COVID-19 Tribal Leadership Session Minutes
July 1, 2020

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*Over 60 participants attended today's meeting.

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Introduction to Meeting – Angie Gorn, NSHC CEO	**Today's Reminder:** - Angie Gorn is out of office and Kelly Bogart will be leading the call - Please keep phone muted unless speaking or asking a question - No call on Friday July 3rd - Tomorrow we will have some guest to answer some epidemiology questions Note- Any questions may be sent to Reba Lean at rlean@nshcorp.org anytime or text to 907-434-1927 and they will be answered during the 11:00 am call.
Medical Staff Briefing – Dr. Mark Peterson, NSHC Medical Director	**Dr. Mark Peterson gave medical staff update on the following:** • **Alaska:** 978 positive cases • **ANMC:** N/A • **NSHC:** 10 positive cases, 6 recovered, 4 active, 9,487 tests done, 3,727 unique patients, 7,875 negatives, 9 returned positive in our lab, 1,603 pending
Guest Speakers	**Dr. Bob Onders, Roald Helgeson with ANTHC and Dr. Cliff Schneider, infectious disease specialist in Anchorage introduced themselves and said thanks for being invited to today's call.**
Survey	**Megan gave update on survey:** - 910 people participate in the survey - Overall, our responses were extremely positive - This is for the Alaska Airlines mileage ticket and the winner is from Nome Charlotte Keyes
Question and Comments	○ **Are there specific data that ANTHC is looking at right now, doubling time models, or any data that you are looking at that were using to prepare for the future?** ▪ Dr. RH: I think we are looking at a lot of the same data that you present on a regular basics on these calls and what Alaska is presenting but also the situation unit monitors the case doubling rates and the rates hospitalization. One thing I would like to mention that we monitor very closely is supply change. Do we have adequate testing supply's, here at ANMC and in the regions? There are so many components to that supply change in order to provide testing both here in Anchorage and support the regions and their testing and PPE. To me that has been something that changes almost on the daily, weekly basics that really, we must monitor closely. This is kind of the key opportunity in the rural regions with potential increase risk with housing and sanitization is early identification and prevention. I think rural communities have a huge opportunity that we may not have in Anchorage right now with the connectiveness and the travel here

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	which is being less regulated in Anchorage. So right now, the ability for us to supply those is critical right now and that is a key monitor that we are doing on a regular basics. ○ **Antibody is a question that comes up and we have talked about it on this call and talked about the fact that incidents is low in our region and that it is not as accurate. Can you talk a little bit about antibody testing? Why you are offering it to employees and people there? How you think we may best use it? Is it useful or not useful? If you could speak to that.** ▪ **Dr. CS:** There are antibody test that are on the market. Some of them are more accurate then others. I think there's been reports of individual clinics in Anchorage using antibody test that are considered less accurate then others. My last understanding from our laboratory director is the antibody test that we have is the one that is thought to be most accurate. Not every antibody test is created equal that's my point there. What is the utility of the antibody test? I think there's two different prongs to that answer. One of them has to do with the population epidemiology type stuff and then there's the clinical piece. From a clinical stand point basically the most prominent use would be following up with somebody that had a positive PCR which you were suspicious of being a false positive or somebody who presented late in their illness and due to the change in viral dynamic of the illness and the increase change of getting a positive PCR the later you are when you present, following them up 28 days later to see if their antibodies are positive. Those are the biggest situation that you would clinically use it. We see situations where you have someone who has zero symptoms, minimal risk factors, but gets screened for PCR and PCR positive but multiple subsequence could quickly done PCR are negative and then we suspect false positives and false positives come up clinically with antibody. For the patient's own purpose and for better understanding PCR work and antibody works. Those are the two big clinical usage. I will all say that clinically there's yet any evidence that if you've been infected that you can't be re-infectious. We all suspect that getting the infection at least in this season differs immunity or partial immunity to infection. That's what we expect but there is no data to back that up yet or at least not in the data that I have seen published. People that I know in various places around the country that have told me that in data they have not seen reinfections but that is not published and so it is completely unformal. The point there is that if you have a positive antibody test on somebody you cannot tell them they are immune to reinfection. That would probably lead to decrease in vigilant with respect to social distancing, mask wearing, and all the other things that help prevent transmission. So that is the clinical side. Then there's the epidemiology side. Which is kind of outside my round since I am not an epidemiologist and the use would be to estimate population prevalence. In a low prevalence population, depending on the specificity of the test, you will have varying rates of false positive test which can complicate the message

