VCHIP CHAMP VDH COVID-19

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

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VDH Updates

Wendy Davis, MD, VCHIP: As always, school-age and child care reports of positive tests are immediately picked up by the VDH contact tracing teams. In case you've heard the news reports, we will share what we know. Stay tuned for the final analysis perhaps in contrast to what you sometimes hear from news reports or read in printed media. Dr. Holmes is very careful about identifying cases, given small sample sizes. The media has indicated it's Crossett Brook school. We will let you know what we know as we know it.

Breena Holmes, MD, VDH: We had some scenarios in important school-related cases that required us to test out our communications and the way the health department and school districts are going to interact in these scenarios. I'm struck by how the media picks it up and puts it forth. Also, the interplay between the health department and the school districts' local control around closure will continue to be parsed out. VDH does not recommend closures, given these are small numbers and VDH is confident about its contact tracing. We have a meeting scheduled with the Commissioner of Health and we need to describe what we think our approach should be to sporadic incidences of cases at school.

Wendy Davis, MD, VCHIP: The latest version of the COVID-19 In Pediatric Patients (Pre-K – Grade 12) Algorithm is now available. We are working on some formatting issues, but the changes aren't too terribly substantive. We added nausea and diarrhea. We added a footnote about influenza. We recommend not testing for influenza when possible in order to preserve testing capacity for COVID-19. We will attach the algorithm to this evening's email and post to VCHIP's COVID-19 website.

Benjamin Lee, MD, UVMCH & LCOM Dept. of Pediatrics: I'm curious to get ongoing feedback on this algorithm to see how it works for everybody. We reference a HAN that will be coming out shortly that talks about influenza testing. At the end of the day, any influenza test that gets sent comes at the cost of being able to send a COVID-19 test. All of the reagents, lab equipment, technician time, etc., are virtually identical. There is a strong emphasis this year to not test otherwise healthy outpatients for influenza and to prioritize confirming COVID-19 test results; please be judicious about testing outpatients for influenza and bronchiolitis in order to preserve testing capacity for COVID-19. The Heatlh Advisory (HAN) from VDH should be coming out soon.

Breena Holmes, MD, VDH: We have our graphic designer back, and she's fixing the graphics for the algorithm. We've added nausea and vomiting. We have runny nose in multiple places and we've received feedback that some people want to change it to congestion. I feel like runny nose is similar enough to congestion. If we need to add it, it's a huge space filler, but if it makes your life easier, we can do it.

From the CDC/MMWR

Early release: Transmission Dynamics of COVID-19 Outbreaks Associated with Child Care Facilities — Salt Lake City, Utah, April–July 2020 (9/11/20) (link here: https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6937e3-H.pdf).

*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: I've looked at the study, though not in as much detail as I would have liked. There are a couple of general comments to be made: first, I do worry about publication bias with this. We have acknowledged that outbreaks in schools are possible, but have yet to answer the following related questions: to what extent will they be contributing to community transmission? Is this the exception or the rule? Will all child care centers and schools be vehicles for spreading COVID-19? We have all of these reports about outbreaks, but we don't have reports for all of the child care centers and schools that have **not** reported outbreaks. For this specific study, they talk about three childcare centers that were identified as having outbreaks. They look at 17 facilities that had at least 2 cases in a 14-day period. I would like to know the total number of facilities operating in this county in Utah at the time. One outbreak was relatively small involving two adults. Another did involve children. My takeaways from these outbreak investigations, if you read closely: all of these outbreaks were started by staff members. It's the adult entering the facilities that are really the risk of introducing virus. In two of the facilities, these were workers who had a known household contact who was symptomatic with COVID-like illness, but had not been tested. This emphasizes the importance of doing testing for household members of essential workers in high-risk settings. In the largest outbreak, it was the only facility that did not require masking in staff members. None of the facilities required masking for children. I can't tell whether people were masking or not. A lot of the children in this facility were in the older age of the spectrum, ranging from 6 to 10 years. If all of the children and staff members had been masking at this facility, could that have averted the outbreak? These are instructive in learning what could have mitigated the outbreaks: more rapid testing of household members with COVID-like illness and masking in the facilities.

