



Russell Meyers, CEO of Midland Health

COVID-19 Public Briefing: Tuesday, July 14, 2020

Transcribed from a previously recorded live event.

Mr. Meyers: Good morning. I'm Russell Meyers, CEO of Midland Health. This is our Coronavirus update for Tuesday, July 14th, election day here in Midland County. Starting off with a few data points, in the state of Texas we are now over 264,000 confirmed COVID-19 cases with over 3,200 deaths statewide. Here in Midland County, 1,194 confirmed cases. We've had our 21st death here in the last day or two. Over the weekend, we announced, or the Health Department announced 90 new cases. I haven't seen today's numbers but that's a huge number, not quite as many as there were the previous weekend. And I am encouraged that since the governor's mandate and since a continuing campaign has been going on in our community to convince people to respect social distancing, to wear a face covering anytime you can't be at least 6 feet away from the nearest person, all of those things we've been reinforcing for a while seem to be catching on. Every place that I go I see more people consistently wearing face coverings and I'm hopeful that in the not too distant future we'll begin to see those numbers drop as a result of the preventive activity that we're all participating in. So, thank you all for doing that. Please do keep it up. The numbers are still high as you'll see in just a moment.

Testing for the hospital, the hospital's testing programs, we still have over 200 cases outstanding. We are beginning to move in the direction of more rapid testing and hopefully those numbers come down, but among the send out tests we've done from our original testing site, we still have cases as old as July the 8th, almost a week old now as of today. Hospital census, 178. It's one of the higher levels of total census we've had in a while. A lot of that is driven by the COVID population. We are at, once again a peak, a record number of COVID positive patients today at 46. 14 of those in critical care. 32 in the medical unit or units that are assigned to COVID patients. Ventilators, we have 12 patients today on ventilators. That's as high a number I've seen in a while. And while we've continued to report that we have 44 total ventilators, that's true. There is a subset of ventilators within that that totals 18 that have some more sophisticated capability that handles the patients with acute respiratory distress syndrome a little bit better, provides a few more bells and whistles to manage that population. So, while we have an abundance of ventilators, those at the higher end to care for the sickest patients are in relatively short supply and we have 18 of those. A total of 12 in use today.

In the Emergency Department (ED), we saw 120 patients yesterday continuing our long-term trend of low ED visit numbers. As this pandemic drags through the summer, I think it's a good time to repeat the concern that we've had really from the beginning. As ED volumes have dropped, we'd like to be sure to reinforce with people if you have a reason to come to the ED, chest pain, symptoms of a stroke, severe abdominal pain, injuries of all kinds, all of those are appropriate ED visits. You will be seen timely, it is a safe environment to seek care, and we would strongly encourage you not to ignore your legitimate emergencies but bring them into the ED as they occur.

Good news, we are now on day 3 of our second testing site at the Coleman Clinic on Florida Avenue. We are doing rapid testing at that site and the first 2 days, Friday and yesterday have gone very well. We expect over 40 patients at that site today. The flow is going well. We are turning around results in real time and so we are very pleased with that. Would like to repeat the thanks we've offered before to the city and the county for helping us with all of the logistics including some of the equipment on site there.



Thanks. I think I've been remiss in thanking Midland Community Healthcare Services folks for lending us a big component of their property, a big side parking lot, and a good bit of the land there on site to assure that these services can be provided while their clinic operation goes on. Midland Health personnel are running the testing site, but all of these other folks have been very helpful to us in getting the ball rolling and making it all happen.

One thing that we've seen as we've adjusted visiting policies that I think is important to point out, we are still limiting visitors. Nothing has changed in those terms. One of the things that is frequently happening now is people are trying to deliver things, food, flowers, gifts, etc. to our patients. We cannot allow those deliveries to come through to our patients. Number one, there's the possibility of contamination from anything that comes into the hospital that we don't know about. And number two, we simply don't have the staff to be dispatched to the entry point and then deliver those gifts or flowers to the patients. So, if you would please, while we are in this limited visiting period also try not to send anything intended for delivery to a patient unless it's absolutely necessary, something the patient has to have during the course of their stay. We appreciate that. We're sorry about that. Sorry we have to restrict visitation as much as we do. We know that that's a burden to families and makes it more difficult on patients, but we simply feel that we have no alternative number one, under the governor's order and number two, just in the interest in minimizing traffic into the hospital and keeping everyone as safe as we possibly can.

