

TRANSCRIPT: Snohomish County Response to COVID-19, April 14, 2020, Press Briefing

Dave Somers: Thank you and good morning. I just really want to start by thanking all our residents in Snohomish County, you're doing an amazing job staying at home, social distancing, being careful. We very much appreciate that. It appears, the data we have, that we have managed to flatten the curve. We've managed to keep cases that need medical attention within the capacity of a critical system, but we absolutely need to keep that and I've got a dog who has decided right at this moment to inject himself. Also want to say, we know that a lot of people are hurting, a lot of families have people that are unemployed or uncertain status and we recognize that. We're working hard to start planning for recovery. I've stood up an Office of Economic Recovery and Resiliency to help us transition back to more normal times. We know that's going to take some time. We need increased testing capacity and a number of other measures. We're waiting for vaccine which is still many, many months out. But we think we can take some actions to start to ease things in the future in the close future and we do need to maintain our social distancing at this time. Otherwise, we'll see a resurgence in cases again. So the actions you're taking are saving lives and we very much appreciate that and again we'll be working to try to help as much as we can get the resources here to allow us to ease up as the cases drop, but also maintain some aspect of social distancing until we get a vaccine in the future. So with that, my best wishes to everybody in Snohomish County. And again, thank you so much. I'll turn it over to Dr. Spitters.

Dr. Chris Spitters: Thank you, executive Somers. Good morning, everyone. Today I have just a few short updates. The first is to talk about our hospitalization numbers among the COVID cases. For those of you who have been monitoring our data updates closely, you might have noticed a large decline in the number of hospitalized cases between the Sunday report and the Monday report. On Sunday we had 115 hospitalized patients listed in Snohomish County and with COVID-19 and yesterday that figure dropped 249 and that wasn't 65-66 people being discharged on the same day, but our staff are balancing multiple demands on their time and periodically check that the hospital records. And so that was just the periodic update. It's not like that happened in real time, but you know, overall, that's a great signal that the decline we appear to be seeing in community transmission and case counts is also translating into a lighter load for the hospitals. As executive Somers mentioned we're able to keep our head above water there.

About data, please keep in mind that our updates at 2 p.m., those are just a point in time snapshot and it's more of the trends that matter than the absolute value on any particular day, especially numbers of cases reported will fluctuate throughout the week based on ebbs and flows in the in the testing and recording system, it also will depend, as I said, on our staff's stability to follow up. The slight increase in daily - or slight decrease in daily cases we're down to averaging about 30 case reports a day from a peak of 80 to 100 a few weeks ago and that certainly benefited not only the community in the hospital system, but our staff's ability to catch up with things. And so they're also catching up on those hundreds of people that we hadn't been able to reach and decreasing that number of investigations pending, and you might notice that over time on the reports as well.

This has been an intense couple of months for everyone in the community including staff many who have been working 60, 70, 80 hours a week. Although heroic, I think that pace for them it's not sustainable or healthy and so to ensure our team isn't burning out we're closely monitoring their overtime rates and trying to bring in temporary workers to augment some of our teams.

We've also expanded our case investigation capacity internally by reassigning some staff from activities that are temporarily lower priority and can be deferred or at least diminished.

In short, you're seeing public health hospitals and our healthcare partners getting to a place where we can collectively catch our breath. We are by no means through this. We just appear to be on the downside, but I would urge you to remember that these very same numbers of cases reported today, were cases reported daily and one or two deaths daily. On the other side of the curve we were in quite great distress. And that was because even that moment in time is a heavy load on the community and the systems that support us.

So make sure you're all taking care of yourselves physically and mentally. Try to avoid oversaturation of news and media and yet remain informed of what you need to do for you and your family and your colleagues to stay healthy. We are in this for a long haul as Executive Somers mentioned. I think there is a good you know cautiously optimistic forecast for maybe not life as normal, but serial steps in that direction with careful monitoring to detect any signal that maybe transmission is increasing and we would need to update our approach.

