MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

June 11th MMS /DPH Call: DPH Update and Summary of Q & A

On June 11, the MMS hosted its tenth COVID-19 conference call for physicians with the Massachusetts Department of Public Health (DPH). Dr. Catherine Brown, State Epidemiologist and Kerin Milesky, Director of DPH's Office of Preparedness and Emergency Management, participated. Member questions to DPH officials were both submitted in advance and answered during the call.

Ms. Kerin Milesky provided an update from DPH:

- On behalf of Commissioner Bharel, Ms. Milesky thanked the MMS for its ongoing collaboration with the DPH. DPH is truly indebted to our health care partners for all they are doing, and continue to do, on behalf of the Commonwealth.
- Massachusetts has begun Phase II of its reopening. DPH is working hard to make sure that public health considerations are at the core of all actions to reopen the Commonwealth. The phases of the state's Reopening Plan will depend on meeting particular metrics. As new information about the COVID-19 pandemic becomes available we may need to adjust our course. The goal is to continue the reopening process and do it safely to protect our residents from the spread of COVID-19. The pandemic is by no means over and we must continue to be vigilant.
- Massachusetts is currently seeing a downward trend in the number of people hospitalized for COVID-19, and a steady decline in the percentage of positive tests. These are encouraging signs, but we must continue our prevention efforts. Information and guidance about reopening can be found at: www.mass.gov/reopening.
- As of yesterday, we now have over 104,000 confirmed cases in the Commonwealth, and more than 7,400 individuals have died of COVID-19. The state continues to expand efforts regarding testing and contact tracing. These efforts are critical to determining contacts of known cases, and the extent of potential spread. You can find Massachusetts daily dashboard on key metrics on our website. Information is posted each day at 4:00 PM. The COVID-19 information is distinct from the re-opening page. Both of them can be found by visiting www.mass.gov homepage. Every Wednesday, DPH posts a weekly public health report, which includes city and town specific data, and many other indicators. The information we provide publicly is extensive, and it's earned Massachusetts an A+ rating from the COVID Tracking Project.
- Two updates from DPH's Office of Preparedness and Emergency Management:
    - Remdesivir: As of Monday, June 8 DPH has pushed out a total of 30,978 doses of remdesivir to 58 hospitals. That is enough to treat 5,163 patients. DPH is anticipating one additional allocation of remdesivir from the federal government next week and will use the same process, which was developed by the remdesivir working group that Dr. Bharel and Dr. Madoff have established to help guide the allocation process. Once those allocations have made, the federal government has indicated that Gilead production is increasing and expects that remdesivir will be available on the commercial market beginning in July.
    - The DPH warehouse has significant supplies of COVID-19 testing supplies, both transport media as well as swabs. If providers do have a need and are having trouble sourcing testing supplies,

they are most welcome to make a request. Visit the mass.gov/COVID-19 web page and go to the testing page. There is a testing supplies drop down with the order form and instructions on how to make a request.

Dr. Brown's responses to questions the MMS submitted to DPH in advance of the call.

