



Russell Meyers, CEO of Midland Health

COVID-19 Public Briefing: Tuesday, July 7, 2020

Transcribed from a previously recorded live event.

Mr. Meyers: Good morning everyone. I am Russell Meyers, CEO of Midland Health and this is our Coronavirus update for Tuesday, July the 7<sup>th</sup>, 2020. Starting with some statistics across the state of Texas we are now over 200,000 confirmed cases of COVID-19. 2,655 deaths in the state. Here in Midland County, 927 was the last count with 17 deaths so far.

Testing remains in large quantities and challenging to get turnaround times back. The testing that the hospital's doing in our testing site we now have 176 cases still outstanding, several days' worth of tests. One of the things we've seen over the last several weeks now is a growing percentage of positive tests in the neighborhood of 30% now over the last 4 weeks. That is not a universal statistic. We don't know about everybody else's testing, those are just the hospital's tests, but that is an interesting and concerning trend over just a few weeks' time now in this second peak.

We are almost ready to go live with our new testing site. We've been talking about that now for several times and it has become quite challenging to get this thing live with implementing a new rapid testing device which we are ready to go with that. We are getting the site ready. Getting it staffed has been a challenge for us, but we are confident that this week we will be able to wrap all of that up and get going with a second testing site and with the implementation of rapid testing so that we can relieve some of these multiday turn around challenges that we are facing with our existing testing.

Continuing on with the hospital census activity, 170 patients in the hospital this morning. We have 9 patients in the regular critical care space and 10 in the COVID critical care unit. So, our critical care capacity is more challenged than it's been in a few days. We have 24 beds of regular critical care capacity, so we are not there quite yet, but we are getting closer. The total COVID census now is 29. That's the highest it's been for several days now. 10 of those in critical care and 19 in the medical units that we have assigned for COVID patients. So, those are trending up a little bit. Despite that, we are continuing to remain on track with surgical cases, but that becomes a day to day assessment, conversation with our surgeons. A lot of cooperation happening there still and as the census grows, we will be challenging that every day.

I'd like to bring Kit Bredimus forward for just a second to talk about a little bit about our surge capacity plans that we have in place as the census grows, if we have to assign new beds and shuffle patients around. Kit knows that plan better than anyone else. I'll ask him to come talk about it. Kit—

Dr. Kit Bredimus, Midland Health Chief Nursing Officer: Thank you, Russell. So, in planning for these surges, again I had mentioned previously that we have different populations that we have to plan for. So, one is just a general population of surge patients that come in for non-COVID related issues. The second is going to be a critical care population of COVID and a med. surge population of COVID and as we know they can kind of transfer back and forth between those two groups. As of right now, our critical care population in COVID is, as Russell mentioned, towards its capacity of 12 beds. So, we have already begun planning for additional critical care space. As of right now we have an expansion plan that will allow for an additional 6, up to an additional 12. So, we can go up to 24 critical care capacity in



our next iteration of the plan. On our med. surge capacity, we have had to transfer our patients into a larger unit. So, we have shuffled some patients in now to our 8<sup>th</sup> floor space that will allow for more expansion of the med. surge population there and again we evaluate this every single day. If we are on track for the plans that we currently have in place also considering our staffing models and making sure that we have enough staff to take care of everyone in the Coronavirus spaces.

Mr. Meyers: When I finish my remarks if there are questions, I will keep Kit around to answer those if you have them. One point that I learned off camera; we do have a surprising amount of capacity available today in our testing center. So, if you've been putting off getting a test and believe that you need one, I'd encourage you to call 68NURSE today as soon as you can. Get them to line you up for an appointment. We can get you tested today. We won't necessarily turn the results around immediately. We are still sending those out for a few more days, but you can get your test done today at our main testing site.

Let's see, I gave you the hospital's census information. Just a couple more quick points. We are up to 10 total ventilated patients in the hospital now. We have ample ventilator capacity at a total of 44 full-service ventilators. But 10 patients on vents is about as many as we've had in a while. The Emergency Department (ED) saw 131 patients yesterday. Still below their historical norm for this time of year. And I think that's all of the census information.

