



# LEDGE LIGHT HEALTH DISTRICT MEDICAL RESERVE CORPS

The mission of the LLHD MRC is to provide trained clinical and trained non-clinical volunteers who will respond during a public health emergency.

June 2020



## CT Responds!



We have certainly seen people respond to the call for volunteers. We have gained 138 new volunteers since March! Our total number of volunteers is now 232. Welcome to our new volunteers.

**Nurses: 72**

**Nurse Practitioners: 12**

**Physicians: 15**

**Physician Assistants: 3**

**Pharmacists: 3**

**Respiratory Therapist: 1**

**Dentists: 2**

**Veterinarians: 3**

**Mental Health Professionals: 9**

**EMS Professionals: 41**

**Public Health/Medical Professionals: 13**

**Non-medical: 58**

## KI TABLETS DISTRIBUTION

The State of Connecticut has made new potassium iodide tablets available to residents and workers within the 10-mile emergency planning zone (EPZ) around Millstone Power Station in Waterford, CT. The affected communities include: East Lyme, Old Lyme, Waterford, New London, Groton City, Groton Town, Fishers Island, NY, and portions of Lyme, Montville, and Ledyard

Potassium iodide, also known as KI, is a form of iodine. KI helps protect your thyroid gland when there is a chance you might be exposed to a harmful amount of radioactive iodine. Taking KI saturates the thyroid with harmless iodine and prevents radioactive iodine from being absorbed. Why is the thyroid gland important and why is radioactive iodine harmful? The thyroid gland uses iodine to make hormones that control your body's metabolism. Radioactive iodine can harm your thyroid gland and can increase your risk of developing thyroid cancer years after exposure.

The tablets are available in each town but we are assisting by distributing new KI packets when possible. Recently some of our volunteers gave out the packets and fact sheets with the "grab and go" lunches in New London and Groton. We are planning on doing a drive-thru KI distribution in East Lyme sometime this month.



# COVID TESTING EXPLAINED BY A MICROBIOLOGIST!

By Elliott Omo-Edo, MPH, MT(ASCP<sup>CM</sup>) one of our volunteers!

As the world battles with current COVID-19 pandemic, the need for accurate testing in the treatment of infected patients and to curb the spread of the disease cannot be overemphasized.

However, not everyone needs a test and if an ongoing infection is suspected, CDC has provided guidance for who should be tested, and what type of test to be done. The decisions about testing are made by state and local health departments or healthcare providers, whereby clinicians use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested.



| <b>Molecular testing</b>  | <b>Serologic (Antibody) Testing</b>   |
|---|---|
| Molecular tests are used to diagnose the presence of an active SARS-CoV-2 infection. Test looks for viral genetic material which is usually present when persons are infected.  | Serologic test is mostly used to determine past exposure. Antibody tests detect either IgG, IgA, or IgM antibodies from an immune response elicited by a prior exposure to SARS-CoV-2 if present.   |
| Molecular testing could be either be a PCR, TMA or other test platform.   | ELISA- a more complex and accurate antibody test is known. Quicker and cheaper commercial serologic tests are available.  |
| Most molecular testing uses respiratory specimen such as: nasal wash, nasal brushings, nasopharyngeal swab, oropharyngeal swab collected in a viral transport media (VTM)   | Blood, plasma or serum, depending on the test method or instrument.   |
| Turnaround time ranges from minutes to 1 – 4 hours depending on the test platform used.   | Turnaround time ranges from few minutes (15- 20) to 2 hours. However, based on the increasing workload, most commercial laboratories take 5-7 days to turn out a serologic test report.   |
| A reliable test method for ongoing or acute SARS-CoV-2 infection with a high degree of sensitivity and specificity. 95-98% sensitivity and specificity.   | Preferable for asymptomatic patients. Test method alone cannot be used to diagnose an active CoV-2 infection. False positive results for the test may occur due to cross-reactivity from pre-existing antibodies, presence of non-SARS-CoV-2 coronavirus strain or other possible causes.   |
| It takes 1-3 days after infection before the virus starts to replicate in the saliva, throat, nose (mucus membrane)   | It typically takes 1 to 3 weeks after someone becomes infected with SARS-CoV-2 for their body to make antibodies; some people may take longer to develop antibodies.  |
| CDC recommends that clinical laboratories should rely on molecular testing to diagnose the presence of SARS-CoV-2 infections.   | CDC is not using its antibody tests for diagnostic purposes, and thus is not accepting antibody test requests intended for COVID-19 patient diagnosis.  |
| Most molecular based tests that uses two or more targets (PCR) are likely to have high specificity (few false positives)<br><br>CDC recommends that if a clinical laboratory initially uses antibody testing for diagnostic purposes, follow-up testing using a molecular viral test should be performed. | According to CDC, results from antibody testing should not be used as the sole basis to diagnose or exclude SARS-CoV-2 infections or to inform infection status.<br><br>Negative results from antibody testing do not rule out SARS-CoV-2 infections, because individuals who have been exposed to the virus may still be within the estimated incubation period (1-3 weeks), and thus not have detectable antibody the test is designed to detect. |
| Generally speaking, these are the most reliable tests. Thus are the only test currently recommended for the diagnosis of COVID-19 infection   | In general, these tests aren't reliable enough for individuals to act based on the results. They are limited in specificity and sensitivity.  |
| Yale-New Haven Health System, Hartford Healthcare System and other major healthcare/hospitals in Connecticut are using the molecular testing methods in the care and treatment of patients.   | Commercial laboratories, doctors' offices, pharmacies and most supply chain store testing employ the serologic method of testing.   |

