



Russell Meyers, CEO of Midland Health

COVID-19 Public Briefing: Thursday, June 25, 2020

Transcribed from a previously recorded live event.

Midland Health's portion included. Report and Q&A from the Midland Health Department not included.

Mr. Meyers: Good morning. I'm Russell Meyers, CEO of Midland Health. And we are here today for the Coronavirus update for Thursday, June 25th. We're going to take a little bit of a different direction today. We're fortunate to have Dr. James Humphreys on the line with us. Dr. Humphreys is the Medical Director of the Midland Health Department. And I'm going to allow him to make some opening remarks and I would imagine he will probably take some questions and then I will proceed with a report from Midland Health.

--Midland Health Department's comments not included in transcript--

OK, well I'll proceed now with the report from Midland Health. We'll start talking about testing. There were a couple of questions there about testing that I'll try to address a little bit. It's a little difficult for us to track the exact numbers of positives given that there's some retesting going on, but we think we're probably in the 10% range and it appears in recent days to be slightly trending up. So, there was a time when you look historically where the numbers were considerably below that. So, 10% is probably a pretty good benchmark for the number of positive tests. We are also seeing as Dr. Humphreys described, the numbers he was quoting I believe were probably daily numbers that certainly the component that was our drive through testing lines up well with what we've been doing daily lately. Those numbers are up considerably, and we are actively working on establishing a second drive through testing site which we hope to be able to talk to you about in our next conference which I believe will be Monday. So, we are working on that now and hope to have that confirmed soon.

You've been given the numbers from the state, I'll give you a little bit on the hospital. Our testing is for the most part turning around still in 2 – 4 days. We right now have 153 outstanding tests and the oldest of those was from this past Monday. So, we're still within that typical time frame. The hospital census is 162 this morning. We have a total of 20 COVID patients in the hospital, 6 of those are in critical care. So, those numbers are continuing to trend upward. You may recall at the worst of it we were at a total census of 32. As recently as last week we were down to 3. So, from 3 to 20 is a week is a pretty alarming growth rate as we've seen across the entire state. We are continuing to have that experience as well. But the majority of those are skewing younger. They are not as likely to be in critical care, but we are still experiencing a good amount of growth. Ventilated patients, there are a total of 7 in the hospital. Of course, we have 44 ventilators available, so we're in no danger of running out of ventilators. We do have a pretty substantial critical care population now. A total of 20 patients in critical care counting the COVID patients. Our base capacity for critical care is 24, so we're closer to our capacity than we've been in quite a while. We do have contingency plans to add additional critical care capacity should we need it. But we are getting close to the original capacity. The ER volume continues to be surprisingly low. 113 patients yesterday. The same day last year had 201 patients. So, we continue to see people staying away from the emergency department (ED) and while we understand and appreciate that people are staying away for minor illnesses and primary care, we continue to want to emphasize with everyone in the community that if you have what is in your mind an emergent



condition especially if it's chest pain, symptoms of a stroke, a traumatic injury, severe abdominal pain come to the ER. Do not hesitate. Don't wait. It is a safe environment, perfectly safe for you to come to the ER. Obviously, we are at a low volume point so you shouldn't have a long wait, but most importantly, don't allow what's a legitimate emergent condition to get worse to endanger your life. That's not what we should be doing at this time. If you think you should come to the ER, then please do come. That's our census numbers.

A few other things that I think are important to point out, we were talking yesterday about our employee exposures. Since the beginning of this, we've had 9 total employees who've turned out to be positive for COVID. That's a pretty small number relative to the 2,000+ that work for us. Two of those have recovered and 7 of them are still out and being monitored by our employee health team. As things spike, we are reconsidering a lot of things that we had relaxed during the course of the last few weeks. One of those is working from home. We had 60 or so employees in non-clinical work who were regularly working from home and could do their jobs effectively from remote sites. Many of them have been brought back into the hospital as we've reopened and gotten somewhat back to normal. We are now revisiting that and probably will be pushing some of that same group back to working from home in the days to come. So, that's an important point not just for the hospital, but for other businesses locally. I talked to one yesterday who was looking for advice. And I think if any of us who have the ability to work from home, who can be fully productive in an environment away from our workforce and away from other people that's good advice and we should probably be reconsidering whether returning to working from home is worthwhile for our businesses.

