RCMA call with Dr. Kaiser, Riverside Co. Public Health Officer
May 14, 2020 – Questions to be addressed

1. **What were the factors on which you originally extended the order to continue masks and social distancing until June 19, 2020? With the recission of this order what are the specific guidelines and what do we tell our patients?**

I'll cover this question with the next one, since they are related.

2. **Why has the county decided to lift the mask requirement? It does not seem safe for people to go without a mask especially since there can be asymptomatic carriers. What advice do you have for clinics and other businesses?**

Without getting into the political discussion, the Board chose to replace the orders with an official strong recommendation for both facial coverings and social distancing. I'll just say personally that I use a surgical mask when I'm seeing patients, including the N95 I would normally wear for communicable TB patients, and a face covering at all other times when I'm in stores or in the administrative offices, and I continue to recommend that physician offices and hospitals do the same.

3. **Is Riverside County doing rigorous contact tracing on all new positives? If no, why not? If yes, why aren't you sharing the information with the public?**

The answer is yes, and this is even a state requirement. The state demonstrated their forthcoming comprehensive system for contact tracing earlier this week. It's not clear to me what is meant by "information" here but naturally anyone who is considered at risk, and we have a very conservative definition as anyone who has worked with us on a TB exposure can attest, will be contacted. Beyond that, however, contact tracing, which really is a basic public health intervention, is taking an unjustified black eye because of its mischaracterization as an intrinsic invasion of privacy and I don't want to provide more grist for that particular disinformation mill. We intend to conduct contact tracing for COVID-19 in the same way we would for any other communicable disease with the utmost concern for safety, comprehensiveness and safeguarding the privacy of those we interact with.

4. **What are the thoughts on the number of cases that continue to grow in the county vs. deaths and hospitalizations which seem to be somewhat stable?**

The hospitalization question seems to be at least in part an artifact of folks staying away from EDs and urgent cares, particularly those without PMDs who used those settings for primary care purposes. But I'm not sure I'd characterize our deaths as particularly stable; there have been over 85 in the last 14 days. The larger question, and the one I think this question is implying, is whether the medical opinion on how dangerous the virus is is changing based on the increasing case rate. Our crude case fatality rate, based on the numbers at hand, is about 4.3%, keeping in mind that even with asymptomatic testing there are probably more undiagnosed living individuals than undiscovered deaths, so this number is without doubt an upper bound. That said, this value has not changed a great deal in the past few weeks.

5. **We are planning for our staff to return to work as an essential business. Our administrative staff are located in a non-clinical area and are not in the same building where patients are seen. We do plan to implement physical distancing policies, but do we need to require our administrative staff to wear masks?**

The County has no specific requirements at this point, only recommendations. However, the State has guidance for office workspaces including a formal checklist. Most of these include what you think should be there, including symptom screens, cleaning schedules, social distancing and facial coverings. Before reopening, the State requires a site-specific protection plan and risk assessment, though this does not have to be extremely formal or verbose as long as it hits the major points in the guidance document. These are all at covid19.ca.gov.

6. **If we are using appropriate PPE can we start seeing non-urgent patients in our offices? it seems that we are better educated and equipped than the liquor store**

I would certainly hope we are all better educated than the corner booze hole! I am aware of no specific state limitation on physician's offices seeing non-urgent patients. There is still substantial argument over droplet vs airborne precautions for COVID-19 but health care workers should wear at minimum a surgical mask for patient visits and we strongly recommend offices adopt this requirement for patients. Since even an asymptomatic patient could potentially be a suspect, the need for an N95 is a judgment call, though a reasonable middle ground might be using an N95 for seeing patients with any respiratory symptoms and a surgical mask for others. Just to show I'm putting my lungs where my mouth is, yesterday every patient I saw in person was masked, and I used a surgical mask with appropriate social distancing where possible except for patients on respiratory isolation where I used an N95. There is also room for using an N95 for an extended period but this can be very difficult. Rotating between reused N95s on different days has been employed in some settings; you'd need at least 5. This is predicated on coronavirus survival within the mask matrix having an upper bound of around 72 hours.

7. **Should all patients for elective surgery be required to have a negative recent Covid-19 test?**

The American College of Surgeons is not specific on this, but the general recommendation is that a negative PCR test prior to surgery is advisable and we have ample county capacity if you are not able to do it yourself. Alternatively, you could screen plus or minus a mandatory quarantine period, which the ACS also lists as a possibility, but given currently acceptable levels of test availability it would seem simpler just to test them. The bigger question is what to do if they're positive and how you clear them after. Again, for the county we are using modified non-test criteria, generally 10 days after the date of test assuming they were never symptomatic or that they have been afebrile with substantial improvement in respiratory symptoms in the past 72 hours. If you decide on the higher standard of two negative tests 24 hours apart, be advised you will be waiting several weeks in some cases for clearance.

