

VCHIP CHAMP VDH COVID-19

September 2, 2020 | 12:15-12:45pm Call Questions and Answers*

Breana Holmes, MD, FAAP, Director of Maternal & Child Health, Vermont Department of Health (VDH)

Abbot-BinaxNow machine

The new Abbot-BinaxNow machine has been prominently featured in national news. The FDA produced these bullet points about this new point of care antigen test:

- This test is to be performed only using nasal swab specimens collected from individuals who are suspected of COVID-19 by their healthcare provider within the first seven days of the onset of symptoms.
- The BinaxNOW COVID-19 Ag Card can be used to test nasal swab samples directly using a dual nares collection (swab inserted in both nares).
- The BinaxNOW COVID-19 Ag Card is only authorized for use in laboratories in the United States, certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. §263a, to perform moderate, high and waived complexity tests. This test is authorized for use at the point of care (POC), i.e., in patient care settings operating under a CLIA certificate of Waiver, certificate of compliance, or certificate of accreditation.

FEMA released the following about the test:

- A new rapid Abbot test has been approved for use. This provides results within 15 minutes of testing and is the size of a credit card.
 - The federal government has procured 150,000,000 to send directly to states on a pro-rata basis with the concept that they be provided to schools, day-care centers, critical infrastructure, first responders, or other users.
 - Priorities for distribution would be set by the state with the exception of some federal prioritization for healthcare workers, long term care facilities, and senior care centers.
 - They will be available between now and December time-frame. The Federal Government has 100% of production between now and December, so there won't be competition on the market until this contract is fulfilled.
 - EUA is for both symptomatic and **non-symptomatic** individuals
 - Online information: <https://khn.org/morning-breakout/us-set-to-buy-150-million-rapid-covid-tests-from-abbott-labs/>

I wanted to call this out right away to my colleagues; there's a discrepancy. Vermont's Scientific Advisory Group (formerly known as the Serology Work Group), which includes your esteemed colleagues Drs. Raszka and Lee. This link shows all of the representation on this work group: <https://www.healthvermont.gov/sites/default/files/documents/pdf/VDH-SerologyWorkingGroup-FinalRecommendations.04.16.2020.pdf>. We also have adult infectious disease, epidemiology, and laboratory sciences. We are going to meet early next week to guide Vermont's leadership in the use of antigen testing moving forward, which is going to lead to a HAN that is going to come out just about antigen tests. There is a

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HAN that's about to come out about all the testing platforms. This antigen test consensus needs to be very Vermont-specific. There is a lot of pressure out there both from the White House and other folks around schools and testing. We in Vermont believe that antigen tests are best used for symptomatic people. There will be some very neutral, scientific information to follow. There's some rumors that these would be good platforms for school nurses to administer tests in schools. School nurses are not CLIA waived, and they're not part of our clinical laboratory system. That is not a choice or an option in Vermont.

AAP resources

Some particularly good resources came our yesterday that we wanted to call out for you. We will send these in tonight's communication. There's some really nice guidance on what to do when caring for children with acute illness: [Caring for Children With Acute Illness in the Ambulatory Care Setting During the Public Health Emergency](#). Here is the AAP News item on this guidance: <https://www.aapublications.org/news/2020/08/28/acuteillnessguidance082720>

There is ongoing messaging from our great AAP President, Sally Goza, MD, FAAP: <https://services.aap.org/en/pages/message-from-aap/>.

There is also a special resource on transporting critical ill patients which may be of interest to some of you.

Interim Guidance: Transport and Telehealth During Pandemic

When transporting critically ill patients who have or may have COVID-19, AAP guidance emphasizes a balance of infection control with transport safety to reduce risks for medical staff and patients. Although telehealth is an important mode of health care service delivery, its quick and uneven uptake in some areas is increasing existing disparities in access to care.

AAP guidance: [Frequently Asked Questions: Interfacility Transport of the Critically Ill Neonatal or Pediatric Patient With Suspected or Confirmed COVID-19](#)

AAP guidance: [Guidance on the Necessary Use of Telehealth During the COVID-19 Pandemic](#)

This is a good reminder of the necessity of telehealth as we continue to experience COVID-19. I do imagine in the next few weeks on this call we are going to head very squarely back into the conversation about telehealth and reimbursement.

