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Safe return to school: a call to action

On the topic of ‘return to school’ this year, anxiety abounds for parents and children, as well as teachers, school staff and nurses, nurse practitioners, departments of health and legislators. Since school is considered “the work of children,” we must carefully consider all aspects of ‘return to school’ in light of the current, unprecedented COVID-19 pandemic. Many compelling questions emerge, but first and foremost the question to address is: Can children return to school and be in classroom environments that assure health and well-being for all?

The National Parent Union conducted an online COVID-19 survey of 500 parents with children from kindergarten through 12th grade on May 4 and 5, 2020. Lowe’s data revealed a significant level of anxiety among parents concerning return to school for their children. A New York Times article reported that 6 of 10 parents are considering continuing with home learning rather than sending their children to school in Fall 2020. Some of the parental anxiety and decision making by parents may be attributed to uncertainty as the pandemic remains a viable threat throughout our country.

Planning, testing and masks are a critical component for safe return to school

Guidance from the CDC for opening schools was posted on the CDC website on March, 19, May 19, June, 3, and July 23, 2020. The guidance emphasizes the importance of school officials and administrators collaborating with local health officials for decision making regarding return to school and decisions about closing schools, while the most recent statement did stress the importance of reopening schools. The initial interim CDC guidelines did not address two major issues, masks and testing, that must be resolved either locally, or nationally by implementation of best available scientifically based health safety measures prior to any child’s/adolescents return to school. However, the CDC guidance on July 23, 2020 does recommend masks for children and staff in school settings, except those under 2 years old, and those with some medical conditions. Since wearing masks has been met with controversy, the work of health care professionals (HCPs) is to gain the support of parents, children and school personnel to wear masks during school. And, while recommendations presented in this paper are consistent with CDC guidelines and supports wearing masks, it also provides more stringent considerations for testing school personnel and children. All HCPs realize the ever evolving and changing health care recommendations as the pandemic moves across the country and the world. Thus, what is considered best practice today based on the available evidence, may be shown to be incorrect tomorrow. Making reasonable changes to tackle the twists and turns that emerge every day in this pandemic is a major challenge. HCPs at the local, state, regional,
and national levels have a major role in helping non-HCPs make sensible decisions based on scientific data to protect all individuals. Return to school decisions must be based on the science with the overall goal of the health and well-being of the children/adolescents, the school personnel and the community as a whole. One size and one decision will not fit all.

The CDC guidance on COVID-19 from July 23, 2020 supports using “cloth face coverings” to prevent the spread of the COVID-19 virus, and includes in their practical recommendations that schools put “cloth face coverings on school supply lists and provide cloth face coverings as needed to students, teachers, staff, or visitors who do not have them.”

Indeed, the scientific evidence from COVID-19 public health measures supports wearing masks as the new norm for all adults and for all children older than 2 years. Thus, we believe that wearing masks is an essential component of safe return to school. However, children with chronic illnesses, including pulmonary conditions, and those with disabilities may be advised by their physicians and NPs, not to wear face masks. Thus, some protection for children, who are too young to tolerate wearing a mask or are unable to wear masks, may be provided by other children and school personnel who can safely wear face masks in school settings.

The CDC guidance of July 23, 2020 also states that “[The CDC] does not currently recommend universal symptom screenings to be conducted by schools.” School nurse practitioners (NPs) and school nurses are educated on public health screening measures and are ideally suited to appropriately screen students and all school personnel prior to entering school for the purpose of preventing exposure of individuals with COVID-19 or any communicable disease symptoms from spreading the virus to contacts at the school. The value of having a school nurse for every school was supported by the AAP policy statement in June 2016.

In this pandemic, the school nurse is an essential part of the healthcare team (e.g., private practice physicians, school based health centers, community clinics, and the department of health) overseeing the health of the children and school personnel and should be employed in every school (See Safe Return to School: Call to Action Part 2 online at contemporarypediatrics.com/safe-return-to-school-part-2.)

Another major concern identified in the original CDC guidance is the recommendation to close schools for 2 to 5 days when there is a confirmed case of COVID-19 in the school system. Opening and closing schools for 2 to 5 days will be disruptive to everyone. Testing prior to return to school may prevent schools from opening and closing in a chaotic fashion.

Plans to reopen schools must be based on local and state public health data as well as primary and secondary prevention strategies that minimize the potential for viral spread, and avoid a cycle of frequent opening and closing of school systems due to outbreaks of COVID-19. The authors believe that testing of students and school personnel prior to reopening schools is the cornerstone of primary and secondary prevention strategies. And while the most recent CDC guidance does not recommend universal testing of children and staff, it however, proposes other testing strategies based on local and state data.

