

Transcript for Friday Open House for Providers
July 17, 2020

Presenters:

Betsy Tilson, MD, MPH, State Health Director and Chief Medical Officer of NC DHHS

Zack Moore, MD, MPH, State Epidemiologist and Epidemiology Section Chief, DPH, NC DHHS

Hugh Tilson

All right everybody it's 1230 let's go ahead and get started. Thank you for participating in our office hours for providers. Prior provider forms were cancelled for a variety of reasons but as COVID-19 continues in North Carolina, maintaining these communication channels is important. We're going to try a new approach office hours to facilitate that communication between DHHS leaders and providers about COVID-19. We've got these scheduled every other week through August. We'll reassess then whether this approach works better than the other approach and is accomplishing our goal of effective communication. Meantime, please let us know any feedback about how we can make these even better. Next slide please, Nevin. I name's Hugh Tilson I'm the director of North Carolina AHEC program I'll be moderating today, I think everybody knows but just to be sure you guys know who the panelists are Dr Betsy Tilson is our state health Director and Chief Medical Officer. And, as you can see, Zach Moore's are state epidemiologist and chief of the epidemiology section. Please Please join me in thanking Dr. Tilson and Dr. Moore for making time in their crazy busy schedules to do this I happen to have a little bit of line aside about how hard they're working and thank you all for all that you do. I really appreciate your making time for this. I also want to thank everybody who's making time to be on the call, and know how busy your schedules are. We hope that this information will help you do your jobs a little bit better and make navigating these trying times little easier. Next slide. You're going to hear from Dr Tilson Dr. Moore with some brief updates and then they'll hold office hours and I'll try to facilitate that by asking them questions.

You can only participate in questions using the q&a feature in the black bar on the bottom of the screen. If you're on the webinar and if you're on the phone. Send us an email at questionsCOVID19forum@gmail.com questionsCOVID19forum@gmail.com that's the same address that we gave you to send questions in advance. We'll make sure that the DPH has these questions and although we may not be able to respond individually to each of them. They will inform future guidance and future office our topics will make these office hour recordings available to the public on the NCAHEC website tomorrow. And. Let me now turn it over to Dr Tilson.

Dr. Betsy Tilson

Thank you very much and, yeah, this will be a new forum we think really flexible and responsive. Zack and I will do a very brief update in the beginning, we, we did get some of the questions proactively so a couple of questions I will I'll try to answer proactively with my comments. Hugh will toss us questions as well and have this be kind of an informal yeah office hours which hopefully will be helpful and give us guidance as we go forward of how we can be the most helpful to you. I think one of the things that we

have, we continue to learn is that information is changing so rapidly, and I know it's hard to keep up with everything it's hard for us to keep up with everything as well so just having those open channels of communication as things change can be really helpful. So thanks for participating.

Okay, so I'm just gonna touch briefly on three topics, some of that again was a question that we got ahead of time that I hope to, I can address. So first thing is, last week hopefully many of you have seen me pushed it out through a lot of our provider channels, but there was a, we pushed out last week a couple things. One was around a standing order for diagnostic testing for COVID-19. Now for many of you who are providers, this may not be all that helpful for you because you are providers, you're an ordering provider you can order the test. But what we've been finding is that some of our community based testing, and some of our long term care testing. That was a barrier for people getting a test if they didn't have that ordering provider on site again at that community base, or at the SNF testing. So in the most recent Executive Order was authority for the state health director to issue a standing order for diagnostic COVID-19 testing and so that is there and it's up on our provider guidance. Doesn't override anything it's not mandated to be used, but if you especially if you are working on helping to organize community based testing it is a tool that can be used to authorize the submission, the collection of submission of samples.

We use the vehicle of that standing order also as a way to communicate a couple other things that went out simultaneously. One is we updated some guidance on isolation and quarantine and specifically what to do, what a patient should do after testing after they have the test while they're waiting for the results and then specific around isolation and quarantine and so that's embedded in the standing order as well as well as the free standing document up on our website under patients, under investigation. It's a little bit more user friendly than some of the things that we had. And so we hope that will be really helpful and clarifies that people upon having testing really should isolate the other thing that we are finding is that really high attack rates within households so there's also a recommendation that households quarantine at the same time, if they have one person being tested, so that is in their English and Spanish, and then a standalone.

And then the other thing that it alludes to is pursuant to state law state law requires. So, we had required physicians having to report positive COVID tests so that has been since February COVID has been a reportable disease that has been a requirement for physicians to report, positive results. The state law state law got passed that that to increase that requirement of physicians to report positive and negative. And then for non physician health care folks so MPs, PAs, pharmacists also have to report positive and negative. So that's a new data reporting requirement that we were required to do. And so that that guidance is in there. The link to the order as well as the guidance of. A nice kind of silver lining of this is that if you are a provider and you are sending your lab to a lab that is reporting to like LabCorp, Quest, one of those labs. And as long as you can confirm that the lab to which you are sending your your results are sending their results to, to, to us to DPH then you don't have to report your. Well health care provided that physicians don't have to report positive or negative, physicians don't have to report negatives physicians still have to report positive but you don't have to report the other one so that's all

in there, and there's a lot of detail into those reporting requirements, and we can talk more about that, if you would like.

