All BH Provider Call w/PHS – April 24, 2020 – 10 a.m. – 11:00 a.m.

MEETING NOTES

ATTENDING

Aliya Jones, Stephanie Slowly, Kathleen Rebbert- Franklin, Iva jean smith, Marian Bland, Steven Whitefield, Susan Steinberg, Cliff Mitchell, Maria Rodowski-Stanco, Marion Katsereles, Rebecca Perimutter, Sydney Rossetti, A. Park, Dana Heilman, Deirdre Davis, Elizabeth Murphy, Frank Dyson, Kyle Kenny, Marianne Gibson, Mary Viggiani, Rebecca Jones, Robert Harris S. House, V. Walters, A. Alvanzo, Amanda Rosecrans, Andy Owen, Erin Russell, Joe Adams, R. Farah, K. Stolle, R. Bonaccorsy, Shelly Choo, A. green(?)

ANNOUNCEMENTS

Opening Remarks from Dr. Aliya Jones - Good Morning everyone and thank you for joining us again for our weekly call with All BH providers and PH to discuss issues and areas around COVID-19. This meeting is being recorded. Rebecca Perlmater will present for us today from PHS.

These weekly BH Call-ins will provide a platform for PH to provide an overview of the PH response to COVIC-19 to help you be responsive, effective, and remain well.

Any questions that arise after these sessions, we encourage you to continue to submit them to Sydney.rossetti@maryland.gov by Wednesday before that week's Friday call.

DISCUSSION

Rebecca Perlmatter, Epidemiologist, Infectious Disease Epidemiology and Outbreak Response Bureau, Public Health Services will give updates today on COVID-19 issues.

1. **Latest Data from CDC on Coronavirus (See attached PP)**

   We will look at some of the numbers that have come out in the last 24 hours. For the latest data on cases you can also review the PP slides. It is reported that 2,729,274 cases of COVID-19 reported worldwide as of 7:30 this morning. The US has the most cases reported globally so far. The US reported 828,441 confirmed cases (reporting 4.22.20 data) with 46,379 total deaths so far and 55 States and territories reporting cases at this point in time. If you look at the map on the right, it might look somewhat optimistic comparted to last week because there are fewer states in the dark orange color that is because CDC has changed their scale and the dark orange color is the10, 000 plus club rather than 5,000 plus club and we are still there. Maryland reported 16,616 cases as of yesterday, 879 of those reported in the last 24 hours, 723 deaths reported, 43 new, 3,618 hospitalizations with 141 of those newly reported in the last 24 hours. We also had 68,100 test that came up negative that came up negative so far on Maryland residents.

That means that we are still running about 20% positive which is a sign that we are still in the heat of the outbreak. The vast majority of the cases are located in the DC metro area along with the Baltimore metro area. This is our total case count over time. As you can see the total number of cases does keep going up, which is what we would expect because this is the total case count. There has not been a lot of increase over the last couple of weeks in the number of new cases reported in the previous 24 hour period. This is what people refer to when talking about flatting the curb. We are staying fairly study about 600 – 800 cases per day. It is a lot of cases, but it is not going up. It looks like it could be a sign that social distancing may be working. Not sure about that, but we will not be sure about anything for a while. Keep up the good work everyone; stay home. We have case counts by gender as you can see it is fairly even split men and women both in case counts in deaths women predominate in cases and men predominate in deaths, but not a major difference in those numbers. We have case counts by age, as you can see, vast majority of cases are in the 30 – 60 age range. This is not just a disease in the older population. However, there are more deaths in the older population in the 70s and 80s even though that are not as many cases, the rate of deaths is higher. Looking at data broken down by race and ethnicity - a majority of the cases are of Non-Hispanic African American, followed by Non-Hispanic white, followed by Hispanic. Just keep that in mind that this is a disease effecting a lot of different race and ethnic groups.

2. **Interest in Testing Asymptomatic People**: Some people will want to do this for a lot of reasons. There are some employers who want asymptomatic people to be tested before they come back to work. Sometimes you may have providers who want a negative test before they come in. There are a few problems with this. It is really hard to get testing if you are asymptomatic. It is not recommended, so there are not a lot of doctors who will order it and not a priority for the lab. So, if your provider's office is saying unless you have negative test you cannot come in. It almost like they are saying you can't come in. It is very hard to get a test if you do not have symptoms. We have to remember that a negative test does not rule out COVID-19 at a later date. It is just the date that they had the test. An Asymptomatic person can be negative on the day they had the test and two days later they could be shedding virus and you will never know because they have that negative test. If you have someone who had a negative test and they were asymptomatic when they got that test and then they develop systems, they still need to get tested again, because that negative test does not mean much. You cannot be sure if someone was negative 2 days ago that they will still be negative today. Asymptomatic testing is really kind of a gamble when you get those negatives. Positives are meaningful, negatives not so much. We also do not know what it means if you are asymptomatic and positive. Are you shedding the virus? probably, maybe, some. We do not know how much but it is definitely a question. Most virus are more infectious in the early stages of system onset. It is possible that you are much less infectious when asymptomatic. We do not know for sure. This is not a recommendation for a lot of people to come in for an appointment. That is why everyone is wearing a mask. If you are asymptomatic and positive for COVID -19 the mask will help contain any virus in droplets you would be shedding.