We clearly are concerned about the continuing growth in positive results. I'm very hopeful myself that the governor's mask order will affect behavior and will begin to moderate some of the growth. I think we are beginning to see evidence that people are behaving differently. Where I've been in the last few days there are many, many more masks being worn more consistently than before. We have a variety of business; I think we said earlier that the MRT has done a nice job of recognizing businesses that are requiring masks. We would applaud that and continue to encourage those local businesses who are willing to do so to step up and require your customers to wear a mask while they are in your establishment. We are certainly doing that in the hospital, and I think it's one of the best ways that we can continue to minimize the spread if people will take that face covering requirement seriously. So, please do continue that.

I think that's probably a good—Oh, one more point. An important point, we've talked about Remdesivir and its availability or lack thereof. We did get 80 vials of Remdesivir on Saturday. As of late yesterday, we still had 72 of those available which is about a dozen patient's worth of treatment. The treatments vary, but 10, 12 patients or so in hand. We are very hopeful getting some more through the governor's special allocation as he has recognized Midland and Odessa as increasingly concerning spots among a number of communities in the state where cases are growing and the need for the drugs and other support is apparent. So, we are hopeful about getting some more. But we do have a small supply of Remdesivir in house as of today.

I believe that's it. Time for questions.

Tasa Richardson, Midland Health Public Relations Manager: We have a question on Facebook. Is there any medicine someone can take at home to lessen the chance of needing hospitalization?

Mr. Meyers: If we are talking about a patient who is already positive, no we don't believe so. There are a variety of medications that have worked in the hospital. There clearly are people out there saying that



some medications work for which there is no scientific proof. No carefully evaluated and peer reviewed studies that prove the efficacy of any of those treatments. So, we are not aware of anything that's over the counter or available to any individual that will make any difference in their care.

Tasa: We have several questions kind of relating to the same thing on Facebook regarding Dr. Bartlett's, how he's treating his COVID patients and are we willing to try that?

Mr. Meyers: That's gotten a lot of press recently. I had a couple people ask me about it just yesterday. Dr. Wilson has addressed it in the past and I'm going to ask him to come forward and address it again.

Dr. Larry Wilson, Midland Health Chief Medical Officer: Thank you Russell. Yes, I listened to Dr. Bartlett myself and I was very impressed with the information that he provided regarding Budesonide and helping with Taiwan and other countries. So, I went online, and I reviewed that. And Taiwan specifically has done a very good job with public health. They've done a very good job with face covering, they've done a very good job with social distancing. As a result of all of that, they've had a very low number of total cases in their country. So, when he was mentioning a minivan's worth of people, 7 people dying in Taiwan. That's 7 people dying out of 442 total cases. Which is about 1.5% mortality rate which isn't different than the mortality rate as of the beginning of July in Midland. So, there hasn't been a reduction in mortality from cases, there's been a reduction in cases. And the reduction in cases is related to social distancing, face coverings, and protecting one's self from exposure, one to another. I really want to encourage everybody to fact check, do your homework, understand what we're talking about. We are not making things up in this country, I promise you. It's not a conspiracy theory. It's not false science. This is good information based on peer reviewed data to give you the best practices. In fact, in the article that I read about Taiwan's public health and the wellness that they've done by keeping the disease load low in their communities, they also specified that they are looking for Remdesivir just like everybody else in the world is because it's one of the best therapies that we know of today. So, I appreciate everybody's worry. I worry, too. Russell emphasized and I continue to emphasize face covering, social distancing. We can mitigate the disease load in our community. But Budesonide and other therapies like that have not been shown to be beneficial. There have been patients that have come down with COVID in our community that have been on Budesonide and other inhaled steroids as their normal therapy going into it and they have not had a better outcome than anybody else in the community. So, I just want to encourage everybody to fact check, understand what's going on, be careful about it, and please listen to the peer reviewed information that we're providing, others are providing, and stand by that. So, thank you.

Tasa: We have another question from Facebook in regards to the COVID test. How long does it take to get the results back and what is the fastest test results that you can get?