I think that's really the extent of my prepared remarks for today. I'm happy to take questions and then we'll have a closing statement after the Q & A.

Tasa Richardson, Midland Health Public Relations Manager: We had a little bit of freezing video at the first of the press conference. Our audio still stayed through, but the media has requested so that they can capture that video if you could repeat those COVID patient numbers and ventilator numbers.

Mr. Meyers: I can do that. Ok, going back to the statewide statistics, over 264,000 cases in the state and over 3,200 deaths. To date in Midland County, 1,194 confirmed positive cases of COVID-19 with 21 reported deaths in the county, 90 new cases of course you saw that earlier from the weekend. The hospital's census is 178. In the hospital today, we have a record high number of COVID patients at 46. 14 of those in critical care, 32 in the medical units. We are awaiting the results on 205 send out tests. The oldest of those going back to July the 8th. ED traffic yesterday was 120 patients. And today we have a total of 12 patients on ventilators. I believe 8 of those are COVID patients in the hospital.

Tasa: Thank you. We have a question from Facebook. When a patient is in the hospital with COVID, how well does MMH communicate with the family members about the condition of their loved one? For example, treatments and medications given as well.

Mr. Meyers: Kit, do you want to come talk about that? Our nurses have been very creative in finding ways to communicate with families and facilitating communication between patients and families when they can communicate. I'm going to ask Kit Bredimus our Vice-President, Chief Nursing Officer to address that in more detail.

Dr. Kit Bredimus, Chief Nursing Officer: Thank you Russell, so currently we are again at a point where we are trying to communicate as much as we can to the community and to the family members about what the conditions are of their loved ones. Part of that is through video visitation. We are using iPads

to help try to communicate with folks so they can see their loved ones and we can have those communications. And we do try to make regular contact with the families to answer any questions that they may have. As we've grown in our census, it has become a little bit more of a challenge so those communications are getting a little bit shorter and a little less frequent, but we are trying to put as many resources into that as we can including involving our patient advocates and others who can help facilitate some of those questions and answer that to the best that we can.

Mr. Meyers: We didn't talk much about staffing today, but staffing does continue to be a challenge for us. We have a large number of employees who have tested positive who have been held out of the workforce for extended periods of time. That is waning now, but with the census growing, the COVID isolation population growing, it becomes more and more difficult to handle those aspects of customer service that we expect of ourselves every day. So, Kit and the team are working hard to make sure we don't drop those balls. If you happen to be a family member who's concerned that you're not getting adequate information, I would number one be sure that you've talked to other family members. We can't always communicate with everyone that wants to hear from us. We need to have a designated family member who gets the information about a patient. But first do that, and then if no one in the family is getting adequate information, please do call us. Call the nursing unit. We'll make sure you get connected with the clinical manager and get an update and get you on regular schedule.

Tasa: We have a question from Sammi. Sammi, go ahead.

Sammi Steele (NewsWest9): I have a few questions. What's the difference between the medical care unit and the critical care unit?

Mr. Meyers: Well, we've had critical care patients and medical patients throughout. The critical care unit is patients who require more extensive monitoring. If a patient is on a ventilator, they are on a critical care unit. They are the sickest patients. The medical unit is a step down from that. Nobody on the medical unit requires a ventilator. They are not requiring active monitoring. They are still isolated, but they are just not as sick. So, that's not unlike what we do every day. We have critical care patients, usually they get well. They step down into a medical or a post-surgical environment before they go home, but critical care is the highest level of care we provide in the hospital with the maximum amount of technology deployed, the highest level of staffing day to day, an active intensivist who's responsible for the patients on that unit every day, just a much more intensive level of care than in the medical.

