

Transcript for NC DHHS and NC AHEC COVID-19 Testing Overview
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Presenters:

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Hugh Tilson

It's 530, let's get started. Good evening, everybody. Thank you for participating in today's webinar. This webinar is put on by the North Carolina Department of Health and Human Services and North Carolina AHEC to provide an update by DHHS leaders on COVID-19 testing guidance and resources and to provide a forum for you to ask questions of those leaders. My name is Hugh Tilson. I'll be moderating today. As you can see, we've got a very busy agenda today with lots of great speakers for you who will also provide timely and useful information as part of this presentation.

Before I turn it over to Secretary Cohen, I'd like to take a brief moment to thank everybody for making your time in your schedules to participate in this evening's webinar. Both the panelists and those of you who are on the webinar. We know how busy everyone is we hope the information provided tonight will help you in your important work and make navigating these trying times a little easier. Next slide please. After you hear from the panelists, we'll turn to your questions we've learned in past forums that the panelists will often address your questions during their presentations. I encourage you to wait until they're through their presentations before submitting a question. To submit a question, please use the q&a function on the black bar at the bottom of the screen. That's the q&a function in the middle of that black bar on the bottom of the screen to submit a question? We'll record this webinar, we'll make the recording a written transcript of it, and these slides available to the public as soon as possible on the North Carolina website, probably either later this evening or tomorrow morning. Next slide. Let me now turn it over. Secretary Cohen. Thank you so much.

Dr. Mandy Cohen

Perfect. Well, thank you. And thanks to all who have joined pleasure to be with you this evening. I know there's so much going on. And you're going to get a lot of great information from the team at DHHS here. They're going to go through some of our data in detail. They're going to go through some where we are in terms of testing and where we need your help. But what I wanted to share as we go into this, I think you've seen in the news already that our trends are heading in the right in the wrong direction, excuse me, and I need your help. We've been working really hard since March to to improve our

capability to respond to this pandemic. We're in a much better position to respond our PPE supply is better. We've worked with hospitals on their surge planning. We've ramped up testing capacity. We we continue to have tracing capacity that we're deploying to our counties. So we've used our time well, but now we know we knew we couldn't stay locked down forever. And we're trying to find that balance of reopening. But while keeping the virus spread low.

So while we're gonna focus on on a couple pieces of the puzzle, in response, I don't want to forget that you are all leaders in your community. You are you have incredible voice in your community to share the message about the fact that we all can play our part to keep this virus spread low by doing the three W's which are the wearing of a face covering, Waiting six feet apart, the social distancing, and the washing of the hands. And I know we're going to focus mostly on what's going on with testing. But I also want to make an ask of all of you to be sharing that message within your communities, with other community leaders, and to help folks understand why that is so important. And then how all of those individual actions, everyone doing the three W's all together, can still change the trajectory of the numbers that we see. I think everyone has is is saying, Well, like I guess that's it. The numbers are what they are. My point is, is we can change the trajectory, they are going in the wrong direction now it doesn't mean it needs to stay in that direction. And I think if we take all those actions together. So love to have your help being leaders in your community using your voices, whether it's in your local paper, working with your your county elected leaders working with your county health departments, and others just using that voice to share key messages, particularly with communities that are you're going to hear are more impacted by this. So if particularly if you are in communities that are higher proportion of Latinx or African American, we know that our historically marginalized communities are disproportionately impacted here. So again, using your voice, to draw attention to the need to focus our efforts on those populations that have been unfortunately, neglected in the past, we want to make sure that we are focusing our efforts. So then you're going to hear a lot of good information about testing and the importance of testing. We want to make sure that we are testing not just people with symptoms, but people who also have exposure and work in settings that might create exposure for them particularly we're also asking folks to get tested if they've recently attended a mass gathering, like a protest. So the team will go through all of that. But we want to make sure to be communicating that message loud and clear. We're hearing some anecdotal stories back of patients who say I called my doctor. And they said, Nope, you're not eligible for testing. And I tried to tell them I went to a protest as they said, Nope, you're not having symptoms. So we want to just make sure that we're all on the same page about guidance. And particularly knowing that COVID-19 can spread when you aren't showing symptoms. I think that is a really critical piece of this virus and making sure that we are doing all the things that we can to jump on top of this. And I think recognizing the viral spread before people have symptoms is a really important part of that.

Alright, so thank you for your help on sharing key messages about the three W's in your community, and then this focus on testing that you're going to hear from our team today. Thanks for all that you are doing. Make sure to stay in close contact with us. This is a rapidly evolving situation. So guidance changes. I, I'm sorry about all of the change and evolution here, but we're trying to read be nimble and

react to the science as best we can. So stay close in touch with us. And with that, Hugh, I'll turn it back to you and over to our fantastic team.

Hugh Tilson

Thank you, Secretary Cohen. Who's next? Do y'all have the agenda.

Dr. Shannon Dowler

Yeah. So next slide. We'll go to the epidemiology, Zack.

Dr. Zack Moore

Hey, good evening, everybody be able to hear me okay.

Hugh Tilson

Yes, we gotcha.

Dr. Zack Moore

Okay, great. Well, I am going to run through some of the data for you just to make sure we're all on the same page in terms of trends real quick, nationally, and then focusing in of course on what's happening here in North Carolina. As the Secretary already mentioned, our trends have not been going in the right direction lately. So I want to get into that a little bit. So you have the context. So next slide, please. Okay, I think I just have maybe two slides on the national picture. This is just a graph of the number of cases over time since the outbreak began. And you can see when you look at it, from the 10,000 foot view nationally, that we had the biggest peak in April, and that, if you will recall, was largely driven by the massive outbreak in New York City and the tri state area. And then there's been what looks like a general downward trend with some leveling off recently. But that's not the story when you zoom in a little more and look at different parts of the country, things look very different in different regions. Next slide, please.

