Q & A from the TDH COVID-19 Provider Webinars

This is a running Q&A list.

Responses are listed with the most recent answers at the top of the page. This is a rapidly-changing situation and information may already be out-of-date. Please refer to www.tn.gov/health or www.cdc.gov/coronavirus for the most recent updates.

Questions for August 7, 2002 Webinar

Q: For MDI use instead of nebulizers, how are some ways to provide treatment to acute pediatric practices? Do you know of any resources to get supplies to provide MDIs in these acute cases, and is there a way to bill for it?

A: The practice can either write a prescription for itself ("for office use") and fill it at the pharmacy or request sample MDIs from a pharmaceutical rep. MDI treatments administered in the office are billed the same way nebulizers are billed as long as the treatment is provided by a health care worker. The CPT code is 94640 and includes reimbursement for the cost of the medication.

Q: If a student tests positive, does the entire classroom have to be quarantined or just those within a 6-foot radius.

A: Quarantine anyone who spent 10 or more minutes within 6-feet of the confirmed positive case. Keep a seating chart in a binder or google doc for each classroom in the school to easily identify close contacts.

Q: We test for COVID-19 weekly because we work in a nursing homes. Once a nurse has recovered, her test can remain positive for weeks—so do we keep testing weekly on these recovered individuals? If not, when do we resume weekly testing?

A: Staff who have been diagnosed with COVID-19 should not be re-tested for 90 days from the date of their positive test. Resume weekly testing after the 90 day period has elapsed.

Q: How many cases in one school will warrant the closing of the entire school?

A: The number of cases needed to warrant school closure depends on the school, its staffing capacity, and the circumstances of the cases.

Q: Are there salient talking points for parents who insist on back to school screening testing for all

A: The CDC and TDH discourage mass testing of asymptomatic individuals. This testing places an enormous burden on testing resources and makes it more difficult for symptomatic people to get the testing they need. The testing of asymptomatic individuals also comes with a higher chance of a test not detecting the virus due to lower levels of virus in people who do not have symptoms.

Q: A child with moderate persistent asthma had an asthma exacerbation requiring an ER visit that happened on the first day of school when she was required to wear a mask for 2 hours. Would anyone excuse this child from wearing a mask?

A: It's unlikely that the mask caused the exacerbation but that may be difficult for parent to accept. You may find it reasonable to excuse the child from wearing a cloth face covering temporarily If the child is that bad, they should stay home. Some parents are convinced that the mask caused asthma attacks, but the reality is that it did not. If you must excuse the child put an end date on the excuse, give them a pass for a week. While the child is at home, he/she should practice wearing a mask.

Q: What is the time required between seeing one sibling in an exam room (with a facemask on), going outside of the exam room and coming back, that would reset the clock for having no more than 10 min contact time with 6-feet to say or and provider are not exposed?

A: The CDC does not clearly define exposure as being consecutive minutes or cumulative. TDH has elected to consider the exposure in terms of consecutive minutes, although this could change should CDC further clarify its guidance. If the provider is in appropriate PPE (surgical mask or N95, eye protection, gown and gloves) the provider would not be considered "exposed" and would not require quarantine, regardless of time spent with the patient. If the provider was not wearing appropriate PPE and the patient tested positive for COVID-19, this exposure may be considered significant enough to warrant quarantine, even if the time spent in each session was less than 10 minutes. Public health should be consulted in these situations.

Q: I noticed the CDC lists 15 min or more within 6-feet in defining direct contact. Is this a change? In TN, are we still going with 10 or more?

A: There was no specific evidence or policy statement to support the change from ≥ 10-minute time frame to a ≥ 15-minute time frame. TDH will continue to use the ≥10min for the time being.

Q: If students wear masks, in the hall, but take it off at the desk in the classroom (6-feet apart), is this safe?

A: Students should wear their facemasks while in the classroom. A facemask is important to wear when students are indoors and when social distancing of at least 6-feet is difficult to maintain. See Additional Considerations for the Use of Cloth Face Coverings Among K12 Students.

Q: Would we consider sustained contact with brief periods of football practice close contact?

A: Yes, two teams lined up helmet to helmet for multiple plays would likely require quarantine if one player was positive for SARS-CoV-2. We have football teams who are currently in quarantine or isolation because of this type of close contact.

Q: If our pediatric office started testing patients for COVD-19, could you tell us if this will increase our medical assistants' chances of getting the illness and at what percentage? If we test outside, is PPE to be changed for each patient?

A: Certainly, health care workers are at higher risk of being infected with SARS-CoV-2 because of their exposure to infectious patients. It's best to limit the number of staff who have close contact with patients and to ensure those staff are wearing appropriate PPE and know how to properly don and doff that equipment. Any time testing or other higher risk procedures can be performed outside the risks to those individuals is reduced.

Q: Did you say appropriate PPE is a shield and mask for patient contact?

A: Correct. Ideally, the provider would wear a surgical or N95 mask and eye protection when within 6ft of a potentially infectious patient, plus a gown and gloves for direct patient contact.

Q: So, you would recommend seeing WELL patients in full PPE as well? How do we mitigate risk to providers and staff when we book two siblings on the same day

and say the well kid calls 2 days later and say they are positive. I want to avoid 14-day quarantine.

A: It's a very tough call, but children are most likely to become infected by the adults in their lives. Asking questions the day of the appointments, preferably prior to the patients arriving at the office, can help to determine if full PPE would be required for a well visit, in addition to awareness of your community's current transmission statistics. If you are in a low transmission county and the family denies symptoms in the household, you should be relatively safe. It's always best to wear a surgical or N95 mask and eye protection with all encounters. Remember, too, that a health care worker deemed "essential" may continue to work while quarantined so long as they are compliant with wearing a mask at all times.

Q: I purchased air purifiers for every exam room with MERV 13 medical-grade filters. (And we only see well children in these rooms currently.) Not sure this will just give a false sense of assurance or will help. Thoughts?

A: Not familiar with that particular equipment, but measures taken to improve air exchange can certainly reduce risk of transmission. The presence of one would not impact quarantine recommendations.

Q: What about countries that counted on "herd immunity" ?

A: Current studies suggest immunity may be inconsistent and may wane within the first 100 days after infection. At this time, there is no evidence that natural herd immunity is possible and, even if it was, estimates suggest 60-70% would need to become infected with the virus to achieve it. With a case fatality rate of ~1% in Tennessee, that would result in approximately 40,000 deaths in Tennessee. We need an effective vaccine.

Q: What is the current false-negative rate of the state test? Should there be retesting if there is strong clinical suspicion that the patient has COVID?

A: Unfortunately, false-negatives result from many factors— specimen collection technique, transport and processing; timing related to the patient's exposure and infectious period; community disease burden; and the sensitivity of the testing platform itself. If the person in front of you has symptoms consistent with COVID-19 (especially if they have had a known exposure), repeat testing is absolutely encouraged.

Q: What do "inconclusive" tests mean on PCR? Do we need to isolate or quarantine that employee until we get a repeat test that is conclusively positive or conclusively negative?

A: “Inconclusive” can mean different things, depending upon the laboratory. It may mean the specimen was not adequate for processing. It may mean the specimen had bacterial overgrowth that made detecting viral RNA difficult. It may also mean that the specimen was handled improperly. If an individual is in isolation because of symptoms they should remain in isolation and be retested as soon as possible. If an individual is in quarantine, retesting is not necessary, and they should complete their quarantine period.

Questions for July 26, 2020 Webinar

https://arcg.is/1LiCCP

Q: Will the public be able to check what counties are “open” for visitation?
A: You may see your county’s status for Long Term Care Facility visitation here: https://www.tn.gov/health/cedep/ncov/data/clusters-in-long-term-care-facilities.html

Q: What outreach efforts are being done by the health department to outreach to the disadvantaged populations?
A: TDH’s Office of Health Disparities Elimination has created a task force of more than 200 community leaders who participate in a weekly call to discuss the needs of vulnerable populations. That office also working with communities to schedule testing events. TDH is also working to provide testing capability to Community Health Centers.

