Transcript for Friday Open House for Providers
September 14, 2020
12:30-1:30

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

We just went live. So I was getting ready to introduce everybody and get started. So we're glad. We're glad you're here so that we can get started. Yeah. Now that Betsey is here, good afternoon, everybody, and thank you for participating in today's office hours for providers. Just as a quick reminder, we set these office hours up a couple months ago, in response to the need for communication channels between DHHS leaders and providers about COVID-19. Next slide. My name is Hugh Tilson. I'm director of North Carolina AHEC program. I'll be moderating today. I think everybody knows but just to be Sure you can see our panelists today. Dr. Tilson and Dr. Moore. Want to just stop and say that we tried, we asked a couple weeks ago whether these continue to provide value and we got very strong feedback that they were valuable, especially as we enter into the flu season. And so Dr. Tilson and Moore have agreed to continue doing these for the next at least couple months. And so please, please join me in thanking them not just for today, but for their ongoing commitment to providing this incredible access to these these really impressive state leaders. So please join me in thanking them.

I'm gonna turn it over to Betsey in just a couple seconds. I do just want to just remind everybody that today's September the 11th and encourage you to remember the event so that day 19 years ago, in whatever way you're most comfortable with, but just to recognize that it's one of those important days in our country's history and so please find time to remember that, let me also thank you for making time in your busy schedules to participate in our webinar today. We know how busy you are and important your work is and we hope the information that you get today will help you do that work and will help make navigating these trying times a little easier. Next slide. You're going to hear from Betsey and Zach with some brief updates. And then we'll take your questions. You can submit your questions using the q&a feature in the black bar on the bottom of the screen. We have received some questions in advance. So we'll start off with those but you've got time to submit your questions. Again, use that q&a feature. And we will get to those. We'll record these office hours and we'll make that we'll put that on the AHEC website probably tomorrow morning. And I think next slide Nevin we have some links that we've just discovered might be helpful. So we've put those up. So now Betsey, let me turn it over to you.

Dr. Betsey Tilson

Thank you, really happy to be here. And I don't really have any kind of proactive things that I would want to talk about because we got some questions ahead of time, I think that we're really good. And so I can, I'm happy to launch into the into the questions. And I have them in front of me too. So I can do the ones

we got earlier, or you can tee up once we got later. But before we do that, Zack, I don't know if there's anything that proactively you wanted to cover.

Dr. Zack Moore

Um, well, maybe just a little bit. You know, well, just the real quick, big picture stuff. I think people are aware that we saw a resurgence in confirmed cases after colleges and universities open driven by the 18 to 24 year olds and that has started to wane but we're keeping a close eye on it and that we are still watching really closely on our school aged population and really have not so far knock on wood seen increases in that age group or a lot of clusters or outbreaks in schools that are open, which is an increasing proportion of kids that are headed back into some form of in person. I think it was 50% of districts 20% of kids, initially, but they're more and more coming back in all the time. So that's tentative, encouraging news so far.

And I guess the big thing on my mind is antigen testing. And I think that's in the questions. So we'll probably get to it but just the increasing volume of antigen testing that's being done out there and antigen test platforms and being disseminated to all kinds of venues across the state and country and that is really shifting the landscape. Both in terms of testing and in terms of surveillance, so you know, that's something that we're working hard on. And you've seen multiple iterations of, or maybe you haven't seen, but there have been multiple iterations of guidance that have gone out not just about appropriate use, which is a moving target, but also reporting, which is a, you know, a major challenge. And there's new options being rolled out for people to get those results reported. So that we can incorporate those into our data, as it becomes an increasing proportion of the testing that's being done in the state. And we are looking to start posting those results on our website probably within the next week. Lots of little tweaks and things to look at there, but there have been about 30 states so far, that have started with reporting those, and we're looking to join that list. But as you can imagine, you know, we've never asked for reporting of every rapid flu test done in the state. And there are things to work out with that process. So I would just, just maybe something to highlight before we get into questions. And yep, I don't think anything else, so we can probably get into it.

Hugh Tilson

Great. Well, Betsey, you've got the questions. Do you want to just kind of run through those quickly, and I can follow up if needed. And then we got one question in the q&a. Let me just remind everybody that that's how you can submit questions is using that q&a feature?

Dr. Betsey Tilson

Ah, yeah, let me just dive in. So the first question was about vaccines, question mark update. So I This is a good time to talk about update and so a little bit, definitely, we can definitely talk about COVID backscene by a little bit about flu, flu vaccine as well, that obviously this is a big year that we really want

to do as much flu vaccination as possible just for a little background. North Carolina actually is in the top quartile of the percentage of people who get flu vaccine in the country, which is the good news. The bad news is that still only about 50% of our people get their flu vaccine, and that's, and that's one of the best. So we have lots of room for improvement. And the other thing that we see in our flu vaccine is disparities amongst our our racial disparities among the uptake of flu vaccine. So we really are wanting to not only push out the update of flu vaccine, but also do do making sure we're evidence of pushing equity. Can you hold on just one second, I'll be right back with you. With them continuing with that.

