



Russell Meyers, CEO of Midland Health

COVID-19 Daily Briefing: Friday, April 3, 2020

Transcribed from a previously recorded live event.

Mr. Meyers: Good morning everybody. This is Friday, April the 3rd. Our daily Coronavirus update. I'm Russell Meyers, CEO of Midland Health.

Starting with numbers today. In the state of Texas, we have just short of 4,700 confirmed cases now. In Midland County 19 cases of Coronavirus or COVID-19. 70 deaths to date in Texas and 1 death in Midland County. Testing that has been done through the Midland Health test sites, over 400 tests have been sampled. We have 16 positives, 309 negatives, and over 100 tests still outstanding. Most of those are at least a week old and we continue to wait for those longer-term tests. The more recent ones are turning around now still in 24-48 hours. So, we are encouraged by that.

If you look at the hospital census, we are at 120 patients total today, about 44% of occupancy. The ED had what seems like a new low at 82 patients yesterday. We continue to see unusually low volumes in the ED. In our CCU unit we have a total of 14 patients in our 2 COVID-19 or PUI wards. We have 7 critical care and 14 now medical surgical patients for a total of 21 PUIs in the hospital. Only one of those 21 is a confirmed positive. We are treating all of them as if they are positive. 4 of those patients who are in the COVID-19 critical care space are on ventilators.

Quick word about facilities, you see the numbers that I just gave you at 14. Our medical surgical census is at it's highest so far. The original unit we had assigned for those patients had only 12 beds, but we have made contingent plans to take the larger part of the 8th floor and turn it into our COVID-19 medical surgical area. So, we activated that yesterday. Those 14 patients are on the larger part, what is normally the ortho-neuro unit on the 8th floor. That has a capacity of 30. So, we have ample capacity to grow that space and we've assigned it specifically to this purpose. In the meantime, we are taking the 12-bed unit we originally assigned which is the separate unit on the east end of the Scharbauer Tower on the 8th floor. A 12-bed unit that we are now converting to critical care expansion capacity. And we expect to have that available immediately probably today. I don't think we need it for a while, but it will be available for the next group of COVID-19 patients or PUIs that need critical care beyond the original 12 beds we've assigned on the 5th floor, the critical care floor.

So, with all that in mind I want to take a moment just to recognize our facilities team. The changes we've had to make to facilities have been frequent and challenging and our facilities guys have stepped up in each case. For example, when we converted the 8th floor unit to its original Med Surg complement, they had to make some significant changes to the airflows to enhance the negative airflow in patient rooms to keep the virus inside of the room and avoid airflow out into the hallways. They did that essentially overnight. They've done the same thing with the larger 30 bed area. And as we progress, they will continue to make those kinds of changes where they are needed to make sure the environment is as safe as possible. Another example of that that was set up just yesterday in the ED, there is a 6-bed ward space that we are able to separate from the rest of the ER environment and put suspected COVID-19 patients in that area. We've also been able to creatively achieve negative air pressure in that space. So, thanks and a big shout out to our facilities team for all of the challenging and



creative work they've had to do to make our facilities as safe as possible and frankly to keep them operating day in and day out as they always do.

Let's see. PPE update we've had a pretty good few days of deliveries. We are encouraged about what we hear from our suppliers about further deliveries that are on their way. So, we are feeling a little bit better about our supply of things like N95 masks. Certainly not out of the woods if we have a huge growth in cases. But as of now we have an ample supply for the cases we have today at the use rate we have today. We continue to be very appreciative of the donations we've been getting from the community each day including yesterday. We've had a substantial gifts come in. We'll be back out there today at 10:00am, here right outside the front door of the Abell-Hangar Pavilion and our staff will be happy to take donations of PPE.

Let's see. We've talked some about testing. In our conference yesterday with the Unified Command Team, a question came up about the testing that we are doing from our testing site and whether there was a charge to the patient or not. And I think the answer I gave was accurate but let me clarify just to be sure. We are registering patients as they come for testing. We do expect to bill insurance providers or other 3rd party payers if they are available if the patient has insurance. We do not expect to have any patient incur any out of pocket costs, but we will register you. If you have insurance, we will bill insurance. We will do our best to collect something for this testing. The other point that I'd like to make is that this is specifically the COVID-19 test. If you are receiving other services, other laboratory work or anything else from the hospital we are not treating those patients any differently. We are registering them. We are expecting their out of pocket payments to come in. We are billing their insurance, etc. So, not really much that's different from our normal practice except we are not collecting up front from patients who get a COVID-19 test and as their bills are processed by their insurance companies, we are probably going to have available resources locally to cover their out of pocket costs. So COVID-19 patients only will be covered by that policy.

