All BHA Provider call w/Public Health Services – May 1, 2020 10 a.m. – 11 a.m.

Meeting Notes

Attending

Aliya Jones, Stephanie Slowly, Kathleen Rebbert- Franklin, Frank Dyson, Scabrera Cabrera-Bently, Roe Bonaccorsy

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. We are going to talk about reporting and Surveillance for new reporting.

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. There are well over 3 million cases worldwide. Case counts do continue to go up. The United States is still number one. The death count is almost a quarter million people globally at this point. Some good news, in mid-December 2019 the city of Wuhan China had been reporting a number of mysterious cases of pneumonia. It was later detected that they were infected with COVID-19. They went on lock down starting in early January and ended on April 7th. Wuhan China has not reported a located transmitted case in 26 days. An outbreak is reported to be over and done after the 2 of the longest incubation periods after the last case. The longest incubation period is 14 days. They made it to 26 days. We are very hopeful that 2 days from now that Wuhan will declare the outbreak will be over. There has been over a million cases reported in the US, 26,512 reported in the last 24 hours, more than 60,000 deaths and including 2,552 in the last 24 hours. Cases over time new cases in the last 24 hours. 19 states are reporting more than 10,000 cases of COVID-19.

Some states are starting to end their lock down. We are going to see what happens next. There is still a lot of transmission going on. When people start to gather and go out again, it is going to be an interesting experience. We will be watching what is happening in other states. Maryland is not going down, yet we had reported 23,472 cases with a record breaking 1,730 new cases in the last 24 hours, Maryland has reported 1,098 deaths, 51 reported in the last 24 hours, almost 5,000 hospitalizations and 100,000,000 negative tests reported. That is also good to know. We are going to talk about these numbers. Sometime numbers can be deceiving. As more test are going to be done, the more test you do the more false positives you will have. It does not necessarily mean new cases in the last 24 hours. We are still climbing in Maryland. This is perhaps a better indicator of where we are in terms of critically ill patients because we can look at the number of acute care hospital beds that are being used for COVID-19. This is also increasing. Looking at the trends over time can be important to see where we are going and what might be happening next. Gender breakdown still slightly predominant females in terms of case counts and males in terms of deaths. While more women are contracting it because of occupational exposure because more doctors and nurses are female then male, so there could be some occupational skewing here. There are a series also why men are more accessible to poor outcomes than women more including hormone issues. More to come there. Looking at age, the vast majority of our cases are in the 30 -60 age range, but the deaths increase as age goes up. The most deaths are in the 70 and over 80 groups. Breaking down on race and ethnicity, largest number of cases in the Non-Hispanic African American population, followed by Non-Hispanic Whites, Hispanics. We will see what this is going to show in a long run. This is just something to keep in mind in the current situation.

Surveillance 101

Data are being reported now that we have not seen before. It is not always easy to interpret. There are a few questions we have to ask when looking at surveillance data?

- What is the question? What are we trying to answer?
- What does the data represent?
- How many cases:
- With this Data, the questions are:
    a. Who is sick?
    b. How sick?
    c. Deaths?
    d. Who is at Risk?
    e. How many have had a meaningful recovery?

We want to know who is at risk. How big is the population at risk? How sick are they? What do they look like? What are the gender discrepancies, Age discrepancies, racial and ethnic discrepancies that could cause an impact on how many cases you have and what your outcomes are going to look like. When you look at the numbers you have to ask yourself these questions and remember that sometimes the numbers lie. A quote from an economist, which is true, "if you torture the numbers long enough, it will confess to anything." So, you have to look at these numbers, are they just numbers of cases? Is it just a pure case count or is it a rate – rates are the number of cases divided by number of populations – the number of people in your population at risk. If you remember your 4th

grade math, the numerator (the top of the fraction) is the number of people who are sick, the denominator (the bottom of the fraction) is the number of people at risk. This can make a huge difference. If you have 2 nursing homes reporting 20 cases, and one has 500 residents and the other has 100 residents, these nursing homes are going to look really different in terms of cases and their burden of disease because they have such different denominators. So, rates are important because they can help adjust for population health. Then there is something called risk adjustment. For example, age is a risk for severe outcomes. For example, if you have a facility reporting 10 deaths and their average age is 50, you might be more worried about them, then a facility reporting 10 deaths and their average age is 80, assuming they have the same number of populations and same number of sick. Rates are easy enough to calculate. Risk adjustments get more complicated; your statisticians do this; they can look at these numbers and they create complicated formulas that you can use to adjust your numbers to base your risk on your population. It is a better estimate, but way more complicated. So, when looking at your numbers, make sure you check what your numbers mean.

