



## Public Health and Epidemiology of COVID-19 for Doctors of Optometry

Updated January 11, 2021

The American Optometric Association (AOA) Health Policy Institute (HPI) is providing information relevant to the eye health and vision care community regarding the novel coronavirus (SARS-CoV-2) and COVID-19.<sup>i</sup> Every doctor of optometry should understand the risks associated with this outbreak to ensure continued ability to care for patients.

### Historical Background:

On Jan. 30, 2020, the World Health Organization (WHO) declared COVID-19 (then known as 2019 nCoV) as a global health emergency. The U.S. Secretary of Health and Human Services (HHS) declared a public health emergency on Jan. 31, 2020, under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID-19.<sup>ii iii</sup>

On [March 30, 2020](#), the WHO reported that the rapidly increasing demand on health facilities and health workers threatens to leave health systems worldwide overstretched and unable to operate effectively. The focused message was that physical distancing measures are necessary to slow the transmission of the virus to aid the health care system and mitigate the risk of systems collapse. Adding, "to suppress and control COVID-19 epidemics, countries must isolate, test, treat and trace. If they don't, transmission chains can continue at a low level, then resurge once physical distancing measures are lifted. Don't assume your community won't be affected. Prepare as if it will be. Don't assume you won't be infected. Prepare as if you will be."<sup>iv</sup>

The U.S. Centers for Disease Control and Prevention (CDC) stresses that COVID-19 can result in severe disease, including hospitalization, admission to an intensive care unit and death, especially among older adults (ages 55 and over) and adults with certain underlying health conditions. Everyone can take actions, such as social distancing and staying home, to help slow the spread of COVID-19 and protect older adults from severe illness.<sup>v</sup>

### COVID-19 in the United States

The post-holiday surge of COVID-19 has thrust the U.S. into its darkest days of the pandemic, with cases rising in nearly every state. The country reported 300,594 new cases on January 8, 2021 and more than 4,100 deaths on January 7, 2021.<sup>vi</sup> On January 10, 2021 the U.S. recorded 35% of all worldwide cases that day.

According to a January 11, 2021 [New York Times data base](#), 22.4 million+ people across every state, plus Washington, D.C., and three U.S. territories, have tested positive for COVID-19, and at least 374,428 people with the virus have died (a +47% 14-day change). Case numbers remain persistently high across the country with 208,338 new cases and 1,777 new deaths reported in the U.S. on January 10, 2021. Over the past week, there has been an alarming average of 254,866 cases per day, an increase of 38% from the average two weeks earlier. Cases are now rising in all states. The country has set records for cases, deaths and hospitalizations in recent days even as officials imposed new restrictions seeking to curb the virus's spread. In California, the state currently with the most known cases, more than 2,729,525 people have had COVID-19 and 42,241 of those were in the last seven days. Florida, which now has 1,477,002 COVID-19 cases, has passed New York, which has 1,135,849 cases. You can find nationally where cases are rising the fastest [here](#).

### ***Latest COVID-19 Research Developments:***

#### **Infection Control:**

With substantial community transmission the use of eye protection in addition to N95 masks for infection control is now recommended for doctors of optometry and their staff working in close proximity of patients, as part of PPE. <sup>vii</sup>

**Vaccine:** Two COVID-19 vaccine candidates have been approved in the U.S. including Pfizer-BioNTech and Moderna vaccines and there are currently 20 vaccines in Phase 3 testing and 7 vaccines in early or limited use according to the New York Times Vaccine Tracker. The emergence of more contagious variants has added urgency to the country's [vaccine rollout](#), which has gotten off to a slow start. Reported cases of the B.1.1.7 variant of SARS-CoV-2 have been confirmed in at least eight states in the US. The variant was first found in Colorado, then later in California, Florida, Georgia, New York, Texas, Pennsylvania and Connecticut.<sup>viii</sup> As of January 10, 2021, approximately 6.7 million people have received at least one dose of a Covid-19 vaccine, far short of the goal federal officials set to give at least 20 million people their first shots before the end of December, 2020. At least 151,000 people in the United States have been fully vaccinated, according to a New York Times survey of all 50 states. Doctors of optometry in many states are receiving vaccinations as part of the CDC recommended (1a) initial role out. In many states doctors of optometry have requested to be included as COVID-19 vaccine providers in their state.<sup>ix</sup>