Mr. Meyers: Today, the testing that we are doing at our site is taking 4 to 6, 7, even 8 days to turn around. The labs that we are sending out to are seeing increasing volume and are a bit overwhelmed. There are tests available and we have those tests that we are getting prepared to implement probably later this week that will turn around results in less than an hour. It's really pretty short run time on the machine, but it takes a little bit of time to get the swab, and line them up, and get the result turn around. So, inside of an hour, certainly same day. What we are hoping for is a transition of our testing site and an additional testing site, one or more additional ones that can be doing those rapid, short turn around tests and provide results while the patient waits versus, you know, several days later and having

to track down the patient and having them assume that they're positive in the ensuing days. So, that progress is coming. I keep promising that it's coming. We get a little closer every day, but we've had some particularly some staffing challenges getting set up to run those units. And just as soon as we can flip the switch and turn them on, we will. I expect it to be later this week.

Tasa: There have been studies that show that O blood type people are less prone to get serious symptoms. Do you agree?

Mr. Meyers: I have no idea. That's a physician question and Dr. Wilson's going to come back. The question Larry was is there reason to believe that O blood type patients have a better time with this?

Dr. Wilson: Thank you for that. So, there is some very early and preliminary information suggesting that serotypes of blood types may have an influence on the disease and those data do support that O type blood maybe do better in general, population of O type blood with the infection tend to do better than other blood types. But I want to emphasize its very early information. There's not a lot of supporting and large-scale studies, peer reviewed to support that. But it's information that is available and that's probably where somebody picked it up.

Mr. Meyers: Thank you, next.

Tasa: How many outstanding tests are you still waiting on results?

Mr. Meyers: 176 as of this morning, which is down from over 300 last week, but it's still a huge number.

Tasa: Is Dexamethasone being used on severe cases?

Mr. Meyers: Yes, that's another steroid treatment that's being used either orally or by injection and as I've understood it, Dr. Wilson's nodding off camera so I'm hoping this is right, we are more using it as patients get more severely ill. It helps to reduce inflammation in lungs as they are being treated especially if they are on a ventilator. It gives them a better chance of recovery. That's our usage of it so far.

Tasa: How is the situation with employees being handled who have tested positive?

Mr. Meyers: That's a growing concern for us. Clearly, as of yesterday, I believe we were at 56 employees who had tested positive since June 1<sup>st</sup>. Many of those have recovered, the ones that have not recovered have been sent home to self-isolate, to be monitored on an ongoing basis by our employee health group. We don't allow anybody to come back to work until they have met the criteria for being well and not putting others at risk. But it's a growing number and the challenge for us, of course we are worried about our people being sick to begin with, but when you take 40 or 50 people out of the workforce, that begins to be numbers that we'll feel. They're scattered across the organization. Some of them are nurses, some of them are working in other clinical spaces and we miss those folks. We don't have an overabundance of any type of staff, so that is an ongoing concern. We are staying on top of it with our employee health team.

Tasa: Does the hospital perform ECMO for patients presenting with hypoxia?

Mr. Meyers: We do not. We don't have that capability.



Tasa: If you have heavy symptoms like coughing when you call 68NURSE or use BasinMD will a doctor prescribe a medication for the coughing and treatable symptoms, or you just need to take a COVID test?

Mr. Meyers: I presume that the doctor, of course every case is different, but the doctor you talk to will evaluate your condition and provide treatment for the symptoms that you are undergoing whatever they are if there's a treatment available. You're not going to get that from 68NURSE though. They don't have prescribing capability. If you call 68NURSE, they will either tell you to go see your doctor, tell you to come to the emergency room (ER), if your symptoms line up with our criteria they'll make you an appointment to come and be tested in our testing center, but they don't have the ability to write medication orders. BasinMD, a visit on BasinMD with a physician, you can get a full-service visit, so very different from calling 68NURSE. Either one is a good option.

Tasa: Do you think this disease might be airborne?

Mr. Meyers: I think there's no question that the disease is airborne. That's the reason for the masks to begin with. You've probably seen lots of different graphics and different ways of illustrating this. When I put on my mask, the droplets that come out when I speak, when I cough, when I sneeze are restricted by the mask. The disease is airborne in those droplets. And so, if we knock down the droplets with a mask or a face covering, the chances of the person in the room with me having a droplet reach them go way down. But there's no question that the virus does exist in the air for just a little bit in decreasing concentrations depending on the concentration of the people in the room, the air flow, whether you are outside or in, there's lots of factors in that. But it is airborne. There's really not any question about that.

