



Herbert
Henderson
Office of
Minority
Affairs

COVID-19 Advisory Commission on African American Disparities

MINUTES

July 30, 2020

7:30 AM

Via Zoom

Chair: Jill Upson, Chairperson and Director, Herbert Henderson Office of Minority Affairs (HHOMA)

Commissioners: Pastor Rahsaan Armand, Mt. Zion Missionary Baptist Church
Owens Brown, State Conference of NAACP
Joylynn Fix, WV Offices of the Insurance Commission
Delegate Caleb Hanna, Nicholas County, House District 44
Romelia Hodges, StriveN4
Delegate Sean Hornbuckle, House District 16, Cabell County
Mike Jones, Kanawha Institute for Social Research and Action (KISRA)
Reverend James Patterson, Institute Church of the Nazarene
Senator Patricia Puertas-Rucker, Jefferson County, Senatorial District 16
Tiffany Samuels, WVU Cancer Institute
Keisha Saunders, Tug River Health Clinic

Presenters: Dr. Clay Marsh, WV COVID-19 Czar, WVU Medicine Vice President
Dr. Lauren Spadafora, Epidemiologist, BPH
Dr. James Arnaez, MPH PhD, Lead Epidemiologist - Health Statistics Center
Lieutenant Colonel Tanya McGonegal, WV National Guard (WVNG)

Call to Order: Chairperson Jill Upson called the meeting to order at 7:32 a.m.

Dr. Clay Marsh announced that Dr. Ayne Amjad had informed him that she would be unable to attend the meeting because she was on her way to Charleston.

The Chair began the meeting by welcoming everyone and introduced Dr. Clay Marsh to provide an update.

Update - Dr. Clay Marsh, WV COVID-19 Czar, WVU Medicine Vice President:

Dr. Clay Marsh began by stating that he did not have a lot of information to update. Overall, West Virginia has made progress and the Rt value is down to 1.0. He explained that a value less than 1.0 means that the virus is receding and that, hopefully, it will fall below 1.0 over the next few days. Currently, the southern coalfields of the state and Kanawha

County are experiencing challenges. He stated that appropriate mitigation strategies should be the focus for these areas.

Dr. Marsh shared the results of a German study where people were tested with a heart MRI (Magnetic Resonance Imaging) 71 days after COVID. The test group was comprised of 100 participants: 53% male and 47% female. Abnormalities of the heart were found in 78% of the participants, with 63% having evidence of active inflammation of the heart called Myocarditis. It appeared that the coronavirus had affected the hearts after being infected. He continued by stating that the severity, length, and pre-existing conditions did not matter.

Dr. Marsh shared information that was released, in April, about COVID having an impact in brain function in younger people. He then added that heart attacks, strokes, confusion, psychosis and memory loss were some of the side effects presented by COVID. The narrative that, generally, most recover and few people die from COVID is incorrect. He added that there are longer term effects that may become disabling in certain people.

In addition, he shared a study on outpatients that tested positive for COVID-19 that was conducted by the Centers for Disease Control. Surveys by phone were conducted 2 to 3 weeks after patients recovered with a negative test result. The CDC found that 34% still did not feel well enough to return to their normal lifestyle. A group of 18 to 34-year-old did not feel well enough to return to work after 2 to 3 weeks. Dr. Marsh explained that this data shows that there are consequences of COVID: short, medium, and long-term.

He continued on to explain that COVID had spread to 1 million people in 99 days in the United States; 43 days to hit 2 million; 28 days to hit 3 million and 15 days to hit 4 million. Between July 18 to July 24, Florida residents between the ages of 17 and 24 years, saw a 34% increase in positive tests and a 23% increase in hospitalizations. He explained that young people can get sick from COVID, heart and brain problems can occur months later, about one-third will not feel well enough to resume daily activities. He then added that these findings may be the tip of the iceberg from a health standpoint. He stated that the situation inspires diligence in mask-wearing and social distancing for him. Dr. Marsh further explained that the risk to minority groups, African American, Hispanic, and Native American communities, is much higher for having more severe problems. He then added that the subtle, chronic problems could possibly become the worst part of COVID.

Chairperson Upson asked Dr. Marsh about any testing recommendations as flu-season approaches. She added that people may assume that the flu symptoms are COVID.

Dr. Marsh stated that flu vaccinations are critical this year. He explained that new tests being released. BioFire, an antigen test, looks for certain proteins in Influenza A and B, and Respiratory Syncytial Virus (RSV) and now, COVID. He explained that it can be difficult to differentiate between the early symptoms of COVID and Influenza. He shared that some COVID specific symptoms include lesions to hands and feet, internal mouth sores, and changes to smell and taste. Tamiflu can be taken early to reduce the ability of the virus to enter the cells in the body. Dr. Marsh concluded that it is anticipated that this flu season will be a challenging time.

Secretary Crouch added that the flu vaccine must be promoted this year. The recent articles and studies should impress upon people the need to get vaccinated and to wear masks. There are long-term effects that can result in death in many cases. He concluded by stating that masks need to be worn until there is a vaccine to provide protection from COVID.

The Chair read a question from the chat, which asked if any children participated in the German study.

Dr. Marsh explained that no children were a part of the study and should be considered. It is known that the rapid rise in positives is largely due to younger people being infected. The study covered middle-aged adults with an average age of 47, in a hospital in Germany. He concluded by stating that children and young adults are an important sub-group to consider.

Secretary Crouch stated that there is concern as more children are acquiring the virus in West Virginia. He shared that three children under the age of 14 became infected after attending a pool party.

The Chair then read another question posted in the chat, which asked how the flu vaccine performed in Australia.

Dr. Marsh stated that he was unsure, and that Australia had some COVID-control issues. He added that the flu vaccine worked well, but COVID-control policies were less effective. He replied that he would have to follow up on the question.

Dr. Lauren Spadafora, Epidemiologist, BPH

The Chair shared that there was a phone call the previous week involving one of the mobile testing sites. A few of the task force members expressed their concern that the data collection questions were a little too intrusive and may discourage participation. She then stated that Dr. Lauren Spadafora was invited to the meeting to speak about how the data form was created and to answer any questions.

Dr. Spadafora began by thanking everyone for the invitation to the meeting. She added as the flu epidemiologist for the state, there is a full, two months ahead in preparation for the flu season. She shared that she, too, has concerns about the upcoming flu season and has spoken with laboratories about multiplexing.

Dr. Spadafora added that, according to the reports from Health Command, there is indeed a drop in minority attendance at the testing events. In the first and second weeks of testing in May, minorities made up approximately 30% of attendance; now, minority attendance ranges between 5 to 10%. She added that the declines were also seen in counties with multiple events. The drop-off was more gradual in Kanawha County.