3. **COVID 19 and HIV Infection**: The CDC has a whole webpage about HIV and COVID 19 infection. However, the theme of the webpage is that the risks of infection for COVID 19 for those who are HIV positive is still unknown. I am sure that there is going to be a lot of information about this coming out over the next year or two, but right now we are still in the unknown phase. We are aware that being Immunosuppression is a documented risk factor for more severe disease, so people are at a low CD 4 count are at a higher risk for severe disease. Those who are HIV positive should practice social distancing, hand hygiene, wear mask in public and keep taking all prescribed medications. Other than that, there is not a lot of information out there at this time. There will be more to come, and I will let you know if there is anything else.

4. **Surgical Mask vs. N 95s**: These are for 2 very different purposes. N-95s are going to filter the air and that means that they have to fit very tightly around your face, nose and mouth. It has to fit tightly to make sure that there is no air getting in around the edges. They are not comfortable. It is hard to breath, it is warm. This has to fit tightly which will catch airborne particles around the edges. This will filter some small airborne particles, as small as 0.3 microns which includes most viruses. These are not being recommended for the general public right now. It is hard to breath and hurts your face. Unless you are in an occupation where you are going to be exposed to chemicals. Surgical Masks catch most droplets and are a lot less uncomfortable and will block germs. This is good for most general situations. If you are hanging around people who might have COVID-19 and they are wearing a mask that mask is going to catch most of the droplets and sprays that they will be producing as they talk or sneeze, or cough or whatever and if you are wearing a mask it will protect you from those same large droplets. In most situations there is not a lot of random COVID-19 virus floating around in the air without droplets. In most situations, a surgical mask is good enough to catch the droplets with the germs in it from both sides from the inside and outside. This is why we generally recommend that most people wear a surgical mask. If you are practicing airborne aerosolizing procedures on patients then we do recommend the N-95. Most people do not need that level of protection or discomfort.

5. **PCR Testing**: This is how most people are going to be tested for COVID-19 (see photo from the CDC website on PP slide to indicate what is involved in getting testing for COVID-19). This is not just a Q-tip up the nose. This is definitely an uncomfortable procedure. So, what PCR testing will detect is whether there is viral RNA in the nose. I read about the presence of viral RNA it is a bit like finger prints at the scene of a crime, if you find someone's finger prints at the scene of a crime sure maybe they did it, but maybe it means they were they were there yesterday or the day before. So Sometimes viral RNA especially when the person is systematic, they probably got COVID-19 but if they are not systematic maybe they had COVID-19 last week and you are getting the visual dead virus RNA out of the nose. A dead virus would not be infectious, but it would still come up positive on PCR. With this disease we are also learning viral shedding can be intermittent. You can come up

positive on day 6 and negative on day 7 and positive again on day 8 and what that means in terms of infectiousness we are not sure about yet. To be continued. This does detect either current or recent infection, but it does not indicate infectiousness at this point.

6. **Antibody Testing**: Everyone is talking about antibody testing. Taking a blood test to see if people had a previous infection and reopen the country. There is a lot of countries who are planning on doing this. That is an issue because looking at Bullet .3 - We do not know if having antibodies will confer immunity. So, we do not know what that means if you come up antibody positive. If you come up IGG positive with COVID-19, are you immune to COVIV-19? We do not know that. It might be, but then how long does this last? Is this going to be like Chickenpox or Measles where you get infective once and then you are immune for life? Or is it going to be like norovirus, or the common cold and you get infected and you are immune for a few weeks, a few months, maybe a year and then you are susceptible again. There is a lot we do not know about those antibody tests. This is not going to diagnosis you with COVID-19. Usually it will help identify people who have recovered from COVID-19. But we do not what that means. Not all people who recover from COVID 19 have antibodies. So, you could have someone come up negative, but they really have had COVID-19. Some may have antibodies to one of the other Coronaviruses. There are 4 human coronaviruses out there, that circulate a lot and they cause the common cold and they are going to come up positive on some of these tests. There are also a lot of test out there. There are a lot of people who are going to want to sell you antibody test to you and 90 something of them have presented their product to FDA for emergency use authorization and FDA has only granted emergency authorization to 4 brands of test. Most of the tests out there did not get FDA emergency use authorization because they were detecting too many false positives or too many false negatives or both. There is a lot of talk about antibody testing, but this is still too early the use of antibodies will be helpful in terms of determining immunity. This is one of the most recent papers that came out about antibody testing. It come out China because that is were a lot of this research is going on. They looked at a 175 people who had tested positive for COVID-19 who were negative. They made sure that the Neutralizing antibody did not react with STARSCoV 2 from 2002. They were looking to see if STARSCoV 2 coronavirus antibody was detected 10 to 15 days after system onset. 10 of those 175 people never develop antibody not even 2 weeks after their infection and 30% have low levels of antibody. So, does having low level antibody not protect you or does high level antibodies protect you. We do not know. There is so much we do not know about antibodies right now that these tests are useful for research and developing estimate about how many people have been infected, but they do not provide information about immunity.

