MINUTES
JENKS CITY COUNCIL
TUESDAY, FEBRUARY 16, 2021, 6:00 P.M.
VIRTUAL MEETING

The Agenda for the Jenks City Council was posted on the City's website at 5:31 p.m. on February 12, 2021. The meeting was called to order at 6:00 p.m. on the above date with Mayor Robert Lee presiding. A roll call vote of members was taken as follows:

Kaye Lynn	Present – Videoconference
Donna Ogez	Present – Videoconference
Craig Murray	Present – Videoconference
Gary Isbell	Present – Videoconference
Cory Box	Present – Videoconference
Dawn Dyke	Present – Videoconference
Mayor Robert Lee	Present – Videoconference

Invocation was given by Cory Box

Pledge of Allegiance was given

INCOG Report *Cory Box left at 6:07 p.m. and returned at 6:09 p.m.* Councilor Isbell gave an update from INCOG.

City Manager's Report *moved up from end of agenda* City Manager Christopher Shrout presented his staff report and answered questions. Various City departments gave an update on the severe weather situation and answered questions: Fire Chief Ostrum, Public Works Director Tim Doyle, Major Jackson.

Business

1. Consideration and appropriate action relating to a request for approval of the Consent Agenda. (All matters listed under "Consent" are considered by the City Council to be routine and will be enacted by one motion. Any Councilor may, however, remove an item from the Consent Agenda by request. A motion to adopt the Consent Agenda is non-debatable.)

    A. Approve minutes of the regular meeting held on January 19, 2021
    B. Approve Encumbrances and Expenditures
    C. Monthly Reports
    D. Request Acceptance of a 15-foot public utility and access easement offered by David Tyler and Stacey Bagwell for drainage improvements in the Sanco 4th Addition, specifically 304 East Duncan Street South (Lot 19, Block 5 of the Sanco 4th Addition) [Cloyde]
    E. Request Approval of Resolution No. 728 approving and authorizing an amended trust indenture of the Metropolitan Environmental Trust, which provides for

clarification language of the trust indenture and for the addition of the City of Wagoner, Oklahoma as a beneficiary, and ratifying the acceptance of the beneficial interest in the original trust indenture; and finding that such actions are in the best interest of the beneficiaries and the communities that they serve. [Doyle]

F. Request to approve JZ 21 PUD-112.mi1, a request by Kevin Jordan for an exception to the required exterior materials for Lot 3. **General Location:** North of 121st between Elwood & Elm

G. Request to approve JZ 21 PUD-26.mi1, a request by Spencer Pittman for a minor amendment to PUD 26 for a reduction of the 20ft build line as pertains to the Plat. **General Location**: 219 E 111th Pl

H. Request by the Jenks Garden Club to use Jenks streets for the Herb & Plant Festival from 7 p.m. on April 23, 2021 to 6 p.m. on April 24, 2021. [Shouse]

Craig Murray asked to pull Item 1.F. Dawn Dyke made a motion to approve Item 1, pulling 1.F. Donna Ogez seconded the motion. A roll call vote of members was taken as follow:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

2. Consideration and appropriate action relating to items removed from the Consent Agenda. Craig Murray asked questions about Item 1.F. Planning Director Marcaé Hilton answered the questions. Kaye Lynn made a motion to approve Item 1.F. Donna Ogez seconded the motion. A roll call vote of members was taken as follow:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

3. Request to appoint Jeffrey Beyer to the Planning Commission to fill a vacant seat for a term ending on May 03, 2021 Planning Director Marcaé Hilton introduced Item 3 and answered questions. Gary Isbell made a motion to approve Item 3. Dawn Dyke seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes

Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

4. Request to approve Ordinance No. 1541 re-enacting Jenks City Code Chapter 14 "Offenses," Section 14-4-3 "Face Covering And Social Distancing During COVID-19 Pandemic Civil Emergency"; providing for severability; and declaring an emergency
Council discussed Item 4. City Attorney Teresa Nowlin answered questions from the Council. *Kaye Lynn shared documents against the mandate and Gary Isbell shared a document in favor of the mandate with Council during the discussion. All documents will be included at the end of the minutes.* Public comments were left via voicemail and played during the meeting. The following individuals gave comments:
    - Dr. Robert Marsh – 12051 S 18th S E – against Ordinance No. 1541
    - Bridgett Burritt – 716 W 120th Ct S – against Ordinance No. 1541
    - Autumn Folks – 914 N 1st St – supports Ordinance No. 1541
    - George Bourland – 3714 W 109th St S – supports Ordinance No. 1541
    - Clay Clark – 1100 Riverwalk Terrace – against Ordinance No. 1541
    - Julea Marriott – 4702 S 195th E Ave, Broken Arrow, OK – against Ordinance No. 1541
    - Jenise Beck – 1908 W 91st St – against Ordinance No. 1541
    - David Randolph – 745 W 99th St S – supports Ordinance No. 1541
    - Andrew Bloomer – 12249 S Glenn Ct – against Ordinance No. 1541
    - Claire Farr – 11902 S Date Ave – supports Ordinance No. 1541
    - Lory Lolli – 522 W E St – supports Ordinance No. 1541
    - Dr. Hang Vu – 1101 S Hudson – against Ordinance No. 1541

    Gary Isbell made a motion to approve Item 4, amending Section D to include an expiration date of May 31, 2021. Dawn Dyke seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	No
Donna Ogez	No
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	No
Dawn Dyke	Yes
Mayor Robert Lee	Yes

    Motion Carried.