Q: Will there be any use for these Alternate Care Sites (ACS) when things go back to a normal level? Homeless, mental health, etc.?
A: That has not yet been determined.

Q: Who owns these ACSs? The state, metro, or something else?
A: The state is leasing these locations and the build-outs were paid for with federal COVID-19 relief funds.

Q: What measures will be taken against Nursing Homes that are not following guidelines when opening? Immediate shut-downs, slaps on wrist?
A: Sanctioning of nursing homes is determined by licensure.

Q: Sorry if I missed this . . what public health education initiatives is TDOH launching to promote face covering use and hand hygiene

A: You can find a PSA toolkit on TDH's COVID-19 Resources website.

Questions for July 24, 2020 Webinar

Q: For MDI use instead of nebulizers, how are some ways to provide treatment to acute pediatric practices? Do you know of any resources to get supplies to provide MDIs in these acute cases and is there a way to bill for it?

A: The practice can either write a prescription for itself ("for office use") and fill it at the pharmacy or request sample MDIs from a pharmaceutical rep. MDI treatments administered in the office are billed the same way nebulizers are billed as long as the treatment is provided by a health care worker. The CPT code is 94640 and includes reimbursement for the cost of the medication.

Q: Does the health department inform the education department in guidelines, or does each district do what they want?

A: TDH has worked very closely with DOE and has provided guidance on health-related issues. Ultimately, the districts make their own decisions unless there is an executive order on the state or local level.

Q: Can you comment on studies suggesting BCG and MMR may offer some coronavirus protection?

A: There have been a couple of studies suggesting BCG (vaccination against tuberculosis that is no used in the US) and MMR (measles, mumps and rubella vaccine) may provide some protection against SARS-CoV-2. India, which uses BCG, is the midst of a terrible outbreak. While it would be wonderful to have an available vaccine that is shown to make a difference, the data are not very compelling.

Q: What is the TDH doing to expand Contact tracing in the state of TN?

A: TDH is working with a staffing company to hire hundreds of contact tracers with the goal of contacting every positive individual within 24h of a positive test result.

Q: As face shields have become more visible part of PPE, many folks (some school administrators and non-medical companies) have been thinking a face shield can replace a mask. What is the TN Dept of Health doing to educate on this point?

A: A face shield is not a substitute for a cloth face covering, but wearing a face shield in addition to a cloth face covering is acceptable. A face shield is primarily eye protection for the wearer. The CDC does not currently recommend the use of face shields as a substitute for masks as there is not enough evidence to support the effectiveness of face shields for controlling respiratory spread. Reasoning: This virus spreads through respiratory droplets produced when an infected person coughs, sneezes, or talks. It may be possible that a person can get COVID-19 by touching surfaces and then touching their mouth, nose, or possibly their eyes.

Q: Is there a positivity level that will force mandated masks? Or will that never happen currently?
A: Not that has been stated by CDC.

Q: How do HCW get in the study of antibodies?
A: You may want to consult the NIH clinical trials website: https://www.nih.gov/health-information/nih-clinical-research-trials-you

Q: I have been receiving supplies from TEMA and the gowns that were supplied did not clarify if they are fluid resistant, how might I find out if they are? Thank you!
A: All of the gowns supplied by TEMA are splash resistant.

Q: Do you listen to TWIV (this week in virology). Episode 640 mentions rapid antigen testing and how $1 daily antigen tests could be the way to safely reopen schools and the economy. It was fabulous. The podcast is hosted by a virology professor at Columbia, who wrote the textbook Principles of Virology. If you don't listen, I highly suggest it. The first 30 minutes of episode 640 are truly inspiring. Do you think rapid antigen testing is something we could make a reality in TN?
A: There are two rapid antigen testing platforms with FDA Emergency Use Authorization—both have been diverted to the federal government for distribution to nursing homes. The tests are fairly sensitive, especially in the first 5 days of symptoms.

Q: If we are looking to buy Quidel or Cepheid testing, is there any info from the state to guide re. specificity, etc.?
A: Cepheid cartridges have been in short supply and they are discontinuing their single plex test for COVID-19 and replacing it with a more expensive multi-plex test for COVID-19, flu A and B,

and RSV. Quidel analyzers have been in short supply and largely bought up by the federal government for distribution to nursing homes. Of the two, Cepheid is more sensitive and Quidel is faster and much less expensive.

Q: Is there a difference in quality of molecular testing v. antigen testing?
A: Molecular testing has better sensitivity and lower false positive rates.

Questions for July 10, 2020 Webinar

Q: Predictions for August? Any guesses for when TN will peak?
A: We anticipate increasing numbers.

Q: If we continue to have ICU and hospital admissions persist at this level due to COVId-19, what capacity will exist to care for flu related admissions later in 2020? If hospitals remain stressed at this level in the fall/winter, will we surge?
A: Hospital capacity will certainly be an issue if we are still with high COVID-19 burden and add influenza on top of it.

Q: Are we differentiating between dying from COVID and dying with COVID?
A: Yes. All of the death certificates are reviewed by the Office of the State Medical Examiner to ensure they are only counted as COVID-19 related deaths if COVID-19 contributed to the death.

Q: Do you anticipate any increases as schools and universities open in mid-August?
A: Yes.

Q: Will TN do a free flu shot day again this year? How will messaging be done to increase vaccinations without people believing that they will be protected from COVID-19
A: Yes! Fight Flu TN is scheduled for November 19 and flu vaccine will be available across the state through local “flu PODs”. Look for specific locations and times in mid-November.

Q: In pediatric clinic, should we be testing all the patients with symptoms of COVID-19 (without clear diagnosis of ottis, ext.)
A: Yes.

Q: So many of these tests yield results with a recommendation that they be considered "presumptive negative." Can a patient who tests "negative" be thought of as "not infected" or "not exposed" based on any single test?
A: All of the tests have potential for false negative. If a person is symptomatic and the test is negative, it's worth repeating. A negative test today may only be negative because the viral load was below the limit of detection for the test.

Q: We have been seeing similar symptoms for the flu and we tested for COVID-19 in which COVID-19 is negative. Would you recommend testing for both flu and COVID-19? Or if we test for flu and it is positive should COVID-19 testing be considered as well?
A: In the pediatric population research suggests co-infection is relatively uncommon but if you have a positive flu you may still want to send off a COVID-19 test.

Q: Could you clarify the case fatality rate? I think I heard you say it was 10.1%, but I think I read it was 10.1 cases per 100,000 which would be 0.01%. For those parents are comparing this to flu, what is the typical death rate/case fatality rate for flu? This is not to minimize the severity of deaths but to be able to understand our impacts in this state.
A: Nationally, the typical case fatality rate from flu is approximately 1%. Nationally, the case fatality rate from COVID-19 is approximately 4%.

Q: In the THAN update yesterday, it recommends eye protection (in addition to standard precautions. Does this mean safety googles, glasses, or will face shields be acceptable for that?
A: All of the above are acceptable.

Q: What are your recommendations for albuterol treatments when the wheezing associated respiratory infections arrive?
A: The CDC states albuterol treatments MAY be aerosolizing. If giving them, a health care worker needs to have eye protection and an N95 mask at minimum. It would be better to give albuterol via MDI with spacer/mask, if possible.

Questions for June 12, 2020 Webinar

Q: How will the state's capacity to test be impacted when all these businesses and nursing homes start testing weekly?

A: Capacity has varied from lab to lab due to backlog and shortage of reagents. As demand increases, lag times will lengthen while the supply chain catches up.

Q: Could you also discuss testing asymptomatic patients before non-essential surgery?

A: Many facilities are testing patients prior to outpatient surgery. False negatives are more common in the asymptomatic population and a negative test result does not ensure that a patient is not infected but, at this time, it's the best tool hospitals have to identify positive patients.