Second big news that happened this week was a decision around K through 12 school, hopefully many you have seen but the decision was made to go to a plan B, which allows for in person learning, but a hybrid model and requires reduced density such that you can achieve social distancing as well as a whole bunch of other safe and healthy, safety and Health protocols. So that announcement was made on Tuesday on our website under guidance under education. There's very very very in depth K through 12 guidance as well as protocols and what to do for a presumptive or confirmed case. Q and A's, all sorts of companion documents, that's in there so hopefully you're aware of that. As part of that conversation and this was some proactive questions we had was around our requirements for face coverings. I think many of you are aware, executive order came out. Now a couple weeks ago of requiring face coverings for people when they're out in public spaces in the eo executive order it is required for 11 and up, and then strongly recommended for littler ones out in the public first k 12, we are requiring face coverings for K 12 as well that goes beyond the EO just because kids being stationary in school for much longer time. Just pose more of a transmission risk than somebody kind of walk into Costco or walk through a retail store. So that's a little bit of a difference in those requirements.

And then finally, my last bullet and then I'll stop talking have Zack do a couple things and then field whatever questions you want questions around immunization rates. So this was a topic that we've talked about fairly often. We saw a big, big dip in immunization rates and then well child visits and office visits in the beginning of this pandemic so dipped really deeply in March, end of March beginning of April. And so, and we're doing a lot, try to do a lot of proactive work about messaging, a lot of different ways to get those kids back in immunization rates back up. I'm looking at some trend lines that we're doing much better now we're still not quite at 2019 levels but we are getting much better so that's good news as those immunization rates are going up. We're really trying to do a lot of focus, push out now, as we had think about heading back into school, July is adolescent vaccination month, the Academy of Family Medicine has been doing a lot of outreach as well as a peace society as well as within DPH on adolescent vaccines. We're going to be doing a lot of public messaging on the importance of vaccines and our Medicaid team is also looking, working with practices on looking at care gaps around vaccinations, as well so we're trying to do a lot of emphasis on really encouraging kids getting in for well child and vaccination rates so that we're kind of ready. Once kids go back into school. So I'm going to stop there that was maybe a little bit too much, turn over to Zack and then, and then we can field your questions.

Dr. Zack Moore

Okay. Hey, can you hear me. Yep. We got to you. Okay, all the many unmutes cancel each other out sometimes. So I appreciate everybody being on as Betsey said gonna keep it brief so we can get to your questions. I think that's the idea for this format. I will sort of sketch out a little bit of the at the picture, although you know i don't think you'll hear anything too shocking. All, all out there in your daily news

but we are seeing increases, all across the country, and you know at first, lit up in the southeast, and Southwestern parts of the US but then that has since expanded out so that we are now seeing it all across the west coast and the Midwest, etc. So, the only place that's really not being upticked is up in the northeast, particularly the areas that were hardest hit back in March and April. And then looking here in North Carolina. You know, I should say maybe regionally first the southeast still continues to be one of the hardest hit areas with the biggest increases, not only in cases but also now, and it upticks in, in deaths, which of course is a lagging indicator as so often said, and you know we are seeing those increases, particularly in Texas and Florida but not limited to those really starting to pick up elsewhere.

So in North Carolina, we certainly are. You know our trends are very concerning we've had big increases we just had our fourth I believe day of more than 2000, new cases added to our to our case counts for a 24 hour period. You know, I will say that we are not seeing the same kind of rate of rise as as our other southeastern states. And you know I believe that that has a lot to do with early aggressive actions that were taken here, sort of cautious approaches to, to our community mitigation strategies as well as of course all the great work from people out there in our provider community and our, you know residents. So, you know, we but still. Despite not having quite the same rate of rise that we're seeing elsewhere, we still are seeing very concerning increases and the increases are being driven entirely by younger age groups. We have not seen much increase in people over 65, which is a good thing. You know, long term care facilities continue to be a huge concern and source of, you know, about half of the deaths that have been recorded. But, but overall those, those numbers have not increased the increases we're seeing are mainly in people 25 to 49, but also with pediatric patients and really all the younger age groups. And then the other really notable trend that you're probably aware of is increasing disparities with our Latinx population, particularly being hard hit, making up more than half of the cases in many of our counties and a very large disproportionate segment of our cases statewide. So that's very concerning and something that you probably are aware of working a lot on intentionally trying to do outreach in that community, African American community also disproportionately affected, compared to whites but not not to the same degree as as Latinx population.

So I guess those are probably some of the big things I would point out you know we're always still very focused on our healthcare capacity. And fortunately we have not encountered any hospital capacity issues. Yet, that's something that we're always very concerned about and we've seen in, you know, what's happening in other states where, where they've had larger increases. And there's going to be new data on our public facing dashboard about hospital information coming out soon and I think will help people have a better picture of what's going on there.

