

Transcription for Office Hours for Providers
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Presenters:

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Hugh:

All right everybody it is 12:30, let's get started. I want to thank you for participating in today's office hours. As a reminder, we established these a few months ago to maintain connection channels between DHHS providers and leaders about COVID-19. I am Hugh Tilson, director of AHEC program, I am moderating today, and as you can see we have great panelists. Dr. Betsy Tilson who is the state health director and Dr. Zack Moore who is the state epidemiologist and the chief of the epidemiology section. Based on feedback, Dr. Tilson and Moore have continued these through the end of the year. Thank you so much for your feedback and Betsy and Zack, thank you for making time for doing these. I know how busy you are and really, really appreciate it. Next slide.

We are going to let Betsy and Zack give a quick update and then we will turn to questions, as a reminder everybody is muted except for our speakers. Two-way questions, one is the Q&A feature at the bottom of the screen and the other is using email, which is questionscovid19forum@gmail.com, For those of you on the phone that is the way to submit questions.

We have updated links based on on-going activities, we want to make sure this is available to you. We are trying to make the links more accessible and we know we will post this later today, along with a recording. We are trying to figure out how we can get these links more available on a timely basis so you can click on them. And we are thinking through those options as we speak but we will post these on the AHEC website so you can have links. With that, I don't know if Betsy has gotten on you, it doesn't look like it.

Betsey:

No, she's here.

Hugh:

I Betsy, you made it.

Betsey:

I did.

Great, oh my pleasure, thank you all very, very much. I am happy to be with you all, this is actually, I really enjoy this and it is a lovely afternoon Friday time that I really look forward to it so thank you for allowing us this opportunity to talk with you directly.

There is a lot going on, and so I just wanted to proactively talk to you about some of the things that are on this, and some of the resources that you have. I am happy to answer any of the questions about this topic but I wanted to make sure you are aware of things that are going on and resources you have for that. The first one, and I know we have talked about this briefly in the past, but where we are with

the COVID-19 vaccination plan. We did submit that plan to the federal government last Friday, and they posted on our website, if you would like to look through the plan, including the two page executive summary, if you would prefer to see that instead of the 140 page plan that goes into more detail. But feel free if you want to read the 140 pages. I will note it is labeled interim plan, with a big draft watermark on it. That is intentional and that is actually by direction of the CDC, they said put draft on it because we know there is so much more information and guidance and things will change, and this will be a living, breathing document and we expect revisions. So don't think we posted it by mistake when it says it is a draft. We will be making revisions as we go more and more in there. Really, really high level about the plan. There was one that we have about guiding principles, of that plan which I think is really important because as the details will change, we want to be sure we are grounded in good guiding principles, you will see those in the executive summary in the plan. But, as our whole response to COVID, we went to have a lens of equity when we think about our vaccination plan. We want to think about inclusivity, with a lot of engaging internal and external partners to help formulate that plan, including including the North Carolina department of Medicine, an external advisory committee for us. Multiple stakeholders from family medicine, from the medical society, from our clinical partners. As well as experts in health equity and public health in marginal populations. You will see a list of who is involved in our advisory committee in the plan. Again, especially a nod to include leaders from historically marginalized populations, to make sure they are being treated equitably. We want to be as transparent and accurate as possible and pushing out public communication as much as we can. That's one of the reasons why we wanted to fully post that plan. We will be building an end-to-end data system to ensure we have good data that we need to have decision-making, but also have that publicly accessible data so people can see what we are doing, the progress we are doing and if there are gaps in coverage or equity, we can all work together to address that. And then to be sure we are using our resources as good stewards of our resources, and have quality improvement.