Question: *Address the Memorial Day holiday, and the demonstrations. Is DPH employing any new strategies to stay ahead of possible spike in infection? Will DPH do more testing?*
Dr. Brown: We have been thinking about the risks associated with reopening, and how that was going to impact our case numbers. The recent events that have resulted in all of the demonstrations that have been happening across the country, while so important for all of us to talk about, and to finally start to address some of these inequities that are so deeply entrenched in our society as a public health professional, I will say that the protests definitely give me pause as I think about them happening in the context of a pandemic. They certainly provide opportunities for people who have COVID-19 to transmit the disease to others. We have recommended that individuals engaging in protest social distance and wear a mask. I should say, social distance to the extent possible. We are hoping that people are taking those things into consideration as they continue to demonstrate and force us as a society to think about where we really need to go from here.
The good news is, as mentioned, that the statistics so far are good, that we are still trending downwards in terms of number of cases, number of patients hospitalized, and average deaths. But COVID is still here and I think we have to anticipate that both reopening and the protests are going to result in an increase of cases. The question that is outstanding is, what is that exactly going to look like- how many cases are we talking about? We are, in Massachusetts, doing a whole lot of things to help reduce risk such as the recommendation for masking, the social distancing, gatherings required to be under 10 people. All of those things are really important, and we have to continue them as we continue to move through reopening. One of the questions associated with this was if DPH will do more testing? I'm not sure how to take that question, one is that the state public health lab has capacity to do testing. When you look at all of the laboratories that are doing testing, we, from a capacity standpoint, are really just a drop in the bucket. So, testing has been expanded. Capacity has also been expanded greatly since the early days of the pandemic. I'm not sure that DPH increasing our testing is really going to meet the need. What we are working on is making sure that our testing guidance, the recommendations around who we would like providers to consider for testing are staying current. We are actually right in the middle of an update. Currently, anyone who's even mildly symptomatic should be tested and anyone who is identified as a close contact of a confirmed case should be tested.
Then there's the usual recommendation that if, in your clinical judgment, you think someone should be tested, then you should test them. Now that we're into reopening, and in light of the protests, we're trying to add in some language that encourages providers to talk to their patients and assess whether or not they have been in situations where there were people around and social distancing was not possible. This could happen in the context of a protest, or in the context of a daily commute on public transportation, or in the context of work. So, we all need to be thinking about those things, and broaden who we consider to be a priority for testing. I anticipate that you're going to see some new guidance from us in relatively short order on that.

Question: *Please comment on/clarify the WHO statement on asymptomatic transmission? Does DPH recommend any change in current public health practices (masks/social distancing)?*
Dr. Brown: We've been getting a lot of questions about the WHO's recent statement on asymptomatic transmission. You will notice that WHO tried to walk it back the next day. Here's the way we at DPH think about asymptomatic transmission. We know this virus is spread through respiratory droplets. There are a lot of outstanding questions about COVID, but that is one thing that we know. Respiratory droplets are the way this is transmitted. People who are actively symptomatic and coughing and sneezing produce more respiratory droplets than someone who is not. That likely makes them more infectious, but there are plenty of data, published data now, that shows that even individuals who are pre-symptomatic or actually completely

asymptomatic are contributing to transmission. They may not be the primary drivers of the pandemic. People who are symptomatic, who are producing respiratory droplets, we anticipate that they are going to be to contribute more to spread. Our read of the literature, and our understanding of the epidemiology, is that asymptomatic transmission can and does occur. At this point, we are not recommending any change in the current public health practices around masking and social distancing. We still think those are critical to help us manage and keep COVID-19 under control. To the extent that all of you are talking to people, and our influential members of your community, respected members of your community, I would ask you to help us with making sure that that messaging gets heard. Nobody likes to wear masks, but we believe very much that it is an important public health practice.

Question: *Please define "close contact" as far as contact tracing? Is there a difference in recommendations between a known close contacts of a COVID+ case in the community and clinical close contact with patients in the health care setting?*
Dr. Brown: For the purposes of COVID transmission, a close contact is defined as an individual who was within six feet of a confirmed case of COVID-19 and have spent at least 10 to 15 minutes. either while they were symptomatic, or within the two days prior to them developing symptoms. That's a close contact.
For people who are asymptomatic cases, if you are within six feet for 10 to 15 minutes of that individual either in the 10 days after their positive test was taken, or in the two days before their positive test were taken, that is also a close contact. Those are individuals who are recommended for testing and need to quarantine.
There are differences between the way we treat close contact outside of the health care setting. Through all of this, we have said that if you're wearing appropriate PPE when you, as a clinician, are working with a patient who has COVID, that is not an exposure. However, you can imagine that there are situations where an exposure could occur in a health care setting. For example, where you don't know that the patient has COVID, you are not wearing the complete PPE which is still recommended to be a surgical mask and a face shield in addition to a gown and gloves. If you are not wearing all of that PPE, and you've spent 10 to 30 minutes working with a patient, then you would be considered a close contact. However, you are also in a group of people that is allowed to work, once you're identified as being a close contact, as long as you remain asymptomatic and stay masked. I do think it's important, to the extent possible, to know what patients you have seen, so that if you become a case, and we need to notify your patients, we'll know who those are. But also, the reverse-- if a patient is identified as being a case, we want to make sure that we can identify you all as being a close contact, and let you know. Again, close contact is within six feet, for at least 10 to 15 minutes, without PPE. Those are your definitions for close contact.