#### **The Impact of COVID-19 on the Eyes: *Currently recruiting***

To characterize eye symptoms related to COVID-19 the NIH/National Eye Institute (NEI) is currently soliciting individuals over age 18 who have been diagnosed with COVID-19 to take an online survey.

The survey responses are designed to allow researchers to learn more about eye symptoms in COVID-19 infection, including how common they are and how they relate to other COVID-19 associated symptoms.

<https://content.govdelivery.com/accounts/USNIHCC/bulletins/2b05221>

### **Neurologic abnormalities in those who recovered from acute COVID-19: *Currently recruiting***

To characterize ongoing neurologic abnormalities in those who recovered from acute COVID-19 infection yet have persistent neurologic symptoms, the NIH is recruiting individuals for a new study entitled; *An Observational Study of Neurologic Function After COVID-19 Infection*.

Despite clinical recovery from the acute infection, some individuals continue to experience ongoing symptoms, at times several months after recovery, and many of these symptoms are neurologic. The NIH Clinical Center provides the breadth of expertise and resources to best investigate this patient group. This study will collect a broad array of specialized neurologic testing in this group who, despite recovering from the acute SARS-CoV-2 infection, continue to experience neurological symptoms. It is hypothesized that this group will have abnormalities on neurologic testing that may identify discrete phenotypes of COVID-19 sequelae.

<https://clinicaltrials.gov/ct2/show/NCT04564287?cond=COVID-19&fund=01&draw=2&rank=4>

### **Immune response in patients with current or prior COVID-19 infection: *Currently recruiting***

To characterize immune response in patients with current or prior COVID-19 infection the NIH is recruiting individuals for a new prospective observational study entitled; *Investigation of the B- and T-cell Repertoire and Immune Response in Patients With Acute and Resolved COVID-19 Infection*.

Patients infected with COVID-19 have an unpredictable risk to worsen and die, making it difficult to decide who can quarantine at home and who should be monitored for respiratory failure as an inpatient. This risk may be related in part to the patient's immune response which can be characterized with respect to the B- and T-cell repertoire. Determining patterns of immune response which correlate with clinically effective immunity may help in determining risk. Furthermore, in patients with hematologic malignancies, it is not known if they should be steered away more from treatments which harm B-cell immunity or steered away from treatments which harm T-cell immunity. Characterizing the immune response in COVID-19 patients will quickly answer this question.

<https://clinicaltrials.gov/ct2/show/NCT04362865?cond=COVID-19&fund=01&draw=2&rank=10>

Since COVID-19 is a new disease, very little is known about possible clinical sequelae that may persist after resolution of the acute infection. In addition, the characteristics of the initial cellular immune and antibody response to SARS-CoV-2 (the virus that causes COVID-19) have not been fully defined and it is not known if the immune responses generated by infection provides long-term protective immunity. The NIH is currently recruiting individuals for a new *Longitudinal Study of COVID-19 Sequelae and Immunity*.

The purpose of this study is to establish a longitudinal cohort that has recovered from COVID-19 and characterize the clinical sequelae of acute infection, characterize the immune response to the virus, and follow the evolution of the immune response over time and determine the extent to which natural immunity is protective against re-infection.

<https://clinicaltrials.gov/ct2/show/NCT04411147?cond=COVID-19&fund=01&draw=3&rank=11>

### Surveillance of Individuals Following SARS-CoV-2 Exposure: *Currently recruiting*

People who have had contact with a person with a known SARS-CoV-2 infection are being told to self-quarantine for 14 days. This is done to avoid potential virus spread. But the actual time it takes for a person to develop an infection after being exposed to the virus is not well known. The proper quarantine time could be less or more than 2 weeks.