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	you can give to people and the way that you can interpret data potentially. The antibody test and the PCR are approved for use under emergency use authorization which requires only that they have analytical validation in a laboratory not clinical validation. So typical test will not only be clinically validation, but they will also be clinically validated in studies basically. The test performance permeators for sensitivity that are publish with the package inserts for the labs are the analytical ones and may not translate to perform in a clinical setting. We have more data on how that works with a PCR and have seen zero data on how it works with the antibody. There's been some papers circulating but don't think they address that specific point. Then there is unpublished data that has been mentioned and don't think I would base anything off. If your resources are stretched thin and effort to adequate contact tracing positive PCR and isolation and quarantine for positives and if your resources are stretched thin with that and with the travel mandates and with the PCR testing I wouldn't threaten you efforts to have staff to be adequately staffed for contact tracing, quarantine, and PCR testing. I wouldn't compromise that for the antibody test. The antibody test won't help you control the pandemic. ○ **What are you seeing that makes you fearful of the current situation? Maybe the increase number of cases we are seeing, but what makes you confident that maybe in 9-12 months or sooner we will be over that?** ▪ **Dr. CS:** I think that with respect for confidence I feel good about our current situation with testing capacity and with PPE supplies. We were lucky in that other places were hit hard, and we haven't been yet, and we were given the opportunity to prepare adequately and we really didn't have a panic situation like other places the advance timing wasn't available. That makes me much more confidence. I think that any place in the United States that you would want to be right now is Alaska and that's because we were afforded that benefit which it could not be overstated on how much of a benefit that is to get resource with that capacity. I also think a more confident about how well we will do in Alaska. We do have overcrowding in rural regions, we don't have large complex's like apartment buildings that can be sources of out breaks. Those things make me feel good, and we have a lot of outdoor activities and still have our stuff outside. The recreational activities are more geared to outside in the urban setting and in the rural a lot of the subsistence actives are outside and transmission is felt to me more less like outside then it is inside because there's air current that disburse the droplets and makes them less dense in the air. So, to be able to get infected there are various things that must go into how transmission is spread. What makes me fearful is not specific to Alaska really, it's more specific to our country. Different countries have had different approaches with respect to recommendations for Lessing the pandemic and those are obviously essentially physically distancing and wearing masks around people that aren't part of your household, and hygiene.

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	Most importantly is physical distancing and mask wearing when you are around people that aren't in your household. Those are the things that make me fearful because it has become very politized and when you go out and about in Anchorage at least and maybe somewhat in Nome you want to go into some building and 80% of the people aren't adhering to those recommendations. That's what makes me fearful there is no control over that which is understandable because we have a free society. ○ **Do you expect to see more hospitalizations and deaths a month from now?** ▪ **Dr. CS:** If you are going to get hospitalized from COVID-19 it usually happens the second week of illness. When you see an up kick in infections, I would expect a delay in hospitalizations. We have seen an up kick in hospitalizations across the state and that is in the state data. The number of people who have been hospitalized I think is in the 60's now and it was much lower a month ago. I think it's just going to be a delay. We had a couple of weeks of 20 new diagnoses a day in younger people, but it takes time for that to increase and get into more at risk populations. There is going to be a delay for sure. ○ **Dr. Onders can we get an update on the cethead cartilages and do you happen to have an update on the M2000 that NSHC requested?** ▪ **Dr. O:** We are still working on both of those requests. The one missing link in testing is the higher capacity testing that is regionally based. We don't have that right now and finding some solution. What I heard on the cethead testing is that they can fill 5% of the order on a national basis. That makes me concerned that cethead is not going to be the answer regionally basis and we must investigate other testing solutions. There was a call this morning with the white house and congressional related to testing equipment. We are still advocating, and we think the need is to have that regionally based. No concrete answer right now. ○ **Are there out of state health care workers that are rotating into Alaska and if there are can that be stopped?** ▪ **Dr. S:** There are many out of state health care workers that travel to all regions of Alaska in order to provide care and each organization has their requirements of approving their plan with traveling staff with the state of Alaska. To answer the first question yes there are out of state workers that travel in and I think the second question is can this be stop and unfortunately I think probably the answer is no because we have a reliance on out of state healthcare workers to provide accurate access to care no just ANTHC or ANMC but I think all facilities. I think most regional facilities that I have spoken with have providers who travel back and forth to do their shifts or periods of work at the hospital. It's probably different for each organization but I would be surprised if that would be able to be stopped without causing a real problem with healthcare. I think that there are safe ways to litigate that. I mentioned each organization has their own policy about that and having them do testing with rules around wearing mask, symptoms

