SARS-CoV-2 and COVID-19 Executive Daily Digest
The University of Kansas Executive Daily COVID-19 Digest Working Group

DATE: June 4, 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 June 3rd, 2020)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Confirmed cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Kansas Health System*</td>
<td>1057</td>
<td>20</td>
</tr>
<tr>
<td>Ford county</td>
<td>1794</td>
<td>8</td>
</tr>
<tr>
<td>Finney county</td>
<td>1518</td>
<td>10</td>
</tr>
<tr>
<td>Wyandotte county</td>
<td>1419</td>
<td>74</td>
</tr>
<tr>
<td>Leavenworth county</td>
<td>1094</td>
<td>7</td>
</tr>
<tr>
<td>Seward county</td>
<td>888</td>
<td>2</td>
</tr>
<tr>
<td>Johnson county</td>
<td>865</td>
<td>66</td>
</tr>
<tr>
<td>Sedgwick county</td>
<td>616</td>
<td>21</td>
</tr>
<tr>
<td>Lyon county</td>
<td>377</td>
<td>5</td>
</tr>
<tr>
<td>Shawnee county</td>
<td>334</td>
<td>7</td>
</tr>
<tr>
<td>Jackson/KS</td>
<td>102</td>
<td>1</td>
</tr>
<tr>
<td>Jackson/MO</td>
<td>656</td>
<td>22</td>
</tr>
<tr>
<td>KS State</td>
<td>10,092</td>
<td>224</td>
</tr>
<tr>
<td>MO State</td>
<td>14,189</td>
<td>791</td>
</tr>
<tr>
<td>USA</td>
<td>1,894,846</td>
<td>108,806</td>
</tr>
<tr>
<td>Global</td>
<td>6,542,851</td>
<td>386,581</td>
</tr>
</tbody>
</table>

*TKUHS had a total of 250 hospital admissions. TKUHS changed the way data is reported starting early June which may affect the numbers when compared to the last few days.

By June 3rd, 2020, 135 clusters (92 active and 43 closed) with 5,244 cases and 152 deaths reported in KS*

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Number of cases</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 private companies (17 closed)</td>
<td>460</td>
<td>5</td>
</tr>
<tr>
<td>34 long-term care facilities (11 closed)</td>
<td>731</td>
<td>117</td>
</tr>
<tr>
<td>14 gatherings including religious’ gathering (8 closed)</td>
<td>168</td>
<td>12</td>
</tr>
<tr>
<td>10 meat packing plants</td>
<td>2,767</td>
<td>10</td>
</tr>
<tr>
<td>6 group homes (4 closed)</td>
<td>54</td>
<td>2</td>
</tr>
<tr>
<td>5 healthcare facilities (3 closed)</td>
<td>44</td>
<td>0</td>
</tr>
<tr>
<td>3 correctional facilities</td>
<td>1018</td>
<td>6</td>
</tr>
<tr>
<td>1 School/Childcare</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

*https://www.coronavirus.kdheks.gov/DocumentCenter/View/1125/Historical---June-1?bidId=&fbclid=IwAR0ktLAZK8xhzMmdIlIV99RVt8YpuBj2EElcy-mQJVKG22P3eaTdDHMjrV0Q
### Key Highlights

- Concerning increase in COVID-19 related hospitalizations and deaths are noted. Predictions herein include Kansas state, KC metro, Wichita and greater KS locations (outside of KC and Wichita metro areas). Close monitoring of COVID-related infections, hospitalizations and deaths remains critical over the next weeks.
- By June 3, 2020, 135 clusters have been identified in KS, of which 92 remains active. New clusters contribute to the increased numbers of cases in KS. Clusters are associated with private companies, aggregate living including long-term care facilities, food processing facilities, large gatherings including religious gatherings, and correctional facilities.
- Deaths among long-term care facilities account for > 50% of COVID-19 related deaths in KS.
- On May 25, 2020, the FDA pulled 27 antibody tests that are not following guidance.
- People’s behavior does not always correlate with restriction and re-opening policies. Reported mobility data provides insight into this issue. [link](#)
- Many antibody tests for COVID-19 exist, but 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. The positive predictive value of even an excellent diagnostic test may be low when testing persons who are unlikely to be infected. This issue is discussed in greater detail below. [Link](#)
- Based on the best available evidence to date, until a sufficient medical intervention is able to be deployed broadly, a vaccine is developed, or testing/contact tracing resources become more plentiful, 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 June 3rd, 2020 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 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 and cases. The increase in cases relates to the identification of clusters in the KC metro and the greater KS locations (outside of KC and Wichita metro 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.
- Surveillance of cases, hospitalizations, and deaths is essential to ensure early identification of another “peak” and understand the effect of behavioral and policy effects on disease spread. COVID-19 related death is the most robustly reported data point. Because death occurs late in the disease process, however, disease-promoting behaviors or policies may be in effect for many days or weeks before increasing COVID-19-related deaths are observed. New cases and hospitalizations are also lagging indicators of disease spread.
• No matter what model we use, however, it is very unlikely that we will reach healthcare capacity at the state level. Metro areas with small hospitals and limited inpatients and intensive care capacity remain at risk of reaching capacity rapidly.
Green lines indicate actual events and blue lines indicate calculated events based on actual data of the number of cases. Detailed notes about graphs: in Appendix 1. There is no accurate data about hospital census at this point.

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.

