



Russell Meyers, CEO of Midland Health

COVID-19 Public Briefing: Tuesday, July 9, 2020

Transcribed from a previously recorded live event.

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

Mr. Meyers: Good morning everyone. I'm Russell Meyers, CEO of Midland Health and this is our Unified Command Team Briefing for Thursday morning, July 9th. We have a number of speakers for you today. I'm going to kick things off. I'll hand it off to Dr. Wilson to make some remarks. We'll continue with Mayor Payton. I believe Judge Johnson will be joining us and then we'll close today's proceedings with a special message from Secretary Don Evans who is a member of the governor's task force on reopening Texas. So, we have a lot to talk about today and we're going to dive right in.

Some early statistics, in the state of Texas over 220,000 confirmed cases now with over 2,800 confirmed deaths from COVID-19. In Midland County, we passed the 1,000 cases mark and have reached 1,020 confirmed cases with 19 deaths to date. Midland Health continues with our single drive through testing site. I have more to say about that in just a moment, but as of now, we have 424 outstanding tests from our testing site. That is as big a number as I can remember. Most of those are from the last 3 days, but we do have outstanding tests as far back as last Friday. So, we continue to see struggles with the send out labs keeping up with the demand that's coming to them from all over the country and we are being affected by that. We do have some solutions at least in the near term. One thing to note about testing, we don't have access to the data for everyone's testing, but those tests that we have been doing ourselves at our drive through site and sending off have reached an average of about 30% positive over the last 4 weeks. Prior to this peak period, they were running less than 10% positive. So, we are more often seeing patients who are tested and turning out to be positive if they have symptoms.

The hospital census today is 164 total. We are at our all-time high now for COVID cases with a total of 34. 8 of those are in critical care and 26 in our medical unit environments. I was asked the last time we met to provide an age breakdown on the hospitalized patients to give you a general idea of what we are seeing. I can tell you in critical care, they are pretty evenly spread from people in their 70s down to people in their 40s. In the medical units we have several patients that are in their 90s and we have a couple of patients in their 20s and each decade cohort is pretty evenly represented from the 90s to the 20s. Our biggest group is those in their 50s with a total of 9 patients. So, a pretty widespread, consistent in both critical care and the medical environment across all different age ranges.

The hospital is, as you can tell, very full. We have 9 non-COVID critical care patients as well as 8 critical care patients with COVID. 26 COVID patients in the medical unit. So, we are hard pressed to accept any transfers from outside hospitals now. That's a process that's ongoing for us. When we close to transfers from outside the community, our team reevaluates that every few hours. We know we have an obligation to serve those around the region who don't have the capabilities we have, and we want to keep ourselves open to that as much as we can. But we can't promise to do what we don't have the capacity to do. So, we are carefully evaluating that every few hours and for right now, no critical care transfers are being accepted.

We are still doing elective surgical cases and expect that we will continue to do so, but that continues to be a day to day, even an hour to hour evaluation especially with regard to surgical cases that will require a post-operative inpatient stay. So, for right now we are still on track with those that are scheduled.



Let's see. More on statistics. Ventilators, we have 9 in use. 7 of those are on COVID patients. Remember we have 44 full-service ventilators. So, we've never run short of ventilators and are not close to that at this point.

We've talked about our employees a couple of times recently and it continues to be a significant concern for us. We have a total of 53 employees now who have tested positive. Several of those folks have gone through the recovery period and returned to work, but we have many more who are being monitored now and have not tested positive. So, lots of concerns about the continued availability of our workforce, of course about the health and well-being of the people we care the most about who work with us every day, but I am happy to report that no member of our workforce has been hospitalized.