Question: *Is there any increased reliability/performance data for antibody testing? How is it being used in MA and for who and in what circumstances is DPH recommending serology tests?*
Dr. Brown: The FDA, after being totally hands off on the development of the antibody testing originally, has realized that might have been a mistake, and has reversed their stance. They are now requiring that antibody tests that are on the market receive an EUA, and they've also created a web page where you can find the reliability and performance characteristics of these tests. You can actually go online and look at the tests that are EUA approved and look at what their performance characteristics are. There are actually quite a few that are over 90% for both sensitivity and specificity, which is really, pretty good. Obviously, their positive, predictive value is best in the setting of high infection rates, but there are some reasonable tests on the market. If you look through all of the tests and look at the data, you can also see that there are several that have pretty poor performance characteristics that we would not recommend. From a diagnostic standpoint, we still don't recommend serology tests. It's not because of lack of efficacy, because I've just told you there are some that actually are pretty good. It's really because they can't tell you anything about timing of infection. What we need to know, in order to stop transmission, is when was this person infectious and the serology tests just don't tell you that. There may be clinical situations where you need to do a serologic test to diagnose somebody. The situation that comes to mind, for me, are the kids who are presenting with, what's

being called pediatric multisystem inflammatory syndrome (PMIS). For some of these kids, they are negative on PCR testing, but are positive by serology. That is a specific circumstance, as an example, where a clinical diagnosis really does need to default to a serologic test. Serology is also helpful if it's done as part of a seroprevalence study, so we can get an idea of how many cases we missed through regular molecular testing in a community. I think you will see that there are increasing situations where there will be seroprevalence data available from different places. At this point, this is the primary place where serology tests are useful at this moment in the pandemic. As we learn more about what immunity looks like, I think serology tests maybe become increasingly important. Right now, we don't want to see people using serology tests when what we're really trying to do is diagnose people and know where they are in their infectious period and so, molecular diagnostics are really what's necessary.

Question: *Does DPH have a recommendation regarding airflow in the office setting/use of fans during the summer months?*
Dr. Brown: Understanding airflow dynamics is not my area of expertise. However, as a department, we feel pretty strongly that fresh air ventilation can help. Therefore, air circulation can help reduce risk of transmission of COVID, but it has to be done appropriately. When I talked to Dr. Madoff about this before the call, we were thinking if you're using a fan to bring fresh air in from the outside, or from outside the room that you're in, and you're really trying to circulate the air, then that could be beneficial. But if you're sitting in a room that's a little bit too hot and humid and have a fan on and all it's doing is blowing air around the room, and if there are other people sitting in the room, that could potentially serve to increase the possibility for transmission. So, if you're thinking about fans as providing ventilation and increasing air circulation, in a way that it's not just air recirculation, then there may be some benefit to it.

