Russell Meyers, CEO of Midland Health

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Transcribed from a previously recorded live event.

Midland Health's portion selected out of the Unified Command Team Press Conference.

Mr. Meyers: Thanks, Erin. It really is 21. The hospital's activity is down just a little bit today. Census is very high at 262, but only 68 of those patients are COVID+. 24 of those in Critical Care. 44 in the Medical COVID units. We had pretty good activity in the Emergency Department (ED) yesterday at 157 patients. We have 28 ventilators in use.

With regard to our workforce, we are continuing to depend to a great extent on the FEMA supplied contract nursing staff and respiratory therapy staff. We still have 75 employees quarantined. 46 of those are currently COVID+. There's another 61 employees who've had some level of exposure and are self-monitoring but continuing to work and check in with employee health every day.

We've had good success with the monoclonal antibody infusions. 236 patients have been treated to date. Only 1 of those patients, a very small percentage, has been hospitalized. We understand another one had an ED visit, but 2 patients with any kind of advancing disease out of 236 is very good success and we hope to continue to use that infusion therapy for the limited number of people who are eligible for it: patients over 65 who are newly positive but not yet in need of hospitalization as well as a variety of folks who have other complicating conditions. I think we have a self-referral form and information up now and that will continue to be available on our website.

I think the most important thing for us to talk about today is probably vaccines. This is a work in progress for sure. We've had a lot of calls as many providers around the community have and there simply isn't a lot of good information yet about vaccines. We have gotten enough vaccine to deal with our workforce, with healthcare providers in the community. We are now actually on round 2, the second dose of the Pfizer vaccine for people who got it in round 1. Just to give you an idea, the state has had a significant challenge in reporting data on vaccines. You may have heard reports from people at the department of state health services suggesting that hospitals have vaccine sitting on the shelves and aren't moving rapidly enough to get it administered. I think by in large that's probably not true. It's not true here. What we are experiencing is some challenges with reporting into the state's data bases. If you look today, for example, on the state's website you'll see that it says Midland Memorial has given 1,287 doses of vaccine. In fact, we've given 2,751 more than twice as many as the state's database says we have. Of the original Pfizer allocation, which was 1,950 vaccines, one really good positive piece of news was that every vial of vaccine that was supposed to have 5 doses of vaccine in it, it in fact has 6 doses in it. So, the 1,950 turned into 2,270 doses. We administered 890 of those to hospital employees and another 1,380 to a wide variety of first responders and care providers and others around the community. We have done over 400 of the second dose now which we just received a few days ago and we got 100 doses of the Moderna vaccine and all of those have been spoken for as well. So, the state's working to catch up its reporting system. I think that's going to be a continuing challenge, but please understand that as we are able to get our hands-on vaccine, we are delivering it as rapidly as we can. We have had some conversations among the Unified Command Team about the need to stand up a mass vaccination effort. And we are going to continue to talk about that and get a plan in the works

very soon. The challenge with that plan is we don't know when to expect to receive a quantity of vaccine that would support that effort. We can prepare the people and the sites to do it, but unless we have the vaccine of course we can't deliver it to a large numbers of people. So, we're talking to the state. Hopefully there will be some new information either later today or tomorrow and then again next week on enhanced distributions, but the state is hampered not only by its challenging reporting system, but also by the Federal Government's roll out process which is not particularly well organized and what I understood from this morning was that the state doesn't find out what it's getting from the Federal Government supply until the day it gets it. So, the ability to plan ahead is what's missing right now. We are hopeful of changing that in the near future.

On the testing front, testing volumes are still pretty high averaging about 1,300 patients a week. We do have some testing capacity and we are opening up testing to some more people. People who are in need of a test for any reason, not just those who have been exposed or who have active symptoms. We are allowing those to call 68NURSE to get appointments for a limited number of slots that are available for people with no symptoms or exposure. The only caveats to that are if you have been positive in the last 90 days or if you've had a negative test within the last 5 days, we'll ask you to wait. Otherwise, if you call 68NURSE and you want to get tested chances are we can get you tested within a day or two, even if you have not had any symptoms develop or an exposure.

I'd like to call on Dr. Wilson now to make a couple of remarks and then I'll come back and take questions.

