

Transcript: Snohomish County Response to COVID-19, April 17, 2020, Press Briefing

Executive Dave Somers: Well, thank you. And thanks for joining us today. So since the beginning of the COVID-19 pandemic, one concern of ours, and one possibility is there might be unmonitored pockets of the virus spreading in communities that are hard to reach. In particular, those who are living without permanent shelter. Without interventions into those communities, they could see significant outbreaks and contribute to overwhelming our healthcare system and also spreading the virus more widely throughout our community. So we needed to innovate and so I'm proud to announce today we are forming and have started a new pilot program that we are calling our SAFE teams. SAFE stands for Snohomish County Agencies for Engagement. These teams will be composed of physicians, community paramedics, social workers, and law enforcement officers. It's really an extension of our embedded social worker program that has been really successful over the last few years. So it's really a great example of a partnership and collaboration across multiple sectors, law enforcement, our medical folks and our social teams.

So the SAFE teams will be visiting encampments in areas where people are known to congregate and will be assessing COVID-19 symptoms and connect people to services as needed. So these efforts are just part of the coordinated efforts that are being lead by the Snohomish County Department of Emergency Management, it's just one aspect, the other activities will continue. But we thought this was a very important intervention in these communities and really important community mitigation program. So we want to really thank our partners in this.

And as we move forward also we are planning for recovery, particularly to help our business community, it's been very hard yet. I have a task force of business folks and community leaders that will be having their first meeting on Monday to begin to come up with some plans and strategies on how we can all work together to help our businesses as we come out of this pandemic. And I'm very happy and was very pleased to see that Boeing will be commencing operations at the Everett plant, really the first folks are showing up today, senior managers, etc. First shifts will be starting on Monday. So glad to see that. And I know they put in significant safety features for the workers there at the plant and grateful that they're able to start some operations there.

So our residents have really been successful at flattening the curve. The virus is still out and around all of us in our community. So we need to keep these efforts up. We need to keep this thing, keep a lid on it so we don't overwhelm or medical system. So keep doing what you're doing. Thank you for that. It's working. And as we move forward we're going to be looking for ways to progress safely for all our communities, our family members and friends.

So with that, I'll turn it over to Dr. Spitters with the Snohomish County Health District

Dr. Chris Spitters: Thank you, Executive Somers and good morning everyone. Today I'd like to share some reminders about stay home, stay healthy, to discuss COVID-19 compared to the flu, and give you an update on some data. First, I'd like to build on what Executive Somers mentioned with the news of Boeing phasing back into operations. Boeing has been working to make significant adjustments to their operations with COVID-19 in mind and are doing so as a critical infrastructure and essential business. It's worth keeping in mind that non-essential business activity remains unapproved by the governor's declaration and, but nonetheless, as we look forward down the line all businesses and our counties should be anticipating what they

would do when the time comes that they're allowed to return activity. And so if you haven't already done so, we really encourage you to start thinking about that. You can look for materials on the Snohomish Health District website as well as the Department of Health and CDC websites that address businesses. So planning for how you will phase back into operations with respect to COVID-19 is important and as Boeing is demonstrating not everyone will be returning to work at the same time. If telework is an option obvious we obviously we encourage and promote that as much as possible to maintain social distancing as efforts to restart some semblance of normal activity returns. Evaluate options for staggering shifts to reduce the number of employees in an area at a given time, staggering lunches breaks, etc. Ensure that employees will perform self health checks before or as they arrive at work. And then reporting if they have symptoms and then not entering the workplace at that time they have fever, cough, difficulty breathing or other symptoms of a respiratory infection. Likewise, if they become ill during the day they should be sent home immediately.

Understand that cloth face coverings will become a new normal for us for a while, especially in settings for physical separation of six feet or greater cannot be maintained for an extended period. Encourage employees to wash hands prior to leaving work and again upon arriving home. Changing and laundering clothes or showering after work are other good product practices, especially kind of doing that in the entryway of the house or the garage, leaving those materials behind before entering the common living area where others share space.

For the broader community, I want to remain clear we are still under a stay home, stay healthy order from the governor. As some essential businesses restart or expand, they are there to perform just that, an essential business. Now is not the time to venture out for a playdate, visit family that you haven't seen in a while or engage in other activities that really aren't necessary. We remain, we must remain steadfast in our collective commitment to slow the spread of infection meanwhile, as over the coming period we take or observe efforts to resume some normal activities will be closely monitoring data and coordinating with our other public health and health care partners to ensure that cases don't increase. But again, meanwhile, for the vast majority of us, there's no change in the governmental or public health direction about your day to day activities, which are to stay home unless you have an essential activity. Both I and my colleagues are noticing over this week a substantial increase in the amount of morning traffic. I saw the morning lineup southbound which I haven't seen in a couple of months resuming so just a heads up to try and avoid unnecessary trips, please.