So maybe that's it for the epi. A couple other things I wanted to touch on that have been asked or come up one is about different testing modalities, so, particularly antigen testing came on the scene, relatively recently. And there are now two FDA emergency use authorizations to companies that have emergency use authorizations for their antigen tests. Sofia and Becton Dickinson I think I have that right. So, just wanted to point out that those tests are different than the molecular assays. They are basically and you should think of them like rapid flu tests. So all the limitations that we know, or hopefully know with

rapid flu tests apply with the COVID antigen tests and particularly that's low sensitivity. So, we have heard a lot of stories about antigen tests being used to replace molecular tests in places where it's really not appropriate. Specifically, you know their intended use is in symptomatic patients in whom COVID is suspected. That's where they're of most use, and they are much less useful for screening of asymptomatic patients. So they're they're not equivalent to molecular tests they have different performance characteristics. So we have put out a guidance document on that that's on our website. The Association of public health laboratories has also put out some more detailed information about differences and where it is or is not recommended to use antigen tests. They do have a high specificity meaning that the likelihood of false positives in general is low, although certainly happens. And because of that, we are using positive antigen tests to trigger all the interventions so people who have a positive advantage in tests should definitely be considered COVID patients and that means all the isolation and the public health measures that follow and the case investigations are happening for people with positive antigen results. So those results are reportable if you're using a point of care tests, it's not going off to the lab providers are required to report those to public health actions can be taken.

And then two other things real quick just sort of emerging data merging information on reinfection, I think there's some reasons for optimism on that front. Several new publications that have basically indicated there's there really is no solid evidence for reinfection with COVID-19. At this point in the pandemic. Not to say it hasn't happened not to say it won't happen further on, but certainly it does not appear to be a major or common phenomenon. So based on that, I know CDC is looking at their guidance and we're looking at our guidance about people who have had a documented infection, not needing to be re quarantined if they're exposed within probably going to be three months after their initial infection not needing to be retested. If they're exposed again, within three months their infection so you can be on the lookout for that guidance. Although you know, like I said that's still sort of under consideration, but the evidence is mounting that that's an appropriate way to go, which is, which is good. I do think it's important to recognize that people can be PCR positive for a long time after their infection, and that does not necessarily connote infectivity in fact there's pretty clear evidence that people with typical mild infections, do not have culturable or viable virus detected beyond eight to 10 days after their onset of symptoms, and some of those people can go on to shed or weeks or months. Some of them will shed intermittently be negative and then positive again. But that does not connote infectivity so also probably looking at changes in guidance to discourage the use of test based strategies for ending isolation, which are, resulting in people being stuck in isolation for longer than is necessary and also draining our testing capacity. And with an emphasis, then on using time and symptom based methods for ending isolation. We've all heard the 10 days after first onset of symptoms plus three days with fever resolved and other symptoms improving or 10 days after positive specimen collection for people with no symptoms, it is the case that those with more severe infections and people with immuno compromising conditions have culturable virus detectable longer, more like up to potentially 20 days so there may be differences in those groups but by and large, we're really encouraging businesses not to require two negatives for people to come back, etc. So those are just a couple things I wanted to share with this group in terms of maybe a little bit of good news, in all this. And what we're saying in terms of duration of infectivity and likelihood of reinfection. And with that I will stop and we are available for your questions.

Hugh Tilson

Great. Quick reminder to everybody, submit questions using the q&a feature, or if you're on the phone, you can't do that send us an email at questionsCOVID19webinar@gmail.com got a couple of follow up questions act to your comments. One is we're being heavily marketed by bio fire and other companies that do office space respiratory panels that includes SARS CoV2, we do these in offices that net helpful to the state, ie is point of care SARS CoV2 testing using the respiratory panel is something you would encourage or discourage.

Dr. Zack Moore

Yeah, I guess probably neither the short answer, I think those are definitely viable options and we recognize that point of care testing is very desirable for a whole bunch of reasons so certainly would not want to discourage that. Currently, the issues that I pointed to with antigen testing with low sensitivity also apply to point of care or near patients molecular tests like the Abbott ID now those, those tests even the molecular ones that are that are potentially point of care have lower sensitivity and there's recommendations on most if not all of them that a negative test should not be considered confirmatory and should be needs to be confirmed with another FDA authorized molecular test, I certainly don't know about bio fire. And if those same if they have that same caveat there but I would, I would read the fine print, just to make sure that you understand, whatever assay you're considering bringing into the office and if there is a recommendation that negatives, need to be repeated then certainly think about how that factors into how, how you anticipate using those tests, those, you know again might not be appropriate for for testing of asymptomatic people. But in terms of multiplex I think that's really definitely something that, you know, we expected. COVID is going to be added on to these multiplex PCR so it'll be very interesting for us to learn about co infections etc but yeah I wouldn't really encouraged or discouraged typically.

Hugh Tilson

Go ahead, Betsey sorry.

