Transcript for DPH Weekly Forum for Providers
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12:30-1:30 p.m.

Presenters:
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Hugh Tilson:
It is 12:30. Let's get started. Good afternoon everybody. Thank you for participating in today's COVID-19 webinar for providers. Today's webinar is part of a weekly series put on by the NC Division of Public Health and supported by AHEC to discuss recent updates to the state's COVID-19 response and to provide a forum for you to ask questions of DPH leaders. As an FYI after consulting with many of you, we have decided to move these from regular scheduled weekly webinars, to moving them to an as-needed basis in response to significant developments. Today will be the last regularly scheduled Friday Provider forum. My name is Hugh Tilson and I will be monitoring today's forum. Today you will be hearing from Jean-Marie Maillard, welcome back, and Britney Richo. Thank you so much for taking the time to be with us today. We know how busy you all are and really appreciate your carving out time to provide us with this important information.

Before I turn it over to our presenters, I want to thank everybody for taking the time out of your busy schedules to participate in today's webinar. We know how important your work is and how challenging this is and we hope that the information provided today will help you do that important work and make navigating these trying times a little easier.

Next slide. After you hear from our presenters, we will turn your questions. There are two ways to submit questions, one is using the Q&A feature, the black bar at the bottom of the screen. If you are not on the webinar, and you are calling in, the only way to submit a question is by using the Gmail account, which is questionsCOVID-19webinar@gmail.com.

We will record the webinar, we will make the slides available, along with the recording and a transcript on the NC AHEC webinar and I'll turn it over to Jean Marie for the update.

Thank you. And good afternoon everyone. Just to be clear, I usually try to monitor the questions on the zoom meeting, today for some reason, I think we have some Internet problems. I am unable to monitor the call there. So I will just to the questions that Hugh may relay verbally. During the call. And I just wanted to say there is not a lot of new things to share this week. But there's definitely no slowing down of the intensity of activities in response. So for this call, I would just provide an update on numbers, that was done earlier. And I will give a couple of words on guidance and talk about contact tracing and finally relay information from some recently published studies.

So in terms of numbers, worldwide, a total of 5,850,000 cases have been reported, with sadly 361,000 deaths. In the US, we have 1.7 million cases we have passed the 100,000 threshold of death recently. Today's total reported on the Johns Hopkins site gives 101,000 deaths reported. If you look at the CDC website, you may observe some discrepancy because I believe it's due to the fact that the CDC website updates just twice a week.

In terms of state updates, as of today, 26,488 cases have been reported. 859 death have been reported. We currently have 680 hospitalized COVID patients. The trend of hospitalized patients has been increasing slightly over the last few days. And this is important in terms of interpreting what is going on and the current direction of incidents for example. Especially when you consider the fact that with a very intentional increasing in testing, the number of positive lab confirmed cases may be difficult to interpret in how much being due to the increasing in testing versus what is an indication of the current trend.

So hospitalized patients, you wouldn't expect that to change based on increased testing. So it's an indicator that many people are keeping an eye on right now. The only good thing there I would add is that there is no shortage of ICU beds. The latest report we have is that there's actually a current ICU bed occupation is somewhere around half of the available beds, so there is no shortage of at the hospital level for caring for the most effected patients.

Quick word on North Carolina numbers by County, as that the two counties with the highest counts are Mecklenburg and Wake County, that's our most populated counties. So in part, no surprise, although it is combined with outbreaks that we see everywhere. But currently Mecklenburg has close to 4000 cases and Wake County has reported 1600 cases. In terms of number of reported outbreaks in North Carolina, the current total is 177 . 89 of these being in nursing homes, 37 in residential care facilities. 17 in correctional facilities. Six in other types of settings, and 28 in meat processing plants.

These sometimes lead to decisions to do extensive testing, and so there are some of these outbreaks with a large number of cases, because there's an intent to try to identify all infected persons in the facility or the plant to try to do a more efficient control . When that happens you can see a large increase in cases. And if I many of the persons tested, if we have a large number of asymptomatic cases.

The weekly report syndromic surveillance was just released yesterday. You can find these on the state website. Actually if you follow the information about COVID on the main page of the Department of Health and Human Services, you can fairly easily go to these reports, especially if you click on those leading you to the dashboard and so this report is fairly extensive and shows us that is a gradual increase in the last couple weeks we've seen an increase in COVID like illness. As seen in the emergency department visits. And just an additional word about hospital ED visits. Since the COVID outbreak increased in the state, we have seen a dramatic decrease in hospital emergency visit, down to about half the

normal level that we expect to see. Over the last three weeks, there's a very gradual uptake, slightly going up week after week. So that is something we also to follow.