DPH officials' responses to questions the MMS received from physicians during the call:

Question: *I am the team physician for a residential college sports program. They are interested in reopening, having athletes return to their campus in July, when we'll be, hopefully, in Phase III. With daily symptom checks, and masks, and distancing all appropriate, I have two questions: Massachusetts recommends two-week quarantine for anyone who comes from out-of-state. Given that we've reopened hotels, my guess is that we don't require people to make two-week reservations. I wonder how that would apply if it would? And equally, if not more important, do I need to have my athletes in quarantine? And if so, for how long? And secondly, how many cases of COVID-19 can we have, can we discover, before you shut us down and tell everyone to go home?*
Dr. Brown: I'll start with the 14-day quarantine first. The Governor's recommendation is that individuals who are coming into the states are requested to quarantine for 14 days. This is a recommendation and a request and is not an enforceable order. I also believe that it is in effect through the end of Phase II. I'm not going to promise that it won't be extended, but for the moment, we know that it will be in effect through Phase II so, it may not apply to your athletes in July, assuming that we have actually moved into Phase 3. Please remind me of your second question.
Follow-up: How many cases of COVID-19 can we have, can we discover, before you shut us down and tell everyone to go home? The NCAA can provide guidelines and rules, but the only two entities that can shut us down, legally, are the State DPH and the local department of public health. I've reached out to them. They haven't given me any guidance quite yet. I know the state has the ability to say to an institution that they need to stop what they are doing.
Dr. Brown: I think what you're really asking me is what the metrics would look like that might trigger us to do something like that and I can't, I'm sorry. We have talked about this internally. It's sort of that old story of, we'll know it when we see it, which I know is not helpful to you in this moment. What I would also say though is that, we're on a good trend right now and I don't think that there is a lot of desire to have to go back to stay-at-home. What I anticipate is that if we start to see shifts in the trends, if we start to see things start to move

in the wrong direction, that there will be smaller, subtler public health recommendations that we would employ to try to reduce risk, rather than jumping back to everybody stay-at-home again. I could imagine that some of those things would be stepping back a little bit on some of the reopening or being a little bit more forceful about the gathering size. I think we would have to see some really extreme increases before we're going to move back into shut down. I think that's the best that I can give you in this moment.

Question: *Is it possible that the Department of Public Health could bring health disparities with regard to COVID as its top priority for this season?*
Dr. Brown: Thank you so much for that question. The answer is it's hard to have a top priority, but this is absolutely something that we are very concerned about on many levels. We have seen in data largely from other states that there's been disparities, racial and ethnic disparities, particularly, in the deaths related to COVID. We have not seen that in our data, but we have certainly seen some of our municipalities that have fewer socioeconomic advantages and perhaps more crowded living quarters. We have certainly seen many of them be impacted disproportionately by COVID. The Commissioner and I, and others at the department recently had a conversation about COVID and the philosophical decisions around shutting down, which really disadvantaged certain parts of our population much more than others. The need to reopen was critical for some of these populations. There is this real sort of public health balance between preventing the pandemic from roaring back, but also making sure that people in our society can work and get money to feed their families and to stay in their houses, apartments. I think we are looking at approaching this from many different directions. The Commissioner has a Health Equity Advisory Group established within the department. They are working on many of these issues and I anticipate that you're going to hear from her and also see some of the results of that pretty soon. We are very concerned about disproportionate impact, not only from COVID itself, but also from the public health recommendations associated with COVID. I hope that helps a little bit.
Follow-up: Thank you for sharing with me about the governor's health equity group. I'm interested to know how Massachusetts Medical Society could work best with them to try to make it a high priority because it overlaps the systemic, institutional racism and cultural racism, as well as the lack of access to health care.
Dr. Brown: Absolutely. I believe, Dr. Rosman, you have a call in to the Commissioner to discuss some things. I'm wondering if this is an item that you could bring to her to ask how the medical society might facilitate those discussions.
Dr. Rosman: Yes, thanks for that. There are a lot of things that the medical society is going to be working on. We really appreciate the relationship we've had this year and in the past with the Department of Public Health and our priorities are certainly aligned that way. I'll take this moment, I was going to say it in the closing comments, but I'll take this moment as well to note that on June 30 at 7:30, we're having our fifth virtual member forum on the impact of COVID on vulnerable populations and disparities. Commissioner Bharel is the featured presenter. So, mark your calendars. We really do appreciate you, Dr. Brown, and the Commissioner, and all of the hard work at DPH and being your partner.

