Date: Thursday, May 28
Title: "COVID Wizards—Infectious Disease and Epidemiology"
Presenters: Dr. Michael Gelman and Dr. Gio Baracco Lira

Bios

Dr. Michael Gelman

Michael A. Gelman, MD, PhD, is an Infectious Disease specialist who leads Infection Control and Antimicrobial Stewardship at the James J. Peters VAMC in the Bronx, NY (the county with the highest per capita death rate in the US), where he was selected as 2020 Physician of the Year - Partner in Collaboration **before** the pandemic wave. He has been the VISN 2 High Consequence Infection lead since 2017 and has been part of VA's national response to COVID-19 since late January 2020.

Dr. Gio Baracco Lira

Gio Baracco Lira is an ID physician and hospital epidemiologist. He is the Chief of ID at the Miami VA Healthcare System and Professor of Clinical Medicine in the Division of Infectious Diseases, University of Miami Miller School of Medicine.

Questions

(1) How can we know if a "second wave" is starting? What should we be looking for/how suspicious should we be?
    a. Remember the experience in Seattle, New York, and New Orleans – it's nowhere until it's everywhere
    b. What's different this time: we have widespread testing available and we've seen this (Keep clinical suspicion and keep testing; remember individual cases happen before large numbers, and PCR isn't perfectly sensitive)
(2) How should VA manage re-opening to protect patients and staff?
    a. We can't be "Fortress VA" because emergencies will happen (e.g., retinal detachment in someone not tested yet)
    b. We can't go back to "the way we were" because there are sure to be asymptomatic PCR false-negatives
    c. Will depend on four things: local prevalence, availability/turnaround of testing, invasiveness/urgency of care, burden to veteran – broad principles can be national but the balance must be struck locally
    d. Encourage virtualization where possible – including "unbundling the visit"
(3) Let's talk about Risk…Not only actual (medical) risk, but other risks (economic, legal, reputational, etc.), risk perception, risk tolerance, risk mitigation, risk communication. How are you both, as Epidemiology and ID leaders, balancing these risks?
    a. Providing context, perspective, data, and mitigation strategies.
    b. Guiding principle here should be one of good faith, openness, and integrity (say only what you mean but say it in a way that others can make sense of it and act on it = "see the FAQ" is less helpful)
    c. Two principles that I learned in the Zika epidemic of 2016:
        i. "Emerging infectious diseases is a game of successive approximations"
        ii. "If you run a process enough times, you will discover every possible failure mode"

    d. This translates into: come with humility, know areas where you cannot commit but you can advocate (e.g., leave policies, telework), and commit to continuous improvement as we learn more about this disease.

(4) I would like to talk about CLC/Nursing Homes and some of our State Veterans Homes. Some would argue we have done a great job inside the house…How do we keep that up and what does that look like in terms of testing/PPE…In that lane, why have we struggled less than some of these facilities in the community? How can we help…again, outside the walls
    a. VA as 'protective' some have said…debunk or discuss
    b. Outreach in terms of education or other; or perhaps bringing more folks in to the VA

(5) What is the state of our understanding about PCR tests that stay positive for many weeks to over two months?
    a. In one Chinese study, median duration of positivity was between 3-4 weeks
    b. We are already seeing both patients and employees still PCR-positive 2 months out
    c. There is still some evidence most of the infectious risk is from right before symptoms start through 7-10 days after