The NIH is now soliciting individuals for a prospective longitudinal cohort study of contacts of individuals with exposure to severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2). The aim is to correlate results of reverse transcription polymerase chain reaction (RT-PCR) using various sample types, assays, and culture. We will perform serial screenings of NIH employees who have had contact with reported, suspected, or known cases. We will also enroll individuals with previous or current infection who are asymptomatic at enrollment. The serial screenings will be done at multiple timepoints over 2 days using (RT-PCR) tests of nasopharyngeal (NP) swabs, saliva samples, midturbinate swabs, antibody assays, and culture. Researchers hope this study can be used to help improve public health guidelines for quarantines, social distancing, and returning to work after a possible SARS-CoV-2 exposure.

<https://clinicaltrials.gov/ct2/show/NCT04383444?cond=COVID-19&fund=01&draw=4&rank=28>

People who get COVID-19 have a wide range of symptoms. They also recover from COVID-19 in different ways. To learn more about the range and timing of symptoms that people have before, during, and after COVID-19 infection NIH is currently recruiting for a study entitled: ***Natural History of Post-Coronavirus Disease 19 Convalescence at the National Institutes of Health. Currently recruiting***

In this study, researchers will use survey data to describe the different ways people experience and recover from COVID-19. They will also use the data to help create future studies to understand why some people do not fully recover.

<https://clinicaltrials.gov/ct2/show/NCT04573062?cond=COVID-19&fund=01&draw=14&rank=130>

### **Disease Transmission:**

COVID-19 is of high concern because it is a novel virus, meaning it has never occurred before in humans. It is important to note that the virus is transmitted person-to-person through either direct contact or an exchange of bodily fluids. A [study published in the New England Journal of Medicine on March 17, 2020](#) found that viable virus could be detected up to three hours later in the air, up to four hours on copper, up to 24 hours on cardboard and up to two to three days on plastic and stainless steel. With airborne transmission still not, to date, fully incorporated into public health directives, 239 scientists in 32 countries [have outlined the evidence showing that smaller airborne particles can float in the air and infect people](#), and are calling for the WHO to revise its recommendations which accepted the evidence on July 7, 2020.<sup>x</sup> This evidence shows that SARS-CoV-2 can stay in the air longer and travel farther in tinier bits, called aerosols, and that these aerosols can be generated by people talking, breathing or singing. This SARS-CoV-2 aerosolization combined with staying indoors in colder months can produce much higher

rates of infection in the fall and winter. According to October 5, 2020 projections from the University of Washington's Institute for Health Metrics and Evaluation, COVID-19 could kill more than 2,900 people a day in the U.S. by December 27, 2020.<sup>xi</sup>