Dr. Spadafora shared that she developed the in-take form along with Dr. Erica Thomasson shortly before the testing began in mid-May. She added that, in creating the form, the goal was to be prepared for anything that was asked of them. There was concern that the form was too long, but never heard that it was intrusive. She added that Dr. Slemp had final approval, but was not sure if anyone on the call had reviewed the form. She stated that the questions about employment status, housing status, medical care and reason for testing were added to determine if underserved, under- and uninsured populations and targeted areas were being served. The medical care focused questions were included to help to get results back to those tested. The question regarding reasons for testing were included to address whether or not the tester was at lower risk at contracting the disease.

Dr. Spadafora then listed the pros and cons of changing the questionnaire. The cons for eliminating the questions included: minority populations may be discouraged to participate, decreased information to guide program success and planning future events, decreased information to report back to leadership, funders, media and public. The ultimate question is whether the data questions are critical in evaluating the program success. So far, 1600 test attendees indicated that they were not in medical care. Approximately, 25% indicated that they were not employed, which indicates a generally underserved population is being reached, regardless of race. At this point, Dr. Spadafora decided to open the floor to questions and comments.

Chairperson Upson mentioned that she had previously suggested obtaining the bare minimum of questions at the testing site, but that Dr. Spadafora shared that it is much more difficult to obtain the needed information after the testing once a negative result is received. The challenge is that some people are concerned about having to leave work to quarantine and therefore, prefer not to discuss employment. The Chair added that this was a main area of concern and was mentioned on the call.

Romelia Hodges began by stating that her concern was that, at this point, the minority population is now familiar with the information that is going to be asked of them at the testing events. Ms. Hodges shared that Morgantown, which served approximately 3,000 people, received instruction from the National Guard, the Public Health Director and Q-Labs to just fill out the highlighted demographic information. Ms. Hodges then added that she has participated in six testing events in different counties, but the information has been standard. There is not a lot of time to ask many questions of the participants. She then stated that the addition of personal questions that had not been previously included would create an area of distrust. Ms. Hodges mentioned that there were 88 positives from the Morgantown testing event. She then explained that it would be much easier to obtain the detailed information from the 88 individuals during contact tracing than from the 3,000 people being served at the testing events. Ms. Hodges explained that local volunteers are being used to register the testers. She then suggested the possibility of the National Guard or health department resuming the task of taking the testers information onsite if additional questions are added to the intake form. Ms. Hodges added that the health departments are understaffed and that is why community volunteers are used to support the data collection process.

Dr. Spadafora stated that she considered stopping by a testing event to observe the entire process. She admitted to being overwhelmed by having to organize lines and ask questions during similar events. She added that it was important to collect information to ensure participants receive their results and proper coding be added to assign participants to the correct health department.

Ms. Hodges described the process that the volunteers follow for obtaining the personal data. She then added that she is a little more aggressive and convincing than other volunteers and often obtains the last four-digits of the social security number, hoping that it can be cross-referenced in other databases. Ms. Hodges then explained to Dr. Spadafora that she did not want to create anymore distrust, but is willing to help, if additional information is needed.

Dr. Spadafora stated that the additional information would be a leadership decision and noted that it was good they were on the call to hear the discussion. She then shared that Health Command is reaching out to local health departments for feedback, as well. Dr. Spadafora then stated that Ms. Hutchinson wanted additional information about the “in care” question to ensure that it was not eliminated. She then suggested developing a separate online survey that included the “in care” and other feedback questions about the overall experience to be completed at home. She also suggested stating that the online survey is voluntary and that the questions are designed to help improve the process.

Ms. Hodges suggested that a pre-fillable form could be sent out to the community ahead of the testing events. She added that allowing the community to voluntarily fill out the form prior to testing may yield better results. Having a survey included when the online results are accessed was another suggestion offered by Ms. Hodges.

Dr. Spadafora concluding by agreeing that the suggestions offered by Ms. Hodges were great ideas to try to build trust with the communities.

The Chair noted that there were no hands raised to ask questions or comment. She then moved on to the next agenda item and introduced Dr. James Arnaez.

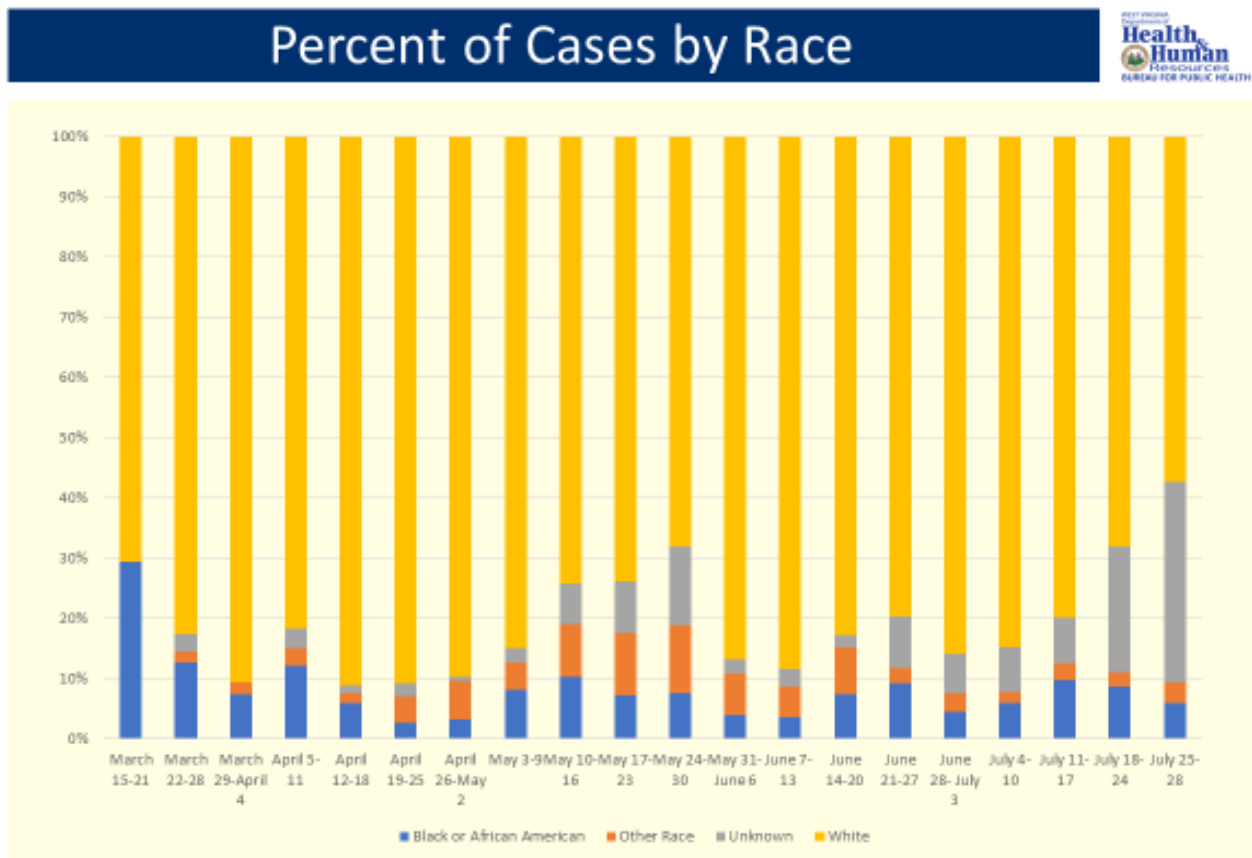
Minority Data Update – Dr. James Arnaez, Epidemiologist, WV Bureau of Public Health:

Dr. Arnaez reported that the data shared today is preliminary and was accessed through the WV Electronic Disease Surveillance System (EDSS) on July 28, 2020. The information is only accurate through the day it was accessed. Some numbers are small, and caution is needed for generalization and interpretation. Percentages presented are with missing data excluded.

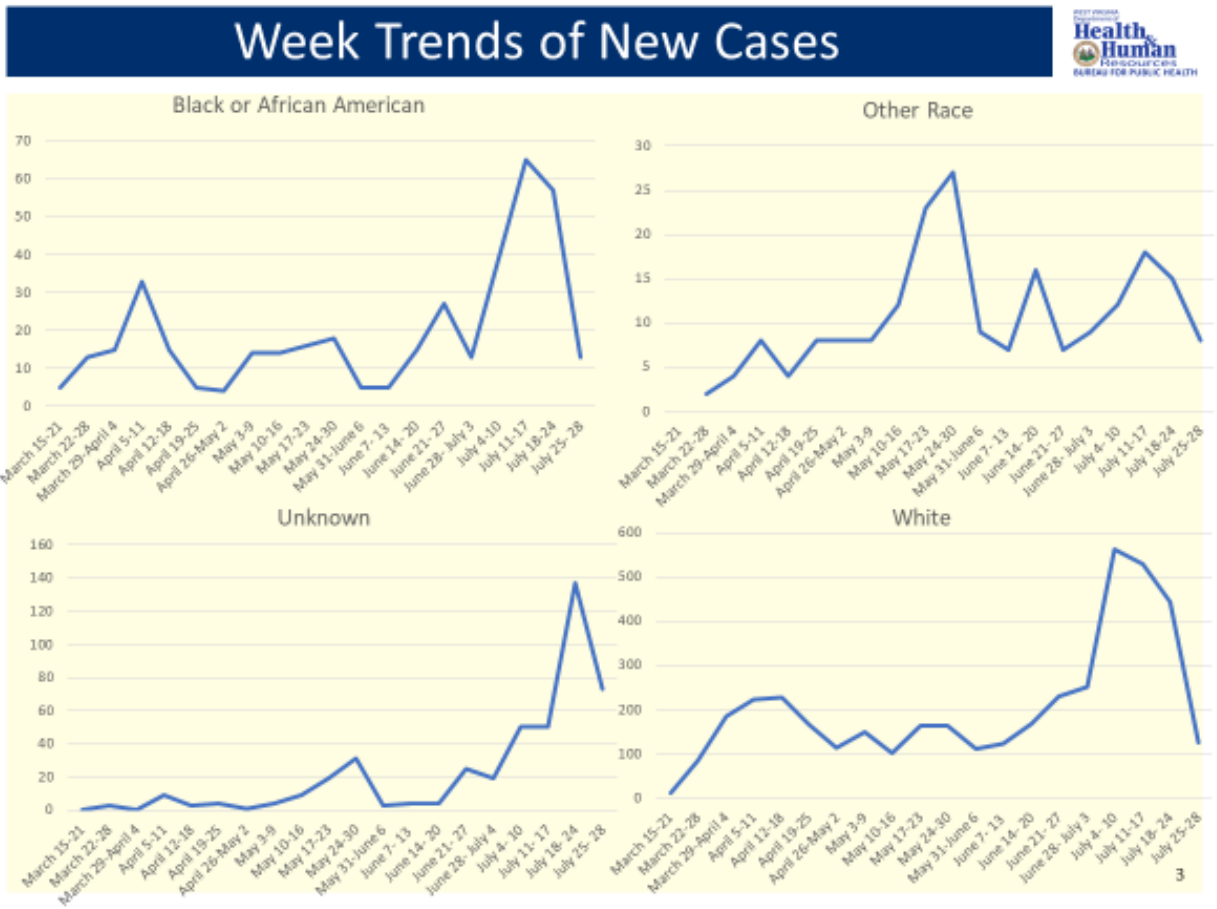
Dr. Arnaez noted that file size issues have occurred over the past couple of weeks. He added that the lab report date, which had not been generating, is typically used for this report. All time-dependent variables are using the date that is reported to the state.

The following report was provided:

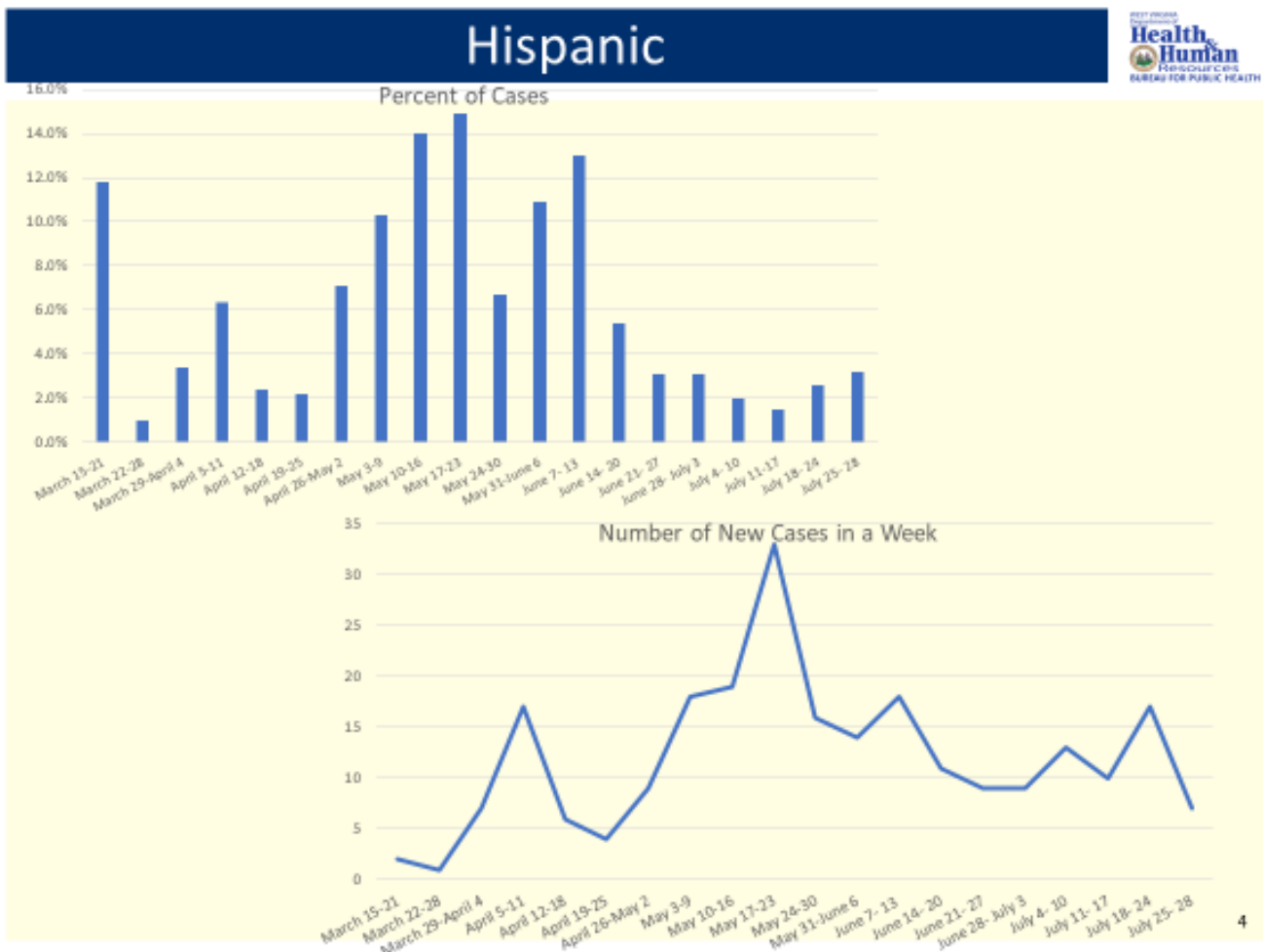
Dr. Arnaez stated that during the weeks of July 11-24, approximately 9-10% of cases were African American, which is a bit higher than the first half of the month.



Dr. Arnaez stated that African Americans and the White population had the highest number of cases during the week of July 4-10, 2020; peaking at 64 on July 11-17; and around 57 cases on July 18-24. There was an increase of over 500 new cases among the White race, remaining above 400 over the last full week.



Dr. Arnaez reported that the Hispanic proportion still remains under five percent with a mild peak during the week of July 18-24. Numerically, the Hispanic population's numbers are still fairly low.



Dr. Arnaez noted that the percentages that make up the past month's totals were consistent with the previous week.

Past Month Highlights

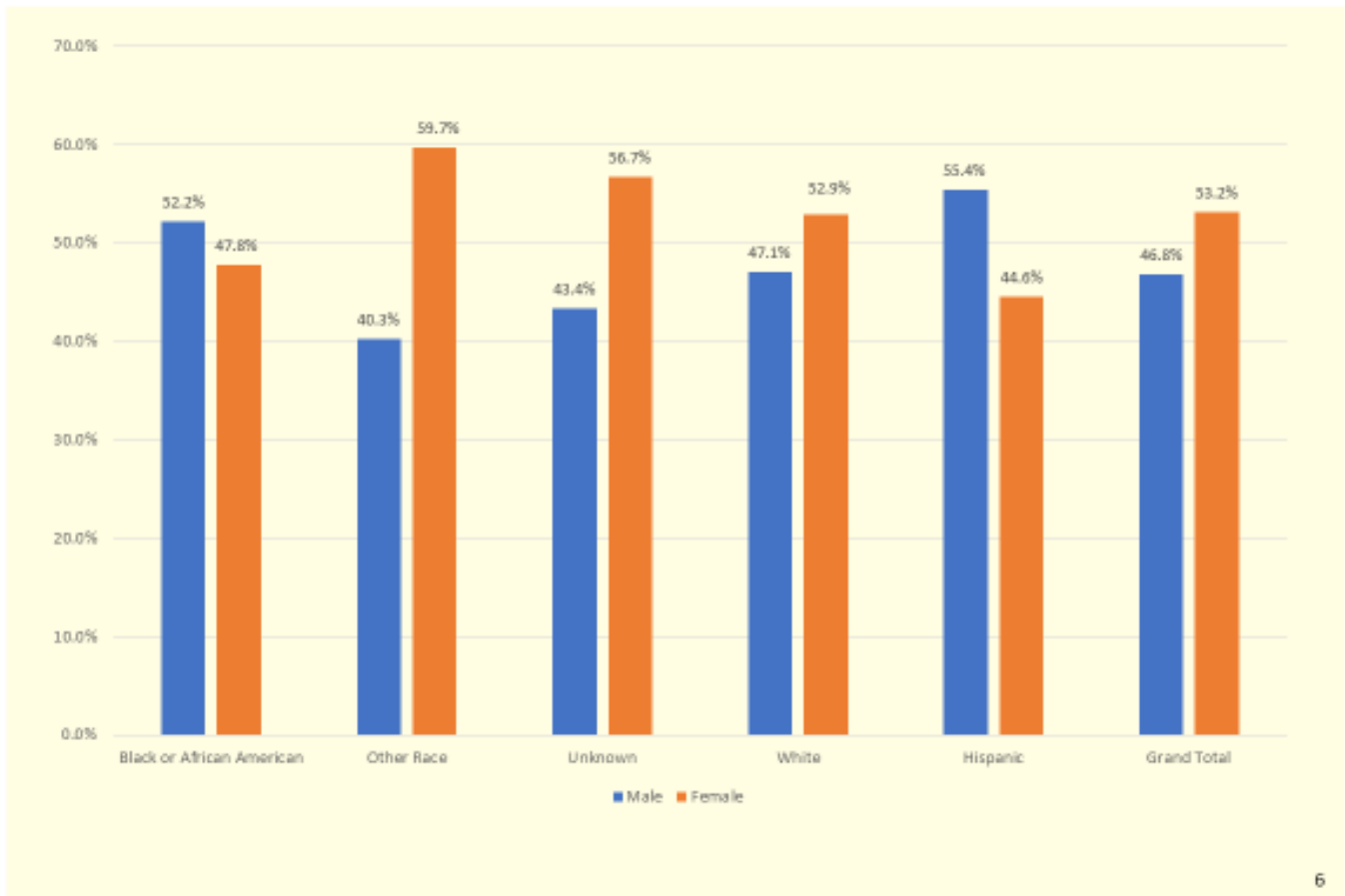


- **Black/African American**
 - 187 COVID-19 cases in past month
 - 39.2% of total COVID-19 cases in this group
- **White**
 - 1911 cases in past month
 - 40.2% of total COVID-19 cases in this group
- **Pre-existing Conditions**
 - 44.6% of Hispanic cases have a pre-existing condition.
 - Greater than cumulative (33.9%)
 - 40.4% of Whites have a pre-existing condition
 - 24.6% and 27.4% of Black/African American and Other Race cases, respectively have a pre-existing condition

