Transcript for DPH and NC AHEC Weekly Forum for Providers
March 27th, 2020
12:30pm – 1:30pm

Presenters:
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Hugh Tilson:
Good afternoon everybody. We will get started in about three minutes.

Please stand by for real time captions.

This is the March 27 version of the COVID-19 form. Our moderator will begin in about one minute.

Good afternoon everybody. It is 12:30 PM. Let's get started. Thank you for participating in today's COVID-19 webinar for providers. This forum is sponsored by the North Carolina Division of Public health and NC AHEC to discuss recent updates to the state's COVID-19 policy and their real-world applications. My name is Hugh Tilson, I will be moderating today's forum. Before we get started, I would like to take a brief moment to recognize the challenging times everyone is facing and to thank all of you for your hard work and commitment to your patients, residents, families, friends and others in our state. Working together, we will get through this.

The presenters today are Dr. Victoria Mobley and Dr. Jean-Marie Maillard. Thank you for joining this discussion today. After some brief logistics, Dr. Mobley will give an update on the state's COVID-19 response and respond to questions submitted in advance. We will then take questions from you. As a reminder, this form is intended to provide updates and responses to issues related to the state's public health response. Questions related to Medicaid changes or telehealth will be addressed in other webinars. Please visit the NC AHEC website for more information on those and other relevant webinars. After our presenters are through, you can submit questions using the Q&A function on the black bar at the bottom of the screen. We have learned in past forums that the presenters often address your questions during their presentations. We will have time to get your questions. I encourage you to please wait until the presenters are through with their presentations before submitting a question. Please note, we cannot take questions from those of you have called in, only those of you who are entering this through the webinar function. Please do not submit questions using the chat function, only the Q&A function. We will not answer questions submitted via chat. Lastly, we will record this webinar and make that recording and a written transcript of it and these slides available to the public as soon as possible on the NCAHEC website. Dr. Mobley, thank you very much.

Dr. Mobley:
Good afternoon everyone. I am going to do a very brief update and then get right to your questions. Thank you to all of you who submitted

questions in advance. I will try to get to all of them, and of course, if you need clarification after my response, please feel free to enter that into the Q&A box. My colleague, Jean-Marie Maillard will be monitoring that box. Some of you may get answers to your questions as you submit them if they can easily be typed in and sent to you while I am answering the pre-submitted questions.

So today, as of this morning, we have over 700 confirmed cases in the state. The three main updates that I want to make you guys aware of that are coming down the pike, so not quite here, but the first two, you should be seeing these put into place in the upcoming week. The first is that we are going to be updating the testing criteria for COVID-19 testing through the state lab of public health. As more and more commercial labs and academic labs come online and are able to test for COVID-19, that will allow the state lab to focus more on high-priority patients and healthcare workers who are symptomatic. Those groups will be hospitalized patients. So presumably, individuals with more severe illness. Healthcare workers and first responders who are symptomatic. Patient who live in or have regular contact with high risk settings, high-risk settings including long-term care facilities, homeless shelters and correctional facilities. And lastly, persons who are at high risk of severe illness. So the individuals who are over the age of 64, are immunosuppressed, and individuals with chronic health conditions.

The second update comes from the CDC. If you go to their website you will see they released interim recommendations on potential changes in specimen types. As you know, right now the requirement is for a nasopharyngeal swab, it is uncomfortable and often requires a nasopharyngeal collection device. But they have announced that specimens from the mid-turbinates and nares are just as effective or as sensitive. So if that stands out -- the state lab is doing a validation process to not only validate that their sensitivity for those two different specimen types, sp the anterior nare and the mid-turbinate swab are just as sensitive as the nasopharyngeal swab, but also whether or not instead of using viral-culture medium, which we know is in short supply, whether or not sterile saline could be used. If that pans out, that actually might greatly reduce the need for PPE when collecting specimens because it also allows the patient to collect their own specimens. They don't have to shove the swab all the way to the back of their nasopharynx. It is much more easy for them to put a swab and swirl it around and put it into a tube with sterile water. So stay tuned for that.

Lastly on our website, we have updated long-term-care guidance. I think it is important for you guys, particularly those of you who see patients in the hospital, because we don't recommend keeping individuals in the hospital longer than they clinically need to be there. We know, even before this pandemic, the longer individuals stay in the hospital the more at risk they are for acquiring hospital associated infections. So releasing COVID-19 patients when they are clinically stable and ready to go to long-term care facilities, skilled nursing homes, is permissible as long as the nursing home can reasonably take care of them. So being able to maintain their isolation status until the end of the recommended period, having staff with the appropriate PPE that can care for them until that time.