Hugh Tilson

We will hold.

Dr. Zack Moore

Do you want me to go somewhere else?

Dr. Betsey Tilson

Yeah, why don't you to go if you want to keep going with flu vaccine, and I just need a couple of minutes and I'll come I'll come back in. Yeah. So got to run.

Hugh Tilson

All right. Okay. You're up.

There are a number of the questions about testing. And we can go back yeah,

Dr. Zack Moore

Yeah, sure. That would be fine. Because I know Betsey has been leading a lot of that vaccine work. So she's probably got important perspectives there. On the testing front, there were questions about what we're doing to improve testing in hotspots and sort of recognizing that access to testing and turnaround times have improved, but maybe not or definitely not uniformly across the state. We do have some areas where that's continued to be a challenge. So first, I would just plug our find my testing sites feature on our on our website, because there there is a lot of testing out there. Certainly not as much as we would like in all parts of the states. So but, but there is a lot out there. So that's maybe the first thing to make sure people are aware of and then in terms of improving access, there's a lot happening with our local health departments and directly from contracting with vendors from the state level, to deploy additional testing resources out into underserved areas. And we had a whole round of what was called champ which I'm not going to remember what it stands for. We have a lot of different champ programs

in the state. But this one was targeted at historically marginalized populations and underserved areas and big testing push that was very successful at, you know, reaching some of the places where we're, where this has been a bigger challenge. And we are now working on an updated versions of that to deploy additional testing resources out. I don't really have a lot of specific details to share, but basically using our data to identify where we're seeing a mismatch between testing volume and disease, and also with a real focus on populations, that historically marginalized populations that are at increased risk of infection, and trying to kind of triangulate between those things to figure out where we can most strategically deploy testing resources.

And then, you know, Dr. Tilson and I just before this got off of a testing surge working group that involves a lot of the large academic and commercial laboratories in the state and so there's a real coordinated effort to make sure that we're not just from the state or local health department level but across academic and private industry, thinking about our collective testing resources and how we can deploy those. So, you know, I'd say there's maybe that's already way too long on this question. But there's a lot, a lot of effort going on, to make sure that we are getting access to places where there have been challenges. And I think back to my initial comments about antigen testing, I think we're going to start seeing that becoming a bigger piece, the federal government is actually pushing out directly to a bunch of different types of facilities, starting with nursing homes, but that's going to be expanding, pushing out antigen and point of care testing. So, you know, hopefully all that will result in shorter turnaround times and shorter drives and easier access for people to get tested. There was a question also I'm sorry, is there omething else on that.

Oh, no, no, I just am back. Just wanted to let you know. Okay. Had a Little emergency.

Okay. Okay. All right. I'm just gonna do one more thing of the another testing question. And then if you'd like to pick back up on vaccines you can do that. So there was a question about our data and about whether the testing totals represent tests or represent unique individuals. And what happens about people who are tested multiple times. So the couple answers, the first one is that our cases or positive tests are unique individuals. And so no matter how many positive test results you get, and some people get a lot, especially, you know, we've really tried to discourage testing for release from isolation. In the vast majority of cases, using a symptom and time based strategy is more appropriate, but there's still are a lot of people getting tested over and over again. And, you know, the way that the information comes into our system, when there's additional results, they link back to that same event. So our cases are individual people not see if I'm tested positive today. And next week, I'm still just one case. But in terms of tests and volume, those are number of tests. So they're not individuals. They're not what we call de-duplicated. We do not have the ability to do that right now, because we're actually getting our total testing volume in a couple of ways, but one of those ways is, you know, ideally, we're getting them all the laboratory results submitted electronically, but a lot of laboratories and providers aren't able to do that yet. So we're getting just sort of aggregate numbers of tests done so we can't tease apart individual people. So I guess that's maybe another bit of long winded answer there. But again, the positive cases, those are unique individuals. The total testing volumes that that we're posting on our

website are are just what they say their number of tests, not number of individual people. Betwey do you want to go back to vaccine.

Hugh Tilson

Actually, can we before we do that, we got a couple of questions that followed up on some of the testing. So can we if we can just... Has the state published guidance on testing algorithm for COVID and flu when there's uncertainty after clinical assessment?

Dr. Zack Moore

No, so we have not yet,excuse me. And we've had a lot of communications with CDC on this and they are working on guidance along those lines that we're expecting any time now, as we get into flu season, hoping it's sooner rather than later. So we are we have had a lot of discussions about it. And if the CDC guidance doesn't materialize, we're probably going to be putting something out. But for right now, we are expecting national guidance on that to be coming soon.