To talk about guidance, directing you to the state website is very extensive coverage of multiple aspects of how, so I just talked about published data. But there is also a lot of guidance that's there, available that can answer many of the questions that either professionals or general public may have. It is organized to try to help retrieve information by topic. For example, there is a health care group, childcare group, education group of guidance, there's one for businesses. One for individuals and families. One for human services and housing and sheltering. And another one for animals and veterinary services. I encourage you to consult these because quite often they will help answer questions.

Now to talk about contact tracing and testing, I've already said that there's intention to increase testing and we talked about that earlier. We are still in the middle of that increase, it will continue to be emphasized in North Carolina and every other state. States are currently receiving very substantial financial support from the federal government to boost the testing, and that's why some of the labs will test more but we are also seeing a new testing sites, in pharmacies, for example. What goes along with that is for us, the challenges of monitoring the data that are reporting by all the sites. Both positive and negative. As we try to keep up with those aspects. The data also increased activities for contact tracing through a contract with CCNC and another with AHEC, our host today. And this is making progress and we are reaching implementation of all the innovations brought up in that area of response. There's a lot of training that's going on. The app, the software application that will be used is by Microsoft and is being adapted for use in North Carolina. The acronym for it is CCTO and that's a work COVID-19 Community Team Outreach tool. And we have heard that over a thousand contact tracers I believe there are around 800 being regular staff form local health department and at present close to 200 hired specifically for this initiative. Are being trained and beginning to do contact tracing in the state.

My last section of my briefing today is about some studies that you may have heard about too. One significant one is Lancet article released on May 22. That relates findings of studies of hydroxychloroquine or chloroquine when used alone or in combination with macrolide for treatment for COVID-19. That is showing what we have heard from earlier reports as well that there was actually an increased risk of in hospital mortality in patients receiving these treatments. Decrease in hospital survival and also increased frequency of ventricular arrhythmias when used for treatment of COVID-19, and this is not new. It was an adverse event that is known to happen with these medications, so that is now further the documented.

There is also a report, first, well not first, but one report about use of survivor plasma as treatment. And it is considered safe. There's a small study that was just released and two larger ones that are going on. But that small study showed that the death rate of those infused with

survivor plasma was about half that of similar patients who did not receive plasma. So that's very interesting. And part of the considerations associated with these sort of studies, well should essential staff possibly receive plasma infusions at regular intervals. I don't know that this is decided yet but it's under further consideration.

Next, and I will be honest. I have not had time yet to read it, but yesterday there was an article, a New York Times article that's kind of synthesizing a number studies and talking about herd immunity. So released from the New York Times on May 28. Interesting part here is that for different diseases, you need to reach a level of immunity in the community at fairly high proportions. The higher the infectiousness of the disease, the higher the herd immunity needed for prevention. And it's around 97 percent for measles which is extremely communicable. I think there is a general idea that for COVID, you would need to be above 60% of immune persons in the community to expect a break in the chain of transmission. And interesting facts there is that New York City, which was terribly affected by very very large outbreaks, the estimate currently or at the beginning of May, was just shy of 20 percent. We are far from reaching the level that would provide protection, and again that's the idea of if we can get a vaccine, it will boost that level of immunity in the population tremendously, hopefully, and that will be what will offer protection.

But not every location in the US was effected as New York was and we are beginning to see studies coming out of seroprevalance, there were two that were released recently. One in Los Angeles from early April. Testing about 865 residents. They found 4.3 percent prevalence. This is really high and this is 43 times greater than the communities case count in that community. So very significantly higher than what the confirmed cases would inform. Indiana did another study end of April, ending on May 1, testing 4500 residents. Their finding is that they estimate their prevalence of 2.8%. In their case that was 11 times greater than the reported incidents. We take that study and extrapolate it to North Carolina, we would say our prevalence, true prevalence in the state of North Carolina is probably closer to 290,000 cases as opposed to the count that I just reported. 26,488, today. It's around 13 fold higher than what the confirmed cases are. This is not a surprise. But we're beginning to see documentation of that. And just as a reminder, we have I believe four studies that are put in place, some have started already in North Carolina to help us with the sort of estimated findings. But it will take time before we start hearing results from that. So I will stop there. And let Britney tell us about her update.

