



Russell Meyers, CEO of Midland Health

COVID-19 Daily Briefing: Tuesday, March 31, 2020

Transcribed from a previously recorded live event.

Mr. Meyers: Good morning everyone. I'm Russell Meyers, CEO of Midland Health. This is our update for Tuesday, March 31, 2020. I'd like to begin by thanking the mayor and judge and the superintendent for working together with us to coordinate these press events and live updates. I think it will be efficient and hopefully helpful to the community for us to be together each day at the same time. Just to repeat the schedule that we have revised now. At the hospital we'll be doing a briefing every Monday, Wednesday, and Friday – just hospital folks at our Abell-Hangar Pavilion and we'll be doing that on Facebook live and other live forms. And then on Tuesdays and Thursdays we'll be here at 9:00am with the rest of the Unified Command Team. Thank you all for being here.

Quick update on the case numbers. In Texas there are now 2,800+ confirmed cases. There have been 38 deaths statewide. 13 total confirmed cases in Midland County and 1 death. At the hospital, we have now sampled over 300 patients. We are still waiting for over 100 results to come back. But so far only 10 of those 300 have been positive. We have 168 negative tests. Dr. Wilson will talk some more in just a moment about the nature of the testing and what some of those numbers might mean.

At the hospital, our census is 108 today which is only 40% of capacity. We continue the relatively low hospital volumes. Significant ability to ramp up capacity here in the near term if we need to. ED visits continue to hold in the near 100 range which is on the order of about half of our typical ER visit volume. People are staying home. They are managing their own minor illnesses. We've seen lots of evidence of that. In our Critical Care Unit, we have 11 patients. Those patients we consider PUIs, a term we've begun to use regularly for people who are showing the signs and symptoms of a COVID infection but are not yet confirmed positive, there are 5 of those in Critical Care and 5 in a special Medical Surgical unit that is separately cohorting those patients. So, a total of 10. None of those 10 have a confirmed positive test, but we are treating them as if they do.

A few other updates. Visiting restrictions at the hospital remain in place. We're trying to severely limit the number of people who are not hospital workers who are coming in and out of our facility. When you come to the ED now as a patient you are going to be given a mask when you enter out of an abundance of caution. That is our policy as of a couple of days ago. We made a minor change to visiting restrictions yesterday. Since the beginning we have allowed a few exceptions: a pediatric patient with a parent, a patient who is incapacitated and unable to speak for themselves who needs a caregiver with them, and a partner for a laboring mother. In most cases that's the father. And we had put a restriction in place that didn't allow fathers to go into a cesarean section, into the operating room environment. We've changed that as of yesterday and we've loosened those restrictions so the fathers can go now into a planned c-section. Of course, if the patient has to be intubated and there are more invasive procedures happening then we'll ask the father to leave, but that loosening of restrictions happened yesterday.

We are still accepting PPE donations. That's an important part of our effort to assure there's enough of that kind of equipment to protect all of our employees who need it. That's gone very well. The community's been incredibly generous. We moved the location for that collection as of today. So, at



10:00am this morning we will be relocated to the Abell-Hangar Pavilion. That's directly across the street from the main hospital, facing Andrews Hwy and the Walgreens store right out front. We'll be doing collections from 10:00am – 12:00pm today. If you have PPE or hand sanitizer or anything else that you would like to donate.

On that note also, you may have seen a feature in the paper today about one of the folks who is sewing masks. We have a large army of people who have sewn for us and for others in the community in the past who have repurposed their efforts to sew handmade masks for us. Those masks are very useful to a lot of different people. They're not N95 respirators by any stretch. But they can be very valuable and have been. We've handed out hundreds of them. We need all of them that we can get because they're very popular. We're putting them on every ER patient. Many of our employees feel safer wearing a mask throughout their day. So, anyone who wants to sew and has a desire to help us you are welcome to do that, and we'd appreciate that effort.

Finally, the last thing I want to do. We have been thinking about how we can tell the community about some of the special work done by perhaps some unsung heroes in the hospital. Today, I'd like to talk about respiratory therapists (RTs). That's one of probably the least understood of the health professions. But our RTs perform all sorts of tests and therapies that relate to the ability to breath and to do so successfully. Most importantly they manage our ventilators. And so, the fact that they're doing that they're involved in the patient's breathing and the ventilation means they're absolutely on the front line. They are the person that is most at risk because they're right in the patient's face dealing with their exhalation and often with intubated patients on ventilators. So, our RTs are among our most versatile employees. Over the years our critical care physicians have taught them to start arterial lines and to do things to make it easier for our physicians to do their work. So, a shout out and praise and thanks to our RTs today. Thanks to all of them. If you are around the hospital, one day you'll be able to be in the hospital again. They are the folks in the wine-colored scrubs. A great part of our team.