Sammi: Great, and then my other question so it was 24 COVID patients in the COVID unit before you hit like your next stage at the hospital for your preparedness. I forget exactly what you guys called it. But, so now you've entered that second stage, what has that process been like?

Mr. Meyers: Well, it's been challenging, no question. We are dealing with you know in the first round, we had 32 patients at the maximum. And then as you all know we dipped far down. We at our lowest point, we had 3 patients in the hospital. That doesn't seem like that long ago. Now, we're back well above that original peak to 46 today. So, that's happened also in the face of a mounting number of employees who have had community acquired exposures and have become positive and taken out of the workforce. So, we've got more patients, moved around isolated in areas where they're not accustomed to being, we have fewer staff to take care of them, we are putting a bigger burden on the rest of the staff asking them to do more, and they are stepping up. No question, we are very proud of the staff and the effort that they have made to step into the breach. To continue to do their work every

day with a good attitude and a positive approach recognizing that we don't quite have all the resources we want. We are pursuing traveling nurse and other staff who could be deployed on a temporary basis to fill some of those gaps while we wait for our people to get well and come back to work. So, there's huge challenges in all of that. There's challenge for our engineering guys in shuffling patient populations and beds around and making modifications to those units as we move around. So, there's nothing easy about any of this. The team has done a great job of preparing a multistep surge plan and we are well into that plan, but we haven't exhausted all of the components of it yet. So, we have a very good plan. We know what to do here, but executing it is not easy. And it challenges our people every day.

Tasa: We have a question from Caitlin from the MRT. Do you believe the increase in COVID patients is related to the July 4th weekend, or have we not seen an influx because of that yet?

Mr. Meyers: Well, I think that we've thought from the beginning that was part of it. This is 10 days after July 4th here on the 14th, so we should be in the thick of whatever that weekend may have produced here today and over the next couple of days. But we were already well into this growth process before the 4th of July weekend hit. It really began with the Memorial Day weekend and hasn't let up. And so, but we also have not had time to experience the results of a new push to wear face coverings and be more serious about limiting gatherings and doing more social distancing. And our community appears to be responding well to that. So, in the next few days I have a great deal of hope that we may actually begin to see those results. But it's very hard to know where we stand or what's coming tomorrow at this point.

Tasa: We have a question from Sammi. Do you know how many staff have tested positive? It was 50 last week. Is there an updated number?

Mr. Meyers: Yeah, I don't have a current number. It was down, yeah, we had peaked in the low 50s, the last number I saw which is a couple days old we were down to about 37 who were still considered to be positive. Hadn't gone through the full recovery process and been released. I suspect that number's gone down a little bit more since then. But that's in the ballpark.

Tasa: We have a question from Mitch. If Governor Abbott instates another temporary lock down, would that help Midland Memorial deal with the spike in Coronavirus patients in West Texas?

Mr. Meyers: Mitch, it's hard to know the answer to that. I suspect it would because we know the first time around-- You know, if people are not gathering, if they're not interacting with each other then we're going to have less distribution of the disease throughout the community. That seems to be pretty clear. How soon that would take effect we don't know. What the offsetting impact on the hospital would be I think would be concerning. Certainly, through April and May when we were basically not doing anything but COVID patients and the odd emergency that came through the ER, those were difficult times for us. We deployed people into different roles certainly, but it had a devastating economic impact on the hospital. We are not necessarily advocating for that. Where we are now, with the reduction in elective procedures, trying to minimize the number of inpatient procedures that we do that can be deferred, that seems to be helping a little bit, but it's hard to know what would happen or if we even could pull off a complete economic shut down like we did the first go around. I couldn't really say.



Tasa: We have a question from Sammi, you might have seen MCH and ORMC are asking for more nurses and respiratory therapists in the community to help out. Is this something you're looking into?