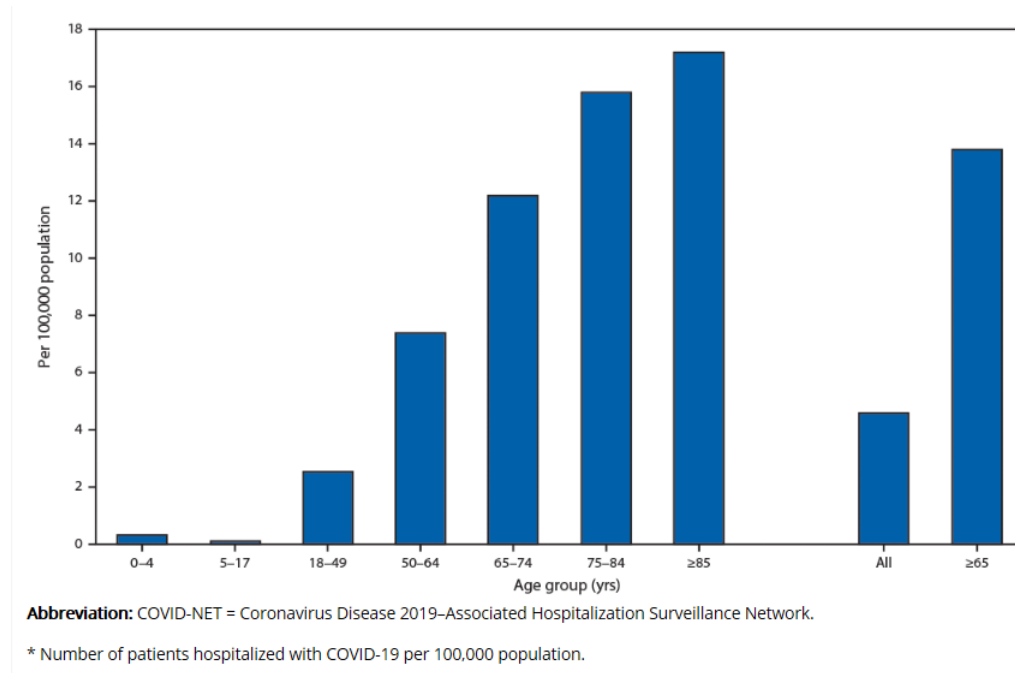
On June 3, 2020, it was reported in the *Annals of Internal Medicine* that asymptomatic persons account for approximately 40% to 45% of SARS-CoV-2 infections.<sup>xii</sup> This highlights the necessity of assuming all people as possibly being carriers. Dr. Thomas Frieden, chief executive at [Resolve to Save Lives](#), an initiative of Vital Strategies to prevent epidemics and cardiovascular disease, and former director of the CDC, adds that superspreading events may involve people with symptoms that linger but who are not sick enough to stay home. The secondary attack rate of transmission of a virus is therefore an important number to monitor. This number ( $R_0$ , pronounced R-nought or r-zero) serves as an indicator of how easy the disease spreads from person-to-person, as indicated by its reproductive number, which represents the average number of people who will catch the disease from a single infected person. An outbreak with a reproductive number of below 1.0 will gradually disappear. Early in the pandemic the  $R_0$  of COVID-19 has been reported as high as 4.08 while other studies estimating the  $R_0$  to be between 1.5 and 3.5.<sup>xiii xiv xv xvi</sup> Based on these numbers, on average every case of COVID-19 would create three to four new cases. Recent reports now present state-by-state estimates of  $R_0$  and confirm in New York State the  $R_0 = 6.4$ , explaining what is known about COVID-19, that it has the potential to spread rapidly, especially in urban areas. Estimates of  $R_0$  reveal potential challenges for vaccination campaigns: using the rule of thumb that a proportion  $1 - 1/R_0$  of a population needs to be vaccinated, vaccination coverage will have to be roughly 60% on average among the states. However, when the  $R_0$  variation among states is considered, the  $R_0 = 6.4$  for New York state suggests a vaccination coverage rate of 85%.<sup>xvii</sup>

On September 24, 2020, the CDC reported that from June through August, the incidence of COVID-19 was highest among adults age 20-29 years old with young adults now accounting for more than 20% of all confirmed cases. The CDC study confirms that these infected young adults seeded waves of new infections among the middle-aged, and then in older Americans.<sup>xviii</sup> The storming of the U.S. Capital on January 6, 2021 and defiance of common precautions known to spread the disease is now thought to become a COVID-19 superspreader event, which will be impossible to track, according to the *Washington Post*.<sup>xix</sup>

