



Russell Meyers, CEO of Midland Health

COVID-19 Daily Briefing: Thursday, April 2, 2020

Transcribed from a previously recorded live event.

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

Mr. Meyers: Good morning everyone. I'm Russell Meyers, CEO of Midland Health. And I am going to lead off today's Unified Command Team briefing. Today is Thursday, April 2nd, 2020. The days of the week are running together I'm afraid. I'd like to begin by echoing the mayor's remarks to our Chinese American community. Thank you all very much. You all know that PPE is a precious resource in this time in the hospital, for our first responders, for all sorts of folks who are taking care of patients. Every donation we get is a tremendous help. We thank you all very much. Lots of other donors have been very generous as well. We continue to see that. Every day now, weekdays, our hospital folks are manning a donation center at the Abell-Hangar Pavilion on Andrews Hwy. across the street from the hospital. We continue to get generous donations from all over our community. And once again we say thanks.

Some numbers to begin with today. Just short of 4,000 cases now confirmed in the state of Texas and 16 confirmed cases here in Midland County. In Texas there have been 58 deaths and only 1 here in Midland County so far. At the hospital we have a testing site that we've had up and running for several days now. Now have almost 400 tests that we have administered. The results for about three quarters of those are back. We are still waiting on a little over 100 exams. 13 of our exams have been positive. One of the things we have seen is that as we find successful lab testing facilities that turn around our tests quickly, they begin to get overwhelmed. They really perform for everybody. And then the turn around time slows down. So, over the last couple of days we have seen a slowdown in resulting and we are hopeful that that picks back up soon.

Census in the hospital is 117 today. We had only 84 patients in our ED yesterday, an extraordinarily low Wednesday. But that's been our pattern over the last couple of weeks. ER traffic is down significantly. In our critical care unit, we have 16 patients. We have now a total of 20 patients who are considered PUIs. 10 of those in our critical care space that's separated specifically for COVID patients. 10 more in the Medical Surgical unit that also is segregated for a total of 20. When Dr. Wilson comes up in a second, he is going to talk a little bit about a bit of a policy change we have for how we are cohorting patients. That's not necessarily representing a large increase in the number of patients, but rather a change in our classification system that he'll explain in just a moment.

Ventilators always of interest. We have a total of 9 ventilators in use in the hospital. 6 of those are patients who are on the COVID unit and 3 other patients are on ventilators. A total of 44 standard ventilators are available. So, 9 out of 44 plus we have another supply of 37 disposable or single use ventilators in addition to those. So, we still have an ample supply of ventilators. We've talked a couple of times about employees. Those who are being either monitored or quarantined because of some level of exposure. As of today, we have 17 employees who have been asked to stay home, self-report, self-manage, and work with employee health group to determine when they are safe to return to work. Most of those folks actually were exposed in some other way or they are being quarantined for some other reason besides exposure to a patient in the hospital. We now have 8 employees who have had



some level of exposure but are asymptomatic and are safe to work with a mask and protective equipment. So, we continue to monitor each of those employees every day.

As I told you a really significant increase in donations. We've been very blessed. We've also had some of our suppliers finally come through with PPE. As of yesterday, we are up to 138 days of available N95 respirators at our current use rate. That's about the highest number we've had since this crisis began. Of course, if the use rate goes up, those numbers go down fast. And we continue to be careful in managing access to especially N95s. But all of our PPE is carefully managed.

We've had an update in our management of our employees who are traveling. As you have seen the CDC recommendations for high risk areas have grown daily. And there are multiple cities now in the US in addition to many international sites that are considered to be high risk. And so, we put a rule in place asking our employees if they have traveled outside of this state in any way to any place, they are to check in with our employee health folks and be monitored for a while whether they are symptomatic or not. We are just trying to be as cautious as we can with possible exposure.

We heard a report yesterday from the state department of health services about a new study that had come out of Singapore where they were seeing evidence that people who were asymptomatic are able to transmit the virus. Obviously, some of that work is still preliminary. Dr. Wilson may want to talk about it some more. It's an opportunity for us to reinforce once again the vital importance of social distancing. Just because the person you are in the room with or standing behind at the grocery store isn't exhibiting any symptoms that doesn't mean that they're not potentially carriers. And the possibility of infecting you or your family is real.

Finally, to end my remarks I'd like to give a little praise and thanks to our environmental services (EVS) team. The people that clean the hospital throughout the facility, every patient room. These are people who are absolutely on the front lines. They've taken very well to the heightened expectations we have for disinfecting, for cleanliness in hospital. We've had virtually no housekeeping staff who've called in sick throughout this time period. They are dedicated, showing up every day on the front lines. Even training other employees who are not accustomed to doing cleaning work and how best to do cleaning and disinfecting where we have opportunities to use non EVS personnel. Thank you very, very much to our environmental services team. We are very proud of you. And we couldn't do it without you. So, a second for questions for me before I call on Dr. Wilson to give a medical update.

