Transcript for Friday Open House for Providers
August 28, 2020
12:30-1:30 pm

Presenters:

Betsey Tilson, MD, MPH, State Health Director, Chief Medical Officer, NC DHHS

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

Hugh Tilson

Good afternoon, everybody. And thank you for making time to participate in today's office hours for providers. This is a reminder, these office hours were established a couple months ago now to maintain communication channels between DHHS leaders and providers about COVID-19. This is actually the last one of these that we have scheduled. So please let us know if you're interested in continuing them and we'll figure out what the right cadence for that might be. Next slide, please. My name is Hugh Tilson. I'm the director of the NC AHEC program. I'll be moderating today. I think everybody knows that the reason you're here is to hear from Dr. Betsey Tilson she's the state health director and the Chief Medical Officer for NC DHHS, and Dr. Zack Moore he's our state epidemiologist, please join me in thanking Betsey and Zack for making time in their crazy, crazy schedule. To do this, I have a little bit of line of sight into how crazy busy they are. And I really appreciate y'all making time for this.

I'll turn it over to Betsey in just a second. But first of all, let me thank everybody, for making time today. We know how important your work is. And we hope that this information will help you do that important work a little bit better and help make navigating these trying times a little bit easier. Next slide, please. Everybody is muted on this except for our presenters. So the way you submit questions or comments is using the q&a feature on the black bar at the bottom of the screen. So submit your questions that way and we will get to them. Second is, if you're on the phone, you can't do that. So the only way you could submit a question is by using the Gmail account, which is questionscovid19forum@gmail.com. And we'll get to those questions. Want to let you know that we'll do our best to get to all of our questions, and if we can't, then we'll try to incorporate them into next time we do this. And I think we've got some links, Nevin, that we've got on the next slide. So let me put those up during our conversation. And now Betsey, let me turn it over to you.

Dr. Betsey Tilson

Thank you. Great, thank you very, very much. And we're happy to be with you all, let us know if you want us to continue or change the frequency. I think continuous communication is really important. So we're happy to do it. There's just a couple things that I'll just highlight. One, just want to go over kind of recent events or some of our recent trends. You know, we have been going down pretty much through the mid to end of July and early August, all of our trends are going in the right direction, which was

great. I think we anticipated and expected that when kids were going Back to School, both k 12 and institutions of higher education, we might see more increased viral spread, which was one of the reasons that we remained pretty conservative and cautious and we're extending our phase two over the summer because we wanted to state to be in as good a place as possible. When we knew our educational settings were open.

I'm sure many of you have heard or seen on the news that we've had some pretty big visible clusters in some of our big universities. Most of you probably know Carolina and state and ECU have seen significant clusters and they all reverted to remote learning and getting kids off campus. One thing just to note that this we get this question a lot as the universities are dedensifying, is that kind of spread virus across the state. Just so you know, the big universities those kids who identified as positive or close contacts. They all have isolation and quarantine capability on campus and the majority of kids are isolating in quarantine in their in place. For those kids who either were in like a resident not not not a known close contact or not a known positive that everybody's being encouraged to get tested before they leave, and then are being told to do a 14 day quarantine when they go home. So we're trying to minimize any of that spread off campus as much as possible.

In terms of K 12, we've seen a couple little blips here and there. But no, kind of major signal from K 12. We'll be following that for sure as well. We certainly have seen cases and a couple clusters and a couple schools have closed for short term but haven't seen huge, huge signal yet from K 12. We are watching it. And the one thing that we have seen in our statewide metrics is one if you're following closely following we have seen a bump in some of our overall statewide metric And the biggest drivers in that bump are 18 to 24 year old. So that's what we see coming from and hoping with dedensifying we'll see a decrease again in those in those trends. So that's one kind of current trend and events.