This is one view of that. There's lots of different ways but I think the color scheme here kind of illustrates what's happening at this particular point in time, which you can see that the red color indicates increase or increasing number of cases. And you can see, particularly, unfortunately, around the southeast and Southwestern parts of the country, we've seen this sizable increase in cases unfortunately, in recent weeks, also a couple areas, the Midwest and the Northeast, whereas I'm sorry, the Northwest, whereas the Northeast where they had a larger outbreak earlier on is generally seen declining incidents recently. Next slide, please. Okay, so this is what's happening here in North Carolina

at least looked at from what we have mainly been focused on, which is the number of laboratory confirmed cases. And, you know, as we had said in the beginning, that is an imperfect measure, here or anywhere in the world of what's going on. There's lots of reasons why the number of positive tests may not always accurately reflect what's happening, but it is important for us to track. So this is the number of lab confirmed cases in our state by the date of specimen collection. And you can see unfortunately, this clear trend, I don't probably have to explain too much about that to you. The green line is the that seven day moving average you can see going up rather steeply during recent weeks. And that blue bar there is just as a reminder that things will change over time as labs are sometimes received a while after a specimen was collected. So the numbers in there are likely to shift as we as we go forward, but clearly not the direction of trend that we would like to see. Next slide please.

Okay, so this is maybe more of a positive story and partly explains some of that increase in cases which is this is the number of total tests reported in North Carolina. And we've had a big upward trend in the number of tests being performed here, which is a good thing, and represents a lot of work to expand capacity across our state. And you can see the purple bars are the number of tests reported. The yellow line is the average number, but we've had a very big increase recently, and there's no bar on this one. But the, you know, the data will change again, over time a little bit, but the number of tests has gone up a lot. There's been a lot of work that's gone into that and that is definitely part of what's driving our increase in cases. But unfortunately, we know that that's not the whole story. Next slide, please. Okay, skip everyone go back. They look the same, but they were different. Yep. That purple and gold color scheme.

This is actually different. This is actually the percent of all those tests that were positive for COVID-19. And this is one way that we have of knowing whether the increase in testing and increase cases is being driven entirely by testing volume versus other things. Again, there's no perfect metrics out there. But this one is concerning. It's not been steeply increasing, but we have seen sort of this general upward trend, you can see the yellow line in terms of the percent testing positive, which is hovering around 9%, which is definitely higher than than we would like to see and, you know, reflects in part that we're trying to focus on people who are at the most risk, but still a clear indicator that there's a lot of virus out there in our communities. Next slide. Okay, so another concerning metric and trying to understand, you know, to what extent our increases being driven by testing versus by transmission, is the number hospitalized. And this is an important thing for us to be looking at these numbers here are the number of people who are in the hospital with COVID-19 on a given day. So it's not just new admissions, but the number of people that are hospitalized, which helps us to track our our hospital capacity and ability to respond to a surge. But you can see that that number unfortunately, has also been trending up. Certainly not as steeply as the total number of cases. But we have seen an upward trend in hospitalizations, which is concerning. Next slide, please.

Death data death recording does always lag behind case reporting cases are generally identified days to weeks before they die if it ends up being a fatal case. So there's a built in lag there we have not seen a big increase in deaths recently, which is certainly wonderful but we are keeping a close eye on this to, to

see whether, you know, some number of days or even weeks after our big increase in cases if that starts to be reflected in our mortality data. Okay, next slide. Okay, I just wanted to talk briefly about some of the demographics of our cases and not going to go through all this. But if you could go to the next slide, sorry, I didn't know if I'd be driving, making someone work hard. A couple of things to point out first on the race and ethnicity data is the disproportionate number of cases among Black or African American residents in North Carolina. You can see they make up 26%. I think this was yesterday's data of our total cases. So disproportionate to the percent of the population. Next slide. And also Hispanic ethnicity. And this is really striking. And this is something I've got a couple slides later, but the proportion of cases that are of Hispanic ethnicity has taken a sharp increase recently. And this is something that Secretary Cohen mentioned that we're very focused on trying to make sure that we are getting to this population, increasing access to testing, etc. Next slide, please.

And I just wanted to highlight the age breakdown. This is all on our public dashboards. It's just a screenshot. Looking at you know, I think there's this perception in some places that this is really most cases are in, in the elderly or older population. That's not actually the case when you look at who's being diagnosed the largest proportion is in that 25 to 49 and then the 50 to 64 year age range. Next slide please. Okay, this is different, this is demographics of fatal cases of deaths. So you can see have got that age distribution obviously very different, so well, the case burden is in sort of all age groups, and in the younger adults, particularly, the deaths are definitely skewing towards the older age range as we have seen throughout this pandemic. Next slide, please. And unfortunately, you can see the disparity in the black, cases among Black or African Americans that are fatal is even more pronounced when you look at deaths than when you look at total cases, which again is a reason why there's been this very intentional focus on historically marginalized populations and trying to really get at these disparities and make sure that we're doing everything we can to help address those. Next Slide.