Dr. Betsey Tilson

No, that's okay yeah I wanted to chime in a couple on that thinking through it I got a question this week from, from my provider as well, with point of care testing and thinking through the tests with lower sensitivity, you want to think through the populations that have a higher kind of pre testing probability, those are probably the patients with whom you want to use a test of lower sensitivity. And so thinking through so then this came up with antigens as well so that antigen testing for asymptomatic folks, probably not great but for symptomatic, folks. We have a pretty high pretest probability, and that's that's that may be okay thing it's the same thing with the point of care and molecular testing that it may be symptomatic folks or thinking through those, those populations with a high pretest probability. The other thing also want to and this leads back to data reporting is that the point of care testing if you do point of care testing then you also need to report the results of that point of care testing which is

different right so for flu, we don't have to do that. But again if you're if you're doing tests and you're sending it off to a lab corp they report to us no problem but if you're doing point of care testing, then you still you need to report the positives and the negatives of your point of care testing. So just as a follow up on on terms of data reporting requirements, and that is new we're aware and that is new

Hugh Tilson

Question about where on the DHHS website the guidance for the use of antigen tests can be found.

Dr. Zack Moore

Yeah, there's a lot of guidance up there. It's under the health care section under provider guidance, right where the, the sort of general provider guidance is located. All right, and the APHL thing I mentioned the Association of public health laboratories I believe is posted on our state laboratory website just to keep things interesting.

Dr. Betsey Tilson

Yeah, and it's allowed this chime into yeah if you go up to on our main website if you go under guidance, and then you type guidance for healthcare providers and local health departments and you scroll down kind of midway. There's also the provider guidance and that has the has the antigen testing it has the temporary order. It has the guidance for data reporting it has a standing order, all of that is under the provider section of the all health care provider and local health department guidance section.

Hugh Tilson

So if you guys, what we can do for two weeks is we can put a slide that has all that information on it's just to make it easier as a follow up for a couple weeks from now got a number of questions kind of asking these general things. It's taking really long time to get test results back and quarantine period is about the same as the time for getting test results back. Do you anticipate expedited or improved test result timing and what does that mean for patient management, given the kind of disconnect between test results timing and the natural ending of quarantine period, how do you advise.

Dr. Zack Moore

Yeah, I Betsey I can start, that's okay, because it because I think it really, in my mind points to the importance of what happens at the time that the sample is collected. And then, you know, the information that's given to the patient at that point, especially now that we're seeing, you know, again, shortages in all kinds of different places in the supply chain and that's, that's, you know, the state is working incredibly hard to make sure that we're accessing all the resources we can from a laboratory perspective to decrease those times, but I do not expect those problems to disappear. So I think, in my

mind, it's really important that at the time that a patient is tested. They are given clear instructions on isolation and quarantine and control measures that that document that Dr Tilson mentioned earlier, I think that, you know, that's critically important and, you know, something that recognizing that it might be 8 days and that's a terrible thing but you know, you got to maximize those opportunities to make sure that people know what they're supposed to do if they're being tested because they have symptoms they need to know that their household members should not be going out until they get that result back so I think that makes that all the more important and, you know, we certainly hope that those times will improve, but we need to recognize that if we're waiting until that result comes back in a lot of cases we've really missed the opportunity to prevent transmission. So, did you have anything to add.

Dr. Betsey Tilson

Now just put an exclamation point that as soon as somebody has tested, well so first off just a little public health purity right you isolate somebody who is sick you quarantine their contacts, just FYI. And so right as soon as somebody has tested. They need to be go into isolation, while they're waiting and that is clearly on our guidance since that's one of the things that can make sure you have that link. It's really clear. So folks could get isolated and again because we're seeing such a high kind of attack rate within a household, then also the other family members should should quarantine while they're waiting for those results critically, it's really critically important. I guess the good or the bad news is, if these results are coming back so late. Once you get it you might already be kind of pretty much through your, your isolation phase, I guess, better, good or bad. Through that, but it is critically important that all those control measures should go into place at the time of testing, and we are trying to again this this is a national supply chain everybody's seeing it and the kind of the good and the bad news is that North Carolina. We're actually even though we're not in a great place we're doing better than other other states we're doing better than Florida and Texas, South Carolina and so there's any gonna be any like federal push to support it's going to be states that are doing worse than us. So I think the supply chain, and the delay and lab report that's going to, it's not something the state's going to be able to solve on our own we're going to try every way we can.

And also look for some federal guidance, but I also think this gets into that earlier conversation about the utilization of point of care testing right and if the delay in the molecular, you know the gold standard molecular tests is going to be delayed. What's the creative way, where are the roles of the other of the other testing modalities right so you've had a symptomatic person with a pretty high pretest probability, maybe that is a place for antigen there is a place for point of care and at least then we don't need to send those off for confirmatory molecular testing, and back in Scott and I had a dialogue with a provider today, this week about that thinking, thinking creatively of when we, when we can use those point of care testing to decrease the demand on the lab molecular testing and another way. We're also trying to think through in terms of provider guidance. Like, who are the populations that you really don't need to test and therefore decreasing the demand and so for example, really going to when we think about release of isolation going to what we've really been pushing out is a time based and symptom based release of isolation, we've talked about that, you know, 10 days after your symptoms. Your onset of symptoms, and then three days of resolution no fever no symptoms, really going to that clinical release of isolation and not requiring a test, you know, a negative test to release isolation. So, we've been trying

to push that hard that the test base release isolation is really not not value add and really strongly discouraging that. And we're also trying to think through other other provider guidances identifying what populations, you shouldn't test, so that we can make sure there is as much capacity for people that you should test.