Second thing looking ahead on the horizon a little bit. Flu season will be upon us before we know it a couple things really wanted to ensure that we are encouraging flu vaccination as much as possible. We got some more money from the CDC and they'll be doing a lot of public messaging. We are shipping out VFC supplies, vaccine for children's supplies should be going out. We'll be ordering more and pushing out. And then you also got guidance about the bi directional sharing between commercial and vaccine for children's supplies. That memo went out last week I believe. And you can do bi directional sharing and that our immunization branch really did a great job in streamlining that process and not you don't have to call the help desk anymore and it's so much easier process. So hopefully you got that. Also just looking ahead to flu, we do have gotten more and more evidence of the possibility of coinfection with flu and COVID we will be working on some clinical guidance for that. But pretty much the take home will be if someone shows up with flu like our code like illness, unlike what we said in the in the spring where we had lots of circulating flu and not much COVID or really any COVID we could do flu first and if it's negative then do COVID it'll be more I was do both flu and COVID cuz we're not gonna be able to distinguish the two and then also, there will be evidence of CO infection and I just heard from State but they also had co infection of strep and COVID. So anyways, you're gonna have to test a lot for COVID.

And then third day on the horizon, yay COVID vaccine. We are working hard on our on our immunization plan. It is due to the state the federal government October 1 on what our plan will be for math, COVID vaccination. Clearly all of our immunizing providers, we're going to make sure that you get them enrolled. So you can do covered vaccine just like you did H1N1 vaccine, we're going to try to maximize our regular vaccination channels, and then also been through more vaccination, like mass vaccination sites or non traditional channels to try to get out vaccine as much as possible. It is possible that we'll get some very small allocation, they say even as early as November 1, that will be really reserved for kind of critical workforce and potentially like skilled nursing facilities really, really high risk folks. And we'll be going through a prioritization activity to be sure that we're very transparent on that prioritization. And then the expectation is that we'll get ramped up production and we'll have more starting January, and then more and more from January through June. So kind of wide population vaccination as we get into the first half of next year, so, we are ramping up for plans. Get that on your radar. Please, please, please. Because the way we'll end this pandemic is getting people vaccinated. And so we want to be sure all on board for that. Okay, I think that's it for me proactively.

Dr. Zack Moore

Thanks. Yeah, I don't have a lot to add. I think. As Betsey already said, we're in a precarious point right now with the with COVID in North Carolina. As I talked about last time, the ideal would have been to continue that downward trajectory and get into a good position for a respiratory virus season. But we're going the wrong way. And we will, we'll see how the sort of rapid mitigation efforts that have been put in place around colleges and universities how how effective that is, and blunting the change. And it's also interesting to note that it's not necessarily entirely attributable to colleges and universities and really too early to see much in terms of K through 12 reopening. So I think, as always, we're, we're trying to keep a close eye on where these infections are happening and who you know how we can intervene most effectively. It's constantly changing picture. I wanted to just point out one thing that I'm sure I think already did come up in the chat box, which is about the CDCs updated testing guidance. The first thing to notice that there is no change in our testing guidance in North Carolina and the CDC update do include a an instruction that people should continue to observe state and local recommendations. So for us here in North Carolina, we have not made any changes. You know that. Still, we're aware that it does create some confusion and I think probably the most, well, maybe a couple but prominent, different in the new guidance is regarding people who've had close contact with a confirmed case but have no symptoms, where the new guidance says the testing may not be indicated in that group. Where we in North Carolina and I think a lot of other states, still continue to recommend testing for people who were close contacts to confirm cases recognizing that there is a lot of asymptomatic infection out there and for use in interrupting transmission. So that's that's one major difference where we still are recommending that.

And then the other is that the CDC guidance has some language, it's always been how you read it, but it is basically stating that people who don't have a specific known exposure and don't have symptoms do not need testing. And, you know, I think in our guidance there are several situations listed where testing

is still recommended and appropriate even for people with discrete recognized exposure is particularly for people who are either at higher risk for risk closure by virtue of their occupation or being a member of a group that's got higher rates of transmission or if they're at higher risk for severe illness and they are concerned they might have been exposed so a lower threshold than actually knowing that you had contact with a with a known case that But we do still recommend testing for for those folks and then also recognizing that there's lots of situations where there are screening programs out there. Which is acknowledged to the CDC guide. So all that to say no change in our testing guidance for North Carolina. We continue to look at it but for right now, it's remaining where it is and I know CDC is also constantly re looking at their guidance and they've received a lot of feedback on the update. So, we're expecting there might be some changes on that front. And I think that is all I will say and then we can get to your questions.