Hugh Tilson

Another question about antigen. One is some of the health department's North Carolina are not recognized as positive, rapid antigen test as positive. Specifically, one of the counties, can you provide guidance on the health department's stance on whether antigen tests really are positive tests and should be recognized as such.

Dr. Zack Moore

So, I guess it depends what you mean by recognized so people who have a positive antigen result are being treated as cases so they are being you know, a case investigation is done control measures are given. There's an attempt to elicit contacts from them. So everything that would be done for someone with a positive piece PCR test is being done generally for someone with a positive antigen test. And that's true in New Hanover County and everywhere else. So, in terms of, again, what's meant by recognized we have not yet been publicly posting our positive antigen results. That's something that we're moving towards, as I said at the beginning, and we've been in contact with all of our local health departments about that. And some local health departments have actually already started posting that information on their county dashboards and county websites. And we're moving towards that at the state level. And hopefully, we're going to have, you know, some uniformity again, so that you can look at New Hanover's data and our data and we'll be as close as we can get it. But yeah, they they are being treated as cases people with positive anitge results. Just like they would be if they were tested with a molecular test, which is not to say that those tests are equivalent, there are the point of care tests including the point of care antigen tests have lower sensitivity. So there are still recommendations for following up a negative antigen test with a positive with a FDA authorized molecular test if you have a

clinical suspicion of, of COVID-19. So there are differences but a positive result is being treated as a case for investigation and control measure purposes.

Hugh Tilson

We got a question about needing more clarification about point of care testing individual provider offices, when and how do we access these tests?

Dr. Zack Moore

I'm not sure I have in terms of access, like getting platforms, antigen testing platforms or antigen testing kits into an office setting. I think is what the question is, and I don't have an answer for that, as I said, there's been a lot of a lot of this stuff has been bought up by the federal government for deployment to nursing homes and other settings. So I know there's been some of the antigen platforms that have been a little harder to come by. But there's sort of an increasing number. I think there's four different ones that have FDA emergency use authorization now and that numbers, that that was last week, so it might even be higher now. But there's more different variations of antigen tests coming on the market all the time. So hopefully, they will be easier to easier to come by. I'm not sure if that was the question, but that was my interpretation.

Hugh Tilson

That's perfect. What's the upper limit of normal to expect residual RNA molecular test positivity to linger four weeks, eight weeks, 12 weeks?

Dr. Zack Moore

Well, right now, option C, 12 weeks where and this is, again, you know, we're still learning about this virus but the guidance currently is that there's no need to retest someone who's tested positive within the next three months, even if they're re exposed, we do know that there is prolonged can be prolonged or intermittent PCR positivity in people who have COVID-19. And, and that, that can go on three months, potentially even longer. But that doesn't mean that they're infectious. The duration of shedding live, viable virus and actually being infectious is is is much shorter with a few exceptions, is you know, less than 10 days, which is why we had set that as the period for isolation. But the PCR positivity even after you're no longer infectious can can linger for a long So, three months is where that marker is currently set. If someone is, you know, three months in one day out from when they from their first infection and they get exposed then they do need to be quarantined again, and should be tested, etc. But, you know, we're learning more about reinfection all the time. Right now we know that it can happen. It's been documented when people do sequencing and you find that they were infected with different viruses, one time and then another so it can happen. We also know it's rare so far, but we're still pretty new into this. And so we'll see. Over time, you know, hopefully that picture will become clear.

Hugh Tilson

Got a follow up question about combined COVID-19 flu and RSV. Do you have any comments? Apparently, labcorp announced three days ago that they have a combined test. Do you have any comments about how providers might assess the appropriate use of this combo test?

Dr. Zack Moore

There's going to be a lot of that coming up. And even in the point of care realm, there's going to be a lot of combined flu and covid testing or source code testing out there. And our state lab is going to be doing combined testing for a lot of the a lot of samples that we receive in house. So in terms of appropriateness of those assays, I think they will be very useful. Hopefully, we'll have very mild flu season. That would be great. That's what has happened in parts of the Southern Hemisphere, but we we don't know. And I think there's a high likelihood that we'll have a period where we have co circulation of both and those assays will be really helpful for you know, not having to make a decision about whether to go with one or the other first. So I think that's something that's gonna be a major feature of testing this fall and winter, the combined assays.

Hugh Tilson

I'm gonna follow up is the person who tests positive more than three months from their previous test if that were to happen count again, or is the statement that the cases are unduplicated still apply?

Dr. Zack Moore

Right now it does not count for our case count. So we're it's one once in a lifetime thing for us currently. So there is a bit of a discrepancy there because we treat people like a case if they test positive more than three months later, in terms of isolating them, doing the investigation looking for contacts, but we're only we're not counting them. We're not counting second cases yet. And this is you know, something that really hasn't come up fortunately a lot so far, but I do expect that we will start allowing for people to be counted as per tab, subsequent infections counted. We're not there yet. Right now, every case that's listed is an individual person. But the further we get into this and the better understanding we have, especially when we can do sequencing, you know, genetic sequencing and really see, is this the same virus that they had before? Is this a different one? I think we're gonna likely start acknowledging repeat infections, in our case counts. But I don't know. That's something that's still being sort of debated nationally. So right now, no, you don't count. For the case, counting purposes. You don't count again.