Mr. Meyers: Our human resources staff is beating the bushes for just about every possibility that we can find. We've been more focused on traveling staff because they are current, they are in the workforce now, and potentially available. We've had some luck with that. I think we certainly would welcome recently retired folks who still have current licenses and have a desire to work in the near term. We have a number of jobs that those folks could fill even if they are not ready to do patient care. So, certainly an option we are open to and would be very interested in anyone who wants to come back and work.

Tasa: We have a question from Caitlin from the MRT. At this point in the surge plan, what's the capacity of the medical unit and critical COVID unit?

Mr. Meyers: Let's see. I'm going to let Kit, the expert, the author of the surge plan come and talk about that and give you a better sense of it. We still have some capacity to grow into.

Dr. Bredimus: So, I believe the question was on medical specific, the med. surge population. That plan goes up to 42 beds. We should be releasing some rooms today. Again, we've mentioned previously that there is construction going on on the 9th floor that is affecting our 8th floor bed capacity. That should be finished by the end of this week, so we should be able to occupy a few more beds and open up capacity on our med. surge areas, at least 8 beds there. And then we also have some additional space in our CCU COVID overflow area that we can use kind of as a mixed space there. So, all in all we have a potential of additional 6 in one side and additional 8 on another, but again that doesn't mean that those are necessarily staffed beds at this point. So, we are continuing to find resources to be able to staff those beds appropriately including using the Team models where we have 1 nurse, with a team of other personnel that can help assist that nurse in care.

Mr. Meyers: Yeah, I think it's true of most hospitals that are dealing with an uptick in disease right now. It's not physical space that is the challenge. It's not even the ventilator availability, it's staff. And so, while we may be able to add more physical beds and make them available, having enough of the right, well trained people to care for patients in those environments is the day to day challenge and of course as our people get well, it gets easier to do that. But moving into physical spaces and shuffling patients around isn't the hard part of this work.

Tasa: Ok, we have a question from Facebook. Do you have the age range of the COVID patients in CCU?

Mr. Meyers: I do. Hold on just a second. I didn't make notes of that, but I got that information this morning. So, the CCU patient population goes from the decade of the 20s to the 90s, pretty much where we've been throughout this most recent spike. A very wide range, pretty evenly distributed. No one range of ages stands out. In the medical population, the biggest group is in their 50s, but also spread from the 30s to even one patient who's over 100 today.

Tasa: Thank you, we have a question from Facebook. Can someone explain why heart surgeries are considered an elective surgery?

Mr. Meyers: Well, they are not always. There's a variety of reasons why heart surgery happens. Sometimes you're talking about a valve replacement which can really be a chronic disease that's been

going on for a long time. That is a scheduled procedure. It's not unusual for heart patients to wait to have their procedures until their systems have cleared of anticoagulants so they don't bleed excessively. But then there are urgent cardiovascular cases where there's been an event that's happened that can't be fixed in the cath lab and has to go directly to the operating room. So, just like with other types of surgery, our surgeons and anesthesia providers are talking every day about the relative urgency of the cases that they do, deferring those that they can. But it is not unusual at all for an open-heart surgery to be an elective, scheduled procedure. These days that's probably more common than not, I would say.

Tasa: We have a question from Dillon from the media. People talk about how the death rate is low, but that doesn't seem the case here in the basin. Do you know the death rate in Midland and if deaths are trending up or down?

Mr. Meyers: Well, the death rate is, if we are talking about confirmed positive cases, you've got about 1,100 cases and 21 deaths so it's about 2%. What we don't know and never have known, and I think is part of the debate, is how much broader is the positive community? How much bigger is that denominator? It's bound to be bigger than 1,100 so the death rate is bound to be less than 2%. Beyond that, we just don't know because we aren't testing broadly enough to know what the full spread of the virus in the population is.

Tasa: We have a question from Facebook. Do I need to have symptoms to be tested?