Requesting Your Assistance - David Nelson, MD, Pediatrics Emergency Medicine at UVMHC – Vermont Healthcare Emergency Preparedness Coalition (VHEPC)

Dr. Dave Nelson has been an active participant in our call and a great member of our Department of Pediatrics and Emergency Medicine, and he is part of a Vermont Healthcare Emergency Preparedness Coalition (VHEPC). He's describing and asking for our engagement with a survey. He wanted to remind us that this is a multi-disciplinary partnership to improve and expand preparedness, response, and recovery capabilities with four core disciplines: emergency management, emergency medical services, hospitals, and public health. He is encouraging interest and participation. VCHIP has joined this coalition. Right now, input is needed from all of you about gaps and needs about this pandemic. If you could note this link: <https://www.surveymonkey.com/r/vhepcgapassessment>. Please take this assessment to support our coalition.

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Health Equity

Another great opportunity happening tomorrow was sent to me by Dr. Becca Bell. Boston Medical Center is having Health Equity Rounds. Look at this topic! The Other MIS-C: Multisystem Inequities of School Closures. So clever. This fits in with what this group has been talking about for so many months. There is a lot more going on than just this virus, and what are the impacts of lack of in-person school for our children's health. I hope some of you can join Boston Medical tomorrow, Thursday, September 3, at 8 am. Here is the link to register: https://bostonmedicalcenter.zoom.us/meeting/register/vJwlfugpqDwivaG1_nkyO_FHsH2WGWivQ. Here is additional information: <https://twitter.com/HEHsuMD/status/1300865519361425408?s=20>.

Health Department Updates

Barriers to anterior nares testing

The feedback keeps rolling in about barriers to anterior nares testing. Thank you for that. VDH is going to get an FAQ together and get it out to you to see that the barriers are all surmountable. I absolutely promise you that some of them are artificial and need maybe some administrative support to understand that this test is accurate and easy to do. Those of you who have been doing it have confirmed that for me.

Rutland Outbreak

There was a press release yesterday. There was a specific situation at the Summit Lodge. The people working at the lodge were incredibly helpful. There has been some concern that the folks who were at the party weren't giving us all of the information VDH needed initially to do the proper contact tracing. Since the press release, this has improved, and now I believe we've reached almost everyone. The Commissioner talked about this in the press conference. This is of grave concern because many of the party-goers were from out of state, and, as you know, with an outbreak with wide reach, we won't know the full extent of it for several weeks to come.

Information contained in the press release:

- The Vermont Department of Health is investigating a community outbreak of COVID-19 cases in Rutland County. The outbreak is associated with people who attended a private party at the Summit Lodge in Killington on August 19, 2020.
- To date, the Health Department has identified 14 cases among people who attended the event and their close contacts – meaning the virus has spread to one or more people who did not attend the private party. Health officials said Summit Lodge followed state protocols and guidance and has been a cooperative partner in the outbreak investigation.
- The Health Department contact tracing team has been working to reach the more than 40 party attendees. Contact tracing is a critical part of the state's ability to contain outbreaks, and officials urge anyone who is contacted to please respond to calls from the department.

HAN on Possible Association of Neurological Conditions with COVID-19

This HAN was written by our great colleague Jennifer Read, MD, who is on this call today. It's just alerting clinicians that the CDC has formed a unit to better understand possibly association of neurologic conditions with COVID-19. The unit is asking that you as clinicians contact the health department through the email listed below (AHS.VDHNeuroCOVID@vermont.gov) if you have patients who meet these criteria.

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The U.S. Centers for Disease Control and Prevention (CDC) has recently formed a unit aimed at better understanding the possible association of neurological conditions with COVID-19. New CDC unit will provide subject matter expert assistance to health departments and clinicians for patients who meet the following criteria:

- Patients hospitalized for >24 hours
 - **AND**
- Patient with laboratory confirmation of a SARS-CoV-2 infection (laboratory confirmation in the previous 6 weeks (42 days)) or patient had a known exposure to a laboratory-confirmed COVID-19 case within the 6 weeks (42 days) prior to onset of neurological symptom(s)/condition(s)
 - **AND**
- The patient has or had neurological symptom(s)/condition(s) in the previous 6 weeks (42 days).

