SARS-CoV-2 and COVID-19 Executive Daily Digest
The University of Kansas Executive Daily COVID-19 Digest Working Group
DATE: May 5, 2020

Daily Overview
- This working group will provide daily evidence updates to healthcare providers, hospitals leadership, policymakers and the public on issues related to the coronavirus pandemic.
- The Daily COVID-19 Digest includes information about:
  (A) Tracking and Anticipating Spread and Hospitalizations
  (B) Health Care Decisions
  (C) Pharmacologic Treatment of COVID-19
  (D) Relevant Government Actions
  (E) Other Relevant Developments

Pandemic Status (as of May 4, 2020)

<table>
<thead>
<tr>
<th></th>
<th>Confirmed cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Kansas Health System*</td>
<td>455</td>
<td>14</td>
</tr>
<tr>
<td>Wyandotte county</td>
<td>879</td>
<td>61</td>
</tr>
<tr>
<td>Ford county</td>
<td>832</td>
<td>2</td>
</tr>
<tr>
<td>Finney county</td>
<td>586</td>
<td>3</td>
</tr>
<tr>
<td>Seward county</td>
<td>580</td>
<td>0</td>
</tr>
<tr>
<td>Leavenworth county</td>
<td>529</td>
<td>5</td>
</tr>
<tr>
<td>Johnson county</td>
<td>504</td>
<td>45</td>
</tr>
<tr>
<td>Sedgwick county</td>
<td>436</td>
<td>13</td>
</tr>
<tr>
<td>Lyon county</td>
<td>255</td>
<td>2</td>
</tr>
<tr>
<td>Shawnee county</td>
<td>128</td>
<td>5</td>
</tr>
<tr>
<td>Jackson county/MO</td>
<td>351</td>
<td>15</td>
</tr>
<tr>
<td>KS State</td>
<td>5,383</td>
<td>156</td>
</tr>
<tr>
<td>MO State</td>
<td>8,946</td>
<td>386</td>
</tr>
<tr>
<td>USA</td>
<td>1,210,742</td>
<td>69,788</td>
</tr>
<tr>
<td>Global</td>
<td>3,610,006</td>
<td>252,346</td>
</tr>
</tbody>
</table>

*TUKHS had a total of 132 hospital admissions.

By April 29, 2020, 55 clusters reported in KS

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Number of cases</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 clusters in long-term care facilities</td>
<td>401</td>
<td>68</td>
</tr>
<tr>
<td>20 private companies</td>
<td>170</td>
<td>4</td>
</tr>
<tr>
<td>6 meat packing plants</td>
<td>378</td>
<td>0</td>
</tr>
<tr>
<td>6 religious’ gatherings</td>
<td>99</td>
<td>8</td>
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<tr>
<td>2 group homes</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>2 healthcare facilities</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Lansing correctional facility</td>
<td>115</td>
<td>2</td>
</tr>
</tbody>
</table>
### Key Highlights

- The disproportionate number of cases to the population and the recent increase in numbers of admissions in the greater KS locations outside of KC and Wichita metro areas is concerning.
- Predictions in this document include Kansas State, KC metro, Wichita and greater KS locations outside of KC and Wichita metro areas. Rates of new COVID-19 cases in KS are affected by new cases identified in the KS regions outside of the KC/Wichita metro areas. It will be critical to follow these numbers closely and assess their effect on hospitalization and deaths over the next weeks.
- By April 29, 2020, a total of 55 clusters have been identified in KS. New clusters are contributing to the increased numbers of cases in the state mainly in the food processing industry, aggregate living including long-term care facilities, religious gatherings, workplace and a correctional facility.
- There are a multitude of different antibody tests for COVID-19 with variable performance. Tests vary in the viral antigen(s) they target. It is not yet clear which antibody responses, if any, are protective or sustained. A “positive” test is exceptionally difficult to interpret because the performance of these tests is not well known. For some assays both sensitivity and specificity may be poor, or at the very least undefined. Details in the digest [Link](#).
- Physical distancing and decreasing the number of contacts is working, and remains an essential element, to slow the spread of COVID-19 – ‘flatten the curve’. Stay home and stay safe!
- Assuming continued physical distancing at current levels, peak utilization is expected to occur between mid-April and mid-June 2020. The total peak number of hospitalizations range between 250 total hospitalizations in Kansas (best case) to 422 (worst case) in the models that are most closely matching the data to-date.
- Based on the best available evidence to date, until a sufficient medical intervention is able to be deployed broadly, it remains likely over the longer term that COVID-19 will persist in our community to varying degrees that will require continued management.
- Additional data through significantly expanded testing, and hospital reporting, will be critical for continued management of COVID-19 over the foreseeable future, including to ensure the most informed decision making by State and local government officials, and community leaders.