And that, before I get into the questions, I do want to say that I know a lot of counties in North Carolina have issued shelter in place or stay at home orders. At this time, that is not what the state of North Carolina is ordering. Providers should, therefore, contact the jurisdiction that issued the order to inquire about how essential or mandatory services or providers are defined. As you're trying to decide whether or not you should be going to work everyday and continuing to go about your business life.

I am going to go ahead to the first question. I will read the question and give you my thoughts. **My provider has asked about information on the duration of the virus or symptoms both in healthy patients and patients with underlying risk. How long should we expect patients to be symptomatic or ill?**

It is a hard question to answer. Recovery depends on a lot of different factors, one of the main ones is that individual's immune system and their response to the infection. There is also the added question of whether or not this patient is in one of the clinical trials, testing out one of the many potential treatments for COVID-19. We do know that individuals who are more severely ill and immunocompromised patients may shed the virus longer than folks with mild symptoms. But again, we can't give a definitive time of when should expect individuals to get better, and when you can expect them to no longer be shedding the virus.

The next question, can you please provide a suggested list of supplies to have on hand and the quantity?

If by supplies you are referring to PPE, that depends on what procedures you and your facility, hospital are performing. At the very least, you should try to maintain an adequate supply of the recommended PPE for assessing and treating patients with COVID-19. That includes facemasks, N95 respirators, those should really be reserved for procedures that are expected to generate aerosolized particles, gloves, gowns, eyeshields and/or goggles. Those are minimum PPE, but again, it is unclear what PPE you need and how much you need. That is a question that you will have to answer based off of the activities you do. The CDC has developed a tool to help you called the PPE burn calculator. If you Google CDC PPE burn calculator it will take you to that website. It is actually extremely useful for practices and hospitals to assess how much PPE you use and help optimize it's use to help preserve it for longer.

The next question, as an example, we have an aid or nurse who sees a patient today. Tonight, we get a call from the patient that he has developed fever and respiratory symptoms. Our protocol is to advise the patient to contact their PCP to report the symptoms and obtain further guidance. Often the PCP refers the patient for COVID-19 testing. Does the aid and nurse who saw the patient that morning need to take any special precautions pending the COVID-19 results?

I think you could think of this question in a few ways. If the patient hadn't developed symptoms yet, then the risk of transmission would have been relatively low but of course we can't say it was zero. We are still trying to understand the impact of asymptomatic transmission in this

pandemic. That aside, you need to assess whether the healthcare worker was wearing appropriate PPE. And then, the risk exposure kind of stratifies from there. Appropriate PPE, we would not consider them a risk, or at least it would be a low-risk. Not appropriate PPE, then it is up to you and your practice to assess what the next steps are. So the CDC has a table that can help guide you in this. Although for medium and high risk exposures, they recommend if it is feasible to do a 14 day quarantine for the healthcare provider. We understand that that's not always feasible, sometimes practices have limited staff and you may need to continue working. In that case, there is actually guidance for how the healthcare worker in their facility should monitor that healthcare worker either until the COVID-19 test result comes back on the individual they were concerned about, or until the end of their 14 day quarantine period. But allows them to continue to work, with or without wearing a mask during their interactions with future patients. So I encourage you to look at the guidance put out by the CDC. It is extremely helpful in helping to identify mechanisms that will allow your staff to continue to work even after potential exposure.

Next question, I think this is, I drive by a primary care clinic daily which is boasting increasing visits for any reason and doing COVID-19 testing. I find this irresponsible and worry about exposures that could inadvertently lead -- I think the main thing is they are worried that a clinic is boasting about increasing business with testing for COVID-19 and the questioner wants to know who they can speak to about this.

I would encourage you to contact your local health department if you have concerns within your jurisdiction. All local health department phone numbers can be found online.

Next question, when can healthcare providers who have had an exposure to a person under investigation, return to work if the PUI's COVID-19 test is negative?

Right away, as long as the healthcare worker is feeling well. They can go right back to work.

Next question, how far do you extend the chain of exposure? This is the example that is given, a PUI comes in after lying to a screener, has a fever and now is in a regular clinical area as a PUI. This is not discovered until the nurse has taken vitals etc. They were in close contact with the patient for five minutes. The nurse goes home and is told that the patient is COVID-19 negative but that nurse has been in close contact with another nurse, etc.

Once someone is exposed, there is an incubation period. They don't immediately become infected or infectious. As long as your healthcare worker or nurse, perform the appropriate before and after hand hygiene, and all of the steps that we expect all providers to do before and after seeing a patient, then the nurse that the nurse came in contact with, would not be a concern. I think that was the main answer. Then the nurse that had the exposure, without the appropriate PPE, can self-quarantine. Back to deciding whether or not she or he self-quarantines while continuing to work, taking additional measures to make sure that they

identify if they become ill and protect the patients that they continue to see at the time. So they self-quarantine until the results come back. And then of course, you follow the CDC guidance for when you can stop self-quarantine or stop the self-isolation if symptoms develop. I hope that answers the question.