Dr. Larry Wilson (Vice President, Medical Affairs Midland Health): Thank you, Russell. I've got a couple of topics that I'd like to discuss with you today. The first is related to pressure from some patients coming into the hospital and their families regarding alternative therapies and what Midland Health's position is on approaching those kind of circumstances.

First, I want to reiterate what Russell had mentioned. We've been doing well with COVID. We had a little bit of a downturn after Thanksgiving leading up to Christmas which seems to be a little bit more of a surge once again. We've been in the 70s for the last several days with patients in the hospital. Fortunately, we discussed at our COVID Steering Committee meeting yesterday, it doesn't appear that as many of those patients are getting as sick as we had seen in previous surges. So, the number of patients in the hospital may be rising, but we're not seeing as many in Critical Care. Whether that's going to last, we don't know, but it's a favorable circumstance as we sit today. And that leads me to a point that I think is really valuable is that over the year that we've been managing the COVID circumstances and the patients in the hospital, we've adopted therapies and interventions and we've continued to grow and change and improve what we're doing. We've recognize that, for instance the Remdesivir has a role in early cases that are of sort of a low acuity, early oxygen requiring patients. It's not good for every patient. It's good for a certain subset of the patients. We have a similar circumstance with Dexamethasone, an IV (intravenous) or oral steroid medication that seems to be beneficial for people that are on high oxygen requirements that are getting much more ill, but then again not that valuable in other patients that are in other circumstances. There is recent information and our critical care doctors are beginning to look at the Ivermectin. That's been a conversation point here before. There's some favorable information in some preliminary not very well-done studies, but given that it's got a very, very low risk profile the risk-benefit opportunity there seems to exist. And for our critical care doctors they are thinking of using it and they may have already started using it both

here and in Odessa in certain very limited circumstances and for some particular patients. I bring all that up to suggest that we are looking at this every day, every week. We have 3 COVID Steering Committee meetings a week. We have journal clubs reviewing the latest literature on pretty much a monthly basis. I am getting information, our ID doctors, our Critical Care doctors, and our hospitalists are getting information through their different portals on a daily basis that we share when we see something that's of interest that we think is of value. The fundamental important piece to that is that we look at it from a standpoint of the risk-benefit scenario. You know, is there a risk to doing a therapy that may not be well thought out yet or well-studied because all of this is on the fly. We're doing things very, very quickly as we learn and develop with the COVID scenario over the last year. Normally studies take months to years to fully vet and we are doing these things much more quickly to try to save lives and do the best we can and improve the quality of life for every individual that we treat. But we have to weigh into that consequence the risk of those therapies. We recognize that this is very unsettled, very uncertain. It creates a lot of stress. There's a lot of unknowns. And we as humans, we have a tendency in the face of the unknown to try to fill that void with some information, look for something that may sound too good to be true and you've heard me say before when it sounds too good to be true, it frequently is. So, some alternative therapies have been promoted by a variety of different people under a variety of different circumstances unfortunately they've gained some traction under some circumstances. But when you look at it from the standpoint of the body of individuals that are professionally trained and educated and involved in this, we look at it from a very different perspective. We look at it from the risk-benefit analysis and from the standpoint of what we already know about those drugs, how they should work, mechanisms and other factors, a lot of things play into this. And we discuss those things at great length, and we come to the conclusions about what we think is a reasonable risk to take and what's not and try to do everything we can to help save every life that we possibly can. When patients come to us or family members come to us very, very passionately with an alternative therapy we are more than happy to listen to them and talk to them about it, try to explain whether you know we can try that. It doesn't seem like there's much risk. It might be something that could be beneficial. We're happy to work with you, but in those circumstances where we feel that the risk is greater than the benefit and we can't convince the family or the patient to accept that we are obligated morally, ethically, professionally by oaths and every other circumstance to do the right thing for the patient under all those circumstances and we will continue to do so. Unfortunately, in some circumstances when we can't convince a family member or a patient to accept that, they may continually call our nursing staff, our physicians, others in the staff and really get to a point where it becomes an acrimonious distrustful kind of a conversation which helps no one. And so, I am asking that everyone understand that. That everyone be patient, recognize that we are doing everything in our power to do the best we can for every patient every day all the time and it's very demoralizing for our nursing staff and our physician staff to have an angry family member talk to us like we are trying to kill their family member because we are not willing to try an oral inhaled steroid or use hydroxychloroquine when we've recognized that that really does not seem to help and there's just a number of circumstances like that that have arisen that I feel it's really important to bring this to everybody's attention. And we will listen, and we will talk, and we will try to help everybody get to the same point. If you continue to be distrustful and not like it, I don't think it's in anybody's best interest for us to be engaged at that time and we will not continue to engage in those conversations. If you wish to pursue those therapies, you are welcome to reach out. I'm sure somewhere in the country you can find somebody who'd be willing to try something that's not well agreed to by the vast majority of healthcare professionals. And if you