Q: Please give us the reference again for the NEJM article concerning the challenges of a negative PCR test

A: https://www.nejm.org/doi/pdf/10.1056/NEJMp2015897?articleTools=true

Q: Is the Physician's support only for physician's or can NPs, Pas, nurses or techs call? If not, are there resources?

A: The physicians' support line is only for physicians (https://www.physiciansupportline.com) , but the State has a line that can be used by any COVID-19 response worker: 888-MHART-TN

Q: The front page of the Tennessean 2 days ago showed a person getting the test done -- incorrectly. It was not nasopharyngeal. Can anyone teach how to do this correctly? "False negatives...."?

A: Specimens may be obtained by nasal, mid-turbinate, oropharyngeal, nasopharyngeal, or saliva collection, depending upon the testing platform.

Q: Is "pool" (multiple sample) testing being considered for testing of larger populations like universities, athletes, etc.?

A: "Pooled testing" means combining the specimens of several individuals into one specimen and testing the combined specimen for the virus. Pooled testing is sometimes performed as a means of saving resources, such as testing reagents, and sometimes saves on the cost of testing, but it is only a reasonable consideration when the chance of identifying a positive

individual within a population is very low. If the test is positive, each specimen that was included in the pool needs to be tested individually. Some suggest pooled testing NOT be performed when the positivity rate in a community is >10%.

Q: What is sens / spec of TN DOH COVID-19 test?

A: It depends upon the platform. In the lab, it's >99% however there is variability in specimen collection which may impact these statistics.

Q: What is specificity of PCR (false positive)

A: Generally, very low (<1%)

Q: Have any small healthcare practices been identified as clusters of COVID-19 cases?

A: Not to our knowledge.

Q: Any updates on saliva testing?

A: Rutgers University has developed a saliva PCR test.

Q: Understanding how there's little clinical value at this time... What is the best test or lab available for antibody testing?

A: IgG has greater sensitivity than IgM testing. FDA lists sensitivity and specificity of antibody platforms here: https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/eua-authorized-serology-test-performance

Q: Can you comment on K-12 school opening in fall. Low (but rising) prevalence of COVID in children under 10 seems encouraging. What should be done now to prepare?

A: If schools are to be able to remain open it will be critical for students and staff to be able to maintain physical distancing and to be complaint with wearing cloth face coverings.

Q: What kind of guidance should dental offices follow? Are they eligible for PPE assistance?

A: Dental offices should practice infection control practices as outlined by CDC. We are uncertain if TEMA will fulfill PPE requests.

Q: How can we determine if a NH is compliant?
A: Nursing home compliance is handled by licensure.

Q: Is there any assessment of risk for allowing visitors (some of whom will be carriers) into nursing homes? With the relative non-compliance of a portion of the population with preventive measures, it seems very risky to open nursing home doors.
A: All visitors to nursing homes should be screened for COVID-19 exposure and symptoms, should wear cloth face coverings, and should practice physical distancing.

Q: Why is it taking the FDA to validate point of care serology tests. I know of one company that submitted their kits over a month ago and no response yet! it could happen in 1/2 day with the number of cases the US has experienced. Any explanation? Its not like there are thousands of different kits to validate!
A: FDA has a lot to do and is likely understaffed like most government agencies.

Q: Who is paying for LTC/NH testing?
A: The State is paying for it with COVID-19 relief funding.

Q: Has the state decided how long they will continue to pay for testing for everyone?
A: No.

Q: Why has the government decided to pay for private companies to do testing on their employees?
A: The Governor extended the offer to a few Tennessee-based businesses.

Q: Is the conclusion that University remained closed until everyone vaccinated?
A: No. There won't be vaccine available for the public until early 2021, most likely. They need to enforce physical distancing and wearing cloth face coverings.

Q: Is the LTC facility mandate extended also to assisted living facilities? or just to nursing homes?
A: Just LTCFs

Questions for June 5, 2020 Webinar

Q: Who determines when schools reopen, governor or schools?
A: School districts make that determination unless the Governor signs an executive order.

Q: Should people on immunosuppressive meds stop taking their meds if concern for infection?
A: Don't stop taking your immunosuppressive meds without speaking to your doctor. If you are immunocompromised, the best way to prevent COVID-19 is to follow all of the guidelines. Wash your hands, avoid touching your face, wear a facemask, practice social distancing, and clean and disinfect frequently touched surfaces. For more information, check out the CDC resources.

Q: Are multi-generational households more likely to see rapid spread?
A: Possibly, if for no other reason than for the increased numbers of members of the household each having their own sources of exposure.

Q: What steps are being taken with migrant farmer groups to stop spread? Aren't they living in close quarters?
A: Migrant worker living conditions are often abysmal. Local health departments are working with those individuals and with the farms to make sure people are following guidelines.

Q: Are we still sure that food will not be contaminated if coming from a farm with an outbreak?
A: There has been no evidence of transmission via food.

Q: What about U-Pick farms? Same issue regarding life of virus on plants?
A: This does not seem to be a concern.

Q: With change to rules regarding giving names of tested people to police, fire, etc are there plans to retest in poor areas and get better outcome of people?
A: TDH continues to reach out to vulnerable populations to facilitate testing events.

Q: Is there concern about an increase in cases due to protests?
A: Outdoor protests are lower risk than indoor gatherings. Many people have worn masks.

Q: Any recommendations about kids and summer camps? Any evidence of increased spread with kids in cohorts from international data?

A: Would not recommend sleep over summer camps. Day camps should only be held if social distancing can be maintained.

Q: If the state is struggling to test numbers so far, how will the state handle colleges/universities going back?
A: It's likely to be a big problem.

Q: We've heard about long-term employees being tested each week. Who will be paying? How will the state process all these extra tests?
A: As of now, the State will pay for the processing through outside labs.

Q: How long will state continue to provide free tests, PPE, etc.? When will providers be expected to pay?
A: We have not been provided an end date.

Q: Any recommendations about kids and summer camps? Any evidence of increased spread with kids in cohorts from international data?
A: Overnight camps pose significant threat of transmission. Day camps should ensure appropriate social distancing, hand washing, and wearing of face coverings when indoors and/or unable to socially distance.

Q: Is there a limit to how many times we can request PPE?
A: Not at this time. Requests should be reasonable and reflect a 2 week burn.

Q: What appears to be impact of COVID19 on vax rates in TN?
A: It's been huge. Approximately 42% decline.

Q: Are the screening questions for employees going to remain as what is recommended currently, i.e. diarrhea, sore throat, etc.? We are reaching a problem of sending employees home every day to await testing results when it maybe minor symptoms not related.
A: Likely, yes.

Q: If there is a push for testing, why have testing hours been shortened in health depts.?
A: The TDH has a comprehensive list of Assessment Sites along with times and contact information on our webpage.

Questions for April 23, 2020 Webinar

Q: Do you think we can make any inferences regarding prevalence and infectivity from countries with higher test rates?

A: We'll certainly get more information from countries that have gone before us as time goes on. Iceland has some interesting data, including infections as a percentage of tests conducted (peaked at 27% on March 21, 2020). Their peak incidence is at around 8% and in the 40-49yo age range. https://www.covid.is/data

Q: Because of undetected mild cases, doesn't the number of actual cases in U.S have to be much higher and the mortality rate much lower than reported?

A: Absolutely. As of today, <1% of the US population has been tested. Mortality data is more reliable, but the incidence numbers will increase dramatically as more testing is done.

Q: Other than CDC and Johns Hopkins web sites, what online sources are you consulting for RELIABLE and up-to-date information about COVID?

A: www.FDA.gov is a reliable source for new testing information. www.tn.gov/health has updated data for Tennessee everyday at 2pm. www.AAP.org is also a great source of information.

Q: What percentage of the unrestricted weekend tests were positive?

A: Of the more than 11,000 specimens collected at the drive-through sites April 18-19, 2-3% tested positive. Of the individuals testing positive for COVID-19, 55% were asymptomatic.