Next question, any reports of third-party transmission of the virus, i.e. a person who is tested positive and has a visitor and the visitor goes home to their family?

So, if you're asking can the visitor transmit the virus to their family, the answer is yes. They can come of course have acquired the infection and eventually will start shedding the virus. Again, that doesn't happen immediately. But the bigger risk here from this question is, whether or not the visitor performed the appropriate hand hygiene after coming in contact with someone who had COVID-19 before going home to their families. Of course, if you carry a virus home on your hand, on your clothes, you can certainly transfer that to others. Weather it be directly or by contaminating high touch things in your house. This is why good hand hygiene is so critical.

Next question, do we need to submit CDC forms for patients suspected of coronavirus via phone visit if we are not testing them? How will epidemiology numbers accurately be captured if we are only testing those who have shortness of breath?

As far as the reporting, North Carolina law requires providers to notify the local health department that covers your jurisdiction of suspected or confirmed cases of reportable conditions. COVID-19 is now one of our reportable infections. It requires you to report immediately to your local health department if you suspect or have a confirmed case. So based off this question, you have to decide whether or not you suspect, because you're not testing, which is fine. If they are mildly ill and the guidance is don't come into a healthcare setting just to get a test. But if you are a provider and you suspect, you are supposed to report that by phone immediately to your local health department, and then complete the part one disease report card form, which is also on the DPH website, within seven days. And for that form, it is most important to complete it and Fax it in, if the test result is positive. So in this case, you know testing is happening, and that probably won't need to be done.

That being said, to address the kind of bigger question, even if we increase testing, we would still not be able to determine the true burden of infection. Encouraging mildly ill people to present to a healthcare setting where sick and vulnerable individuals are receiving care only increases the likelihood of disease transmission to those vulnerable populations, and also to the healthcare workers, the ones who are caring for them. So this has the unfortunate consequence of resulting in burning through what is already an extremely scarce supply of PPE right now. So prioritizing populations who are ill who are more likely to have severe illness after infection is really key here so that we can make sure to preserve the healthcare worker force that needs to be well and able to take care of these individuals.

As far as understanding are true numbers, even if we tested everybody, we would not know the true burden. We do have mechanisms in place using already existing surveillance systems to better understand the burden of COVID-19 in North Carolina, and that has added benefit of being able to understand this pandemic in our state without putting more patients and first-line responders at risk.

Next question, should we allow families to still do resident laundry in skilled nursing facilities? Many families like to do their loved one's laundry.

Currently DHHS recommends restricting visitors to skilled nursing facilities unless it is an emergent need or end-of-life situation. So I would say No, you should not still let family members do their laundry. Really you should try to restrict as much as possible visitors to these facilities as these facilities, the residents in them are really among the highest risk population. Everything we can do to prevent introducing COVID-19 into those facilities and to these individuals should be taken, every measure should be taken. There is guidance on that on our DHHS website. Long-term care setting guidance. It was just updated in the last couple of days.

Next question, do we know how protective the immunity is once having recovered from COVID-19 infection? And, are PPE still necessary in treating COVID-19 patients by providers who have themselves recovered?

To the first question, we don't know a lot about immunity following recovery from COVID-19. But we believe that there is likely some short-term protection, at least from what we can see from studies looking at other coronavirus's. Also, there are some clinical trials looking, not just at medications that might be beneficial, but in giving the sera of recovered patients, patients who have recovered from COVID-19, giving their sera to patients who are currently infected with COVID-19 and has severe illness to see whether or not you get some of that transfer of antibodies from those who have recovered.

That data will come out hopefully we will see some at least temporary immunity, but as far as whether or not the healthcare worker should wear PPE once the healthcare worker has recovered, I would say you should wear PPE if you clinically would have worn it outside of having ever had COVID-19. So, the healthcare workers who had COVID-19, you should not go back to work until you have been cleared, so all the condition based precautions have been removed. Whether that be the test-based or non-test-based strategy. So if you're back at work, then all of those conditions have been met, and then the decision to wear PPE should be based on the same requirements that you had before you had COVID-19. So the patient with respiratory symptoms, you should wear the appropriate PPE. Patient with G.I. symptoms again, appropriate PPE.

Next question, should healthcare providers self-quarantine from mild URI symptoms with a temperature less than 100 while awaiting COVID test results.