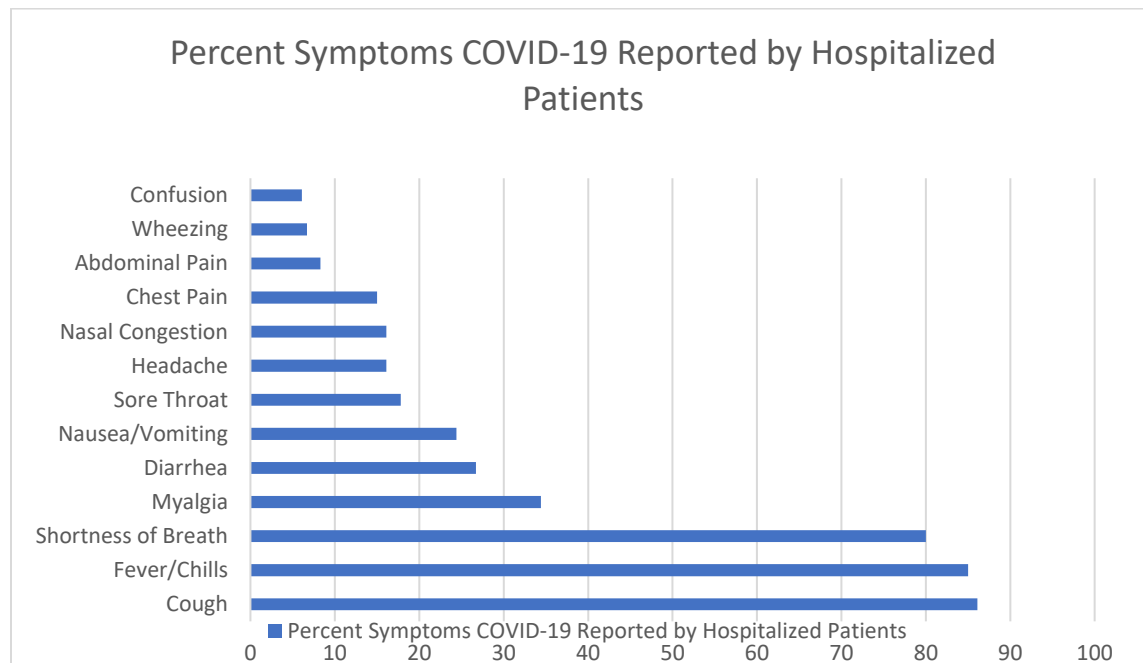
### **Morbidity and Mortality**

The CDC believes that symptoms of COVID-19 may appear in as few as two days or as long as 14 days, with median estimates of five to six days after exposure. American adults of all ages—not just those in their 70s, 80s and 90s—are being seriously sickened by the coronavirus. On April 8, 2020, the CDC released [Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020](#).<sup>xx</sup> On January 8, 2021 a new study found that most (76%) of COVID-19 patients still have at least one symptom six months after first falling ill. Fatigue or muscle weakness is the most common symptom, with sleep difficulties and anxiety or depression also frequently reported. Lower antibodies against COVID-19 in patients six months after becoming ill compared with during acute infection raises concerns about the possibility of re-infection.<sup>xxi</sup>