The biggest news that I have to report today is about testing and it's multifaceted. What we've been working on for a couple of weeks and are now prepared to say will go live tomorrow is a new testing site. I think most people know that we've been testing at the back of our West Campus by appointment only for a long time now, for several months. Drive through testing has gone very well, but all those tests have been sent out to outside labs and they've taken multiple days to get results. Effective tomorrow morning at 9:00am, on a limited basis initially because we are trying out some new equipment, but tomorrow at 9:00am, we'll have a new testing site open at the Coleman Clinic on East Florida Avenue. People are very familiar, I think, with the Coleman Clinic on the east side of town. So, we'll have our West Campus site and the new Coleman Clinic site both available starting tomorrow running Monday through Friday typically 4 hours a day for the time being. Two things that are important to understand about the Coleman Clinic site. One is, we are trying out a new piece of equipment. We have rapid testing capability on a fairly limited basis, and we are going to be using it at the Coleman site. So, certainly tomorrow and perhaps into the early part of next week, we'll be scheduling a limited number of patients there to make sure that the staff can keep up with the volume, understands how to use the machine, to register patients timely, to do the whole process in a way that's efficient and doesn't promise more than we can deliver. As has been the case with our West Campus program from the very beginning, it will still be the case in both testing sites going forward. We will only test patients by appointment. The way to get an appointment is through 68NURSE. I think you see that on the screen now. Simple statement, if you have symptoms and believe that you need a test, call 68NURSE. If your doctor has told you need to go get tested, call 68NURSE. We'll route you to the appropriate people, make an appointment for you, get you to the site that makes the most sense for you, and get you tested as soon as possible. We'll be using the Quidel Sofia 2 units at the Coleman site and hopefully at the West Campus site next week or in the not too distant future. Those units should be able to turn around results in about an hour start to finish for most patients, but we want to be sure we test that theory and make sure we actually can turn results around that fast before we open it up to widespread and high volume testing. So, that's the testing story. I think it's a very good story, but we're still a little bit hesitant about going full blast until we prove it out and we'll be starting with that tomorrow.

The last thing I'd like to say about that is we've had great cooperation from the emergency management teams at the city and the county. We're using some city equipment. They've been very helpful in helping us set up logistics, procuring PPE, a lot of cooperation happening to get that Coleman site live and thanks to the folks at the city and the county for helping us out.

I'd like to ask Dr. Wilson to come up. He's got a couple of comments to make and then we'll move on through the agenda after Dr. Wilson.



Dr. Larry Wilson (Vice President, Medical Affairs): Thank you, Russell. So, I'd like to remind everybody, you know, hearing a lot of information and I think some of it is expressed in the frame work of sort of frustration about the lack of progress or, you know, it doesn't seem like we've moved very far in finding cure for the COVID infection, the pandemic as things have been going forward. I'd like to remind all of us that we're about 6 months into this pandemic and it started off in hotbeds in Seattle, California, New York City. What was recognized quickly with that, was that the best cure or the best way to slow the disease was prevention. And with increased social distancing, increased protection of the vulnerable population, wearing face coverings, mitigating the exposure of others to the infection they were able to dampen down their curves, slow down the progress of the disease, decrease the load on their hospitals and in their society, and begin to open up economically and begin to get back towards normal. Other parts of the country that didn't get hit as hard with the virus early on, very quickly opened up when the opportunity was there to do so and unfortunately perhaps not with the same level of personal choice of being careful with social distancing, face covering, etc. So, we've seen an uptick in disease in other parts of the country including our own state of Texas and in our own area here in Midland. Since Memorial Day, the swing up has been very, very noticeable. We've had over 50 confirmed cases on a daily basis for a few days now. Our hospital has 34 patients hospitalized now. So, I want to remind us all that despite the fact that we made some great progress in terms of our treatments and keeping people well once they get infected, you know, an ounce of prevention is worth a pound of cure. And if we prevent the infection, that's where we're going to have our best opportunities.