So if a healthcare worker develops symptoms of a URI, they should self-isolate either until the COVID-19 test results are back or until they're no longer symptomatic. So, right now we are really worried about COVID-19 but there are other things that we as healthcare providers could expose our patients to if we work while we are ill. So keep that in mind. Also keep in mind that if a significant proportion of folks with COVID-19 do not present with a fever, so although we use that as a screening measure, the absence of fever does not necessarily mean you don't have COVID-19. It's actually the absence of a fever may be more likely in some of our vulnerable populations like the elderly individuals and folks with immune-compromising conditions who just aren't able to manifest a fever in response to infections.

Next question, what are the recommendations regarding well-infant/child checks and reaching immunizations?

A great question. It is a hard one. As much as possible if you can do well-infant checks virtually, that would be best at this time. We understand that not knowing how long this kind of response is going to be necessary, we don't want to end up with a cohort of unvaccinated children. As pediatric practices are moving more to virtual and telephonic check ins, I would also encourage you to start thinking about how or if you can develop a plan to try to keep children as close to their vaccination schedule as possible. I'm not a pediatrician, I don't know what that would look like, but maybe if you scheduled appointments and then had check ins the morning before to make sure parents and child have no respiratory symptoms, and if not, proceed with bringing them in just to get the vaccine done, and then send them home. But again, I think the ability to do this will vary by practice and it may not be something you are able to do, but it is definitely something we would encourage you to think about how you could keep those schedules going.

Next question, where can independent primary care practices get N95 masks, surgical masks, gowns and facials when our usual outside supplier is out of stock or too low to meet demand?

If you need to request PPE, the process is for you to contact your local emergency management office. If you don't know how to contact them, you can do that through your local health department. They can give you the appropriate person and phone number to reach out to. I can't guarantee that a request will be filled, but that is the process for trying to obtain additional PPE.

Next question, if we believe a patient needs emergency care for respiratory symptoms with shortness of breath, should we use the hospital connect line to see which facilities to send them to?

I would say it depends on the acuity of the issue. If they are in acute respiratory distress, I would say call EMS as you would normally do and let them know the person has respiratory symptoms, all the EMS in the state now know what to do as far as PPE precautions in response to someone with respiratory distress.

If the patient doesn't need an urgent transfer to the hospital, I think it is reasonable to call the hospital connect line if that is what

you would normally do. But I honestly don't know what you mean by hospital connect line. So I may be off base with that one

Next question. Why have Quest and LabCorp testing swabs for COVID-19 been taken away from independent practices?

I wasn't aware of that, so I can't provide you with an answer. I would recommend, though, it was Quest and LabCorp that stopped supplying this log, that you call your LabCorp request contact to ask about that. That does seem concerning.

Next question, if an independent office has no ability to test and as an outpatient office employee develops symptoms and has possibly exposed patients but does not meet current criteria for testing, for example, they have a cough or sore throat without fever. Will the health department come check that employee? And the second question is does the health department make home visits to test or does a patient have to go to the health department?

There are 100 counties in North Carolina, about 86 health departments. To understand what resources capacity your local health department has, you really have to contact them and ask. Because that varies by local health departments.

Next question, what is primary cares role in this? I am in pediatrics, it appears unless they are in immediate respiratory distress we are told as of March 23 not to test due to limited tests and PPE. Kids present with vague symptoms sometimes, but we know our big vectors for transmission. We have moved all fevers and are respiratory symptom screening patients outdoors in a tent, that is most of our sick patients. Well-child and things like ADHD are indoors and can often be used with telemedicine. What are your guidelines in how we limit transmission? right now all clinical staff wear one surgical mask unless visibly soiled, as we are within six feet of the patient. All patients included, sick and well, because it is one mask. PPE protecting for respiratory pathogens. Please give us some direction.

Okay. I think I understand the question. I would say, if you're bringing ill children for evaluation, whether that be in the clinic or in your tent outside, you should absolutely test them. If you have the testing supplies available. Especially since you've already brought them in for evaluation. We are not recommending that you bring a child in solely to test for COVID-19 if you would not have had them come in before this pandemic based on their clinical symptoms. What we don't want is for you to change your clinical practice or judgment because of COVID-19. That means if you normally would have asked a parent to bring in their ill child due to concern regarding their reported symptoms, you should absolutely still do that. The same PPE you use to evaluate and examine the child to collect your viral respiratory panel and COVID-19 testing. It is very smart and practical to move towards extended PPE use.