Some of our big chunks of planning and operational activity, is, again, engagement with our external stakeholders, communication. We expect there to be high vaccine hesitancy with the vaccine. So we are thinking about communication strategies and having tools which I will get to at that side. And then provider enrollment, outreach enrollment, in order for providers to be able to do COVID vaccines, they have to be enrolled with the federal program. So we are starting that enrollment already. We started with the health departments and hospitals, we are already enrolling them. And that we will be thinking through the providers to get to our long-term care settings and engaging pharmacists there. And then we will be working with providers that can get some of our critically marginalized populations: like our farmworkers, high risk folks in congregant settings, make sure we get those providers. And then will be rolling out more and more for a broader base of provider enrollment. We will also be building an end-to-end data reporting system in North Carolina. And I am sorry to say, and I will be the bearer of bad news, but our North Carolina innovation registry is not robust enough to have all of the reporting requirements, all the time limits of reporting, all the functionalities that are required for this specific vaccine. So we will have a separate system for this vaccine, that will interface and dovetail into an NCIR, so you can have that complete vaccination record in NCIR. But, there will be a separate system for the COVID vaccine. Let me be just transparent about that upfront. We need to get that up and functioning first, and then we will integrate it into NCIR and on the back and make everything as provider friendly as possible but that will not be there day one. So, let me just be the bearer of bad news.

Okay, so that is a little of our vaccination plan 101. What you have in this slide is some communication tools that we have put out already, thinking through an infographic that talks about the process of the production of COVID-19 vaccine. And then, I think it is a nice vaccine 101, feel free to take these tools and use them in whatever setting you may be doing-- outreach or talks. We are learning that people have a very low level of this vaccine literacy, at all. Like what will the vaccine do. So the deck walks through that, what does the vaccine do. Then it walks you through the

process of the COVID-19 specific vaccine and how is it that we are able to speed up production. And then it gives you an overview of the plan. Then there is a nice one page infographic on the process for specifically the COVID-19 vaccine, because that is driving a lot of hesitancy, people are equating speed with cutting quarters or efficacy. And we try to give you a nice one pager that you can understand yourself, because I think as healthcare providers, you need to be comfortable with the process. And then be able to articulate that to people who look to you as an authoritative voice, which you are. So that is all there.

The next chunk of stuff and Zack can talk a little more about this, but I guess Zack will talk about our rising numbers, we are having a rise in numbers that is making us very nervous. And it is widespread activity across the state, and we also wanted to get a little more targeted. New this week is a cluster report we have up on our website, you can see where all the clusters are. And of course, the clusters are not, they are a small portion of the total spread. But the clusters give you an idea of where the high risk settings are, and what we are finding in North Carolina, as across the country, it is the smaller social gatherings where people feel more comfortable, "I know you, you can't be infected." Our family gatherings, or social gatherings which we expect will increase as we move into the holiday season, very, very high risk. People aren't violating mass gatherings, they aren't being egregious, just the smaller, 10, 15, 20 social gatherings where it's spreading. But we are also finding a big uptick in spread in our religious settings. More so our churches and other religious settings. And so, what you see then is also linked to, we have guidance from private social gatherings, guidelines for get-togethers, please use those as tools, give them to your patients, talk through these are high risk categories-- just because you know the person doesn't mean they don't have COVID. So we want to give those tools and handouts to you, and we also have a faith leaders toolkit, if you're well-connected to your house of worship, to your faith leader, maybe your faith leader yourself, please, please, please help us reach out to faith leaders and think to how these congregations can keep everyone safe because we are seeing big rises in these settings. Also flu vaccine, COVID isn't the only vaccine, we also want to increase the flu vaccine. So the communications department and I did end up doing a video about the importance of the flu vaccine. It actually has a little video of me getting the flu vaccine. It is just a little one minute or maybe 1.15 minute video on the importance of the flu vaccine. For those of you who have closed circuit TV or run patient education in your waiting room, it is on our YouTube channel, feel free to use that if you would like. That is part of the encouragement to get the flu vaccine, and feel free to use that.

And, the only other thing is I hope everybody voted, I early voted today, yay. So make sure everybody is voting, it is an important piece that we can do to improve the health and well-being of all of us, is to be engaged in civic activity. So go vote.

That's it, we can go into any detailed questions you have about that, but I wanted to proactively make sure you knew those resources, and those are the kind of things we are working on. And I know that is a question that we can queue up with. And with that, I will turn it over to the illustrious Dr. Moore who can give us, Dr. Morris epi corner, which is what we are seeing. And he can do our Dr. Moore's epi corner.