Okay, and I mentioned I have a couple two slides here on the issues of race and ethnicity. This one shows over time and I'm sorry that uh, despite valiant efforts by many of us the access got left off there, but I think you can still see a trend. Over time, based on the week of illness identification with race and ethnicity, and so you can sort of focus on that dark blue segment. That's the number of cases in people Hispanic or Latinx population. And you can see that unfortunately, we've seen a big increase that's over the past several weeks, really, in the top bars, ones that don't yet have race or ethnicity data completed. So we'll see what the rest of it looks like but a clear trend towards increasing proportion among Hispanic and Latinx community and again I apologize for the slide issues. The green I believe is white, non Hispanic and orange is African American, I might have this mixed up. Anyway. Apologies for that. Okay, next slide, please.

Okay, and this is looking at it another way not over time, but as total disparity in terms of cases per hundred thousand population really stands out even more in all age groups. And if there was a legend here, you would see that dark blue is again Hispanic, sorry for the slides, Hispanic or Latinx. So you can see in all age groups, the rate per hundred thousand population is strikingly higher in that group. Unfortunately, also higher in non Hispanic, Black or African American, which is represented in the

orange bars here compared to white, which is in the light green bars on the right. So clearly, we are still seeing this disproportionate impact. And that's a major focus for us, all of us going forward in this pandemic. Next slide. Okay, and this is, I think, my last slide, we'll see. But just as a reminder, as I said, you know, we need these case, report data. They're very important, but it's not the whole story. We do have lots of other ways that we're trying to monitor activity, aside from cases and hospitalizations and deaths, and that includes our syndromic surveillance looking at people who present to for care with respiratory illness that is consistent with COVID-19. This red line here, shares on top the percent of visits to emergency departments for CLI, or COVID-like illness, which you can see had a big increase, and has been declining nicely, although it has sort of leveled off recently. And it's still way above what we'd expect for this time of year. The two dark or the two gray lines, what we'd expect for similar illnesses in emergency departments for this time of year. So still way above normal, but a downward trend and some leveling off. We have several other surveillance things, I would encourage you to take a look at our dashboard and look at the CLI report. There's a lot of other ways that we're trying to get a more holistic view. Believe that's my last slide, let's go forward and see. And Yep. So I will pass it back to the next person. Thank you.

Dr. Shannon Dowler

All right, Scott sound you're up.

Scott Shone

All right. Thank you, everybody. I don't have a lot to update. I'll fly through and then save time for questions at the end. Next slide. So I showed this slide last time we presented and I showed it again to say not, not a whole lot has changed. We're still looking at two main types of tests, diagnostic tests and antibody tests. With molecular these real time PCR tests, looking for the viruses, genetic material, predominating, there's still one antigen test that's received the FDA EUA that and I think I talked about that last time with its its reduced sensitivity with potential for 20% false positives on that antigen test. So while antigen tests are, in my opinion, going to be a significant game changer once we can get more reliable tests, these tests just need to be used in certain certain situations and they're not ideal obviously for widespread asymptomatic screening because of the reliability and their sensitivity. And again, antibody tests, we still struggle with some of these rapid tests and their sensitivity specificity those more have have received authorization, but we're seeing substantially more reliable data coming out of the serum tests, a laboratory based antibody tests. And and the you know, the correlation between presence of antibodies and, you know, timing of infection and immunity still is an active area of research. So next slide.

And again, you know, the two main types of tests as I said, laboratory based and point of care both for Molecular tests and antigen tests. There have been a growing number of point of care tests that are coming out or actually, I would say near patient, they're not exactly right at the bedside. Obviously, the rapid test, the stick tests are but but there are an increasing number of those tests and platforms that are available with results that are typically under an hour. But again, you sacrifice sensitivity for

specificity, which I'll show on my next slide, I think, or, actually, no, this next slide is not meant to be read, but meant to show the overwhelming number of methods that are now that have now received an FDA EUA. As of today, we're well over 100 different both diagnostic and antibody tests that have received EUAs, a lot of them function on the same premise. So they're sort of the same idea with a different tweak in terms of real time PCR assay. And really, I would say the volume of tests circulates around this supply chain whack a mole that we've been playing since the beginning of the pandemic, where development -- because one, you know, one specific manufacturer had challenges. I would say my comment would be that some labs are running these, usually typically smaller labs, larger labs with higher throughput, our hospital labs, our large commercial labs, state lab, have tended to stick to one or two, maybe three different methods to support our capacities. But But I just wanted to sort of show that that the list of EUAs on the FDA website continues to grow. Our staff at the state lab continue to monitor it, we look at performance characteristics. And I would say that, based on our assessment, these molecular tests real time PCR tests continue to demonstrate a higher level of sensitivity and specificity than the rapid tests. And I think my next slide is where I want to draw attention to your warning.

Yeah, so there's been a few tests recently, including the antigen test that I mentioned, the Abbott ID Now was reclassified or there there, the instructions for use contains this warning. And there's a new assay that just came out. That's also a rapid, molecular based test that have within their instructions for use a limitation that I just want to draw to everybody's attention. And it's not really a warning so much as wanting ton make everybody aware that for some of these tests that are coming out that have high speed, but low sensitivity, the FDA has said negative results are treated as presumptive, they're not definitive. And so if a negative result on these tests that have this limitation, are inconsistent with clinical signs or symptoms, or if you're going to be making infection control decisions or patient management decisions, then that individual should be retested with an authorized molecular tests of higher sensitivity. So again, these I think these tests I don't want to Well, I'm not trying to caution anybody against using them. But they have a very defined utility. And, and and while their costs contend to be low, the speed of results can be high. They do come with some limitations they say everyone should be aware of and and I know it's hard for everybody to be an expert on these. So I'll just say again, if you have any questions, please email the state lab. Our team's happy to look at this. As I said, our team has been monitoring the EUAs as they come out. And so we can help if there's any questions about a test. And and I didn't mention this, but I did mention this last time. Obviously, all these tests have regulatory requirements. So depends if you're a high complexity, moderate complexity, or in some cases, a wave lab, what tests you can perform, and I think I might have one more. No, I don't. So I think I hand it off back to you sir.