Questions

1. Antibody testing?

   Response from PHS: Yes, they are available. What do they do for us is a harder question.

2. What are the recommendations for individuals that are consider for admission for an inpatient psychiatric facility having a negative COVID-19 testing prior to admission?

   PHS Response: If a patient is symptomatic, they should be tested. If they are symptomatic and come up positive, they should be admitted under isolation or under transmission base precautions. If the person is not systematic, then probably not, they should be admitted to psychiatric ward. This is what we are considering for long term care facilities - new residents should be moved into an observation unit for 14 days and after 14 days and they do not develop systems and they can relax precautions. This probably more useful than a negative test. If person shows up at emergency department would that person go straight to psychiatric department or perhaps go to medicine before taking them to inpatient unit. Depending on their medical and psychiatric status. This would have to be judgement call. It is harder to keep a psychiatric patient in isolation. If you think you can keep this patient in their room on the psychiatric ward and workers wear appropriate PPE, it is fine to keep them there.

3. Malaria meds and antibiotics:

   PH Response: Once upon of time there was Study in France that indicated that patients that were taking erythromycin (antibiotic) hydroxychloroquine (used to be malaria med). There was this one study in France that indicated that of the 26 patients that they looked at, it looked like there could have had some benefits for the patients that received that combination of antibiotic and hydroxychloroquine. So there has been some more studies done because people became interested in this. There has not been a double blinded randomized control trial of any of these combinations. Everything we say is based on observational trials. It is harder to give any kind of firm answers. However, there was study done in Brazil looking at this hydroxychloroquine use. There are a few issues on hydroxychloroquine. It can have side effects. It can cause heart issues, blindness and eye problems. In the study in Brazil, they had to end the study early because people who were getting the higher dose of hydroxychloroquine were dying at higher rate than those getting the lower dose. There was a Study at the Veteran's Administration looking at 600 patients using this combination died at a higher rate than those patients getting regular care. There have been no Randomized control trials. No really good detailed studies about this. At the moment it is very hard to endorse something that there has no evidence, has potential side effects and down sides. The Malaria medication is not used for Malaria anymore because all the Malaria is resistant to hydroxychloroquine, however; it is used a lot for people who have an autoimmune disease.

4. Has there been any Altitude Sickness Medication Trials?

   PH Response: I have not seen any medication trials on high altitude sickness. I have seen a couple of articles that show people with severe COVID-19 disease in the ICUs where it looks more like High Altitude Pulmonary Edema then Acute Respiratory Distress Syndrome. No trials of Zimax to treat it.

Questions for BHA from PH:

1) Have you seen any patients come in with a recent COVID-19 positive test or are under investigation for Coronavirus and how do you handle that?

   BHA Response: 1) Many additional clients and 2) Overall service utilization is way down.

2) Have you seen any increases in patients coming in for seeking treatment for anxiety or stress associate with COVID-19, but is not directly related?

   BHA response: Peer support specialists who are holding groups virtually are going well and telephonic contact is helpful as it provides 1:1 support and allows patients time to discuss their anxiety.

3) How is the telemedicine going? I would like to hear about how the none face to face contact for some of the therapy is going.

   BHA Response: Telehealth is going well.

BHA OFFICE UPDATES, CANCELLATIONS, AND RESCHEDULING

Closing from Dr. Aliya Jones. Thank you, Rebecca, for being here to answer our questions. Please send your thoughts or questions before the next meeting so we can get these questions to Rebecca as soon as possible. Thank you for making this meeting interactive giving our providers an opportunity to ask questions as it is a great way to keep people engaged. Keep yourself safe, staff safe and your patients' safe as well.

Conference call meeting is scheduled weekly on Fridays for 1 hour 10 a.m. – 11 a.m. Next meeting will be held Friday, May 1, 2020. Please be sure send in your questions ahead of time.