As a part of the clinical consultation, relevant medical records and/or patient specimens may be requested.

REQUESTED ACTION:

Contact the Vermont Department of Health at AHS.VDHNeuroCOVID@vermont.gov if you have patients who meet the above criteria for assistance in coordinating clinical consultation with CDC. There are lots of clinical consultation opportunities here, and we're looking forward to pursuing this study/association.

Social Autopsy-Drug Overdose Trends

Please go to this document that we'll send tonight called the [Social Autopsy Report](#). It's the first in-depth look at how those who died of drug-related overdose in Vermont interacted with state agencies and where improvements could be made. There are lots of areas for improvement, not surprisingly. This report was funded through a grant we have called Opioid Overdose Data to Action from the CDC. The report found of those who died, nearly all had interaction with at least one state agency in the years before they died.

The Vermont Department of Health has released the state's first Social Autopsy Report, an in-depth look at how those who died of a drug-related overdose interacted with state agencies, and where improvements in the state's efforts can be made. The release coincides with the observance of [International Opioid Awareness Day](#).

The Social Autopsy report examines data from 2017, when 109 Vermonters died of an [accidental or undetermined drug overdose](#). The report found that of those who did, nearly all had an interaction with at least one agency in the years before they died (98%). Two-thirds interacted with three or more state agencies, including the Vermont Department for Children and Families and the Department of Vermont Health Access.

Funded under the Centers for Disease Control and Prevention's Overdose Data to Action grant, the Health Department partnered with the Departments of Corrections, Children and Families, Vermont Health Access (Medicaid), and Public Safety to analyze each department's data.

Practice Issues: VDH HOPR Team: PPE and Risk Assessment in Healthcare Settings, Will Fritch, Kayla Donohue, and Jennifer Read, MD

Will Fritch, RN, VDH Infectious Disease and Epidemiology Program: Before COVID-19, my focus was on healthcare associated infections and antimicrobial resistance. During this response, I am one of the team

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leads for our health care outbreak prevention and response team, aka HOPR. I'm joined on this call by my co-team lead, Kayla Donohue, and Dr. Jennifer Read.

Kayla and I are each HOPR team leads. Our other two HOPR team leads are Jennifer Read, MD, and Mallory Staskus. In addition to the four of us in VDH's central office, our team works closely with the Public Health Nurses working in each of the Department of Health's 12 Local Health Offices. If one of your practices is contacted by HOPR because of a positive case, you may hear from either one of the four of us or from one of our Public Health Nurse designees that we work with. Before we move forward, I'll give a bit of an overview of HOPR's scope of work, to help distinguish us from other teams at VDH, like contact tracing. HOPR works across the spectrum of prevention *in healthcare settings specifically*.

In our primary prevention efforts, where we're trying to prevent cases in healthcare settings entirely, we conduct work such as proactive infection control assessments with long-term care facilities. We partner in providing technical assistance, both one-on-one in response to received inquiries, and more broadly through webinars with our partners at DAIL and Licensing. On the secondary prevention front, we've contributed to larger surveillance efforts, such as in our partnering with DAIL to develop the Long-term Care Facility ReStart or reopening guidance.

Finally, and this is probably our most recognizable function and when we'd most likely be interacting with you all, in the tertiary prevention world, once we've already identified a case, we pull together a rapid response team to work with the affected facility to discuss next steps, including exclusion and quarantine, duration of isolation, and follow-up testing. Diving deeper into those response functions: I will first give an overview of the healthcare contact tracing process, and then we can explore in a bit more detail how our team handles risk assessment following an exposure with variation in different factors, such as types of PPE utilized.