The CDC now has guidance for this on their website which you can find. Their guidances for continued eye protection and facemask use. Really, what they are recommending is for areas where there is low PPE, keeping

on your mask and/or eye protection between seeing patients with similar clinical symptoms. So still trying to cohort as much as possible, patients coming in with respiratory issues, And cohorting the healthcare providers that see those patients so the provider seeing this respiratory patient doesn't go and see a well-child next. If you can do that, that would be ideal. But really, your healthcare providers are going to have to be cognizant if they are keeping on that mask or eye protection, that they are one, not touching their face, and that they still take appropriate measures to take off appropriately the gown and gloves in-between patients and perform appropriate hand hygiene before re-gowning and regloving and seeing the next patient. And having internal measures where it is not just on the person wearing the PPE to monitor for soiling or the extended PPE getting wet. That there is someone else who is also keeping an eye on them. So if you see the PPE that you're using between patients get wet or soiled, that it is immediately identified, removed and replaced.

Next question, is it okay for aids at our home care agency to keep going to visit client homes to provide service? When should they stop and how is the home care sector affected. Other than PPE, what options do we have?

That is a hard one. I know oftentimes home aids are critical to the health and well-being of the clients they serve. I think there is guidance on the Centers for Medicare and Medicaid services website for home healthcare agencies that you can access and we can certainly provide you the link. We provide you with a link to the guidance they have. I think it comes down to affecting what are the other alternatives. If you're home health aide does not continue to see this patient, would the patient be able to get the resources and care they needed? Or would someone else have to come in to provide groceries and to do daily home health aide activities? And if that is the case, than trying to assure that your home health aide has the appropriate PPE they need to continue to do their activities is critical.

Next question, since there is a shortage of PPE, what is DHSR's stance on all employees wearing PPE if no outbreak is in the facility? Recommendations have been posted out there for all healthcare providers to wear masks when working, but if supply doesn't allow for this, will facilities be cited that there are zero cases in the facility?

I am not sure what guidance you are referring to, but we don't encourage all employees in facilities to wear a face mask all the time. PPE should really be reserved for when it is needed, facemasks and eye protection should be worn one by individuals who have been properly trained on how to put it on and take it off, and two by individuals whose normal duties they would be expected to come in contact with a patient's bodily secretions- saliva, blood, feces.

So appropriate PPE should be worn at that time when they are doing activities where exposure risk is presumed to occur or will likely occur. For example, if you're seeing someone for a sprained ankle and they have no respiratory symptoms, I would not PPE it up and go and see them. That doesn't seem like a good use of your PPE. I guess I would question what guidance you have seen out there that recommends PPE be worn at all

times, even for situations where there is no identified risk. Also, I would just say mainly for the situation you report, we really encourage frequent handwashing and hand-sanitizing and disinfecting high touch services like doorknobs and tables and toilet handles. This is the best thing to do to keep facilities, to keep the risk of COVID-19 from coming into and spreading quickly throughout the facilities. Of course, all employees should be not just encourage, but directed if they are ill at all they should not come into work.

Next question, annual physicals and other nonemergent appointments scheduled with community providers, do you recommend postponing these at this time?

Yes. If it is not urgent or emergent, the recommendation is either to postpone or switch to a virtual visit of some sort. Telephonic, face time. Any virtual or telemedicine visit that can take the place of an in-person visit is what is recommended at this time for nonurgent or emergent needs.

Next question, if a nurses aide working at a patients home develops symptoms of fever and cough and is sent home, when can that employee return to work if symptoms are not severe the aid will most likely not -- what is the best practice to ensure the safety of our beneficiaries?

There is guidance on our website, on the CDC website, for when you can release a symptomatic person who did not get a COVID-19 test from isolation. They have to have 72 hours with no fever without the use of any fever reducing meds. Their symptoms have to have improved and it has to have been at least seven days since their symptoms first started. So 72 hours, no fever, no fever meds, symptomatic improvement and at least seven days since their symptoms first started. After that, that is the non-test-based strategy to release individuals from transmission-based precautions, when they can return to work.

Let me make one additional point. If the healthcare worker is someone who typically sees the higher risk groups, so older individuals, and immune-compromised individuals, it really is worthwhile considering whether or not to use the test-based strategy instead of the non-test-based strategy. That is what the CDC would prefer, not a firm you have to do it this way, but because they're working with a particularly vulnerable population it is the preferred method to have two negative molecular tests taken at least 24 hours apart. In addition to the criteria I just listed, 3 days with no fever with no fever meds etc. So adding two negative tests is an additional precaution, particularly for healthcare workers that are going to go back to taking care of our higher risk populations.

Next question, can you allow roommates to dine together in a common area as long as others are six feet apart?

The roommates should also be six feet apart. So unless the roommates are husband and wife, which I know there are some facilities where they admit both husband and wife and they share a room, we are recommending the social distance is six feet apart for everyone, even if they are friends,

they should still eat and maintain that six feet of social distance as much as possible.

