, MD, VDH: Yes, UVM has students doing sputum before arrival.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Oral/sputum specimens have been used for some time in adults.

Q: Are we going to start saying no "buffs", "gaiters", bandanas with the new cloth facial covering study that showed they weren't better than no mask?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: My advice has been to use other types of coverings. We do not know if doubling them will be more effective, but currently, we have recommended alternatives.
A: Breena Holmes, MD, VDH: I agree. We say that it was one study, but well done and single ply doesn't work.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Face shields are not first line.

Q: Do you think the Governor will make that change to his definition of masks for the state?
A: Breena Holmes, MD, VDH: I actually don't know if he's defined masks.
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: That I do not know. We circulated a personal primer on face cloth coverings saying that coverings should be two layers.
A: Ashley Miller, MD, South Royalton Health Center: I will look for your primer.

Q: Some daycares seem to be requiring doctor's notes for kids to return to daycare after colds. If they want to return within two weeks of the first symptom, do they need to be tested? It seems excessive; it is pretty impractical to test every viral URI for COVID, even now, but so much less so once the

respiratory season really hits. And parents can't miss 2 weeks of work each time their child is ill! That's what the guidance document suggested! I'm thinking about that draft of what to do in the different probability scenarios. I'm still focusing on the feeling better but not tested, because I don't see how we can test every URI.
A: Ashley Miller, MD, South Royalton Health Center: Agreed. I feel like I'm going to be doing a lot of tests.
A: Leah: Nor do I think that kids can stay out of school for 2 weeks for a cold.
A: Becky Collman, MD, Collman Pediatrics: Well, one of the really hard things is that with that list of symptoms, EVERYTHING might be COVID!
A: Jill Rinehart, MD, UVMCH Pediatric Primary Care: I agree, and when it gets better, it could have been COVID. Thank you all. Lots of home time for kids this year.
A: Alex Bannach, MD, North Country Pediatrics: Trying to think hopeful about not testing every URI, otherwise I agree, it would be a lot of tests, unless our strategy of minimizing any spread of anything really works and there simply will be no sick season this winter.

Q: Are the adults on board with ordering asymptomatic testing (for our parents)?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: We, in UVMMC, do NOT recommend testing asymptomatic adults (unless trying to get out of quarantine, etc.).
A: Breena Holmes, MD, VDH: We aren't encouraging asymptomatic testing. Do you mean if they were exposed to a COVID-19 person?
A: Jill Rinehart, MD, UVMCH Pediatric Primary Care: Children returning to VT from outside hospitals whose parents need to be tested to return to work is one situation, or quarantine for weeks. Also, if parent is going to be at our hospital after being in Boston inpatient with their child. I've run into a few moments when it is clear that parents should be tested and they call their medical home and are told to go to a pop-up and refuse to order it for them...pop-ups full, etc.

Q: On the guidance document, what happens to kids that have moderate pre-test probability but are able to get tested?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: If they are tested and negative, I would assume they could return to school once illness is resolved. If in the moderate test group, a negative test is very handy. The child could return when symptoms resolve. Keep in mind there are non-COVID illnesses.
A: Breena Holmes, MD, VDH: High pre-test is about access to testing in many ways and low pre-test is the time of just watching and waiting, not even involving the medical home. This moderate pre-test group is that if a kid has a fever AND one of the symptoms (not cough or runny nose, as they were addressed in high-pre-test probability) like diarrhea, and this whole box is about no exposure, just general public symptoms, that needs a consult. That's when you decide do you test if you have a test, can you get access to a test if you don't have one, are you going to see the kid to talk through an alternative diagnosis which will get the kid back to school. If you're not going to see the kid or you don't have a test, then you have to essentially do the CDC recommended 10-days isolation since symptoms appeared.

Q: Are school nurses currently involved in developing the return to school guidelines or not yet?
A: Leah: Not all nurses are involved. It seems to be dependent on districts. The PowerPoint that was sent out for the teachers was nice, but it did not have nurse issues addressed. I am guessing that something else will be going to the nurses
A: Breena Holmes, MD, VDH: So the second we can get this document "final" as a working document, the school liaisons are planning community meetings where they'll pull the primary care doctors who see kids together with the school nurses to go through scenarios, see how it's working and talk about communication. The crux is how are you going to share your medical decision-making back to the nurses.