Question: I was reading yesterday that you commented that a portion of tests that y'all had requested for the hospital, not all of them have made it go through so far. That right now you guys are waiting on a lot more tests that you are wanting, but don't have access to yet. Can you kind of elaborate a little bit more about that situation?

Mr. Meyers: The question is about testing availability. And I think there are 2 different answers to that. One is there are 100 plus tests that are still outstanding that we've sent off to a remote lab. And they've had difficulty getting those results out. Some of the results are now over week old, as much as 10 or 11 days old. We continue to talk to them every day about getting those results. They are so overwhelmed that their backlog is continuing to affect us. The other side of that question is a test that we will be able to run on our own laboratory equipment so we have control of the whole cycle within our hospital lab. We had ordered about 1,000 of those tests after they were released by the FDA. Unfortunately, we were told yesterday or the day before that we were only going to get about 60 of them and a good half



of those have to be used in the calibration and quality control process. So, very, very small numbers of tests available to us that will be available to be run in our own lab. And so that's really not a game changing number. We remain hopeful that we may get large numbers of those tests available to us in the future. Here in the short run, we'll just have a handful of those tests to be used on our own hospitalized patients. And that really won't change our ability to test in the community.

Question: I also wanted to ask what is y'all's plans as far as financing all these tests. Does that mostly fall on the county or the hospital themselves or the patients?

Mr. Meyers: The question is about financing tests. The biggest answer to that is we have been given a generous donation very early in this process by one of our local foundations to finance testing. And so, I don't think we have any concern about the cost of testing at this point. We do understand there will be some government support as things go along. We have not taken any payment from patients. We have asked them for their information if they are insured to give us the ability to be able to bill their insurance later if that seems to be appropriate which remains to be seen depending on governmental funding. But patients have not been asked to pay anything up front for any testing and we expect that to continue. Ok. Thank you all very much. I'm going to call now on Dr. Wilson our Vice-President of Medical Affairs and Chief Medical Officer to give a medical update.

Question: Russell can I ask one question from our Facebook page?

Mr. Meyers: Go ahead.

Question: Can someone talk about the model UT has come out with about COVID-19?

Mr. Meyers: I can talk about that. Tasa's question from our Facebook watchers is about the model that the UT System- there are a group of social scientists who have been using a model to assess the pattern of the disease progressing through each of 22 or 23 cities in the state of Texas and a statewide model as well. We received that initial modeling yesterday and we are still digesting it. I guess the first statement is thanks for the team at UT-Austin led by Dr. Lauren Meyers who has provided this initial modeling for us. As we begin to think about what the worst-case scenario looks like, when that worst-case scenario might occur. This is the kind of data that would be very useful to us. We haven't really digested the data enough to be able to comment on it yet. Give us a couple of days. It will begin to inform some bigger picture planning probably both here and in Odessa coordinated together so that we can anticipate how many ICU beds are needed in the worst-case scenario. How many inpatient hospital beds? If it's more than we have how are we going to get those. That's work that's still going on right now and I hope to be able to comment on that probably next week sometime. I think it will be a few days before we fully digest it. Thank you. Is that all? Ok, thank you. Dr. Wilson.

Dr. Larry Wilson: Good morning. I'm going to start with Russell mentioned about with the COVID units and the PUIs and how we are designating them in the hospital currently. So, we've had, as you know and Russell alluded to as well, increasing information about the sporadic testing ability or the shedding of the virus in individuals. That asymptomatic carriers might be shedding the virus and exposing others to it. Even people that have the virus may be shedding on one day and not on another day so there's a lack of clarity on what's going on there. So, our PUI patients that come into the hospital and they are having respiratory difficulties or anybody who comes into the hospital with respiratory difficulties requiring critical care management they'll go to the critical care unit and if we think they might be a PUI patient

they'll be in the COVID ward of our CCU. Medically managed patients that don't require that level of care will be on our COVID medical unit. And when they have their initial COVID test come back if it's negative, they will remain there. We have been moving them out, cohorting them only if they're known designated positive test. We are recognizing that that may not be as accurate as we'd like it to be. We don't want to expose any our staff unnecessarily if we find out later that somebody who was initially negative turns out to be positive. So, it's going to increase the numbers over time in those units and as long as the patient's in the hospital we are going to be keeping them there for the time being. So, we're going to be mentioning that. We are doing some other preliminary assessment. I think I might have mentioned yesterday also. That we're going to do serial testing on a group of patients that are coming into the hospital to see if they're negative on one day positive on another day. Or if we can truly believe that that first day of negative is true a negative and we're negative throughout or if we need to test 2 days in a row. We're just trying to sort that all out for ourselves, so we have the best information we have. And we protect our population the best we can. A point to that also is this uncertainty about when somebody might be shedding or not shedding. I want to go back to a point we made a day or two ago about masking more regularly that that can help improve this social distancing. So, if I'm standing 6 or 7 feet away from somebody and I sneeze there's water droplets that will spread into the air and they may potentially be exposed. If I'm masked, it will dampen that. So, it's common sense. It's not going to prevent the disease. I hope people recognize that wearing a mask around in the community is not going to avoid getting exposed, but the social distancing piece of that is the most important part that will help decrease the spread of water droplets into the air. I think that's the take home message from that piece.