Tasa: Ivermectin has been used by some hospitals particularly in Florida and other countries with very encouraging results. It is cheap and easily available. Has MMH considered using this drug?

Mr. Meyers: We'll have to get back to you on that one. I think the answer to that is no we are not using it. We'll do a little research and give you a better answer on—Oh, wait. Dr. Wilson's got a thought.

Dr. Wilson: Russell's correct, but I just want to emphasize that you can read in a variety of different places all kinds of things being tried with some very, very promising results being described in non-peer reviewed, non-critically studied information. So, I just want to caution everybody to be careful. If it sounds too good to be true, if it's being described as the silver bullet, if you are hearing things about things that are just so perfect that it's too good to be true, it probably is. And you know there's a lot of physicians all over the country that are working very hard and all over the world working very hard looking at this disease and the things that come out that are helpful quickly get disseminated and are discussed. So, we'll do some homework around that particular medication and get some feedback to you, but I want to caution everybody to just be thoughtful about what I just said because everybody wants something that makes this thing go away. We all would like to see this go away, but it's not going away really quickly. I'd like to make one other point to what Russell was just describing about the airborne. There was an article referred to me by Dr. Gary Ventolini with Texas Tech yesterday that shows compelling information that the dominant way that this infection is spread is airborne. And it goes back and emphasizes the same points that you've been hearing us say here over and over again and I wish everybody would just understand and listen to that face coverings and social distancing is the main way that we can reduce this disease burden in our community. It's the main way to do it. It's an



excellent article if anybody would like a copy of that from the press, let Tasa know and I can give you the reference to the article, but I think it's all valuable information for us all to pay attention to.

Tasa: OK, Sammi from channel 9 has a question. Sammi, go ahead.

Sammi Steele (NewsWest9): Thank you guys. Yeah, my question is in regards to home testing. Where does it stand? How close are you guys in being able to do that here locally? It's something we're starting to see pick up a little bit and I'm just curious where Midland stands.

Mr. Meyers: Sammi, did you say home testing?

Sammi: Yes.

Mr. Meyers: You know I've heard of a little bit of that happening. I know there are insurance companies that are promoting it for their insured patient populations, in fact my father who doesn't live here had a home test just last week. It sounds a little dicey to me. It's very, very difficult for an individual to sample themselves adequately. As my dad was describing it to me he was basically just going to rub a q-tip inside his nose and I can tell you our clinicians have said from the very beginning that's not going to deliver an adequate sample. The chances are that he could test negative and still actually be positive because he didn't get far enough into the back of his throat. And so, we are dubious of the home testing's efficacy. But it's out there for sure. I think it's being promoted more and more.

Sammi: Ok, great thank you. And I have another question real fast. With an increase in you know COVID patients at the hospital how are you guys and potentially preparing more beds for COVID patients. Any idea of cutting back on elective surgeries? And then, what is that financial impact if you are starting, you know, to cut back on elective surgeries?

Mr. Meyers: Multiple points to that answer, Sammi. Kit addressed a little bit ago the surge plan. And we do have a significant multi-step, multi-faceted plan for expanding the bed capacity that's available to patients who need it for COVID treatment. We are pretty close to taking that next step and assigning some more beds. As that evolves, if we continue to get more COVID patients it will challenge our ability to do surgery. We are looking every day. Last week we were talking to our surgeons about limiting the number of cases that they do that require 1 or more days, especially more days of inpatient stay after the surgical procedure. We'll continue to talk about that on a regular basis. If it gets hard enough, the next step would be that no inpatient elective cases could be done. And those possibilities remain on the table and will continue to. We've got great cooperation with our surgeons and our anesthesia providers who understand that the gravity of the situation and are prepared to deal with it. It's hard on their patients clearly if they have a case that they need to do. There's very few surgeries that are not necessary. We call them elective because they can be scheduled, they can wait. It doesn't mean they can wait forever. So, we are going to work really hard not to do that. But the more COVID patients we have, the closer we come to the risk of having to cancel cases or defer scheduling especially inpatient elective surgeries. So, with regard to additional beds we do have a surge plan. Every time we take more beds out of service and devote them to COVID patients it challenges the other patient populations that would have been in those beds. So, that's an ongoing concern, but our team is on top of it. We know exactly what we'll do next. Probably the biggest question we have is how we are going to staff increases in beds, increases in critical care capacity which we are prepared to do from a physical standpoint, but it's much harder to just create critical care nurses out of thin air. And so, we are actively sourcing