That is the end of the questions. Let me make sure I did not miss any. I think that is it. Do you have any? So I think we can probably take some questions that came up.

Dr. Maillard:
A question of people who smoke or vape, there is some guidance for general recommendations that was placed on Monday on the state website on COVID-19 that specifically addresses that.

Hugh Tilson:
Can they get that at the DHHS link that's on the slides?

Dr. Maillard:
Yes. It has been posted. I just could not find exactly where was.

Next question, where not reporting all patients with URI symptoms [Indiscernible – muffled] no time to process all those reports.

Dr. Mobley:
I think that is fine. The requirement is to report all suspected or confirmed cases of COVID-19, and obviously when you say suspected, there is wiggle room in that. So if you're testing somebody for COVID-19, then I would say your suspicion is at least that they could have it, and in that case you would be required to call your local health department and let them know that you're testing someone. But just calling them about anyone with URI symptoms, that is not required and not advisable since this is allergy season and the end of the flu season. There are a lot of people with URI symptoms that will not be or get tested for COVID-19 or are really not suspected of having it.

There was a question about kids with fever and do they come in. I did talk about that. Like said, don't change her clinical practice in judgment for the pandemic. If you would have seen them before, then see them now, and whether or not you order a COVID-19 test is really should be purely based on your clinical judgment of whether or not you think they have symptoms consistent with COVID-19 and whether or not they are mildly ill or you are concerned enough that you would potentially change your clinical management based on their results.

Dr. Maillard:
Next question is about testing and why not test everybody? I just responded to another question similar to this one.

The guidance is actually influenced by a number of criteria, some of which are how much testing is available. Right now, the state lab is still [inaudible] approval process with priority groups, but commercial lab have started testing, although we're hearing there are serious backlogs in commercial testing. That is all part of another criteria, a couple of criteria, with the shortage of supplies to do specimen collections, that is being worked out too. For example, trying to use saline instead of viral transport media. And lastly, the concern about

saving PPE to where it is absolutely needed when patients are admitted for treatment. All of that gets into the decisions of what guidance is issued for that day.

Dr. Mobley:
I see one about when we will get our PPE, I contacted Office of EM last week and have not heard from anyone. That is a very understandable concern. Hopefully you contacted your local EM office and not the state EM office. If that is the case, I would actually call them again and continue because they may tell you that unfortunately they got your request and can't fill it now, but at least to get an answer and can plan what you're going to do with your practice and with your patience based off of the response about weather to anticipate PPE coming to you.

You are talking about PPE and stuff, we don't know who has or does not have ... okay.

So, the question is, if we have mild symptoms as a provider, do I have to isolate until I have a chance to get tested? I thought we were not testing those with mild symptoms.

Your correct, we are not. Isolate until you meet the non-test-based strategy. You have to be three days with no fever and no use of fever lowering medication. Your symptoms have to have improved and a have to be at least seven days since your symptoms first started. Once you reach that, you fulfill that criteria, you can be released from your isolation and go back to practice. As I mentioned, providers who are seeing more vulnerable patients, if you can get a test for clearance, and really we are looking at providers seeing patients probably in the hospital and skilled nursing facilities and places like that, if you can get a test, great, if you can't, that is okay. You have been cleared from the non-test strategy and as a provider you should continue to take all the pre-cautions that are appropriate in making sure you don't give something to your patient or acquire something from your patient.

Dr. Maillard:
There is another question, I think we have also covered. Our office is making non-ill appointments in the morning, is it sufficient to continue scheduling well-child checks? You have that earlier in a question too.

Dr. Mobley:
I don't quite understand the question. You are seeing well children -- I sure. As much as it is possible we are discouraging face-to-face visits, but we understand sometimes that needs to happen, particularly for very young children where pediatricians lay hands on and do all the tests I have not thought about since medical school to make sure that they are thriving and growing as they should. That yes, that is fine. For those patients that it needs to happen, but as much as possible if you could move to a more telemedicine or telehealth approach during this time when we are really trying to slow this spread of COVID-19, that would be ideal.

Hugh Tilson:
Just to clarify, the question was is it okay if we make only well-child visits in the morning and then sick-child in the afternoon? Your answer is yes, but it's probably not the best.

The question was is it okay if you try to split it that way?

Dr. Mobley:
I think that's actually ideal. I probably would do it that way if you're going to be seeing both well and sick children on site. I would try to cohort the well-child visits at one time and have the children with symptoms come at a different time. So you don't have the mix of well and ill children sitting in the waiting room together, waiting to be seen. That is actually smart way to do things.