As the population of COVID patients ramps up, we are beginning to experience some concern with PPE specifically gloves and isolation gowns in that category. And probably the most concerning thing and the strangest really is a shortage of swabs. The long q-tips that are required to capture a nasopharyngeal sample to test patients. Those have been very difficult to get. Each of laboratories has its own particular type of swab that's required. And we're using multiple laboratories now because there's so much testing going on. So, we are concerned and continuing to seek new sources for swabs for testing.

As I said earlier, we are actively working on establishing a second testing site and/or extending the hours of the site we are running now. The demand is growing. We continue to be following the CDC guidelines and testing only patients who have some amount of symptomatology. We are not open to all comers. We are not saying just come on if you want to be tested. You have to have some reason to be tested. At least one or more of the symptoms that have been quoted, fever, shortness of breath, cough, malaise, nausea, loss of the sense of taste or smell, and an exposure to someone who has active disease. So, we're continuing to keep our testing site open, but we're also actively working to make another one available.

Elective procedures were one of the things we took back to normal status a few weeks ago and we are still in a relatively normal procedure access point at this time, but we are actively talking about it every day. Our surgeons will meet today in fact to talk about surgery volume. As the census goes up, as we have more and more COVID patients and they spill over into additional units; we now have 2 dedicated medical units and a dedicated critical care area; it becomes more and more difficult to put elective inpatients into available beds. And so, we are going to be talking about this on a regular basis. We'll talk about it today. Do we need to dial back any element of our elective procedures to recognize that beds are becoming more difficult to get? That's something that Dr. Wilson has led, and we've been very

diligent in staying on top of it. But as the numbers go up, it obviously changes our perspective a little bit.

Perhaps the most meaningful thing that we are doing right now is returning to our more restrictive visitation policy. Effective at 5:00am tomorrow, we will return to a policy of zero visitors, so no accompanying visitor with most of our patients. For several weeks now we've been allowing one visitor with every patient, inpatient or outpatient. We are rescinding that and so going forward there will be no visitors allowed with any inpatient or outpatient unless they meet one of the exceptions. The exceptions are: for patients who are actively dying or who are near the end of life and need family opportunity to be with them at the point of death, patients for whom another person is responsible, an incompetent patient who requires a family member or a guarding to speak for them, a pediatric patient, a labor and delivery patient actually can have 1 support person and a doula, the individuals who assist with coaching through the labor process. The labor and delivery population really is the only place we can have 2 people at a time, one of them being a doula if the patient chooses that. Otherwise, we are eliminating visitors for now and we'll continue to reconsider that policy as the numbers change. If they go back down, we will certainly reopen as soon as we can. That impacts the way we are handling our entrances as well. Nothing's really any different for patients and visitors. All patients and visitor traffic for whatever reason, if it's coming to the hospital, must come to the ED entrance. There's no other way in. We will screen those patients. The patients will be given a mask. In the rare occasion where a visitor is appropriate, the visitor must bring a face covering of some sort or will not be allowed into the hospital. No visitor will be allowed into the hospital if they are sick, if they have a fever, if they have any other symptoms. We will not allow a visitor under 18. Patients under 18 are ok and a parent can come with an underage patient, but no visitors under the age of 18. So, we are trying to limit the potential for exposure of our vulnerable patient population, of our limited workforce trying to be as careful as we can and returning to those visitor limitations that we experienced early in the process. I'm sorry to have to do that. And I know that's a burden for many people in the community, but it is something that we feel we must do for the safety of our patients. I believe that is all the remarks that I need to make this morning and I'd be happy to take questions.

Tasa Richardson, Midland Health Public Relations Manager: Ok, we have some clarification on the visitor policy.

Mr. Meyers: Ok.

Tasa: That was 5:00am tomorrow?

Mr. Meyers: That's 5:00am tomorrow. That's correct.

Tasa: Then could you go over the exceptions one more time?

Mr. Meyers: I sure can. The exceptions to the visiting policy are just a few. I'll read from the policy just to make sure I get them right. The first is government personnel. If we have a surveyor from the state department of health of course they'll show us a badge and we'll allow them to come in. Adult family members of end of life patients who are actively dying. So, if there's a patient here who is near the point of death, we will allow family members to come and say their goodbyes to the dying patient. Mothers on the labor and delivery unit may be allowed 1 support person, typically a family member and 1 doula if they choose to have a doula during the process of labor and delivery. Once they have

delivered, they may still have 1 support person while they are an inpatient with their baby on the Mother and Baby Unit. Pediatric patients may have 1 parent or guardian with them at all times. And they may switch out if the parents want to do so. And in the case of pediatrics, 1 parent may spend the night with the patient at their discretion. The visitation for the Neonatal ICU (NICU) that's governed by a whole different set of guidelines and if you happen to have a patient in the NICU, then the staff there will guide the parents and the family members as to what visiting can be allowed in the NICU. I believe that's all the exceptions. So, that means outpatients if you're coming here for surgery or endoscopy something that requires anesthesia, we do require those patients to have someone available to take them home. And so that support person will be asked to wait outside the hospital in their car to share a contact phone number with the staff in endoscopy or surgery and they'll call you when it's time to pick your patient up.