Hugh Tilson

Sounds great. Thank you all. First of all, did want to let you know that you have a lot of fans out there, people asking you to continue to do these. They're incredibly helpful. And we'll talk about - but as we teed up the question of are they helpful? Do they continue? Ya'll have a lot of fans out there. We did get some questions submitted in advance about the Yale test. I think The saliva test and wanted to know what your thinking is about that. And so I'll just ask what do you think about that?

Dr. Zack Moore

So, I'm happy to start and then Betsey may have other insights but a lot of confusion and some misrepresentation about the saliva direct test and what it is and what it isn't. I think there's, the way it's sort of rolled out in the Media coverage of it imply that this was a rapid test that was easier collection. And could be more, you know, lead to easier access to testing more broadly. That's not necessarily the case. What it is is a method for detecting nucleic acid from saliva that doesn't require an extraction step. So that's really sort of the, the benefits of it. It's, you know, potentially easier to collect although there can be challenges and issues included infection prevention issues with collecting saliva from some people. And that it doesn't require an extraction step but it still does require, our lab directors not on so I'll go ahead and say moderate or high complexity lab and I think I'm right about. That, you know the once the specimen is collected it doesn't have to go through an extraction step, but it does still have to be performed in a in a laboratory and it's you know several different platforms, molecular testing platforms that can be used for that but it's not rapid test, I'd say a big concern with the saliva as a specimen source is with sensitivity and the the indications are that it's anywhere from 10 to 50 times less sensitive than a nasal pharyngeal swab. Of course, you know Always new data coming in on specimen sources and relative performance characteristics but that's in my mind, the big concern is that it's potentially lower sensitivity. So that has impacts sort of like with the current point of care tests or near patient tests. On what situations you would consider saliva or saliva direct for because the negative tests might not, there's the potential that some infections could be missed with that method. So I think it's another tool. It's another option that people have and that's great and there's lots of stuff coming out on the market, testing wise and this is certainly not going to sort of, it is not the end all be all not

going to lead to a radical change in the testing landscape but I think at this point but it is another option out there for people. So Betsey did you have thoughts on that?

Dr. Betsey Tilson

Reviewing I have the American Society for microbiology on what is Saliva direct and you verbatim said all of that exactly 10 to 50 times less sensitive. And just to clarify, you actually need a high complexity lab to run it and it's not a point of care. So, it's another tool but just be aware of the sensitivity, it's easier for patients as opposed to getting something stuck up their nose.

Dr. Zack Moore

As a pediatrician though bet the I don't know your feeling but saliva is not always so easy.

Dr. Betsey Tilson

It's true. It is true that it's not going to get, actually I think there's a kind of a running joke between the lab director is that when there's a magic bullet we'll let you know, or something like that. I think they say it in a more funny way but the point is this is a tool, not a magic bullet. And when, when we find one we'll let you know.

Hugh Tilson

Speaking of testing got a question about can you comment on pooled testing protocols

Dr. Zack Moore

We'll have to start inviting Scott to these calls.

Dr. Betsey Tilson

I'll take a shot and then Zack you you jump in as well. But yeah, that should be really nice Scott is so smart and so good it might be good for him to join us as well. So we've been, we've been doing a fair amount of talking about pool testing so just for the concept for folks. What it is is that you, you put a bunch of people, this is layman's terms but you put a bunch of people kind of samples into one sample and then you'll, you could run multiple people's sample in one test. So it can make it easier, because you only need to run one test to test, five people. So that's what pooling means now it works well if you have really low. Well, when we take a step so you put a bunch of people in the sample and then if they're all negative, free. They're all negative and then you don't have to rerun it but if it's a positive, then you don't know which one of those samples was positive. And so you have to rerun it individual, you'd have to redo a test on each individual sample. So it works well if you have a really low prevalence population. Most you expect most are going to be positive, and most are going to be negative and

you're not going to have any positive so thinking through like Duke is thinking about it they tested all their, their kids before they came into school think their prevalence was like less than 1%. They're thinking of doing pooled testing of surveillance will continue to test the kids on a serial basis with pool five kids. So as long as your prevalence is really really low it can allow you to do that surveillance and and be able to preserve testing capability. But if your prevalence is high and it's kind of likely that you'll at least get one positive and those five it doesn't really help you at all because then you have to just rerun those tests if anything it kind of increases the number of tests that you have to do. So we've been thinking about it a lot. You still have to be a high complexity lab. Our big commercial labs, don't have interest in developing that that capability I think some of our universities might be thinking about it, even thinking about it more in the surveillance way and and true testing way. So, that's kind of a delay and I, except for Duke I think they may be thinking about that capability, I don't think we actually have any labs that are doing it in North Carolina as we speak.