Hugh Tilson

Dr. Dowler and Dr. Tilson

Dr. Shannon Dowler

Yeah, so now we're gonna have some fun talking about who gets a test. So real life practical examples. Betsey is going to start us off with the next slide, Nevin, with our current recommendations.

Dr. Betsey Tilson

Great. Yeah, and hopefully you all have seen this. We pushed this out early last week, it's not markedly changed from the one we pushed out a couple weeks before, but we just, A. we hope it adds a little bit more clarity on who has a kind of higher risk of exposure, and then it does have this new piece about the mass gatherings and protests and rallies. So that is a new piece of the guidance and again, kind of doubles down on some of the earlier guidance we were pushing out. So hopefully, you all will have seen that hopefully, you are sharing that with your colleagues, far and wide. And just to go over the first two bullets, I think those are fairly well adopted that none of that should be I think, confusing or, or new to people but certainly anybody with symptoms suggestive of COVID-19 and to remember that the symptoms there's a wide range of possible symptoms in COVID-19. Of course, the classic ones being you know, fever and cough and shortness of breath, but we're seeing a wide range of nonspecific symptoms as well; headache, sore throat, some of the things we're seeing in kids is actually more GI and some of the data coming out with that multi inflammatory system is kids presented as an outpatient with a mild GI stuff and then got really sick and ended up in the hospital. So just be on the lookout for a lot of classic but also very nonspecific symptoms as well and have pretty low thresholds. Especially as Zach was saying our numbers are going up we know there's a lot of virus out there. So have low thresholds and think through some of those a typical a typical symptoms.

Second is if your a known contacts. So certainly somebody has to contact tracing or the health department is said you are a close contact. Close contacts absolutely need to be tested regardless of symptoms. So even if they don't have symptoms, they should be tested. Ideally, our guidance is for if you have you have no symptoms. guidances like about five or six days after the known contact, and that's just because the median from incubation to symptoms and therefore maybe positivity if you're asymptomatic is about five to six days. So we just don't want you to test too early if they're a known contact without symptoms. So ideally about five to six days after the known contact, but symptoms should not make a difference for testing. If there's a known contact. Then that big group that we've been talking about over the past month or two, right, this really leans into the data that we are seeing, this is that disproportionately, the burden of that is on our marginalized population. Those who are in high risk occupational settings, we're seeing clusters in certainly our meatpacking and manufacturing. So we are seeing clusters and trends in our high risk populations and not so much that the populations are at high risk but their settings and their risk of exposure is is high risk and with the big chunk of this infection which is asymptomatic, there was a recent meta analysis that showed almost up to 45% of infections may be asymptomatic. So just a big burden of asymptomatic disease. So, just want to make sure remember that these populations are at higher risk of exposure, or a person who has higher risk of disease have really low thresholds. And if there's, you know, any chance of exposure or concern, want to test and you'll see that as we play out in some of the scenarios because this this piece seems to be tripping people up a little bit. So we'll walk through different scenarios and pros and cons.

And then the new one is about the mass gatherings, rallies, protests. So this was a combination of one, you have been around a bunch of people may or may not in social distancing, and we also know that spread, when people have more respiratory efforts, so they're yelling or chanting or singing, especially without a mask, there's a risk of transmission. So this is important one, not only because it could be the person was infected and went to the protest and therefore could have been spreading it to other people that's important for us to know that, or they may have gotten infected there. So this is a new one. And then actually, there was just some data that came out a story came out that those, especially those who may have been exposed to tear gas was part of those, that's such a respiratory irritant, that could actually have potentially increased the risk of having an infection as well. So low low thresholds. And we are seeing a bunch of not just the social justice rallies, but there's also been, as you probably know, a fair amount of mass gatherings at car races and at fishing tournaments, there seems to be a fair amount of mass, unauthorized mass gatherings going on so have a low threshold for that. Alright, so those are some of our our guidance and I, on the bottom, I think is the link to it, but make sure that you have those and we will update as we go forward. Alright, so let's put our...

Dr. Shannon Dowler

Yeah, next Mmm. All right, so I'm going to give some clinical cases and Betsey is going to tell us whether she would test them or not. And then we might throw some zingers at her while we're in between. So Linda is a 55 year old home health aide, she has diabetes and hypertension. She's been working full time, and she's worried about having been exposed to COVID. So she sends a message on the portal her PCP asking whether or not she can get a test. What's the best answer?