traveling nursing staff and trying to prepare for what we see on the horizon as continued growth. The last element of that plan really impacts the other elements. We are building out the 9<sup>th</sup> floor of the Scharbauer tower with great generous support from the FMH Foundation and the Scharbauer Foundation to get that 48-bed unit built. It will be built with critical care capacity so should we need a dramatic expansion of critical care going into the fall and early winter we will be prepared to do that. It has recently impacted our bed capacity on the 8<sup>th</sup> floor because when you work on the 9<sup>th</sup> floor, some of the work has to drill through the floor, the plumbing work especially. We are pretty much at the end of that. We just put 5 beds back online that were out of service on the 8<sup>th</sup> floor, so we have new internal capacity already that helps with some of these challenges. But in the longer term, by what we hope is about Mid-October, we'll have a whole new floor online that we'll be ready to assign to whatever patients need it. We are hopeful of being able to staff it. That really still remains the big challenge. Did I get all the parts of your question Sammi? Is there anything you want me to follow up on?

Sammi: Yeah, you did. In regard to staffing more beds for the COVID floor, out of those employees who have tested positive, have there been a certain department or unit that's there's been quite a few positive cases that they've had trouble staffing?

Mr. Meyers: They are pretty well spread around. The biggest impact has been in our business office, surprisingly enough. And we are doing some facilities changes there and spreading those people out even further, sending more of them home to work than we had before. That's been the single biggest concentration that we have. But otherwise they are spread all over the hospital.

Sammi: Interesting. And then that mobile testing site that you guys are starting up, any concrete details that you can share with us? Location? When it's going to get rolling?

Mr. Meyers: We are working on a site at the Coleman Clinic which is on Florida Avenue on the southeast side of Midland. People are probably pretty familiar with the Coleman Clinic. They have quite a bit of property there. We have a cooperative relationship with the city and the county to get an outdoor facility set up, a trailer, and some drive through capacity. The challenge we have is getting our new rapid testing machines fully live, getting the registration process for the patients, and most importantly getting a handful of staff members in hand ready to go and do the testing work. And we are very close to having all that done. It will be handled just like the existing site. So, we'll take orders from physicians, we'll schedule cases through 68NURSE. It provides one more accessible site. We've got a site on the west side of town. We'll have a site on the southeast part of town. Making it more accessible to more of our community when we are ready to go. I wish I could tell you exactly when we are going to pull the trigger and say go. I hope it's within a couple of days, but until it's ready I'm not going to say so. I know we had some active work going on today to try to finish up preparations and we are very close to being able to announce that it's ready to go. But access to it will be exactly the same way we do it now. If you think you need a test, call 68NURSE. If they work you through the symptoms and you do need a test, then they will schedule you at one or the other site, and in the near future we will be able to turn those tests around in the same day, within the visit at either of the sites going forward. So, very close, but not quite ready to say go.

Tasa: We have another question from Facebook. How are our stockpiles of testing supplies holding up?

Mr. Meyers: Testing supplies, you know they are all over the place. Depending on which test we are talking about. We are ok with swabs at the moment, although that's a day to day management

challenge. We are very encouraged by the rapid testing machines that we are implementing. We have several hundred test kits available now that are in hand for the Quidel Sofia 2 machines that we are just about to turn on. So, we are encouraged by that and we are being told by the manufacturer that if we keep ordering, the tests will keep coming. So, we tend to be skeptical about that because we've not always gotten what we've ordered from other vendors, but this one is performing very well so far so I'm hopeful that once we get the new site turned on, once we put rapid testing in place we'll be able to begin to crank out tests more rapidly. But we are still not going to be taking all comers. Just a reminder, this is going to be people with symptoms or some other significant reason due to exposure that they need to be tested. It won't be just anybody who walks up and asks for a test.