Dr. Zack Moore

You were spot on and so the last bit but I know there are some people who are doing pool testing in certain settings here in the state. So I think it is, you know, like you said, in a low, low prevalence situations it can be a helpful tool.

Hugh Tilson

Got some questions about the Abbott rapid test, specifically the new Abbott $5 antigen test Binax now COVID-19 AG test. According to the rep they are not selling to doc offices do to deal with Federal Government to send to hotspots. Even so is current recommendations still to do molecular test as backup on every negative antigen test.

Dr. Zack Moore

So, not necessarily, it's recommended that you do a follow up with a FDA authorized molecular assay if you have a negative test and someone in whom COVID is suspected so if you have someone who's being tested who's got clinical illness are tested because they're a contact or part of an outbreak. Then, then a negative should be followed up. If testing is being done which is, although you know the current FDA, emergency use authorization assays are indicated according to their package inserts for for testing of people with symptoms within five days of onset but we recognize that they are being used for screening in some settings, and the federal government has sort of acknowledged that and pretty much endorsed that that's, you know, one, one potential use so if they're being used for screening in a person, in whom there isn't a very high pretest suspicion then it's not necessary to to follow up a negative antigen results with a molecular assay. Betsey anything to add to that?

Dr. Betsey Tilson

Nope.

Hugh Tilson

Got a question about wondering if patients with mild symptoms and exposure should be tested. Since quarantine could be over by the time the test is back. How do you respond to that timing question.

Dr. Betsey Tilson

Can you repeat the question again I'm a little confused by it.

Hugh Tilson

think this may be a carryover from when there were significant delays in getting test results back. But the question was if you have a patient with mild symptoms and exposure. Do you want to get them tested. Because by the time the test results come back they may be through with quarantine anyway. So how do you. I think that's, that's the genesis of that question.

Dr. Betsey Tilson

Okay, so the first thing is just in terms of terminology if somebody is sick and you're testing them for sickness and they're in isolation. If somebody is in a close contact and you don't know if they are sick or not that's quarantine. So you know what they have to do that to stay home by themselves. That's not that what they do is different, but the terms are different because then the length of the time is different so if you are sick and are being tested or suspected then you need to isolate them for 10 days, or until you have no symptoms or no fever for 24 hours. If you are the close contact of somebody who's no positive you have to quarantine for 14 days regardless. Even if you get a test during those 14 days and that test is negative. You still have to quarantine for 14 days we've talked about this in the past you can't test yourself out of quarantine. If you're a close contact with because it take could take up to 14 days for you to develop or a positive. So to your first question I think if you think somebody has it should I bother getting a task if they're gonna have to just have them do the 10 day isolation anyways, which I think kind of was part of the point of the CDC stuff like if you think they have it, the test isn't really going to change what you're doing to have to isolate for at least 10 days. So, I think when those turnaround times are so long I can understand that, now the turnaround times are better two to three days. And I think it does help to do the test. Because although they're still gonna have to do that isolation, at least we know if they're positive and then that will then inform that contact tracing and to know if they have those close contacts it's easier. We don't really do close contact with someone who you suspect. We do close contacts of those who've had a confirmed confirmed case I would still, I would still test, because it informs contact tracing. And also, people will say too that if someone knows they're positive then they're more likely to really adhere to that isolation. I'm not sure I have huge amounts of evidence in there but that's what I've gotten ground from providers.

Hugh Tilson

Great. We're gonna move to vaccines. First of all, you are being encouraged to brag about how innovative you are being and allowing bi directional vaccine for children so somebody recognizing the great job. Great work, y'all are doing. Just want to comment on that. I do have a specific question about the COVID vaccine, which is how is it possible to get COVID vaccine by November 1 if no phase three studies are completed.