**Figure 1. Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019—COVID-NET, 14 States, March 1–30, 2020**

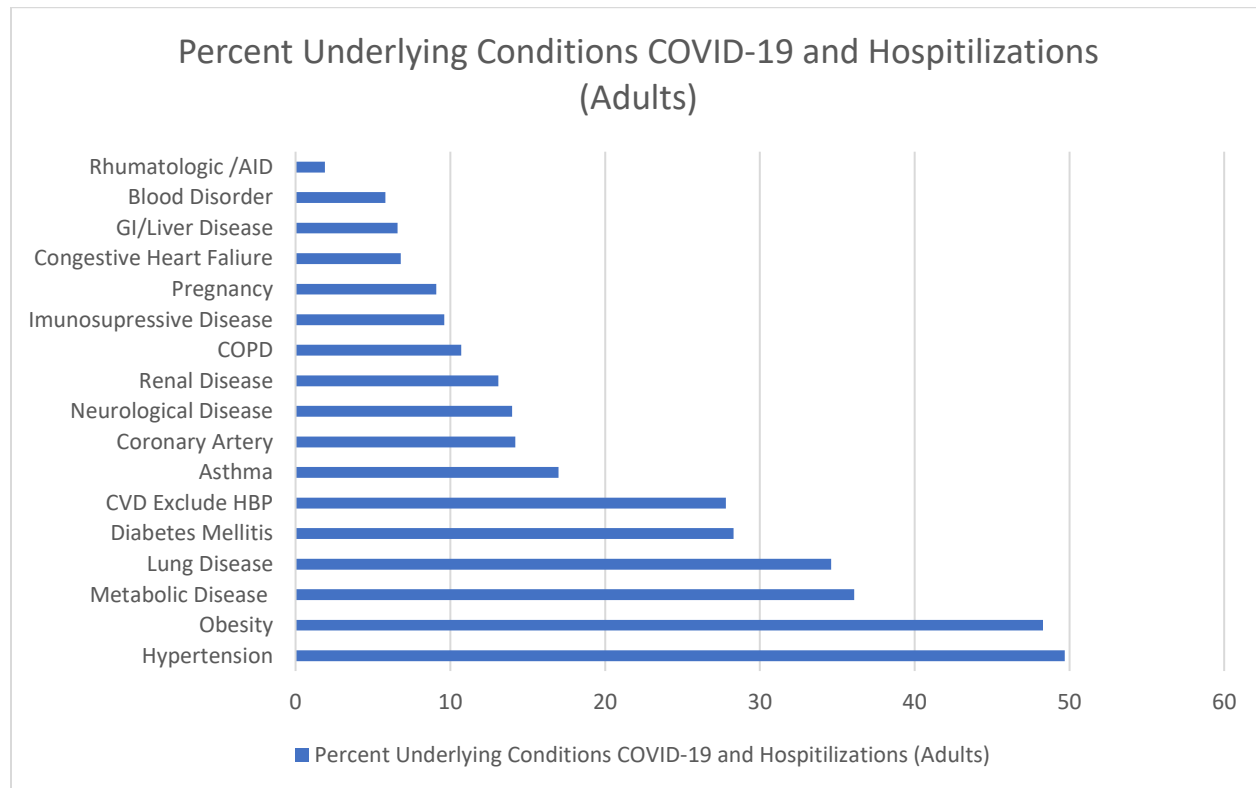


**Figure 2. Underlying symptoms among adults aged ≥18 years with coronavirus disease 2019 (COVID-19)–associated hospitalizations—COVID-NET, 14 states,\* March 1–30, 2020. (Adapted by HPI)**



COVID-19–associated hospitalizations in the United States are highest among older adults, and nearly 90% of persons hospitalized have one or more underlying medical conditions. [Hospitalization Rates and](#)

**Figure 3. Underlying conditions among adults aged ≥18 years with coronavirus disease 2019 (COVID-19)–associated hospitalizations—COVID-NET, 14 states,\* March 1–30, 2020. (Adapted by HPI)**



From the beginning of the spread of the coronavirus, public health officials have repeatedly warned that health complications of COVID-19 are more severe among people with underlying health conditions, of which diabetes, cardiovascular disease and obesity are prominent. New data from CDC researchers showed that people with underlying health conditions were 6 times more likely to be hospitalized than those with no such conditions (45.4% versus 7.6%) and deaths were 12 times higher (19.5% versus 1.6%).<sup>xxiii</sup>

Analysis of COVID-19 cases by race and ethnicity showed incidence out of proportion to percent of the overall U.S. population for Hispanic (33% COVID-19 vs. 18% population), Black (22% COVID-19 vs. 13% population), and American Indian/Alaskan Native populations (1.3% COVID-19 vs. 0.7% population).<sup>xxiv</sup> Among those aged 65 years or older, a population at higher risk for death from COVID-19, 26.8% have DM. Hypertension and severe obesity are present in 68.4% and 15.5% of individuals diagnosed with DM.<sup>xxv</sup> Among people with diabetes with COVID-19, it is possible that higher BMI and A1c levels are linked to worse outcomes.<sup>xxvi</sup> Also, researchers believe that disruptions caused by the pandemic, including increased stress and changes to care, diet and physical activity routines, could contribute to worse outcomes for people with diabetes, and could exacerbate health disparities.<sup>xxvii</sup>