5. Request to approve Emergency Clause for Ordinance No. 1541, making it effective immediately upon passage Cory Box made a motion to approve Item 5. Gary Isbell seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

6. Request to approve JZ 21 SUP-111.mi1, a request by Bell Land Use, LLC, for a minor amendment to SUP 111 to establish new boundary lines, establish allowed uses, determine current facilities and uses, and eliminate approved conditions not in keeping with the vision. General Location: 528 E 121st St S Planning Director Marcaé Hilton introduced Item 6 and answered questions. Robert Bell (1011 W G St; applicant) addressed the Council. Dawn Dyke made a motion to approve Item 6. Gary Isbell seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

7. Request to approve Ordinance No. 1542, amending Ordinance No. 1474, relating to SUP-111.mi1 Gary Isbell made a motion to approve Item 7. Dawn Dyke seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

8. Request to approve Emergency Clause for Ordinance No. 1542, making it effective immediately upon passage. Gary Isbell made a motion to approve Item 8. Donna Ogez seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

9. Request to approve Change Order No. 005 for the 111th Street & Elwood Avenue Improvements Project (ODOT Project Number STP-172B(276)IG) for changing the 8-inch barrier curb and gutter to a 6-inch barrier curb and gutter in the design documents. There is no cost for this change order. City Engineer Chris Cloyde introduced Item 9 and answered questions. City Manager Christopher Shrout also answered questions. Cory Box made a motion to approve Item 9. Dawn Dyke seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

10. Request to enter into an agreement with Universal Field Services, Inc. for Right-of-Way Acquisition for Main Street (Elm Street to 1st Street)(ODOT project number STP-31550(04)) in the total amount of $45,600 including the City portion in the amount of $11,400; funding for the same is included in the 2020 G.O. Bond Projects (Account No. 27-860-5393)(Main Street Improvements – Roads & Bridges). City Engineer Chris Cloyde introduced Item 10 and answered questions. Cory Box made a motion to approve Item 10. Donna Ogez seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes

Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

11. Request to approve the loan agreement between the JPWA and JAA for $400,000 at a variable interest rate starting at 0.50% due March 1, 2026, with monthly principal and interest payments starting April 1, 2021. [Sauceda] Finance Director Robert Sauceda introduced Item 11. He and City Manager Christopher Shrout answered questions. Cory Box made a motion to approve Item 11. Donna Ogez seconded the motion. A roll call vote of members was taken as follows:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried.

12.

Adjournment. Kaye Lynn made a motion to adjourn. Dawn Dyke seconded the motion. A roll call vote of members was taken as follow:

Kaye Lynn	Yes
Donna Ogez	Yes
Craig Murray	Yes
Gary Isbell	Yes
Cory Box	Yes
Dawn Dyke	Yes
Mayor Robert Lee	Yes

Motion Carried. The Jenks City Council adjourned at 9:18 p.m.

Robert Lee, **MAYOR**

CITY CLERK

Exhibit A: Councilor Lynn Documents

OKLAHOMA COVID-19 WEEKLY REPORT

Weekly Epidemiology and Surveillance Report
February 5– February 11, 2021

PURPOSE To provide up-to-date weekly epidemiological data on COVID-19 in Oklahoma.

SNAPSHOT

	Feb 5 – Feb 11	Change[1]	Total
Cases	12,336	-21.1%	409,401
Recovered cases[2]	15,893	-9.8%	382,342
Deaths	267	3.5%	3,948

1. Change from the week of Jan 29- Feb 4, 2021.
2. Currently not hospitalized or deceased and 14 days after onset/report.

CASES

Persons aged 50 and over	Females	Pe ag an
34% of cases	**53%** of cases	**9** of

KEY POINTS

- **12,336** cases were reported in the past week
  21.1% decrease from the week before (Jan 29 – Feb 4)
- **267** deaths were reported in the past week
  8.8% decrease from the week before (Jan 29 – Feb 4)
- **23,020 (5.6%)** cases have been hospitalized
- **3,332,630** specimens have been tested in total
- **620,746** vaccine doses have been administered in total

The average age of cases wa

The youngest case was **less** oldest case was **100+ years**.

The average age of individua

The youngest individual to di **than 15 years** and the oldest

OKLAHOMA COVID-19 WEEKLY REPORT

Weekly Epidemiology and Surveillance Report
January 29 – February 4, 2021

PURPOSE To provide up-to-date weekly epidemiological data on COVID-19 in Oklahoma.

SNAPSHOT

	Jan 29 – Feb 4	Change[1]	Total
Cases	15,635	-15.0%	397,065
Recovered cases[2]	17,613	-18.8%	366,449
Deaths	258	-8.8%	3,681

1. Change from the week of Jan 22- Jan 28, 2021.
2. Currently not hospitalized or deceased and 14 days after onset/report.

CASES

Persons aged 50 and over	Females	Pe ag an
34% of cases	**53%** of cases	**9** of

KEY POINTS

- **15,635** cases were reported in the past week
  15% decrease from the week before (Jan 22 – Jan 28)
- **258** deaths were reported in the past week
  8.8% decrease from the week before (Jan 22 – Jan 28)
- **22,317 (5.6%)** cases have been hospitalized
- **3,243,791** specimens have been tested in total
- **494,085** vaccine doses have been administered in total

The average age of cases wa

The youngest case was **less** oldest case was **100+ years**.