Q: Best practices for seeing pts safely in the office? Home masks on pts, 50% case load so no crowds, 6 ft away for most of visit, etc.?

A: PPE guidance by activity type may be found here: https://www.tn.gov/content/dam/tn/health/documents/cedep/novel-coronavirus/TDH-COVID-triage-and-assessment.pdf In general, it's recommended that well care be separated by sick care by location and/or time of day (i.e., well care in the mornings, sick care in the afternoons). Everyone should be masked (homemade is fine for patients and staff who are not participating in direct patient care). Health care workers providing direct care should wear surgical masks, gloves, gowns and a face mask or goggles when providing that care. We would recommend patients wait in their cars or be brought straight to an examination room rather than waiting in a waiting room.

Q: The state mentioned that they have some antibody tests-from what company?
A: The state's platform for antibody testing is a high-throughput platform from Abbott Labs called the Architect.

Q: If you say requirements have dropped, how is it that physicians cannot get people tested at a nursing home that have fever, cough, and shortness of breath? What are you doing to educate nursing home facilities, etc.?
A: Testing criteria have been eliminated for testing through TDH. Private institutions may have established criteria in place. We continue to work with nursing homes to ensure they are taking appropriate precautions to prevent the spread of COVID-19 and to assist them in obtaining testing for their residents and staff.

Q: Differences/best practices OP v NP swabs. Patients have gotten different results from different test types
A: Our preference is a nasopharyngeal swab.

Q: Is the Abbott ID now molecular test acceptable for preoperatively clearance for endotracheal procedures?
A: Those performing airway procedures are among the highest-risk of contracting SARS-CoV-2 infection from their patients. The Abbott ID now molecular test is a rapid CLIA-waived testing platform. It's FDA EUA was recently revised as viral transport medium was interfering with test results. Specimens must now be run from dry swabs, which makes testing at remote labs now unfeasible through this platform. While a negative test does not ensure the patient is not infectious, a positive test would assist in allowing a provider to postpone a test until the patient if free of the virus.

Q: If we now have N95 but never fit tested (ambulatory setting) can we still use them?
A: You may use N95 masks without official fit testing; however, only providers who are performing aerosolizing procedures should wear N95 masks. Surgical masks are appropriate for ambulatory care if aerosolizing procedures are not being performed.

Questions for April 10, 2020 Webinar

Q: Tell us more about antibody testing. When can we expect broader testing and how accurate is it?

A: There are several antibody tests available on the market, only one of which (Cellex) has received FDA Emergency Use Authorization (EUA). Specificity and sensitivity will vary widely depending upon the test being used. It is important to note that many tests require blood draw, not just a finger stick, and some cross-react with antibodies to commonly-circulating coronaviruses. None should be used as the sole means of determining if someone has been exposed to the SARS-CoV2 virus.

Q: Do you see kids going back to school before May?

A: While the decision to return to school is ultimately left to the individual districts, there is currently no indication to suggest students would return to school prior to May 1.

Q: When do you see a surge in numbers coming? How is our bed availability and vent availability?

A: There are several different models that have been released, all with a range of predictions. The Vanderbilt model suggests a peak between mid-May and mid-June, depending upon the degree of social distancing. Currently, Tennessee hospitals report approximately 35% of floor beds and 35% of ICU beds remain available. The Civil Corps of Engineers is working with TEMA to stand up alternative care centers in Nashville and Memphis for overflow patient care.

Q: In nursing home care, what is the PPE requirement for caregivers (RN, LPN, CNA) --should they be wearing masks and gloves?

A: While CDC does not provide specific guidance around PPE for staff working in long-term care facilities, it would be reasonable for staff to wear surgical masks while working with residents. Excellent hand hygiene should also be maintained.

Q: I work in long-term care. In facilities where there have been known positive cases, does the nursing home have an obligation to reveal that information to the employees and vendors in that facility? Should I report them if they haven't?

A: According to CDC, in coordination with local health officials, communicate the possible COVID-19 exposure to all residents and workers, volunteers, and visitors. This can be done by placing signage in common areas and entrances/exists and by letter to all residents. Residents could be advised to inform their recent personal visitors of potential exposure.

- Maintain confidentiality as required by the Americans with Disabilities Act (ADA) and Health Insurance Portability and Accountability Act (HIPAA.

- Messages should attempt to counter potential stigma and discrimination

Q: Currently, symptomatic children without underlying chronic disease do not meet criteria for testing. Wouldn't testing these children be helpful particularly if primary caregiver is a grandparent/older adult with HTN, COPD, etc.
A: Criteria were established by individual institutions, not by CDC. We agree that testing of symptomatic children who have high-risk household contacts would be reasonable.

Q: How do we bill for audio-only visits for TennCare claims?
A: TennCare guidance for billing for telemedicine visits can be found here: https://www.tn.gov/content/dam/tn/tenncare/documents/TennCareMCOEPSDTTelehealthGuidance.pdf

Q: What are guidelines for return of pts and staff after infection/quarantine?
A: Individuals may be released from isolation 7 days after their onset of symptoms plus 72 hours after returning to wellness. Individuals placed in quarantine may be released 14 days after their last contact with the infectious individual, as long as they have not developed symptoms. If the infectious individual is a household contact, their quarantine count begins after the case's last day of symptoms.

Q: Any updates on vaccine trials:
A: Vaccine trials are ongoing. It is still expected that it will take 12-18 months before a vaccine will be available for use.

Q: Is there planning for PPE stores for the next wave?
A: TDH did receive some PPE from the Strategic National Stockpile. Those supplies were sent to the acute care hospitals. At this time, we are not aware of additional PPE that is coming to Tennessee through the SNS.

Q: How should we counsel re: holiday parties this weekend - families are wondering about gathering for meals Sunday -how should we answer?
A: Mass gatherings should be avoided.

Q: Shouldn't we be ramping up testing to be proactive? What is the holdup?
A: Testing is becoming more widely available each day. Over the next week, TDH will hold testing events at each of its county health departments. There are many rate-limiting steps

when it comes to testing—availability of swabs, viral transport media, staff to collect the specimens, appropriate PPE to protect staff, lab capacity to run large numbers of tests, lab staff, reagent supplies, testing equipment.

Q: Is there any possibility/research that veterinary CV vaccine, while not conferring immunity, might mitigate the severity of human COVID.
A: Per the State Veterinarian, the bovine coronavirus vaccine would not be useful.

Q: If a quick test comes back as COVID neg, is there still a chance that the pt could test positive later?
A: Yes. The reliability of the test depends upon the timing of the test with respect to the individual's viral load, the quality of the sampling technique, and the sensitivity of the test itself. Some estimate the false negative rate as approx. 30%. Additionally, a negative test at the moment of the specimen collection does not eliminate the chance of infection prior to or after that time.

Q: What do we know about immunity? Is there true immunity? Do we have to worry about fall off?
A: Short answer is "not much". We don't know if antibody is protective against SARS-CoV-2 nor how long that protection would last. Experience with other coronaviruses suggests immunity will be short-lived. Detection of antibody should not be used as sole means of diagnosing current or past infection, nor should it be used as a reliable indicator of protection against future infection.

Q: How is the Health Dept doing on contact tracing and follow-up?
A: TDH is rapidly expanding its workforce to provide for the extensive need for contact tracing and follow-up. The volume of contact tracing varies with location across the state, with the largest numbers of cases identified in the Memphis/Shelby, Nashville/Davidson, and Mid-Cumberland regions of the state.

Q: When will we see mass antibody testing? Will we be issuing "immunity certificates" or similar?
A: We don't know if antibody is protective against SARS-CoV-2 nor how long that protection would last. Experience with other coronaviruses suggests immunity will be short-lived. Detection of antibody should not be used as sole means of diagnosing current or past infection, nor should it be used as a reliable indicator of protection against future infection. Antibody

testing may be helpful on a population level to understand the spread of the virus, but it should not be used to reassure an individual of their immunity against future infection, nor should it be used to issue an "immunity certificate" that would be used to reassure others of that individual's resistance to future infection.