Dr. Betsey Tilson

Yeah, so and just up front, spoiler alert, I going to have a really low threshold for testing because we are we really gonna need to get our hands around, around around testing. As Zach said, you know, our present positive, we've been bumping around 8,9, 10 percent, we really need to get our present positive down below 5 to 3%, which means we need to do a lot more testing in people than than we are now. So there's my spoiler alert. So with this one thinking through, so the couple things that I think through so you look at our at our guidance, so one, she has comorbidities, right? She has diabetes and hypertension, so she has to two things that put her at risk for higher clinical severity. Second, she is a full time healthcare worker. So there is she has that exposure. Now she's a home health aide. So I'm not sure how many people she comes in contact with. Maybe it's just one person, I'm not sure how many people if she's going from person to person to person, and has fair amount of patients, I would even have a higher level. So that's one thing I would ask about, like how many people is she taking care of. But so she may be has exposure, but the other piece too, is that she is taking care of people who are at really high risk. So it'd be important for her to know if she's positive, she could also then transmit it to the person that she's taking care of and put that person at a higher risk as well. So I think in the beginning now, the question you're going to ask us, and we don't have the answer yet. So that's the second spoiler is what's the frequency? How often should we be testing frontline health care workers? We're still work figuring that out. There's been some studies that looked at, you can do healthcare workers weekly or bi weekly, and we haven't figured out that frequency yet. So for right now, I would

kind of lean in on and have a low threshold. So for her, I think I probably would. And the other thing that I would really be sure of is, and again, as Zack will tell me, we're not going to be able to test our way out of this pandemic, we're going to need to do prevention, I would 100% make sure she is wearing a surgical mask every time she goes in and sees that patient because we do not want her patient to be exposed. If she has COVID-19. And I've been hearing stories about in home, home health aides and not wearing masks when they're going to see patients. So I probably would, because she's got a bunch of things in there. But you know, there's no right answers to all of these, but I would lean in.

Dr. Shannon Dowler

You'd test her. All right, next next case. All right. So to me as a 23 year old healthy server at the Waffle House. She's been working overtime since the restaurant opened to dine in customers, although only every third booth is being used. She wears a cloth mask when she's at work, and she lives with her parents and her dad's currently in chemo for colon cancer, is she someone who should get tested.

Dr. Betsey Tilson

So right so based on our guidelines, right, she's a frontline worker, essential worker, she's had the potential chance of exposure. Now good for her. Yay, yay, yay, her wearing cloth mask. That's great. But that's probably protecting the employees maybe is giving her some protection, but she's probably protecting her patrons. I'm not sure if the patrons are wearing masks, probably not. That's one message that we need to get out is really getting our patrons to wear masks, but she's even at a restaurant. So it's really hard for patients to wear masks while they're eating. So she may well be having a fair amount of exposure. Now the good thing is that she's young and healthy, yay. So she may not have bad clinical severity, but she's going to go home to a household with someone at very, very high risk. And one thing we do know is that where spread is greatest is in that household that that secondary attack rate is really high in the household. So she has she has exposure she meets our guidelines. And although she may be okay, she could easily spread it to her high risk household So, okay.

Unknown Speaker

All right. All right, great. Next slide. Alright, so Raul is a 29 year old also healthy. He's a construction worker and he feels fine. He does not have any health insurance. His income supports his family of five. Several people on the job site have been out sick, and his wife really wants him to get tested. But when he asked his boss, his boss said, don't worry about it. What are Raul's best options?

Dr. Betsey Tilson

Yeah, so lots of things in here, right? He has sick co workers. And we know we're seeing clusters more and more clusters in construction high risk setting and he has sick co workers. So definitely an exposure there. So as Shannon would say, your local FQHC is such a great resource for not just getting testing but also linking him to a medical home because he may not have, he may not have a medical home. But we

also have federally supported sites so Walgreens, Walmart, CVS. Especially Walgreens and Walmarts that he can get free testing as well there, but getting making sure he has a link to a medical home is even better. So there's a local FQJC that would be a great option for him.

Dr. Shannon Dowler

Awesome. All right, next slide Nevin. All right, John is a 19 year old he has a past medical history of mild intermittent asthma and seasonal allergies. He's had a few days of just mild cough feeling a little draggy, not much appetite. He did attend several protests over the prior weekend, but he wore his mask faithfully. His mom said go get a COVID test, but his primary care office said that since he had very mild symptoms, he probably didn't need to. What do you say?

Dr. Betsey Tilson

So I don't mildness of symptoms don't matter. If he has symptoms, he has underlying comorbidities, right. He's got asthma, he has symptoms and he had a high risk exposure. So test test test, I would say and then yay for him wearing masks. Yay. But still could have had, you know, they're not, especially depending on what kind of mask he wore. You know, it's not 100% in terms of protection, so,

Dr. Shannon Dowler

So mom was right, as always, right? Mom's are usually right. All right, next slide. All right, Angelica is a 26 year old Spanish speaking pregnant farmworker, she recently arrived in North Carolina from Florida, where she traveled in a large van for two days getting from southern Florida up to North Carolina. She feels fine. She's not sure where she's gonna go for pregnancy care in North Carolina. What would you advise her about testing? Yeah.

Dr. Betsey Tilson

So again, looking at our data that Zach was saying, you know, we are seeing a big jump in our Latinx community. And she had that high risk exposure traveling in a van for two days. So yeah, this one was the one that I pause the most on, but she does have that exposure in a large van. I don't know that I would serially test her throughout her pregnancy, but I think because of that recent exposure of the travel in a van, I probably would lean in and and test her and then I would send her to either her local health department or her FQHC or make sure he she gets connected to a pregnancy medical home to get good wraparound care management and pregnancy care.

Dr. Shannon Dowler

Yes. And this is one of the big things we're pushing with our testing sites around the state is really trying to link people to medical homes. And so she Angelica is a perfect person to get linked to a medical home

with a test. All right, next slide. All right, this is our last case and then we get to move on to Dr. Burns. So Betty Ann is a 70 year old, 74 year old active member of her local church choir. They've been having church with the windows open and everybody sits far away from each other. And she only goes out rarely to the grocery store. But she does go to church and she volunteers at the local library reading program, should Betty Ann get tested.