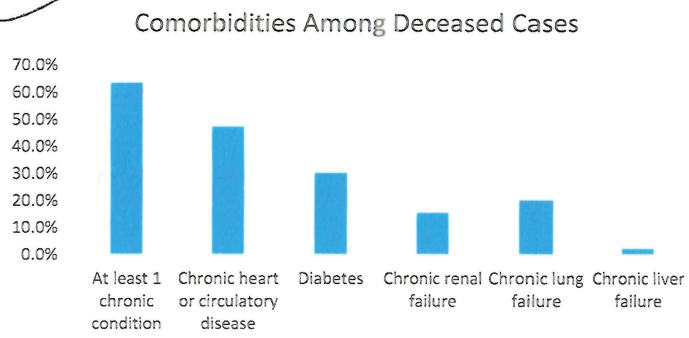
The average age of individua

The youngest individual to di **than 15 years** and the oldest

COMORBIDITIES AMONG DECEASED CASES

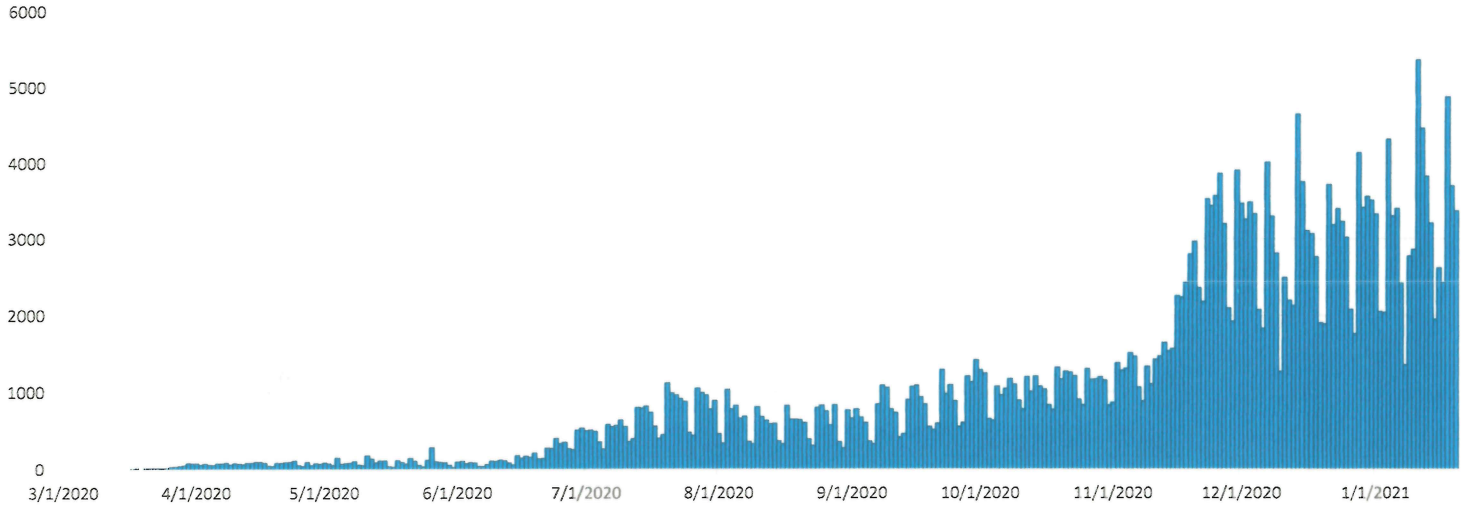
Comorbidities	Number (%)
At least 1 chronic condition[3]	1,991 (63.4)
Chronic heart or circulatory disease	1,487 (47.4)
Diabetes	949 (30.2)
Chronic renal failure	488 (15.5)
Chronic lung failure	636 (20.3)
Chronic liver failure	68 (2.2)

[3]Chronic conditions include; chronic heart or circulatory disease, diabetes, chronic lung failure, chronic liver failure and renal failure.



RECOVERED CASES

Distribution of **recovered cases of COVID-19, March 2020 – January 2021, Oklahoma**



Note: A recovered case is an individual currently not hospitalized or deceased AND 14 days after the onset of symptoms

HEALTH CARE

Health Department unable to determine mask-mandate impact

January 26, 2021

Ray Carter

Director, Center for Independent Journalism

View Bio

Officials at the Oklahoma State Department of Health say they are no longer able to provide accurate data on what, if any, impact mask mandates have on COVID-19 transmission and will no longer be providing that information to the public.

That change is occurring even as one lawmaker has filed a bill that would subject Oklahomans to fines of up to $1,000 for failure to wear a mask in public.

House Bill 2192 (http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20INT/hB/HB2192%20INT.PDF), by state Rep. Jason Lowe, would create the COVID-19 Save Lives Response Act. The bill would impose a statewide mask mandate until the Oklahoma State Department of Health confirms that COVID-19-related hospitalizations have remained at or below 300 for 30 consecutive days.

"It is time that our state takes action against COVID-19 to save lives and to successfully and safely reopen schools and our economy," said Lowe, D-Oklahoma City. "Though it is great that the Pfizer and Moderna vaccines are now being distributed throughout the state, it is still necessary that we practice social distancing and wear masks to protect our communities until enough people receive the vaccine."