Hugh Tilson

So, this one may be a little personal but our drive thru site is starting to hear my child is going to college in x state and must test negative no more than five days before the first day of school, give specific guidance for that college students. Sorry Betsey I thought I'd ask you that.

Dr. Betsey Tilson

That's not our college student is it?

Dr. Zack Moore

I've got one of those two. Ah, well, and I think that, unless something changed Betsey, you know, the general guidance is not to recommend sort of entry screening for arriving students into institutes of higher education, which. That doesn't address the question of what happens if your kids college is requiring that. But as a general measure of the matter, and Betsey please correct me if something's changed but that's not one of the recommended strategies.

Dr. Betsey Tilson

If Brian is not an, actually K through 12 actually CDC came out pretty declarative thing that CDC does not recommend proactive casting his kids going back into K 12. And they're actually CDC actually in their into of higher education guidance as well says, although we get that some are doing it, we do not recommend those proactive testing. So the university, so I get some universities are doing it it's not CDC recommendation it's not our recommendation, that doesn't really help the person on the ground, of how to, how to do it. I think that's gonna be be hard. I mean, we do have a lot of the testing sites, you know whether or not the providers or urgent care are willing to do it but it is not our public health priority it's not a recommendation it's not CDC guidance on that.

Hugh Tilson

So, other tangentially related questions How should clinicians approach positive patient patients whose employers insist on repeat testing until a negative test result is obtained. How long after each positive test should we wait before performing the requested retest.

Dr. Betsey Tilson

So they, their businesses should refer to our business requirements where we say our business guidance we say pretty clearly you should not require a negative test before your employee comes back to work. That is, and we could maybe make sure that that is because make sure people see that the, we've been really well. We have communicated to the business community that that should not be done that they should not require a negative test before they can return to work.

Hugh Tilson

Getting questions about testing staff of the practice. My question pertains to testing strategy. I've been offering testing every three to four days post exposure and if negative testing again an eight to 10 days post exposure does that seem reasonable for staff that are asymptomatic exposed.

Dr. Zack Moore

Well, maybe not, you know, who are exposed meaning they had exposure were they wearing appropriate personal protective equipment, either in their personal lives or in their occupation should really be excluded from work for 14 days after that exposure that's the baseline recommendation. And having a negative test at three days eight days 10 days does not end that quarantine does not end that work exclusion. So that should be the baseline expectation for staff who have an exposure. Now, in general, we do recommend that people get tested on or about six days after a recognized exposure, primarily for the purpose of if they end up being positive, then we can continue identifying contacts and trying to interrupt chains of transmission, but a negative result. As I just said, doesn't get you out of the rest of your 14 day quarantine. So, yeah, so I guess depending on how you're using that strategy if you're using it to have staff with recognize exposures continuing to come into work and you're not in a crisis staffing situation and I would not recommend that.

Dr. Betsey Tilson

And what I would recommend though on the front end is that this is this, the importance of prevention can't be overstressed I don't even have to sign up for that medication, but. But as we really think about how we're going to -- with this and so really really really ensuring that your staff and your patients are all really practicing universal prevention strategies, but making sure that everybody is getting masks, patient and provider all the time, because that level of risk of exposure, really, if you look at the the that level of risk is depending on you know, is the patient wearing a mask is the provider wearing a mask but as much as possible having that upfront personal protective equipment as well. It's going to be really really really important as you start thinking through the risk of exposure to our healthcare workers,

Hugh Tilson

Gotta come at it that applies even in the break room in the lunchroom when they need to maintain their distance while they're eating, just as a kind of follow up to that about risking. One of our primary care providers who consistently wears both mask and facial shields in all patient interactions became covid positive we can't identify the source. She's careful at both work and home, do we need to notify her patients.

Dr. Zack Moore

So that is a very tricky question. So you're talking I, I'm just to make sure I'm understanding. I think we're talking about somebody who worked, seeing patients during their potentially infectious period. And, you know, current CDC guidance, is that patients who were cared for by a clinician or health care provider who became positive are considered exposed, even if that provider was using appropriate PPE so although it's a little confusing, but you know the PPE is, is to protect the provider. So, you know, if they're caring for COVID patients and wearing appropriate PPE they are themselves not considered exposed but if the provider is positive. The patients are considered exposed, which would mean notifying patients of a potential exposure if they were cared for, you know, in close proximity etc. During the time when the person was potentially infectious. So, that is one of the pieces of guidance that is come under a lot of scrutiny and, you know, I think there's a strong argument to be made that the use of appropriate PPE during a clinical interaction is also protecting the patient but I can really only tell you where things stand right now which is that those patients are still considered exposed even if appropriate PPE is being used.

Hugh Tilson

Got a couple of questions about the standing order does the Standing Order mean anyone can get a test for any reason they want or do they still have to have one of the quote reasons to have a test.

Dr. Betsey Tilson

So if you look at the standing order on the very front line, it says, Those who meet the current DHHS criteria for testing. So, it is meeting the current recommendations for testing.

Hugh Tilson

And if a child is positive would the Standing Order allow the parent to be tested.