Dr. Maillard:
Question a paper from a COVID-19 response team looked at various pharmacology interventions and question strategies of transmission versus mitigation strategies [Indiscernible] that suppression is a better choice for areas that have the resources. What strategy is North Carolina using?

Some places have gone to a level where they were taking people out of their household for quarantine for isolation. This is not something we have been able to take up practically in North Carolina so far. So the strategy used in North Carolina is mitigation, which is slowing transmission with the intent of having more time to get supplies for example and lowering the peak so hopefully having less of the high risk persons exposed.

Dr. Mobley:
So clarify if we should [Indiscernible] triage cases that we recommend to get COVID-19 testing elsewhere to the local health department...

If you are sending them somewhere for a COVID-19 test, I would say yes, though you could have the patient call you and let you know they actually did get tested because if they do not get tested, I think that would meet the suspected criteria or definition as it loosely is defined. So yes, I would say if your patient actually does subsequently get tested, even if not for you, then letting their local health departments, the local health departments for which they are resident in that County know that they have been tested is theoretically what, is required in the public health admin code.

Dr. Maillard:
Question about, can a person get COVID-19 more than one time?

I have seen some physicians from China and Italy where they said this is happening and based on what has been described with coronavirus is typically been before COVID-19 it seems to be the case. I don't know how much experience there is with COVID-19. Can't really go beyond that.

Dr. Mobley:
That is a hard question to answer since this virus was first identified in December of last year. We just have not had a lot of time to understand the post-infection immunity and potential for reinfection. We just have not had enough time to really understand that yet.

Dr. Maillard:
Question of turnaround time at LabCorp which is currently 8 to 10 days.

We heard recently that the backlog was not quite as much as they have communicated to the state, but it is still very substantial. So we can't really respond precisely except to say that they have a way to try to assess that [Indiscernible]

Dr. Mobley:
I will add to that because I did get a couple of calls from clinicians who said that they were still waiting for the test results, even though the patient had met all the criteria for the non-test based strategy to be released from isolation, and that is fine. If your test results don't come back before you are able to release them based on the three criteria I mentioned before, that is okay. If the test does come back positive, the patient has already meet the criteria to be released from isolation, so they don't have to go back into isolation just because the test came back, if they have already ready met the criteria to come out of isolation. I hope that makes sense.

Who -- you are typing these questions faster than we are scrolling down.

Hugh Tilson:
One question came in about do we have guidance on standardization about washing clothing, disinfecting, etc. by healthcare workers when they arrive home to prevent possible spread to family members?

Dr. Mobley:
If the healthcare workers were wearing the appropriate PPE which includes the gown and gloves at work and were careful about taking it off so you don't -- appropriate offing of your PPE is supposed to prevent you from contaminating underlying clothing. I would say if all of that is done, than the risk for carrying it home in your clothing is extremely low. That being said, it is never a bad idea when you come from a hospital setting, not just for COVID-19, but we have all kinds of superbugs in the hospital, all the other things we were worried about before COVID-19 and will be worried about after. So if your healthcare provider who was working in the setting where that is a risk, then coming home and washing your clothing is always a good idea. I would say the standard way you would wash her clothing, warm water, the normal detergent and all that stuff is appropriate. There is no different level of care for your clothing that you need to take based specifically for COVID-19.

Dr. Maillard:
There is a question on washing, how to change clothing, washing clothing after seeing patients.

Dr. Mobley:
That is what we said.

The next question which it is, should daily monitoring of staff be done? For example, arrival in the morning and prior to leaving the office in the afternoon?

That is a decision your facility should make. Some of them are, a lot of facilities and some hospitals are screening employees as they come in with a forehead scanner for temperature and then they are asking the employees if few questions about whether or not they have respiratory symptoms. Other practices are having their employees attest that they have taken their temperature that morning. Whatever makes sense for your practice, I think is advisable.

[Indiscernible - muffled]

So Hugh,you have any others you pulled out that you think we should answer?

Hugh Tilson:
-- I am sorry. I was on mute. Any guidance about use of nonstandard masks, homemade masks?

Dr. Mobley:
Oh goodness. That is a hot question right now. We don't have guidance for that I will say. Particularly not for healthcare workers at this time, which you know, I think most of you on this call are. There may be guidance coming about that.

Dr. Maillard
There will also be guidance on the possible reuse. There are several studies on the way looking at UV, hydrogen peroxide vapor and other ways to repurpose the PPE. That is being done now. When they have results, we will give you more about that.

Dr. Mobley:
If a patient is seen in their PCP office but are later seen elsewhere, they are tested and found to be positive, will the PCP office be alerted?