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(https://www.ocpathink.org/post/health-department-unable-to-determine-mask-mandate-impact?print)

Under Lowe's legislation, any Oklahoman age five or older "who is medically able to tolerate a face covering shall be required to cover his or her nose and mouth with a mask or face covering when in a public place and unable to maintain, or when not maintaining, social distance."

The bill also mandates that there "shall be no nonessential gatherings of greater than ten individuals for any reason at any location in the state, including, but not limited to, parties, celebrations or other social events." HB 2192 also bans certain outdoor public gatherings "on public property such as streets, sidewalks, parking lots, parks or playgrounds."

Under the bill, individuals who violate the proposed mask law would face fines of $1,000 per violation, while those who violate the ban on group gatherings would face fines of up to $15,000 per violation.

"A mask mandate is long overdue," Lowe said. "We have actual data that shows mandates help decrease the spread. If the executive branch won't act on its own, it is imperative that we as legislators put into place precautions that save lives."

The "Weekly Epidemiology and Surveillance Report (https://oklahoma.gov/covid19/newsroom/weekly-epidemiology-and-surveillance-report.html)" issued by the state has long provided data that compares COVID-19 infections in areas with mask mandates to parts of Oklahoma that do not have mask mandates.

That data has not provided consistent support to claims mask mandates have a dramatic impact on infection.

The biggest difference in rates was recorded early in August with areas that mandated mask-wearing on the wrong side of the infection equation. According to the state report, on Aug. 1, areas with mask mandates had a 40-percent higher per-capita incidence rate of COVID-19 than parts of Oklahoma without mask mandates, based on a seven-day average number of cases.

By the start of September, there was little difference in incidence rates in the two areas. Then, in October and November, the per-capita COVID-19 infection rate was higher in areas that did not mandate mask-wearing.

But the report issued for the week of Nov. 27 to Dec. 3, 2020 showed a reversal of that trend. At that point, there were 73.3 COVID-19 cases per 100,000 population in areas of Oklahoma with mask mandates, compared to 70.3 cases per 100,000 population in areas that did not mandate masks.

From Sept. 1 to Dec. 1, the overall per-capita increase in COVID-19 infections in both parts of Oklahoma was almost identical.

The following state report, covering Dec. 4 to Dec. 10, was expanded to include COVID-19 rates in areas that had a mask mandate prior to October, areas that had issued mask mandates since October, and areas that had not mandated mask-wearing.

The state report defended separating mask-mandate areas into two groups, stating, "Because mask usage prevents new infections but does not impact those currently in the incubation period, it is not appropriate to include these recent additions in the same group as communities that adopted mandates prior to October. Indeed, it is likely that increasing disease rates in these communities influenced the decision to adopt mandates."

At that point, areas without mask mandates had lower per-capita infection rates than both

sets of mask-mandating communities. Areas that did not mandate masks also continued to have the lowest per-capita COVID-19 infection rates of the three groups during the week of Dec. 11 to 17.

Then, in the week of Dec. 18 to 24, infection rates were highest in areas that mandated mask wearing after October, while the lowest rates were recorded in areas that had mask mandates in place prior to October, with non-mandate areas ranked in the middle. That pattern continued the week of Dec. 25 to 31, and the week of Jan. 1 to 7.

However, the Jan. 1 to 7 report showed that areas with no mask mandate reported 72.6 cases per 100,000 population, compared to 101.2 cases per 100,000 residents in areas that had imposed masks after October, well past the amount of time supporters claim mask mandates begin to reduce rates.

That pattern continued the week of Jan. 8 to 14 when areas that did not mandate masks recorded 84.3 cases per 100,000 population, compared to 133 cases per 100,000 in areas that had imposed mask mandates since October.

Recent state reports have noted, "Of course, mask mandates are not the only mitigation effort being employed, and it is not possible to determine what effect that alone has."

The report for Jan. 15 to 21 was the first that did not include mask-mandate data on COVID-19 rates.

A spokesman for the Oklahoma State Department of Health said it was "getting increasingly complex" to provide that data "given the varying implementation dates and city variance, so there is no plan currently to include the graph/table in future reports."

nothing had changed what changed over months -

Ray Carter

Director, Center for Independent Journalism

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WUHAN VIRUS

CDC Study Finds Overwhelming Majority Of People Getting Coronavirus Wore Masks

OCTOBER 12, 2020 By Jordan Davidson

A Centers for Disease Control report released in September shows that masks and face coverings are not effective in preventing the spread of COVID-19, even for those people who consistently wear them.

A study conducted in the United States in July found that when they compared 154 "case-patients," who tested positive for COVID-19, to a control group of 160 participants from health care facilities who were symptomatic but tested negative, over 70 percent of the case-patients were contaminated with the virus and fell ill despite "always" wearing a mask.

"In the 14 days before illness onset, 71% of case-patients and 74% of control participants reported always using cloth face coverings or other mask types when in public," the report stated.