Some people are wondering why we are requiring and continue to advocate social distancing and putting in so many measures for COVID-19 when people die from other respiratory infections like the flu every year, and sometimes comparisons are made between COVID-19 and influenza in terms of the losses of life in our community. It is true that COVID-19 and the flu are respiratory infections, both can be deadly. But first, COVID-19's about 10 times as deadly, at least. We observe fatality rates of about three for every hundred cases reported, maybe the real number is somewhere down around 1%, but that's at least 10 times greater than the average annual flu outbreak, which is one in 1,000 cases dying. And it's so it's important to recognize that COVID is not the flu. The length of the flu season varies but its lasts for months, every winter and fall sometimes extending in the spring. During the last two flu seasons, 40 to 45 people died. These were relatively high numbers and even compared to recent flu seasons. But they are less than half of what we've seen this year so far, even, with COVID-19, so we're

really talking about completely different phenomena, both in terms of human suffering, hospitalizations, impact on the health care system, and loss of life.

We also know a lot more about the flu. It's been around for, known to us for at least 100 years. We know the symptoms. We know how to treat it. We know how to prevent it. We do not have widespread immunity to COVID-19. We don't have a way to prevent it. There is no vaccine and there is no proven treatment. So social distancing and containment efforts are really our only tool right now. The risk of transmission is also higher. And as I mentioned earlier, our losses of life and suffering are higher. So the measures we put in place are important to save lives and save healthcare resources.

And it's worth remembering that 100 years ago when the 1918-1919 influenza epidemic occurred and killed nearly three quarters of a million people in the U.S., out of the hundred million residents that lived here, that those were transmission and death rates much more like what we were anticipating without interventions here in the COVID epidemic. And at that time, social distancing and a lot of the same measures that we're implementing now were in fact put in place. We had no vaccine to protect infection and there were no antivirals for treatment. Again 675,000 people died during that, 675,000 people in the United States died, 50 million people died worldwide from that. So the control efforts, we are using non pharmaceutical interventions such as isolation, quarantine, good personal hygiene, use of disinfectants to clean frequently touch surfaces, and limitations of public gatherings. It worked then, it's working now. But we're not done. We've got to continue these efforts. These efforts may appear extreme but they do work and they work best when followed in harmony by the entire community.

Now I'd like to turn to two things about data. First, I want to talk about some racial and ethnic data related to COVID-19. On Tuesday, we took a question about COVID-19 whether outcomes we're seeing were different across race and ethnic groups and I provided a partially reassuring report that our hospitalizations and deaths at the last look, which was about two weeks ago, didn't look any different. So I did ask our lead epidemiologist to take a look at the data that we have now, and based upon the roughly, almost 2,000 cases for which we have race and ethnicity data, I do want to say that, like what we've seen reported in other metropolitan areas across the U.S., there is a racial and ethnic difference in the incidence of case reports. So Caucasians, you know, U.S.-born Europeans have an incidence of about 85 recorded cases per hundred thousand, Asians very close to that at 93, people of African American descent, though, almost double 157. Alaska Natives and Native Americans, 165. And Native Hawaiian or Pacific Islanders, 197. So compared to Caucasians and people of Asian ancestry, Latinos, African Americans or others of, you know, non-foreign born Africans and Native American or Pacific Islanders appear to have roughly double the rate of disease. And I would tend to just refer you to comments made at the national level about why that might be. One, in terms of risk of acquisition, to the sad, difficult extent that race and ethnicity are tied to occupation and income to a degree. You know, lower wage earners tend to have less flexibility around social distancing and doing remote work. So that might be greater risk of acquisition going to, coming home from, or being at work. And then some of the underlying conditions which predispose toward poor outcomes like diabetes, high blood pressure, heart disease, lung disease, asthma, we know are more prevalent in these populations. Some of the inequities that exist in our society around health related to race and ethnicity.

Hospitalizations, numbers are small, but it does appear, so we can't calculate reliable rates for African Americans or Native Americans just because the number of hospitalizations has been

so small, less than five. But when, even when you extrapolate those up, we don't see a difference. But again, small numbers, hard to draw firm conclusions. Latinos, we do have enough numbers and it suggests that hospitalization rates, maybe 50 to 75% higher than for Caucasians and Asians, and then death rates again in the minority groups numbers are really too small and so it's really hard to say anything definitive. But what we can see is that Asians, Caucasians, and Latinos don't appear to have any significant differences in death rates. So that's a little bit different than what's been reported in other settings. Again, the caveat, small numbers in African Americans and Native Americans.