So, I'll take questions from the hospital's perspective. Dr. Wilson is going to follow me so if you'll save your medical management questions for him, I'd appreciate that.

Anybody have a question for me?

Question: Why the change in allowing fathers to come and see a c-sections?

Mr. Meyers: Why the change in allowing fathers to come and accompany their wives or significant others in a c-section. Everything we are doing is evolving. The restrictions first allowed fathers to be in the L&D suites and so for about 12% - 15% of our patients a normal delivery turns into a cesarean section. And traditionally we have allowed fathers to be in the room with them. And as we thought about it we had at least one father who spoke up. I think we had a question a couple of days ago from a mother who was about to deliver by section and was facing the prospect of doing that without her husband in the room. As we get feedback, we can re-think. We can reprocess. I think our main purpose for not allowing them in the first place was to preserve PPE. We found as we talked about it that we have special packs just for fathers to go into c-section rooms. We weren't really using those for anyone else. So, it was a pretty easy decision to make at that point.



Question: You talked about respiratory therapists being truly on the front lines. Is there any therapist that could speak to the press about that via facetime or something like that so you could really get a firsthand perspective?

Mr. Meyers: The question is about allowing one of our respiratory therapists to be available to the press. I'm sure we can work that out. If you'll work with Tasa, we'll find somebody who can speak to you directly. Thank you.

Question: How many people on staff are able to work the ventilators?

Mr. Meyers: How many people on staff are able to work with ventilators? We'll there's lots of different categories of people who work with ventilators. Of course, we have our critical care physicians and our pulmonologists. We have a total of 2 pulmonologists and one full time critical care physician. They are the ones who direct the usage of the ventilator and determine what patient goes on it, what settings it has to provide the therapy they need. We have a small army of RTs. I couldn't tell you how many of those we have. But all of them are trained and actively manage ventilators as they are in use. I'd have to find the number out. It's 25 – 50 RTs I think. In that ballpark.

Question: So, yesterday you touched on how we haven't seen a spike. It's been pretty consistent. But I was reading articles about states surrounding us. How their doctors are anticipating the peak being 17 days. Is the state of Texas anticipating a similar trend? And we haven't quite reached that peak, but we're getting there?

Mr. Meyers: The question is about when does the virus peak? That is a yes. We are anticipating that we are not at the peak. There is some very good work being done using various epidemiological models. We got some information yesterday from the UT system where they are attempting to model most of the major cities in the state. They had done a model for Austin already and their peak was actually several months into the future. And the predictions depend very, very heavily on the extent to which we take seriously the shelter in place, social distancing, hand hygiene admonitions that we're getting from our public health folks. The more we distance, the more we stay at home, the farther out that peak happens and the shallower the peak becomes. That's really important because the worst-case models show far more need for hospital beds and critical care beds, as you've seen in New York than any of us can put together. So, if we do the mitigation strategies that we are talking about we have a chance to manage this within the resources we have. That modeling we expect to be provided specific to our region, Midland-Odessa, sometime in the next few days. We know that the UT scientists are working on that now. And that will be very helpful for us as we plan for what the worst case looks like, how many resources we will need to add to our communities complement of beds, critical care capacity as it unfolds.

Question: With regard to tests, you say we are up around 300 so far, and with the peak not here yet we are probably going to climb a little bit more. Are your sources for testing getting better, coming back faster?

Mr. Meyers: The question is about our testing labs and whether they are getting better. Yes, the majority of tests results that have not been received are at least a week old. There was a period with one of our lab partners when they had a really difficult time getting results out to us timely. They are still struggling to finish up those older tests. The tests we've taken in the most recent days really about



the last week have come back for the most part in the 24-48 hour time frame. So, the most current work we are doing is coming back quickly. The older tests we've taken we are still waiting on.

Ok. I'm going to ask Dr. Wilson to come and follow me.