### A. Tracking and Anticipating Spread and Hospitalizations

#### Projected local spread

As of May 3rd, 2020 the available data on confirmed cases, hospitalizations, ICU use and deaths could be consistent with different predictive models. The updated predictions based on a variety of widely used models for COVID-19 pandemics suggest that:

- We are likely to experience a prolonged but **fluctuating plateau**. We remain uncertain about the "shape of the curve". We are likely to have a slower and more prolonged downward trend and could experience other “peaks” in the future.
- Data driven predictions are very close to actual observed numbers of deaths
- Data driven predictions are higher than actual observed numbers of cases- likely because of low testing except in the KS regions outside of the KC/Wichita metro areas (i.e Southwest Kansas) where reported cases are exceeding predictions. This relates to the identification of clusters in these areas.
- It will be critical to follow closely the number of new cases in different metro areas and assess their effect on hospitalization and deaths over the next weeks.
- There is more uncertainty about hospitalization data because of different assumptions (e.g. proportion of cases hospitalized, length of stay...etc). However, no matter what model we use, it is very unlikely that we will reach healthcare capacity in the next 4 weeks at the state level. However, metro areas with small hospitals and limited inpatients and intensive care capacity may reach capacity rapidly.
Having accurate data about cases, hospitalizations, and deaths is essential to ensure we can identify early any concerning signs of another “peak”.

We will continue to update the models according to actual data and continue to test the models assumptions daily.
Notes about graphs on previous page: Data accessed May 3rd, 2020 at [https://github.com/nytimes/covid-19-data](https://github.com/nytimes/covid-19-data) and at [https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/](https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/). Parabolic models are estimated with a constant, linear and quadratic terms for number of days since the initial case was reported in each state (beginning January 25, 2020). This functional form allows for the possibility that the increase in the number of cases could decrease, i.e. that mitigation efforts could ‘flatten the curve’ (in contrast to continued exponential growth). This framework allows for the calculation of the maximum number of new cases (e.g. where the curve reaches a maximum and begins to decline).
Estimates from the IHME (Institute for Health Metrics and Evaluation) at the University of Washington are derived from the implied death rate using reported CDC statistics\(^1\). The revised IHME model was updated multiple times, with the latest update on April 27, 2020 after revising estimates based on additional available data and assumptions. Estimates were revised to better fit observed data including adjustments to account for international data, to allow for different effects of social distancing across locations, and to better fit areas with a small number of confirmed cases. Importantly, the revised IHME model assumes physical distancing using the New Zealand Government alert system Level 4 which is consistent with existing, robust physical distancing in effect in Kansas as of April 1\(^{st}\), and this model assumes that these physical distancing measures will stay in place until the end of May.

CHIME model estimates generated at https://penn-chime.phl.io/. Inputs for population (KS, 2,814,700; KC, 2,501,151; Wichita, 675,126), market share (100%), date of first reported case (3/7/20 for KS and KC, 3/13/20 for Wichita), and previous number of hospitalizations (KS, 263; KC, 200; Wichita, 30). Default values were used for all other parameters. Population for KC and Wichita includes counties in the Combined Statistical Area (CSA) as defined by the US Census Bureau. The CHIME model, as depicted, was run as of April 1\(^{st}\), and assumes a constant rate of additional COVID-19 hospitalizations based on trends on that date. The mitigation effects of government mandated physical distancing on COVID-19 hospitalizations were not fully apparent as of April 1\(^{st}\). This model has been revised to account for changes in hospital treatment variables, such as hospital length of stay. Unlike the revised IHME model, however, it has not been revised to account for the additional effects of physical distancing that have been realized.

The numbers of new cases and hospitalizations in other areas in the state are small and insufficient to make accurate forecasting predictions.

The effect of physical distancing on the number of contacts and the extent of the infection

The basic rate of infection spread depends on (a) the period of infectiousness (approx. 14 days); (b) the number of close contacts a person has, and (c) the likelihood of transmission of the virus to a susceptible person with each contact. The primary goal of physical distancing is to reduce the effective rate of infection by reducing the number of contacts each person has. There is incomplete understanding of how physical distancing efforts have influenced the number of close contacts the average individual has. Agent-based transmission models simulate daily interactions between people and can project the fraction of the population that will become infected under various social-distancing scenarios. An example is presented in appendix 1.

B. Health care decisions

Personal protective equipment (PPE) for health care personal and patients in the hospital

PPE for healthcare personnel is needed to protect both individual providers and the healthcare system itself. Inadequate PPE supply may result in shortage of healthcare personnel due to infection and/or quarantine. Infected healthcare personnel may also act as a vector for transmission to patients. Hospitals and healthcare systems, including TUKHS, face challenges in projecting PPE requirements and availability. Projections of future health system PPE use follow projections for total number of persons under investigation (PUIs) or contracts hospitalized, and ICU patients, emphasizing the urgency of reliable projections.