A quick reminder as I finish my remarks. The weekend is coming. This is our second weekend since we've been doing these press briefings. The mayor did a good job I think reminding people yesterday of how important it is to recognize that the social distancing expectations, the shelter in place, the avoidance of big crowds, the need to carefully disinfect surfaces and wash hands, the need to stay home and self-isolate if you're sick, none of that changes just because it's a weekend. It's tempting to get out. The weather may be challenging. It's gotten very cold today, so that may help keep people inside. But it's really important to remember the rules are just the same. Until this virus begins to turn down, until we see a reduction in cases in the community and in other communities around the state, we don't need to be backing off of the protections we've put in place to keep our community healthy. So, please remember that as you go through this weekend. We'll be back here on Monday morning at this site at 9:00am for another round of press briefings. We'll bring you up to date at that point. And I'll take questions at this time.

Question: Is a part of the reason for the hospital occupancy being down is part of the thing about elective surgeries and all that. Would you want to talk about that?

Mr. Meyers: Yes, Mark's question is about the decline in the census and whether that's related to our suspension of elective procedures. Yes, it is. I don't think it's exclusively related to that. If you look at the ER volumes, that's another big part of it too. You know we've seen ER volumes cut basically in half or



even cut deeper than that. I think that really is about social distancing, it's about people staying home recognizing that a lot of the reasons that people come to the ER in normal times are fairly minor illnesses that they can probably manage themselves. They can call our 68-NURSE hotline and get advice; they can use over the counter medications. And when we're asking people to stay home, people are actually staying home. The ER traffic always yields some amount of hospital admissions and other kinds of work. Elective procedures, and surgery, and endoscopy, and heart institute, and other places all of those turn into inpatients as well. So, the combination of reduced ER volume, reduce traffic in the community, and the suspension of elective procedures I would say has led to the hospital's lower census. And at this time, that's a good thing. It allows us to deploy our resources where they are most needed to fight the virus. There's no question that all of that elective work still is out there. It needs to be done. I know, you know, 3 years ago now I had both of my hips replaced. And I could have waited to do that you know if we were in crisis. But I couldn't have waited forever. I was in pain walking. I couldn't get up out of a chair easily. That's what people face now. Things that need to be done but have to be deferred. They're toughing it out. But on the other side of this we have a lot of work to do for people who really need it. So, we've asked them to stay home and just ride it out with us.

Question: There was a report that came out from The University of Texas and I know you've said yesterday you haven't had a chance to review it yet, but it estimated that between 1,000 and 1,500 people could require hospitalization at virus's peak 100 – 200 could require ICU treatment. Can you just go over the hospital's total capacity as far as number of beds and ICU beds?

Mr. Meyers: I sure can. The capacity is kind of about- The question is about the UT study that was released, I think the MRT ran part of it in this morning's paper. The hospital's capacity is a little bit of a moving target. As a starting point, we are licensed for well over 400 beds. A license in Texas simply reflects sort of historical activity more than anything else. In terms of operating beds, we are at 237. That's our official operating bed capacity. When we opened our Neonatal Intensive Care Unit, that adds 6 more beds. We had 12 of those in the original complement. So, just a handful of additional beds. So, we are in the mid 200's in terms of operating capacity day in and day out. We obviously have a lot more facility than that. We have the old building that remains standing but hasn't been used for patient care services for a long time. It would be very difficult to put those older beds back in service, but there is one unit that's been used for day surgery consistently. So, that's a possibility with another 20 or 30 beds. The exact count I'm not certain of. But we are beginning now to reevaluate all of that space in the old building to potentially see what's available to us if it should be needed in the long term. In terms of Critical Care capacity, we have a good bit of flexibility there. In terms of our day to day operation we are typically using 24 beds on the 5th floor as critical care. The entire 5th floor, 48 total beds was built so that it could be critical care when the time comes. Both built and equipped. So that 48-bed unit could become all critical care as needed. As I told you just a little bit ago. We've got a unit on the 8th floor, 12 beds that our facilities team has put together a plan to add monitoring and some other capabilities and turn that into critical care space. So that would get us up to 60 total critical care beds that could be used immediately. The challenge with all of that is staffing. You can make buildings work a lot easier than you can get enough skilled people to take care of patients. A critical care nurse, a RT who can manage a ventilator, an intensivist physician, an infectious disease physician, all of those are resources that are in very short supply. So, our ability to suddenly double our critical care capacity is limited. Our team is working on plans to use the talented critical care resources we have and stretch them by asking some of



