TRANSCRIPT: Snohomish County Response to COVID-19, May 15, 2020, Briefing

Dr. Chris Spitters: So I just wanted to start off telling you that as of yesterday's accounting we had 3,049 cases of COVID-19 involving Snohomish County residents. Of these, 2,777 are confirmed cases, that is a positive PCR tests from the respiratory tract, and 295 are probable. Now, those two numbers don't exactly add up to the 3049 because of differences in the time of day when we got those numbers and finalized them, but they're roughly add up to 100%. And so about the 295 probable cases. Of those, 35 are folks who had a positive serologic test for COVID-19 and who, upon interview by the Health District, reported what we call a clinically compatible syndrome, a constellation of symptoms that sounds like it could have been COVID. And so those two in combination, according to the case surveillance guidelines, provide enough evidence for us to call them quote “a probable case.” And then we also have an additional 20 or 30 positive serologic results that have been reported in and that we have yet to interview the cases about that.

So that leads to, I think, the source of some of the questions that are out there because two of those individuals with the positive serologic results upon interview reported a COVID-like illness back in December 2019 which, as you know, is about a month or so prior to when we first recognized the initial detected case in Snohomish County in the individual who had arrived from China. And so, of course, that raises a lot of questions about when things really did begin in the U.S. here. So it leads me to want to address that because there was some reporting yesterday that I think expressed a higher level of confidence in the meaning of those two cases possibly attached to December than I as a public health official are we as an agency really feel. First is, is that the symptoms that those individuals reported, you know, overlap greatly with other respiratory tract infections. There was no testing of those infections that occurred at the time, so it's possible and frankly, I think, more likely that they had a non-COVID respiratory viral illness in December and subsequently had an asymptomatic or minimally symptomatic COVID infection, you know, subsequent to that and prior to now, prior to when they were tested. And, you know, there's a, there's a saying in medicine. When you hear hoof beats, think horses not zebras. And so, you know, the horse in that scenario would be that they had a non-COVID infection in December, and then subsequently got infected with COVID but didn't know it, developed antibodies, and then here we are. But it's, you know, I can't, we can't say that with 100% certainty. I think that's just the more likely scenario.

But I think the important overarching message is a couple of things. One is just to encourage you as we go forward, use of the word probable in public health case definitions has a completely different meaning than it does in day to day life, or even in clinical medicine. In fact, when you look through the guidelines for case surveillance, that's our national guidelines, there's a statement that says, you know, these are guidelines for public health case definitions and surveillance. Because we have to put situations in certain buckets and codify them so that we can count them and then move on. But that doesn't always mean that the clinical, that the surveillance coding or assignment matches the clinical diagnosis and many times people get managed clinically much differently than their surveillance diagnosis. So that's one thing is sort of caution around the meaning of the word probable in day to day life versus in public health case definitions.

The other was just, you know, the notion that I've sometimes seen that patient zero, the individual diagnosed in mid January, was the introduction of what is now occurring in the U.S. and that's that is clearly false. There have been multiple introductions of the virus into the U.S.

Molecular epidemiologic analysis has shown that, that there are multiple different strains of the virus. And although that strain introduced, or apparently introduced in mid January is the dominant one in this Pacific Northwest region or in Washington, it's, there are other strains that are dominant in other parts of the country. So this is a multi focal problem, not something that just spread from a single introduction

Needless to say, I think that that kind of brings us around to acknowledging that there is uncertainty about when exactly the virus was first introduced into the US, maybe it was that individual. That was the first introduction in January. It certainly wasn't the only one and, you know, I think it's reasonable to assume, given reports like the ones that we've had and others around the country, that introduction may have occurred prior to mid January, as we initially suspected. And while that's of scientific and academic interest, it doesn't really change where we sit today or where we have to move ahead in the future and our focus remains on suppressing transmission and safely navigating our ongoing attempts to incrementally return to economic, social, educational, spiritual and recreational activities that we hold dear and have had to forego in recent months, and, to a great extent, will still have to forgo a great deal of that in the future as we try to balance physical and economic and social well being in people moving ahead. And so I just urge your patience and that and apologize for any excitement, anxiety, what have you that the our communication in the past 24 hours created.