Question: *now We are expanding our ambulatory surgeries and scheduling patients for various procedures. I'm wondering if you can expand the criteria for COVID testing to include that this PCR test is required two days before ambulatory surgery. It takes that amount of time to turn over the test. And there's always a potential for droplets or the rare-- hopefully never-- case where you have to perform CPR in case the patient decompensates. I just feel that's a risk if we don't know their COVID status?*
Dr. Brown: That's a great question. It's one of the things that Dr. Madoff and I were talking about in light of our producing new guidance. We are talking about that type of recommendation. We may not be that specific. But certainly, to recommend that patients who are entering health care, I don't mean, necessarily, showing up at your PCP's office, but as you're saying, coming into a hospital or an ambulatory care setting, that testing in advance when you have the luxury of that time is a good idea. I will just share with you all two things. One is that I want to be really clear that when we put out this guidance, it's recommendations. That it's absolutely

things we're asking you all to consider, things that we consider important, but that is never meant to replace any type of clinical judgment that you all should exercise with all your individual patients. I want to encourage people not to feel that our guidance, particularly at this point, is proscriptive. It is meant to focus attention on kind of what we see as the most important issues. We encourage you all, because you're all smart, educated people, to think about it with your individual patients and where it might be appropriate. The one other thing that I will say is , and I have had some conversations with some of the Massachusetts Medical Society leadership on this, as well as multiple conversations with other people, that one of the complicating factors here, as is true with everything, is the insurance coverage. Our guidance does not necessarily translate into insurance coverage. So, this is sort of a difficult line to walk where we actually want as much testing as possible and in a perfect situation we would just ask insurance to pay for all of it. We live in the real world, and that may not be possible. I had a lot of thoughts in response to that question which is along the lines of what we are thinking of for our new guidance that should be coming out. It makes sense to me from an infection control standpoint to consider that type of testing.

Question: *Has any thought been given to waiving the requirement for a physician referral for testing? It is still required at many test sites and it can present a barrier to care? What are the barriers to contacting patients quickly after they have had a positive test in terms of finding their contacts? In Singapore, they're contacted within 15 minutes of the test. I understand in Massachusetts that can be up to five days, which is problematic. I'm just wondering what kind of public information campaign is and has been carried out to raise awareness in the contact tracing effort because many patients who are being contacted are hanging up or refusing to share contacts?*

Dr. Brown: Those are all good questions. We are talking about the physician referral question. It is a barrier for many people. The hesitation so far has been wanting to maintain that patient-physician relationship and making sure that there's somebody available to talk to the patient when they have a positive result to help explain, what does that mean? And what are you going to do with that information. I'm speaking for myself and not for the department. I think we are moving into a time where it's just more important to remove as many barriers as possible for testing and I am generally supportive of that approach. Now talking as part of the department, the internal discussions that we have had really do seem to reflect sort of increased movement in that direction. I'm not committing the department to anything. I'm just saying this is a real issue and we are looking at all of the possible ways that we can reduce barriers to access to testing. The contact tracing question is a great one. The biggest time delay in terms of contacting a case once we have the positive results is the time it takes to do the test. There are some laboratories that really have great turnaround time and we get those results very quickly. That enables us to move fast in terms of doing the isolation, identification of close contacts, and then quarantine. There are other laboratories, unfortunately, some of the ones that do the majority of the testing that because of the volume of testing that they're doing, the amount of time that it takes to get those test results back is multiple days. In some cases, we've even seen over five. That's one issue that I think we're facing that I don't really know how to fix. The other thing that is being worked on at a national level, this is another thing that's not directly under our control, but it is something that's being looked at, is that the priority for laboratories, obviously, is to get the results back to the ordering provider. We understand that, but unfortunately, they have also then deprioritized getting the results to public health departments. We've actually seen an increase in the amount of time between when a provider gets a result and when the Department of Public Health receives it electronically. That helps delay things as well.