B. Pharmacologic Treatment of COVID-19
- On June 3rd, the New England Journal of Medicine published the results of the first study about using hydroxychloroquine for prophylaxis after exposure. The authors concluded that “After high-risk or moderate-risk exposure to Covid-19, hydroxychloroquine did not prevent illness compatible with Covid-19 or confirmed infection when used as postexposure prophylaxis within 4 days after exposure”.
- On June 3rd, The World Health Organization (WHO) resumed the hydroxychloroquine arm of the SOLIDARITY trial after reviewing safety data.
- There are reports questioning the validity of the Surgisphere data that is the bases for the two large publications in the Lancet and NEJM. Both journals issues statement of concern and are investigating the matter.
- By May 15, 2020, Kansas received 36 cases of Remdesivir which are being distributed to hospitals with COVID-19 patients.
• 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 28, 2020, the FDA issued an Emergency Use Authorization (EUA) for emergency use of oral formulations of chloroquine phosphate and hydroxychloroquine sulfate for the treatment of COVID-19.

• 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.

• There are >1000 clinical trials worldwide of various regimen from the list above. Interactive figures and raw data of all COVID19 trials.

• SOLIDARITY trial: (Remdesivir; Lopinavir/Ritonavir; Lopinavir/Ritonavir with Interferon beta-1a; and chloroquine or Hydroxychloroquine) Large global 4-arm randomized clinical trial launched by the WHO on 3/20/2020 with a sample size of 10,000 hospitalized patients.

• DISCOVERY: French add-on study to SOLIDARITY with 3200 participants in France, with a similar design and drug regimen as SOLIDARITY.

• U.S. Clinical Trials: a large number of actively recruiting clinical trials using sarilumab, nitric oxide gas inhalation, remdesivir, hydroxychloroquine, monoclonal antibodies from convalescent serum or lopinavir-ritonavir combination.

• A registry of clinical trials can be found on the WHO and clinicaltrials.gov websites.

C. Relevant legislative actions

As part of ongoing efforts to limit the spread of COVID-19:

• On May 26th, Governor Kelly vetoed a bill that limited power, signed a new state disaster declaration, lifted statewide order and returned control to counties and called a special session of the Kansas Legislature.

• On May 14, 2020, Governor Laura Kelly announced a new “1.5” phase in KS, effective May 18th, which continues reopening efforts while preserving some data-driven restrictions necessary to prevent community transmission 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, Wyandotete County, KS, announced working in concert with Johnson County, KS, in extending its stay at home order through Sunday, May 10.

• 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. Under this plan, businesses may open with 10% of building occupancy (or 10 persons, whichever is greater). Customers remaining inside a business for more than 10 minutes will be required to provide their contact information, to support contact tracing.

• On April 28, 2020, President Trump signed an executive order invoking the Defense Protection Act to keep meat processing plants open.
D. Other Relevant Developments

Testing

- On May 25, 2020, FDA pulled 27 antibody tests that are not following guidance. A list of these tests can be found under the FAQs on Testing for SARS-CoV-2.
- Emerging data highlights the poor accuracy of some of the COVID-19 testing when evaluated in clinical settings.
- On May 9, 2020, the Food and Drug Administration (FDA) issues and Emergency Use Authorization (EUA) for the first COVID-19 Antigen test. The Antigen test is very specific, so when the results are positive it is confirmatory of having COVID-19. However, the test is not sensitive and has a high rate of false negative results, so a negative test cannot rule out having COVID-19.
- 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, for several reasons:
  - 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.

Social impact

- People’s behavior does not always correlate with restriction and re-opening policies. Reported mobility data provides insight into this issue. Different sources report on mobility data that can be tracked at a country, state and county level.
- Different studies found a high prevalence of “asymptomatic” infections in congregate living situations. In one of the studies, 81% of passengers and crew on an expedition cruise ship who tested positive for
SARS-CoV-2 showed no signs of illness. Data from Lansing correctional facility, showed that out >2000 people tested, 818 confirmed positive tests but > 700 of the total positive cases have been asymptomatic.

- A retrospective cohort study published in the New England Journal of Medicine from Ochsner Health in Louisiana underscored the racial disparity of the Covid-19 pandemic. While African American comprise 31% of the health system’s population, 76.9% of the patients who were hospitalized with Covid-19 and 70.6% of those who died were African Americans. However, after adjusting for sociodemographic and clinical characteristics, in-hospital death did not differ between the black and white population.
- The Center for Disease Control (CDC) issues reopening guidance for cleaning and disinfecting public spaces, workplaces, businesses, schools, and homes.
- The CDC and Occupational Safety and Health Administration (OSHA) issued 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, 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.

References
This KU COVID-19 Executive Digest is authored and updated by Reem A. Mustafa and Tami Gurley-Calvez (lead authors), Daniel Parente, Mark Meyer, Robert Moser, David Wild, Jack Beal, Edward Ellerbeck, Ian Thompson, Laura Mussulman, Caitlin Smith, Christian Dodge, Akinlolu Ojo and Joseph LeMaster.
Appendix 1
Data accessed June 3rd, 2020 at https://github.com/nytimes/covid-19-data and at 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. The revised IHME model was updated multiple times, with the latest update on May 26, 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 1st, and this model assumes that these physical distancing measures will stay in place until the end of May. This assumption may be violated in Kansas during phased re-opening beginning in early to mid-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 1st, 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 1st. 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.
Appendix 2
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.

**Personal protective equipment (PPE) for healthcare 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 the University of Kansas Health System, 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.

**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)
- PPE required per COVID-19 positive/suspected patient (available from data about hospitalized patients)
- Historical hospital market share, and projections of whether this is expected to remain stable throughout the course of COVID-19 surge
- Expected number and severity of cases in a specific hospital (both total and per week)
- Period of time that social distancing/community mitigation strategies must remain in place to manage the outbreak

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**Types of PPE**

<table>
<thead>
<tr>
<th>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; Does not require fit testing; 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; 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 - Provides head and neck protection - Can be re-used by the same healthcare provider</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Gloves</td>
<td>- Does not require fit testing - 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>
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</tbody>
</table>