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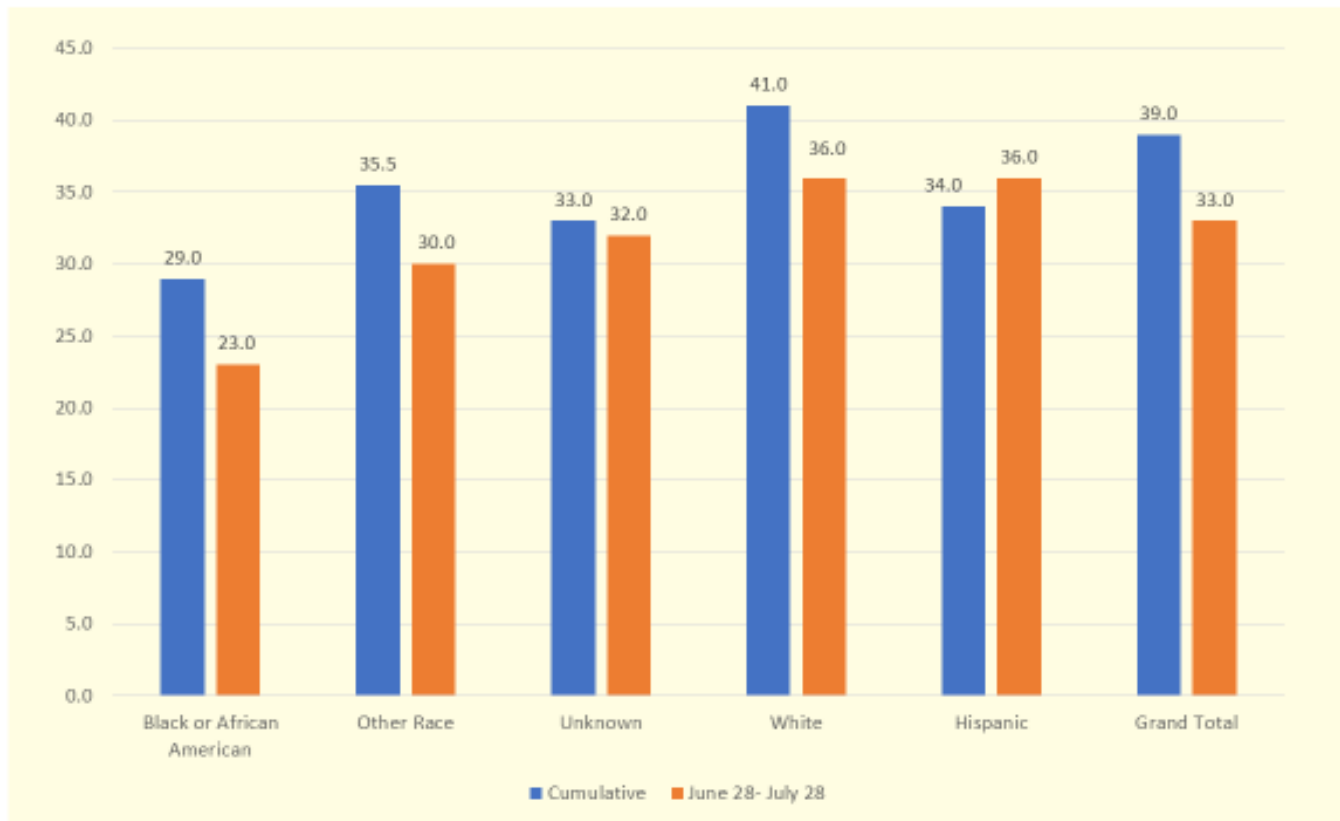
In looking at gender for African Americans and Hispanics, Dr. Arnaez noted that there is still a close majority of male cases over female cases over the past month. Comparatively, nearly 60% of the Other Race category has been women and 40% men.

Race/Ethnicity and Gender-Past Month



Dr. Arnaez reported that African Americans had the lowest median age in past month at 23.0. He then explained that the median is the threshold at which 50% of the sample lies above and below. African Americans accumulate half of the cases are below the age of 29 years. Other groups typically range within early 30's.

Median Age of COVID Cases by Race



Showing the prevalence of cases by racial groups in different regions. Dr. Arnaez indicated sharing this slide as a reminder for the group.