Having said all of that, a lot of the information that's been out there about different kind of treatments I'd like to remind all of us, that we've made some great progress there. There's been the COVID Convalescent Plasma (CCP) seems to be very successful in helping decrease the load of disease on individuals. Remdesivir has been out and been widely provided through the government through Gilead and helped reduce the length of stay in the hospital and mitigate the degree of illness that people have experienced with that as well. Recently, information about using IV and oral steroids seems to be promising for some of the sicker individuals in decreasing the inflammatory reactions and helping people stay better longer and sooner. And various therapies in the hospital, high flow oxygen, restriction of fluids to some extent, proning of the very sick individuals have all mitigated the mortality rate, decreased the mortality rate, helped people do better, longer, sooner. A lot of mixed information remains out there about hydroxychloroquine. It's been, you know, the golden child at one point in time then kind of fell off everybody's radar screen. There seems to be some information out there again suggesting it might have some benefit. Figuring out the right population that it might have the benefit in still remains to be seen, but it's being utilized to some extent again. You've heard information about inhaled steroids. I've done as much homework as I can around that topic, and I'll touch on that again briefly in just a moment. And then last time we were here I mentioned something about or somebody else asked about Ivermectin I think it's called. It's an antiparasitic drug. I hadn't heard anything about it, so I did a little homework around that and had some help from Kit Bredimus our CNO on that. And what we found is that it's been an antiparasitic agent for quite a long time that seems to have some anti-viral benefit. And it's been tested in vitro. So, in glass tubes or in a laboratory not on animal studies for anti-viral benefit. And it seems to have some promising decrease in viral growth in development, but there may be some promise to that, but so far it hasn't made it into the medical literature. That's why I had not heard anything about it, but it's in the research literature and hopefully there will be more information there going forward. So, I just want to remind everybody that work is going on. We're 6 months into this frustrating. I get that it's not fun to social distance and wear face



coverings, but it is really the way to mitigate the disease, decrease the disease load in our community, and stay open and doing things the way that we'd like to be doing things again.

So, back on the inhaled steroids. I've done some homework around that. I found one valuable article in a European Respiratory journal. In that article, they have no definitive information whatsoever. There's not been any large studies in its utilization. They do make some points. COPD patients and asthma patients are often on inhaled steroids. That's their therapy. In that population, it has been shown that there's been a reduced number, or they have less COVID infections than other populations. Now, could that be because they're on the inhaled steroids or is it because they are more careful because they know they're at risk. There's no information to support that one way or another. What is recognized is that if they do get the infection, they have a mortality rate 3 times higher than the general population does. So, it certainly is not curative if you're on inhaled steroids and you develop the infection. Whether it might help in prevention or not, is not clear and there are no definitive studies. I would love everybody to just take the time to be thoughtful about any new therapies that come along. We're all frustrated. We all somewhat have anxiety around this, and we all want something that can just fix it. And the most valuable thing that can fix it right now, is public health and prevention and let science do its work and move forward. Hopefully we'll get to a better place in the near future. So, if you get an opportunity, go online, research it yourself. I know there is at least one advocate out there for inhaled steroids being very, very beneficial. Maybe there are others. Most of science isn't there. Most of medicine isn't there. Be careful, be thoughtful. Do your own homework. Read it yourself and come to your own conclusions. So, thank you.

Mr. Meyers: Thank you Dr. Wilson. I'll ask you to stay nearby because I think we'll take some questions now. We had agreed with each of the speakers that as each organization completes its remarks, we'll open to questions specific to those remarks and those organizations. We're open for questions at this point.

Tasa Richardson, Midland Health Public Relations Manager: We do have some questions from Facebook. How accurate are the rapid tests that we are doing?

Mr. Meyers: The rapid tests are not going to be quite as certain as the PCR testing that we do in our own lab or that the many send out labs will do. They are, I believe we agreed on, 85% sensitive which essentially means that you're going to get 1 to 2 inaccurate negatives per 100 tests. Do I have that right? (asking someone off camera, response not heard from off camera) 15, I'm sorry. 15 inaccurate negatives. So, the risk is on the negative side. If those tests produce a positive result, we can be highly confident that that patient is positive. If the test produces a negative result, we can be about 85% positive that that's a legitimate negative. So, it's not perfect. Patients with severe symptoms will still need to be careful about monitoring their own behavior and self-isolating. The negative test that there's reason to doubt can be re-run, can be confirmed on some other instrumentation. But the good thing about the rapid tests is that they're available, they turn results around rapidly, and we can avoid these lengthy waits. On the downside, I was told right before I came in here this morning that while we had initially a good result in securing the machines and the test kits to run on those machines, the manufacturer has now put us on notice that they are moving to an allocation basis meaning they can't keep up with the demand. We have, I think as of this morning 1,800 test capacity in hand and we're not really sure when or if we'll get more. So, we'll use those as long as we can use them. There's the possibility there may even be a second type of rapid test that we can get our hands on and we are



evaluating that night now. But we'll use them as long as we can. Results will come out quickly and if we have to revert to send out tests again that remains an option.