Our healthcare contact tracing process really kicks off following notification of a positive case to VDH. This can come from a testing laboratory directly, from an ordering provider, or from several other sources, such as interstate notifications from neighboring state health departments. Once VDH has received notification, our Contact Tracing team will reach out to every individual positive and begin the contact tracing process. This includes eliciting information on their close contacts and following-up accordingly. The few exceptions in which this is handled slightly differently are long-term care facility residents and inmates in correctional facilities, for whom we might instead work with a provider at the facility level.

Meanwhile, our team, HOPR, will follow-up with any healthcare facilities that might have infection control questions or concerns, and with any facilities in which there is concern for transmission in the facility, such as when it's a staff member who tested positive. We also work with the facility to determine who, at the facility level, would have identified as close contacts, in case this adds to the list of contacts that our Contact Tracing team has already elicited. We have found that this happens not infrequently, and that the facility-level knowledge of things like scheduling and unit or patient assignments are valuable supplements to our contact tracing efforts.

That leads us to what we actually consider an exposure. We follow CDC guidance on this topic, and specifically guidance addressed to healthcare settings (link: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>).

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An important first step in identifying who might have been exposed is determining whether contact was close and prolonged. Close contact is defined as being within 6' of a person with confirmed COVID-19 or having unprotected direct contact with infectious secretions or excretions of a person with confirmed COVID-19. Prolonged contact is contact lasting 15 minutes or more or contact of any duration in the presence of an aerosol-generating procedure.

Once we have confirmed that contact was both close and prolonged, we review the types of PPE that were used to determine whether the exposure was low or higher-risk. Low risk exposures, such as close/prolonged contact with a case but with all recommended PPE employed correctly, do not require any measures beyond those that we are all currently undertaking, such as monitoring for symptoms and staying out of work if sick. Higher-risk exposures are when we start to get into the realm of work exclusion and quarantine. I'll get more into that now.

There are a few types of close and prolonged contact that would be deemed high risk. I'll review these now in accordance with the type of PPE worn by the potentially exposed healthcare personnel. First, if you have a healthcare provider who is not wearing either a facemask or a respirator, so no mask-type PPE, then any close and prolonged contact is considered higher risk. It's really useful to have universal masking in place. Now say that you've done that, and that your providers are all wearing masks at all times while working, the next way they could have a higher-risk exposure and potentially end up quarantining, is if they have close/prolonged contact with a positive patient or coworker who is not masking. In order to avoid exclusion here, they would also need to be wearing eye protection. So, no mask, all close/prolonged contact is high risk. With mask only, you're okay if the source is masked. If the source is not masked, you need mask and eye protection. Finally, if a provider has contact with a positive person in the context of an aerosol generating procedure, they must wear all recommended PPE, including gown, gloves, eye protection, and a respirator, to avoid higher-risk exposure. If any of those equipment are missing in the context of an aerosol generating procedure, the contact is higher-risk.

We created a flowchart and supplemental document based on the CDC guidance that we just reviewed to help determine when work exclusions are indicated based on the types of PPE employed. This includes all the same information we just discussed, but in a slightly different format, but hopefully more user-friendly. This document is still in draft form but will be released this week. We hope this will be a useful tool.

That was a lot of information for us to throw at you, so I think now we'll shift over to some scenarios before closing with Q&A.

Scenario 1 – SARS-CoV-2-positive patient: Three days ago, a 13-year-old male was seen in your office complaining of nausea, vomiting, and abdominal cramping. His temperature at the time of visit was 38.3° C. You did not see the patient, but you've been tasked with determining whether any of your staff might need to be excluded. The PA who saw the patient, who suspected COVID and collected the specimen, reported that the child was not wearing a mask when they entered the room but that she (the PA) was wearing both a mask and a face shield and that she donned gloves and gown for specimen collection.

What additional questions do you have for your staff? (Answer: Did any other staff have close/prolonged contact with this patient? Did they have close/prolonged contact with any other patients, such as in a waiting room area?)

Scenario 1 (continued):

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- Other patients
 - Positive patient was in waiting room for < 10 minutes and was masked at that time, per front desk staff. He also sat > 10 feet apart from the one other patient in the waiting room at that time.
 - Other staff
 - Front desk staff interacted with positive patient for < 5 minutes, were masked, and confirmed that the patient had a mask on at that point
 - Patient was seen by an RN before the PA. RN stated that she wore a mask while seeing the patient but that the patient was not masked in the exam room. Contact was close and prolonged.