When the pandemic began, data from other countries led healthcare providers (HCPs) to believe that children were less affected by COVID-19 but may be asymptomatic carriers. However, as the pandemic spread in the United States and Italy, there were news reports of chronically ill children hospitalized with severe symptoms. The most troubling occurrence is the new presentation of the COVID-19 complication of the syndrome, Multisystem Inflammatory Syndrome in children (MIS-C). The etiology of MIS-C remains unclear. According to reports from the CDC, children who developed MIS-C may have been infected weeks before the appearance of MIS-C symptoms, and/or were symptomatic carriers.

Thus, based on these presentations of COVID-19 in children, testing strategies for children must be considered on all levels to protect all children, school personnel, and the communities in which they live. As of this writing, data for widely testing children for COVID-19 in the U.S. is non-existent.

Innovation is an outcome of a crisis. New, non-invasive methods for testing for COVID-19 in children should be developed. Saliva sample testing may be a reasonable solution that can be developed, and, as of this writing, is under investigation as a point-of-care test.

Once testing policies and methods are in place, only then can we proceed with developing other policies
that address a safe school environment for children and adolescents, and all school personnel that work every day to educate and care for our children/adolescents.

**Screenings are critical to safely reopen schools**

Children have been out of school since March 2020 and may not have had their usual access to healthcare throughout this pandemic. Screenings to identify problems in physical, emotional, social, and behavioral health are a critical strategy for the design and implementation of effective strategies for healthy children. Thus, we encourage all HCPs, including school nurses, to assume a leadership role in the design and implementation of screenings for the identification of children and school personnel who may present with problems that may have arisen during stay-at-home orders (e.g., anxiety, school phobia, etc.).

Screening is a critical part of the process for prevention of transmission of COVID-19 within school systems. An innovative, reliable method for screening children and school personnel prior to going to school each day should be implemented. Some health care systems and other clinical practices have already implemented the use of a web-based application or ‘app’ that can be used to screen for temperature and emerging symptoms one-hour before reporting to work each day. This screening tool asks the individual to report the morning temperature, and also asks other pertinent questions about symptoms and possible exposure to an individual with COVID-19. If negative, the employee reports to work. If any portion of the screening is positive, the individual does not report to work that day. For parents who do not have access to cell phones or apps on their devices, a plan

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### COMMON AREAS/SHARED ITEMS

- Bathrooms, including routine cleaning, timed bathroom use for individual students or groups, and use of no touch doors, soap dispensers, and faucets.
- Minimize number of students in hallways with timed use for individual students or groups, designated walking lanes, and one-way hallways, will take pre-planning but it is critical for the safety of all students, teachers, and school personnel.
- Routine cleaning of shared areas, such as hallways, lobbies, and stairs, and also libraries, lunchrooms, offices, and classrooms.

#### Use of appropriate strength disinfectants
- Focus on doorknobs, handrails, and other frequent contact and touch areas.
- Keep doors open, if possible, to eliminate contact when opening and closing.
- Prohibit use of water fountains, and provide bottled water and/or touch free bottle filing stations.
- Eliminate shared items such as books, art supplies, etc., and provide these items for children to use.

### CLASSROOM INNOVATIONS AND SOCIAL DISTANCING

- Use assigned tables and chairs for each student.
- Provide lunch and snacks in classroom rather than shared space of lunchroom.
- Use of common spaces, such as library and lunchroom, should be timed for individuals and groups and cleaned on a scheduled basis.
- Special considerations: playground, sports, band/chorus/music.

#### Minimize or eliminate shared use of play, sports, and music-related items and equipment as the virus can spread when young children touch contaminated equipment and then touch their hands to their eyes, nose, or mouth13 and if shared, clean routinely and between each use.

- Use of playgrounds are not recommended, including water playgrounds, and those located within local, state, or national parks as these are often crowded, can easily exceed recommended guidance for gatherings, and pose challenges to keeping surfaces clean and disinfected14.

- Teachers should design and implement innovative strategies to educate all children and adolescents in light of the ‘new norms’.
- Social distancing: Successful concepts for outdoor classrooms have been implemented in the U.S. and in Scandinavia as open air and distance reduce transmission of the virus.
- ‘There is no bad weather, only bad clothing’ as Montessori schools have successfully implemented educational experiences outdoors15.
  - Consider outdoor classrooms as part of the ‘new norm’.
- Physical education classes should be in outdoor spaces.
  - Encourage activities that are socially distant.
    - Running.
    - Practice skill building for sports to maintain social distancing.

- Consider alternative models of education delivery.