TABLE. (*Continued*) Characteristics of symptomatic adults ≥18 years who were outpatients in 11 academic health care facilities and who received positive and negative SARS-CoV-2 test results (N = 314)* — United States, July 1–29, 2020

Characteristic	No. (%) Case-patients (n = 154)	Control participants (n = 160)	P-value
Previous close contact with a person with known COVID-19 (missing = 1)			
No	89 (57.8)	136 (85.5)	<0.01
Yes	65 (42.2)	23 (14.5)	
Relationship to close contact with known COVID-19 (n = 88)			
Family	33 (50.8)	5 (21.7)	<0.01
Friend	9 (13.8)	4 (17.4)	
Work colleague	11 (16.9)	6 (26.1)	
Other**	6 (9.2)	8 (34.8)	
Multiple	6 (9.2)	0 (0.0)	
Reported use of cloth face covering or mask 14 days before illness onset (missing = 2)			
Never	6 (3.9)	5 (3.1)	0.86
Rarely	6 (3.9)	6 (3.8)	
Sometimes	11 (7.2)	7 (4.4)	
Often	22 (14.4)	23 (14.5)	
Always	108 (70.6)	118 (74.2)	

In addition, over 14 percent of the case-patients said they "often" wore a face covering and were still infected with the virus. The study also

demonstrates that under 4 percent of the case-patients became sick with the virus even though they "never" wore a mask or face covering.

Despite over 70 percent of the case-patient participants' efforts to follow CDC recommendations by committing to always wearing face coverings at "gatherings with ≤10 or >10 persons in a home; shopping; dining at a restaurant; going to an office setting, salon, gym, bar/coffee shop, or church/religious gathering; or using public transportation," they still contracted the virus.

While the study notes that some of these people may have contracted the virus from the few moments that they removed their mask to eat or drink at "places that offer on-site eating or drinking," the CDC concedes that there is no successful way to evaluate if that was the exact moment someone became exposed and contracted the virus.

"Characterization of community exposures can be difficult to assess when widespread transmission is occurring, especially from asymptomatic persons within inherently interconnected communities," the report states.

In fact, the report suggests that "direction, ventilation, and intensity of airflow might affect virus transmission, even if social distancing measures and mask use are implemented according to current guidance."

Despite this new scientific information, the CDC, Director of the National Institute of Allergy and Infectious Diseases Dr. Anthony Fauci, and many political authorities are still encouraging people to wear masks. Many states and cities have even mandated masks, citing them as one of the main tools to "slow the spread" of coronavirus and keep case numbers in their area down.

Ok Council of Public Affairs

OCPA

BUDGET & TAX

Federal COVID funding in Oklahoma far exceeding actual need

January 25, 2021

Ray Carter

Director, Center for Independent Journalism

View Bio

Projection not met

When the COVID-19 pandemic first began sweeping the country, Congress responded by approving in March 2020 a huge package of bailout funding for state governments via the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.

But roughly 10 months later, millions of dollars remain unspent in Oklahoma because the anticipated need never materialized, including at the state's health care and education entities.

The CARES Act included an increase in the Federal Medical Assistance Percentages (FMAP) used to calculate federal matching funds for state Medicaid programs, which funneled millions more in federal funding to states to pay for COVID-19 related health needs.

But Oklahoma Health Care Authority CEO Kevin Corbett informed lawmakers that those expenses have not appeared in the volume anticipated.

"I will tell you today that those needs have not necessarily presented themselves in the manner in which the COVID response or the COVID FMAP was intended," Corbett said. "In other words, we haven't seen the level of utilization equal to the amount of support that we have received, so that has obviously increased our level of cash reserves."

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(https://www.ocpathink.org/post/federal-covid-funding-in-oklahoma-far-exceeding-actual-need-1?print)

In a normal year, the agency maintains about $80 million in cash reserves. Currently, the Oklahoma Health Care Authority has $217 million in cash reserves, primarily as the result of unspent federal COVID-19 bailout funds.

Millions of health care and education dollars remain unspent in Oklahoma.

Corbett told members of the Senate Appropriations Subcommittee on Health and Human Services that increased demand for those funds could still appear due to COVID-19, but "we haven't seen the utilization at this point."

The Oklahoma Health Care Authority is the second major agency to publicly acknowledge a surplus of unused federal COVID-19 funding.

Earlier this month, officials from the Oklahoma State Department of Education reported (https://www.ocpathink.org/post/nearly-100-million-unspent-from-school-covid-funds) that just $46 million of $144 million in CARES Act funding directed to K-12 schools had been expended by the middle of the ongoing school year.

Even as those millions remain unspent, a far larger infusion of federal "emergency" funding is headed to schools as the result of the December passage of additional bailout funding. An analysis by the Southern Regional Education Board estimated (https://www.sreb.org/sites/main/files/file-attachments/december_2020_stimulus.pdf?1610055978) that Oklahoma will receive another $660.7 million in new federal funding for state school districts, although the Oklahoma State Department of Education could retain 10 percent of that amount.

Ray Carter

Director, Center for Independent Journalism

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(https://www.ocpathink.org

MEDPAGE TODAY®

Op-Ed: Why PCR Cycle Threshold Is Useful in Coronavirus Testing

— It can help better triage patients, physician argues

by Robert Hagen, MD
January 4, 2021

With the increase in positive COVID tests, physicians, contact tracers, and hospitals in our town are very busy. I would imagine the same can be said for your community. With this time of year being normally very high for hospital usage, a strain in the healthcare industry has come to all regions from all angles.

Might there be a better way we can use our resources wisely? Knowing COVID patients' cycle threshold (Ct) values could benefit patients, physicians, and their community.

Many patients test positive for COVID without any symptoms. What does that mean? Medical tests need to be taken in context. Patients question whom they might have gotten it from, whom they might have given it to, and why their spouses -- whom they have lived with in close contact -- do not have it. Some become deniers of proper restrictions and proper healthcare, only making everyone more vulnerable.