So with that, I'd like to turn it over to Executive Somers and thank you.

Executive Dave Somers: Dr. Spitters, there's two questions in the chat box really for you. One, is it easier for me to read it, or would you like to just read it?

Chris Spitters: I'll go ahead and read it, sure. Is this the one question from KNKX?

Dave Somers: Yes.

Chris Spitters: I interviewed a man whose 82 year old mother lived in a memory care facility and Everett and developed severe shortness of breath, and then died of acute respiratory failure at Providence hospital on February 22. He thinks it's a 50/50 chance that she had COVID-19 but that there was no testing done at that point. Do, do I think it is possible that she had coronavirus. Yes. Is there any effort underway in Snohomish County to re examine earlier deaths before the state's first official coronavirus deaths to see if they were due to coronavirus infections? No active efforts at this time. I'm certainly not pressing the medical examiner other folks to look back, I think resources are limited right now. And as I said, while that is of, certainly, you know academic and scientific interest to me and many people out there, I don't think it's really changing the where the needle is on what we're doing now and where we have to go. Someday maybe that work will be done, but it's not a, not a priority for the disease control operation moving forward. How would you go about doing it? Do you need blood or tissue samples and are those available to be analyzed? And I'll just confess my, you know, forensic and pathologic medicine is not my forte. It's possible that you know some tissues could be recovered and tested by the PCR test for that, keeping in mind that the long period of time since the person died probably affects the sensitivity and the ability to do the testing, getting consent from next of kin, medical examiner or other pathologist having the time to do that, you know, and the resources to do that are probably the main barriers. So both technical and resource. But, again, we know that it's conceivable that that work can be done, but I view that as a scientific endeavor and not a public health disease control endeavor at this time because whether, you know, the scenario raised right there sounds, you know, quite possible that that

was COVID-19 but it's not going to change what we have to do today and tomorrow and next week to get where we want to go.

There's, I'll handle a couple more of these questions, if that's okay. What are the implications of having had COVID-19 in the U.S. earlier than originally thought if that turns out to be the case. Well, then it arrived earlier than we thought. And that means they were probably more unrecognized cases, probably other unrecognized deaths like the one that we just addressed. But beyond that, again, I don't think it changes where we're at right now. And it changes what's in the rearview mirror but it doesn't change what's out in front of the windshield. So I'd say let's keep our hands on the steering wheel and off the rearview mirror. At least that's what we have to do with our limited resources and our, you know, our focus and mission is to deal with what's ahead.

Can you speak to the status of testing in the county, how extensive, how many given, what types, antibodies, serologic, plans for more extensive testing, etc?You know, yeah, this is a frequent question we have, and, and the answer remains that about 2,500 PCR tests are done weekly for COVID-19 mainly focused on people with symptoms of COVID-19 who are seeking care. Some care providers are also testing asymptomatic people who seek testing, although that's not our emphasis at this time. The health district’s testing activity right now is focused on long term care facilities, where we're testing anywhere from, you know, a couple of hundred to a few hundred staff and residents of long term care facilities weekly. And then our community based testing, meaning testing of non institutionalized people who are seeking testing who are unable or have chosen not to get it through their personal health care provider. We've done a little bit of that. We had that stretch in the drive through, a little bit smaller volume testing last week. This week we're more in planning phase for future community based testing, but we're looking, I think, to probably try to bring on you know 500 to 1,000 tests a week. Trying to get us up closer to three to 4,000, several community based settings have more capacity to do testing than they've had to do because demand is a little bit low. So our, our goal of having roughly 5000 cases, 5000 tests available weekly for diagnosis of current COVID-19 is ongoing and that's where things sit. The serologic testing again is really, we've talked about that before, and just to try to summarize, its main benefit right now, serologic testing, is for assessing the prevalence of prior infection in the population. Its accuracy in any single individual can be limited. Its ability, you know, we don't know whether presence of antibodies to COVID-19 affords any immunity to reinfection and, if so, for how long. So we're discouraging its use as a means for counseling individuals about their future risk of COVID-19 or their need to engage in social distancing or hygiene measures, and we're also discouraging its use for occupational placement, if you will, you know, for instance, someone who has a positive serologic test, does that mean we can put them in harm's way with greater confidence than someone who is sero negative? Possibly, but can't say probably or for sure. So we're discouraging that use. As time passes, hopefully we will develop greater certainty about that. And there you have it.