Dr. Betsey Tilson

Yeah. Yeah. I could. Yes, that's a perfect

Hugh Tilson

Concise answer. Our practice would like guidance about managing newborn visits in the office versus virtual whose mothers are COVID positive. Local community hospital tests all moms at the time of delivery and performs COVID tests newborns for discharge of the moms COVID positive, how should they manage the kid, I think is what that question says,

Dr. Betsey Tilson

I think the question is if I think this was a pre question is, can that mom like can the mom come in with the baby for a well for like a newborn visit. So, I'll do a couple and then Zach. Tell me your thoughts. So first off, there is guidance on the CDC, on the CDC website specifically about pregnant and postpartum and breastfeeding and newborn care. It's relatively new, there was a -- study that came out. Oh I don't know maybe about two or three weeks ago now, I promise I'll get to the question but I just want to expand a little bit on pregnant breastfeeding and around the kind of mother baby diad because there's some new information out there. So first thing, one of the things that we that looking through the last five months of data, what we are finding is I think is what we were kind of expecting, is that typically pregnant women can have poor clinical outcomes with respiratory viruses we see this with flu. We weren't really seeing it with COVID yet but we weren't quite sure and this data looks at and looks like there is pregnant women have a higher risk of hospitalization and ICU care if COVID. Not, not a higher risk of death from this lease data set by higher risk of clinical severity.

So that's just one piece and so now the pregnant women are in, not they're not in the official high risk category but they're in the population that should take precaution category so just want to make sure people knew that. And then the recommendations for the mama after delivery and breastfeeding is, if as much as possible that the mom can stay six feet away from the baby, obviously that's really hard but 6 ft away from baby and then if she is going to interact with the baby making sure that she has a cloth face covering really good hand washing and limit the amount of time with the baby. When it comes to breastfeeding, you know there is a risk of a risk benefit on that. And, you know, if the mom is gonna breastfeed directly then again making sure she has a cloth face covering and really good hand washing and minimize the amount of exposure outside of breastfeeding, or having them on pump, and then having somebody else give the breast milk via the via the bottle, so there is that, that, that neonatal and breast feeding advice. And it really would be again until that mom reaches that that time and symptom based release from isolation that those extra precautions should be are recommended. That's a hard one because obviously there's a lot of risk benefit and risk of that that mom baby diad especially around breastfeeding but but the pumping in somebody else giving the milk is an option. In terms of coming into a health care setting, but I think it would be ideal if somebody other than a known COVID positive.. If the dad or another family member would be able to bring that that that baby in. Otherwise, for sure masking. And I think we have found that if the patient is masked and the provider is mask and you're making sure everybody is kind of away from other people there may be a relatively low risk of spread but I would say that kind of best practices have somebody who's not COVID positive as possible bringing that newborn. In, or just really making sure that if you know that that that mom is, you know, not being

interacting with anybody else and six feet away from anybody who might be attending them. Zack, do you have other advice or thoughts about that. No.

Hugh Tilson

So let me ask, how should pediatricians approach fluoride varnish Is this considered an aerosolizing procedure any recommendations for PPE.

Dr. Zack Moore

I have certainly never seen it considered as an aerosol aerosol generating procedure, trying to think back to my own personal experience and see how that might even happen.

Dr. Betsey Tilson

Yeah, I don't see I think maybe someone may be getting a little bit confused if you look at the guidance for dentists. There's a whole litany of guidance for dental procedures, there are some dental procedures that can create aerosolization like when they use like that water spray there's all sorts of stuff that dentists use that code aerosolize. So it may be some of kind of confusing some of the recommendations for high risk dental procedures with this just because it has to do with teeth I don't mean that in an insulting way but I don't see how fluoride varnish would be considered an aerosolizing procedure. My guess is this is getting confused with some of the dental recommendations.

Hugh Tilson

Got a couple questions about testing reporting so one is can the testing result be automatically forwarded to the PCP.

Dr. Betsey Tilson

No, no. Please go. You're smarter than I am.

Dr. Zack Moore

I was trying to envision I assume that this means the test is done, somewhere else. You know if the person goes to Walgreens or CVS or whatever, can the test automatically be forwarded to the PCP. Which, you know, no. That's a hard place for us at the state level to operationalize anything like that. I will say that there will be COVID results shared through our state's health information exchange beginning next month. So to the extent that providers are part of the health information exchange system. If they have an existing relationship in that system with a patient and there's a covid

result that result will go out to those providers, but unless I'm missing something in the question beyond that, it. There's not really a way to ensure that test results, done by another provider or in another setting are routed back to the primary care provider.

Dr. Betsey Tilson

The only thing I'll add again if you look in the Standing Order there is an expectation that if the patient has, has a primary care provider that that information is collected at the at the sample collection site, and there's an expectation that the that the results would be shared back with the primary medical home if the patient identifies that exactly how that operationalized in all the different community settings I think that, not sure how that all will happen in every different setting but at least there is an expectation for those testing done under the standing order that that the PCP name is collected and samples are shared back with PCP. But as you can imagine there's a lot of operational logistics

Hugh Tilson

Kind of related question if the performing lab uses electronic reporting report positive and negative results to the health department of the county which patient resides is the physician collecting the specimen also required to report. So that seems like duplicate work.