# CONTACT TRACING

Since the start of COVID-19, Ledge Light Health District has been doing contact tracing that includes interviewing positive cases about their symptoms, occupation, medical conditions that might put them at greater risk and close contacts. The purpose of contact tracing is to prevent transmission of disease to others. We ask about close contacts: people they have spent more than 10 minutes in a space of less than 6 feet. Close contacts tend to be family members, close friends and co-workers. So far contact tracing has been relatively easy as most people have not been to many places due to the closing of businesses. The majority of close contacts were quarantined as they were notified by the positive case. Isolation of anyone who is sick is a minimum of 10 days as long as 72 hours have passed with no fever (and use of anti-fever medications) and there is an improvement in symptoms. Quarantine of people who have been in contact with someone with COVID-19 is two weeks as the incubation time (time exposed to getting sick) is 2-14 days.

As the cases increased we trained a group of volunteers who expressed an interest in contact tracing. They have been doing a great job but do find it challenging to cold call people to interview them. Most people are thankful for the phone call but some people feel their privacy is being invaded and some even hang up on us!

We are requesting that people interested in helping with contact tracing take the Johns Hopkins Contact Tracing Course that is 5 hours online:

<https://www.coursera.org/learn/covid-19-contact-tracing?edocomorp=covid-19-contact-tracing>

There are two roles that volunteers can fill: interviewing positive cases and communicating daily with positive cases in isolation and contacts in quarantine to ensure that they are doing ok, following instructions and answer any questions.



One of our MRC volunteers doing contact tracing had experience doing Ebola contact tracing in the Congo and Liberia! I had the pleasure working with Anita Repp RN when she worked in the Infectious Disease clinic at L+M Hospital so I was delighted when she joined our unit. I asked her to share her experience doing contact tracing with Ebola cases. Her story on the next page could be made into an adventure movie!

Anita shared that while the context, the disease and certain challenges might be different, the use of contact tracing remains an essential tool to isolate potential cases and prevent the spread of the virus.



Anita covered in dust and dirt after a road trip in Africa!

An article "Ebola Strategy Brings Good News to Liberia:

<https://www.npr.org/sections/goatsandsoda/2014/10/28/359355410/an-ebola-strategy-brings-good-news-to-one-liberian-town>

# CONTACT TRACING WITH EBOLA

“ I could never have imagined that my first experience with contact tracing would entail a 2 day open boat trip, sleeping in a mud hut with chickens, climbing a mountain and running for my life through flames. Contact tracing from the comfort of my living room feels very comfortable in comparison and while the setting is different, the rationale remains the same, and the skills required are the same; to be able to listen, communicate and empathize.