- Split sessions (alternating 2 days or 3 days per week, alternating weeks, etc.)
- Middle and high school student cohorts could remain in one classroom, with expert faculty rotating to the classroom, rather than children and adolescents rotating to classrooms, which allows for better contact tracing, if a student, teacher or school personnel tests positive for COVID-19.
infectious disease

THE NEW NORM FOR CLEANING CLASSROOMS

- Equip rooms with disease-transmission reducing capabilities such as routine cleaning of ventilation ducts
- Consider installing air filter or purifier systems
- Classroom should be cleaned on a schedule, whenever students are in common spaces and/or outside of the classroom

BATHROOMS

Based on the literature and WHO recommendations we recommend the following:

- Children must sanitize hands upon arrival at school with either a hand sanitizer or soap and water, and frequently during the school day
- Parents or schools should either supply each child (based on age) with a personal hand sanitizer that is 60% alcohol based OR
- Schools should have hand sanitizer no-touch hand washing stations throughout the buildings
- Urinals should be replaced with separate toilets with touchless entry
- Children should have scheduled bathroom time at least 2-3 times during the school day, and more often in the younger grades
- In classrooms with young children that have a bathroom in the classroom, personnel who can monitor the use and cleanliness of the classroom is highly recommended
- Appropriate adult supervisions should be available at all time
- It is recommended that a registered professional nurse (RN) be present in every school for provision of care if there are associated concern
- The RN must have a private bathroom for use by children who might become ill at school, and appropriate staff for disinfection after each use

Call to Action for Educational Equality

COVID-19 brought to the forefront nationwide educational inequality. As HCPs, we know the importance of being lifelong learners and the importance of early childhood education and continued excellence in education throughout the K through 12 years. It was distressful to hear many parents report that their children did not have access to computers, tablets.
and/or the internet at home to continue their education virtually. To achieve meaningful societal change, social justice and educational parity, we encourage educators, parents, and all community members to analyze the local educational needs and to plan accordingly to meet the needs of all students.

Conclusion
As Erik Erickson said, “School is the work of children.” We value the education our children receive throughout the US each year preparing the children to develop into healthy, kind, valuable, innovative and productive members of society in whatever careers and professions they choose. The immediate closing of schools at the onset of the COVID-19 pandemic has further enlightened everyone on the value of educators and the school systems. All HCPs want children to return to school safely and free of the threats of contracting COVID-19 within the school environment. Thus, our recommendations are based on the best available evidence as of this date and time. Screening, non-invasive testing, masks for all children over 2-years old, eye protection, social distancing, cleaning, transportation, and bathroom use are critical to the health and well-being of the children, all school personnel, their parents, family members and the community in which they live and grow.

Survey shows primary care physicians not ready for next COVID-19 surge

More than a third of respondents said they are not ready. KEITH A. REYNOLDS

More than one third of primary care physicians in the United States are not ready for another wave of COVID-19, according to a survey.

The survey is the 15th part of a series by The Larry A. Green Center, the Primary Care Collaborative, and 3rd Conversation aimed at gauging how the COVID-19 pandemic has impacted primary care physicians. More than 30 percent of respondents said that their practices felt unready or spent from the demands of the pandemic, while more than 40 percent said they were not ready for another wave of the disease. Personal protective equipment (PPE) shortages continued to plague practices as 45 percent of respondents reported that they were out of PPE, while 61 percent reported that they were reusing it, according to the survey.

“While new federal, state and health plan virtual health policies have helped primary care, these turned out to be necessary, but not sufficient support,” Ann Greiner, president and CEO of the Primary Care Collaborative, said in a news release. “Plus, more financial support from the Provider Relief Fund is needed as is testing and PPE. You can draw a straight line between lack of primary care support and bad patient outcomes, particularly for patients of color.”

Cash was also a factor in practice distress as less than 50 percent of respondents reported they had enough cash to stay open and one third said they had laid off or furloughed staff within the past four weeks. Compounding this issue, 53 percent of respondents said their patients were not scheduling well visits or chronic care visits, the survey says.

Adding to primary care physicians’ stress, about 70 percent of respondents said they were not ready for reduced or terminated payment for audio and video visits which the Centers for Medicare & Medicaid Services (CMS) will terminate when the national emergency is declared over unless Congress intervenes, the survey said.

“Primary care is holding on by a thread as our country faces a surge in COVID-19 cases,” Christine Bechtel, patient advocate and co-founder of 3rd Conversation, says in the release. “Anyone – whether a policy maker, an insurer or patient – should be totally alarmed. This surge is a preview of what’s to come during the impending second wave, and this data tells us that we are in deep trouble. I don’t know how much longer we can shout at the wind, but I’ll say it again—health care is only going to get more expensive and less available from here on out, unless policy makers and insurers act fast to prevent even larger economic and health catastrophes resulting from the imminent collapse of primary care.”

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