Dr. Larry Wilson: Good morning. Several of the questions have been related to the testing. I want to just kind of talk a little more about what we are learning about this virus and what I'm hearing from colleagues around the country and in studies to give a little framework around that. This virus is wiley. It is a very efficient virus for doing the job that it wants to do. And that creates the problem that we've been seeing all over the world. It seems to be apparent that the virus can be spread before a person is symptomatic. It seems that even if somebody is symptomatic and they have the virus in their system and we've diagnosed the virus with a test, that if you test again on successive days, they'd be negative and may be positive on different days. So, it behaves in a very good way to protect itself from being discovered and spread itself quickly before people recognize it is as even there. We've seen patients coming into our hospital that we're pretty confident have the virus, that have presented with headache or neurological symptoms. We had a patient that proved to have a positive test that had shown up in another facility a day before hand which a blackout spell in a young person. That would normally be worked up as a syncope episode. And not be treated as though it's this virus. The following day with respiratory tract symptoms and fever the patient was tested and proved to have COVID. So, this is a very efficient virus and I mentioned. And it hides itself well and I think that's part of the reason that many of our tests so far in patients that we believe are infected, as Russell mentioned and that you've heard me speaking about previously have proven to be negative. We have a meeting everyday on the COVID Clinical Operations process and we're making adjustments as you've heard over and over again it's a fluid issue. And we're managing it as we go. And we're going to probably start based on the meeting today with our multidisciplinary group including our infectious disease doctor and lab to start testing patients that are hospitalized that we believe have it on a daily basis to see if we find COVID infection on day 2 or 3 as opposed to just going with a negative that we had on day 1. That has been our policy. We are going to move away from doing that. So, you have heard some things about tests and I'm beginning to believe that there is some validity to doing more testing. Not so much that we find what we know is true. That the virus is in our community. That we define it a little bit better and we can confirm that more readily in patients that we're hospitalizing already. I think the take home message from the points that I just made I think it's very, very important that we behave in a reasoned paranoid fashion. That everyone you know might have this virus. They may not be acting symptomatic, but they may be spreading it. They may be having different kind of symptoms, but they may actually have COVID. So, we have to continue to the social distancing. We have to continue to be practicing good hand hygiene and other practices that you've heard us ad nauseum speaking about. But this is fundamentally true, that it's in our community. That we may not be able to get it on first testing. But it's out there and if we're not careful about this the spike that you've heard Russell mention and you've heard us talk about before could come. And we could be in a situation like you are seeing in Dallas or you're seeing in New York or you are seeing in other parts around the country. This is a serious issue and if we don't take it seriously it could create a bigger problem down the line.

I appreciate Russell's shout out to our RTs. They're front line individuals that are in the face of this on a day to day basis. I had a phone call last night from one of our anesthesiologists, Dr. Brad Brock concerned about that as well. And his point was that those on the front line are dealing with this every

day. We have patients in the hospital now. We have our first responders here that are going out and responding to people every day that may have this virus. And if we don't do our part as citizens to protect them, then they are risk. And they could end up in the hospital themselves. And we're seeing that all over the country. And we're getting reports of guys in my specialty emergency medicine that are on ventilators. I don't want to end up on a ventilator. I know these guys don't want to end up on a ventilator. So, if we all do the right thing it's not just about protecting ourselves from one another, but it's protecting our healthcare providers, so they are there to protect us as this disease progresses. Because no matter how you shade this, we are talking about bending the curve down. We are not talking about eliminating it. This disease is in our community and we are going to be seeing some of it. They key is to see less of it and to do the best job we can at managing that.

One last point I want to make because this is something you've heard me speak a little bit about before. This social distancing piece is the most important part of what we do. Because the spread of the droplets is how the disease is spread. You heard Russell mention that we are masking people as they come in the hospital, we are providing masks to them. There's increasing information out there suggesting that what common sense- to mitigate the spread of our breath and the water droplets can help. So even though the masks; the CDC and others say don't really prevent you from getting exposed; it can decrease the spread of our breath in the air and our coughing and our sneezing in the air. So, wearing a mask if you have a mask is not a bad thing to do. And I've kind of switched on that. You've heard me say before, just social distancing is the key but just that mechanical bridge can be protective. And I think that anything we do to try to mitigate that. So, you heard the mayor saying let's be cautious when we are going to the stores. If you go to a store and there's a congregation of people out front all closely knit, go to a different store. Let's be wise about what we are doing. Don't allow yourself to be in close proximity to others. Everything we can do to mitigate the spread is going to dampen that curve and help prevent this disease from spreading and having a spike like we're all worried about seeing in different parts of the country. So, thank you. I'll entertain any questions.

Question: You called it a very efficient virus. So, in kind of an answer to those that talk about the flu numbers being greater and trying to battle that argument how would you compare the efficiency of the this to the flu?

Dr. Wilson: The flu is pretty transmissible also. But we are learning as we go with this as you know. But there's reports that what I described is occurring all over the country. That people are finding that people are testing positive when they are asymptomatic. We're having people that are testing positive on one day and negative on another day. The atypical presentation on the front side is true. So, those are behaviors that are a little bit different than influenza. Influenza typically comes on like a ton of bricks and you know you got it and that's what it is. And so, this behaves differently than that.

Question response: Yeah especially the point about you can transfer it without even showing signs yourself.

Dr. Wilson: Yeah, right.

Question: You made a comment the other week that you are worried about some of the negative tests that we've gotten back may actually be positives. That the tests weren't sensitive to catch all likely

correct cases. Is that still a concern of yours? Is there anything else you guys are trying to do to get a hold of those that may have slipped through the cracks?