New research also suggests that COVID-19 and diabetes may be a two-way street. Not only do people with diabetes and COVID-19 suffer disproportionately higher rates of severe outcomes, it is also possible that COVID-19 is triggering new cases of type 1 and type 2 diabetes or a new type of diabetes, and among people with existing diabetes, it may be triggering severe metabolic complications, such as diabetic ketoacidosis.<sup>xxviii</sup> Other new studies show that nearly half of hospitalized COVID-19 patients without a prior diabetes diagnosis have hyperglycemia, and the latter is an independent predictor of mortality at 28 days.<sup>xxix</sup>

To help assess this bi-directional hypothesis, a new global registry to track COVID-19-related diabetes, called CoviDiab, has been started by Kings College London and Monash University.<sup>xxx</sup>

Most recently (October 16, 2020), CMS reported new survey data on Medicare and dual eligible beneficiaries and COVID-19. Survey findings indicate that 21% of Medicare beneficiaries report forgoing non-coronavirus (COVID-19) disease care due to the pandemic.

Here is the most recently reported CMS billing data (Received by October 9,2020). Key highlights:

- More than 1,191,402 Medicare beneficiaries have been diagnosed with COVID-19 this year through September 12, translating to 2,002 cases per 100,000 beneficiaries in urban areas and 1,254 per 100,000 beneficiaries in rural areas.<sup>xxxi</sup>
- The 332,672 Medicare beneficiaries hospitalized with a COVID-19 diagnosis this year through September 12 translates to 567 hospitalizations per 100,000 beneficiaries in urban areas and 334 hospitalizations per 100,000 beneficiaries in rural areas. Among those hospitalized with COVID-19, the five most prevalent chronic conditions for Medicare fee-for-service beneficiaries were: hypertension (80%); hyperlipidemia (62%); chronic kidney disease (51%); anemia (48%); and diabetes (50%).<sup>xxxii</sup>
- Medicare COVID-19 Data Snapshot: Only 32% of hospital discharges of beneficiaries were able to return home unaided; 21% expired at the hospital. The remainder required skilled nursing at a facility (22%) or at home (14%). Average cost of hospitalization (at discharge) per beneficiary was \$24,659. Total Medicare payment \$5.1 Billion.
- Medicare COVID-19 Data Snapshot: Medicare hospitalization rates for Black beneficiaries were approximately 3.2X higher than for white beneficiaries. Medicare hospitalization rates for Hispanic beneficiaries were 2X higher than for white beneficiaries.<sup>xxxiii</sup>

## **Conclusion:**

Global concern has escalated due to the rapid spread of the disease internationally including alarmingly high numbers of cases identified and presenting in the U.S. Evolving information from the CDC on the outbreak can be found at [cdc.gov/coronavirus/2019-ncov/about/index.html](https://www.cdc.gov/coronavirus/2019-ncov/about/index.html).

As discussed above, this information is evolving as public health organizations track and learn more about the spreading COVID-19 coronavirus. It is important to monitor for changes in information from the [CDC](https://www.cdc.gov) and [WHO](https://www.who.int) to best protect against infection.