our other workforce for example from areas like the recovery room or the operating room to team up with experienced critical care nurses as needed to expand that capability. But, it's very difficult to suddenly create a large supply of new critical care nursing staff. And so, we'll be focusing on how best we can do that with the resources we have. How much capacity we can bring online. I believe that the

UT study- and I have certainly spent some time with it. There are at least 3 or 4 other models that we are also considering. And the models offer widely varying projections on how fast the peak might come with regard to the maximum number of COVID-19 cases we might see in our community and what that maximum number is. It's a really wide range. So, the reason we're trying not to comment on which model we think is right, because we don't really know yet. There's a good bit more conversation to be had internally about what's the target we should be using and planning for. I think the UT study is at the high end of those targets. But I hope that probably next week, maybe later in the week we'll be able to talk more about which model makes the most sense to us and how our plans are being shaped to that kind of most likely case as the virus begins to peak.

Question: We have a question on Facebook. How can the community show their appreciation for our local healthcare workers other than PPE donations and following guidelines?

Mr. Meyers: That's a really good question from Facebook. How can our community show its appreciation other than PPE donations and following our social distancing guidelines? Well those 2 things, probably not in that order. I'd put the social distancing first and then PPE donations. Those are right at the top of the list of the way that people in our community are already showing their appreciation and certainly can do more especially with regard to respecting our call for people to stay home, social distance, and make sure we avoid spreading the virus. If you are looking for other ways to show appreciation, there are a couple of things that come immediately to mind. The Midland Memorial Foundation has a COVID-19 support fund that a number of people in the community have donated funds to. And there's no question that as we unroll the next few weeks and months, the hospital -- the health system -- is going to be really challenged financially. We've talked about elective procedure deferral. One of the things that's the most difficult about that for us to manage, not only the patient challenges that come with enduring pain for longer that you could have fixed with a surgery or waiting on your annual endoscopy or whatever it might be the hospital benefits greatly from a revenue perspective from those cases. Those are the most lucrative, and in many cases, the most profitable things we do. So, what's left that we are doing now is work that tends not to pay for itself. So, we'll be facing some financial hardship over the next few months. And anybody who makes a financial donation to our foundation to help offset some of the cost of managing this pandemic that's incredibly appreciated. We are also seeing local restaurants come together to provide meals to our employees. Here and there. It's not necessarily a daily thing, but many of our local restaurants, their local franchise owners have stepped up to provide meals. I heard from someone yesterday who was working on organizing something a little bit more regular that would be funded by people in the community. You might watch for efforts like that and participate. The other thing than anyone can do is look for ways to help care for your neighbor. We have so many folks in our community who will struggle to care for themselves, who perhaps live alone, who have transportation challenges, who simply can't get out and navigate this very different world that we're in now. So, if you have a neighbor, if you have an older family member, anybody that you can help one on one while we all face this challenging pandemic then please do that. And know that you are helping our healthcare providers when you do that. If we can keep people



healthier, if we can keep them away from the hospital, we're all going to benefit from that. Very good question. Thank you.

Question: We have another question. How long is it currently taking to get the testing back?

Mr. Meyers: The question is how long is it currently taking to get the testing back. Current tests, tests we send out today should be back on Monday. Typically, 24-hour turnaround time. We've seen a couple of delays here recently that have gone a little longer than that. But for the most part we are getting it back next day or no more than 2 days later. We still have an old backlog of cases that are more than a week old now that are not yet reported. Some of those are beginning to trickle in. But the tests we are sending out currently are coming back pretty quickly.

Other questions? Ok, so we let Dr. Wilson and Dr. Bredimus off the hook today. They are standing by but thank you for giving them a break. Thank you all for being here. We'll be back here Monday morning in this spot at 9:00am and then of course Tuesday and Thursday with the Unified Command Team at the county annex, here Monday, Wednesday, and Friday at 9:00am. Certainly, will do that next week. Thank you all.