Second data item I want to just talk about how we collect and record death information. The Snohomish Health District receives reports of deaths associated with COVID-19 from a number of sources. These include hospitals or healthcare facilities, other state or local health departments, the Snohomish County Medical Examiner's Office, and through our very own case investigations. All deaths, all that data provided are confirmed either through test results on conducted before or after death. There could be other underlying health conditions they contributed to the death, but if COVID-19 was diagnosed in proximity to the death it's still considered in public health terms a COVID-19 related death. So for instance, someone who has congestive heart failure, much like in this way similar to influenza, that develops a severe illness due to this viral respiratory infection, ends up hospitalized and because their overall health status is marginal that COVID infection and its consequences can be enough to cause fatal disease, whereas in someone who didn't have congestive heart failure, it wouldn't. And so congestive heart failure was contributing, but so was COVID-19. And so those are counted as COVID-19 associated deaths.

Our county level death data will likely not match numbers provided by the Washington State Department of Health or the Snohomish County Medical Examiner's Office because of the diverse sources through which we seek that information. So we'll tend to have higher numbers than you see from those other sites. We will provide numbers for Snohomish County residents with death associated with COVID-19. If a resident died in a hospital or facility in another county, they would still be counted as Snohomish County if they in fact resided in Snohomish County. And numbers sometimes vary between reporting agencies, depending on the time of day and when the counting is done.

So that wraps up my comments for this Friday. To share more about the processes that they are involved with and what they are seeing with respect to COVID-19, I want to turn it over to our Snohomish County Medical Examiner Dr. Lacy for his comments. Matt.

Dr. Matt Lacy: Thank you Dr. Spitters. My name is Matt Lacy. Good morning, everybody. I'm the medical examiner here in Snohomish County. The medical examiner has the legal authority to investigate sudden and unexpected deaths, but one of the types of deaths that we investigate are those that are thought to be due to infectious disease that have a public health concern. And obviously COVID-19 falls into that category. That being said, the majority of deaths in Snohomish County from COVID-19 are coming from people who are dying in hospitals, they have a diagnosis. They have a doctor who is aware of their diagnosis, who signs their death certificate. Although we are often made aware of those cases, we do not, meaning the medical examiner's office, do not get involved because it's a natural death and it's clear why that person died.

Where we do get involved are cases where persons die in the community in their homes or in non-hospital type facilities with suspicious symptoms. And by that I mean fever, some sort of new respiratory complaint, and no other adequate explanation for that. Those are the cases where my office gets involved and we may perform post-mortem testing for COVID-19 to determine if those deaths are related to the disease. We do autopsies in limited types of cases, ones that there might be other reasons to do an autopsy or ones where we think the person is unusual in terms of their characteristics for a COVID-19 victim and we might want to do an autopsy to confirm the infection. But in the majority of cases, we are simply doing the nasal pharyngeal swab testing that is the most common test now for the virus. And in those cases, we use a very rational approach. I've already laid it out, it would be somebody who has a risk factor such as an exposure, where they're coming from a facility where there's a high incidence of the infection, they had a fever in the last two weeks of life and new and unexplained respiratory complaints. And in those cases, we do a test. If the test is positive then typically their cause of death statement would list COVID-19 as a cause with the other conditions they have as contributing factors on the death certificate. We are doing very few of these tests. Overall I think approximately 30 times since COVID-19 started have we tested people who may have had it and roughly a third of those have been positive or still pending. So we are finding cases but not a great, great number. In terms of the death certification, again we use a rational approach, in my opinion, and really nothing has changed about the way certify deaths due to COVID-19 from any other type of infectious disease and we certify infectious disease deaths every year. If it is rationally the underlying cause of death, it is so stated on the death certificate. If, if there's no rational reason why it would have contributed to death, the fact that somebody may be infected doesn't go on the death certificate, unless it caused the death. So that's, that's our approach here in the medical examiner's office. Again, we're certifying a very small number of the deaths in the county. And I think that's true in medical examiners' offices nationwide. Most of these deaths are certified by clinicians, but I'd be happy to talk about our process if there any questions later. Thank you.

Dave Somers: Dr. Spitters, there's a question about we talked last week about the need for more testing before we can use up, what specific plans we have for more testing?