OEPS Regions



Surveillance Regions and Current Coverage by Regional Epidemiologists

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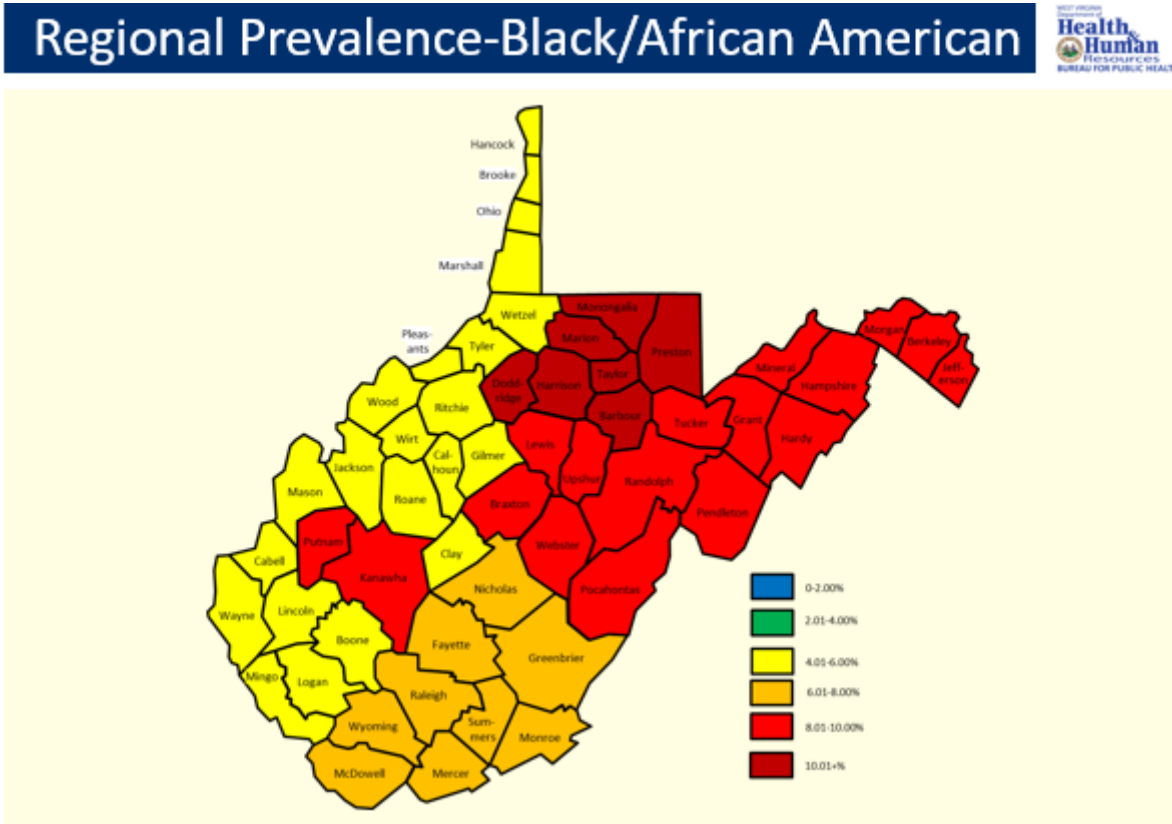
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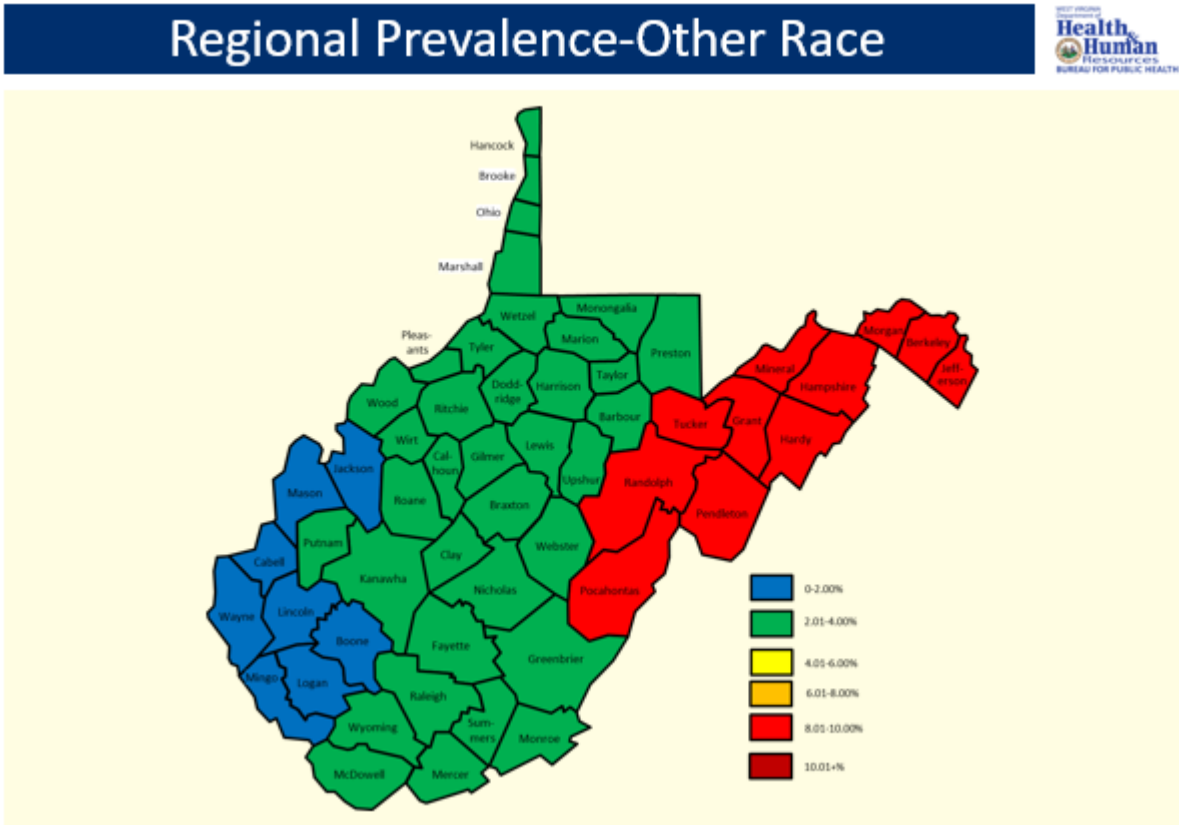
<p>Shannon McBee</p> <p>Division of Infectious Disease Epidemiology WVDP/HR/BPH/OEPS</p>	<p>350 Capitol St., Room 125 Charleston, WV 25301-3715 Office: (304) 558-5358 Fax: (304) 558-8736 Email: Shannon.M.McBee@wv.gov</p>
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Last Updated: October 2019

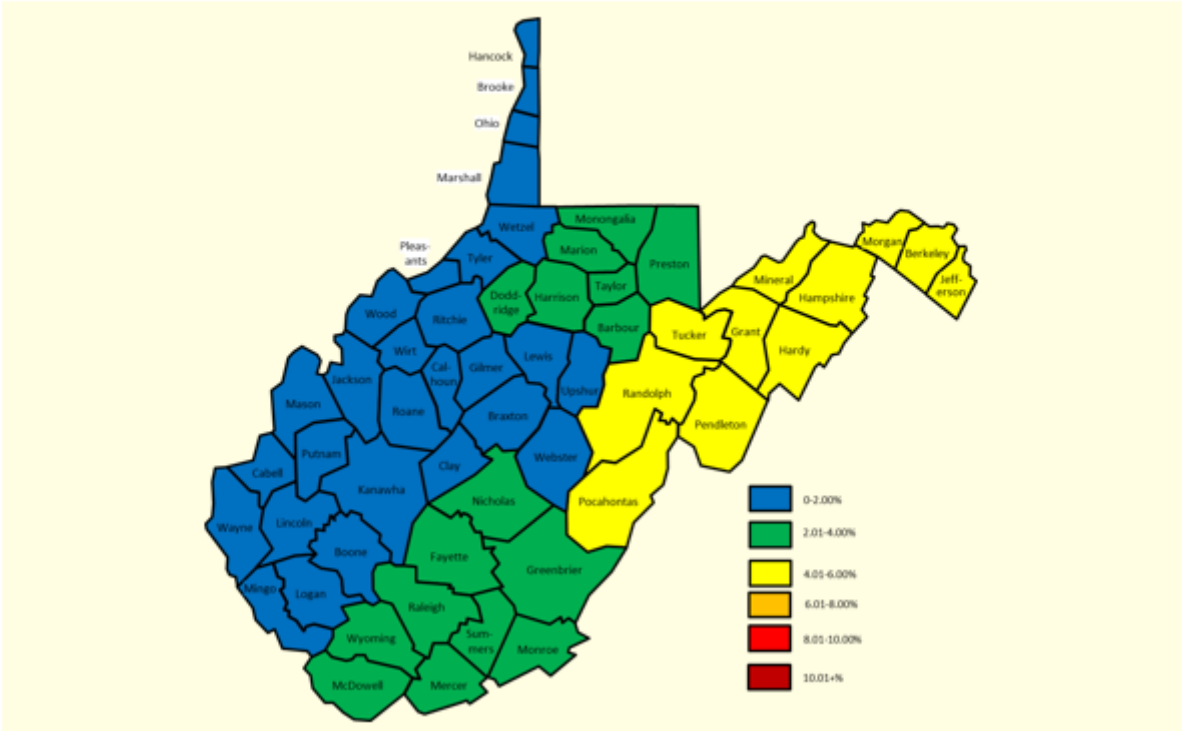
For African Americans, the major change is in the central regions which contains Putnam, Kanawha, Braxton, Lewis, and Webster counties has between 8.0-10.0 percent cases in the African American community.