Practice Issues: Return to School

Breena Holmes, MD, VDH: we are finalizing the algorithm one-pager companion piece for parents and are almost done. It was unfortunate there were cases in school when we've only been at it for 4 days, but when you think about 80,000 kids in schools across the state, that's okay. Please keep the feedback coming.

Questions/Discussion:

Q: Where is the new COVID-19 protocol posted?
A: Wendy Davis, MD, VCHIP: The latest version will be the last version (for now!). We had some last minute formatting updates and we should be able to attach it to tonight's email. Just a reminder, the changes are not too substantive. We added nauseas and vomiting where diarrhea was in the symptom list. We are adding a footnote about influenza testing. Routine testing of otherwise healthy outpatients for influenza is strongly discouraged this season in order to preserve testing capacity for SARS-CoV-2.

Q: Can we test for flu in our office?
A: Breena Holmes, MD, VCHIP, VDH: Yes, if you have rapid flu tests, go for it.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: Are you referring to rapid point-of-care testing? If so, you can use them, but we would still want providers to be mindful of not burning through them at high volume. The swabs that get packaged into those kits are swabs that will be diverted from the suppoy chain for COVID testing. For flu testing, there are exceptions for high risk groups who will still be eligible for testing. The HAN gets into these specific details. Please preserve flu testing for those admitted into the hospital for respiratory Illness and for those in certain high risk groups.
A: Alex Bannach, MD, North Country Pediatrics: We usually run some flu tests at the beginning of the season to establish that influenza is indeed here, but then defer to clinical diagnosis. Would probably still want to do that, but it is a limited #.

Q: If a COVID-19 test is being ordered, can flu or RSV test be run on the same swab? This will really help with identifying an alternative diagnosis. I have found the swabs sent in the packaged COVID-19 "kits" are too large for small children's noses (similar to the adult vs. pediatrics flu swabs). I am using the strep swabs instead of the COVID-19 swabs for small children but I'm not sure what to do with the unused larger swabs.

A: Michelle Shepard, MD, UVMCH Pediatric Primary Care & VCHIP: Our kits come from a UVM MC. I also would consider packaging smaller swabs in COVID kits for kids (then larger swabs available for adolescents and adults).

A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: Let me check in with our lab to see if we have a way to collect those swabs to be diverted to use them elsewhere. At the end of the day, the primary consideration is will the testing change management. So for children with clinical bronchiolitis who are being admitted into the hospital, I would argue that knowing if it's RSV isn't going to change management. So for patients admitted into the hospital with clinical bronchiolitis, we're recommending those children not be tested and just be managed by the clinical syndrome. That is one difference that is different in pediatrics.

A: Alicia Veit, MD, Timber Lane Pediatrics: The flu test does not often change management for the child, but it does change management for other family members who are high-risk.

Q: What about flu and RSV Ag test that our local hospital lab runs? Does that cut into COVID-19 testing as well?

A: Benjamin Lee, MD, UVMCH & Larner COM Dept. of Pediatrics: Any type of test that uses a swab impacts COVID testing. The swabs have to get packaged into testing kits so those get diverted from COVID testing. Any type of test that requires a swab, we would ask they be judicious about using it. Any type of antigen test, as long as you're somehow trying to get a swab from the nose, it has an impact on COVID testing. If those swabs come in the kit, those are dedicated to those kits. Still, please remain judicious in using them so that we're not creating an increased demand to be diverted to new kits to be ordered.

A: Alicia Veit, MD, Timber Lane Pediatrics: In our office, testing is frequently requested because it has implications for other family members, for example, whether to provide prophylaxis for a pregnant mother.

Q: We need your help with runny nose and congestion, as we consider runny nose and congestion as a continuum. Can you weigh in and tell me if we need to add runny nose and congestion?