Tasa: What is the rationale in not testing patients that are being seen in the hospital for elective surgeries?

Mr. Meyers: The rationale has primarily been that we are not testing anybody like that. If they have symptoms, if they have exposure, we are testing them. To date, the inhouse machine that we have available to test has had very limited capacity because the supply chain has not been able to deliver enough test cartridges. So, we've tried to be very careful with those. Test patients in the ED who are symptomatic, test employees where that's necessary, we've tested our in-house patients who have an ongoing disease process underway. But we haven't really had the capacity to do more than that. There are places I know that are doing pre-operative for pre-procedure testing on everybody who comes in. Our clinicians have not decided it was time to do that yet, and our ability to test timely and turn around immediate results is very limited. I think that's another issue we'll be talking about more in the days ahead as our testing capacity grows, but as of right now that's our reasoning.

Tasa: Has the Army Core of Engineers or National Guard contacted the city or hospital for help?

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

Tasa: Why is Remdesivir the drug of choice being used?

Mr. Meyers: Well, Remdesivir is indicated for some patients. It has been shown to shorten the length of recovery and to improve patients once they have the disease and they are hospitalized. It's had a couple of peer reviewed studies. Dr. Wilson keeps talking about, and we've all talked about, the quality of research. Scientific research is very complex, and it requires multiple iterations for it to be legitimate. It's got to be peer reviewed meaning the researchers that do the work have to hand their details over to somebody else to check their work, look at it carefully and assess whether they applied appropriate methods. There are often times control groups for patients who get the drug are compared to patients that look like them who look like them and don't get the drug to make sure there's really a discernable difference. They have to carefully check the side effects and the unintended consequences of the drugs. So, it takes quite a while for any of these cases to get properly studied. Remdesivir is one of the ones that has been through a study for our clinicians to believe that it actually has been proven to work. It's not a cure, it reduces symptoms and aids in recovery at a faster rate. And it's in very short supply. Unfortunately, we are getting as much of it as we can and happy to get it, but we can't get an abundant source just yet.

Tasa: We have a question from Caitlin from the MRT in regard to Remdesivir. How long do you expect the latest allotment of Remdesivir to last and how are you determining which patients receive it?



Mr. Meyers: I think Dr. Wilson is probably better equipped to answer how we determine it. It's going to last as long as it lasts. We've got 72 vials in hand. That's a dozen patients worth, give or take depending on how the physicians use it, but the indications have to arise before it gets used. So, I'll let Larry talk about that.

Dr. Wilson: I think Russell really adequately answered that question by in large. I mean it's really a matter of a patient meeting the criteria for needing Remdesivir and then being provided it. With regard to how long it will last with maybe 10 – 12 doses or availability of allotments for patients for about 10 – 12 more patients, with our current admission rate it's not going to last very long. And this is going to continue I think our admission rate, the trajectory we are on is going to continue for at least another couple of weeks because as you've heard us say here before you set the stage for two weeks from now by your behavior currently. Russell's mentioned, I've heard from other individuals as well that more recently we are seeing people are starting to pay attention. We are seeing more mask wearing in the community. Perhaps we'll begin to have a downtick in the amount of disease in the community 2 – 3 weeks from now. But until then, we hope to get more Remdesivir to be able to treatment patients when they meet clinical indications for needing it. We are trying to administer it earlier so that they are enabled to recover more rapidly without getting terribly sick. As Russell mentioned, we've got about a third of our patients currently in the critical care unit which means they are pretty sick. So, we are hoping we can bend that curve down as well with the therapies that we have.

Mr. Meyers: Great, thank you.

Tasa: If it gets to the worst imaginable, does the west campus come into play?