Dr. Betsey Tilson

Yeah. But yeah, so, physicians are special. And there is predating public health law that physicians have to report positive so physicians have to report positives. They don't have to report negatives, if they know their lab, the lab is reporting negatives and non physician health care people don't have to report positive or negative but predating public health law that physicians still have to report positive so is it duplicative, but that's predating public health law. Anything else on that one?

Dr. Zack Moore

No. Yeah, That's right. That's not a covid thing, that's a broader state law that covers all reportable conditions that physicians are required to report suspected and confirmed cases,

Hugh Tilson

Kind of follow up on the NC health connects will test resulting testing results from NC HealthConnex be alerted to the providers are available in the clinical portal will be pushed or do they have to go get it. Do you know.

Dr. Zack Moore

Pushed. And I don't know enough about that mechanism to say more than that.

Hugh Tilson

Okay, I got a follow up comment as a pediatric dentist I would recommend wearing a face shield when you apply for in foreigners to avoid saliva splash spiting from the child. That's what we do.

Dr. Betsey Tilson

That's a good idea.

Dr. Zack Moore

Yeah and you know just as a reminder, face masks, not base covering so used to saying face covering, now masks and eye protection are recommended for all clinical encounters whether COVID is suspected or not. I don't think face shields. And I don't know if that's addressed specifically in the dental guidance, but that's definitely good practice. You know, regardless of suspected COVID.

Dr. Betsey Tilson

Hey, can I riff on facial shields just a little bit. This is the downside of having a casual. So there's a lot of conversation more than I really expected on the conversation about when face shields are an acceptable alternative to face covering face mask. There's been a lot of conversations about this in in like a preschool environment. As part of as part of school for kids who really need that kind of just to see the face. You know, little kids, respond so much to the kind of your, your facial expressions also for kids who may be deaf or hard of hearing where they have to see the mouth. There's a lot a lot of conversation around alternatives to an opaque face covering. So a couple things in that that one they do there is a clear face covering that are made the supplies are a little bit limited right now but that could be a really good choice for people for whom seeing the mouth is really important. So, a clear face mask, it would be a good choice. The issue with a face shield is that, as was previously discussed the evidence for face shields, is that it protects the person, the wearer from the saliva of the other person so it's good protection, but there is no evidence that it provides any source controls so prevents those droplets from the infected person out. So, a face shield is not a good substitute for a face covering or face mask if you're using it as if you want to use it as source protection. So, and the CDC says it really shouldn't you know it does not recommend a face shield as source protection, and some of our language what we say is about you know opaque face mask. If you can't use that if you have a clear face mask. That's great. And then if you just can't use anything, then a face shield is okay, but until you have a better source of protection.

Hugh Tilson

Anything else? Got a couple questions about the dashboard. Why are there high numbers of cases with missing race and ethnicity data on the dashboard.

Dr. Zack Moore

Basically, when we get lab reports in, they do not come with race and ethnicity data. Now that's something that we, and actually the federal government are working to improve there's new requirements for laboratories to include race and ethnicity with their with their reporting of course that means they have to get race and ethnicity data from you the providers so it's sort of not an easy fix. But at this point in time. We don't get race and ethnicity data, barely ever when we learn about new cases. So the way we get race and ethnicity data is when we get that result, somebody at the local health department starts making phone calls to reach that patient or gets into the medical record and tries to find that information, so it's a labor intensive process. So, you know, we have more complete data for further back in the past but for new cases there's always going to be a huge proportion that are missing that data, because it has to be manually collected and entered.

Dr. Betsey Tilson

And I will point out that exactly what Zack said so typically you know when you're sending off a flu you don't put race ethnicity data on a lab result it's just not you know pertinent we don't do it, but in these new data reporting requirements and so I urge you to look at that. There is an expectation and both we had it as a state. And then the federal requirements will go into place August 1, is that at time of sample collection, you have to then report race and ethnicity and so that as you were submitting the samples to the lab, then you have the race and ethnicity and then when the lab reports to us. We will have the race and ethnicity data so unfortunately, to get more robust race and ethnicity data. It's going to have to be gathered at the time of sample collection when you're submitting those, those labs, so that's why

Hugh Tilson

I'm finding it difficult to interpret the NC dashboard hospitalization data so in some where this catches all in patients who are covid positive, even if they are not admitted for COVID. Can you clarify.

Dr. Betsey Tilson

Yeah, I'll clarify. This has been a big point of conversation, I'm not quite sure what so what we get from our hospitals report daily on the number of patients who are hospitalized covid positive. The vast majority of them are, they're hospitalized because they're covid positive. There might be a small amount that it's a kind of an ancillary thing but the vast majority of people who are hospitalized are hospitalized because it's covid positive and we're gonna go and reach back out to our hospitals to give us kind of a more concrete estimate of it but i, this has gotten a lot of attraction or a lot of attention. But it's a, it's, it's not a thing what the, what we're seeing of our hospitlas Is there any you know talk to any of your hustle they'll see your, they are getting they're getting more and more and more patients who are being

admitted, because of COVID-19 so it's, it might be a little bit but it's not playing much of much of a part in those trends. And what we're also seeing just FYI like the the pre search, you know a lot of hospitals are doing kind of pre procedure testing pre hospitalization testing and the prevalence rate is like less than 1% on that kind of proactive testing so it's not much might be a little bit but it's not much it's not what's driving it.