Dave Somers: Great. Thank you, doctor. Couple things today. First of all, obviously since the pandemic started we've really been fighting on two fronts. The first front is protecting people's health and protecting people's lives and to that effect we've been tracking how many people have been infected, how many people are dying, and how our healthcare systems are holding up and withstanding the extra demands. So that's been a major focus of all of us, obviously. The second priority and second front is really related to the economic impacts on people's lives by the stay at home efforts and social distancing efforts and there are just many families in the

county and across the region and state that have been very negatively impacted, in their everyday negatively impacted. And we're all very anxious to get going again. But in order to, there have been some resources, but in order to help today I'm announcing and proposing, along with the Council Chair Nate Nehring, the creation of two small business assistance programs. These are funded by the CARES Act dollars so passed down to us by Congress. The first program is we're calling Snohomish County Small Business Relief Recovery and Resiliency grant program. And this program will target, support the businesses that have really sustained the heaviest losses this year, particularly the service industry. The second program is we're calling the First in Flight fund and it will target Paine Field airport tenants and other aerospace businesses in Snohomish County that have been directly impacted by the virus. The Paine field airport is really an economic engine for the state, creates $60 billion in annual revenue to the state. It's really the backbone of our economy. So we really need to make sure that our small businesses there and our aerospace industry is assisted as much as we can through this. So both of these programs are meant to provide really a lifeline for small businesses and employees whose lives have been impacted by the virus and the proposal is going now to the county council for consideration and we hope that it will be adopted quickly so we can get those dollars flowing out to our businesses.

The total economic package that we're proposing is about $34 million in business support, small business support. So the two programs I just mentioned are really the first phase of that, and there'll be more to come. And each of those programs about seven, Seven and a half million dollars each. We've also watched the blue ribbon economic and workforce recovery Task Force and district advisory groups, and those have been meeting and we're taking input from businesses around the county and how we can best help them to weather the economic impacts and come out into recovery. We also created an Office of Economic Recovery and Resiliency at the county to really be a focal point for assistance out to businesses and we've also assisted in setting up a response fund with Community Foundation of Snohomish County and local partners. And lastly, we also did the extension of the deadline for individual property tax payers. So all these together are intended to be assistance to our small businesses and all the families that are hurting so badly during this pandemic, so that's it for me today, I will turn it over to Mark Murphy of our department of emergency management.

Mark Murphy (Department of Emergency Management): Alrighty. Good morning, and aloha Friday. So a little bit about the operations that we've been doing here at the county with resourcing, we have a staff that is basically a mixture of county departments and the health district. And we've been running the resourcing section where we try and source medical grade PPE for our responders and care communities. And also we are running a warehouse that we had to establish a bit over two months ago. We've been going pretty hard at this about eight months, or three months now. And just kind of give you a little bit idea, we've been out actively working to procure personal protective equipment medical grade. These are the gloves, the masks, the gowns, the NIOSH 95 higher filtration masks, things along those lines. But we've also been running a program through the state where they've been providing bulk PPE equipment to us.

And kind of give you an idea, we started out initially just supporting the five major hospitals, the 21 fire districts and departments, and the 13 law enforcement agencies. And then that has significantly grown to what our support base that we're providing support to, that jumped up to 623 long term care facilities and just recently 600-plus dental facilities. And to kind of give you

an idea of what that has kind of entailed, to this point, we've had over 2,603 individual requisitions and that could be anything from like two or three hundred boxes of masks to you name it.