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	monitoring, and CDC based recommendation and I think those help eliminate the risk of healthcare workers bringing the spread in. I understand the concern, but I think the bigger concern is our own community and adhering to the recommendations to eliminate the spread of the pandemic. ▪ **Dr. P:** Norton Sound our providers any providers that come in from out of state we require a 7 day quarantine and testing on day 1 and 7. We have not had any incidences in our region where a health care has brought in COVID-19. o **Can you explain more about the false positives?** ▪ **Dr. P:** We have had a total of 9 cases in our region and I will say that only one of those has been symptomatic and the other 8 have been asymptomatic. I will say that at least 3 who popped up positive who really didn't have any contact with anyone that we know of. We talked on this call about how important it is to treat every positive as a true positive and because the risk is to high to not do so. However, like in other region we had a case where we had a positive, they were tested a few hours later and they were negative and had state swabs done for two days and those ended up being negative later and there was concerned if the Abbott ID Now is accurate or not. ▪ **Dr. S:** First thing I want to say the big point that you made already is that if someone is positive you have to manage them like they are positive because there is no gold standard test to be a tie breaker if it was a true positive or false positive. Just because you feel like you are seeing false positives you should not become less trustful in this data or alter the way you manage patients because of their test results. I think we must expect to see false positives. Even good test being done in a low prevalence situation will results in varying percentages of false positives or false negative results depending on the prevalence. I would not begin to doubt the use of the extremely resourceful available point of care test that we have called the Abbott ID Now. o **Can we talk about the upcoming flu season?** ▪ **Dr. S:** I don't know how to comment on that. There will be both viruses circulating and think we will get better at clinically identifying one from the other and just because you got influenza doesn't mean you don't have COVID-19. I think it has been very well reported that people coming in with two things with the virus. Maybe our flu season will be less impactful because we have closer attention to hygiene and all the various factors to limit the pandemic and it may limit the influenza season at that. o **Does food and diet have an impact with antibodies? Native traditional Diet vs process food diet.** ▪ **Dr. S:** If we are strictly talking about antibodies, I don't think your diet will really affect an antibody response to the infection. I think more to the question is do we expect folks who eat more of a traditional subsistence diet over a more processed food diet to have a higher or lower risk of having bad outcomes with the infection or are

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	potentially being able to avoid the infection? I think that in the short term the answer is probably no what diet you eat probably doesn't affect your risk of acquiring the disease. I think with diabetes, high blood pressure, obesity, those are severe risk factors with COVID-19. ▪ **MAS:** I was wondering if you could speak a little bit more about this question. I think also one of the answers is that eating processed food put's your immune system at a tough spot meaning there is more likely you will have death as a result with COVID. If you are a smoker, not eating healthy, that leaves your body less capable of fighting COVID. Whereas if you are eating a traditional native diet your immune system is strong and more able to fight COVID and be health. I think that is part of the discussion that was just not emphasized. ▪ **Dr. S:** What you eat for sure effects your immune system and it effects many things about your body and it is an interesting area of discussion and study. ○ **Request was made for ANMC to educate their patients that are traveling about quarantine and know the mandates for the villages.** ○ **If there is an asymptomatic patient in one of the villages, what would be your insight to the community? Would you tell them that maybe not to worry because the spread with an asymptomatic patient is lower than one that is symptomatic? Or would the chance of community spread be the same?** ▪ **Dr. S:** I don't think I would give a message of less concern because someone is asymptomatic. I don't think we fully know that honestly. I think what we do know is that the infection is most transmissible early in illness then later in illness most likely due to changing viral dynamic during the illness. If anything, I would emphases the isolation, contract tracing, social distancing, etc. that are already being emphasized for all cases. ○ **Gerald Brown, City Council Member, announced that the City of Nome is going to be having a work session on Monday July 6th to discuss the end of the emergency ordinance related to COVID-19. It's at 5pm at Old St. Joes. The current emergency ordinance is set to expire on July 14th. If anyone would like to express their thoughts to the City of Nome they can at the meeting or drop it off at the city hall or email them to any of the member of the council or John Handeland the mayor.** ○ **MAS: I think what might be helpful is public education on the risk of COVID to our community to vulnerable populations.** ○ **Was the 10th case patient showing symptoms?** ▪ Dr. P: No not at this point. ○ **Does the patient come just from Anchorage or were they passing through the lower 48 into Nome?** ▪ **Dr. P:** It's a good question but unfortunately, we cannot give that details. I can say that it appears to be travel related from an area from where there has been more COVID than our region here. ○ **Comment was made about possibly putting some education out that if you have traveled recently and feel fine you still may be a carrier and that**

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	quarantine is important. ○ **Do we know if the 10th case was going to travel outside of Nome within the region?** ▪ Dr. P: No. I will say that the state will say it's a Nome base case. There is no reason it couldn't have been. Imagine people going through without symptoms to the village. It's going to happen, so we need to continue testing in the villages and catch these early. The village travel requirements are so important. The villages are able to set their own travel requirements so please keep them strict and make sure to make it a requirement to test in Nome and to quarantine in the village when they get home to their village and test on day 7 so we can catch it in the village. ○ **How can a community enforce requiring quarantine?** ▪ **Dr. P:** If somebody has a positive COVID-19 test and refuses to isolate we can take legal action on that and they can be incarcerated and that has happened in the state already. We would have to get Dr. Zink to sign off if they are to be deemed to be public health hazard to others. It is difficult to make others quarantine and isolate. Its gets back to the education piece and the rest of us need to do it and do our public health duty to project the right message and image to others. ○ **MAS: A follow up from today's call. I think it would be helpful not only the importance of providing education at patient housing or around ANMC campus what quarantine requirements are but do they really understand or know the importance of quarantine and what does it mean when they choose to do quarantine. That deeper level of education to help people understand. I think that may be helpful as travel increases and that there are patients travel that we are providing the importance of quarantine.** ▪ RL: That is something that we are trying to do. We do hand out this information to patients that are traveling outside of the region. We are trying to cover all our basis for traveling patients so I can share the information that is going out with you so you can see exactly what they have their hands on.