I think the system we have for follow up by the local board of health or the community tracing collaborative is pretty solid. If we could reduce some of these other time lags, then we would be in a better position. I don't think we're ever going to be within the 15 minutes. To your point about the educational campaign and the issues about people not answering the phone or hanging up, these are real. These are real issues that we are struggling with. The Community Tracing Collaborative, and the department, and the COVID-19 Command Center have been working closely. There's actually a campaign that is just about to be launched. I believe that you will see the website Monday.

It’s not just a website. It has additional materials associated with it. There are print materials that are being sent to testing sites so that they can provide those to people as they're being tested. It helps let them know why they're being called by either a local board of health or a contact tracer. We're hoping that that will start to build some of the trust with the system, so that people understand why it is that they're being contacted and that it's a really important part of being a member of the Massachusetts society right now. We really need everyone to cooperate in this response.

Question: *I was wondering if you can provide any guidelines about visiting with non-social distancing in a couple who's been separated for the last several months because of COVID. Specifically, the example is a young couple in their 20s who both are observing as much safety precautions as they can. One of them lives in a household where there is an essential worker who goes out to work every day. The couple lives in the Midwest in two different states. One of them lives in Chicago. And they were wondering if they were able to get a COVID test and both tested negative whether they could have a real visit with each other?*
Dr. Brown: That's a complicated question. I'm not entirely sure from what you've provided exactly why they're not able to see each other without socially distancing. Generally, what I would say is that I would advise individuals to talk to their own providers about their living situation, what they do on a daily basis, and what their risks of exposure are. The one other thing that I will say, is the method of travel. If you get in your private vehicle and you drive somewhere then you're probably at relatively low risk of having been exposed along the way. But I certainly worry about people who take planes, trains, or buses. I think it increases the chances of somebody being exposed. The one other thing I would say is that a test result is only as good as the moment that test was taken. It doesn't really tell you in advance what happens after that moment. Individuals should talk to their own providers to think about sort of what their actual risks are and then what are the next steps in order for them to feel comfortable to be able to visit.

Question: *I'm a member of a committee that's trying to figure out when our local historical society can reopen. I'm the medical consultant and the question came up at a meeting this week about air conditioning. Is there a problem with air conditioning spreading the virus around everywhere?*
Dr. Brown: The answer is not that we know of. This is one of the things that we still don't totally understand about COVID is whether there is any possibility of some limited aerosol transmission. This is clearly not measles, but it is very transmissible. There are some lingering questions about potential for limited aerosol transmission and until we really know the answer to that, it's very hard to understand how air conditioners and HVAC systems in general might contribute to distributing the virus. The historical societies I've seen are usually relatively small. I don't know if that's true of yours, but I think that if people are wearing masks, and socially distancing, and washing their hands a lot, that I'm not sure that air conditioning adds a significant level of risk.

Question: *I just wondered if you could give an update on testing, if there's different types of tests other than the nasopharyngeal swabs, the PCR testing. I've heard in other states people are getting simple testing and that there is serology testing.*
Dr. Brown: I talked about serology earlier. Again, I just want to stress that we don't really recommend that for diagnostic purposes in most situations at this moment. What you're really asking about are different sample types for the molecular testing, for the PCR. There are some laboratory assays that are approved for anterior nasal swabs. There are, I believe, even some that are now approved for saliva. I think there are other options. It depends on where what laboratory the sample is going to. You need to know what the options for that particular assay are because not all sample types are approved for all assays. Obviously, there are advantages to the anterior nasal swabs and to saliva swabs. They can be self-collected with observation which reduces the amount of PPE that the clinician needs in order to get the samples. So those are available. It just depends on what laboratory is doing the testing.