Q: Can healthcare workers wear procedure mask for testing patients or must they wear N95? If contact with positive COVID-19 pts wearing only procedure mask are there special precautions like quarantine or self-monitoring?

A: HCW performing aerosolizing procedures should wear N95 mask, eye protection, gown, and gloves. If a HCW has close contact with a positive patient and is not adequately protected, they should mask and self-monitor for symptoms. If they are non-essential, they should be quarantined for 14 days.

Q: We are hearing confirmation that pediatric positivity is very low. Do you see any change in recommended PPE over the next month or so as ILI decreases? In other words are we burning thru PPE in low risk clinical settings of sore throat, otalgia and even.

A: Agree, pediatric patients are relatively low-risk as a population. Unless performing aerosolizing procedures or working with a suspect COVID-19 patient a surgical mask will likely be appropriate. It would be prudent to screen the patient and family members for symptoms before seeing the patient to understand your risk and plan accordingly.

Questions for March 27, 2020 Webinar

Correction to statement on the webinar: place of service code 02 = telehealth, not "home".

Q: Other state pharmacy boards have restricted chloroquine products. Any plans to do that here?

A: The Commissioner of Health, Dr. Lisa Piercey, issued a directive on March 26, 2020 that stated "we discourage inappropriate prescribing or hoarding of this medication for prophylaxis or treatment of COVID-19, which may limit access for patients that require these medications for therapy for approved indications."

Q: Are insurance companies accepting well checks for telephonic visits and are EPSDT criteria being relaxed?

A: We have not yet received final guidance from TennCare regarding EPSDT criteria when visits are done via telehealth. We will update as soon as that information is available.

Q: What are the recommendations regarding infant vaccinations schedules? Should these be considered essential visits?

A: Childhood immunizations should be prioritized. If a practice is unable to accommodate all well-child visits, they should prioritize immunizations for those ages 24 months and younger.

Q: Any guidance for in-patient billing codes for patients in isolation for whom direct physical exam cannot be performed in the setting of PPE shortage?

A: Someone in the facility will need to examine the patient at some point during the day. Guidance around conservation of PPE may be found here: https://www.tn.gov/content/dam/tn/health/documents/cedep/novel-coronavirus/PPEConservationGuidance.pdf

Q: Are you saying that a patient who is hospitalized and seriously ill should not be treated with hydroxychloroquine and azithromycin? Or that these patients should consult with their attending and ID to decide on a case by case basis?

A; Check with your hospital's policy for treating seriously ill patients with hydroxychloroquine and azithromycin. Use of these medications for prophylaxis is discouraged at this time.

Q: Is 4-5 d post-exposure when test is most likely to be positive (i.e., least likely to be false negative)?

A; It is most likely that a test will be positive when the patient is most symptomatic.

Q: Any change/recommendations in wearing masks when rounding at multiple hospital nurseries?

A: There is currently no guidance around wearing masks when attending to newborn rounds. Given the close proximity of the provider to the newborn during exams, wearing a mask would be reasonable. Check your hospital's policy.

Q: What are the guidelines re: burial and funerals currently for non-covid-19 positive patients?

A: Mass gatherings are discouraged. Consider gathering close family only (with appropriate physical distancing) and perhaps delaying a larger memorial gathering or live stream the service to allow others to attend virtually.

Q: One of my concerns is what guidelines are we using for juvenile detention centers? A friend of mine states they currently have no guidelines other than no visitation.

A: TDH is working very closely with DCS around their policies and procedures for juvenile detention centers.

Q: Should children with fever and diarrhea be screened as positive and precautions be in place given the possibility of GI symptoms?

A: Data from children's hospitals continues to suggest the infection rate in children is quite low. In the absence of symptoms of COVID-19 in household contacts, the risk of a child who has purely GI symptoms having COVID-19 appear to be low. At this time, we would recommend contact precautions.

Q: What are the specificity and sensitivity of the tests being used?

A: Depends on the test, the clinical course of the patient, the technique of the person obtaining the sample, and the lab performing the testing. PCR tests are usually quite sensitive (90s) but that can be negatively impacted by poor specimen collection. PCR tests tend to be highly specific (90s), but blood antibody tests are now available that cross react with commonly-circulating coronaviruses. We recommend checking the FDA's approved test list when considering testing: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2

Q: Any information on the use of steroids in seriously ill COVID-19 patients?

A; Evidence suggests systemic steroids may significantly worsen outcomes from COVID-19. Current guidance is to avoid their use in patients with COVID-19.

Q: How often should we be re-evaluating COVID-19 positive patients?

A: Depends on the condition of the patient and the stability of the home environment. Use the same clinical judgement you would use with any other patient.

Q: What evidence supports the 7 days + 72 hours from feeling well for positive patients to be cleared from isolation? There are reports of viable virus longer than that.

A: The basis for this guideline is unclear at this time. While there are reports of detectable virus being present beyond 7 days, there are not reliable studies to suggest those individuals are still infectious. CDC's guidance for discontinuation of home isolation is here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html

Q: Do you have a recommendation for how outpatient clinics should provide bronchodilators for possible COVID-19 patients? I've heard that hospitals are discouraging nebulizer use in these patients.

A; There is concern for aerosolization of coronavirus through the use of nebulizers. Therefore, it is recommended that health care workers providing nebulizer treatments don full PPE, including an N95 mask. If possible, provide albuterol via MDI and spacer.

Q: Should we check LFTs on all suspected positive patients?

A: At this time there is no recommendation to check serology on all suspect patients.

Q: Any truth to reports to avoid ibuprofen use in COVID-19 or suspected COVID patients for orthopedic complaints? Is it ok to recommend NSAIDS or oral steroids for musculoskeletal complaints in non-COVID-19 patients?

A: There have been case reports of worsening COVID-19 in patients who have been given NSAIDS, but at this time the FDA has not felt this data to be compelling. Currently there is no recommendation to avoid NSAIDS in the COVID-19 population.

Q: Any recommendations for croup patients needing racemic epi via nebulizer? Should we keep the room empty for 3 hours afterward?

A: Current data suggests the likelihood of a child with respiratory symptoms having infection with SARS-CoV2 is very low. If racemic epi is needed, the health care worker should wear PPE out of an abundance of caution, but the procedure is likely low-risk. The need to keep the room empty depends on the air exchange of your facility. If able to keep the room empty for 2-3 hours after a PUI has been in the room, it is reasonable to do so. Most practices would not have enough rooms to be able to abide by that kind of recommendation. We recommend reserving rooms for sick patients that are separate from those used for well patients.

Q: Health care workers who are COVID-19 positive: after isolation and resolution of symptoms, do they need a negative test prior to returning to work?
A: COVID-19 positive health care workers should be in isolation for 7 days plus 72 hours of feeling well before returning to work. They are not required to have a negative test. They may want to continue to mask for an additional 7 days out of an abundance of caution.

Q: Can we release a patient who has been in isolation for 7 days + 72h of wellness but whose test results have not yet returned?
A: Yes.

Q: If a patient is tested and ultimately has negative test results, what is the guidance regarding lifting isolation/masking, etc.?
A: Providers should consider the patient's circumstances when considering early release from isolation based upon negative test results. If a patient had significant exposure (e.g., household contact who was infectious) and had symptoms consistent with COVID-19, the provider may wish to have the patient complete isolation despite the negative test results.

Q: I work in the ED. What precautions should I take when I return home with respect to undressing myself?
A: There is not clear guidance from CDC, but it would be reasonable to change clothes and shower prior to having contact with household members.

Q: Are strep tests considered aerosolizing procedures?
A: Yes.

Questions for March 20, 2020 Webinar

Q: Will everyone who goes to drive thru be tested or is there a trigger to shut down?
A: Those presenting to drive-thru testing locations are screened for symptoms. Those who do not meet criteria (fever, cough +/- shortness of breath) will not be tested. Testing capacity is limited by the availability of supplies and is location-specific.

