



MASSACHUSETTS MEDICAL SOCIETY

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May 28th MMS /DPH Call: DPH Update and Summary of Q & A

On May 28, the MMS hosted its ninth COVID-19 conference call for physicians with the Massachusetts Department of Public Health (DPH). Commissioner Monica Bharel, Dr. Catherine Brown, State Epidemiologist, Dr. Larry Madoff, Medical Director of the DPH's Bureau of Infectious Disease and Laboratory Sciences, 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.

Commissioner Bharel provided opening remarks:

Thank you so much, Dr. Bombaugh, and thank you to the Massachusetts Medical Society once again for hosting these calls and for being partnered with us. Thank you to all of our community of health care professionals who have been working tirelessly during this this unprecedented pandemic. We at the Department of Public Health have been committed to being on these calls with you throughout the pandemic response, keeping you updated as we learn more, and answering your questions to the best of our ability. We appreciate the time with you, not only because we can help answer questions that you have, but it also helps us to understand what issues you are managing and dealing with and provides an opportunity to hear your helpful suggestions about how to improve how we all care for our patients during this most challenging time.

I want to take a moment to thank Dr. Maryanne Bombaugh, who is in her last week of being the Massachusetts Medical Society's president. I'm not sure you could have guessed when you started your presidential year that you would be dealing with the pandemic of a lifetime. I have really appreciated your leadership, your courage, your camaraderie, your collaboration, and your tireless efforts during this time. It's been a great pleasure to partner with you. Thank you for that, and I look forward to our continued collaboration with Dr. David Rosman.

Massachusetts began a cautious and phased reopening process on May 18. I hope the message came across loud and clear that as we move through the phased process of reopening that it will be based on the data. Our goal in monitoring the public health data and the metrics that we have been following, and will continue to follow, is to make sure that we can sustain our health care capacity and protect the most vulnerable among us. If you haven't had a chance, I do urge you when you have a moment, to go to our website just take a look through the reopening Massachusetts guidelines. You can get a sense of where we are and how we are looking at this and it includes the public health metrics that we are using to guide the reopening. The metrics are things we've been looking at for a while together now on our COVID-19 dashboard. They include the positive test rates, the average hospitalizations, number of hospitals using surge capacity, and the number of deaths that we're seeing. There is sector-specific guidance available as well, including guidance for our sector, health care.

In terms of our testing numbers, we continue to have one of the top testing numbers here in the United States, but as I know and as you know, we need to do more. We need to do more not only in increasing the capacity of testing, which is very much part of our plan, but one of the things I hope you can help us with is thinking about not only having capacity to test, because all of us know from our clinical work, it's one thing to

have capacity, and another to be able to engage our patients and the individuals who are at highest risk to get that testing done. I really would appreciate your support and creative assistance in those areas.

Additionally, we are sorry to report, more than 6,500 individuals in Massachusetts have died from COVID. You may have seen that yesterday, as a country, we also, unfortunately, passed the 100,000 point for deaths. In Massachusetts, this is just a tremendous loss of life that is so hard to comprehend. I really appreciated the personalized ways in which The New York Times listed out with much dignity the names of some of some of those individuals we've lost. And if you're like me, you've lost people by now, close to you, or patients, or colleagues. And together, I know that this is one of the most difficult parts of this pandemic, and we mourn these losses together.

We have started to see some downward trends in the number of people who are hospitalized for COVID and the number of hospitals having to use their surge capacity is coming down. As we increase the number of individuals get tested, we're also seeing a lower percentage having positive tests. So, those are all things moving in the right direction. DPH will continue to watch these numbers with the reopening. Dr. Bombaugh mentioned in the opening remarks about PPE and equipment. We very much want to work with you to make sure that you have the tools and resources you need. We will continue with our expanded testing and case and contact tracing work, so that as new cases come forth, we are able to quickly understand who their contacts are and quarantine individuals to prevent as many clusters as we can.

There are a couple of areas where, from my point of view, it would be wonderful to have your ongoing support and collaboration. One is around testing and making sure that individuals who need it most understand how they can access testing, be encouraged to get tested, and then following up the individual. Another concern that I know we are all talking about now is making sure that we get back on track with our routine vaccinations. It's understandable that the fear this virus has caused derailed routine vaccination, but we need to do all we can to promote people getting back on track with their vaccinations, especially pediatric vaccinations. Likewise, although we will continue with telehealth as appropriate, I know from my own clinical days, that preventive care is so important, especially for our highest risk patients. We need to make sure patients do come in to get the care that they need in-office and help them to understand how to do that safely. Your trusted voices will be much appreciated in that as we continue together in this unprecedented challenge.

I personally, and on behalf of the entire Department of Health, am simply in awe of, and indebted to, my colleagues in health care, both out in clinics, communities, and our hospitals. It's just been remarkable to see what we are doing, continue to do, on behalf of all of us in this Commonwealth. Thank you for that and I very much appreciate this opportunity to be together and your continued partnership.