Dr. Betsey Tilson

So the the the red flags in here, so one she's older, so that puts her at higher risk. Church is actually a really high risk setting. So they're now great. Yay. They have the windows open and they're apart from each other, but they're inside. And then the singing. Singing again is one of those activities of enhanced respiratory effort. And so we have definitely seen outbreaks, specifically in church choirs because of that singing. And that puts it at really high risk. And we have seen outbreaks. And so I would also this is the other thing I was thinking on this one, make sure you know your local data and make sure you know where there's clusters. So, like, there was out west there was a big cluster associated with churches. So these are these are areas that we're seeing more and more clusters and outbreaks around churches because you know, people together they're inside and then that singing is a really high risk, high risk piece. So again, spoiler alert, I probably would except for her I don't know, she's probably going to continue with the choir so I'm not quite sure the frequency of it but I see several red flags in there. And so maybe I would say this when I qualify is certainly if those cases in that church and you know about a customer in that church then 100% I would because of all those high risk pieces.

Dr. Shannon Dowler

Okay, I believe that is our last case and we are going to turn it over to Dr Burns to to help you figure out how to get those tests done.

Dr. Cardra Burns

Good evening, everyone. I'm just gonna go quickly through two new online tools that we've launched on June fourth, the first one, My Symptoms tool helps individuals determine if they may need to get tested and while there's no substitute to a conversation with a medical professional, our new informational online tool allows people to enter their symptoms to determine if they should get tested for COVID-19. Individuals may use the check My Symptom Portal to input key information related to the need for testing such as health care worker status, chronic diseases COVID-19 like symptoms, age and etc. Individuals will receive either a test text message or email depending on their preferred method of contact. And that provides them a link to the next tool, you can go to the next slide. Which is the Find My Testing Location tool. And this is a resource for anyone who needs to be tested for COVID-19 but aren't sure where to go. Individuals can find testing locations based on their zip code. And it also allows you all, as well as anyone in the community, any users, or even the health department to add new testing sites. These sites are validated before being publicly posted which can take an average of five to seven days. This technology is powered and maintained by Castlight COVID-19 Resource Center, and

thus not endorse per se by DHHS. We do ask that individuals that find sites online, call the testing site or the healthcare provider before going to, going to get tested, just to be able to learn about the criteria, availability, hours and if it's a location, particularly if it's a pop up or drive a drive through location. Additionally, all healthcare providers are not on the site, so we always recommend if you see that you're not a part of the tool to please update by adding your site. Some we know require appointments or referrals, and again these locations are subject to change. In addition to the Find My Testing Place tool, we have also added a field for single or multi day pop up testing events and communities as DHHS is made aware of them. And that concludes my two slides Dr. Dowler.

Dr. Shannon Dowler

All right, thanks so much. All right, we're gonna switch it over to Jay Ludlam who's going to talk to you about the RFQ we have and also paying for tests.

Jay Ludlam

All right, good evening everybody. So, about two and a half weeks ago, the Department issued, what's called an RFQ. So if you're used to the RFP or an RFA we now have introduced the RFQ. It stands for Request for qualified vendors and what this procurement tool allows us to do is create greater transparency for businesses into the different opportunities that are available related to COVID-19 and our response. And an RFQ to permits the state to identify what we feel are qualified vendors, and then we will begin issuing what are called task orders to those qualified vendors for them to bid on separately, related to increasing testing, lab capacity, as well as contact tracers. So, what. So just a little bit of background while we have conducted and continue to increase the amount of testing here in the state. We do have a number of initiatives that the state, either wants to engage in itself or believes it should be supporting directly. And so what we've set up is a RFQ for vendors who offer testing. One of the key features of this opportunity is that we don't want these vendors to cannibalize existing laboratory capacity in North Carolina. Instead what we're looking for are for these vendors to bring additional capacity to North Carolina, from a lab perspective.

In addition, we do need certain capabilities in the field by these vendors. So these vendors might need to set up a high throughput site or sites across the state or across a particular region as we try to combat a particular, an outbreak or a hotspot. Or just to engage in, for example, a concerted effort to test facilities or prisons or large scale testing. Similarly, we're looking for potential vendors to be able to bring up a site in one location and then the next day, tear it down and bring it back up in a different location and so on, and and so that we can direct those sites ourselves. What we have found is we have partnered with a number of national, through a national program that you know the Walgreens and the Walmarts of the world. But oftentimes those sites are determined at the federal level and while the state can influence their where they go. Sometimes the state has no control. So through the RFP process and these high throughput and mobile vendors we'll be able to direct their resources more strategically to locations we feel would be best. Regarding lab capacity, we do have approximately 32 private and hospital labs performing COVID-19 testing. But there are instances where the state lab, again, based on

a particular initiative that we may want to engage in in the future, may need to reserve lab capacity at a major laboratory. And this RFQ process will provide us the procurement vehicle to do that.

And I'm going to do contact tracing and then come back to equity in just a second. So, contact tracing. As many of you know, we have an existing contract with CCNC, who is now authorized to hire up to 450 contact tracers and case investigators. We do anticipate though that we will need to potentially hire as many as 3000 total contact tracers so there while much of that capacity is handled at the local level and there are many full and part time individuals who work at local health departments already that do act as contact tracers or case investigators or support the work of those of those personnel. The state does anticipate needing certain specialties, certain languages, or the ability to connect with particular communities that are again having outbreaks or hotspots. So, you know, one of the themes of tonight is to address the, the rise and the disproportionate impact on the Hispanic communities, or the Latinx communities. We have seen a very large demand for bilingual Spanish speaking contact tracers through the RFQ that will be able to put out particular task orders to to hire a pool of just bilingual Spanish speakers or we could pick, or direct a task order to a particular community, faith based community that might want to may want to offer certain, community members up as potential contact tracers or case investigators.