Before I wrap up, I want to reiterate some comments that Dr. Beecroft made on Friday that I think we're very important and that is we're continuing to hear reports from acute care facilities, particularly emergency medicine providers that some people are waiting too long before seeking emergency care. Hours and sometimes even minutes can count with urgent health issues like strokes, heart attacks, heart failure, certain intestinal problems that can become catastrophic, and they've seen a few of those where the folks stayed away a bit too long. Now, in no particular case, can I say well that that was maybe due to people taking the, you know, avoid going to your health care provider message too much to heart. Or maybe there's concern about going to places where COVID patients are not wanting to catch things like COVID. First I want to assure you that the hospitals do indeed have infection control, infection prevention measures in place to keep a COVID and suspected COVID patients separate from those who are seeking care for other reasons. So the hospital is a safe place to go. And in fact, avoiding going there, especially if you have one of these acute things like a stroke or symptoms of a stroke, symptoms of a heart attack, difficulty breathing, a history of heart failure, things like that, things aren't going right, go in, go to the emergency room. If you're in doubt about it, call but don't avoid, please don't avoid that's not in your best interest.

So, again our hospitals and first responders are taking preventive measures to protect all patients not just COVID 19 patients and I want to give a shout out to the EMS who are really the frontline in all of this going into harm's way to try to make sure that everyone gets transported for the care they need. They've always been a critical partner with the healthcare system and public health. And to share a little bit more about we at what EMS is seeing around the county, we're joined today by Shaughn Maxwell with the South County Fire District. Shaughn.

Deputy Chief Shaughn Maxwell: Thank you Dr. Spitters and Executive Somers. This is my first time speaking on here. So I was kind of reflecting on how we got to now and it does appear that we are doing well as first responders in this county. And I really think it's from some past disasters that have led to the success. We've come together multiple times. The H1N1, we really came together in this county. The Oso mud slide and then, Executive Somers, your opiate Task Force and building those relationships over the last decade, I think, has really lead to success. There's, there's a lot of I think uncommon relationships in this county due to those disasters and due to the collaboration with public works. I think we have a really good

relationship with public health in this county between fire and the EMS and I think that's part of what set us up for success. I'm seeing what's happening to first responders in other parts of this nation and you ask the question, you know, why isn't that happening to us? I think the other part was the fire service and EMS in this county, there's 1,700 providers and we run close to 100,000 911 calls here. And very early on we didn't want to take an alarmist approach, but in the fire service we always say, we can send more resources and cancel if you have to and turn people around. And we did that, and every fire chief in this county. We started meeting every day, having a video conference call, similar to this. And we just reported each other, you know, what are, what are the conditions in your area, what actions are you taking, what do you need, what PPE does one department have that they could share with another department. And so we started working early on that and then linking up early with the county, with public health, with the hospitals and it was just, it was just crucial that we all coordinate that way.

Internally we set up some different positions. We set up a science officer that would research all the academic information. We're all being deluged with the media information and we were really working at getting the right information out to our crews and we actually from day one, created a manual that started with one page. And it's probably 14 pages now but we created a manual that was based off of all the available evidence our Medical Director and Dr. Spitters would review this manual. So the entire first responder community, even a lot of the law enforcement, was operating off the same playbook. And I think that that was another part of the success.

I don't know the exact numbers for everybody but so far with South County, we're the largest we have 300 providers, and we don't have a health care related infection in any one of our firefighters at this point and we took a very aggressive and early stance on wearing PPE on these calls. We've also coordinated with if we had alternative responses to go out and check on people that may not need to go the hospital when we were worried about the hospitals being overwhelmed. And in this county we have community paramedics who are specialists, especially designed to go out and work with people in their homes, especially the most vulnerable, the elderly. They're specialists in that. So we already have that setup in this county as well. And we've also worked very closely with places like Seattle Fire in King County and sharing information and sharing ideas. The logistics department up here at DEM, we've done very well I believe with equipment, PPE in this county because they're creative, they're industrious. We kept saying, you know, we got to think of new ways and everybody really worked at being very creative. I think that was part of the success, too.

And I know a lot of the successes in Snohomish County have been shared actually around the nation on larger conference calls just how we're doing things because we're successful and because we were kind of hit early on.

Thank you.

Joint Information Center: Alright, we will be taking questions via the chat feature. So please begin submitting those in the chat box.