Hugh Tilson

Gotcha. You guys may not know the answer to this one because it's a Medicaid question but got questions about coverage for antigen tests, especially the quidel sofia that are greater than 96% sensitivity. So can you guys do you have any information about whether Medicaid is going to cover antigen tests?

Dr. Betsey Tilson

This is Betsey, I got this one. I talked with Shannon Dowler this morning and she's working on working on that. And what would be the clinical coverage policy and hopes to actually make something live relatively soon in the next week or two. So she's actively working on that clinical coverage policy.

Hugh Tilson

Thank you. All right. Let's turn to vaccines. So you were giving an update?

Dr. Betsey Tilson

Yeah, and I do apologize for being distracted. So a couple things one, was just leaning into flu. Clearly, we want to have as high as much of a flu coverage as possible. As Dr. Moore said, we are seeing the rest of the world a little bit quiet, but we don't want to expect that will happen in the United States and one of something we actually can prevent, we want to really be sure we are leaning into that. And so we've done a lot of things to try to increase that flu coverage and availability. And then I think I was just getting to that data that Kelly Campbell hold for me last night shows that we have a much bigger uptake in flu vaccine already than compared to next year or last year. So that's really, really good. And we're continuing to try to push that out. So that's, that's great. And we will be will be doing a pretty robust education media campaign as well.

For the COVID vaccine. We are actively working on our plan. It is originally, our plan was due to this the federal government October 1, but then we got some more directions they'll be giving us they've given us some high level guidance and they'll be giving us more detailed guidance. And once we have that we'll have another 30 days to turn them around the plan and we have yet to get that detailed guidance, but we're actively working on our on our plan right now. And we have convened an external Advisory Committee. I actually I should take that back, the North Carolina Institute of Medicine has convened an external Advisory Committee who's really going to help us input into our plan and really help us as we operationalize that plan. We it's a really nice balance of clinicians, kind of vaccine and immunology specialists, as well as lots of our advocates for a lot of our key stakeholder groups, a lot of emphasis on equity and on public health and clinical medicine. So we're excited about that. We had our first steering committee meeting yesterday in our full advisory first full Advisory Committee next week, so we're happy, excited for that and they'll be helping us think through what would be the prioritization and allocation criteria, especially in the beginning when we don't have much vaccine, helping think through what's the communication and messaging and outreach strategy. And helping us think through

enhancing reach reach of the vaccine. So thinking through how do we engage and recruit as many providers as possible? How do we think about really streamlining the how we operationalize our vaccinations not just to our regular channels, but novel channels as well to really open up access to that. So we're really excited.

I don't know when we will actually get vaccine. The operation warp speed, which is the federal government's initiative to really ramp up vaccine is in full swing, what they're doing and in terms of trying to ramp up the speed to get to a vaccine it is it's not to cut corners on the on the clinical trial, but what they're doing is a lot of things in parallel, instead of serial so that they were already planning phase three trials, when they're in phase one trials, and bailing the financial risk of planning down the road. They also are in parallel ramping up production at the same time. As clinical trials are going on so, and the federal government is bearing the financial risk of ramping up that production, so if it turns out that some clinical trials aren't working or a vaccine candidate isn't working, then they will just bear the risk of that production that it'll just be a loss. So they're doing a lot of things bearing the financial risk of parallel processes. They also have consistency across the clinical trials. So the outcomes, the safety and the efficacy, outcomes are the same. So there'll be a lot of apples to apples comparison so that they're doing that.

I think a lot of people have heard that that some of the vaccine might be released under an EUA an emergency use authorization as opposed to a full what's called biologic licensing authorization and what that would be is if they do release it out of the EUA that there would still be the all the efficacy data from the clinical trials, and then the safety data from the from the clinical trials would be intact. What would not be then intact is the long term safety safety profile. So what does it look like a year or two post market, obviously, we just don't have time for that. So we won't have the long term safety efficacy, but they will put into place a very robust pharmacovigilance surveillance. So postmarket there'll be, there'll be surveying, so we will have the safety data for at least a month or two after the vaccine. And the vast majority of adverse events happen within a month or two after the vaccination. So we'll have that safety profile, but not the long term safety profile. And the other piece that would be EUA is that you want to be sure you have consistency of product. And so that it may not be the full documentation of the manufacturing processes for consistency of product. So those would be two things that might be not a part of an EUA but not the efficacy and again, that's short term safety, one to two months short term safety.

