

VCHIP CHAMP VDH COVID-19

August 26, 2020 | 12:15-12:45pm Call Questions and Answers*

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VDH Testing – Your Assistance Needed!

- Assessing number of pediatricians and primary care providers ordering the nasal swabs: total of 9 requests since the August 12, 2020 Testing Guidance and Kit Ordering. HAN was sent.
- VDH response: disappointed because we really want pediatric practices testing in practices for kids with anterior nares. We felt that “the availability of nasal swabs and information on billing would be a ‘game changer.’”
- Please help VDH understand other barriers to increased testing by primary care.

Breana Holmes, MD, VDH: Many of you are ramping up for testing and maybe aren't there yet. Please let us know your thoughts. Maybe this is preparation before school starts when there will need to be a lot of testing. We are in a fairly classic COVID-19 situation, as we now have tons of supplies and no demand for anterior nares supplies.

Practice Issues: Responding to Changing Guidance from CDC on Who to Test and Physical Distancing – William Raszka, MD, and Benjamin Lee, MD, UVMCH Infectious Disease Physicians.

William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: A key concept for anterior nares testing is that as long as you do the sample collection correctly, it's a really good test, and I encourage people to do it whenever they can.

Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: Revisiting the issue of aerosol and airborne transmission of SARS-CoV-2, results of a new study were released looking at viable SARS-CoV-2 in the air of a hospital room with COVID-19 patients. This study showed that actual infectious viable virus was in the air of these rooms. They had to use advanced techniques to sample the air and collect the airborne virus in a gentler manner that wouldn't destroy the virus during the collection process. They used a couple of different methods which allowed them to collect the virus. A maximum of 74 particles of infectious virus per liter of hospital air were found. It's the first time a truly infectious virus has been able to be collected from the air. What this study can't demonstrate is if the amounts collected are enough to actually pose a threat for transmission.

We have a lot of data from super spreading events. As the pandemic progresses, the creation of environments favorable for the virus make airborne transmission possible. I do not believe the majority of transmission occurs through these routes. No one is saying this virus is as infectious as measles, where someone could come into a room an infectious individual was in two hours later and still catch the virus. We continue to emphasize masking and physical distance. Just because the virus can be transmitted through the air, doesn't mean we adjust our safety and health protocols, as transmission can still occur without masks and in close contact.

When they first tried this experiment, they had to switch the type of room they used for the sample collection because other respiratory viruses were cross-contaminating the samples. Yes, you can pull infectious virus out of the air, but it doesn't mean that's the primary means of transmission or even in a high

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

enough volume for secondary transmission. It does, however, encourage better ventilation systems and trying to do things outdoors, which we have been promoting. I'd like to see how well this can be replicated in the future. We already have evidence from the epidemiology, since we have seen aerosol transmission in the super spreader events.

William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: One of the challenges we all have is responding to the headlines in the press. The study Dr. Lee just talked about was discussed in the media related to whether or not to send kids back to school, when really the study was just a proof of concept. We also really need to take the "Pediatric SARS-CoV-2: Clinical Presentation, Infectivity, and Immune Responses" article with a grain of salt. The abstract of the article suggests infectious children had higher viral loads than adults. They enrolled 49 people who were COVID-19 positive and only 30 participated. The statement attracting so much national media attention was about 9 patients, children of various ages, and compared the viral loads with adults who may have been hospitalized for over 20 days. All data shows that viral loads decline over time in all people. The CDC even said that as of day 10, we no longer have to isolate people who are COVID-19 positive unless they remain ill. To compare these 9 children to people who have been sick for 3-4 weeks is completely and totally inappropriate. Dr. Lee and I have written a letter to the journal indicating our concerns. I would push back when you hear that children have as much viral load as critically ill adults, because it's just not true.

I also wanted to mention the recent announcement from the CDC, since we rely on the CDC for a lot of our guidelines. On August 24, they quietly updated the testing guidelines to indicate people in close contact with COVID-19 positive individuals do not need to test unless indicated by personal medical vulnerability, a health care provider or state or local public health officials. It is yet unclear why the CDC made this change. There are some concerns that there may have been political influence be enforced and recommended, including contact tracing for someone exposed to a person with COVID-19. We do have some leeway in our own state to continue with our policies based on the previous guidance.

Breana Holmes, MD, VDH: I spoke with Patsy Kelso, State Epidemiologist, this morning and we plan to continue with Vermont's testing policies and plan. We are going to test all the people we planned on testing, including close contacts. I also agree with Dr. Raszka that prior to August 24, VDH was in close contact with CDC on all guidelines. There is no explanation at this time for the change, but we will try to figure it out.

Questions/Discussion

Q: I'm wondering if family practices are aware of the availability of anterior nares testing supplies?

Q: I was asked this question, "The advice for school kids/people is to wash their hands often, after eating, outdoors, touching objects, eating, bathrooms etc. Can they use hand sanitizer instead of hand washing?"

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Yes, the only caveat is if the hands are soiled, e.g., with dirt, one should use soap and water.

Q: If our office does testing, who takes them to the lab? We do not have personnel for this.

A: Breana Holmes, MD, VDH: I thought everyone had a courier set up for all labs but maybe that's not true.

A: Ashley Miller, MD, South Royalton Health Center: The hospital lab did not want tests sent to them, because they didn't want to touch the tests. So, now we box them up with do not open indications and have them placed for the state courier. We were told by the hospital that "no one" in the clinics were doing testing, and they were all sending patients to the testing area.