The last few days I've been hearing increasing information and I think there's some question about convalescent serum antibody testing, more rapid testing availability. And there's a lot of hope associated with that. The American ingenuity is phenomenal and we're going to get information more readily and more rapidly. The importance of the antibody testing is we can determine then if somebody's been exposed previously, they've developed immunity. And then those are persons that in 2 ways it's very helpful: 1) their serum can help provide antibodies to another individual -this convalescent serum therapy that's being initiated in the United States now. The other way that it's really helpful is that we can recognize if somebody is immune, we think. You know just like a vaccination would provide. So, if they are tested and they have antibodies they're safer in a sense to work. And the more people that develop antibodies the closer we get to herd immunity. So that in our community there'll be enough people that are unable to spread the virus and so we can reduce the risk to those that aren't that protected. And we hope that with that and with the dampening that goes along with social distancing, etc. that we can ride this out. Keep it at a slow burn, rather than an accelerated burn that we've seen in other parts of the country. And get to the point that we have a vaccination and be able to get everybody protected and put this behind us once and for all you know. But all those things are promising. All those things are very helpful, but there's only a singular thing- a singular thing that's going to stop this disease in our community right now. And that's social distancing, shelter at home the best that you can. Recognizing that we all have limitations in the ability to do that, but if you have to move out into the community do it thoughtfully. Stay separated from others. If you go to the store and you see people aren't following that. Find another store. The social distancing piece of this is going to protect us more than anything else for the foreseeable future. Think about this one point. If we were able to have 100% social distancing. Everybody stayed 10 feet away from anybody else. Anybody with

the virus was self-isolated until they were symptom free, we could kill this virus in a month. It can't survive by itself. It needs a host. It only lives in a host for a certain length of time. Then it goes away and they recover, or they have the healthcare issues that go along with that if they end up in the hospital that 15%. But in a month, you could shut this thing down. Now is it possible to have 100% success in social distancing? No, it's not. But the closer we come to that the better we can do in putting this thing behind us. So, everything everyone can do to help us with that please work on it. That's my spiel. Any questions?

Question: Dr. Wilson, we have one from Facebook. Does the viral load a patient gets in exposure dictate the severity of their case?

Dr. Wilson: There is some thought to that. A couple of comments to that. One, it takes a certain viral load to get infected. If you get a small inoculum you could not get infected. And the larger the load, the more regularly you're exposed the higher the risk. But I don't believe there's enough information to say whether or not a specific viral load will make the infection more severe. Because remember how viruses work. They attack cells, particular cells in this case the lower respiratory tract and then they insert their genetic material into that cell and basically take over the cell's machinery killing the cell. So, it ultimately produces itself and makes more virus. And then it lyses the cell and goes out into the system and attaches to other cells with the new little viral particles. So, that's a phenomenon of viremia. You know where the cells lyse, and they release more virus. That's when you spike a fever and you feel sick. And then it attaches to more cells and it gets quiescent for a little while it takes over the machinery and it recycles like that for a few times until we hope you develop an immunity and it goes away. So, once you get an inoculum that allows an infection to start depending on the individual's immune system, their vulnerability to the infection, etc. it's going to propagate more or less. And so, I think it's got more to do with how hospitable a host you are versus the viral load that you get to start the infection.

Question: How common is it for a false negative?

Dr. Wilson: That's the comment that we've had over the last several days and it's really unclear. I'll say this. The preliminary tests that we do, the PCR test is probably very, very accurate if it's got the virus on the swab and you run the test on that viral swab. It probably works 97% of the time as most of the studies are suggesting. The problem is- Are you shedding? Are you getting a good swab? Are you getting it from the right location? The data we talked about a little while back, nasal swabs may be 63% effective. And so almost a third of the time you'll get a false negative.

Question: Can you tell a little more about how the shedding process works and how your body may or may not be shedding at a time, I guess?

Dr. Wilson: No. I don't think we really understand that. You heard me commenting there about how the viruses attach to cells and how they move through the body, etc. And there's going to be times when there's going to be a larger viral load available in the respiratory tract and other times when it's really in the cells doing its machinery to take over and it remains unclear. There's increasing information about asymptomatic people so before they've ever been sick shedding virus. And there's information as I mentioned before about patients that on one day might test positive and another day might not. So, it's how, and why- I wish we knew. Alright, thank you.