So knowing that they're ramping up and and also, I would say that the clinical trials are really what we call event based trials. So so forgive me, I'm also going to say that one of the ways of speeding up with clinical trials is is big enrollment. So instead of three or 4000 people in a clinical trial recruiting 30,000. And that's important because so that these are event based outcomes so that you have people with a placebo or vaccine, and then you have to wait to see if people actually get COVID. And so the more people you have enrolled, then the more likely you would have events. And that can help you get to the endpoint more quickly. But because these are event driven trials, we don't really know when the trial when we'll have enough events to understand the efficacy and the safety. So we don't know the exact

timeline, but we're gearing up and we're ready. It is possible feasible that we would have some by the end of this year, maybe you know, even by November, depending on the trials, but we but we don't know and if we do get some by the end of the year, it'll be pretty small supply, and then we're planning for is the much bigger supply that would be next year. So a lot of variability, a lot of uncertainties. But we are planning to be ready when vaccine is ready.

And then I would also say that the FDA is putting into processes. They have an external Scientific Committee that will be reviewing the clinical trial data. And they will also have public processes as well. So people can really look at that safety and efficacy data because they're very aware that people are nervous that if a vaccine, quote unquote, gets rushed out, then it won't be safe, it won't be effective. And that means people then won't won't want to have a vaccine and nobody wants that. So they're trying to do a pretty good job of ensuring that safety and efficacy and in a transparent way. So that's kind of where we are, though. There was some specific questions about children. There are no, in the US there are no us trials that are enrolling children. And therefore I don't when we talked about the EUA it may be that an era is only issued for populations in whom the vaccine has been studied. So I think it could be really likely that we would say the EUA is authorized to the vaccine on adults, but not children. And we would have to wait for children. Same with pregnant women. There's not many pregnant women being enrolled. So I think the EUA might be limited to the population on which it's studied. So when would kids come into play? I don't know that answer. Honestly, it may be that as we get maybe towards near the ends of the phase three trials they will start recruiting children. So I'm not sure they're getting pushed to do that, and, and to recruit kids, but currently, there are no kids in the trial. So I would anticipate that we would not vaccinate children up front, because we wouldn't have any any data on them.

Hugh Tilson

Okay, there's a question that's storage.

Dr. Betsey Tilson

Yes, words of wisdom right. So it may be that in the beginning, and we'll see we're still learning about this, but some of the initial candidates it may be that they need what's called a ultra low ultra cold storage, so down to negative 70 degrees Celsius storage. We know we've done a surveillance link we know where we have the ultra cold storage across the state. And also some of these will be shipped on dry ice. But we think in the beginning, in the beginning when we don't have much vaccine, and if it's really requiring this, this ultra low storage, that is this vaccine isn't going to be out spread far and wide to all the practices. It'll be kind of a closed, tight administration site like well know a site that has this ultra low storage will ship a bunch there will vaccinate a bunch of people out of that one site. So some of the question is should we all be buying up a negative 70 Ultra Low storage? No. And the federal government's not recommending that ultra low storage. And so I would not do that. I would not do that yet.

And then up to date on school vaccines. Any update on how back to school vaccines are going and how 2020 North Carolina compares to 2019 at this time, one, I would say the good news is yay, we're better for flu we're better than we were last year. So that's really good. For our routine school vaccinations. We are we're making progress, but we're still below where we were last year. So keep, keep vaccinating away on that. And that's data that we pull from the NCIR, which is not, it's not specific to school, but we can see those doses that are administered and we don't get our full report from the schools until until December 15. And we'll we'll be able to see that a little bit more clarity in December 15. That's what I have on vaccines.

Hugh Tilson

A follow up question. Do you think it's likely we will have several different vaccines with several different EUAs?

Dr. Betsey Tilson

Perhaps so there are six so that the operation warp speed, the other thing they've done is other I think there's maybe 125 different vaccines in in Development, they narrowed it down to what are the most likely candidates. And so they've narrowed it down to six likely candidates. Three are currently in phase three clinical clinical trials. Two are going to go into phase three clinical trials, I think within the next week or two. And I guess the sixth one is still we're not quite sure. So I don't know. We'll have to see. But I think it is possible that we would hope that we, you know, maybe, I don't know, maybe three or four would actually be effective. Yay so I don't know. But I think it is possible that we will have a couple that different vaccines that get an EUA depending on those clinical trials.

The other thing I would say is five out of the six candidates right now are requiring two doses. And it would have to be the same two doses of the same vaccine like not interchanging which will make the complexity of administration and documentation more complex, one candidate it'd be a one dose, but the other ones are are two doses. So we'll see. But I think it is possible that we will have more than one vaccine depending on the outcome of the trials. Oh, the one thing I would say some of you may all know, so the three that are going on in the United States and actually two are in North Carolina, both Duke and UNC are active in that and that is the Moderna and the Pfizer. Those two trials are active and again, we have North Carolina, we're involved in that AstraZeneca was the one that was in, I want to say Texas and also internationally. That was the one that got halted, I guess, this week, they had a case of a transverse myelitis. And so they're halting that right now until they do some more investigation to see if they really think that was from the vaccine or not. So AstraZeneca has been halted right now, but the Moderna and the Pfizer are still going.