Q: Day care setting guidance?

A: Day cares that are continuing to function should screen for illness prior to admitting children to their facilities. If a child has experienced symptoms of illness in the past 72 hours, or if the child has a household contact whom has experienced symptoms in the past 72 hours, they should ask the parents to take the child home. Similarly, staff should be screened for symptoms and asked to return home if they have felt unwell. Facilities should frequently clean surfaces and ask that children and staff wash their hands frequently. Further guidance may be found here: https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-schools.html

Q: Could you post the Seattle Children's study?

A: The study is unpublished, but this was shared on a Seattle Children's webinar on 3/16/20: Seattle Children's has tested 600 children, all of whom were symptomatic. Of those, 4 (0.7%) were positive for coronavirus. Only one of the 4 required hospitalization.
From Italy: of 35,000+ cases, only about 400 were children. Less than 10 children were admitted to ICU, country-wide. Out of 3,000 deaths, only 13 were in patients under age 50 years old.

Q: If we can't get nasal swabs how can we test?

A: You could test by doing a nasal wash and sending that in a sterile container (urine cup?) BUT, as that procedure would potentially aerosolize respiratory secretions, nasal washes should only be done by providers in full PPE, including an N95 mask (surgical mask would not be thought to provide adequate protection).

Q: Mildly ill physician, should I stop seeing patients?

A; Yes.

Q: Dry NP sample or mucous?

A: The sample doesn't have to come out of the nose "mucous-y" but you need to ensure you get a good NP (not just nostril) swab. Be sure to put it in viral transport medium or Amies or sterile saline (check with your lab).

Q: When can an employee return to HC if they were exposed to 1. Positive 2. PUI? Is contact with a pending case essentially the same as a positive?

A1: If an employee is a household contact of a confirmed case, they may return to work after they have completed a 14 day quarantine from the time their household contact became WELL.

A2: While CDC does not require quarantine of household contacts of a PUI, we would not recommend that health care workers return to work until after testing confirms their household contact is not positive for coronavirus. So, yes, treat a pending case as a positive when it comes to household contacts of health care workers.

Q: What is my risk if others in my office are exposed, tested but pending?
A: Low. Those contacts should be quarantined, and contacts of contacts are not considered at risk unless their direct contacts become positive.

Q: To conserve PPE should we rotate the specimen collector or should the MD/NP be the one to collect as well?
A: Any appropriately trained health care worker could collect a specimen. It's recommended that practices limit the number of people who perform that task.

Q: If I test negative do, I need to worry about getting infected later?
A: Yes, you could become infected at any time. Even if you have tested positive, there is no assurance of immunity. There are reports from China of patients who have been re-infected.

Q: Better to reuse N95 or use other things like bandana, etc.?
A: There's no official guidance, but if the N95 has not been splattered with secretions it would be better to reuse the N95.

Q: Will asymptomatic people shed virus for the full 7-14 days?
A: "Shedding" does not necessarily mean "infectious". It's possible to detect viral RNA in the nasopharynx but not have infectious virus present. Currently, there is not data that clearly indicates what percent of infectious patients are asymptomatic or how long they would be infectious.

Q: What is the carrier status of a positive COVID patient after they are feeling well?
A: Per CDC, patients testing positive for coronavirus are thought to be non-infectious after a 7 day isolation period PLUS 72 hours after returning to wellness. Lingering coughs in patients who are otherwise feeling well are not considered high risk.

Q: Is "masked" meaning wearing an N95?

A: When we refer to someone being “masked” we’re referring to surgical masks. N95 is only required for providers who are performing procedures that are at risk of aerosolizing secretions (intubation, suction, etc.)

Questions for March 13, 2020 Webinar

General

Q: What is it about COVID 19 that is triggering such a significantly greater response than that which was done for the 2009 H1N1 Pandemic?
A: COVID-19 is more infectious (by 2-3 fold) than influenza and has a mortality rate that is approximately 10-30 times that of influenza. CDC estimated there were 60.8 million cases (range: 43.3-89.3 million), 274,304 hospitalizations (range: 195,086-402,719), and 12,469 deaths (range: 8868-18,306) in the United States due to the (H1N1) pdm09 virus in 2009-2010. This pandemic has the potential to impact hundreds of millions and cause hundreds of thousands of deaths.

Q: Do we have any specific information on the virus is it similar to virus seen in China or has it been here and mutated to a more potent virus?
A: CDC has not provided any information to that effect.

Q: Do we know how long a person might be contagious PRIOR to developing symptoms? If somebody tests positive, how long prior to that patient's symptoms is it possible for close contacts to have been infected?
A: It’s not clear when the infectious period begins. We do know that individuals appear to be most infectious when they are most symptomatic. Some individuals have become symptomatic within a little as 3 days of exposure.

Q: Can someone who has COVID 19 and then recovers be re-infected with it again later?
A: It’s not thought that there will be long-term immunity to the novel SARS-CoV2 virus. China has had some confirmed reports of reinfection in their population.

Q: What about reports that pts are contagious for 30 days after symptoms not just 14?

A: There are conflicting studies around the length of the infectious period; however, CDC updated guidance for isolation on 3/17/2020, reducing the duration from 14 days to 7 days and 72h beyond when the patient feels well.

Q: Does Tamiflu help?

A: Per CDC, "There are currently no antiviral drugs licensed by the U.S. Food and Drug Administration (FDA) to treat patients with COVID-19. In the United States, the National Institutes of Health (NIH) and collaborators are working on development of candidate vaccines and therapeutics for COVID-19. Some in-vitro or in-vivo studies suggest potential therapeutic activity of compounds against related coronaviruses, but there are no available data from randomized controlled trials in humans to support recommending any investigational therapeutics for patients with confirmed or suspected COVID-19 at this time."

Q: There are countries that have set up mobile or drive through testing sites. Something like that would help keep infected people out of our waiting rooms. We could still report results to patients and counsel them.

A: Each day there are more testing sites becoming available. Governor Lee has announced that 15 remote assessment locations will become available soon. Locations of assessment sites are indicated here: https://www.tn.gov/governor/covid-19/remote-assessment-sites.html

Q: Would ozone generator kill virus in small rooms?

A: There is nothing in CDC guidance to suggest ozone generators should be used to clean rooms after Coronavirus exposure.

Q: Are children or adults with asthma more at risk of serious illness or mortality?

A: Those with chronic health conditions are thought to be at higher risk for complications from COVID-19 than those who are not affected by those conditions. Most serious complications involve respiratory compromise, which would suggest those with chronic lung disease would be at greater risk.

Q: Should schools be closed?

A: The decision to close schools statewide is a difficult one. Many students rely on school feeding programs and many families have working parents who may not have childcare readily available to them. Those issues need to be weighed against the benefits of social distancing.

Q: Do you have or can you post a door and/or website summary sign that practices can use?
A: Sample language might include “STOP! If you have cough, fever, or shortness of breath, please return to your vehicle and call the office for instructions”

Personal Protective Equipment (PPE)

Q: What PPE do you recommend?
A: Please refer to the following for guidance around triage, assessment and PPE: https://www.tn.gov/content/dam/tn/health/documents/cedep/novel-coronavirus/TDH-COVID-triage-and-assessment.pdf

Q: Is there any benefit to a cloth made surgical mask vs paper and disposable?
A: Providers should use surgical masks that have been cleared by the U.S. Food and Drug Administration (FDA)

Q: Will you be talking about the quarantine advice for outpatient clinics? Specifically with multiple providers if a situation occurs where only certain staff are possibly exposed. What are offices supposed to do?
A: The best thing providers can do to protect themselves and their staff from quarantine or infection is to wear appropriate PPE when assessing potentially infectious patients. In the event of an office exposure, anyone who was not wearing a surgical or N95 mask and was within 6 feet of an individual with laboratory-confirmed SARS-CoV2 infection for more than 10 minutes will require quarantine. Anyone who was not wearing full PPE and had direct contact with a patient with laboratory-confirmed SARS-CoV2 will require quarantine. In the event that a health care worker is confirmed to be infected with SARS-CoV2, anyone who was within 6 feet of that health care worker for more than 10 minutes and not wearing a surgical or N95 mask will require quarantine.