Zack:

Okay.

Good afternoon everybody, I guess there are a couple things. In terms of trends, I think Betsy covered it. We are going in the wrong direction, as is most of the country, unfortunately. I mean after we had that sort of downward trajectory through September, we have been seeing an increase over the past few weeks and we are back pretty much to where we were, or even heading above where we were at our peak in July. And when we do look across, it is very spread out geographically, demographically, and we have seen a couple of trends lately where cases in rural counties have been driving the recent increases, more so than cases in our urban and suburban counties. We have also seen bigger numbers of white cases as opposed to non-Hispanic white cases, as opposed to other race

and ethnicity groups, driving the recent increases. But you know, as with all things data, it depends on how you look at it. The rate among white populations is still lower, on a per population basis, than among the LatinX population. And similar to the non-Hispanic black population, but those are a couple of the big picture demographic trends we are seeing. So I guess Betsy mentioned the cluster report, we are constantly trying to figure out ways to share with people, where exposures are most likely, and we really knew from the beginning, that it has been borne out with COVID, that although you can talk about the reproductive number and what number of infection are generated by each infected person, it's not sort of equal with COVID. A few cases result in a lot of transmission and most cases result in no transmission. So it is really important for us to identify and focus on the settings where we know transmission occurs. And it isn't rocket science, you know, it is indoor spaces with large numbers of people, where mask use and social distancing are not adhered to. We do know that ventilation plays a role. Not probably as big a role in general as the other things, but it is important, and the CDC, as you know, recently updated their transmission information to acknowledge, basically, the role of airborne transmission and the role that it can play in certain settings-- what they are calling opportunistic airborne transmission. And, again, we know where these types of settings are, but part of the reason for starting the post aggregate cluster data is to let people see where that is playing out in our cases and how it is reflected.

I guess, maybe a couple things to point out, that are on my mind, and maybe some of yours. First, and I think we have maybe talked about it here before, but there is now guidance from CDC, for clinicians on testing people with respiratory symptoms, when SARS-CoV-2 and influenza are circulating. That is something people have been asking about for a long time, and it will be coming out with an update in our guidance and it's already up on the CDC website so I would encourage you to take a look at that. I know it's a question that people get a lot, but long story short, it is split into people who require hospitalization and people who don't. If it is for outpatient, no hospitalization is required. But the recommended is to test those patients for SARS CoV 2 by a molecular test. Or, using an antigen test, if a molecular test is not available. With all the caveats around the antigen testing. And also it goes into guidance on the prescribing of antiviral treatment for influenza. I should say testing for influenza should be conducted if it will change your clinical management. So test for COVID, test for flu if it will change your clinical management. And then it goes into antiviral treatment. And if you get a positive influenza result or if you have COVID empirically based on the same criteria we always recommend during the flu season. People with progressive disease or people who are at high risk groups. And on the inpatient side, the recommendation is for a multiplex nucleic acid amplification test, to look for both SARS CoV 2 and influenza. And if that is not available, then PCR tests for both of those. I know that PCR tests are becoming more widely available, coming online in our state lab and it is being used for a lot of the specimens that we received. They typically recommend against rapid flu tests for hospitalized patients, which I think is a nice recommendation given the nature of those tests and the empiric treatment for people with severe, progressive illness that could be due to influenza. So, that is kind of it in a quick nutshell.

The other thing that I would point out, maybe, recently, two days ago, CDC came out with a change to their close contact definition to what was really more of a clarification than a change. To clarify that in 6 feet for 15 minutes or more, it doesn't have to be 15 consecutive minutes but cumulative over a 24 hour period. Meaning that if you were with somebody for five minutes at a time over three different occasions, that would count. So I think that has always been our understanding, that it was a cumulative number, we did not have that 24 hour time frame around it, so it is actually more specific for us. But that is, I think, it really emphasizes the point and importance of a couple things. The importance of physical distance as a control measure. You know, it is not just about the length of time, and we certainly don't want people to think that you can have a group of people together, in close quarters for 14 minutes and everything is fine. It also emphasizes the importance of layering the protection measures, it is not just about distancing or mask use or the timing, it is really sort of

about all those things together. So, just to be aware that that is out there. I think that is probably all the things that I would mention up-front. And, I will go ahead and move on into questions.