A: Alex Bannach, MD, North Country Pediatrics: We just got our shipment of tests this week. We will implement next week and the tests will be shipped through the NCH lab. We have not needed much testing recently.

Q: Our lab is saying that anterior nares testing is less sensitive than NP testing, that's why we have been holding off.

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: I am not sure why the lab is saying that. It is similar to doing throat cultures; if you swab the tongue the test is less sensitive. The anterior nares testing is fine when done well.

A: Breena Holmes, MD, VDH: Okay, there are barriers! I have studied this anterior nares testing, and it is accurate. It's the sample collection that people need comfort with. It's an important myth that needs to be dispelled. I thought you might say that kids haven't been that sick. There's probably 5 or 6 reasons why you haven't been ordering the kits, with logistics, and maybe there haven't been a lot of kids you wanted to test? Maybe confirm or deny that theory in the chat box.

Q: If testing indoors, do we change our mask, too? Also, we really can't do much testing indoors if we have to take a room out of order for an hour.

Q: Since the window is rolled up and we are watching, we are not wearing gowns, just normal masks, eye protection and gloves when testing outdoors.

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: To the best of my knowledge, those outdoor doing popups are not changing their entire outfit.

Q: A lack of fitted N95s is a concern for being a PUI. If a test comes back positive, it is a concern for a loss of personnel due to the need for quarantine.

A: Monica Ogelby, Clinical Services Director, VDH: I just sent you an email about minimum PPE required for HCP to be exempt from quarantine.

Q: So, does that mean we won't need to close down our rooms for 1hr?

Q: At what age can one reliably self-collect?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Nobody knows the cutoff for children doing the test themselves, since it will vary by the child.

A: Alex Bannach, MD, North Country Pediatrics: The instructions included with the swab sets are very detailed. We plan on having the parent do the sample collection for younger kids.

Q: If a parent collects, do we need to provide them PPE?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: If you are more than 6 feet away, no need for N95.

Q: Our administration is concerned about patient flow, staffing and PPE. The current plan is to send patients to Copley for RSV/Flu/COVID and rare NP in the office. Wondering what other offices are planning on for rapid flu in office and NP COVID-19 in office? I am just wondering how many kids we would do only COVID testing for, if they are febrile or have other symptoms that would likely be due to RSV/FLU/COVID.

A: Alex Bannach, MD, North Country Pediatrics: If we want flu/RSV/COVID-19 testing simultaneously, we will need a NP swab and I will not do that in the office due to PPE use and the need to block the room for 1 hour afterwards. So we will send those kids to the ER for swabbing where they have the setup. If isolated

anterior nares swab or strep swab, we will continue to do those in the office, as the room can be used afterwards and there's no need for an N95. I think that'll depend on where we are in the season and prevalence in the area, as well as clinical presentation. It will be an interesting winter for sure.

A: Ashley Miller, MD, South Royalton Health Center: If we are seeing a patient that is ill, we will be in full PPE. We will do rapid strep/flu/RSV and anterior nares COVID-19 as appropriate.

Q: Billing wise, I believe we can only bill 99211 for the collection, not actually anything for the test, is that correct?

Q: I have a question about test kits. It comes with a large swab. Can we instead use a small flock swab for young children/infants with the same vial?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Be careful switching swabs, since they are specific to the platform. I will see what I can find out about switching. Traditionally, the traditional throat culture swab can be used as a backup but let me confirm.

Q: Same with the CDC's updated travel recommendations for quarantine?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: We will continue to follow VT guidelines on travel and quarantine.

Q: In the algorithm of low risk, in the last box, it says no diagnosis and no test. It says out for 10 days AND no fever and symptoms improved. Is that supposed to be AND or is it OR?

Q: Any update on gaiters?

A: Jan Rahelich, Nurse Manager, Timber Lane Pediatrics: A lot of homemade masks are 3 layers using interfacing.

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: The gaiters have really gotten away from us. When we made recommendations about masks, they should really be two layers. Since gaiters are by definition a single layer, we did not recommend them. Many of the school districts are buying two layer gaiters, but those aren't really two layers the way we meant for masks. We are hoping that there will be more and better guidance after our call with Commissioner Levine today to talk about gaiters in sports, outdoors versus indoors in the school setting.

Q: Is the algorithm that was sent to school liaisons this morning the final version for distribution?

A: Ashley Miller, MD, South Royalton Health Center: No.

A: Wendy Davis, MD, VCHIP: We will send out the FINAL later today, so please don't distribute the OLDER versions. We will need help to recall the old, incorrect versions of the algorithm.

A: Breena Holmes, MD, VDH: The algorithm does have a date on it. There is an August 26th version. It does still need a correction. It can then be shared with school nurses for discussion. It's a good week for them because they are in school, but kids are not attending yet.

Q: I'm hearing from other parts of the AAP universe that there are needle shortages that may impact flu vaccine implementation. Can VDH help practices who experience shortages?

Q: Am I correct that there is no science to support using foggers twice a week in schools and there is no science to support the change?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Yes, you are correct.

Q: I heard something about changes to CDC guidance for quarantine after travel. Any last minute thoughts?

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Historically, the CDC has only addressed international travel. State rules apply to inter-state travel.

Q: There is a lot of emotional angst about face masks while playing sports. Recreational/club sport guidelines really should be the same as school sports.

A: William Raszka, MD, UVMCH & Larner COM Dept. of Pediatrics: Dr. Lee and I meet with Dr. Levine today to discuss school sports. I agree that trying to align the recreational sport with high school sports and school guidance is not easy. It's a very fluid environment to be sure.