Tasa: We have a question from KWES. Go ahead. Ok, I think we are having some microphone issues. We'll work on that and come back to you. We have a question from Shane at CBS7. Good morning everyone. What kind of stress is the hospital under with more than 50 staff members out and a record number of Coronavirus patients needing care?

Mr. Meyers: A lot of stress. There's no question. We can't have that many of our co-workers affected by this disease and not feel a great deal of concern for them as well as concern for our ability to adequately staff the patient care services that we need to provide. So, we are very concerned about that. The census is high. It's a challenge for us, we hate to turn away transfer requests, especially from the hospitals around us that depend on us to take their critical patients. But we're in that place right now. So, we're not only stressed ourselves, but the bigger, broader region is stressed. I had a call with one of the hospitals in Lubbock a couple of days ago concerned that they were beginning to see more demand for transfers in their direction from small hospitals that usually transfer directly to us and that's true. That's part of our reality as we run low on capacity either staff or space. Those patients are going to have to go farther and farther away when their needs can't be met in their own communities. So, we have a wide variety of concerns that come back to Dr. Wilson's admonition that we should all be focused on social distancing and prevention. You are going to hear more about that from the other speakers on today's panel later on and that's the most important thing we can do. Recognize we have a limited supply of resources here, human resources to take care of the patients that need us. Know that we have to do everything we can to keep those people healthy and on the job.

Tasa: There's a follow up question. Do you have any more staff members coming from out of state to help?

Mr. Meyers: We are constantly working that. There's a lot of demand for traveling nursing staff especially. We've got a few in the pipeline. We are trying to find more, looking for every opportunity that's out there, but a lot of other hospitals are competing for those same people. So, it's not an easy thing to do to get traveling staff. We've had some success. We anticipate getting a few more, but it's certainly not enough to replace everybody where we've lost.

Tasa: Thank you, we're going to go back to channel 9 KWES and see if we can get audio this time.

KWES: Hi there, just real quick. Can we get the number of all the negative and the positive tests right now?

Mr. Meyers: All the negative and positive tests?

KWES: Yeah.

Mr. Meyers: I can tell you all the positives of Midland County. That's 1,020 and you can find that on the Health Department's website. They post that every day.

KWES: OK.

Mr. Meyers: I'm not sure what else is posted there. I don't have that in front of me. The total negatives I'm not sure I have that number. Sorry.



KWES: Ok. One of the questions that we are getting is why the recoveries are so low in Midland County compared to Ector County.

Mr. Meyers: Why are the recoveries so low? I think that recovery number comes from the Health Department if I'm not mistaken and I don't have access to their methodology. I suspect that many patients are lost to follow up and they just don't know. They don't want to count a recovery number that they're not confident of. But that's a question you really need to address to the Health Department to be sure to understand their methodology.

KWES: Ok. Just right now if someone wants to get tested, what are all the options right now as far as testing goes?

Mr. Meyers: I don't pretend to know all the options. I can tell you the options that the hospital is responsible for. And all the options we have are available through a call to 68NURSE. So, you call 68NURSE, you describe your symptoms, they'll make an appointment for you today. This is Thursday, today the only site we have for that testing is our West Campus. They'll send you there with an appointment. Starting tomorrow we'll add the Coleman Clinic Site which we'll also be operating. So, that will be two locations that the hospital operates, and both are accessible through a call to 68NURSE. I know there are other providers around the community that are offering testing, but I'm not in a position to list all of them for you, I'm sorry.

KWES: Ok. Thank you.