Hugh:

Great, thank you guys. We have gotten a couple questions in the Q&A, as well as some submitted earlier, and I forwarded those to you all. I did want to just make a quick observation, that we have put some of the links in the Q&A. Hopefully you can cut and paste those, and we will get this PowerPoint posted onto the NC AHEC website in the next 10 or 15 minutes.

So, let me start with some of these questions. **It is well known that N95 masks protect the wearing more thoroughly than K95 cloth and surgical masks, please comment on whether the N95 is more effective at preventing an infected person from successfully spreading the virus than are the others.**

Zack:

I would be happy to start, not that I have the answer. N95 masks are of course, primarily intended to protect the wearer from exposure. And not as a source control. And I think everyone is aware of that. That even pre-COVID we have generally relied on the use of surgical masks for source control. However, in terms of relative effectiveness, of course, there is a component that they do provide source control. I don't know, and maybe Betsy does, if there is any specific information about the relative effectiveness of N95s versus surgical masks or other types of mask as source control. Sounds like maybe not.

Hugh:

Sounds like maybe not. So while I have got you--

Betsy:

Wait, wait, I was muted-- I was talking but for some reason I was muted. So I was grateful for Zack getting some time because I was looking at that article from Duke that compared, that wasn't really the point of it, but it had compared a bunch of different masks in terms of looking at decreasing spread. I am trying to find that, and thinking through-- oh, it looks like they didn't include N95s in that one. Shoot, I was hoping to have an authoritative source on that. So, I think I can't add to what Zack had said.

Hugh:

If you want to keep looking, I will ask Zack the following question, **where are clusters at gyms categorized? I know that there are 2 in Wake County recently.** Is that a Zack or Betsy question?

Zack:

It should be a Zack question, I will pull it up because we went back and forth so many times on how we would categorize these things. We have not had many issues reported yet in gyms. As you know, they recently reopened and I think this is maybe a good time to sort of talk about what is and is not included in the cluster reports. These are the clusters that end up reported to us, so I think it is important to recognize that a lot of potential clusters may occur and not make it to our attention because people didn't get tested and diagnosed, or people didn't report those particular exposures. They either didn't answer the phone when somebody called to do the case investigation or didn't provide any information about where they had been. So clusters that you know, may occur that are not out there, or that haven't made it into public health reporting yet. So yeah, I think looking at it, the decision was made not to list those separately. At least at the time we were looking at this data, we didn't have clusters in that setting to include. So as we start to get reports from different settings,

we are going to likely be adding onto this report and putting in different categories that may start popping up or become more relevant.

Hugh:
Great.

Betsey:

With that I found the data point. So this is the study that came out of Duck looking at droplet transmission relative to the control of fitted N95 was .1% droplet transmission. They found that wearing a neck gaiter that you can stretch down really thin maybe increased droplet transmission. So a range from .1% for fitted N95s to 110% for a neck gaiter. So in this study and found that N95s were very effective in reducing droplet transmission.

Hugh:

Think you and I think this one may be for you, but I am not sure. **Where is the interim guidance for private social gatherings and guidelines for get-togethers?**

Betsey.

Yes, so again, that direct link. If you go into our website and click on guidance and go to phase three, which is the phase we are in, it is linked in that guidance. In that phase three guidance.

Hugh:

Thank you. **Somebody asked if they could put a link to the mask study in the chat, so if you could send that link, we could get that posted.**

Betsey:

Yeah, I could do that, the other thing is we actually have a whole fact sheet on all of the studies relating to masks, and I pulled this one out . So I could just send you or I could send to Nevin the fact sheet on all of the articles on masks. And then, you could have access to all of them, how about that? And then, I can put in the specific study I was highlighting. But I will send you that because there is a lot of conversation about masks and whether they work or not and really there is overwhelming evidence that they work. So, and we have tried to be able to give a variety of different study methodologies. There really is overwhelming evidence it is protected. So we want to be sure we have that in one place. I will send that to you all and I will just point out which is the specific study I was referencing.