So this through this process we are able to do that. One of the key drivers and reasons why we've gone about it the way we did is in connection with the executive order 143, which the governor issued I think it was about a little over a week ago to address the disparities and communities of color that are, that have not seen the same access to COVID-19 dollars and response, as part of our response. And so we wanted to make sure again that there was transparency about the availability of these opportunities as well as the department has worked specifically with the North Carolina historically underutilized business office or hub through this RFQ process, and the hub not only provided us good guidance on making sure that there were certain aspects of our RFQ that did facilitate connections with historically under utilized businesses, but hub also provides support for those businesses those potential businesses. It can help them in responding both to the RFQ as well as to the task orders. Next slide.

All right, so I'm gonna, I'm gonna wade into the meaty discussion of reimbursements. We're going to shift gears now from the RFQ to reimbursement and I know this is a hot topic. And so let me just preface this with. I'm going to do my best to try to get as many answers out as possible. I'm unlikely to be able to address every single situation that you have encountered, but this is how the system is supposed to work. And, and as I think we're all finding out that it doesn't quite work this way. And so that is also I'm going to tie it back to the RFQ at the end.

I'm not going to read the answers per se, or right off the slides, but one of the questions that I wanted to try to address for people is who should I bill for testing? So built into most of our assumptions, is that, that the state acts, almost as a payer of last resort. And that we would expect it at these testing sites that to the greatest extent possible, that we that we would try to exhaust any commercial insurance any

medicare, medicaid that generally are supposed to cover COVID-19. Now what we have found is that in some cases that these organizations that these insurers, don't cover it, I'm going to exclude Medicaid but don't don't cover it. And that's in part because they're starting to argue that with asymptomatic testing that, that it's more of a public health function rather than a clinical or medical necessity reason for testing. We still would prefer that you can try to exhaust that as a resource, and then any denied claims to go through different processes to, to seek reimbursement.

Actually I'll touch on the RFQ now, one of the controls that the RFQ will give us as as we hire our own organizations to test, we will bill into those RFQs and task orders. Again the requirement that the vendors try to exhaust to other payer sources, but that the state would reimburse the vendor for any unreimbursed costs. And in this way, again we're trying as much as possible to defray or defer costs to beneficiaries or individuals in the hopes that they will seek testing. And in order for us to be able to move them into all the other supports that come along with testing and the identification of positive.

Regarding the next bullet regarding cost sharing. Patients should not be charged for cost sharing we are hearing of some cases of that. And, and we want to hear about it, and we will, and do reach out to those testing organizations to try to instruct them not to be charging cost sharing for testing. Right. Next slide. All right, HRSA a lot of words. This is actually, as opposed to Scott's slide this is supposed to be read. We are going to put, this comes from a document that we're getting ready to publish. So, the, the method of reimbursement for the uninsured is supposed to be HRSA. And we have heard of a lot of issues with HRSA, but HRSA is supposed to be the mechanism. And again, as we set up our own testing vendors through the RFQ process we intend to backstop HRSA, but we here at the State also have limited funds so to the extent possible that any other payer can pay for the testing, that's where we want to go, including HRSA, so I don't I don't even know how to hit the slide, frankly, other than there, we will be publishing in relation to the HRSA uninsured program we will be publishing a, a document, kind of a cheat sheet that helps providers understand how to get enrolled, how to submit claims. And what what to expect. Again, we have heard that there are some issues around this program, but because of the limited funds that we have at the state it is our preference that you attempt to exhaust HRSA, as much as possible. But at the same time recognizing that there are administrative costs to you and your practice doing that. But there is there's just limited funds here at the state level. So, Dr. Dowler give you an opportunity to tell me how to direct any of the HRSA feedback but otherwise I'm gonna hand it back off to you

Dr. Shannon Dowler

Yeah I actually had sent out a message to a bunch of the executive leaders from the different specialty societies asking for feedback from providers on HRSA barriers that we have escalated to sort of get some attention on trying to help that HRSA process work more smoothly for providers. So I think there's widespread recognition that there's some work to be done on that.

Jay Ludlam

And I said it if it makes anybody feel any better. When we have gone to CMS about issues with HRSA, CMS has directed us to the phone line as well.

Dr. Shannon Dowler

Great. Well, we're going to power right through the this next slide is a resource I believe a link to resources. I want to make sure we get to some of the questions, because there are some great questions there are 40 questions in the queue right now. Hugh want to take us through some of the questions, pretty quickly.

Hugh Tilson

I'm happy to there were a bunch of about, children how to get tests for children and how to know where testing sites for caring or testing children how can providers get better access and families get better access?

Dr. Shannon Dowler

Betsey, do you want to take that one?

Evelyn

I'll take some of that but I will also need to probably defer to Cardra and Jay as well so one, from a from a clinical standpoint and from a testing standpoint, there is no lower age limit for the EUA for the, for the diagnostic testing. So that, that shouldn't be a barrier in terms of testing. I think some of our, our pharmacy sites like Walgreens and Walmart. They have 18 and up, I think the CVS one will do lower but with a parental permission. Obviously our FQHCs and our health departments and our private offices do anybody but it's a, it's so from a testing standpoint, there's no lower, lower age limit. But we also say before you go to a testing site its probably good to call ahead to and make sure that they can that they will take kids. I don't know, Cardra, do you have anything is thinking through like, you know, find a testing site, other ways that they can sort.