And we've issued out over 4 million individual pieces of personal protective equipment, which is just absolutely stunning. One of my folks put together these numbers as we were reviewing the data and I'm just utterly humbled at how hard people have been working here. To give you an idea, we've issued about 87,000 face shields, 2 million gloves that's like 2 million individual gloves, 175,000 gowns or coveralls that the medical and EMS community use to protect themselves, 2,000 NIOSH 95 mask type respirators, and 1.5 million procedure masks. So a lot of effort going in there.

Dave Somers: Thank you, Mark. Do we have other questions?

Joint Information Center: This is Kari in the Joint Information Center. We're going to give it a minute here in case people are still typing, just to make sure we don't miss any questions. So if you do have questions please submit them by chat and submit them to everyone so all our speakers can see them.

Looks like our first question is for Dr. Spitters.

Chris Spitters: The question is, I'm interested in learning more about the other 35 cases involving positive serologic tests that are included as probable cases. Can you give a date range for when these individuals stated they had symptoms? I can't right now. I haven't talked to our epi staff about it. I know that the two that were back in December. But the others, I can't tell you. We'll try to let you know and follow up next week. I'll ask them to take a look at that.

Dave Somers: And doctor, there's also a question. Can you talk about the future of testing for the health district? Will there be another drive through site or setup like previously in Everett?

Chris Spitters: We do have planning underway for doing more testing. How exactly it's going to be fashioned, whether it's drive through or fixed site, you know, I'm kind of leaving it to the staff to work on those details, but we'll have information for next week, as Heather said, about what we call community based testing as opposed to institutional testing. Probably two days next week in the north end and then more to follow. And I'd say, stay tuned for that update. But that's the goal, as I said earlier, is to try to, you know, add maybe 500 1000 tests, maybe more per week to what's already available in the community.

Dave Somers: And also for you, Dr. Spitters. Any comment on the updates in treatment for COVID-19. At Providence, doctors are reporting a positive mortality benefit from Remdesivir.

Chris Spitters: Okay. Yeah, so there's no, there's definitely no magic, magic potion yet. The Remdesivir study sponsored by NIH showed a marginal reduction in duration of hospitalization amongst those who received at least one day of Remdesivir. I think it was 11 days in the group that got Remdesivir and 14 days on average in the group that did not. And mortality was lower but not statistically significantly so. So the difference, which I think was 11% mortality, hospital mortality, versus 8% mortality. Those, 11% in those who did not get it and 8% in those who did. So that, that provides a glimmer of hope, it was not a, like a substantial difference, and it was not statistically significant, meaning that the difference could have occurred by mere chance. So more work ahead on that but meanwhile Remdesivir has had emergency use authorization approval from the Food and Drug Administration and the manufacturer Gilead is working with

the federal government to try to make that drug available. So I would consider that sort of a mitigating factor, but it's not, you know, just reflecting on those figures I shared with you, I wouldn't consider that cure, but more of a treatment that has some partial benefit. Other than that, there are ongoing trials with the hydroxychloroquine, with some drugs used to suppress the immune system because it's felt that a lot of the severity of disease is actually due to our bodies, some people have sort of a hyper reaction to the virus that causes the severe illness, the difficulty breathing, organ failure and in some death. So trying to turn that off, in essence. But there's no cure yet and no findings reported from those other studies at this time. So the search the effort, the work is still ongoing.

Are there plans to include testing numbers on the health district's COVID county website. There's a bar chart now reporting positive versus negative results, but it would be great to have access to the data that generates this chart. Yeah, we just get that from the state health department's website. You can go to, you can google COVID-19, WA, Gov. Your first hit should be the DOH dashboard for COVID-19. Let that load, it takes about 10 seconds and then across the top of that there are five tabs, you know, they look at number of cases, hospital capacity, etc. One of the tabs is testing, you click on that, then go over to the county box, deselect the "select all counties," select Snohomish. And you can look at that 24 hours a day and get the numbers, specifically from that source. So there you have it.