Hugh Tilson

Any updates on vaccine for the virus.

Dr. Betsey Tilson

I know a little bit but maybe. So, I think, was it just yesterday. Two days ago I can't quite remember but there was a phase two trial that was completed, I think they had like 45 patients. I think that's right. Something like that. And then looked at efficacy of immune response and look at dose doses of that. And so did see some, some good immune response to the vaccine and so at the end of this month we'll be on another bigger phase of more people, and a longer. The next kind of a phase three so that's good I know there's a lot of different vaccine trials going on this was just one, but at least showed some promising phase two that you could mount an immune response, and looking at the right at the right dose. Zack do you have more on that you might be closer to that data than I am.

Dr. Zack Moore

I just have pessimism to offer that you know the fact that we're launching phase three trials does not mean that we have an effective vaccine. That's why we do phase three trials. And so, we certainly hope that we will see effectiveness and those trials are going to be ramping up, which is great, but that certainly does not mean that a vaccine is on the way, that's how we find out if it is effective or not So, um, you know, always a little bit uncomfortable with the media coverage of the progress towards the vaccine and the way people sort of over interpret the fact that they were entering this or that phase, but uh, you know, we'll, we'll see what happens with those trials.

Hugh Tilson

So we only have a couple more minutes left and I'm a little reluctant to ask this question but I'm going to anyway, has governor Cooper approved a plan B for schools with local flexibility to go into Plan C with DHHS providing recommendations for metrics cut points for local school districts to use to decide when the transition between plans

Dr. Zack Moore

were really a question.

Unknown Speaker

Yeah, no, we're allowing flexibility on the on the ground there aren't any really specific cut points. And so there's a fair amount of local flex flexibility we're happy to work with them but, but no we're not there's no specific cut points or metrics that we are providing for for the local LEA's to make that that decision. If we want to provide that flexibility.

Hugh Tilson

So we're just about out of time. Number of ongoing questions about testing and I'll try to pull these together for upcoming office hours in a couple weeks to help frame that up. I did want to let you both know that you got a lot of thank yous for making time in your crazy schedules so thank you so much for that and then got one comment this is one of the more helpful webinars I attend, can you please continue to this in this format, at least every couple of weeks so know that people recognize you were busy now that people value very much the time that you're making for this has been very productive and constructive so thank you very much before we hang up let me turn it back to you all for any final comments or observations.

Dr. Betsey Tilson

I'll make one and then I'll turn it Zack. And one of the things is that Zack taught me this and I and I keep learning from him but they will, we will never have enough testing capability, or contact tracing capability we will never be able to test and trace our way out of a global pandemic when 40 percent of the people are asymptomatic. We will not what we're gonna do is prevent our way out of it and so doubling down on prevention tripling quadrupling down on prevention is the way that we're going to do this so every place you can think about using your influence using your leadership using your voice. In terms of face coverings out in the public, ensuring that within a healthcare setting people are using PPE, the supporting the isolation and quarantine that we will only be able to prevent ourselves out of the pandemic we will not be able to test and trace our way out of this pandemic and so we're really thinking about that upfront prevention piece, how do we double down on that, how do we think about where and where that started like where are our populations where we're seeing the spread we're seeing in a young adults. We're seeing it in our Latin x population we're seeing a lot of community spread in high density occupations. So as you're working with your patients and thinking about what they're doing when they leave your office, really really really emphasizing when they're leaving the office to wear their face covering practices three W's, that is that is the only way we're going to get a handle on this so please use your voice with your patients and emphasizing that if we could get 80% of our patient population, wearing a face covering when they leave your office out in the public, it would just it could make a huge difference and I really think that's what happened in the northeast. If you go up into the Northeast everybody's wearing face coverings it's just not a, it's not a thing. Everybody's wearing face coverings and you can see how much better. They've been doing yes they're testing, so are we. yes they're tracing story and actually Massachusetts's tracing didn't even really work that well. So yes they're testing and tracing but what they've really done better is the prevention stuff, and everybody is on

board and wearing face coverings and that's. So if you could use your voice in your influence with your patients. And because so many people are resonating around, how can I get a test, test as an intervention test is down, you know, and on the back end. Prevent prevent prevent prevent prevent please forward that message with us. All right back to you.

Unknown Speaker

I think we might have lost Zack.

Dr. Zack Moore

Yeah I keep getting muted. Sorry I'm here, but I was just saying that was very well said and I do we know from a number of studies on vaccines and other topics that folks listen to you. More than they listened to us for sure. So, we, we really do need the provider community to be taking up this message that of the, the face coverings and, you know, we need to recognize that although it feels like it's been forever we're right at the beginning of this pandemic. We have a long way to go. And so we really need to, you know, tighten up on these prevention measures so that we can you know get ourselves to a better place. So, thanks for joining.

Hugh Tilson

Everybody, talk to you in two weeks. Okay.