A: Elizabeth Hunt, MD, Timber Lane Pediatrics; Alex Bannach, MD, North Country Pediatrics; Barbara Kennedy, MD, Timber Lane Pediatrics; Leah Flore, NP, Shelburne Pediatrics: Keep rhinorrhea only.

A: Stacy Strouse, MD, Northwestern Pediatrics: I agree with runny nose and congestion going together

A: Ann Wittpenn, MD, UVMCH Pediatric Primary Care: How about "nasal secretions"?

A: Michelle Shepard, MD, UVMCH Pediatric Primary Care & VCHIP: How about nasal symptoms in the algorithm then a footnote with runny nose congestion?

A: Ellen Gnaedinger, APRN, South Royalton Health Center: Runny nose/congestion/rhinorrhea, any of these will work. The school nurses that I've spoken to in the last week are clear about whether congestion is r/t allergies vs. a brand new symptom. So, the main point is that school nurses are clear whether the runny nose is new.

Q: I think the challenging question is that with a febrile coughing child who is awaiting a COVID-19 test result, do we prescribe Tamiflu? What if they are high risk vs. normal risk?

A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: Any high risk patient with ILI would be a reasonable candidate for empiric Tamiflu.

Q: I need some support/help around the vast amount of mask exemption requests I am getting. I heard from one parent that schools are requiring a certain kind of mask for all sports per recommendations from the Department of Health, is this true?
A: Shannon Hogan, DO, UVM Medical Center Pediatric Primary Care, Burlington: All sports are required to wear masks while playing sports.
A: Kristen Gray, FNP, CHCB, Riverside Health Center: Also, some clarification about mask exemption requests while playing sports if they have asthma, "trouble breathing" with mask, would be appreciated.
A: Kathleen Bryant, FNP, CVMC: I have had requests for mask exemptions for "trouble breathing" with asthmatics as well.
A: Ashley Miller, MD, South Royalton Health Center: https://questforhealthkc.com/2020/09/08/mask-exemptions/
A: Jill Rinehart, MD, UVM Medical Center Pediatric Primary Care (Williston): Mask exemption document: https://www.healthvermont.gov/sites/default/files/VT-Mask-Exemptions-in-Children-and-Adolescents.pdf. Asthma is not a condition for mask exemption. If someone is having an asthma exacerbation, then the mask shouldn't be worn if respiratory distress.
A: Nathaniel Waite, RN, VDH: https://www.healthvermont.gov/response/coronavirus-covid-19/about-coronavirus-disease-covid-19. The page I just posted is where the document Jill shared lives.
A: Breena Holmes, MD, VCHIP, VDH: And the health department is definitely not recommending a certain type of mask!
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: There is no requirement for a specific type of mask. We are stating the two layers are recommended but beyond that there are no specific requirements as to type.

Q: If respiratory distress, seek medical care, i.e., if asthma is causing breathing problems, they should contact clinicians for care/evaluation, NOT simply ask for mask exemption, right?
A: Wendy Davis, MD, VCHIP: Yes, you are correct!

Q: CVSU bought thousands of gaiters. Should they wear two at a time?
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: They can double them over would be one approach as long as they are long enough. One of the other issues is that some gaiters are in fact two-ply and some are single ply. If they are "two-ply" gaiters, they would be ok as is.

Q: Do you all have data about severity of illness in the hotspot states compared to NYC and other northeast? Is the morbidity and mortality actually declining? Or not? There's not much in the MMWR. I'm seeing reports in the news, but the public impression is so wide from intense anxiety to believing it's not dangerous anymore.
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: I don't know I can comment specifically on how the numbers compare to NYC this past spring, but we've been seeing >1000 deaths/day going on a month now. It seems pretty severe to me.

Q: Do you have any specific guidance around allowing valve masks in schools?
A: Benjamin Lee, MD, UVM Children's Hospital & Larner COM Dept. of Pediatrics: ***No valve masks!*** *I am not aware of what that even is, but, in general, no, a valve is designed to release exhalations, which defeats the entire purpose of the mask. At least in this context, in which case the goal is to protect others, not the wearer.*

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