Deputy Chief Shaughn Maxwell: For Chief Maxwell, the department says trying to conserve gear how so? Well that, we've been working closely with our public health department and actually many other many other experts around the nation on this trying to understand the best way and the safest way to preserve PPE. There are lots of different UV light and different kinds of chemicals, but being very conservative with it. Also, we don't want to hurt the first responders

with chemicals or degrade the equipment. So we've taken a very conservative approach. But right now we are looking at a way to use some UV light to hopefully decontaminate our equipment and reuse it. There's, there's been a lot of other structural ways we're also trying to do that. Whereas we will wear a very high level of PPE fully with our eyes and respiratory and a gown, we'll only have the first person go in, check out the scene and determine if the whole crew needs to be in that. We also would have less people in the back of the ambulance when we transport so we're trying to minimize how many people are in direct contact with people in that way you don't have to have a whole team using up all of that gear.

Joint Information Center: Dr. Spitters, it looks like we have a question for you regarding demographic data.

Dr. Chris Spitters: We have, we did a run on race and much like race and mortality and hospitalization didn't really see any significant variation of the, you know, the proportion of total deaths mirrored what the population is for African Americans, Asians. And so we're not really seeing any difference. The numbers are relatively small because of the, you know, predominantly Caucasian composition of our community. So when we're talking about minority numbers, both the denominators and the numerator is are relatively small, but there's no trend to suggest increased mortality, it kind of mirrors what we what we heard the state when they look statewide as well.

Joint Information Center: And Executive Somers, it looks like we have a question for you.

Dave Somers: Sure, there's a question about what the plan is for to begin reopening the county when we're ready. And really, that's a decision to be made at the state level, but we are in discussions with the governor's office. I know the Health District is in discussions with Department of Health. Emergency Management folks are all talking with the state about what that looks like. There's many sort of suggestions and ideas out there, coming from the science world really and what might need to be in place to allow us to start to ease up restrictions. I do know the governor has got a task force together, looking at the construction industry and how that might be able to start opening up a little bit under certain conditions.

We're focused here at the county really on aligning with the state, but also getting folks together to think about what we can do as we start to open up to help people. So in 2008 during the recession we did many steps after coming out of the recession, through the recession to help the building industry and others. Permit deadlines were extended, a number of really features of county government and things that we do, processes that might be an impediment to people, we really looked at and tried to lower those impediments as much as possibly, legally we could. So we're focused really on the transition. The decision to open up will be made by the governor and others.

Dr. Chris Spitters: Kari, I have a question that was submitted I think accidentally and private. Can I just read it?

Joint Information Center: Yes, please.

Dr. Chris Spitters: Okay. This is: how will contact tracing investigations change now that more people have been internally reassigned to the team? Well, it's just that we're catching up on the backlog. So there was a significant proportion, at one time it was up to half, half of the total cases reported to date we still hadn't gotten around to interviewing. So we're just, we're trying to

get that down to zero again. Our current method remains to engage the individual who has the infection, have them talk about their contacts with us, their household, close friends, other people whom they've spent significant time in proximity with and then educating them and then giving them a flyer to give out to those people about watching for symptoms continuing to stay home and doing that for 14 days. So currently, the method is not changed. It's just that we're using those additional staff to catch up on the backlog.

Dave Somers: So there was a question for Dr. Spitters really about a comment I made about ideas from the world of science on what might need to be in place. And what I was referring to, and I'll let Dr. Spitters is certainly more of an expert in this than I, but there's guessing that we really need more robust testing capacity so we can really know where we are in terms of infections. So that's a capacity we're going to have to build up. It's also suggesting that some way of tracing people in contact tracing would be helpful. And I know that there's many that are looking at improving our capacity to do that. So doctor, that's what I was referring to. I'll let you respond.