With our goal being to build a list of potentially higher risk contacts who might need to quarantine, we gather the information shown here. Contact with other patients was neither prolonged nor close, so we're okay there. On the staff side, we also don't have close or prolonged contact at the front desk or registration, but we do identify an RN who saw the patient before the PA to collect information for their history and physical. They were in the room for approximately 20 minutes and were close to the patient. They wore a mask but by this point the patient had removed theirs. What is the recommendation for this RN?

Because the patient did not have a mask on and because eye protection was not worn by this personnel, the healthcare provider would potentially meet the criteria of work exclusion.

Alex Bannach, MD, North Country Pediatrics: What about patients who remove masks while in exam room waiting for MD for >10 minutes and then only put mask back on when provider enters room and asks them to? Does that constitute exposure?

Will Fritch, RN, VDH Infectious Disease and Epidemiology Program: My blanket answer to that and what we might encounter in some of these additional scenarios is that we would want to talk through that with the healthcare provider. We want to hear what was going on with the patient. Was the patient symptomatic? We might want to check in with our colleagues at CDC as well. If we can't come up with answer as a team, we will check in with CDC and get back to you on that.

Breana Holmes, MD, VDH: There is a lot of individuation to these scenarios, and our team is really prepared to help you. Good example.

Will Fritch, RN, VDH Infectious Disease and Epidemiology Program: My You can reach our entire team by emailing COVID19.HealthCareContactTracing@vermont.gov, and we're happy to talk through any of these situations with you.

Scenario 2 – SARS-CoV-2-positive staff:

- Patients seen:
 - RN saw 10 patients on Wednesday and Thursday. All patients were masked. RN was wearing eye protection and a respirator during all visits. Staff is excellent at hand hygiene. Interactions ranged from 10 – 20 minutes. All patients were masked.
- Other staff:
 - Staff maintain mask usage throughout the workplace and office space has maintained ≥6 feet between staff. All staff have remained asymptomatic. They ate lunch both days with one of the NPs.

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When we're talking about exposures to other healthcare personnel, we can routinely factor in the type of PPE worn. If we're talking about a positive patient or a positive colleague, we're really looking at the type of PPE used and making a determination based on that. If you have positive healthcare personnel in your office and you're trying to determine what the risk is for exposure to your patients, then the CDC's guidance means less on any potential PPE worn by the patients themselves because they're not healthcare personnel or trained in the use of PPE. We're really looking more into establish a list of who had close and prolonged contact: less than 6 feet distance for more than 15 minutes. For potential higher-risk exposed persons, we'll get that over to a contact tracing team in partnership with you and the contact tracing team to make the appropriate recommendations.

Questions/Discussion

Q: I meet with the MAUSD nurses yesterday and we discussed the COVID communication tool. They felt that the top part was for them but felt that without a separation on the form, it looked like the nurses need to fill out the diagnosis, which they did not feel comfortable doing or think that was for them. They thought that part was for the health care provider. The parent signature may also need to be optional or where the health care provider can just write that they have discussed with the parent on the phone, as they may not be in your office. We could be seeing them via telehealth or just triaging them over the phone.

A: Breena Holmes, MD, VDH: Thank you for that feedback. I will make that change in the next draft. Just a reminder that folks can use this document to edit and customize as needed in a community, so please do so.: We have 3 new resources that are for helping schools and you in the next week.

A: Elizabeth Hunt, MD, Timber Lane Pediatrics: Health care interaction is likely virtual, so no signature is ideal.

A: Ashley Miller, MD, South Royalton Health Center: If it's just a phone call to our medical home, then I would send it to the RN directly, not via parent.

A: Thomas Bolduc, MD, Timber Lane Pediatrics: Or send via the portal.

A: Alex Bannach, MD, North Country Pediatrics: I agree. I'm hoping to do a lot of those via phone.