8. **PPE continue to be in short supplies for physician offices. What do we do? How can we begin seeing more patients without proper PPE? Where can we find N95?**

The County has been doing several large PPE buys and we are in a better position than we were previously. While outpatient offices are obviously still lower priority than hospital and first responder requests, we are able to start filling some of these requests. Physicians should be reminded that you may not, and probably will not, get everything you request, and you are expected to still make every reasonable attempt to source and maintain a PPE supply chain yourself. The Emergency Management Department reminds everyone that the PPE system is a mutual aid system, and the expectation is that practices and institutions who participate should also be prepared to contribute into the system should PPE stocks again become impacted. If you understand this requirement, please make your requests to mhresource@rivco.org .

RCMA NOTE TO PHYSICIANS: In partnership with Riverside County Emergency Operations Center, physicians will now be able to access a distribution source located in Southern CA where medical offices can order directly in the quantities needed and have the order shipped directly to your office. RCMA will be providing this information to members as soon as this weekend. Please watch your email for the announcement. It will also be published at www.rcmadocs.org/Covid-19

9. **It has been suggested that we should consider all patients COVID-19 positive. If that is the case what are the guidelines for PPE for patients and medical office staff and providers. Are there different guidelines depending upon specialty?**

The CDC does not necessarily have recommendations based on specialty, merely that aerosol generating procedures must use full PPE with N95, and other situations as supplies warrant. However, N95 is still the preferred standard in all settings for suspected patients because of the persistent debate on droplet versus airborne precautions, and as mentioned there are now generally acceptable extended use or recycling practices for N95s that do not require special sterilization equipment. Nevertheless, an increasingly common

middle ground and one I use personally is surgical masks with asymptomatic patients with appropriate social distancing where possible, and N95 for higher risk patients who are symptomatic or have an exposure history.

10. **Can you provide more information on COVID-19 and what is being discovered with children. What are the plans for schools re-opening?**

The K-12 closure order remains in effect until June 19. Further extension versus allowing it to expire is being *discussed but has not yet been decided. I will say for the record that preliminary data suggests that kids seems to get it at about the same rate as everybody else, but they have fewer adverse effects, none of which will probably surprise the pediatricians on the call. There was some early concern they may be more prone to GI manifestations but so far I don't have enough data to correlate this, and we have also not observed any of the so-called Kawasaki-like multisystem inflammatory syndrome cases here to date. We are making open requests to getting more kids through the testing locations – all ages are welcome – and we will be presenting some of this data to the county superintendent's office when we get it cleaned up. The decision to reopen will likely be at the district level in coordination with the state office of education.*

11. **If not already covered, what is the most important thing physicians should know or do when communicating with patients and their concerns over COVID-19. What should be our message to the public from the physician community?**

I think the best message to be made to the public is to please take all of this seriously. There is an absolute mountain of disinformation out there from obvious dreck like "Plandemic" to every armchair epidemiologist out there who doesn't know the difference between a mortality rate and a case fatality rate. But I also want to make it clear that taking it seriously doesn't mean we shouldn't reopen. My folks were small business owners; this would have flattened them if it had hit a decade ago when they were still running it. And there is a good case to be made that at some level the lockdown cure becomes economically worse than the disease, and losing jobs and livelihoods also has negative impact to public health. But the polarization of COVID-19 has now reached a point where if you wear a mask you're a communist, and if you want businesses open you're going to kill Grandma, and in my view neither position has to be mutually exclusive. We're going to reach a point where a vaccine is still off in the future but we may not be able to stay underwater much longer, and when we do we'll have no choice but to figure out how to live with it. If people don't take this bug seriously, then we really will have more deaths, less consumer confidence and even more personal and societal consequences.

PEASE NOTE: RCMA has a Telehealth billing guide as well as information on all COVID-19 funding resources available on its website: www.rcmadocs.org/COVID-19

These two questions posed **will not** be address by Dr. Kaiser. Unfortunately, we are unable to determine who posed these questions, therefore for questions concerning COVID-19 financing assistance or questions related to billing, coding, documentation, etc, please contact RCMA's Physician Advocate Mitzi Young myoung@cmadocs.org for assistance.

- What is the current CMS guidelines with regard to billing AWV? There is some discussion that capture of patient vitals at home via telehealth does not satisfy current guidelines.

- Will there be relief fund coming from CARES Act for pediatricians, Medi-Cal providers and others that do not see Medicare patients?