Hugh:

Sounds great, thanks.

Lots of questions about back to school. **How are back to school vaccines going? Should practices be making any extra efforts to make sure kids get in before October 30th?**

Betsey:

Yeah, thank you for teeing that up. We have been spending a lot of time thinking about that. As you know, we did have that 30 day extension, well a little more than 30 days, of the health assessment of the vaccine. And then we proactively, our school health nurse team reached out to all of our school districts to find out how well we were doing. And, I am sad to say that across the board, we are way, way, way below where we usually are. Some of the health districts were saying this is the worst we have ever seen. There were two or three times the number of kids who are not meeting their requirements. Not exclusive to, but it does seem that the 12th grader, this new 12th grade meningococcal requirement is contributing to it. Not completely, when we looked at some districts it

was somewhere between 18% to a high of 60% of the kids that didn't have the vaccine were the 12 graders, so it is not just the 12th graders. But, it definitely seems to be contributing to it. So, that is a big problem, especially with our 12th graders because of the potential that it could threaten their graduation. We are also hearing from the provider side over the summer, providers saying we have tons of access, please get in. What we are now hearing is access is getting a little bit tighter now, and this will be hard. So make every effort you possibly can, yes, get your kids in but we are also considering whether or not we would think about delaying that deadline, again. So know that is on there, that we are considering it but please try to get kids in before that, but we are thinking very hard about extending that.

Hugh:

I don't know whether this is right, but the next question is does the department have any tools to support the new NCV44 requirement? Is that related to what you were just talking about?

Betsey:

Yes, that is the meningococcal vaccine, yes.

Hugh:

That is the disadvantage of being a lawyer, not a doctor.

Do kids need a negative COVID test to return to school?

Betsey:

So it depends, and we have that updated K-12 guidance. We do have that guidance that if providers can, they don't have to give what the alternative diagnosis is, if they can be really sure and feel comfortable saying that this person has a diagnosis other than COVID-19, let's say like a UTI. If that provider is very comfortable saying this person has something other than COVID-19, I can attest to that there is an alternative diagnosis, then they don't need a negative test. What I will say as we get more into the cold and flu season, just what Dr. Moore was saying, if somebody-- first of, just so you know, COVID can come in many flavors. All sorts of non-specific symptoms. So I would have a very low threshold for testing for COVID, just because we have widespread transmission and there can be so many nonspecific symptoms. So have a low threshold. But if you're exceedingly confident that they have something that explains their symptoms and they don't need a COVID test, then no you don't need to do that. But you do need to have a note that there is an alternative diagnosis. Just remember like in the beginning where we were, in February, you said okay, flu positive, great we don't have COVID. Well you can have flu and COVID, so just because you are flu positive doesn't mean you are COVID negative. It would be good to have a COVID test even if you have another positive. We are also hearing that people can be strep positive and COVID positive. So I would have a very low threshold for it, and I would be testing if you're doing other tests and not say that another diagnosis completely rules it out. But if it is something else, like a kid has a fever and a raging cellulitis or has abscesses or a UTI and it is just a fever, then okay. And if you feel comfortable with it. But just have a really thorough threshold. They do not need a negative COVID test if you are comfortable saying their symptoms are from another diagnosis. And recognizing there can be other co infections going on.

Zack:

If they do have respiratory symptoms, then we do recommend COVID testing, that is part of that algorithm that I just described. With COVID and flu. So in that situation, we certainly would recommend it. These discussions have partly been around, like Betsy said, we didn't want to create an obligation for providers to do COVID testing to get kids back in school when there was clearly some other cause, recognizing that the screening is pretty broad. So, we are trying to balance us,

recognizing on the other side that providers don't love being put in a position of having to provide these return to school notes. But, we needed a balance. Having some ability to have some flexibility for clinical decision-making. And again, if it is respiratory absolutely you should test. There is no other diagnosis that promises or assures us that a kid might not have COVID. That is just not possible. They could be asymptomatic, so we don't want to have it required for anybody who screens positive for symptoms to have to have that test if the clinician didn't think it was necessary.