A: Leah Flore, FNP, Shelburne Pediatrics: Elizabeth points out that the interaction is likely virtual so no signatures, however, the nurses will be faxing these communication forms to your office. The nurses have reported that kids will not be allowed back to school unless a note is signed by their provider, so providers will likely have to fax back to the school with their signatures.

Q: School screening question: student had URI, COVID negative test, symptoms improving. Per algorithm, student can go back to school, however, now they are answering positive to morning screening questions, cough, etc. How should schools handle this?

A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: That is a great question. We technically say symptom resolution, so return to school. So hopefully many kids won't have lots of cough at school. This is an imperfect approach because, as we all know, cough is often the last symptom to resolve and can linger for a long time. The intent for the screening questions is to catch symptoms that might be due to COVID. If it has been reasonably ruled out, we may need to have a clarifier speaking to that. At UVM, for example, we phrase the question, "Do you have X,Y,Z that cannot be attributed to another condition?"

A: Ashley Miller, MD, South Royalton Health Center: Thanks. The algorithm just says improved in all the bottom boxes.

Q: Also, are we starting to address the skewed well visits time line with insurers, i.e., kids coming in late for their 3-year visit because of COVID? If we wait a year as required by insurers to do the next WCC, we

will miss their 4-year birthday and opportunity to do vaccinations. It would be great if we could get insurers to waive the 1-year requirement, even if just for the next year. Also, it will mush all the well visits outside of March thru July, and then overwhelm the medical homes from August to October.

A: Judy Orton, MD, Green Mountain Pediatrics: VT BC (in general), pretty certain CIGNA, MVP and VT Medicaid are now 1 well visit per calendar year starting at age 3 years. We have been getting paid with doing "early" visits this year.

Q: When schools have a hybrid model, is there an option for remote learning on in person days for kids who are resolving their coughs and can't be in person?

A: Ashley Miller, MD, South Royalton Health Center: In our SU right now, there is not. I got a lot of push back and siting of FERPA when I tried to suggest it. This may be a great place for us to focus our advocacy next. Wiith school, the virtual community is different than the in person, so their curriculum won't be the same, so you can't hop back and forth. They are saying that the in person can't broadcast to the sick kid at home, due to FERPA.

A: Kristen Bird, MD, Timber Lane Pediatrics: I was part of a school Zoom call for parents yesterday. They also said remote learning for kids at home on their normal in-person days would not work because each cohort will be in a different place with learning.

A: Elizabeth Hunt, MD, Timber Lane Pediatrics: I have been working with CVSD and they have said that if a child is home sick or for reasons of exposure that they could engage in full remote learning on their "home days". Seems like a nice collaboration of health needs for the population, plus ongoing school normalcy for kids. I guess it is district to district. I'd hope figuring that out would be a priority because kids needing to be home with any symptoms of illness is very important for us to get through this.

A: Leah Flore, FNP, Shelburne Pediatrics: The MAUSD elementary school is saying no to on-line with other kids if they are not in your hybrid cohort days because this will be too difficult for the teachers.

A: Alex Bannach, MD, North Country Pediatrics: Most of my schools are assigning teachers either to remote or in person teaching, so switching back and forth might be difficult, but will address at a meeting with NCSU tomorrow.

Q: If there is a known COVID exposure, is asymptomatic, then 7 days after the last exposure, but if becomes symptomatic before the 7 days, do you test sooner? When I last asked that question, my impression of the answer was to still wait 7 days, but a contact tracer told a family this weekend that if they become symptomatic within that 7-day time, they can test on the day the person becomes symptomatic.

A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: If someone has a known exposure and is in their quarantine period, then develops symptoms, then yes, they should be tested when they develop symptoms. That is the purpose of the quarantine period, to see if they get sick. The 7-day test only is supposed to apply in someone who is asymptomatic.

Q: Can folks wear safety glasses in place of face shields?

Q: Is a routine physical exam of a screaming asymptomatic toddler considered a high risk exposure?

Q: In general, in an asymptomatic patient, I thought not wearing a mask in a room and putting it on when the health care professional enters the room, was ok? The younger kids do this a lot.