Public Reporting: Outbreaks in congregate living settings are now being reported on the MDH Website, which include long-term care facilities, nursing homes, assistant living facilities, correctional facilities, and state run facilities. We are not reporting on facilities that have fewer than 10 residents due to Confidentiality reasons. The data include name of facility, county, number of cases and deaths in staff and residents.

Return to Work Criteria: This has changed for health care workers: Previously, CDC made an announcement of the preferred test base strategy to return to work criteria for health care workers. At this time, it is no longer recommended to use test base strategy, you can use either test for symptom base strategy. The other change is that for symptom base strategy, it is now 3 days after fever resolution, and having improving symptoms for 10 days after on set. It used to be seven days after set. If someone is out of work because of COVID-19, they should stay home for 10 days after their symptom on set. And again, asymptomatic people should stay out of work for 10 days since that positive test. One reason CDC stopped recommending the test base strategy is because they started doing the viral cultures on people looking for live infectious virus. It became apparent that a lot of people could still have viral RNA in their noses after the 10 days, which does not necessarily mean they have the live virus, but just the RNA.

In the past few months, there has been an uptake in the number of calls to Poison Control Center about accidental cleaning and disinfecting. It presented two case studies; one an adult saw a recommendation of cleaning her produce before eating them. So, she put bleach and vinegar in her sink to clean her produce and she winded up in the ER. The combination of these products put out harmful gases. The second case study involved a five year old child. The child was found unresponsive after ingesting alcohol-based hand sanitizer. Her blood alcohol level was 273 mg/dL, as a comparison, you will get arrested if your alcohol level is 80mg/dL if you try to drive. She spent 48 hours intensive care and returned home.

So, it prompted more messaging going out about not mixing chemicals, appropriate cleaning, wearing clothes as needed, storing cleaning supplies out of reach of children, and ensuring you are using your chemicals in a well-ventilated area.

A story came out in Iran giving misinformation about drinking Methanol to cure COVID-19, which resulted in about 900 deaths in the past 3 or 4 months. There was also a story about American using bleach as a cure for COVID 19; it is also not recommended to drink it or even put it in your Nettie Pot and putting it up your sinuses.

Questions for Public Health

1) Since many deaths are among older population and women with longer than man. Can that contribute to larger count women virus men?

   PHS Response: Yes

2) Do we know what percentage of people who have died from COVID-19 with some pre-existing conditions?

   PHS Response: I do not have Maryland's data. The CDC website has some estimated information. I do not have those numbers off the top of my head. I will make a couple of slides about that for next week meeting.

3) Is there demographics of the deaths to see if older population of deaths are predominately white and younger people dying predominately black?

   PHS Response: I do not have the data and would look to see if anyone has published anything about that and see if I can share it next week.

4) As the State starts looking at the reopening in the near future, what are some of the things we should be mindful of as a BH community is thinking about the future with regards to people moving around more as a provider community?

   PHS Response: I think a lot of reopening is going to be slow. We will not be changing all the practices that we just developed over the past 2 - 3 months. As things reopen, we will continue to wear mask and PPE. You will continue to have masks available for your patients. People will be allowed to have smaller group activities/gatherings. Things are not just going back to normal and that could have implications for your mental health of patients/clients. First of the reopening may be outpatient medical services. If you have any programs or providers who had to close for voluntary procedures or inpatient settings, these will be some of the first to things to reopen. This why this is going to continue to be an ongoing situation.

5) Deaths by occupation?

   Response by PHS: We are looking at deaths by occupation. There have been some interesting clusters. The meat packing plant being hit hard. There is a great deal of work being done in the Delmarva, Virginia and the Eastern Shore areas. There have been spikes in long term care, assisted living, correctional and state run facilities; as well as, in the healthcare industry. The top of the list was those in the food production industry or grocery stores. More to come.

6) Is it entirely true that the death rate is under 65 years of age?

PHS Response: Usually in pandemic influenza, most of the times, the highest death rate is in the over 65 age range. However, the 1918 pandemic, hit hardest in the twenty something year old age group, but normally in pandemics there is higher deaths in the very young age group under age 5 and over age 65. COVID is a very different kind of virus; we are not entirely sure what to expect. It looks like the over age 65 death rate may hold, but we are not entirely sure why or if it is going to hold throughout the entire COVID epidemic.