want to go to those facilities and get that care you may, but within Midland Health we are going to continue to practice best care, best management, continue to evolve going forward to do things that we learn are better over time and we are not going to change from that practice. So, thank you for listening to that, but I think it's very important.

The second point that Russell asked me to talk about briefly was the information you've been hearing over the last couple of weeks about these new strains of the virus that have cropped up in Europe with one strain and another one in South Africa. We talked about this briefly at our COVID Steering Committee meeting yesterday and in that meeting the Infectious Disease doctors and a few of the others that have been reading the most recent literature on this brought up that in both cases there's been some modifications, mutations if you will, to some of the protein structures that are on the spike protein that you've heard us talk about. The spike protein is the means by which the virus can communicate with our cell walls and attack our cells and get into our cells. And it seems that because of the spike protein modifications in these 2 new strains, they are more highly variolated or transmissible. In other words, they get into the cells more readily and more easily, maybe 50% - 75% more readily into the cells than the previous strains. I want to give a couple of kind of caveats to that, there's no information whatsoever that they are more dangerous viruses and once they are in the cell, they are not likely to be any higher mortality or higher risk of hospitalization than any of the other ones. There's no difference in that regard. It's the same structure inside the cells. Also, these kind of variations and these mutations or migrations of viruses are very, very common. This virus has been out for a year. Mutations occur on a regular basis on viral-- Many times, they are lethal, you know, and it will kill off the virus. Sometimes it may make it less susceptible in getting into cells. In these particular 2 cases that have been identified, they're getting into cells more readily. Another point to that is that you know the reason they found them is they looked. You know if you turn over a rock, you'll find stuff and in these circumstances in South Africa and in the UK and in other places in Europe they did molecular testing of these viruses and recognized that they had new strains. It's very possible that there's other strains out there that they just haven't gone to that great length of doing the molecular testing to determine that. So, a lot of information out there. I'm sure you've heard some of it. It's very likely that the vaccines that we have will manage these new strains just like they are the current strain. I don't think there's anything for anyone to worry about other than the fact that we have to continue the mitigation strategies that we've been talking about from the day one of this: masking, social distancing, etc., and even more so when you have a strain that's more transmissible than previous strains.

Thank you.

Moderator: Dr. Wilson, the first question is for you.

Dr. Wilson: Sure.

Moderator: CBS7, whenever you're ready.

CBS7 reporter: I was trying to catch you doc before you left the podium. First of all, thanks for all you're doing. Of course, we all appreciate the hard work you and the staff are doing at MMH. My question this morning is have you ever in your career had to deal with let's just say a local doctor who's very passionate about this alternative treatment that he has come up with, calling it a silver bullet, insinuating that it's a cure, and promoting it so heavily that you're having to deal with people are bringing that information with them to the Emergency Room (ER) and instead of saying please help me

and treat me, they are saying, "I want you to do this to me. I'm not an expect, but I heard this works, and this is what I want." Have you ever had to deal with anything like that before?