For certain patients, knowing the Ct value is not useful. In the first few days when a

patient may be early in their infection and not exhibiting any symptoms, the viral load may not have risen high enough to cause a useful Ct value. In these situations, antigen tests done sequentially may be more useful.

As the viral load increases, however, knowing Ct values becomes more helpful. These can be another piece of data that a physician can use to manage a patient's care.

Patients with symptoms who come to the hospital and have a high Ct number (meaning less viral load) and few comorbidities might be best triaged to outpatient treatments. Home oxygen saturation monitoring, daily contact with home health nurses to determine extent of new symptoms, or, if indicated, some of the new outpatient monoclonal antibodies or remdesivir, might be best given outpatient. This would save valuable resources for those symptomatic patients with comorbidities with lower Ct values (indicating higher viral loads) who need more elaborate inpatient treatment and monitoring.

Not all tests used today give us this information. Qualitative PCR testing only indicates a simple positive or negative based on the internal cut-off point at which the machine shuts off. Quantitative testing where you actually know the cycle threshold value is becoming more available. Each have their benefits and limitations.

The FDA has given lab manufacturers a wide latitude in determining the cycle threshold cut-off number of their qualitative tests to determine positive versus negative. These tests were approved under Emergency Use Authorization and have not been subjected to typical FDA scrutiny. With this in mind, the state of Florida has required all laboratories doing COVID testing to report the cycle threshold numbers used in qualitative and quantitative tests.

So how does a qualitative RT-PCR test work? Basically, the manufacturer sets the test to turn off the cycling or amplification process when a certain number is hit. For a qualitative test set at 40, after 40 amplification cycles, if any viral material is detected, it turns off and is reported as positive. If none is detected, it would be reported as negative. If the number of amplification cycles was really 15 or 25, it would still run until it gets to 40 and be reported as positive.

With these type of tests, it's critical to use an agreed-upon cycle threshold value such as 33

(CDC) or 35 (Dr. Fauci) rather than setting it at a potentially misleading 40 or 45. Many of the current tests in use are preset by the manufacturer to these higher numbers.

The World Health Organization issued a notice last week telling the labs "the cut-off should be manually adjusted to ensure that specimens with high Ct values are not incorrectly assigned SARS-CoV-2 detected due to background noise." Could this be a reason why many people test positive but remain asymptomatic? In that same memo, WHO said all labs should report the cycle threshold value to treating physicians.

A quantitative test is designed to come up with the actual cycle threshold value as the cycling process turns off when detecting any virus. There is not a preset value, so a quantitative measure is obtained. A test that registers a positive result after 12 rounds of amplification for a Ct value of 12 starts out with 10 million times as much viral genetic material as a sample with a Ct value of 35. Above that level, Fauci has said the test is just finding destroyed nucleotides, not virus capable of replicating.

It's not only physicians who can use this information. Contact tracers who know Ct values can direct their attention to those with the lowest numbers. "If 100 files land on my desk as a contact tracer, I will prioritize the highest viral loads first because they are the most infectious," Michael Mina, MD, PhD, an epidemiologist at Harvard, has said.

The CDC has been less supportive of reporting Ct values to help guide the treatment of patients. The agency rightly points out that Ct values are not indicated to determine when a person is no longer infectious. That information is just not known. Moreover, the CDC does not agree that Ct thresholds measure viral load in an individual patient.

Still, CDC guidance does acknowledge that "serial Ct values may be useful in the context of the entire body of information available when assessing recovery and resolution of infection." I am not suggesting using Ct values to determine when one's infectivity is over, but certainly when used appropriately and serially it can only help in predicting severity in the management of patients.

Knowing a patient's Ct value is not the panacea for all ills. Ct numbers are not perfect and vary from machine to machine, but at this point they are all we have. Viral cultures are near impossible to obtain and take much too long. Ct values are an important piece of data, especially if it is routinely reported accurately so that skilled physicians can incorporate it

in their decision-making process. I suspect some physicians are already finding ways to access this information. It is of utmost importance that labs use correct reference values that give healthcare workers a chance at directing care effectively.

Simply knowing a yes or no answer is no longer enough. For a qualitative test, at the minimum a positive or negative result AND reporting the lab-cut off Ct value is essential. Ideally knowing the absolute number from a quantitative test is best. I would make an analogy to a hemoglobin and hematocrit test simply being reported as normal or abnormal -- none of us in healthcare would accept that.

There are nuances in medicine that we need to know to best treat our patients-cycle threshold levels are one of those. So if you will, push your labs to tell you your patient's Ct value. It will make triaging and "predicting the future," which we all are being asked to do, much more accurate. After all, is this not a patient care issue?

Robert Hagen, MD, is recently retired from Lafayette Orthopaedic Clinic in Indiana. He's an adjunct professor at Indiana University, a past president and board member of the Indiana Orthopaedic Society, and a past member of the Board of Councilors for the American Academy of Orthopaedic Surgeons.