That I don't know. That all depends on whether or not the person that actually tests the individual let's someone, the health department, know that the patient had been seen elsewhere, that day or the day before. So I can imagine there might be some breakdown in communication where that notification did not happen, but ideally once the patient were questioned after being diagnosed as positive, that would come to light, and then through contact tracing and the office, your office would be notified of the potential exposure.

Hugh Tilson:
I got a couple of questions related to where we are in this process. One is when do you suspect we will see a decline in cases, when you think kids will go back to school, will kids be able to go to summer camps? What should practices be advising their patients and community when asking?

Dr. Maillard:
Where we are on the curve, on the epidemic curve, we are at the beginning of the exponential increase. So this is the beginning, and it will go up for quite some time. How long? we don't really know because the models that are used , there are certain situations where no control measures are applied at all, and that goes up very high, and comes down very fast also. But mitigation alters that. A part of the alteration is we have less cases, which is the goal, more time, which is another goal to try to get supplies for example, but then the total duration of that weight is difficult to assess.

Dr. Mobley:
I am questioning with you. I don't know when this will end. I would say, you know, another few months at the very least we are going to be still in this mitigation phase and trying to encourage people to maintain social distance and providers to try to decrease face-to-face time with individuals who don't actually need the in person visit. I really hope for my own kids sake who are already losing their mind outside of school that at least summer camps or in the fall school will start per their usual schedule. But I don't know.

Hugh:
I got a question about the blood test that has been rumored to be out there, and patient self-testing. As opposed to LabCorps or public health testing. You have any comment on those?

Dr. Mobley:
Yea, not FDA approved.

Dr. Maillard:
The rapid test, some are used in Europe, but they are not FDA approved. We don't see them used approved in the U.S. That would be about serology. They are not perfect. They can give an assessment of the prevalence later on, to assess the proportion of the population exposed, but they are not, the sensitivity is around 85%.

Dr. Mobley:
The other issue is that those tests can actually be detecting other coronavirus', of which there are many. Just because it is positive doesn't mean it is positive for COVID-19. So short answer is, right now there is no FDA approved serologic test that we, from a public health or provider stand point, should be using to determine whether someone is infected with COVID-19.

Hugh Tilson:
Got a question about, what have you found to be helpful to address anxiety and stress during this time? What would you recommend other physicians and healthcare providers do?

Dr. Mobley:
Anxiety for the provider or the patient?

Dr. Maillard:
How about let's start with the providers and go to the patient.

Dr. Mobley:
I mean, I go to sleep thinking about COVID-19 and wake up in the middle the night. Sometimes anxious, sometimes just in despair. I think just really taking a step back and remembering that in looking at the data, this is a pandemic, in my lifetime I have not seen this before, but it is encouraging to me that for the majority of individuals that contract COVID-19 that their symptoms are mild or asyptomatic and they do very well. So I'm trying to focus on at least that one positive aspect in this, shifting all of your attention and thoughts and efforts to figuring out how we can best protect that vulnerable population that we are really concerned about if they get infected that they are going to have the most severe outcomes. It puts things in perspective for me and helps me refocus and not worry about the larger picture. For patients, I would also let them know that the measures they are taking, the social distancing, the staying home, the increasing handwashing and all of the things we are recommending and hoping that they do, are really going to decrease, lower their risk for acquiring COVID-19. Hopefully, that provides some measure of comfort. In this time, I think the bigger thing is the panic on the television and the sold-out grocery store aisles, which just blows my mind that I can't find any toilet paper. So some of that you're not going to be able to allay the concerns, but as much as possible, having them focus on the larger picture is what I would say.

Hugh Tilson:
Great. One last question. A question about ibuprofen and whether folks can take ibuprofen?

Dr. Maillard:
I think this was based on the letter to [Indiscernible] and it was later discounted to be more theoretical than practical.

Dr. Mobley:
So yes, at this time there is no indication, no data suggesting ibuprofen is detrimental for patients with COVID-19.

Hugh Tilson:
Great. It is 1:30 PM. Let me stop and say thank you. Thank you to those of you who may time in your day to listen to this and to send in questions. We think we got around to most of them. Dr. Mobley, Dr. Maillard, thank you so much for your time today, for all you are doing, please extend our gratitude to all the DPH team for the great work you're doing under these circumstances. Do you have any last comments for the participants?

Dr. Mobley:
No. Thank you for calling in. And you know, we try to update the DHHS website as we get more information as soon as possible. Please reach out to us at NC response email, ncresponse@dhhs.nc.gov, if you have questions that come up or questions we did not answer on this webinar. We wish you luck and thank you so much for the work that you were doing trying to keep everyone safe.

Hugh Tilson:
Just you know, you can go to the AHEC website and get a recording of this if you need to catch up on any of the great content. Thank you everybody.
[Event concluded]