Dr. Wilson: I've never had to deal with anything like a pandemic before, of the magnitude that this pandemic has been. So, I think it accentuates every human emotion and every behavior that we've seen. I've seen through the course of the last year a lot of things that just sort of remind us that we are human beings, and we want answers, we want solutions, we want a quick fix. And the reality is what we actually experienced. And it's not that simple and that quick and rarely is. And unfortunately, in this circumstance you know with some of the therapies and the interventions, I think you're referring to the oral inhaled steroids, there's no data to support its use whatsoever and there's some information suggesting harm. And we've had patients in the hospital, multiple patients I've submitted something to our PR folks here at the hospital here that I hope we will be getting out to you guys in the near future that talks a little bit about the number of patients that we've hospitalized that are on the cure treatment as you described it and many of them, you know over 50% of them have died on the therapy. And it's sad, but you know you are going to have people that you know latch onto something like this. You know I liken it to you know we had the recent holiday and the Christmas Vacation movie, and I remember Griswold, you know he was out there doing all his lights in his yard and doing all that kind of stuff and he can't get them to work and he's getting really, really frustrated. And in one moment of complete frustration, he just takes the two you know prongs to his electrical cords, and he slams them together at the same time as his wife is flipping the switch in the back of the house and the lights go on miraculously, he thinks he's found the cure. And in reality, it came from something very, very different. And you've got to take the time to look at all the different pieces of something like this, not just jump to conclusions because you see one good outcome and just assume that that's the reason. It's sad, it's dangerous, but it's out there. And now we have other prominent citizens promoting it as well. It's just wrong, but you know, what are you going to do. So-

CBS7 reporter: Do you think social media has made your job tougher in this pandemic?

Dr. Wilson: Oh, social media has a great role I think in kind of communicating a lot of information to a lot of people about a lot of different things and it could be good or bad. And in some circumstances and unfortunately, I would like people would be critically thinking and if you hear something that sounds too good to be true, look it up. You know go get a real reference and read it. Don't just trust anybody who says anything. If people would just use your intelligence and look up information appropriately you can usually find the best answer at any given time. Yeah.

CBS7 reporter: Thank you, Dr. Wilson. Appreciate you.

Dr. Wilson: Of course.

Mr. Meyers: I think we have to try to work more National Lampoon references into these conferences. That will certainly improve the atmosphere. Any other questions?

Moderator: Scott, did you have any other questions for Russell?

CBS7 reporter: No, ma'am I'm good. Thank you.

Moderator: OK.

CBS7 reporter: Oh, well I do- Russell, how frustrated are you about the question of when are these vaccines going to get shipped and then on top of that just getting a handful of doses every time?

Mr. Meyers: Well, you know, the whole thing is frustrating for everybody who's involved around the country and it's not for lack of effort on the part of some people who have nothing but the best interest of our communities at heart. The challenge that we- I mean we tend to focus on our relationship with the state because that's where we get the vaccine. The state has control of the allocations. They are totally dependent on the Federal Government's delivery of vaccines to the state for then redistribution. They can't control that, so I think we all have to recognize we control what we can. We are trying to get prepared for something that's relatively unknown while you know trying to influence the state as much as we can to recognize that we are capable of doing more here, getting vaccine out to more people faster if we can just get the supply. So, yeah, it's a little frustrating, but like everything else involved in the management of this pandemic, we're all making it up as we go. And the state is no different. They are doing the best they can with the information they have. I got some encouraging information this morning about some tweaks in the allocation methodology that may get the vaccine flowing in larger quantities to entities like us who are able to deliver it in larger quantities. I hope that plays out. So, I think if you chose to get down ever time that something was less than perfectly planned, you'd be frustrated all the time and I think we've chosen optimism and to look at what we can control and to control that and to continue to deliver a consistent message to the community, to be honest and forthcoming about what we know and what we don't know and that's what we can do, and we'll continue to do that.

CBS7 reporter: Last question, is there any talk about using the National Guard like we did for testing to help you guys do vaccinations as well?

Mr. Meyers: I haven't had any conversation about that, and you know as I was just saying until you know that you have vaccine to give it's very difficult to line out the resources and have them standing by. You know it'd be a waste of resources to have multiple vaccine sites set up and the National Guard on hand when we don't know when the drugs are coming. With that said we've been very successful in delivering large quantities of vaccine within the hospital and can do more than we have done. We have also talked with the city. We would expect that people like our outstanding fire and EMS service, the staff at the health department, we've talked to Midland College about the possibility of using nursing faculty and students. I think there are a lot of good resources available here to deliver on a mass vaccine program if and when we can determine that we can get the vaccine. So, we probably don't need the National Guard. Of course, if they dropped 100,000 doses on our doorstep and said get this done in the next week then we'd need a lot of help, but I don't see that happening and I do think that we can manage much greater quantities than we've had available to us. So, we're looking forward to getting more information in the next week or two and very hopeful that we may be able to execute something like that with our local resources.