Dr. Chris Spitters: That's exactly right. You characterized it perfectly. Widespread availability of testing without limitations in the testing supplies so that when people who do have symptoms are presenting for care they can be tested universally because as you're trying to eliminate transmission of a disease case detection becomes paramount. You know, when we were at the top of the curve, whether or not we detected every single infection was much less important than just everyone saying home. That was, that was the most important thing. As the numbers get smaller and we begin to reopen up our social and economic activity, then these individual level containment efforts become much more important. So the capacity to test everyone who has symptoms and in those who are infected to follow up more thoroughly I guess I would say with them and their contacts in a timely way becomes key. So, some of that is having adequate staffing and some of that is, you know, not opening up until the number of cases falls within the capacity that you have. So that's there's sort of a Goldilocks phenomenon there. Other things that need to be in place. An ability to have your acute care facilities to take care of everyone that showing up at the door, that is currently the case. And then having a contingency plan for monitoring what's going on and giving feedback to ourselves about how is this going, if we see a sustained increase in cases and hospitalizations over the course of a week, then maybe we're not, where we've reduced social distancing a little bit too much, or at least in some areas. So those are the key features. And you know, I also hope that at some point, it's not part of the recipe I've been reading, but having serologic testing available. Especially not necessarily an individual level but on a community wide sort of surveillance testing level where you get a representative sample of the population and begin to get an idea of what proportion of the population has already been affected. Because our strategies would be different if the residual susceptibility in the population is 10% as opposed to if it's 90%. We're going to have to be a lot more careful with how we open things up if 90% of the population is still susceptible, as opposed to 10%. Now, the reality is it's probably somewhere in between. But I just give you those two extremes as to help illustrate the principal

Dave Somers: Doctor, and there was an earlier question that got skipped. Does Snohomish health have any demographic data on race or expect any data anytime soon?

Dr. Chris Spitters: You know, we don't. I spoke with our epidemiologist. You know this is very relevant and important question as other cities across the U.S. have found increased morbidity meaning severity of illness, including hospitalization and death among racial and ethnic

minorities, particularly, it appears among African Americans and Latinos. So we've looked and where we have data, which is in about half of the cases, on race and ethnicity we don't see any difference in mortality that's statistically significant. So again, sometimes we're dealing with small numbers, but that's what we're finding at the current time.

Joint Information Center: Now looks like we have a question for Shaughn about whether South County Fire has all the gear it needs and will have continued access to that.

Deputy Chief Shaughn Maxwell: I'd say the short answer and the current answer is yes, but again we always ask why and very early on, I believe the fire service worked together and Executive Somers removed some administrative barriers, so did our fire Commissioners and the logistics team here at DEM. I guess I'm fortunate it was a perfect storm of good things coming together because the fire service in this county is currently well equipped. I don't know if that's always going to be the case. The, the volume of PPE that is going to be needed throughout the summer or the rest of the year for any, you know, second waves or hotspots are a great concern because the amounts that will be needed in the future are likely substantial. And so currently let's say we're okay for now and we're looking to aggressively look for more methods every day to decontaminate and reduce our PPE.

Joint Information Center: And then there was a follow up in that same question for Dr. Spitters. To do more robust testing, what do you need, and who provides that?

Dr. Chris Spitters: Right well, so, you know, we live in a society where most of the healthcare is in the non-governmental sector, certainly the government has, the federal government and state governments play a big role in financing care for the needy and the elderly, but by and large we have a, you know, a non-governmental health care system and we deliver services largely through that. Compound that with, so there's the environment. And then this is a new thing. Remember, four months ago no one knew about novel coronavirus. Three months ago it's, you know, genetic code was sequenced and somebody came up with a method for developing a test. So it really is remarkable. Even with the frustrations we've experienced the speed at which the technology has made testing possible conceptually, and then rolled it out first through the federal government CDC lab and then to state labs, and more importantly now in the context of the way our health care system delivers care, through the private sector, through the laboratories that serve the hospitals and clinics to which we all go. And so it's just been an evolution of that maturation and increased availability. It's improving virtually continuously. In the early phase, the real bottleneck was just the limited number of tests that could be done every day in Atlanta, and then it's that got, as the federal government made that test available, the state labs and private labs to develop their own platforms to run the test and make it available, analytic capacity, the ability to do the test in the laboratory has increased and we've run into other problems. At one point it was personal protective equipment for the health care providers to protect themselves when collecting a specimen and, more recently, we've had shortages of the liquid, the viral transport media that the swab goes in and shortages of the swabs themselves. So those are being resolved, but it's multifactorial getting to the you know the goal of universal testing availability. It's getting better. There have been bottlenecks and there might be another one that I'm not, you know, I can't anticipate what it will be. But who provides it? We all provide it certainly you know in a in a national or global infectious disease crisis, the government has an interest in making that happen. And, and so I think, you know it's state and federal level, the government's trying to do what it can to acquire resources and get them down to the local level, but in the end it's a, we work and live in a complex system of