Mr. Meyers: Well, when you call—There are different places with different policies. Let's start with that and I'll talk about ours. We have 2 testing sites live now and when you call 68NURSE or your physician sends you to get a test, we expect that you will have either had some symptoms or you'll have a collection of exposures and other reasons why it makes testing appropriate. It's not a real black and white type of thing. Certainly, if you have symptoms it's not difficult for us to get you scheduled for a test, if you believe you've had an extreme exposure, or there's some other good reason to be tested, we have not taken a real hard line about that especially if your doctor sends you for a test. So, that's a little bit of a soft answer, but that's the facts. If you have symptoms, that's pretty straight forward. If you don't have symptoms, but you have some other really good reason like a you know an extreme exposure or your doctor has a particular concern, then we'll work with your doctor and make sure you get tested.

Tasa: Can diabetics be asymptomatic?

Mr. Meyers: Yes.

Tasa: Are MMH staff members continuing to test positive and how many have recovered and been able to return to work?

Mr. Meyers: You know, I didn't have that package of information about our staff when I came today. I know there's been, from the peak of our positive numbers which were over 50 down to the 37 or so that I saw in the most recent report a couple of days ago. That's about 15 employees that we know have recovered. There were some prior to that. I don't know about any new positives. Have you all heard any? (asking others off camera) No new positives in the last few days that we are aware of.

Tasa: Have staff been laid off or furloughed from MMH?

Mr. Meyers: No, we haven't done that. We have been very intentional about that from the very beginning, that even though our work has shifted a lot and in the early days we had a lot of people whose regular day to day work involved elective procedures that they were not allowed to do. So, we had to redeploy them to various different creative functions including sewing masks and manning the doors and testing people on their way in and that sort of thing. So, we've made a commitment to our staff to keep them working and keep them occupied even as our volumes have gone down. Today, volumes are back up across almost everything that we do. So, we are in no position to furlough people. We still are concerned about the financial challenges associated with this disease. I think I said in the last meeting or I've said in other settings COVID patients are not profitable. This is a population that costs us money. Every one of these cases that we've analyzed so far has lost money. So, this is not something that we are getting any great benefit from. At the same time, it's a lot of work and it requires a lot of people to take care of these patients and to do all the other things that the community expects us to do. So, we're hopeful that our economic situation remains adequately supported so that we can keep our workforce on the job, keep growing it where we need more nursing staff and others, and continue to serve the growing population that we need to serve, but no layoffs, no furloughs, no intention of doing so at any time in the future.

Tasa: Sammi has a question. Sammi, go ahead.

Sammi: Alright, I just wanted to know if you guys could paint the picture for what it's like to treat these people. You know, illustrate to us that this isn't just a virus. What is it like—

Mr. Meyers: Sammi, could you start over? You were breaking up pretty badly there.

Sammi: Yes, can you hear me better now?

Mr. Meyers: That's a little better, yes. Go ahead.

Sammi: Ok. Could you paint the picture of what it's like to treat these people? You know, this isn't just a virus. Can you illustrate to us the effect that this has on people?

Mr. Meyers: Larry, you want to try that? You're talking—We lost the end of your question, I think. I'm going to ask Dr Wilson to come and talk about that. It seems to me that you're talking about what's the kind of the course of the disease for the patient who ends up in the hospital. Just how does it evolve?

Sammi: Yeah, talking about the severity of it really.

Dr. Larry Wilson, Chief Medical Officer: Ok, Sammi. If I'm understanding correctly, and it's varied, but those patients that end up in the hospital are clearly on the top 10-20% of the population of illness and degree of illness. The large majority of them are respiratory related problems. So, they're having—they are air hungry. They are short of breath. They are coughing a lot. They can't get enough air. Very anxiety producing, very stress producing if you've had asthma or a bad cold with pneumonia ever in your life and if you've been hungry for air. If you have a family member with COPD or a condition like that you recognize what that looks like. It's very, very scary. And they come in and they'll need supplemental oxygen. And then over time, increasing amounts of oxygen and/or even methods to help inflate the lungs against the inflammatory process that's trying to close down the lungs. So, that's when you start moving from that medical condition that was being asked about earlier and you're on the medical floor and you're just getting supplemental oxygen and checked on a pulse oximeter periodically,