Hugh Tilson

Great information. Before we go back to the questions you got a couple that came in, that are more kind of clinical focused. We're seeing patients for hospital follow up after covid treatment, or even just after community treatment of covid infection, are their labs that are recommended to be followed for some period of time, medications that should be continued for some period of time. I'm especially seeing eliquis for three months and magnesium supplements post hospitalization. And then there's a follow up says I'm also hearing that there can be multitude of prolonged symptoms such as vertigo, paresthesia is after covid infection, is there a reliable resource for knowing what may be a covid side effect or a persistent symptom? versus when I should consider additional testing or evaluation? Are you the right people to ask that question?

Dr. Zack Moore

Can always ask, I don't know that I have great answers to either those in terms of the persistent symptoms that obviously a major focus of research and we do know that there are a lot of people out there who have persistent symptoms across different, you know, neurologic symptoms, in particular, certainly respiratory symptoms, but really, you know, the full spectrum of potential longer term symptoms is, is still being described. And I do think there's some information on the CDC website about that I can't say that I've looked at recently, but, you know, I, I would, at this point, have a low threshold for evaluating if, you know, if someone is a ways out from their covid infection and something seems to be either worsening or failing to improve and I would, I would not make the assumption that it's just, you know, lingering side effect I'd, maybe just me personally I'd have a low threshold for doing this. assessments just to make sure that nothing else is being missed because we don't really have a solid understanding yet of, of what this spectrum is with that.

Dr. Zack Moore

And I don't remember the first question, but I don't think I know the answer to it anyway, I was about continuing treatment...

Hugh Tilson

Labs continuing meds, those types of things. Oh. One was a prolonged symptoms vertigo and paraesthesia.

Dr. Zack Moore

Yeah, I think I that was what I was just trying to stress that that piece I don't think I have anything specific on the on the other piece of that.

Dr. Betsey Tilson

No, I haven't seen anything about kind of routine lab monitoring but the one thing I would say is an article, I think just came out this week was made as evidence of penetration into neurological

penetration which might be some explanation of the kind of like migraines and headaches and maybe more of the, the neurological effects of this that might be even more lasting so I think there could be, although you were talking about apparently we're talking a little bit more peripheral nervous stuff, but I think there could be persistent like central nervous system stuff we might see longer term if there is penetration into the CNF neuros. So, just, I think we're going to learn more and more about not just the short term symptoms, but the longer term sequela.

Hugh Tilson

Some more environmental questions safer not to presume a persistently positive person is not contagious, for instance, two months of positivity and a laboring in childbirth a person with surgical need, is it safe for staff to not use full PPE.

Dr. Zack Moore

Well I guess the first thing just as a reminder, is that the PPE recommendations for all clinical care at this point are basically intended to assume that anyone could be positive or could could have COVID-19, given that we have so much asymptomatic and subclinical disease out there so but yeah i and i think if if you have someone who's been tested because of admission for labor or surgery or whatever the case may be. I think it is proven to take appropriate precautions. Even though we know that the majority of those, I guess I didn't get into the exceptions in terms of infectivity being longer, that's really people who've had severe illness or people with immune compromising conditions can be infectious longer, but even in a person who didn't have a severe case and is not immune compromised. I think it's prudent if you got a test result that's positive, it was done for whatever reason. In, in a clinical setting to take precautions accordingly.

Hugh Tilson

Thanks got a question about the safety of caring for people with respiratory symptoms indoors this winter. The practice has helped the filters but not sure that would make a room safe. Are they relegated to tents and they foresee a run on wool socks. The last part was a joke.

Dr. Zack Moore

Okay, yeah, I don't know about the wool socks but in terms of caring for COVID patients indoors. that is certainly something that can be done safely in fact there was just an article that came out about lack of nosocomial transmission in a hospital setting that was caring for high volume of covid patients and implementing precautions accordingly, I'm trying to remember, it was from one of our big US medical centers, which is escaping me right now. But I do think the evidence is that it certainly is possible to care for covid patients indoors, and you know it does not require airborne isolation precautions for care of any COVID patients. So I think, you know, the evidence we have thus far is that the, the guidance, that's been put out there for protection and health care settings is effective as limiting transmission.

Hugh Tilson

So there was a follow up said hospitals have negative pressure rooms COVID has quickly become a primary care problem more than a hospital problem does the analysis change when you move outside of a hospital.

Dr. Zack Moore

No what I was just getting out was that there's, there's not a recommendation that care needs to be provided in an airborne isolation room for all COVID patients, as long as the other precautions are in place.

Hugh Tilson

So, we can go to back to work or contact tracing. What do y'allwant to go to?