Mr. Meyers: The worst imaginable? It could, it certainly could. I think we have a long way to go on this campus before we go to the west campus. There are many challenges in setting up a separate facility 2 miles or more away. None of the basic infrastructure of a hospital is there. It's not a licensed hospital anymore. The building is still there and really isn't materially changed from when it was a licensed hospital. There's no lab, there's no pharmacy, there's no respiratory therapy team, none of the basic infrastructure that we require is there. And so, you get very inefficient. That's why we are not operating 2 campuses anymore. Since 2012, we consolidated. One of the main reasons for building the Scharbauer Tower and choosing to pull all our inpatients back together was we make all those support services more efficient if they are serving patients in a single building. So, it would take a lot to want to set up that additional spot and I'm not sure it's the first place we would go from here. There are other facilities in town that might be better candidates. We have a lot of space within the existing main campus that can be repurposed. We still have the old building that can be with a fair amount of effort it can be turned back on to use for inpatient care, we have recovery room spaces, we have all kinds of spaces within this building that are much easier to serve with our infrastructure than any offsite facility would be. So, it would really have to be the absolute worst case before we went to that.

Tasa: Some clinics are swabbing with a soft q-tip and not going far inside the nose to the throat and other clinics are swabbing with the longer and going deeper. Why the difference in swabbing? Is one more accurate than the other?

Mr. Meyers: Yeah, I think we've said from the beginning that the long swab that goes through the nose all the way to the back of the throat is the most likely to get a quality sample. As I was describing earlier, if you've got a short swab and you're just swabbing the nose, if the virus happens to be in the nose

great, you pick it up, you send it to the lab. It picks it up. It's much more likely, it lives in the respiratory tract, so the nose is the very end of the respiratory tract. From the very beginning we've said and continue to believe that the tests that get a deep sample are the most accurate, the most likely to pick up a positive.

Tasa: If you have recovered from COVID how long do the antibodies stay inside you and is there something we can do to help with the antibodies?

Mr. Meyers: Like to boost antibodies? I think that remains one of the great unknowns of all those. Not only how long do that antibodies last, but how good are they. You know there's varying levels of antibody in the blood. There's some question about people already showing antibodies even when they are still positive for the virus, so there's a whole lot more to be learned about antibodies and I don't think as of now we know of anything that would actually boost them. Not today.

Tasa: When you're out of Remdesivir, what alternatives are you using to treat patients?

Mr. Meyers: I think we talked about this some last week when we were out of Remdesivir. The next biggest opportunity, the next best treatment we have found has been the convalescent plasma treatment that remains available and continues to be used and then there's all kinds of supportive care we are providing to patients as they weather the storm of the disease.

Tasa: Can you elaborate on what constitutes a positive COVID-19 test?

Mr. Meyers: What constitutes a positive test? I wonder if this is a question related to the ongoing issue that has come up in Odessa about presumptive tests, the word that they used for presumptive tests. We've had a difference in the way that our health departments count. In Midland, they are counting every positive test as a positive test. So, if it was done at the hospital, if it was done by a private lab everybody is obligated to report to the health department if they have a positive test on a Midland resident and our health department is counting every positive test. That's not the in case in some other places. If a laboratory, whether it's a rapid test or the longer turn around PCR tests, if they come back positive, our health department counts them in our numbers and they are considered positive.

Tasa: How many in house from other counties are being counted towards Midland numbers?

Mr. Meyers: Well, it depends on what you mean by Midland numbers. The health department's numbers are specifically Midland County residents. If you live in Midland County and you're positive, you are going to be in our health department's numbers. If you happen to be in Midland County for some reason, even if you're in our hospital but you're a resident in another county then you are not going to be in the Midland County's numbers. You are going to be in our hospital census numbers. Those are totally different data sets. But our hospital, we count every patient we have in the hospital, but the health department only counts people who live in Midland County.

Tasa: A follow up question to that is, if someone is re-tested from a previous positive is that counted?

Mr. Meyers: That's not a patient. That's a test. So, no that's still 1 patient. If they are already in the count it doesn't add one more because they've tested twice.

Tasa: I believe that's all the questions we have for today.



Mr. Meyers: Ok. Lots of good questions. Thank you all for your interest and your attention. We'll be back in front of you later this week. We'll talk about when and Tasa will get an announcement out again, but there's too much going on for us to only do this once a week and I continue to be hopeful of giving you a thumbs up on a new testing site and the implementation of our rapid testing. So, hopefully by the next time we talk we can do that. Thank you all very much.