I was working as a medical emergency response coordinator for Doctors Without Borders in Bunia, Democratic Republic of Congo and was asked to investigate with a team a suspect case of Ebola who had died in a small village near Lake Albert. This was an extremely remote and insecure area. We were advised not to wear any PPE (personal protective equipment), so as not to frighten and potentially anger the village. Social distancing was to be our only protection.

Our patient was a fisherman, so we started by interviewing fishermen who knew him. Our introduction and explanations were quick, perfunctory and we quickly ascertained that the fisherman had not shown any symptoms while in the fishing village and had not any close contact with other fishermen. The suspect case had gone back to his village up on the top of a rather tall mountain, and this is where he had started to have symptoms (rectal bleeding, vomiting of blood, and strange bleeding from his ears) and where he died and was buried. Again our introduction and efforts to explain were very quick, and we went about interviewing about 100 villagers, each telling us different versions about how the case had died, his symptoms etc. Nobody had died since the suspect case, nobody had a fever, and no one had exhibited any clear cut symptoms for Ebola. Many though did have symptoms, some of them quite strange, and were eager to talk about them. We used specific WHO paper forms, and were able to identify about 30 close contacts. A government nurse identified himself and we agreed to contact him daily by cell phone every day to see if anyone over the next 21 days exhibited any symptoms. We left in haste, leaving the nurse to explain to the village what had just happened and what if anything to expect.

Descending the mountain, we encountered a forest fire and fortunately our guides were able to get us through safely. We suspect that the fire was set by people who were upset by our mission. The village chief understood what had happened and to ease the tension he brought out his ancient tv with a makeshift antenna and generator to watch a very hazy game of soccer with the whole village.

Suspicion of any official intervention in places like the Congo is common, as there is a long history of mistrust of authority which can lead to people refusing to cooperate, to give misleading information, hide, or even become angered and aggressive. We had come with little introduction or training, had given rushed explanation, spent little time listening to each person, and offered no support or empathy for the fear they were experiencing. We will never know if the fire had been set to intimidate us, but it was clear we had not been as welcome as we had assumed. The experience helped me to never underestimate the importance of taking the time to communicate clearly, to connect with people and to fully listen to their concerns, fears and needs. Whether it is here during COVID-19 or in the Congo, we need to take the time to explain, show respect, to offer support, and listen, listen, listen so that we gain cooperation and information we need. After 21 days, there were no suspect cases, and it still remains unclear whether the fisherman was infected with Ebola as no test was performed.

I also worked in Liberia during the Ebola outbreak, and here contact tracing and community outreach were pivotal in being able to control the outbreak. “Health workers there say there are two main reasons the epidemic here has been brought under control. One is this care center, which means sick people aren’t at home infecting others. The other is a massive campaign to connect with the community and to distribute information.”

The common thread here, is that in order to control an epidemic, it is critical to be able to gain the trust of the community you are trying to help. People everywhere are not different, in that everyone needs to feel that they are not being taken advantage of, not being lied to, not being endangered or put in a compromising situation, and not being intimidated by authority, and their needs are respected, that they are listened to, understood and cared for (empathy).”

# WE HAVE BEEN BUSY SINCE COVID-19 STARTED!

**We have done 19 activities with a total of 113 MRC participants that contributed 413 hours with an economic value of \$19, 620.98!! The State Average was 5!**

Food insecurity is a big issue for too many when there isn't a pandemic but since unemployment has risen it has become an even bigger issue. Our volunteers assisted at the Community Meal Center in March when their volunteers were afraid to help out. Since May 2nd we have been helping twice a week in New London with the "Whalers Helping Whalers" organized by Chef Tomm, the culinary arts teacher at New London High School. He has brought together other chefs to donate their time and started a Go Fund Me for donations to purchase the food. Our volunteers have been helping since the beginning and as Chef Tomm says "they are incredible". Each week over 500 people are being fed a hot meal of chicken, rice and a vegetable.



**Thank you Maryann Ladoja RN for volunteering 30 hours since COVID-19 started!**