Hugh:

This is a related question which is not just the testing, but kind of the isolation and or quarantining. Can you provide any advice for us with back to daycare school notes. We have been providing notes for symptoms we feel confident are not COVID. But if concerning URI symptoms are present or other concerning symptoms for COVID that they remain home for 10 days after the initial symptom onset, 72 hours fever free. We have not relied on negative COVID tests in order to return to school. If it is a known COVID exposure, we recommend a 14 day warranty regardless of testing results, does this approach sound reasonable?

Zack:

Yeah, except I would go from recommend to require if someone has a known COVID exposure. If someone has a known COVID exposure, then they are required to be quarantined for 14 days after the last exposure. And then, the criteria that are given for the return for somebody who is not tested for COVID, is a possibility the thing you all heard, for 10 days plus 24 hours fever free and other symptoms improving if they are in that category where there is an alternate diagnosis that has been provided and the provider decides testing is not needed. Then we don't require them to be out for 10 days. We would expect a more typical return to school, like we would sort of during a normal flu season.

Betsey:

There were two subtleties in there I wanted to pick up, whomever had suggested what their protocol is. They had the old version where you had to be fever free for 72 hours, I just wanted to be sure they were updated which Dr. Moore explained correctly, that that exclusion criteria was ten-day from the first day this season symptoms plus 24 hours fever free and symptoms improving. So that 72 was changed to 24. The other piece is to reiterate that you should not be required, if you are COVID positive, there should not be a requirement for follow-up COVID negative test before you can return to school. In fact, the requirement has changed that if you have a positive test, the recommendation is to not repeat a test for three months, after because you can get these residual PCR positives after the period of activity. So do not, for sure do not require a negative test after a positive test for returning to school. And recommend that you do not even repeat the test within three months because you could be getting these residual PCR positives and you will not know what to do. Just some detail on that.

Hugh:

Thank you. **Now that pharmacists can give more childhood vaccines, what are the reporting requirements to NCIR and back to the medical home?**

Betsey:

This is that HHS thing that has come out. So the first thing is under the PHE Act, the Public Health Emergency Act. It also says that although they are allowed, that new requirement still has to follow whatever state law is there. So that pharmacist still needs to follow the North Carolina state law. And so, North Carolina state law already allows for a pharmacist to vaccinate. It also requires that that immunizing pharmacist notifies the primary care provider and puts in that vaccine into the

immunization registry with the unfortunate exception of the flu vaccine, which is not required to be put flu NCIR, although they are encouraged to do that. So it doesn't change our North Carolina law.

Hugh:

Thank you. **Got a question about syringe shortages, and some facts that I had sent to you. Can y'all comment about syringe shortage, especially for pediatric patients?**

Betsey:

So what I know about it, and I will send it to some of our logistic people too, is that again, there is some-- in getting ready for this massive COVID vaccine campaign clinic and the federal government has gone to a couple suppliers in order to get the syringes. Because when the vaccine comes, it will come with the vaccine and the syringe and the alcohol swab and all the ancillary stuff you need to deliver a vaccine. So the federal government is working with the distributors to get all of their supplies. But not all of them. So I do know, I saw on that note that there were a couple suppliers that said they were out, but it is not like a universal, national shortage. So I would continue to encourage you to keep trying different distributor's, because there should be other distributors that have them. The federal government hasn't bought up all of the supplies, just a couple main distributors, so I would keep trying to find different distributors. I will say, this question has come up a lot and each time I circle back to some of our suppliers so I would keep trying to find another supplier. I will circle back to see if we have any more granular detail on what supplier we know has the supplies. But keep trying.