Dr. Betsey Tilson

Back to work will be quick, there was I think this was Chris Dawson emailed me directly about could there be some kind of layperson friendly language about that people don't need a negative test before they can return back to work so I already am working with our comms team, and they are in for those of you who know our documents closely its in the document for patients that says, what to do after you get a test in that isolation and quarantine document. And it has it in there. But our comms team is also going to put it probably up in our FAQ, because we get that question a fair amount, and have it a little bit more of a friendly place on our website that you can find so once I know where it's posted. Then we can, we can send that out in kind of more, more, lay person friendly language.

Hugh Tilson

Well then, let's turn to contact tracing.

Dr. Betsey Tilson

Yeah, so the I guess I can read the question. Where are we with contact tracing my COVID-19 positive patients seem to be getting a single call from the health department's, like to my knowledge, we are not doing much in any contact tracing at this time is it just too overwhelming. Are those 500 hundred people working on tracing now and I'm just not aware. So just a couple, some stats on that. So we actually have almost 2900 case investigators and contact tracers. That was either folks from the health departments or surge staff within the health department that got cross trained and pulled into case investigation. And also we have another 804 through CCNC in AHEC so that original 500 actually is 804, plus additional from

the health departments and cross trained so we have, we have searched up about 55% of them are bilingual because we were having that big surge in our Latin x community. So they are working, you might not I mean there's just so many patients that you may not see at all but they are working in just some few stats that just last week alone, there was over 66,000 outreach to contacts that currently right now there are 12,000 contacts in active monitoring right now. They are reaching about 60% of the contacts that they attempt that has been a problem is that they can, they can reach out but they don't always get the people who are working really hard on how to increase the success of the contact rate and so last week we got about 60% of the contacts and that was increased from the past month so that's really good. Some of it is that the phone number that they were calling for a lot of people it was looked up as it came across as spam risk. And so they're doing some work on making sure that that phone number doesn't get coded as spam and so we're hoping that will that will work as well, so they are they're hard at work, whereas surge, again, part of it is it's hard to get up with people. And if you get up with a case, often they're hesitant to identify their contacts and we're working try too hard on that and then increase the uptake with our with our contacts so we're working hard on that but it also is there's a lot of cases and there's a lot of contacts as well so we aren't getting to everybody but they are working hard on getting it to as many people as possible.

Dr. Zack Moore

I'll just add that the challenges are not unique to North Carolina there's some states that have been publicly posting some of their data on contact tracing. I know that, Maryland, and New Jersey are doing that. And both of them are finding that more than half of the cases that are reached decline to identify any close contacts or don't, I should say identify any close contacts and and similar to what we're seeing here in in both of those states, about half of the contacts that are are named can't be reached. So there's some fundamental challenges but you know it's still can provide a lot of benefits. Certainly on the individual level in terms of giving people the right information and and quarantine guidance and identifying needs that they may have etc. And some benefit in terms of slowing disease spread but it's, it's, it's not the single answer to stopping COVID spread, for sure.

Hugh Tilson

A couple follow ups How can primary care providers help contact tracers with getting identity, getting information for local health departments when they know of a positive case, are there some key pieces that can be gotten even before the contact tracer gets up with the patient and their families, and follow any healthcare provider not just a primary care provider.

Dr. Betsey Tilson

So the couple things. One is really pushing the message of, you know, answer the call. If somebody calls from the health department, and then also to emphasize the importance of sharing their contact so it's encouraging engagement with the contact tracing. The other piece that I have in this is that it would also be good. Well I guess we should but having the person having the contacts, date of birth, that helps.

Being able to reach out to the contact as well as if we have, date of birth of the contacts of not just the person but the contacts, date of birth, that helps us then to be able to reach out but either by email or by phone as well. So, that could be a helpful piece as well. Zack anything else you want to add to that.

Dr. Zack Moore

Nope, I don't think so.

Hugh Tilson

Can either of you comment on the slow COVID nc app and any plan to promote for exposure notification.

Dr. Zack Moore

Yeah, so this is a one of the order called location based exposure notification apps and then we don't have a lot of time so it won't get into the details. These have been used in a lot of other states and that is something that we've been working on here, doing a slow launch I guess in North Carolina, where if you choose to download this app. It uses Bluetooth technology, it doesn't use GIS doesn't track where you are, but it tracks proximity to other devices. And so that if you do get diagnosed with COVID, you can retrieve. You know you can enter that into your app, basically, and then you can send an anonymous notification to other devices that were close to your device. During the preceding time period, sort of a very awkward explanation of what it is but it's, it's something again that it's, it's not contact tracing it's just an exposure notification. And then people who have that app and were close to your device, or the right amount of time in the right timeframe will get something that says you may have been exposed to someone with COVID-19 and will give them guidance on, you know, recommending that they self quarantine telling them, you know where to go to get more information where they can go for testing etc. So that is something that is being sort of worked on and launched in a limited sense already I think for a limited scope already and probably something you'll be hearing more about going forward. I think the vision is that this might be something that's useful in certain populations like college and university students, etc. It's not a replacement for case investigation or contact tracing, but it's an adjunct measure recognizing that, you know, those have their limitations.