Tasa: Thank you. We have a question from Shane. Shane, go ahead.

Shane: Ok, it may be a question more for the county, but I wanted to ask when you guys account for like all the patients who have tested positive, do you also account like the probable cases? Like the folks who were contact positives and antigen tests and things like that? And are you guys planning on making those available in the future, if not?

Mr. Meyers: Is that a question for the health department? Dr. Humphreys if you're still on you could unmute and try to answer if you'd like.

Dr. Humphreys: We do. Shane, we do count probables as positives from whatever source at this point. Yes.

Shane: Oh ok. In the future would you guys be able to divide up those numbers so we can see which ones came back from just positive tests results and which ones came back from those other antigen test or things like that just so we can understand the data a little more?

Dr. Humphreys: We could look into doing that, sure.

Shane: Ok, great.

Tasa: Thank you, Shane. Thank you, Dr. Humphreys. We have a question from Caitlin from the MRT. What department did the employees who tested positive work in and when did they test positive?

Mr. Meyers: There's no easy answer to that. They are from all over the hospital. What I quoted was the number of people who have tested positive from the very beginning of the pandemic. And so, they've happened at all different times, they work in different departments. As of now, we don't believe that any of them were exposed in the hospital. Their exposures have come in the community or based on travel. But they're not in any one area for sure.

Tasa: We have a question from Facebook. What are the current treatments being used by Midland Health?

Mr. Meyers: Well we do have access to Remdesivir which is available for patients for whom it's indicated. We're using convalescent plasma therapy with some success. Anything else that's meaningful? (comments off camera not able to be heard) Some of the patients is getting Decadron which is—is it inhaled? (asking someone off camera) An anti-inflammatory steroid kind of presentation.

You've heard some of the recent study from England which has a little bit of a shaky scientific base, but it at least sounds promising with regard to inflammation of patients who are ventilated and are critical. So, there's a little bit of that beginning to happen here. Those are the main ones.

Tasa: We have a question from Facebook. I've heard that if you test positive for the antibody test that that counts as a positive case and you are asked to self-isolate for 14 days. Is this true?

Mr. Meyers: I don't think that's true. The antibodies is-- As I understand it, the antibodies are an indication that you have probably been positive in the past and have recovered. So, there's no truth to that. When we test patients who are symptomatic, we are not testing for antibodies. We are testing for the virus. (comments off camera not able to be heard). Ok, the antigen test is different and actually is an indicator of a current positive status. The antibody test is not.

Tasa: Ok, we have a question from Sammi. Sammi, go ahead.

Sammi Steele (NewsWest9): Hey there Russell. I just want to clarify a few things on the capacity. You said the hospital's intensive care capacity is 24 patients and you currently have 20 patients. So, does that mean your capacity is at 83%? Am I understanding that right?

Mr. Meyers: 20 out of 24. If you've done the math that's got to be close. That's not our absolute capacity. That's our baseline capacity. Day in and day out we operate 24 critical care beds. We do have the ability—our entire 5th floor is actually equipped and capable of becoming critical care. We have another unit that we can quickly convert to critical care. So, we have multiple levels of contingency plan to expand that number, but as we currently stand in our base level of everyday critical care capacity it is 24 and 20 of those beds are filled.

Sammi Steele: And what is that max capacity if you use those other floors and other areas?

Mr. Meyers: Well, the first line is 48. The 5th floor has a total of 48 beds all of which have been equipped from day 1 as available for critical care and the second half of those, the other 24 are typically used as a step down. They are not quite as intensively staffed but still with heavy monitoring capability and that sort of thing. Then the next, as I recall the next level if we have to convert an existing med surg unit that was a 12-bed unit that we have prepared to convert. So, as we stand today 24 in operation. An additional 24 that can be easily added. And then 12 more for a total of 60 at the maximum. Now, that's physical beds. That's space we are talking about.

Sammi Steele: Yeah.