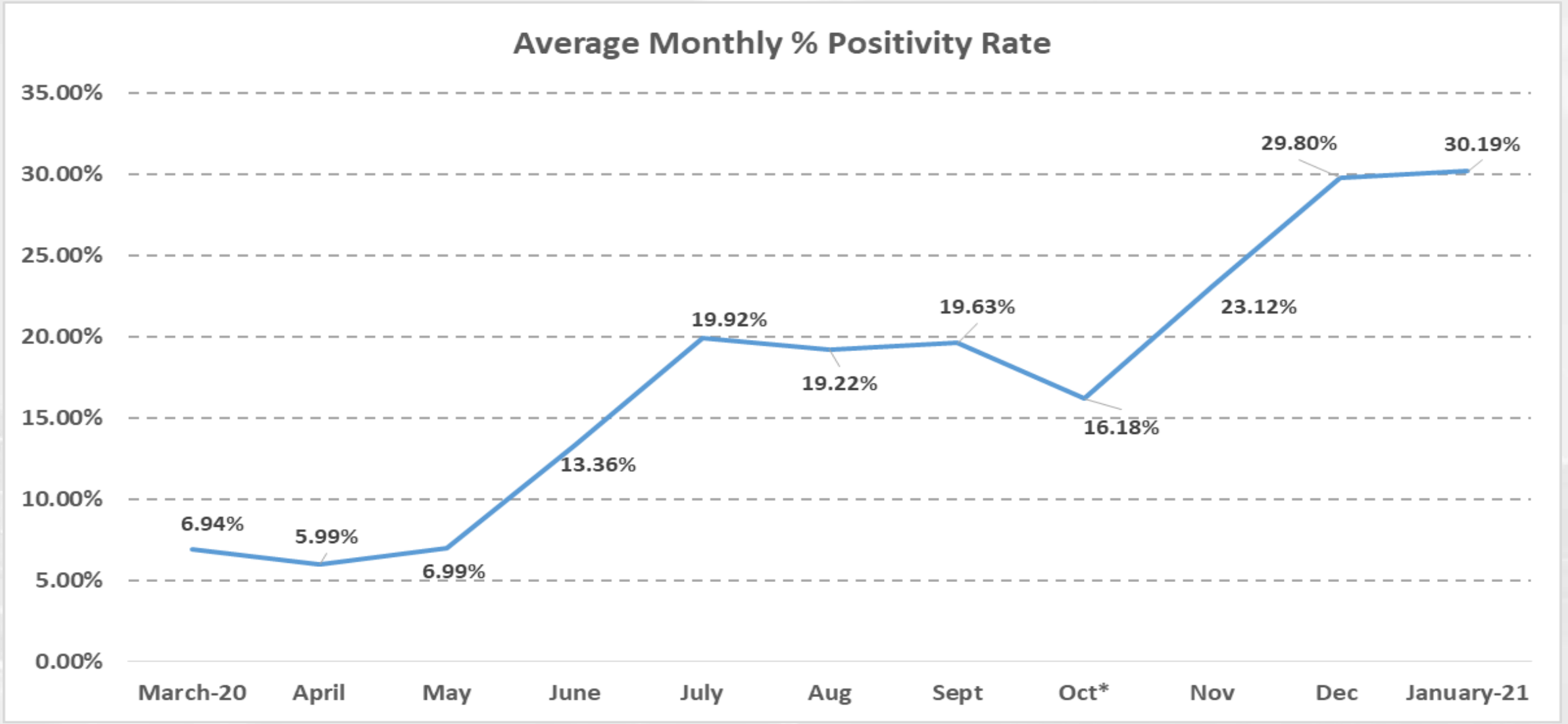
Last Updated January 04, 2021

Exhibit B: Councilor Isbell Documents

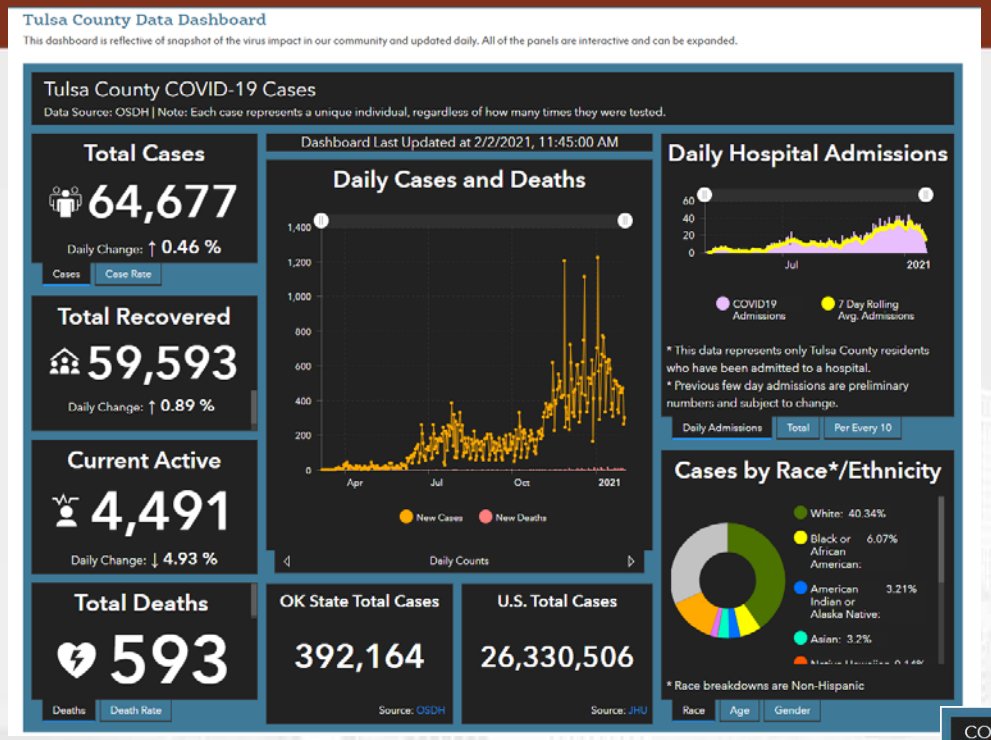
TULSA HEALTH
Department

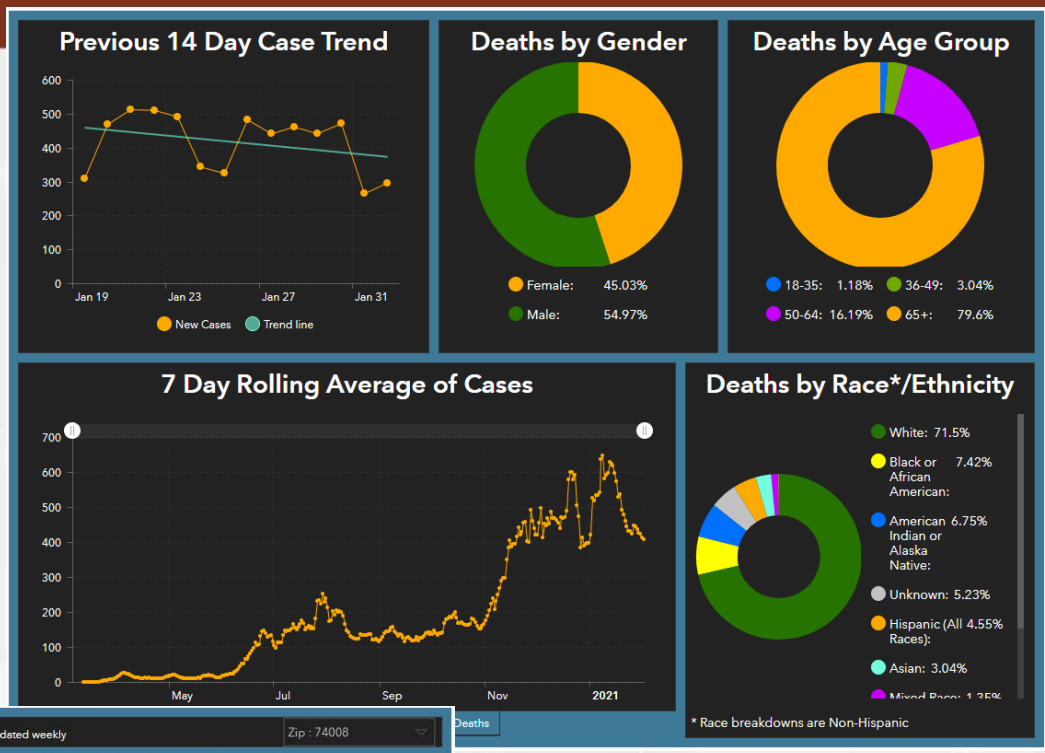