Hugh:

Thank you, just as a reminder to everybody if you have a question there is a Q&A future. Or you can send us an email at questionscovid19forum@gmail.com. **The next question is about Halloween. Any guidance for providers as they're intersecting with their families as they prepare for Halloween.**

Betsey:

We have guidance specifically around fall activities and Halloween. We have a several page guidance document, specifically on the safer alternatives to traditional Halloween activities. We talk about other, I will pull it up right now, so I will walk you through it. If you go to our website and on the top it says guidance, and you click on the big thing that says guidance and you scroll down and it says phase three easing of restrictions and there you will find all sorts of recent guidance. Including social gathering, including facemasks, and guidance for Halloween events. We posted that September 26th. And so, you can send this link out as well. It talks about lower, moderate and higher risk activities. The highest risk activity will be that traditional trick-or-treating, with hordes of kids going house to house and getting within six feet of an older person who is handing them candy. Or all reaching into a cauldron of candy and mixing up fomites, and that is probably not the best thing to do this year. So instead, we talk about, and the CDC has guidance as well, and we talk about having a more socially distanced party or social gathering, where people will be outside or in a park. And separate from each other. We also talk about some strategies for no and low touch trick-or-treating, and if you want to do more of that, a couple of things like if you have like a table, you can put out individual pieces of candy and the trick-or-treaters can come by and self-serve. From the candy that are separated or you can make little treat bags and leave them out for people. Or there is reverse trick-or-treating in your neighborhood where maybe the kids are in costume and people walk by and kind of toss the candy to the kids. There have also been creative things about a candy shoot where you can use PVC piping, if your house is such that you have stairs and a little, you could put the candy through a shoot. And so there are a lot of different strategies for low touch and no touch trick-or-treating as well as alternatives for traditional trick-or-treating. And kind of the more social

distanced gatherings. But this year, the traditional hordes of kids, walking from house to house, getting in close contact and getting candy from a group bowl is probably not the best thing to do this year.

I will send the link with this guidance, as well as the fact sheet to Hugh and Nevin, and they can load that up.

Hugh:

Sounds great, we don't have any other questions so either I can just keep talking and somebody will send one in, which sometimes happens, or you guys can say whatever you want to say in terms of thank you's and goodbyes and parting words. So let me turn it over to Jan. Any final comments for this group?

Zack:

Nothing specific from me-- just thanks to everyone for joining and for everything that you are doing. It is a critical, unfortunately, with the numbers going up. And we know that we could control this, if we could get everyone to do the right things. And so, it is again, as we said in previous calls, I appreciate all of your efforts to help use your positions and your trust with your patients and communities, to help reinforce those messages so that we can try to minimize this, as we get into the season when expect this virus will have advantages that it didn't have during the warmer, more humid months. So thanks everyone for all you are doing.

Betsey:

And I would echo that, I think that the science behind those 3W's is quite compelling. There was one of the great studies out of Thailand that looked at people, if a person was infected, the chance of somebody getting infected from that person and looked at the different control measures and the effectiveness of that. It found that if you achieve at social distancing, it decreased your infection by 85%. Wearing a mask was about 80%, staying less than 15 minutes was another 80% and washing your hands was like 67%. That is really high, think about that. Our typical vaccine, if you had 80% effectiveness with a vaccine, that is fairly high. So the science behind the 3 W's is really, really strong. It is the application of that, or the inconsistent application of that science that has gotten us into trouble. And, so, if you can, and it only so much voice we have, and so we really think through the trusted voices, the trusted leadership, the authoritative voices, there is a lot, as you know, a lot of misinformation and a lot of politicization of prevention right now, which shouldn't be but there is. So you all are respected leaders in your communities, and in your fields. Please, please, use that voice to promote prevention, because it works. And it can work. And it is what we need. We will not make it through this winter well, if people aren't practicing those three very simple methods. There is a lot of code fatigue, we are seeing more in rural areas. I am not sure where you are across the state, but especially if you are out in more rural areas, please use the authority of your voice and really promote, however you can, those 3W's. If we were all practicing it, we would be in a much better place than we are now. It is pretty simple and pretty low cost. So please, do that. Take that charge onto your shoulders, and think about what you can do to be promoting or it will be a pretty rough winter if we don't.

Hugh:

On that note, thank you all very much. I know how busy you are, really appreciate you carving out an hour for us every other Friday. To make sure that we can ask you questions and hear great advice. We will talk again in a couple weeks. Take care everybody.