Hugh Tilson:
Thank you, before we do that, we have a question about where we can find these studies. Can you repeat the sites for those?

Jean-Marie Maillard:
So the Lancet published the hydroxychloroquine study this is dated May 22, it's available online, it's called hydroxychloroquine or choloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis. The lead author last name is Mehra and there a three other coauthors.

For survivor plasma, I'm not sure I will be able to give you the authors. I'm afraid you might need to Google that because I am reading a report about that study, not the study itself. So if I find that I will send it to you after the call. The herd immunity as I said it was a New York Times article dated yesterday, May 28. The title is The World is Still Far from Herd Immunity for Coronavirus. By Nadja Popovich and Margot Sanger-Katz.

And probably of more interest, the seroprevalence estimates. This I got from Aaron Fleischauer who is acting as our Science Director and he shares reviews of articles. This one did not give us the authors. So the Indiana study, the dates of the survey are April 25 to May 1. A convenient sample of 4500 residents. Prevalence found was 2.8%, if you google with key terms, you may be able to find this one. The one in Los Angeles, the dates of the survey were April 10 and 11th. Number of tested persons were 865, and the positive tests in that group were 4.3%. Hopefully with using some of the terms you may be able to find these resources.

Hugh Tilson:
Thank you.

Brittany Richo:
Hello and good afternoon everyone. I just have a quick update. First of all thank you Jean-Marie and thank you Hugh for moderating. This is in regards to the interim US guidance for risk assessment and work restrictions for healthcare personnel. This is located on the coronavirus disease website that CDC provides. Their interim guidance was updated this past week on May 23. And this is guidance in regards to the changing of the definition of prolonged exposure to more closely align with the definition used for community exposures and contact tracing to 15 minutes or longer. It was at 10 minutes and now they had increased that to 15 minutes to better align with the community exposures and contact tracing guidance. And that is actually all I have for an update today.

Hugh Tilson:
Thank you.

We have a couple questions that have come in. Is contact tracing of benefit when there is widespread community transmission?

Jean-Marie Maillard:
I would say yes, we see some examples in Asia. And I would say the statement of contact tracing, increased testing and contact tracing is half of the full statement. Because the part that really helps us control the spread is the isolation or quarantine that follows. Isolation for those found to be testing positive whether they are symptomatic or not, to make sure that they don't spread further in their community and among their contacts and quarantine of the contacts identified through the increased effort. So it does work if you do isolation and quarantine. I would add, like I did earlier, that the success stories that we have read about in Hong Kong in Korea, at some point, maybe not always. We've also heard that they were rigorous in their application of isolation and

quarantine. In that people that were identified for isolation quarantine were actually not allowed to stay home for it, they were directed to reside in facilities used specifically for that purpose. But it does show very good impact on everything in the spread. We intend to increase these activities to help us go in that direction.

Hugh Tilson:
What percent of positive patients reported to the health departments are currently being contacted and having contacts traced and tested?

Jean-Marie Maillard:
I read a message yesterday that it's 63%. And this level was actually comparable to what was reported in the state of Massachusetts. And that's comparable to the tracing for sexually transmitted disease contacts. There are multiple of difficulty, you have to actually find the person. But this is the start of an increase in activity so if possible, it will go beyond that level soon.

Hugh Tilson:
Why can't the studies used already perform serology testing from labs like Quest that are doing hundreds per week. The person is from Fayetteville, but why can't we use existing serology testing to do studies?

Jean-Marie Maillard:
Because you are carefully selecting the population and the methods to make sure you are not biased. So when it's a convenience sample, it becomes very difficult to extrapolate to make statements about the true incidents in a community.

The other reason is the effort is to try to have a variety of people and locations. So when I said we have 3 studies being put in place and a fourth one more recently, they are also spread across this state to help us have multiple sites of interest.

Hugh Tilson:
We are hearing anecdotally from pediatricians that it can be difficult to get testing for children. And not all practices have the PPE or the resources to do the testing. And it can be challenging to find a place to test. Are there any recommendations for resources to help find places to test children for COVID?