CBS7 reporter: Russell, that's all I have. Thank you. Thank you, Erin.

Moderator: You're welcome. Tasa, before we get to your Facebook question Kate Porter with CBS7 has a question. Kate, go ahead.

Kate Porter, CBS7: I'd just like to ask if anyone at the hospital who's be vaccinated has had any adverse reactions that you know of.

Mr. Meyers: Well, there's you know there's a range of impacts of the vaccine. Nobody has had an allergic reaction that required intervention. Those are extremely rare. It's not never, but very, very few of those have happened. Of course, when they do happen, they get a lot of attention. So, those allergic reactions that are severe have not happened. It is common and just I'll use myself as an example. I got my second dose of the Pfizer vaccine the day before yesterday. And yesterday I didn't feel great, you know. It wasn't unmanageable. I was here at work all day and went home and rested and this morning I woke up feeling fine. That's pretty common as we understand it and especially in the 2nd dose. So, we've had a number of reports of just minor, minor. In my case I had some chills and I felt a little bit fatigued. And it you know it passed. I took a couple of Tylenol and it went away. We've been told to expect that. And the other thing on a positive note, we've been told that that's an indication that the vaccine is working. That your body's reacting to it, getting a little bit of a dose of what the symptoms of the illness might be like because your body is reacting and building antibodies. So, it is a good thing. It is happening pretty frequently. But it's not severe. It's very manageable. It does reinforce the need for us to plan well when we are giving vaccines. If people are going to potentially be a little bit down the day after they get their second dose it's probably a good day to be off if you can possibly schedule it that way. And so, we've been working in those terms, otherwise no big deal so far. It's been very successful.

Kate Porter, CBS7: Thank you.

Moderator: Tasa, whenever you are ready.

Tasa Richardson, Midland Health Public Relations Manager: Ok. Will the hospital be giving vaccine to people in the 1B group?

Mr. Meyers: Well, we don't have vaccine to give yet. We have given it to a few of the people in the 1B group. As we were administering our first round of Pfizer vaccines, you know one of the challenges logistically here is when you open a vial, you know you thaw it out from the super low temperature storage environment it's required to be in you have a very limited amount of time to give all the doses in that vial. And because people have been coming into the hospital kind of sporadically, we have here and there pulled in somebody we know to be in the 1B group and said you know we've got vaccine open and available if you show up in the next hour you can have it. So, there's a few of those, but by in large our systematic process has been to get caregivers and first responders vaccinated and we've done that and we're doing that now with the second round of the doses. We will be thrilled to give vaccines to the 1B group if we can get it. That certainly is the next group we would target. We also know the component of that 1B group is the nursing home population. There's a whole separate plan for them that's being executed by the large pharmacy chains under contract with the Federal Government. That is going on and as I understand it will continue to go one for another week or so and then they'll be finished and the vaccines that are being allocated to that process will then become available for the more generalized distribution a couple of weeks from now. So, hopefully that means our vaccine allocation goes up and we can begin to do more for that larger 1B group in the community.

Tasa: What is the current MMH visitation policy?

Mr. Meyers: Current visitation policy, we are back to allowing a visitor for every patient non-COVID, we don't allow COVID patients to have visitors. The infectious nature of the disease and the requirement for isolation just doesn't allow for visitation, but every other patient in the hospital, both in and outpatient, ER patients. The only exceptions being endoscopy and the outpatient treatment center

where we don't have a private space for a family member to be. There's a congregate waiting area which is not safe, but otherwise if you are coming to the hospital, you'll be able to bring a support person with you. If you're a pediatric patient you can bring both parents, if you're an OB/Labor and Delivery patient you can bring 2 support persons one of those can be a doula if that's your choice. So, this is as wide open as our visitation policy has been through the course of the pandemic. And we're hoping to keep it that way. Of course, if you're at the end of life, even a COVID patient at the end of life we've made special arrangements for those families to have brief visits as well.

Tasa: Erin, that's all the questions we have from Facebook.

Moderator: Ok, Russell, thank you.

Mr. Meyers: Thank you.