Dr. Cardra Burns

Yes. Additionally, we are looking to revise the Find My Testing Place, to see how we can add on there for example, kid friendly or accept children, so it can be easily distinguished, and pop up clinics as well in

that feed that we'll be adding an additional field to denote that just again to help them they go a little bit more clear for everyone.

Dr. Shannon Dowler

And then also if you do get testing through your local FQHC, they tend to, they're used to taking care of babies and children and are very comfortable, you know with testing younger humans.

All right, next question you.

Hugh Tilson

So, Shannon I don't, you saw that there were some that particularly intrigued you, you have your finger on the pulse, are there some that you want to ask because I've got some ideas but want to...

Dr. Shannon Dowler

No I want to hear, I think you've got a more naive perspective, I want to. I'm already cynical.

Hugh Tilson

When do we retest previously positive patients, I get to hear that question a lot about how do you know when to test somebody who's already been tested and those types of questions.

Dr. Betsey Tilson

Previously positive. So a couple things in there. So one if you were positive, you, you can release somebody from isolation based on on clinical criteria you don't have to keep retesting to make sure they're negative to release from isolation there's clinical criteria and that is that you need to be at least 10 days from your first day of symptoms, and then be at least three days with recovered, meaning no fevers and markedly improvement of your symptoms so you can have a clinical clinical definition for release of isolation. You don't need to. You don't need to test and keep testing to get a negative. Now the other piece was what if you're positive right, you tested positive. Some of the things we are learning is that with the serology you may not have, we don't know how long that immunity will last and it's possible you could get reinfected which is going to be a nightmare. But, so I'm not sure what we think about if someone was symptomatic and they're positive and they got symptomatic again, it might be worth testing but you don't need to test, keep testing to get negatively test positive you can use clinical criteria to release them from isolation.

Hugh Tilson

Many companies are requiring employee to have a negative test for COVID-19 before returning to work, what is the stance on testing for post respiratory symptoms to return to work.

Dr. Betsey Tilson

So that is not a state requirement that is not a public health recommendation. We actually have written and have guidance to businesses that you don't need a letter or a negative test to return to work. So, that is one of these policy issues, it's not in your guidance, it's not public health recommendations although we've talked about it for employers. If employees do want to like test their employees to come back. Then what we've been talking about with our with our commercial payers, that that's if that's a requirement of an employment, and the employers, probably need to then work on figuring out how to do that and paying and paying for that if they're going to require that their employees. It is not a public health recommendation or clinical recommendation if the employer makes it a requirement, they will have to figure out how to, how to do that and how to pay for and how to arrange for it.

Hugh Tilson

Just about out of time. So one of the questions that came up that is interesting is that quality control for self testing, and whether they're number one if anybody's looking at that, number two if there's a difference in quality of self tested versus professionally administered tests.

Scott Shone

This is Scott, a great question. So, that there's also a distinction between self, healthcare provider observed self collection versus home collection which is, you know, un-observed self collection, the FDA has made a pretty clear distinction, especially on our EUAs that there's only a subset of methods that are approved for truly self collection, especially at home. The rest are supposed to be on site and observed so some healthcare, a health care professional, is to observe the collection to assure that it is of quality. Now I've said it many times and many callers on many attendees on this webinar, probably heard me say or received an email where a test is only as good as the specimen that's collected and so it is important, there has been some good data to show that nasal swabs, even those that are healthcare directed, even if self collected, have a, you know, a quality approaching a healthcare collected swab so we continue to collect data on these and assess that but I think as long as there's a healthcare professional assisting, guiding you know or observing that the level of sensitivity is close to on par with a health care collected specimen.

Hugh Tilson

Thank you.

So, Shannon we're just about out of time. Do you want to keep asking questions, or do you want to call it.

Dr. Shannon Dowler

We got I was just saying I hate to take people's we're already into people's evening time, but there are some fabulous questions in here. And so I think what we're going to do the team will take these questions back and try to get you answers. Do we have their contact information, we do so we will definitely get you answers to the questions, but I think we'll also use those to help inform our next round of FAQ s and guidance. Knowing that some of these things we can't answer yet. There are a lot of questions around payers and who's paying for what, and that's so variable right now I will tell you with my Medicaid hat that I'm often wearing is that we are not putting limits quantity limits on testing at this time and so we are paying broadly for testing. I know that some of the commercial payers are starting to limit that. And so, this is sort of an ever evolving situation but we'll take all these great questions get you answers, and then we'll also use these questions to help inform our next round of FAQs to providers.

Hugh Tilson

Well, thank you, Shannon and thank you everybody for all the hard work that you guys do all day every day. You probably don't hear this often enough but thank you thank you thank you. For those of you who made time tonight to be on the webinar, we hope you found this helpful and Shannon let me turn it back over to you for any final comments.

Dr. Shannon Dowler

Yeah, just thanks to the whole team for staying on and working another late night I think that's pretty much the standard at DHHS for the last three months. And for all of you out there in the field who are taking care of our, our state. We appreciate you joining us tonight. And we appreciate you being there for the patients and working together with us, please let us know give us feedback if you're not getting what you need or if you're having barriers or challenges to things. And otherwise, we look forward to talking to you at the next webinar.

Hugh Tilson

Take care everybody.