Jean-Marie Maillard:
I have heard that also. I think I know the source but I appreciate to learn that. I have tried to share this with people who are more directly involved in setting up the additional testing sites. To see if it can be done not by age, to be tested. And I think as we progress in time, we will see more liberal access to or greater access to testing, and sorry to hear about this age limitation but I hope that we can change in the future.

Hugh Tilson:
By the way, this is our last question. So if you have a question please submit it. Using the Q&A feature in a black in the bottom.

Do the reports that show that prevalence is higher-than-expected suggest the mortality rate of the virus is lower than feared because many people have been exposed without symptoms. You have any --

Sorry.

Jean-Marie Maillard:
That's right.

It's not a surprise. We always see that. Even for all other reportable diseases and depending on the type of disease, we have more or less coverage in terms of the true prevalence. -- for example, for what we do normally, I mean [Indiscernible] and they are reported an estimated to be about 24 lower than the true incidents. So that's a concept that is well known. But what complicates the estimates here is the large proportion of persons who are asymptomatic, so to have a real sense of what the true incidence is in a disease like this one, it really takes a systematic study, its actually going to be done repetitively, sequential testing to what goes on. But the other parts of the statement in the question is true. Once you learn more about the true incidence, the case mortality rate, decreases accordingly.

Hugh Tilson:
When testing for COVID-19, is there guidance as to whether we need to replace all PPE after each testing encounter, do I need to change my gown if I am not the one that does the testing?

Jean-Marie Maillard:
>> I was waiting to see if Brittany would be able to help us here. I think the person who does the collective specimen is the one who needs to change PPE. Healthcare providers not directly involved in the specimen collection, probably not.

Brittany Richo:
>> Sorry, I was on mute. That is correct. Anyone that is testing, it should require all PPE, but if they are not testing, it is not needed.

Hugh Tilson:
That was our last question. We have a couple comments. One is a request to have the sources, the studies emailed out to folks, so we will follow up with you about that. A couple comments about the timing of these, and that rather than having them as needed, perhaps scheduling them on a monthly basis might be helpful. So we will coordinate that with our partners at DPH and relay that and get back to you all. Lastly as a comment that these calls have been very helpful, lots of gratitude to the informed folks at DPH who share their expertise. So let me echo that. Thank you Jean-Marie and Brittany for taking the time today. I also want to just give a quick shout out to my colleague Nevin who is behind the scenes and makes all the magic happen. Nevin, so thank you for doing it so well and so seamlessly. I will now turn it over to Jean-Marie and Britney for any final comments before we sign off.

Jean-Marie Maillard:
Well I would just say what all public health professionals, people are impatient to see relaxation of the restrictions. And that's totally understandable but the careful monitoring of indicators as many of us feel nervous, especially when I talked about the increasing rate of hospitalization. It's not by a lot, but the trend is slightly going up rather than down. So it looks like we will be in that type of situation for several months to come. There's no quick end to this outbreak. And until we have a vaccine. And we talk about vaccines, the good thing is that there are a good number of candidates vaccines who are testing and advancing. So hopefully we will see some of them and we are told possibly before the end of the year. Certainly by next year. And we are seeing some very unique approaches in that area. Like building production sites even before the results of the candidate vaccines are available.

But that's how we will get these vaccines early. And I want to say all of that to say it's going to last quite a while.

Hugh Tilson:
Thank you.

As you were talking we got two more questions. So if I could just ask them quickly. **And we see many more MIS-C cases in North Carolina other than the one last week?**

Jean-Marie Maillard:
There's one last week and there is one that is being, we have questions about a possible case. But that will require testing that is not available, and the question about the testing tools so I'm not sure when that one will end up being a confirmed case or not. I would just add initially we have reports of five or six possible cases and only one of these had met the case definitions so we do get reports that are raising the possibility, and then we are very careful with the medical record in the numbers. And that's the reason we use case definitions is to try to, at the national level all use the same yardstick to call a case a case.

Hugh Tilson:
There was a follow-up that says there's been studies on the use of steroids to help with some of these cases. Have you heard about those?

Jean-Marie Maillard:
I have seen that, but I am not familiar with the details, yes.

Hugh Tilson:
Okay. Now we truly are through with our questions. So thank you all so much. For what you do all day everyday and for making time today to provide us with your expertise. And attendees, participants, thank you so much for taking time to be with us. Everybody take care. Goodbye.

Thank you. >> [Event concluded]