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Q: If someone has a positive COVID contact and is asymptomatic, but then becomes symptomatic prior to 7-days when testing would be recommended if asymptomatic, is it recommended to test prior to 7-days because they have developed symptoms?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: You can test when they become symptomatic.
A: Monica Ogelby, Clinical Services Director, VDH: They can get tested earlier than 7-days, but if they're negative, they can't end quarantine early. So, we tell people, if they can, to wait till day 7 so we have more confidence in the test result. If they're positive, we'll do contact tracing based on the symptom onset date anyway.

Q: Please confirm, moderate pre-test probability NOT tested, are home a minimum of 10-days, assuming no alternative diagnosis. Who of us will be willing to say a non-COVID viral URI?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: It is challenging. The goal is to minimize the risk in school, but some children will be at home a long time.
A: Ann Wittpenn, MD, UVMCH Pediatric Primary Care: Good to know I am not alone being challenged by this.
A: Breena Holmes, MD, VDH: That's exactly it. It's about your clinical comfort. In the setting of runny nose, that's where you have to layer in other symptoms.

Q: I'm trying to understand the risk probability groups. Is there such a thing as "Low Pre-test Probability?" Is that simply someone who is entirely well, no symptoms. And moderate probability is then with essentially any symptoms, but no exposure or travel?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Low test means essentially only one symptom on the CSC group of S/S of COVID other than fever. We are trying to take this out of the medical home.
A: Breena Holmes, MD, VDH: It's defined very clearly from the British Medical Journal at the top of the document and it's four considerations.

Q: So, in that first box, if no alternative dx, and test negative, they still stay home for 10-days, or test negative, they can go back when improving?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: If in the moderate box and test negative, one can return to school once illness resolves.
Q: Becky Collman, MD, Collman Pediatrics: Once improving, or once resolved?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: We have fussed with improved or resolved. What would you recommend?
A: Alex Bannach, MD, North Country Pediatrics: I think either is fine because it's still linked to 10-days either way. Improved allows kids to return after 10-days who might still have residual sx and the 10-days does allow us a little more time to decide if we need to test, so it might decrease the # of tests ordered.
A: Ashley Miller, MD, South Royalton Health Center: I think we said if they tested negative, then they don't have to wait 10-days, is that right?

Q: So, kids often have runny nose/cough for 3 weeks. Is a resolution just "feeling better" or no symptoms? As general pediatrics, I think if a kid is feeling better, with a negative test, I would let them go back. We used to just keep them out of school until they were fever free for 24 hours, and then they could go back with runny nose/cough.

Q: If they test negative and we know it is not COVID, how come they can't go back to school if we know then it is a cold?

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Q: Unfortunately, the test in not 100% accurate, so how do we ever really know?
A: Wendy Davis, MD, VCHIP: I think we've worked to define situations in which to test, which platforms are most effective depending on the context, and timing, and help you identify, as a practice, how to access the slides and PPE needs related to that.

Q: I'm just glad school is starting a bit later so if there is any early spike with return of college kids, it shows before return to public school.
A: Breena Holmes, MD, VDH: There have been a few cases in several of the campuses where kids who have come in from around the country and, as we wanted, were tested upon arrival and have been positive. So that system is pretty tight. I don't think the spike is going to be when they get here. I think it'll be when they start moving about and increase their exposure to each other.
A: Michelle Perron, MD, Timber Lane Pediatrics: Everyone will be wearing masks, so fewer regular illnesses.
A: Barbara Kennedy, MD, Timber Lane Pediatrics: I live in the downtown area and the students from Champlain College have been great. All wearing masks (some even when biking), they walk distancing from others, and have been communicating well in our FPF!

C: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: I do not think that I would worry about false negative results in the moderate group. One could worry a bit more in the high pre-test, but then I would only worry about it when I really highly suspect COVID.

Q: If we know kids don't transmit it and are less likely to have it, why do they have to stay out so long?
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: It has been hard to separate 5-year-olds and 12-years and 17-year-olds. The day care has been a bit different.

Q: If a student does not have a PCP, schools recommend walk-in clinics, who would then connect with the school nurse? (of course, with assistance to family to find a PCP).
A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: That is a bit problematic. I guess that the results will filter back to the PCP and then the PCP has to call.
A: Alex Bannach, MD, North Country Pediatrics: I had schools reach out to me with a question asking if I would be willing to order testing for them while connecting them with the PCP, and of course I agreed.
A: Alicia: I think if a patient does not have a PCP, they should be given a list of local pediatric/family practice/CHC centers.

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