Dr. Wilson: Yeah, it goes back to what I was just describing. The more we learn, the better we are at kind of describing that. So, I think the test itself is probably plenty sensitive. My pathology guys got mad at me for making that comment, because if there's DNA on the swab it'll be positive. But the problem is we don't always get the DNA on the swab, we don't get the virus. And so, when somebody's shedding we don't know really clearly. You know as I just mentioned you can be positive on day one and 2 days later in your disease you are still very sick. You are still in the hospital and you're negative. Why is that? You know. That's a study that was in JAMA out of Singapore. Their hospitalized population they tested them every day while they were in the hospital and they were intermittently positive and negative. The more you test, the more likely you are going to find the disease and I think we should be a little bit more liberal in our own institution about those that we think have it, the PUIs that we have in the hospital. Testing them serially rather than just one time.

Question response: Does that go for some of the other patients who aren't PUIs but larger group of tests to do that multiple times? Or is that something y'all have the resources to do?

Dr. Wilson: So, completely asymptomatic people that we think don't have it but just test them as a surveillance?

Question response: No, I mean just like the total number that you guys have been testing. Do you think those people should have been tested multiple times?

Dr. Wilson: Well, I mean if a patient isn't hospitalized the ultimate message that I think is really, really important is if you believe you've got COVID. Self-isolate, self-quarantine until you are asymptomatic. So, your symptom onset was at least 7 days previous, you've been asymptomatic meaning no fever without any antipyretics or you know Tylenol or aspirin or anything on board for at least 3 days, and your symptoms are resolving. That's the CDC's recommendation. I think that's a good recommendation. There's no reason to just serially test somebody because that's bringing them out in the community and exposing others to them. Just self-quarantine if you have symptoms and follow those instructions. And they're available on CDC.gov to walk you through how to both go on quarantine, what to do while you are on quarantine and how to get off of quarantine.

Question: So, you touched on how this virus is wiley. It is smart. It knows how to adapt and how to camouflage itself in somebody. And so, you're talking about keeping this curve low so that we don't overwhelm the hospital system. So, why do you think it's important that we continue to strive to keep that curve low because you're seeing this virus and more data coming where numbers may not mean anything, but you still need to keep that curve low. Why is that important?

Dr. Wilson: I don't understand part of the numbers not meaning anything. But I think the point is that if we allow the virus to just propagate and the population to say let's get back to normal. Let's just behave like you know it's not here. Once that virus starts spreading as transmissible as it is we are going to have a significant number of vulnerable people and aged people get the virus and are going to get very, very sick and they are going to end up in the hospital and on ventilators. And we have limited resources to manage them. You heard Russell mentioning them. We have 3 pulmonary specialists in our community you know one critical care specialist and 2 pulmonary doctors that manage critical care patients. We

have a handful of anesthesiologists that can manage vents. We have a couple of ER doctors recently out of training that still do some critical care kind of stuff. We've got a handful of other surgeons and neurosurgeons that have fellowship training or some experience with critical care management and can help and step up there. But that's very limited. When you start talking about getting potentially hundreds of patients that might need to be on ventilators in a relatively short period of time. It's not like New York City, but you know for Midland County and for this environment that's a lot of patients. And there's not enough beds. There's not enough ventilators to manage that. So, if we don't dampen that curve, we are going to have really difficult decisions about who gets a vent, who doesn't get a vent. How do you manage those vents? I mean it's just a scary proposition. If we bend that curve downward and we're able to manage that in an appropriate fashion, we all do well.

Question: Will this virus change into something deadlier? Will it mutate into something stronger?

Dr. Wilson: That's an unknown. That's a coronavirus question about how it behaves. But so far, the information seems to suggest it's not migrating very rapidly. There's been some literature that's talking about the DNA structure of the virus. Some viruses seem to mutate very quickly. And this one doesn't seem to be behaving that way. But that's a complete unknown.

Question: I feel like we're starting to see more and more trends affecting not just an older population, but also kids. We recently had an infant who came back positive. How would you explain this to parents to be sure that their kids aren't as vulnerable to the virus as maybe they initially thought?

Dr. Wilson: I think we've known all along that this is not uniquely infecting older people. It just tends to be more severe in older people and in those people that are more vulnerable to the disease. If you have underlying health issues it tends to be worse. So, although we've had some children in the community, and we've had some adults in the community that have come down with it in their 20's and 30's that have ended up on ventilators. We believe they were PUIs they weren't confirmed, but they got off the ventilator. And they went home. And that's the difference between the aged and the vulnerable and the others. You know, you might get really, really sick and go into respiratory failure and need some pretty critical care treatment for a while, but you'll tend to be plastic enough and to bounce back and move on.

Alright, thanks very much for your time.