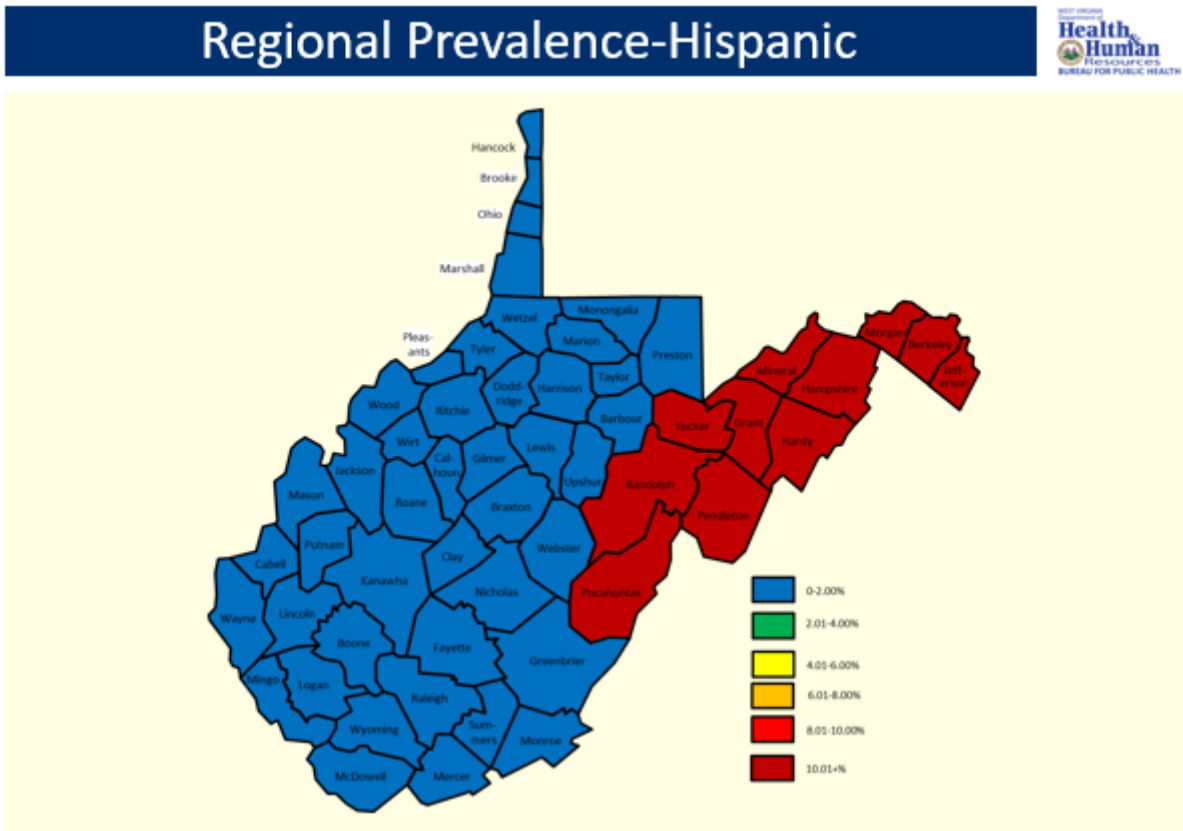
For other races this is predominately in the eastern region. Dr. Arnaez reports 8.0% to 10.0% of their cases, cumulatively, are individuals from other races.



Regional Prevalence-Other Race



Dr. Arnaez reported the eastern region has the highest prevalence of Hispanic population.



The northeastern region continues to have the highest rates of COVID-19 for the African American community and the eastern region for the Hispanic community. Dr. Arnaez reported the following: 634.2 per hundred thousand cases for African American residents and 860.9 cases per hundred thousand for Hispanic residents.

COVID Cases by Region, Race, and Ethnicity



	State	% of cases	Western	% of cases	Central	% of cases	Northwestern	% of cases	Northeastern	% of cases	Eastern	% of cases	Southern	% of cases
Cumulative														
All Residents	6123		978		933		842		1356		1476		538	
Black	477	7.8%	45	4.6%	78	8.4%	46	5.5%	140	10.3%	126	8.5%	42	7.8%
White	4748	77.5%	854	87.3%	646	69.2%	706	83.8%	1025	75.6%	1117	75.7%	400	74.3%
Other Race	246	4.0%	11	1.1%	21	2.3%	18	2.1%	49	3.6%	127	8.6%	20	3.7%
Unknown	652	10.6%	68	7.0%	188	20.2%	72	8.6%	142	10.5%	106	7.2%	76	14.1%
Hispanic	260	4.2%	11	1.1%	17	1.8%	12	1.4%	28	2.1%	186	12.6%	6	1.1%
June 28- July 28														
All Residents	2489		388		373		463		637		391		237	
Black	187	7.5%	22	5.7%	36	9.7%	22	4.8%	62	9.7%	32	8.2%	13	5.5%
White	1911	76.8%	333	85.8%	226	60.6%	383	82.7%	495	77.7%	296	75.7%	178	75.1%
Other Race	62	2.5%	3	0.8%	4	1.1%	8	1.7%	21	3.3%	20	5.1%	6	2.5%
Unknown	329	13.2%	30	7.7%	107	28.7%	50	10.8%	59	9.3%	43	11.0%	40	16.9%
Hispanic	56	2.2%	7	1.8%	2	0.5%	6	1.3%	8	1.3%	31	7.9%	2	0.8%

Dr. Arnaez reported the percentage rate is decreasing for hospitalizations, ICU admissions, and ventilator usage. Only 8.7% of total cases have required hospitalization at this time. There are slightly higher cases in the African American population with 11.0% having required hospitalization.