Dr. Betsey Tilson

So, I'll do my first shot so in the beginning. Thank you. And I know that came from Elizabeth but really Christoph pushed us hard so thank you. Peds society for being such great partners and advocates for everybody. And really I have to brag on Kelly Campbell and the immunization branch and Wendy Holmes, figured that they did that work they were really proactive on it and get it so go Kelly go Wendy go Christoph go Peds Society. Yay. And so, and hopefully you have that again that memo that went out last week I know I was, cause I am a member of the Peds society I did get it through the piece on the listserv so hopefully you got that and Elizabeth, you can also share it with Greg and medical society sothe other providers have added that well let's go through step by step. So yeah, we're very obviously we really want to be sure. Well, we always want to be sure people get vaccinated but this year even more so because it's really important to prevent that twindemic.

So, I am not deep obviously in the clinical trials I am sharing what I have been getting from the federal government there is a couple in phase three trials. So, I, I am not sure of what's behind the curtain but what I've been told and what we are planning for it because I'd rather be over prepared than surprised, is that we may get some small supply November 1 and it would be obviously a very small surprise we'd have to think about how to prioritize. So I think through this operation warp speed. What they're doing is they have funded these five candidate vaccines, and then they're ramping up kind of production at the same time as the clinical trials are happening so they're not, they don't want to wait until the end of the clinical trial to see does this work or not and then have to ramp up production, they're doing it simultaneously. So that whichever one, and hopefully they'll at least be one proves to be efficacious they wil have already ramped up that production line and then they can get it out to so it's being done simultaneous and parallel instead of serial, which means there may well be clinical trials that don't pan out and then there was a lot of money that was spent on wrapping up a vaccine that can't be used, which is why the federal government is backing is backing this and funding that. So, that is, at least what I know. And I want to be prepared for and I want you all to be prepared for. And in North Carolina as you know that Carolina and Duke are both involved in some of those clinical trials, as well.

Hugh Tilson

Got a question from, or comment from Christoph with links to the memo and all those on the QA, so it's accessible we're seeing if we can pop it up on the screen. Got a comment, don't forget to send to your NP providers. I guess it's about the VFC. I often do not get medical society shared notices so as you guys

are thinking about communication on VFC NPs are appropriate audience want to make sure that that gets there. Got a follow up about how often we got to do these. One of the quotes was, and to quote a healthcare provider about flu, we need to rock getting out the flu vaccine this year. So comment on that.

Shout out to your shout out for Kelly, Wendy and Beth, the great team at immunization branch children's health section so know that everybody agrees with your shout out. If hopefully we get a point of care PCR testing setup in our office this fall, how do we do the test result reporting process. Is there an electric process for that in place or is there one in the works.

Dr. Betsey Tilson

On the side of DHHS, late late late nights working with our attorneys we are currently writing that rule. Actually, as we speak up in my inbox. So, guidance on that will be painfully coming. And as we're gonna bring it turning into a permanent rule, where we are definitely working on. We don't want you to be especially not faxing your negative. We're working on it easier electronic ways to do that. Especially because you know with that, with the General Assembly statue that you'd have to be submitting positive or negative. Electronic lab reporting that's the easiest to put out put into place. Kind of a survey or kind of survey to make it easier, and that will all be coming out and rule but just want to be sure there is an existing statue that we can't override with this new statute that physicians specifically so not other healthcare providers where they can report out through their labs but physicians specifically still need to report directly to the health department for positive. All that will be coming out in rule. Soon, actually finished it by noon today. Zack What else do you want to say this painfully detailed process that we've been working on all week long.

Dr. Zack Moore

Yeah, more than a week but it's, so I guess the short answer is that there will be options for electronic submission, and depending on your, you know, capacity within your practice. They may be more or less feasible for you, but we're trying to make them as easy as possible to be able to get everyone who's doing testing able to submit results electronically. For those that are either not able to, or our, or are in process but not there yet you still will be having to fax in positive results to start the ball rolling on case investigations, etc. And then there's survey being or whatever you'd call it being set up for people to report total testing volumes. So that's likely to be what that looks like going forward, but it's a little bit in flux right now.