Q: We are sure we won’t be infected with just a regular mask? Or we just don’t have any options?
A: Current guidance from CDC and WHO is to use surgical face masks for routine exposure and N95 masks when performing procedures that may aerosolize patient secretions.

Q: In a pediatrician's office, the healthcare worker should wear full PPE for any patient with fever, cough, etc. or only if the patient is high-risk (travel, contact with + COVID-19)?

A: As there have been cases of COVID-19 identified in Tennessee who do NOT have travel history, health care workers should wear full PPE (face mask, eye protection, gown, gloves) when in direct contact with a suspect patient. It is recommended that only one person in the office be in direct contact with a suspect patient. Those within 6 feet of a suspect patient should wear a face mask. Those who are more than 6 feet from a suspect patient do not need to wear face masks.

Q: Once a patient has been seen in an office (even if hurried into a closed exam room) and a test is ordered but we don't know what the result is, what do we do with the room?

A: Current guidance state "sufficient time" should be allowed for air exchange in the room. https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html Consider keeping ill patients in a limited number of designated rooms. Consider changing schedules to accommodate well patients in the morning and ill patients in the afternoon to prevent spread. Use dedicated equipment for suspect patients and wipe down all room surfaces after each patient.

Q: Would you recommend PPE if available for Strep or flu testing or hold for pts with more concerning hx or exam for COVID-19?

A: Flu symptoms are indistinguishable from COVID-19 symptoms. Health care workers should use appropriate PPE when assessing any patient with fever, cough, and/or shortness of breath. Most patients with strep do not have respiratory symptoms.

Q: The recommendation from TDH is to masks all patients with fever or cough upon entry to a health care facility. However, we do not have enough masks to provide this in our pediatric practice. Do we provide masks only for those who have possible exposure?

A: If your office does not have adequate PPE we would recommend posting a sign on the office door that instructs patients to return to their vehicle and call the office for instructions. If there is inadequate PPE to safely assess ill patients, divert them to another facility.

Q: If you have COVID and have recovered, do you still need to wear a mask as a HCP?

A: There is no evidence of immunity to SARS-CoV2 virus at this time. Individuals who have recovered from COVID should still wear PPE when assessing potentially infectious patients.

Q: We have masks, gloves, goggles, but not gowns. Will someone who is in direct contact with a patient, without a gown, need to be quarantined? Should and how long should then that staff be quarantined?

A: If a health care worker has direct contact with an individual with laboratory-confirmed SARS-CoV2 infection and neither the patient nor provider was masked, the health care worker should be quarantined for 14 days. If the patient was masked AND the provider was masked, the provider is considered to be low-risk, even if no gown or gloves were worn, and should self-monitor for symptoms but not be restricted from work.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Testing

Q: How many patients are being tested by the state daily? Can you give us a rapid way for getting state approval? I got one approved yesterday, but the process took about 20 min to get approved.

A: Providers may send testing out through their contracted laboratory services provider without consulting TDH. Providers who do not have access to a commercial lab or who have a patient that requires faster test turnaround time (immunocompromised, pregnant, close contact of a laboratory-confirmed case, long-term or congregant care facility resident, critically ill patient, health care provider) may request testing through the state lab by calling 615-741-7247 between 8am and 8pm Central Time to speak to a COVID Response Team member. You do not need to keep the patient in the office while you are waiting to obtain authorization. Send them home to self-isolate until results return. We recommend testing for influenza and considering a respiratory viral/pathogen panel as those results will return more quickly than COVID testing from any lab. Obtain a nasopharyngeal swab and place it in viral transport medium. Label the specimen and refrigerate until authorization can be obtained to send the specimen to the State Public Health Laboratory. While there are many people answering the phones at TDH, the call volume has been tremendous. We are doing our best to answer these calls as quickly as possible.

Q: What is the turnaround time for the test?

A: Testing through the State Public Health Laboratory takes approximately 48 hours from the time the specimen and completed forms are received at the lab. Commercial labs are returning in approximately 4-5 days. These times may lengthen considerably as more testing is requested.

Q: How much is cost of test?

A: We're told the commercial lab charge for testing is approximately $300. The State Public Health Lab will run tests at no charge for those who are symptomatic and uninsured.

Q: Do we need to test children?

A: The number of SARS-CoV2 positive children has been very low. It is more likely that a child will have influenza or a common viral respiratory pathogen than SARS-CoV2. For that reason, providers may want to test for flu and other pathogens prior to sending testing for COVID. Swabs may be obtained at the same time and held in a refrigerator while other tests are pending. If household members report symptoms of fever, cough, shortness of breath or if there has been travel to a location with community transmission and the child is also ill, have a low threshold to test.

Q: Are there any specific guidelines on testing for COVID 19 other than fever and chills and GI problems and sore throat and travel history?

A: Generally, patients present with fever, cough, sore throat and sometimes shortness of breath. Those symptoms, especially in combination with a history of travel or significant public exposures, should prompt testing.

Q: The testing staff then interacts with students in the onsite school, some of which have compromised immune systems. Do we need to temporarily suspend testing of outside children?

A: It is advisable to limit the number of staff who are exposed to suspected COVID-19 patients. Those staff should be wearing appropriate PPE when performing testing. There should be low-risk to your students if those guidelines are followed.

Q: What about a clinic that does not see patients for sickness but for allied health issues such as hearing tests? Most of the pediatric patients we see have congestion with middle ear involvement.

A: Consider screening for illness at registration. Anyone who is febrile should be rescheduled. You may want to post a sign on your door asking those with fever, cough and/or shortness of

breath to return to their vehicles and call before entering the facility. Congestion alone is not a concern.

Q: Do nasal and oropharyngeal have to be in separate transport medium?
A: As of March 13, 2020, only a nasopharyngeal swab needs to be submitted for testing. If you do obtain both a nasopharyngeal and oropharyngeal swab, place them in the same tube of transport medium.

Q: Does the person that swab a patient need to isolate/quarantine as well until the test results are back?
A: Anyone performing specimen collection needs to be wearing full PPE: face mask, eye protection, gown and gloves. Staff who did not wear appropriate PPE while collecting specimens will be quarantined if the test confirms infection.

Q: What is the sensitivity and specificity of the COVID-19 test?
A: PCR testing is very specific and the sensitivity is estimated at >95%.

Q: If patient can't afford test but have symptoms, how do we test for no cost?
A: We are hearing of more locations that will test at no charge, but the State Public Health Laboratory will run tests for uninsured patients at no cost. Call 615-741-7247 for authorization.

Q: Are these lab swabs & media like we use for influenza and herpes?
A: Yes. Use a synthetic (polyester or dacron) swab with a plastic or aluminum handle and place the swab in viral transport medium (the pink stuff) used for herpes testing. We have also just been told that e-Swabs are also acceptable.

Q: What are you hearing about the capacity of EDs and Hospitals to handle evaluating and treating COVID 19 patients? What should we be prepared for?
A: EDs and hospitals are overwhelmed and they are still needing to help patients with MIs, stokes, and sepsis. Please do everything you can to avoid sending patients to the ED. If they would not have gone to the ED for their symptoms 2 months ago, ask them to stay home. There is no treatment for COVID-19 aside from supportive care. EDs should not be used as testing centers.

Q: If a patient is COVID 19+, the family is also quarantined at home 2wks? Or only the + pt and family still able to go to work?
A: Symptomatic patients are in isolation for 7 days + 72 hours from return to feeling well. Household contacts are quarantined for 14 days from the time the patient returned to feeling well.