Hospitalizations, ICU Admission, & Ventilator Use



	Hospitalization	% of cases	ICU Admission	% of cases	Ventilator Use	% of cases
Cumulative						
Total	449	8.7%	175	3.4%	84	1.7%
Black	45	11.0%	15	3.7%	9	2.3%
White	379	8.8%	150	3.5%	69	1.6%
Other Race	12	5.5%	5	2.4%	4	1.9%
Unknown	13	7.3%	5	3.0%	2	1.2%
Hispanic	13	5.2%	4	1.6%	1	0.4%
June 28- July 28						
Total	101	5.1%	34	1.7%	13	0.7%
Black	8	5.0%	2	1.3%	1	0.7%
White	85	5.0%	29	1.7%	11	0.7%
Other Race	4	7.6%	1	2.0%	0	0.0%
Unknown	4	6.2%	2	3.4%	1	1.7%
Hispanic	3	5.9%	1	2.0%	0	0.0%

Reverend Patterson asked if people of color would suffer, at a disproportionate rate, with long-term complications due to contracting the virus at an earlier age. He then asked if the complications persist, regardless of the age, at which coronavirus is contracted.

Dr. Marsh explained that there may be long-term effect from COVID-19. What is known now about the virus is quite different from the previous month. He stated that studies need to be conducted involving the race differences, when it is caught, and preexisting conditions. He mentioned looking into a study of neurological effects in Germany where there was no correlation to a preexisting condition, how sick someone was, how they recovered, or effects after having COVID. He added that 63% of the people tested had evidence of heart injury that were not heart attacks. He described seeing blood vessel clotting from COVID, which could give strokes and heart attacks. Dr. Marsh reported that the MRI's showed inflammation.

Dr. Marsh shared another article published in the American Medical Association journal, which showed there was evidence of the disease found inside of the heart in an autopsy. The virus seems to be able to get into the organs for some people and causes the body to respond, which may create deterioration in organ function. He explained that the decreased senses of smell and taste implies the virus is also getting into the brain and causing reactions. He stated that a lot of people do recover, however COVID is associated with strokes, problems involving memory and paralysis. He describes having to worry about not only African Americans community, but young people as well. Dr. Marsh expressed concern about the long-term side effects on the people that are not following guidelines and precautions.

The Chair read a question from the chat asking if any children have been identified as a super spreader.

Dr. Marsh stated that our schools shut down early in the United States, therefore there was not a spread in schools. According to data from South Korea, children below ten years old seem to catch and spread COVID less easily. However, in West Virginia, there have been cases in young children, which proves it is not impossible. He explained two schools-of-thought: the virus must bind to certain receptors and children do not have as much of the receptor; therefore, lack the ability to affect younger children. He indicates there hasn't been any data or literature that has identified children as super spreader. Younger adults, middle schoolers, and high schoolers have been indicated as super spreaders.

The Chair read another question from the chat box, which asked if there are different strains of COVID-19 that are currently being studied.

Dr. Marsh referenced a study in the journal called Nature, which found that the spike proteins bind the virus to the human body and combines with the angiotensin-converting enzyme receptor. There is a new mutation of the spike protein, which allows it to bind better to the receptor. This mutation is now the most common type of coronavirus in the United States, which is why there have been more positive cases. Those affected by the new mutant virus do not seem to get sicker, but instead are able to infect at a lower concentration. Dr. Marsh concluded that, by comparison, the new mutation spike protein can infect cells easier and more efficiently than the old spike protein.

Testing Plan Update – Lieutenant Colonel (LTC) Tanya McGonegal, WV National Guard:

Lieutenant Tanya McGonegal reported that testing is ongoing. On July 31st and Saturday, September 1st, the Guard will be in Glenville and Jackson and McDowell counties.

Owens Brown stated his concern that African Americans may become stigmatized if they caught the virus. He asked about what ways this could be overcome and how to educate people that feel this way.

Secretary Crouch acknowledged that this is a concern since the contact tracing piece can be difficult as people do not want to give out the pertinent information to track the disease. There is a stigma that is worse in younger people and people of color; there should be more work in this regard.

Dr. Marsh added that when people are stigmatized, they will not want any further involvement or action around them to avoid further stigmatization. It is important as a group to understand and incorporate new ideas along with a message that tries to reduce stigmatization people experience since it interferes with the ability to take care of people and communities. He mentioned being worried that a lot of people will not take the vaccine out of fear; making them feel even more stigmatized.

Owens Brown asked if testing people that have sudden strokes and heart attacks due to the coronavirus should be a protocol.

Dr. Marsh commented that getting tested would be a reasonable thing to do. He stated that blood clotting, heart attacks, and strokes, particularly in people that do not have preexisting conditions, are a known manifestation of COVID-19.

Secretary Crouch added that the key in this situation is the circumstances surrounding the death. He explained that COVID may be a contributing factor, but may not be the primary factor for death.

The Chair mentioned the Romelia Hodges' public service announcement reached 14,322; outperforming other public service announcements.

Ms. Hodges shared updates about the upcoming testing in Fairmont. Ms. Hodges, along with Tiffany Walker, will be leading with the help of Bob Huggins, WVU Basketball Head Coach. Jalen Bridges, WVU basketball player, will give an interview with the news today. She stated that the Jalen Bridges interview/video message will target the college-aged population. He will be filmed receiving the swabbing from a vehicle, which is hoped to help take away some of the anxiety people experience. A young businesswoman within the community has also been chosen to give a similar interview. She stated hopefully young adults will come out to get tested.

Mike Jones suggested holding an event to promote the use of masks among school-aged children called a mascaraed (Mask-a-rade). He stated wanting to give kids the opportunity to come out and decorate masks. During that process, the kids would have an opportunity to decorate masks, while being education on the importance of the importance of wearing a mask and address any misinformation. He stated the idea of the event is to get information out to the kids, letting them know our concerns regarding them in a loving way, then allowing them to spread more awareness of the virus.

The Chair asked if anyone else had any further questions.

Joylynn Fix shared that WV Insurance Commissioner James Dodrill has volunteered to join a national committee on race and insurance. She offered to invite him to discuss the relevant data with the group.

Mikes Jones asks if there are any printed material about the importance of washing hands. The Chair shared that she received a post card in the mail with bullet points regarding precautionary measures. Secretary Crouch mentioned it would be useful and to look for an idea like creating a postcard.

Owens Brown brought up concerns about communities in the southern part of the state that do not have an adequate amount of running water or water deficiencies. He then asked if the spread of the virus has been researched in those

communities. He stated that “60 Minutes” aired a show about certain communities in West Virginia; mentioning that running water must be brought into these counties.

Secretary Crouch stated that the Bureau of Public Health receives information about water issues constantly, which is a part of their responsibility. There are known issues regarding clean water in southern West Virginia. He then explained that the virus is a respiratory issue; although it has not been investigated, there should not be a correlation. He concluded by reminding the group to check the dashboard, which posts the positivity rate by county.

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The Chair shares there will be upcoming COVID-19 testing and she will provide a reports of the outcomes to the task force.

The meeting adjourned at 8:46 AM.