and you're getting some bronchodilators, etc. and having to move to a more invasive approach and perhaps being put on a ventilator and having a tube in the lungs and using various pressure modalities to increase the inflation of the lungs to allow for a person to breathe. So, that's sort of the pathway for the majority of people with the respiratory related conditions that come in with COVID. We are also seeing patients come in with gastrointestinal symptoms. They may lose appetite, they may be malnourished or dehydrated. It could affect different organs in the body, and they can have kidney function problems and liver function problems that require some modalities of care to help maintain nutrition and hydration, etc. And particularly in the older population and in the very vulnerable population also you'll see patients with mental status changes so that their behavior changes so they are not able to take care of themselves or think properly and they need support in that way. And this is sort of you know in very broad strokes that's what we're seeing. But there's a continuum, you know. Persons can come in and have very minor symptoms at first, but they are feeling bad with a bad cough. We can treat that; they can go home. But they have increasing symptoms and they come back. They may seem like they're getting better and then they get worse again. We've had patients in the hospital that have gone to the critical care unit, been put on a ventilator, got off the ventilator, go back to the medical floor, only to deteriorate again. It waxes and wanes in ways that aren't really clearly understood and requires constant management, monitoring, and oversight. Where Kit has been speaking about having to have the nursing staff and other healthcare professionals available to be paying attention to these patients as things move through the progression. One last point is that with many other illnesses that we've seen there's a fairly predictable pathway that people get better within a week to 10 days. This doesn't play that way. It can be 2 weeks, 3 weeks or longer with this post inflammatory process where they just stay ill even when it appears that the infection has gone away, but all of these inflammatory products are still in the system and keeping them feeling poorly. So, the vast majority of people I want to emphasize are either asymptomatic or minimally symptomatic. They get better at home, don't require any of this. I'm not trying to paint an overly dark picture, but in a small subset of the population, those that we are treating in the hospital, that's the course. And they can be very, very sick.

Tasa: We have a follow up question from Sammi. What treatment challenges have you all seen? There's no one proven treatment method for people.

Mr. Meyers: Well, that sort of encapsulates the challenge, right? There's been a number of things tried along the way. Some have worked. There have been a few occasions some methodologies have worked, and they've been proven not to be particularly effective along the way. You know it remains sort of unknown. We know the Remdesivir works, but it's not a cure and it's in short supply. So, that's one of the issues. Early on, there were other medications that were used in the course of managing a patient on a ventilator that were in short supply. We are better served now with everything but Remdesivir. The next challenge is going to be paying for it. We were very blessed that the federal government and Gilead worked out a deal to provide the early Remdesivir supplies at no cost to providers and patients. We are now going to be paying for it. It's still being allocated on a limited basis, but we'll be paying about \$3,200 per dosage, not per dose, but per patient regimen, 5-6 doses. So, that's going to add up fast if we're able to get enough of it to use on the population that needs it. So, there's a wide variety of challenges that have come up along the way, but it all goes back to this being still a new virus. There's a tremendous amount of research going on on many different fronts and it's sometimes conflicting results. We saw that with hydroxychloroquine early on in the process and the



more recently multiple studies said it didn't really provide a benefit. One recent, pretty large retrospective study that said they believed that it does. And so, that's the challenge doctors have to navigate every day. Not quite enough research available and the research that's out there can be a little conflicting.

Tasa: Are you still using convalescent plasma and if so, how do you donate?

Mr. Meyers: Thank you for bringing that up. I was about to forget to ask that. We are still using convalescent plasma. That's been one of the treatments that our doctors believe to have been very effective. There is a growing need for it as the patient population grows. And so, we do have, I think we can post to our Facebook site later, we've got a number in the hospital that can be called and you can also go directly to Vitalant, the blood bank that serves our region and ask them. Remember, convalescent plasma is plasma harvested from people who have recovered from the disease, not just from anybody. I think the blood bank will tell you that they need blood across the board because we have a clear shortage of blood and blood products in the region, but to donate plasma, you have to have had the disease and recovered from it, 4 weeks recovered, and have antibodies present in your system. I know that I've been getting a lot of correspondence from the blood center and they have been offering to do antibody testing as a part of the donation process, so that's a little side benefit if you are willing to go and donate blood or blood products. If you've had the disease and recovered 4 weeks, you can donate plasma as well and that would be very much appreciated.