Dr. Spitters: Thanks. Thank you. So testing. Having a widespread availability of testing is a key ingredient as we come down the, the other side of the curve here and cases become fewer number and the value of detecting, isolating, and identifying the contacts of cases for quarantine becomes of greater marginal impact than it was at the top of the curve. And so the goal is to have rapid turnaround testing, you know, people can, the ideas for people who have symptoms within the same day or the next day to be able to seek testing, get results within a day or two so that then they and we can notify their contents to quarantine. That's the basic principle. The chief, you know, we've had various bottlenecks along the way in testing. Initially it was just development of a test, then making the technology widely available, then the personal protective equipment was a log jam for a while. Currently, the main limitation on availability of testing is about availability of swabs and transport media for the collection of the tests so that that item that moves from the patient's nose to the laboratory. That's not really in our control. We certainly have requests out for swab kits and viral transport media to get that into the community, just like we've been asking for masks and such. Ultimately, I think we'll get there. I do think it's worth noting that, you know, each week in Snohomish County we get about 2,500 tests done. And that may be adequate, we're in consultation with the state health department going forward about all the branches of the transition, containment, mitigation efforts going forward. And so, you know,

identifying that number, what's appropriate for a population of 800,000 people with the amount of disease we've had. You know, that's still under development, but we may not be far off really, and it's more about as time passes, I think trying to move testing from remote testing that takes three to five days sometimes to get results back because it's going to a commercial laboratory somewhere and trying to move the testing closer to the patient, so that the turnaround time is lower. And that's a matter of, you know, commerce and healthcare systems moving forward a process, again, that's only been underway for several months. So I remain optimistic about it. I think overall, the amount of testing that's being done is a huge improvement on where it was at the end of January, and we just got to keep working on that.

Dave Somers: So doctor, this question about the drive through test facility and its status and how much longer to be open?

Dr. Chris Spitters: So I think our plans, I think my understanding, our interim plan is that this was the last week of the drive through testing. You'll recall that the support for that was withdrawn by FEMA and we are demobilizing that effort today. Demand kind of declined over the course of that, plus we, you know, again, we don't have the funding and support from the federal partners for that. They did leave some swabs behind that we're using in long term care facilities. So we're, we're really moving our active testing from the health district to high priority, high incidence settings like namely long term care facilities where outbreaks are ongoing. So that's where the health district's testing capacity will be focused and then we're in the process of acquiring a point of care machine to supplement that activity and maybe get another one out there in a key primary care setting that might need to augment its testing capacity. But again, I think we're going to focus the Health District, the public health disease control capacity for testing where there are fires burning and then, you know, try to keep the overall testing system strong through the primary care and walk in clinic sector. And we're still looking to see if you know obviously if the future changes, either in terms of supplies or demand for that kind of testing, you know, we'll try to say nimble and be able to respond.

Dave Somers: So there's a question about the SAFE team and if it's an expansion of the embedded social worker team of the sheriff's office. Yes, it is an expansion. That embedded social worker program has always been a partnership between my human services department and the sheriff's office, and we're adding in medical personnel. That's important, so that they can talk to the folks, assess their condition, symptoms, make sure they're being handled properly in a safe manner and connected with the services that they need. We have the isolation and quarantine center at Angel of the Winds arena and other abilities. So it really is adding the medical capacity to those teams.

There was a follow up question about the COVID classified deaths and the example is given, if somebody was hit by a car, but they had COVID, would it be listed as a COVID death. Somebody want to clear that up?

Dr. Chris Spitters: Why don't you take a crack at it, Matt. And then I'll follow.

Dr. Matt Lacy: I'll touch on that. There's nothing different about the certification of COVID-19 deaths specifically than any other type of infectious disease death. So the example about the person hit by a car, no, COVID would not go on the death certificate. And just to be clear, the medical examiner's office is not testing every death for COVID. We're using a rational approach and only testing people who we think may have it or may have died from it, but somebody who

clearly dies of trauma, for example, we would not even test for it. So only the rational cause will go on the death certificate

Dave Somers: Thank you. Then our last call, experts seem to agree that widespread contact tracing is going to be key as the pandemic begins to wind down. Does the health district have funding or plans for hiring additional workers to do this contact tracing?

Dr. Chris Spitters: So this is a state level initiative that's underway, we're working closely with the state health department, which is leading an effort to, you know, basically lay out the technical plan, the human resource needs, the technology that would complement human resources, and then how that would all be implemented. So that's a plan and process that needs to be in place before there's any significant lightening up of social distancing. And beyond that, I can't comment more on it, not because there's any big secret, but we're just, we're still in the early stages of working through what is a substantial human resources, technical, and financial endeavor going forward.

Dave Somers: Great. Thank you doctor. I think that was our last question. I appreciate everybody being on today and we'll be back on Tuesday. Thank you.