Additional information about spread of COVID-19 disease and different PPE can be found in appendix 2.

Information needed to make informed projections about the required PPE during the pandemic

- Reports of number of patients hospitalized, admitted to the ICU and requiring mechanical ventilation (available from data about hospitalized patients)
- Estimates of forecast of number of patients hospitalized, admitted to the ICU and requiring mechanical ventilation with best- and worst-estimate of when the peak will occur (best and worst-case scenarios)
- Historic utilization of PPE per isolated patient (available from data about hospitalized patients)
C. Pharmacologic Treatment of COVID-19

- On May 1, 2020, the FDA issued an Emergency Use Authorization (EUA) for Remdesivir to treat hospitalized patients with severe COVID-19.
- On April 24, 2020, the FDA issues a warning for use of hydroxychloroquine or chloroquine for COVID-19 outside of the hospital setting or a clinical trial due to risk of heart rhythm problems.
- On April 3, 2020, the FDA approved plans for nationwide trials of the convalescent plasma and hyperimmune globulin.
- On March 27, 2020, FDA approved compassionate use of convalescent plasma for serious or immediately life-threatening COVID-19 infections under a single patient emergency Investigational New Drug authorization.
- Regimens under investigation (excluding vaccine candidates): Sarilumab (antibody against IL-6R-alpha), Tocilizumab (more potent antibody against IL-6), Nitric Oxide gas inhalation, Remdesivir, Chloroquine or Hydroxychloroquine, monoclonal antibodies from convalescent serum, Lopinavir-Ritonavir combination, Lopinavir-Ritonavir combination + interferon-beta.
- There are >1000 clinical trials worldwide of various regimen from the list above. Interactive figures and raw data of all COVID19 trials.

D. Relevant legislative actions

As part of ongoing efforts to limit the spread of COVID-19:
- On April 30, 2020, Governor Laura Kelly announced that the statewide "Safer-at-Home" order will lift Monday May 4, 2020, followed by a phased-in approach to reopening the state.
- On April 30, 2020, Johnson County, KS, announced extending the stay-at-home order through Sunday, May 10. A phased re-opening of businesses in the county is set to begin May 11.
- On April 30, 2020, Mayor Quinton Lucas announced the city's new 10/10/10 Plan which will be set to motion on May 15.
- On April 28, 2020, the president signed an executive order invoking the Defense Protection Act to keep meat processing plants open.
- On April 15, 2020, Governor Laura Kelly extended the statewide stay-home order until May 3rd 2020.
- On April 15, 2020, Governor Laura Kelly extended the statewide stay-home order until May 3rd 2020.
- On March 29, 2020, the president extended the nationwide social distancing guidelines for another 30 days, to end on April 30th 2020.
- On March 28, 2020, Governor Laura Kelly issued Executive Order to institute a temporary, statewide stay-home order for 21 days, to end on April 19th 2020.

E. Other Relevant Developments

Testing
- Wyandotte County expands testing in long-term care facilities.
- Expanding testing and more sustained strategies for widespread testing and surveillance are going to be essential to follow up the true impact of this pandemic.
- On May, 4, 2020, the Food and Drug Administration (FDA) raises standards and issues new guidance about tests including antibody testing during the pandemic. Tests have to meet standards for quality and accuracy. This development is an effort to control the influx of > 100 commercial coronavirus antibody tests on the marker without full review.
- On April 1, 2020, the FDA issued an Emergency Use Authorization (EUA) for a qualitative test for the detection of IgM and IgG antibodies against SARS-CoV-2. When evaluating the available data, serologic testing appears promising to advance the knowledge about diagnosis and immunology of COVID-19. However, it may not be ready for wide use among the public yet.
  - There are a multitude of different antibody tests for COVID-19 with variable performance. Tests vary in the viral antigen(s) they target. It is not yet clear which antibody responses, if any, are protective or sustained.
  - The antibody response in infected patients remains largely unknown, and the clinical values of antibody testing have not been fully demonstrated.
  - A "positive" test is exceptionally difficult to interpret because the performance of these tests is not well known. For some assays both sensitivity and specificity may be poor, or at the very least undefined.
  - Some FDA-authorized COVID-19 antibody tests are estimated to have 96-98% specificity, which would mean that a positive test result is more likely to be a false-positive result than a true positive result in low prevalence area like KS.
- Using saliva samples to test for COVID-19 is promising but may not be ready for wide implementation. The specifics about how saliva is collected (e.g after cough or not) makes a big difference in the accuracy of the results. Additionally, saliva is complex matrix and clinical laboratories will need to carefully assess RNA stability during specimen transport and the efficiency of nucleic acid extraction using their own specific methods. Which has to be established before accepting this specimen type.
• Multiple Counties expanded community-based testing programs that has increased the number of tests performed on community members. This will likely increase the numbers of new cases diagnosed. It should be noted, however, that this should not increase the number of hospitalizations unless there is an increase in the number of cases beyond the increase in testing.