Q: There are reports of coinfection of COVID19 and Influenza. Should we be testing all patients who are positive with influenza going forward?
A: While there are reports of coinfection, the rate is thought to be very low (on the order of 6%). We do not recommend testing every flu positive patient for SARS-CoV2.

Q: How do you recommend we manage homeless PUIs with pending testing who may be difficult to contact or follow-up with after discharge from an Emergency Department?
A: Following up with those who are experiencing homelessness is always a challenge, no matter the disease process. Advise them to keep at least 6 feet from themselves and the next person and to wear a mask at all times. You may need to ask local public health to assist with contact notification.

Q: If staff who came in contact with the patient who tested positive should be quarantined from 14 days of contact however we aren't finding out results for 5 days and those possibly exposed staff (provider, check-in/check-out, nursing) have continued to work
A: Follow recommendations to have any staff within 6 feet of a suspect patient masked. Mask all symptomatic patients. Providers in direct contact with suspect patients need to be in appropriate PPE. Limit the number of staff who work directly with suspect patients.

Travel

Q: Please elaborate on what you are considering from a travel standpoint as "high risk areas"? Are Seattle and NY metropolitan areas, LA and San Francisco Bay are areas in your "high risk" category?
A: Current CDC travel guidance may be found here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html Caution should be used when working with patients who have traveled to US locations with high case numbers within the past 14 days, but

there is no current recommendation to quarantine domestic travelers who have not had close contact with a confirmed case.

Recommendations

Q: Any recommendations for PCPs over the age of 70 in terms of temporarily limiting practice?
A: If possible, providers at high-risk for complications from COVID-19 should avoid direct contact with suspect patients. Your practice capacity may or may not be able to accommodate that limitation.

Q: I noted you said Zoom was HIPAA compliant for telehealth visits however I was informed that is not the case. Is this a specific version of Zoom to which you referred? Will the telehealth visits be paid by our state insurers including Medicaid?
A: Qualifications may have changes. Please consult the platform for information. We have not heard that TennCare is currently paying for telehealth services. NC Medicaid did just approve telehealth for use during this pandemic.

Q: Sending results via e-mail-is this HIPAA compliant?
A: TDH notifies ordering providers of COVID test results via email using a PUI (person under investigation) number. No PHI is emailed.

Q: I have heard the co-infection with rhinovirus and COVID in the Chinese population was seen. So if our RVP is positive for rhino should we still test for COVID?
A: You may use your discretion when ordering testing through a commercial laboratory. We will generally not authorize testing at the State Lab for individuals with another identified pathogen.

Q: How sick is sick for the employees? Two of my staff members have bronchitis and general viral symptoms. No fever. Do have cough. Don't feel good. But if I send everyone home in my small rural practice, we will go under.
A: The recommendation is that people who are not feeling well remain at home until they are feeling well for 72 hours. Residual cough in a person who otherwise feels well is not a concern.

Q: For pediatrics- parents are asking if they can still have their children play with other children in the neighborhood?

A: Social distancing is recommended. A play date with one or two friends who have no symptomatic household contacts is probably low-risk. There should not be group gatherings.

Q: Regarding telehealth visits, we have been told that these are not billable unless the patient initiates the visit. How do you suggest managing scheduled visits through telehealth?

A: This is a very fluid situation. We would recommend providing the care if it's the right thing to do and billing for the service. Guidance will likely change throughout this pandemic.

Q: Do you have specific guidelines for patients sent home from the ER to self-isolate?

A: Yes. https://www.tn.gov/content/dam/tn/health/documents/cedep/novel-coronavirus/CloseContactGuidance.pdf

Commented [JS1]: We have one more doc that might be more appropriate for this spot "You've been tested for COVID19, what to do next"… it's not online yet…

Q: Primary prevention policies? Restrict visitation for children to SNFs, family to prisons/inpatient psych, etc.?

A: Social distancing is recommended, including restricting visitation to residential facilities. Most facilities have already created their own policies around this.

Q: Any guidelines for possibly using CT Chest for help with diagnosis?

A: Per the American College of Radiology: **Based on these concerns, the ACR recommends:**

- CT should not be used to screen for or as a first-line test to diagnose COVID-19
- CT should be used sparingly and reserved for hospitalized, symptomatic patients with specific clinical indications for CT. Appropriate infection control procedures should be followed before scanning subsequent patients.

https://www.acr.org/Advocacy-and-Economics/ACR-Position-Statements/Recommendations-for-Chest-Radiography-and-CT-for-Suspected-COVID19-Infection

Q: Patient calls with mild URI symptoms and no COVID19 risk factors. Decide that they don't need to be seen and can monitor symptoms at home. When can I tell them they can return to work? Is it symptoms free for 24 hours or longer?

A: They should feel well for 72 hours. Lingering cough and runny nose are likely low-risk in patients who have otherwise felt well for 72 hours.

Q: 6-12 months is the time frame we should expect to be dealing with this, correct? If so, what is the effect in pediatrics of going for 6-12 months without doing well checks, immunizing, etc.

A: Consider scheduling well child visits for the morning, sick visits in the afternoons. If your practice has more than one location, consider having well visits in one location and sick in the other to avoid exposing well patients. Providers can rotate days at the different sites to accommodate their patients. Routine immunizations should remain a priority.

Q: Any practical suggestions about how to handle return to work triage of: 1. Overlapping S/S due to allergies. 2. The "lingering cough" that stays for days even after other URI S/S have resolved.

A: Staff who are ill but not concerning for COVID-19 may return to work after they have felt well for 72 hours. Lingering coughs are not concerning in patients who are otherwise well.
CDC guidance to return to work can be found here: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html
CDC guidance for exposed health care providers https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Q: Did you say the "avoid mass gatherings" recommendation is for the general public or for the high-risk group?

A: All

Q: In your opinion what is the contribution of pre-symptomatic transmission? This has relevance to how aggressive or not one is with self-quarantine including with travel from US areas with increased COVID case reporting.

A: There is not clear data on the transmission of the virus prior to onset of symptoms. Patients have had symptom onset as early as 2 days from the time of exposure. Anyone traveling from a level 3 country should self-quarantine for 14 days.

Q: What are your recommendations for breast feeding mothers?

A: Nursing mothers who have confirmed infection with SARS-CoV2 should take every precaution to prevent transmission of infection to their infant, including hand washing and

wearing a face mask. Mothers may consider expressing milk for another caregiver to provide to the infant. It is not currently known if mothers with COVID-19 can transmit the virus through their breastmilk. https://www.cdc.gov/coronavirus/2019-ncov/prepare/pregnancy-breastfeeding.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fspecific-groups%2Fpregnancy-faq.html#anchor_158416971

Q: Good idea to check temp before entering building?
A: This may cross employment law. Check with your legal counsel.

Q: Also, are you recommending maintaining the prenatal visit schedule?
A: OB offices should be relatively low-risk compared to other primary care specialties. Institute office procedures to protect your patients from illness and prioritize prenatal care.

Q: Are you recommending closure of religious services this Sunday?
A: Yes. In-person gatherings where participants cannot space 6 feet from one another should be cancelled.

Q: Previous recommendations for pediatric patients were that if they were + for other viruses, they were unlikely to be infected by COVID19. Given recent studies saying peds patients have up to 40% coinfection rate, what are the new recommendations?
A: A study of 99 patients who were diagnosed with SARS-CoV2 infection in Wuhan, China showed a viral co-infection rate of 0%. While new data emerges every day, numbers of patients who test positive for one pathogen and are also co-infected are likely to be low.

Q: What precautions should dentist take? Almost all procedures results in aerosolized particles when performing dental treatment.
A: Dentists are at very high risk for becoming infected with SARS-CoV2 from an infected patient. Dental offices should screen patients for symptoms at check-in or via reminder calls and reschedule any patients who report symptoms of cough, fever, shortness of breath or feeling unwell in the prior 72 hours. Dentists and hygienists should wear appropriate PPE in all cases.

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