Mr. Meyers: Could we staff 60 beds of critical care with the people that we have today? That would be very, very difficult. We don't have that many surplus critical care nurses and respiratory therapists to suddenly expand to 60 beds. So, we would be scrambling to find staff to add that number of beds. But the physical space certainly is available.

Sammi Steele: And then just to confirm, you went from 3 patients in critical care to 20 in less than a week?

Mr. Meyers: No, that's not quite right. Last week our lowest point in total patients, not critical care, but total COVID patients was 3. And as I recall that's like 1 critical care and 2 medical. Today, we don't have 20 COVID patients in critical care. We have 20 total patients. Six of those 20 that are in critical care

today are COVID positive. The other 14 are there for other reasons. So, we have a total—The numbers get confusing. We have a total of 20 COVID patients. Six critical care, 14 in medical surgical environments. But when you look at the universe of critical care, we have 20 patients there. 14 non-COVID, 6 COVID. They kind of overlap.

Sammi Steele: And so last week it was 3 total patients, not COVID just regular patients and then now you have 20 of both?

Mr. Meyers: Last week at the minimum we had 3 COVID patients, today we have 20. That's right.

Sammi Steele: Ok, ok.

Tasa: Ok we have several questions on Facebook and then as well from Caitlin from the MRT regarding mask mandates. And the exact question from the MRT is, can you also address if you think Midland's leadership should consider a mask mandate?

Mr. Meyers: The problem with a mask mandate in my mind is enforcement. And I think that's a concern that we've heard the mayor express as well that you know it's fine to say that everybody has to wear a mask, but I think it's very difficult for us to suggest that the police force or others be deployed specifically to enforce a mask mandate. It's also sort of amazing to me that we have to tell adults in our community who are witnessing these explosive increases in positive cases everyday that they must wear a mask. We should all use our good sense, listen to the experts that are talking to us, recognize that we both protect those around us and to a lesser extent ourselves when we wear a mask in public. Fundamentally, if you can't be at least 6 feet away from everybody else around you you should have a mask on, period. That's non-debatable. That's clear. It's been indicated for a long time. It continues to amaze me how few of us are taking those precautions. And I don't think that a city mandate is going to change that a whole lot unless we have the personnel, the manpower to enforce it which I don't believe we do. I think most cities don't. This is a personal responsibility question and its past time for us all to step up and take that responsibility.

Tasa: We have a question from Facebook. If a person needed a test today, how many days would they have to wait before they could get it?

Mr. Meyers: If you are talking about in our drive through testing center, probably next day. Yeah, they've gotten very busy and we're certainly trying to add capacity to make it easier, but if you ask us for an appointment today, we could probably get you in tomorrow. And then you'd have to wait somewhere between 2 and 4 days for results. All we do at our testing site is take the sample, prepare it to be sent off to the outside lab, and then we are dependent on the outside lab to turn those results around as soon as they can. So—not open on Saturday and Sunday. It's a Monday through Friday operation. So, if you call us Friday, we can probably get you in Monday, no later than Tuesday.

Tasa: We have another question from Facebook. Is there anywhere to get a free test?

Mr. Meyers: Well, we are not requiring people—There's all kinds, I've seen all different kinds of pricing structures depending on where you go. Freestanding ERs and clinics in town may be asking patients to pay up front. We are not doing that. We are taking your insurance information and billing that if you have insurance. If you don't have insurance, you're going to get the test without payment. We are not



asking for payment up front in our drive through testing site. So, I don't know that that's necessarily free, but we are not asking you to pay at the time of service if you come to our site.

Tasa: Is 68-NURSE honoring doctors' referral orders for a test?

Mr. Meyers: (comments off camera) Do you want to talk about that? I don't know anything about how that works. Dr. Wilson's going to take that one.

Dr. Larry Wilson (Vice President, Medical Affairs): Good morning and thank you. So, the question is about how would a physician or a provider call and schedule a test I'm understanding. Is that correct? So, there's a separate number that any providers, physicians can call and explain the circumstances around a patient needing to be tested. Russell had mentioned that our testing site will not test asymptomatic persons, but if a provider calls and explains some historical events that might put a person in particular risk or have some particular concerns in some circumstances under those directives we might allow them to schedule a patient to be tested. But again, that's a separate number.

Mr. Meyers: And that number is for providers to call. Not the general public. So, please don't use that if you're a member of the general public. If you're a physician or a community provider of some other sort that's an appropriate line for you to call to register your patient or to schedule your patient.

Tasa: Given the diverse symptoms, how can you tell that someone is actually recovered?