Social impact

• The Center for Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) issues Interim Guidance for the meat and poultry processing workers and employers
• New clusters are contributing to the increased numbers of cases in the state mainly in the food processing industry, long-term care facilities, religious gatherings and a correctional facility.
• Data suggests racial/ethnic and socioeconomic disparities affecting the case detection and fatality rates of patients with COVID-19.
• On April 3, 2020, The CDC recommended wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain (e.g., grocery stores and pharmacies), especially in areas of significant community-based transmission. This recommendation is meant to address the high rates of asymptomatic patients in the community who may be able to spread the virus. Wearing a face mask in a community setting does not protect the wearer from acquiring infection. Understanding of the transmission risk associated with wearing a face mask remains incomplete; however, COVID-19 is thought to spread mainly through close contact from person-to-person in respiratory droplets from someone who is infected.

Update
This is a living document. Information in this document will need to be revised and updated in the near future. We will conduct ongoing reviews of the available evidence and continuously monitor the data to determine if information require modification. Based on the rapidly evolving nature of this pandemic, information will likely need to be updated daily. This document is not intended to establish clinical practice guidelines or the standard of care. Physicians should exercise their own clinical judgement in the care of individual patients.
Appendix 1

Agent-based transmission models simulate daily interactions between people and can project the fraction of the population that will become infected under various social-distancing scenarios (figure below; for example, the blue trace demonstrates active infections under the assumption of 6 contacts per person per day before physical distancing and 2 contacts per person per day after social distancing). Making different assumptions substantially alters the projections for the total fraction of the population eventually affected (<5% vs. > 15%). The impact of physical distancing dramatically affects the number of individuals needing hospitalizations and/or intensive care (including mechanical ventilation). The model with 3 daily contacts suggests about 1,000 hospitalizations in KS at peak versus 14,000 hospitalizations with 4 daily contacts. Reduction in the number of contacts is the goal of physical distancing. Every effort must be made to maximize adherence by citizens to participate in the ‘stay at home’ orders and minimize physical contact with others to whom they could unintentionally transmit the virus.
SARS-CoV-2 is spread via respiratory droplets from talking, coughing, sneezing, and close contact with symptomatic individuals. Procedures like surgery, endoscopy or bronchoscopy can also lead to aerosolization and subsequent airborne transmission. Human-to-human transmission can occur from unknown infected persons (e.g. asymptomatic carriers or individuals with mild symptoms) as well as individuals with virus shedding during the pre-incubation period before symptoms develop. Data related to the spread of SARS-CoV-2 in the early phase of the pandemic have confirmed that healthcare personnel are at higher risk of infection than the general population. Several types of PPE are available and summarized below. The WHO has issued guidance on the use of PPE, following a three-pronged strategy: (1) minimize the need for PPE, (2) ensure PPE use is rational and appropriate, and (3) coordinate PPE supply chain management mechanisms. WHO has developed recommendations for PPE use. KUHS Infection Prevention has developed similar, parallel, recommendations.

<table>
<thead>
<tr>
<th>Types of PPE</th>
<th>Use</th>
<th>Pros and Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical or medical masks</td>
<td>Droplet precautions: block large particles (&gt;5 μm)</td>
<td>Widely available &lt;br&gt;- Does not require fit testing &lt;br&gt;- Cannot be re-used</td>
</tr>
<tr>
<td>N95 mask respirator</td>
<td>Filter at least 95% of aerosols (&lt;5 μm) and droplet-size (&gt;5μm) particles</td>
<td>Requires fit testing &lt;br&gt;- Can be used for an extended period and re-sterilized</td>
</tr>
<tr>
<td>Powered air-purifying Respirator (PAPRs)</td>
<td>Provide high level protection from common airborne viruses that exceed N95 face masks</td>
<td>Does not require fit testing &lt;br&gt;- Provides head and neck protection &lt;br&gt;- Can be re-used by the same healthcare provider</td>
</tr>
<tr>
<td>Gloves</td>
<td>- Does not require fit testing &lt;br&gt;- cannot be reused</td>
<td>- Does not require fit testing</td>
</tr>
<tr>
<td>Gowns</td>
<td>- Does not require fit testing</td>
<td>- Does not require fit testing</td>
</tr>
</tbody>
</table>

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References