multiple inputs and factors and that's, you know, a good thing overall but sometimes it's challenging in a situation like this where you need a prompt, you know, a rapid coordinated response. But I think we're getting there. And, you know, the short answer is, we all have a stake in it that. Private labs, the public labs, state and federal and local health departments, as well as the healthcare providers. Ultimately, I think it continues to improve and we just got to keep going with it as it as it improves

Joint Information Center: Dr Spitters, it looks like we have one more question related to testing for you.

Dr. Chris Spitters: Does relative sample testing involve an antibody test since the current testing is more a picture of an individual's health on the day it's administered? So I'm not quite clear on the term relative sample testing, but I think I'm getting the question which is what's the difference and what's the value of antibody testing, and what's the difference between that and the PCR the diagnostic testing that we're using right now to detect cases. So the PCR tests looks for the genetic code, it looks for the DNA of the germ in the swab that's taken of the nose or the throat and that we use as a tool to determine whether someone's currently infected. Once you are infected within a few weeks you develop some antibodies that become detectable and that persist. We don't know how long. But typically with viral infectious diseases, at least for several months, sometimes for years. Sometimes for a lifetime. Only time will tell with this virus. So the purpose of doing serologic testing, which is the practice of taking someone's blood or serum and then looking for those antibodies is looking for who has been infected. And so that's more of a surveillance tool to get to that number I was talking about, what is the proportion of the total population that's already been infected. And so the means by which we usually go through that is not individual patient testing but going through human subjects approval processes to get it okayed to do de-identified testing, meaning there's no individual's identity involved just leftover blood drawn for other reasons, you know, for blood count for liver tests, for diabetes diabetic tests, whatever. And it's in the lab, it's all been used for the patient care purpose and then the identity of the individual is stripped from that specimen and then it's tested for antibodies. That's typically the way that you do that and then you, you know, then you aggregate all that data together. You've got, you know, some information about the person, where they live, where the specimen was collected, maybe their age and gender. And then you can start to put all that data together from all that testing and get an idea of what's going on in a moment, and then if you do it serially across time, you can get a dynamic picture of what's happening across time.

Joint Information Center: Thank you, Dr. Spitters, and it looks like the very last question we'll take is about what would robust testing look like to you.

Dr. Chris Spitters: Well, to me, that just means widespread availability of testing without limitations in the supplies or the analytic capacity in the laboratory necessary to make it possible for anyone with, you know, the medical term is a clinically compatible syndrome, you know anyone who shows up with cough, fever, difficulty breathing or some combination of that to undergo a test. And we're getting there. From, you know, three months ago, you had to have just gotten off a plane from China and have a cough and fever to get tested. So it's quite a bit better. I think there's still some settings where right now the limiting factor is the swab and the transport media that it goes in to get shipped off to the lab. So it's much better, many more people are being tested. We're not really restricting any anyone's, any clinician's election to test. We're currently we're having a little bottleneck with the swabs and the viral transport media. So,

you know, the goal is for it to be just like if you go in and they think you have the flu. Well, you have a flu test. And so that's just the goal we want. You know, there's no limitation if it needs to be done, it's done. And the add-on would be the closer to the point of care and the faster the turnaround, the better. So there is a new product on the market from a laboratory instrument production company that you can do the test right there in the clinic or the hospital, one of the local hospitals is using those, and that's ideal because now you're eliminating a lot of the turnaround time from testing to results. So that's what we're looking for is to get there.

Joint Information Center: All right, thank you everyone for joining us. We appreciate you taking the time and this video will be available online by noon, please stay tuned for future briefings.