Tasa: OK, we have a question from Caitlin from the MRT. Is the new testing site also going to be a drive through location?

Mr. Meyers: Yes, it is. Very well-- We've got great access there at the clinic. They've got a parking lot on what I guess is the east side of their building that is essentially assigned to us and we'll have good flow and a team out there beginning tomorrow morning at 9:00am.

Tasa: A follow up question is, and when you say appointments at the new site will be limited at first, do you know about how many appointments will be available?

Mr. Meyers: We have talked in terms of about 30 for the 4-hour period and I think they are going to gauge that as they go along, but that's where we are headed. I think we'd like to get them up to about a hundred a day, but in the short term, you know, 25-30% of capacity just until we make sure we've proven the model. That may just be for Friday. We may be able to open wide next week, but we are going to test it and make sure we can do it right.

Tasa: We have a question from Facebook. A 30% positive rate is far higher than the 5% positive rate that John Hopkins advises we should achieve and may indicate testing only the sickest patients who seek medical attention and is not casting a wide enough net to know how much virus is spreading within its communities. Do you foresee with this new testing being sufficient to get to a 5% positivity rate?

Mr. Meyers: I can't speculate on the positivity rate. What I can tell you is that we do not have the capacity and we do not have anticipate having the capacity to test broadly throughout the community, to test all comers, to test anyone who believes they've been exposed, to do the kind of things that the Hopkins study assumes. If we are testing the wide population including many people who have no symptoms and no exposure, then those lower positive numbers are most likely to result. That's not what we are doing. We are testing people with symptoms primarily. On occasion, we'll test someone



who's had a very significant exposure or some other unusual circumstance that requires them to be tested. But by in large, we are testing people who have already developed some amount of disease. So, it's not shocking to see our numbers pretty high. What is concerning is our numbers are considerably higher than in the first round when we were using the same rules and testing fewer people frankly because the demand has gone up. So, our demand has gone up, our positivity rate has gone up, but it's still patients with symptoms primarily. Not a real direct correlation with the Hopkins recommendation.

Tasa: Do respiratory habits have any impact on infection rate?

Mr. Meyers: I'd have to ask you to clarify what respiratory habits would mean.

Tasa: Her follow up question, and I believe this might offer some clarification, is do mouth breathers have a higher chance of catching it?

Mr. Meyers: We don't know. Sorry, I think all breathers have a chance of catching it they're in an area that's highly concentrated like when they are standing next to a person who has the disease if they don't have a mask on, so whether you breathe through your mouth or your nose or both you are much better off staying out of crowds and avoiding people who don't wear a mask.

Tasa: We have another question from KWES. Go ahead.

KWES: So, is the hospital open to testing Budesonide and, if not, are there any legality issues that come with it?

Mr. Meyers: Well, the hospital is not a research organization to begin with, so we are not open to testing anything. Everyday clinicians in our hospital are making decisions on how to treat sick patients who are in our hospital and they are using the best available research that they have seen and read and synthesized through their own experience and training. So, if you are asking would we do a clinical trial on our patients, absolutely not. There are a wide variety of ethical and legal problems with attempting to trial a drug like that in our setting and that's not something that we are set up to do or would consider doing.

KWES: Ok, one more question. Are there any certain blood types that are most vulnerable when it comes to COVID-19, to catching it?

Mr. Meyers: We've heard a little bit about blood types and what little bit I've heard, I'll make sure Dr. Wilson checks me on this, is that type O blood seems to be more resistant. Whether there's anything more to that, I don't—Ok, he's saying that as far as he knows there isn't. Type O perhaps is a little more resistant, otherwise not really much to go on there.

KWES: Ok, thank you.

Tasa: Is there a place to test our antibodies for free?

Mr. Meyers: We do not do antibody testing for free. It is available in both our main and West Campuses by appointment, but we'll either bill it to your insurance or we'll ask you to pay for it and we're not doing that for free.

Tasa: I believe that's all the questions we have. We can move on through the agenda.

Mr. Meyers: Ok, very good. Mr. Mayor, I think you're up next and I'll step aside.