A: Kayla Donohue, VDH: Yes, in general, the removal of a mask of an asymptomatic individual in the room prior to a HCW entering is probably considered low risk. This, however, should be discussed on a case-by-case basis.

Q: What about patients who remove masks while in the exam room waiting for the MD for >10 minutes and then only put the mask back on when the provider enters the room and asks them to? Does that constitute exposure? Provider is in appropriate PPE.

A: Ashley Miller, MD, South Royalton Health Center: This is a very common issue in our practice, patients taking off masks while waiting.

A: Alex Bannach, MD, North Country Pediatrics: Ashley, I agree, despite reminders and posters etc.

A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: I don't think that counts. At UVM MC, currently we allow inpatients to take masks off and then put them on if a provider enters. For outpatient, I think it is reasonable to ask people to keep their mask on the whole time. But, if the patient was unmasked for a short time alone in the room and then puts it back on when the provider returns, I would think this should be fine, although I will defer to our experts at VDH if they feel differently.

A: Kayla Donohue: Ben, I agree in general. But we're always happy to chat through specific situations.

A: William Fritch, RN, VDH: My blanket answer to that and what we may encounter in some of these other scenarios is that we would want to talk through that with you. We would want to hear what has been going on with the patient, was the patient symptomatic, some of those details, and we may check in with our colleagues at CDC as well to come up with an approach and a response to that.

Q: Are regular glasses sufficient?

A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: Regular glasses are not sufficient.

A: William Fritch, RN, VDH: No, regular glasses would not be considered eye protection as PPE.

Q: What about room cleaning after? If a test was not collected in-office (set to curbside), would the room still need to be cleaned and sit for an hour?

Q: Can you wear safety glasses?

A: William Fritch, RN, VDH: No, not safety glasses.

Q: How about the combo mask with face shield for the eyes (1-piece item)?

A: William Fritch, RN, VDH: I think that is something we would want to follow up more directly on if we're talking about a specific product. In general, for eye protection, we're looking at a face shield or goggles, but for assessment of effectiveness of a specific type of PPE or product, I think we could better handle this on a case-by-case basis and pulling in the appropriate experts here or gather the information from the manufacturer.

Q: What about face shields?

A: William Fritch, RN, VDH: Face shields extending below the chin and covering the sides of the face are acceptable as eye protection for PPE. They would check the box for eye protection, not for face mask or the respirator box. If the personnel just had a face shield on and had contact with a positive individual and did not have a respirator or face mask, they would be lacking a piece of the PPE criteria and that would be potentially a high risk exposure.

Q: Breena, in our office, we are discussing the amount of time in a room for a well-child check with asymptomatic kids, no procedures done. If wearing a mask and eye protection, can we be in the room for a length of a well-child check (20-30mins)? If that patient or parent turned positive, my understanding is that if a HCP was wearing a mask and eye protection, then no need for HCP to quarantine, correct?

A: Denise Aronzon, MD, Timber Lane Pediatrics (North): To clarify, surgical mask and shield, not N95.

A: William Fritch, RN, VDH: I think even if they did have symptoms, if we have the health care personnel who are concerned about being exposed, wearing eye protection and a face mask, then we would meet the criteria for PPE sufficient to avoid exclusion for quarantine. I think an important point across the board is that we need to be monitoring ourselves for symptoms and enacting those broader protections at the work place, including those as universal source control on our health care personnel that add in that level of protection even if that person ends up testing positive and was symptomatic. If we're not talking about an aerosol generating procedure and the HCP was wearing eye protection and a face mask, they would not need to be excluded from this guidance.

Q: School nurses in our area are wondering about kids or teachers with no symptoms at the start of school who have a sick contact at home, like a runny nose (not COVID-19+), should this kid go back home? We have said no unless the kid or teacher has symptoms per the algorithm.

A: Elizabeth Hunt, MD, Timber Lane Pediatrics: This has come up within our school district. If no symptoms, OK to be at work.

A: Ashley Miller, MD, South Royalton Health Center: I believe we had said in VT, a person is not considered a case until they test positive, so therefore their household members don't quarantine. I think NH is doing the opposite, quarantine the whole household until a negative test, so we have had issues across the border.