WASHINGTON CHAPTER
AMERICAN ACADEMY OF PEDIATRICS

Promising Practices

Ideas for managing COVID-19 from pediatric clinics around the state

Contents

Approach to Reducing the Risks of COVID Transmission in Pediatric Offices

Limit the number of individuals present within the clinic (providers, support staff, patients & guardians)

Limit the potential for transmission within the clinic

Triage level of care

The vast majority of COVID-19 infections in children are mild. These children are best cared for at home. This is an important message for families.

Create emails, texts, and on-hold recorded messages to families outlining what constitutes mild respiratory symptoms and what care can be done at home. Identify your clinic's most effective tactics to reach all patients and use these to send key message to manage illnesses at home and when to get help via phone. Update these as new information about COVID-19 becomes available, and when to seek more advice/care.
Send information electronically, through robo-calls, or mail, and post signs and have information in your clinic outlining what constitutes mild respiratory symptoms and what care can be done at home.
Phone triage as much as possible to prevent kids who don't need to be seen in person from coming into clinic. Triage providers should use best clinical judgement based on age, severity of illness, and updates on COVID-19 epidemiology to decide when a child needs to be seen in person. (See guidance below about special considerations)

Reduce the potential for sick patients or guardians coming in to the clinic (telehealth visits, calling ahead to remind parents to consider staying away from in-person visits with fever or symptoms of URI). This needs to be balanced with the desire to get back to providing necessary care, recreating confidence for families that the clinic is a safe place to receive care.

Call families with upcoming appointments to assess for signs of respiratory illness, and then triage if necessary. Screening includes a symptom checklist and temperature check. See below for guidance on separating "well" and "sick" care for infection control.

Use telehealth as much as possible.

- Apple Health clinical policy and billing for COVID-19 – including billing codes for telehealth
- WCAAP telehealth guidance for well child care
- Telemedicine for behavioral health care

Reduce non-urgent visits. Prioritize in-person well child visits requiring vaccines, especially for children under the age of 2 years/receiving their primary vaccine series. Consider postponing or scheduling well child care via telemedicine for children over 2 who do not need in-person visits soon.

Which types of visits to see in-person may change as local/state guidance changes. See Promising Practices for Well Child Care below.

Stop allowing walk-ins.

When possible, send refills/meds without an in-person appointment. These can be great options for phone or telehealth visits.

Consider structural protections for infection

Schedule well visits in the morning and acute visits in the afternoon. Prioritize in-person care for the ages that are most critical for in-person visits and for the care that can only occur in-person.

Post signs in the parking lot to call from the car. Consider having both well child and sick/acute visits with respiratory/fever symptoms call from car to avoid waiting room time if feasible for your clinic. Dedicate a phone line for this purpose only so families can reach you quickly.

Consider new clinic flow to support rooming from car, dedicating front desk staff and MAs to parts of the process; for example, can front desk do phone check-ins, give paper screeners, and can MAs be notified when time to do parking lot symptom check for parents/sibs/patients, and rooming.

Some clinics are doing mostly car visits, including calling to get most of the history on the phone then, if needing to swab, go out to curbside and swab with patient in the car.

Screener at front of clinic or in parking lot with temperature check for all -- screen for symptoms and give colored stickers as visual indicator (and have those with symptoms mask at point of entry if not already masked). Encourage patients and family members to arrive wearing their own masks when possible to preserve clinic supply (mention this when scheduling appointments or reminder calls)
Attention to patient flow, limit entry points to better supervise clinic arrivals, measures to limit / prevent time spent in waiting areas, minimizing movement between rooms. Physically separate well / sick –separate entrances / waiting areas and/or hallways, if possible use separate clinic rooms dedicated for well care and rooms dedicated to sick care e.g. near entry/exit, with ready-access to patient bathrooms; with clear signage to direct patients & staff If your clinic has more than one site, consider making a well-child site and an acute visit site – wholly separate care. Or consider "sick" care to occur in "parking lot" clinic.
Evaluate supplies within rooms and team's walking process to minimize entries in and out of room. Establish way to have staff already outside the room help with needed supplies, such as an assigned staff nearby outside of room who can bring needed supplies or walkie talkie to call for needed supplies.
Limit extra people at appointments – only allow patient and one healthy parent/caregiver to come to appointments if feasible. If older siblings are appropriate age and maturity, they could stay in the vehicle during a younger sibling's visit.
Print discharge paperwork from the exam room or slip discharge papers in under the door to reduce multiple entries into the room. Map your typical clinic flow and identify opportunities for reduced entry into rooms.
Promising practices for well child care WCAAP Back to Clinic campaign
Proactively message the importance of continued well child care / vaccinations for 0-2 years old and steps your clinic is taking to ensure patient and family safety. Recommend performing active recall to these patients who are due (or overdue) for their primary vaccine series. WCAAP materials to help recall patients can be found online.
Continue in-person newborn visits at 3-5 days for weight check, jaundice check, and feeding issues. Continue in-person newborn visit at 7-14 days for weight, feeding, and second newborn screen.