Tasa: How do you feel about schools reopening and the risk for increased spread of COVID-19 between children and staff?

Mr. Meyers: You know, our job is tough here in the hospital. We have huge challenges to deal with this population. Even in the face of that, I don't want to trade places with the school administrators. Their job is really, really difficult. There's no clear and direct answer to that question. You are seeing different opinions from different bodies and I know the schools feel the same way. There's tremendous value in getting students back into the classroom, back into their social setting, there's also risk of exposure across students and most importantly from the kids to the adults involved in their care. So, all I can do is say that I have sympathy and concern for their decision, but I don't have an opinion to offer about what they should do. It's just a very challenging part of our current reality.

Tasa: Are you aware if private clinics are reporting the number of tests that they are doing as well?

Mr. Meyers: The private providers in the community are supposed to be reporting their results to the Health Department, their positive results. I don't know of any mechanism that requires them or expects them to report their total number of tests. I haven't seen that anywhere, so I suspect that's not the case. But their positive results, there is evidence that they are consistently reporting to the Health Department. The Health Department's numbers are much greater than the numbers of tests that we've done in the hospital, so I am confident that most providers are delivering those positive results to the Health Department, but the total number of tests, I don't think they are.

Tasa: How is your staff holding up emotionally? Do you need anything from the community?

Mr. Meyers: That is a great segue to our closing comment. So, I will call on Kit Bredimus to make those comments and then we'll close for the day. Thank you very much. Kit--



Dr. Bredimus: Thank you Russell. I just have a few prepared comments that I'd like to make and take this opportunity to thank our healthcare workers, our frontline workers that are out there every day and ask in your help in continuing to support them. We have a fantastic team of doctors, nurses, respiratory therapists, and many other professionals that are working non-stop every day to make sure that we can protect our community from the effects of COVID-19. We have all dedicated our lives to serving others in their time of need, but what we are is human and we are starting to fatigue. We are getting tired. Our frontline staff workers are continuing to see this day in and day out and as we see a rise in volumes it becomes even more challenging. Our heroes are delivering patient care and we need your support now more than ever to continue this fight against a common enemy. Prioritizing mental health and managing stress is critical during these challenging times and healthcare workers are not immune. I can not underestimate the physical and emotional toll that this work takes on us. When this pandemic began, there was an amazing outpouring of support and love for our teams and our social media was filled up with encouragement and praise and it gave us all the strength to keep going. Where there once was that inspiration and optimism, we are now finding ourselves dealing with mistrust, malice, and anger. And it feels like we are fighting a battle on 2 fronts. My staff and I are increasingly bombarded with negative comments and criticism that fill up our social media, our emails, and our texts and it's starting to wear. I cannot begin to explain the feelings of defeat and frustration that come from when you've poured yourself fully into the care of a dying or ill patient just to be met with criticism and anger. I want everyone listening to know that we have the entire community's best interest at heart. You are all our family and friends and believe me when I say that we are trying our best. I encourage everyone to please take the time to acknowledge our frontline caregivers and everyone who works in the hospital to provide care for our patients. I know the road ahead of us is long and it is uncertain, but as the banner behind me states, we are stronger together. Thank you for those of you out there who are continuing to support us and show us simple gestures of appreciation are critical. So, I'm asking you please take the time today to drop a message of kindness to a healthcare worker. This can be in the form of a thank you, a post, a text, anything. We will get through this together, if we show kindness and patient mercy with one another. And to my frontline caregivers out there, everyone who's in the trenches thank you for your dedication and your resilience. Understand that what you do matters more than you will ever know. Thank you.

Mr. Meyers: Thank you Kit for that timely and heartfelt message and that's all for today. Thank you.