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- <sup>i</sup> On Feb. 11, 2020 the WHO renamed 2019-nCoV to COVID-19.
- <sup>ii</sup> [whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/](https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/)
- <sup>iii</sup> [who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))
- <sup>iv</sup> [who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---18-march-2020](https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---18-march-2020)
- <sup>v</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ambulatory-care-settings.html>
- <sup>vi</sup> <https://www.nytimes.com/live/2021/01/11/world/covid-19-coronavirus>
- <sup>vii</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html>
- <sup>viii</sup> <https://www.newsweek.com/infectious-uk-covid-variant-eight-states-1560001>
- <sup>ix</sup> <https://www.cnn.com/2021/01/08/health/non-traditional-covid-vaccinators/index.html>
- <sup>x</sup> <https://www.nytimes.com/2020/07/04/health/239-experts-with-one-big-claim-the-coronavirus-is-airborne.html>
- <sup>xi</sup> <https://covid19.healthdata.org/global?view=total-deaths&tab=trend>
- <sup>xii</sup> Oran D: Prevalence of Asymptomatic SARS-CoV-2 Infection, A Narrative Review, *Annals of Internal Medicine*, June 3, 2020 <https://doi.org/10.7326/M20-3012>
- <sup>xiii</sup> Estimating the effective reproduction number of the 2019-nCoV in China - Zhidong Cao et al., Jan. 29, 2020 Mandl, Harvard University - Computational Health Informatics Program - Posted: 24 Jan 2020 Last revised: 27 Jan 2020
- <sup>xiv</sup> Novel coronavirus 2019-nCoV: early estimation of epidemiological parameters and epidemic prediction - Jonathan M. Read et al, Jan. 23, 2020.
- <sup>xv</sup> Early Transmissibility Assessment of a Novel Coronavirus in Wuhan, China - Maimuna Majumder and Kenneth D.
- <sup>xvi</sup> Report 3: Transmissibility of 2019-nCoV - 25 January 2020 - Imperial College London
- <sup>xvii</sup> <https://www.medrxiv.org/content/10.1101/2020.05.17.20104653v3.full.pdf>
- <sup>xviii</sup> <https://www.nytimes.com/2020/09/24/world/covid-19-coronavirus.html#link-7f8a5627>
- <sup>xix</sup> <https://www.washingtonpost.com/health/2021/01/08/capitol-coronavirus/>
- <sup>xx</sup> [https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s\\_cid=mm6915e3\\_e](https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_e)
- <sup>xxi</sup> [https://www.eurekalert.org/pub\\_releases/2021-01/tl-pss010721.php](https://www.eurekalert.org/pub_releases/2021-01/tl-pss010721.php)
- <sup>xxii</sup> [https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s\\_cid=mm6915e3\\_e](https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_e)
- <sup>xxiii</sup> Stokes EK, Zambrano LD, Anderson KN, et al. Coronavirus disease 2019 case surveillance – United States – January 22—May 30, 2020. *MMWR*. June 15, 2020. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm>.
- <sup>xxiv</sup> Stokes EK, Zambrano LD, Anderson KN, et al. Coronavirus disease 2019 case surveillance – United States – January 22—May 30, 2020. *MMWR*. June 15, 2020. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm>
- <sup>xxv</sup> Muniyappa R, Gubbi S; COVID-19 pandemic, coronaviruses, and diabetes mellitus, *Am J Physiol Endocrinol Metab*. 2020 May 1; 318(5): E736–E741.
- <sup>xxvi</sup> Hartmann-Boyce J, Morris E, Goyder C, et al. Diabetes and COVID-19: risks, management, and learnings from other natural disasters. *Diabetes Care*. June 16, 2020. <https://doi.org/10.2337/dc20-1192>.
- <sup>xxvii</sup> Hartmann-Boyce J, Morris E, Goyder C, et al. Diabetes and COVID-19: risks, management, and learnings from other natural disasters. *Diabetes Care*. June 16, 2020. <https://doi.org/10.2337/dc20-1192>.
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- <sup>xxix</sup> <https://link.springer.com/article/10.1007/s00125-020-05209-1>
- <sup>xxx</sup> <http://covid19.e-dendrite.com/>
- <sup>xxxi</sup> <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>
- <sup>xxxii</sup> <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>
- <sup>xxxiii</sup> <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>