7) Does the 10 day return to work recommendation also apply to employees of congregate housing facilities or nurses, doctors working in nursing homes, hospitals, etc.?

   PHS Response: Yes absolutely. This includes people who are doing housekeeping, doing cooking, activities for daily living for these clients.

8) If a vaccine is able to be developed, do we anticipate it to be like the flu where it hits and misses, or like mumps, measles or chicken pox?

   PHS Response: It is all speculation. We are unsure at this time if a vaccine will be being developed for COVID-19. We can hope it is a good vaccine if one is developed.

9) Are physicians still directed to only authorize a COVID test for people who are showing symptoms might have COVID if test concerned about COVID 19?

   PHS Response: Ordering COVID test is a clinical decision. If a physician is concerned about it, they should order a test. That being said, there are limitations for the results, especially in asymptomatic people. If an asymptomatic person who tests negative, should continue to be observed for 14 days because it just means at the time of the test you did not have it, but it does not mean you may not develop it. If the person has a positive test, means that you were infected recently or are infected. Feel free to order the test but explain to patient that they could still be positive and let them know that they should remain social distance, etc.

10) Based on public health services, how can we encourage men to improve their self-care skills during the pandemic since women seem to do self-care very well?

    PHS Response: This is more in BH wheelhouse. I do take your point; however.

11) How close are hospitals overwhelmed - how close to capacity for beds and ventilators, and based on trends how close are we to reaching that level?

    PHS Response: At the moment we are not in a place where we are running out of beds, we have enough ventilators. We have enough ICU beds, though the ICU beds are fairly full. At this point we are holding fairly steady at this time in terms of case count. The curve seems to have flattened. This does not necessary mean we are safe from it because this virus has proved that it can affect a lot people very quickly. Right now, we are good, and we are hoping we can stay that way.

12) Is it ok for people to split time between home and other residents? Is it ok to baby sit essential workers, and return to shared living environment?

PHS Response: Ideally no, it would be better to stay at home and not visit other houses/residents. In real life, no it is fine just be careful, wear your mask. You do what you have to do to, just keep your family safe. Wear your mask, keep your distance, and wash your hands.

13) Is the State looking at SUD overdoses and suicide rates with an eye to increases and impact of COVID-19 and the availability of harm reduction and the availability of naloxone?

BHA Response: We are definitely looking at overdose rates, suicide rates, we are looking at calls coming through the crisis line, looking at all the information that we can collect to determine what patterns there are and what additional supports there might be to help manage this through the pandemic. Some of the challenges is the lag in time from the time that the data is collected and available. We are actively trying to have as much as a real time understanding of what's going on the ground, so we can deploy additional resources where needed.

14) Immune response test and the Cost?

PHS Response: I do not know the cost. There are a lot of places offering these immune response tests. These tests are measuring weather a person has had an infection in the past. Most of these tests are not very good and quite inaccurate. At this point those immune response tests are not being recommended for making decisions for returning to work or returning to regular life activities. It just means you may have had the disease.

Action Steps- Responsible

Thank you again Rebecca for participation. We appreciate your guidance and support as we make some very difficult decisions to help us all be safe. We did wonder, given the decrease number of questions, if that meant that people felt they did not need that much support at this time given that we are in steady state we are in regard to the Coronavirus. We do have a question for the group which is would you like to continue 60 minute weekly time, or would you prefer that we move to every other week for an hour or 30 minutes. If you can send us your thoughts about that so we can react. I wanted to remind all of you to remember to take care of yourself, your family and your staff. We are in a marathon not a sprint. We will likely see increased need for and challenges for BH community services in the future. We are not seeing an overwhelming negative reaction at this time, but we know what to expect from previous studies on what happens during a disaster, such as. PTSD, suicide increase. Be ready for what is to come. We are trying to be proactive as we can. We do have resources on the BH website, the COVID page entitled - Mental Health Supports during crisis. Provider links are there so providers can reach into their own types of treatment modalities and people. With that , I just want to say thank you and everyone please have a wonderful and safe weekend. Looking forward to hearing from you next week.

The next meeting will be held on Friday, May 8, 2020 from 10 a.m. – 11 a.m.