Continue in-person well child visits for the primary vaccine series, generally obtained at 2, 4, 6, 12, and 15/18 months. If children have been following an “alternative” schedule, try to catch them up as efficiently as possible. Some clinics are splitting well-child care into in-person vaccine and anthropometrics only and conducting the rest of the visit by telemedicine.
Outside of completion of the primary vaccine series, other visits requiring vaccines (such as 4 year and 11 year visits) should be next prioritized pending local/state guidance on infection risk.
Continue to provide non-vaccine well child checks via telemedicine unless there are other reasons for in-person assessment or management.
Consider delayed visits for sports physicals, especially as sports physical forms may now be valid for 2 years.
Follow recommended infection control protocols CDC Infection Control in Healthcare Settings Poster: Sequence for Donning PPE Keeping Safe at Home in the COVID-19 Era
Patients at risk for COVID-19 according to CDC criteria should be placed in an isolated room designated for this purpose as quickly as possible.
Minimize ‘aerosol-generating procedures’ (AGP) including nebulizers within the clinic. Consider asking patients to bring their own inhalers to clinic for use if they have them.
Minimize the potential for sick staff members coming in to work (education, symptom & temperature checks at the beginning of the day).
Staff & patient education around hand & respiratory hygiene, physical distancing, with physician leaders modeling behaviors and encouraging staff daily.
Where supplies allow, providing masks, reminding staff (and self!) to keep hands away from face & mask. Consider universal masking of staff.
Limit / modify use of staff common areas, encouraging physical distancing between staff on breaks and in staff work areas (i.e. physically spacing out desks/computers).

Implement a cleaning plan for the clinic, with increased frequency of cleanings including regular surface cleaning, concentrating on 'high-touch' areas including telephones, keyboards & door handles. Including cleaning of rooms outside of clinic rooms that are used by patients including common areas and bathrooms.

Have signage for isolation rooms that indicate clean/dirty, time of last cleaning, who cleaned it.

In waiting rooms, physically space out chairs/seating (remove seating if needed), and place signage / floor marking for lines to facilitate social distancing. Remove toys/books/shared objects in waiting rooms.

Coping with PPE shortages

PPE Conservation in difficult times

Suggested facemask or respirator use, based upon distance from a patient with suspected or known COVID-19 and use of source control: "Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies"

DOH Conservation Strategies for PPE:
https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/ConservationStrat-PPE.pdf

- Reserve N95 respirators for those requiring aerosol generating procedures per DOH Infection Control Guidance.
- Use a face shield over a respirator or facemask to prevent contamination.
- Shift eye protection from disposable to re-usable devices (i.e., goggles, reusable faceshields).
- Shift gown use towards cloth isolation gowns; consider use of coveralls.

WASHINGTON CHAPTER
AMERICAN ACADEMY OF PEDIATRICS

DOH Guidance on Extended Use / Re-Use of PPE:
https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/PPE-Reuse.pdf

- Extended use is the practice of wearing a piece of PPE for repeated close encounters with several different COVID-19 patients without removing between encounters.
- Re-use is the practice of wearing a piece of PPE by one healthcare worker (HCW) for multiple encounters, removing it after each encounter, without cleaning or laundering between encounters. Extended use is generally favored over re-use because it is expected to involve less risk of contact transmission during donning and doffing.
- HCP should avoid touching PPE while in use. If PPE is touched, perform hand hygiene before and after. PPE may only be reused by the same HCW. PPE should not be shared between HCW.
- Any PPE that is torn, damaged, or wet must be discarded immediately and not re-used. Also discard immediately and do not re-use an N95 or facemask that becomes difficult to breathe through.
- Discard PPE used during an aerosol generating procedure

Monitor supplies of PPE, disinfectant, hand sanitizer. Active monitoring of inventory and pro-active ordering of items can help reduce/prevent shortages. Consider PPE usage and accessibility when determining if/when to expand which types of patients/visits may be seen in-person in clinic

Guidance on N-95 reuse
https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html

- Use a cleanable face shield (preferred) or a surgical mask over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls), when feasible to reduce surface contamination of the respirator.

Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response (https://www.cdc.gov/coronavirus/2019-ncov/hcp/checklist-n95-strategy.html)

If your clinic has suggestions to share regarding patient flow, PPE, or testing, please let us know so we can add them to this list.