Mr. Meyers: There are rules for recovery. Some number of days free of fever. Dr. Wilson's going to come save me from myself before I try to get through these.

Dr. Wilson: This is again, that's available at the CDC or the Texas.gov websites for your own information. But once onset of symptoms, one must be 10 days out, and then have 3 days of no fever without using any anti-fever therapy, as well as reduction in other symptoms. And that's considered a time-based clearance or recovery if you will. One can also be tested with an RNA PCR test and have a negative test after presumptive recovery from symptoms and that is considered a negative test too. So, they test positive while symptomatic and then feel as though they're recovered and have another test done that is testing negative and that's a test-based. So, there's both a time-based and a test-based recovery.

Mr. Meyers: That's much better than I could have done. Thank you, Larry.

Tasa: The governor has cancelled elective cases in other parts of the state. Is MMH going to cancel elective cases soon as well?

Mr. Meyers: I am not aware of the governor taking that action. I'll have to go and look that up. (comments off camera not heard) Oh, ok. Dr. Wilson's telling me he just did that this morning. So, well have to become a little better acquainted with what the governor actually did. I don't expect that to be a local governmental mandate, but our surgeons and our medical staff leadership are actively talking about that on a regular basis and they will talk again today. If we find that we need to dial back elective procedures, we certainly will start with those that are likely to require an inpatient stay. That's where our first concern is that as our beds get more full, we want to be sure that we don't do a surgery that requires an inpatient stay and then find that we don't have a place to put that patient after their surgery is completed. So, we'll be talking about that today. The answer may be different on Monday and we'll certainly talk about it some more the next time we meet.

Tasa: How many of the hospitalized patients are in their 20s and 30s?

Mr. Meyers: I don't have that information. Sorry.

Tasa: A follow up to that is what is the threshold that a COVID patient would require to be hospitalized besides just self-isolating at home?

Mr. Meyers: What causes a patient to move from self-isolating to requiring hospitalization? You know, I think it's somewhat your own assessment of your own body's ability to recover. It's increasing shortness of breath. I think that's one of the most important ones. Intractable high fevers. I guess those are the most important ones. (comments off camera not able to be heard) Here comes Dr. Wilson.

Dr. Wilson: So, the COVID infection as we've talked about in the past is generally a respiratory infection. But it's a viral infection that can affect multiple organs in the body and just like with any other illness when one reaches a point of feeling so sick that they're not being able to manage themselves comfortably at home getting checked out by their provider or coming into the emergency room for evaluation is an appropriate thing to do. So, under those circumstances then there's medical indications for hospitalization. As Russell mentioned respiratory, if there's an oxygen requirement for instance, then one must have oxygen supplied and that's a hospitalization requirement. Sometimes people become dehydrated or they might become just so weak or have neurological symptoms that they can't take care of themselves and that would be reasons for hospitalizations as well. And there could be a multitude of others depending on what organ systems are being affected. But it's a medical decision that meets a threshold and it requires hospitalization.

Mr. Meyers: Each of those is a judgement call of course on the part of the physician who's making the decision on the admit. Typically, the ER physician in consultation with the infectious disease doc or the hospitalist.

Tasa: A question in relation to the visitation policy.

Mr. Meyers: Ok.

Tasa: Would a father be allowed in the ER with the mother if the pregnancy is considered high risk and is experiencing pregnancy complications?

Mr. Meyers: That's an interesting one. The labor and delivery cut off rules are still at 20 weeks I believe. So, a patient who is 20 weeks or greater gestation and is experiencing complications is going to go to labor and delivery. And certainly, in that case the father can go along. At a lower level than that, I think that's probably more of a case by case concern. And so, that will be evaluated at the time of presentation. The staff will determine the appropriateness of the father's presence in the ER if that's where they are at a more shorter-term gestation. So, case by case. It's hard to give a clear answer to that.

Tasa: Another question regarding the visitation policy regarding an adult child-like minded. Want to know if she can be accompanied due to her state of mind?

Mr. Meyers: Well that's one of the criteria that if the patient—I may not have mentioned that one the second time through. Just to be clear, any patient who requires someone else to speak for them. The

patient has dementia perhaps or may be a child or a young adult whose mental development hasn't reached the point where they can speak for themselves and they require a guardian or someone with power of attorney to speak for them. All of those patients that require someone else to speak for them and make their decisions, that person may come with them no matter what the reasons for it are.

Tasa: With all the current testing being done, are all these symptomatic people?