COVID-19 Overview
Tulsa County

Kelly VanBuskirk, MPH

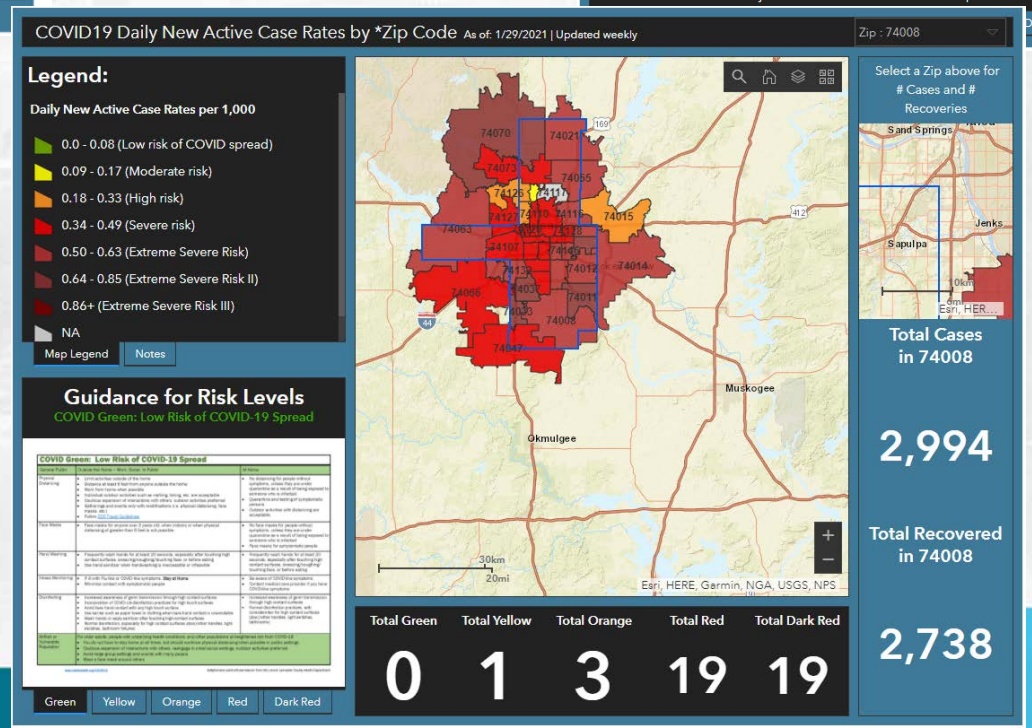


TULSA HEALTH Department





Interactive Data Dashboard



THD TULSA HEALTH Department