Dr. Betsey Tilson

Yeah, and the only thing I would add is that kind of pilot testing at first and that says different targeted rollouts for colleges and universities mid to late September, so that's the place we're going to start piloting it mid to end of this month.

Hugh Tilson

Thanks, we have one more question. It's a follow up to the earlier conversation about closing rooms, and the environmental status so just reminding everybody if they want to submit questions use the q&a feature. But the follow up was CDC recommends closing rooms for four hours that quickly eats up your whole clinic and no rooms are left again, there's much to comment on, but just that was submitted wanted to see your reaction.

Dr. Zack Moore

Yeah, I recognize that, you know, there's a lot of challenges there I don't know that I have anything, any special guidance on that but. Yeah, definitely. Another reason why we need to keep levels low because recognized, particularly in outpatient ambulatory settings can be can create problems for your operations.

Dr. Betsey Tilson

Yeah. And having dedicated team or dedicated room, like a respiratory room like you don't want respiratory patients in all of your rooms because that will shut down your whole clinic, but I think as we saw before, you know, if it's, and I know every practice is different but if it's possible to even have like, you know, one of your practices the the respiratory practice where you have a dedicated team or a dedicated room, that can help.

Hugh Tilson

So we don't have any more questions.

Dr. Betsey Tilson

There was a proactive suggestion to do a shout out for WIC, and so I would like to do that a WIC reminder would be great. So that is true, WIC is awesome. So one of the things that we have found is our rate of food insecurity and so first off I think North Carolina was the second worst in terms of food insecurity, especially for families with young children so we were not starting in a good place. And I think our food insecurity rates have maybe even doubled. So, you know, so many of our families are out of work, no money. Big food insecurity so this is not the time to have a drop in WIC. So really being sure you're encouraging and making sure your patients are getting enrolled in WIC and there is special kind of WIC on COVID adjustment. And so people can get their WIC benefits issued remotely, and automatically they don't have to do an in person WIC clinic, while we're in the midst of in the pandemic they can get their benefits electronically loaded onto the E WIC account so that is really huge that they don't need to come in they can just get those benefits loaded and we have a really nice handout in both English and Spanish that talks about the, the E WIC, and the fact that you can just get your benefits, automatically loaded on your WIC. So I would maybe, maybe show Hugh that you could, we could add this to this link or somehow send these, these flyers out there this avenue would be would be great so be sure that everybody is maximizing WIC and knowing they don't need to come in to in person to get

their WIC benefits. And we are a signal that all of the WIC benefits are not being redeemed and that is just, you know, that's, that's just not the place you want to be. We want to be maximizing all of the support that we have for our families, especially food for our young kids and our pregnant women that no WIC dollars or what benefits should go on receipt that's just a charge.

Hugh Tilson

It was a reminder that families need to use it WIC allowance before the end of the month since they do not carry over.

Dr. Betsey Tilson

That is true. Yeah. So here are the highlights, if you got WIC you've got WIC, right so everybody who get WIC should there are benefits are automatically issued under COVID-19. You don't have to use all of your WIC allowances in one groceries, one one grocery trip you can do multiple ones throughout the week. I mean, yeah, throughout the month, however, right your WIC allowances don't roll over you have to use it, a whole balance. By the end of the, the end of the month.

Hugh Tilson

We got a compliment, by many metrics North Carolina looks like an outlier among our southern state counterparts in a good way. This is likely because of the terrific teamwork we have among DHHS and providers in our state. Thanks for the partnership to keep our patients and communities healthy so yay y'all, meaning everybody on this call. Got a question CDC says observe persons for 15 minutes after influenza vaccine. This is going to cause social distancing problems at vaccine venues. Is this really an important recommendation.

Dr. Zack Moore

I'm not gonna say it's not. CDC recommendations being incorporated by reference it's North Carolina's rules. We do try to follow those so again. Recognize challenges but I don't know Betsey if y'all have talked about that in the vaccine group,

Dr. Betsey Tilson

No that that has not come up at at it. But we usually, it would be hard pressed to intentionally veer away from CDC guidance.

Hugh Tilson

It's 1:29 I know y'all need to be someplace at 1:30 so thank you thank you thank you for your commitment, and your availability and your access. Please know how much everybody appreciates it Do y'all have any final comments before you hang up?

Dr. Zack Moore

Nothing for me thanks to everybody for joining.

Dr. Betsey Tilson

No thank you and I apologize for the disruption at the top of the call.

Hugh Tilson

Somebody says thank you y'all are incredible. What a great way to end. Take care. Bye everybody.