Mr. Meyers: The testing we are doing by in large is symptomatic. You heard Dr. Wilson talk about if a physician has a patient that they need us to test for you know some collection of reasons that don't include symptoms, it may be severe exposure or risk that's usually high. There is a little bit of judgment that will apply there, but for the most part in our testing center we are only testing people with symptoms.

Tasa: Can we still be tested for antibodies?

Mr. Meyers: Yes. Antibody testing remains available at either the main or the west campus. We've published numbers you need to call. You do need to call for an appointment. You'll have to pay for that test. But it's readily available.

Tasa: Is the hospital experiencing any shortages in PPE?

Mr. Meyers: We talked a little about that at the beginning. We are beginning to see challenges with gloves. Some sizes of gloves have been a problem really throughout. We're broadening that now. Glove availability is becoming a little bit more questionable here lately. Isolation gowns periodically have been problematic. The more of them we use, the more we draw our supplies down and replenishing those supplies has never been very easy. So, we are concerned about gloves and isolation gowns. And it is not necessarily PPE, but it's an important supply item and that is the swab to do the nasopharyngeal sampling that we then send to the labs. Those swabs have been in great demand and our ability to replenish our supplies is a little challenged right now.

Tasa: If one family member in the home tests positive, can the other household members be tested even if they are asymptomatic?

Mr. Meyers: That's a case by case question. I think that's one you'd want to raise with your physician. We have, as I said and as Dr. Wilson said earlier, in unusual cases where it's a particular high risk it might be appropriate to test, but as a general rule we are still only testing symptomatic patients.

Tasa: Is the state helping provide backup PPE?

Mr. Meyers: We are in constant communication with the state. And they have been helpful here and there. They are not prepared to meet all of our needs, but they have been helpful. There are some stockpiles we've been able to access. There's some resources they can get that we cannot. So, we certainly are getting some help from the state, but that can't be our only resource. We are resourcing— We are talking to every potential manufacturer and vendor out there and distributor to make sure that we have what we need. The state is a help in that for sure.

Tasa: Have any recovered patients been re-infected?



Mr. Meyers: I don't know the answer to that. (comments off camera not able to be heard) None that we are aware of. Dr. Wilson's going to come talk a little further about that.

Dr. Wilson: Yes, I think Dr. Humphreys made a comment about some of the things are a little bit sticky to be able to define perfectly, clearly but we have identified some of the patients that we've had admitted in the hospital that appeared to be improving, in fact some have even gone home or back to a residence and then rebounded and came back in more ill again. But it was still in a time frame that would be considered related to the original illness within a 30-day window or so. So, everybody doesn't follow a track of becoming ill within 5 – 10 days, improving, fever going away, and being better within 14 days to 15 days. There's paths through the illness that can linger for 6 weeks or longer in some circumstances. And in those cases, I don't believe it's a re-infection. We have not seen anybody who has gotten ill with the infection, gotten well and back out in the community behaving, everything's normal for a period of time and then rebounding and coming back with another sperate infection. We have not seen that at all.

Tasa: Are the antibody test results being tracked anywhere?

Mr. Meyers: Not that I'm aware of. No.

Tasa: I believe we've had a lot of questions on Facebook. I believe we've gotten to most of them. A lot of duplicates.

Mr. Meyers: Ok.

Tasa: Please keep the questions coming. We'll be monitoring it all day and trying to answer those, and we'll be reviewing in case we didn't get to your question, but I believe that's all the questions we have for today.

Mr. Meyers: Ok. We obviously, the level of concern has risen in recent days. We are back to a fairly high level of infections and some additional restrictions beyond where we've been for several weeks now. And so, that's an indicator that we should be back in front of you regularly. And so, we will be back here Monday morning at 10:00. And we've scheduled one I believe for next Thursday as well, so we have at least 2 press and Facebook Live events scheduled for next week. We'll do more if we need to depending on the circumstances, but no less than those 2. I think on Monday we should be able to tell you some more about additional testing availability. We hope to have that all lined up and ready to talk about on Monday. And then anything else that comes up over the weekend we'll be prepared to talk about. One last comment that's not really related to COVID, but everything's related to COVID these days. We do have a sales tax election scheduled and the primary runoff elections are also scheduled. Early voting for those elections begins on Monday. Beginning Monday for the next 2 weeks headed for a regular election day on July 14th. So, if you haven't heard about that, please check with the county elections office for details and if you are a registered voter in Midland County please do vote in the next 2 weeks or on July 14th. Thank y'all very much.