Hugh Tilson

As you're finalizing this comment I can currently output a CSV file with all data from my EMR but where do we send it? Local health department is setting up a secure site for upload if the state wants to centralize reporting that would be great.

Dr. Zack Moore

Yeah, and maybe we can share a link to the guidance that we have from the state for submitting electronically. There it is on our website. If you look under the health care guidance there's a guidance document for submitting results electronically that walks through that process.

Hugh Tilson

Any comments on patients presenting with only GI symptoms I continue to hear stories of childrenslash young adults being told by UC no need for testing with N/V/D only. Lit review I found 23% of patients presented with GI symptoms only and this can lead to delay in diagnosis.

Dr. Betsey Tilson

And so nausea, vomiting, diarrhea.

Hugh Tilson

Thank you. Lawyer in me not the doctor sorry.

Dr. Betsey Tilson

Yeah. So, as the more I've been seeing kids, particularly seem to present with more gi symptoms than other populations and sometimes purely gi symptoms. And even though that it was looking at some data and some kids with those multi system inflammatory. I should know what FC means one children. Anyways, and that fair number of them presented just with gi symptoms so I think kids specifically I would have a higher threshold for testing with gi symptoms because I'm seeing more and more of that in that population. What do you got Zack on that.

Dr. Zack Moore

No, I mean it's definitely been described, but I yeah I don't think I have anything in addition to what you said.

Hugh Tilson

Got a comment agree that gi symptoms are not being recognized as a need for testing in COVID-19 and ER and urgent care. So, we don't have any more comments coming in or questions at this point. And if you have any more questions or comments please submit them using the q&a feature. While we're looking at that. The Nevin has updated the slides that have the, the Peds, the vaccine for children link in there so wanted to make sure you all know that is there. How many of you have this question just came

in how many MISC cases have been reported in North Carolina. Any information to share about reporting these cases.

Dr. Betsey Tilson

So for those of you interested, it is on our dashboard our publicly available dashboard, if you go there and CLI surveillance. That's one of the things that are public health epidemiology report so it's on there and I think it's updated every week I think that's right.

Dr. Zack Moore

Thursdays.

Dr. Betsey Tilson

As of today, we have 20, as of yesterday we have 25 as of today, so that's our surveillance, as a weekly surveillance on page 10. 25 so far, and two new last week. We started recording in May.

Hugh Tilson

Got a question, any difficulty in getting information providers, trying to figure out exactly what but I wonder if it's about the MISC that you're talking about.

Dr. Betsey Tilson

I don't understand the question.

Hugh Tilson

I don't either any difficulty in getting information providers is all that I got so I asked for more, so yea about MSC.

Dr. Zack Moore

So there are links where Betsey was just pointing for the surveillance report there's links to additional information about MISC. And we do have reporting guidance on that, which, unfortunately I'm not able to pull up right now. Yeah, we have. So you know you can certainly report those to your local health departments. And somewhere. We do have guidance on on reporting of suspected MISC cases, this date, I apologize. There's a lot of guidance on here. I'm not able to pull it up right now.

Hugh Tilson

While you're looking can you comment on state lab testing turnaround time.

Dr. Zack Moore

Pretty good.

Dr. Betsey Tilson

48 hours. 72 at most but typically 48 turnaround time really accross the board has been much better. And the state lab we've always, I think we've maxed at 72.

Hugh Tilson

All right, so we don't have any more questions coming in. If I keep talking long enough, we usually get one or two more. But let me just kind of summarize by reading a comment that we got thank you so much for doing all these teleconferences, unprecedented access for frontline Doc's to expert advice and decision makers during unprecedented times is greatly appreciated. Please continue this access so I think on behalf of all the folks that are participating. They extend their profound gratitude and would gratefully request that you'd continue to do these just got somebody saying, Amen love these calls. So Betsey and Zack I'll loop around with you guys to figure out cadence but why don't we plan on doing them, maybe every other week for a little while, but we can talk offline and see if it's that's the best way to do that.

Dr. Zack Moore

Sounds good, thanks everybody for joining.

Hugh Tilson

Yeah, last thing is thank you for all the work you're doing and please take care of yourself. So likewise back to everybody. Keep up the great work.

Dr. Betsey Tilson

No, thank you all.

Hugh Tilson

Everybody take care.