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Office of the Governor of the State of Iowa
Iowa State Capitol Building
Des Moines, Iowa 50319

Dear Governor Reynolds,

I appreciate your actions and disclosures after my previous two letters regarding the coronavirus pandemic. Thank you.

However, I am adding detail and a deadline to my final request from my letter on Thursday. In it, I asked for additional background and information about the four component, twelve-point pandemic assessment tool that is used nowhere else.

Substantial controversy already surrounded this Iowa-only tool. Then yesterday, the Iowa Board of Medicine and the Iowa Medical Society both requested you take actions that the tool does not currently recommend. The people in those organizations are a part of our state, and would be familiar with any distinctive characteristics of Iowa that might justify a distinctive tool. As a result, it is crucial to add transparency and answers to the debate about whether the tool should guide our lives and livelihoods.

Whether we in Iowa's capitol are acting on valid, predictive data and science to contain this pandemic affects the rest of our state, our nation, and our world. As I wrote to you earlier, trusting Iowans with basic information helps them make better-informed decisions about their actions, which leads to a better outcome for both our health and our economy.

As such, I repeat my request for background and information about the assessment tool, and clarify it with the following specific questions.

(1) Are any other states are using a similar tool to guide their current pandemic responses?

(2) Specifically, where and when has such a tool (approximately 4 components, with approximately 3 triggering thresholds each) been used before? If never, what is the most similar tool that has been used before in similar circumstances?

(3) How was this tool created and how were the components selected and set? Over what time period? Who, specifically by name and title, was involved in instigating, creating, supervising, critiquing, evaluating, or otherwise guiding in any way the creation and refinement of the tool?

(4) The tool has specific points given for certain trigger thresholds under each component. For each component and each threshold, how were these points selected and which model was used to select these specific points?

(5) Was there a logistical regression used to identify the component and trigger system? If so, what underlying data cohort from what epidemic or pandemic was analyzed?

(6) Were other tools evaluated? What criteria were used to select this tool over others?

(7) Is the tool able to determine the impact of specific interventions on reducing the transmissibility in the community? If not, how is this being evaluated? For example, does it reflect the degree to which a stay-at-home order for those 65 and older would impact the spread of COVID19? If it does not, what are you using to estimate the impact of that or similar measures?

(8) The "percent of population over 65" is a static number that won't vary during the pandemic. Several highly impacted counties (Johnson, Polk, Linn) have very few older people and would not trigger this threshold even at 15%. Why did you include a component that could never be triggered in many of Iowa's bigger, already more highly impacted urban areas?

(9) The "percent of identified cases requiring hospitalization" is not linked to the size of the outbreak, nor the availability of PPE. For example, if there are only 10 COVID19 cases in a population and 2 are admitted to a hospital, it would add 3 points. However, if there are 100,000 and 11,000 were in the hospital (far beyond the beds actually available), it would only add 1 point. Why were these thresholds selected as percentiles, rather than a ratio of total hospitalized vs total available hospital beds, ICU beds or ventilators?

(10) The "rate of COVID19 infections per 100,000 population in past 14 days" component does not consider 1) if the counts are increasing or decreasing or (2) how quickly they are changing. Why did you select a metric that would not measure to how fast the diseases is spreading, which could indicate whether the state is on an exponential growth curve, and if so, where?

(11) Long-term care facilities are isolated from the community by design. Thus, they would not be as affected by community transmission and social distancing interventions in the community, nor would they as strongly affect economic and community essential operations. For example, large factories for food production are critically important for the functioning of our society and would also be more affected by widespread COVID19 disease. So why were only "long-term care outbreaks" considered when many other critical areas of mass gathering would give a better sense of community transmission? Why did you not include essential factory workers diagnosed with COVID19 in the tool? Or healthcare workers?

(12) For each of the components and regions, how many Iowans would need to be infected, hospitalized and have died before the tool would trigger 10 points? If the tool reached 10 points or more in every region of the state, how many Iowans would have COVID19 at that point?

I consider this letter itself an informal request like my previous two letters. Sharing the answers to these questions should take very little time, as any tool using rigorous data, logic, and science would have answered them before being put to use. I am asking you kindly to please provide complete and responsive answers to these questions to the public by noon Monday. If you prefer, it is not necessary you reference me or this letter when you respond publicly.

I again repeat my offer of assistance and, as always, I am happy to discuss at a minute's notice.

Sincerely,

Rob Sand
Auditor of the State of Iowa