DPH officials' responses to questions the MMS submitted to DPH in advance of the call.

Question: *Can you please discuss the 6 key public health indicators and trend data you are monitoring during reopening and what the metrics need to show to move to the next phase? What would be the key indicator(s) that suggests we are going in the wrong direction?*

Dr. Brown: The metrics are being used to monitor what's happening. I hope you all are already aware of them. If you're not, I would encourage you to take the opportunity to go to our website. It's pretty easy to find the COVID pages if you just go to www.mass.gov there's a banner at the top which will get you directly to all of the COVID information. We have a nice dashboard that includes a lot of the data that are being collected through the Department. The six key public health indicators are: the positive test rate (only molecular tests, PCRs and antigen detection, not serology tests); the number of individuals who die from COVID on a daily basis; the number of patients with COVID currently in hospitals; health care system readiness as measured by number of

hospitals that are using surge capacity; testing capacity in the Commonwealth, and finally contact tracing capabilities. Those are listed on one page of the dashboard. You can see on the following page that, fortunately, we have been doing pretty well in terms of reducing our average positive test rate. We're looking at kind of a seven-day average to assess the trend, and we're down 71% from the beginning of May. The metric looking at the number of COVID patients who are currently hospitalized- that's a three-day rolling average and we're down 41% since the beginning of May. The number of hospitals that are using surge capacity were down 62%. And then a three-day rolling average of deaths, and we're down 65% there. We really are headed in a good direction. All of these metrics are showing trends in the negative direction, which is what we want. But definitely, at the Department, we are all watching these very closely to look and see if anything starts to move in the wrong direction. If we start to see increases, we will have conversations and provide advice to the administration about the appropriate steps to help ensure that we don't regress too much during this reopening process.

Question: *Are asymptomatic close contacts of COVID-19 cases able to get tested at no charge/cost sharing? Have any barriers to testing been identified?*

Dr. Brown: The Department has been working closely with the Division of Insurance (DOI) on this issue. The DOI has assured us that they cover, they tell their carriers to cover testing that meets DPH guidance. I have heard, both from the Massachusetts Medical Society and other individuals, that there's some language within the guidance that has led to some confusion among the insurance carriers. We are in the process of working on addressing that, so it becomes clearer for everyone that anyone who meets the recommendation from DPH for testing for COVID is supposed to be covered. There certainly remains some barriers to getting tested, although we're making good strides in the right direction. I think one of the biggest problems is the lack of geographic distribution of many of these testing sites. There really aren't enough in Central and Western Massachusetts. In some other locations, you have to drive a little ways in order to get to a site. Then there are issues around each site having their own rules and requirements, and they take different insurance, etc. We are working on many fronts to try to address a lot of those issues. I know CVS is opening 10 new testing sites across the Commonwealth, which is certainly going to be helpful. We are working with our partners in the Community Tracing Collaborative to try to pull together a more complete set of information about the currently available testing sites and what the parameters are for people to get testing in those areas. So, hopefully, at least there will be one place to go to get complete information about where you or your patients might be able to get tested.

Question: *Does DPH recommend molecular COVID-19 testing prior to surgery/procedures for asymptomatic patients? If so, in what circumstances?*

Dr. Madoff: This is something that I know that a number of health care facilities are considering and something that, certainly, we will look at in the Department as we develop guidance going forward. There is not currently a recommendation to test individuals prior to surgery or to a procedure. In certain circumstances, it could make sense to reduce risk. I think it is really important that we not lose sight of the fact that many patients with COVID are asymptomatic, and that patients can develop symptomatic illness and can become PCR-positive at any point. So, even if testing is done soon before a procedure, it's still possible that someone could be positive during a procedure and, of course, no test is perfect. The presence of a negative test can be somewhat reassuring but does not absolutely guarantee that an individual isn't going to cause an exposure during, say, an intubation, or during a health care visit. This is something that we're looking at, it is something that a number of institutions are doing or considering, but it's not currently part of DPH guidance.

Question: *What is the recommended time between seeing patients in exam rooms? Do exam rooms need to be aired out between patients??*

Dr. Madoff: At the moment, we are recommending that a room, in the presence of a known COVID exposure, if someone is symptomatic, and has COVID, or is highly suspected of having COVID, what we would suggest would be to leave a room vacant for 24 hours prior to cleaning. That is the CDC health care guidance. But, for the vast majority of patients who don't have COVID, who aren't having symptoms of COVID, and aren't causing an exposure, we're not recommending anything other than routine patient spacing and routine cleaning between patients.

Question: *What specific PPE (masks, gloves, gowns, etc.) is needed for primary care/family medicine?*

Dr. Madoff: This is something that has been difficult to manage and difficult to even follow as guidance has evolved during the outbreak. It is a sign of how much we keep learning about COVID, and how much we've become aware of. For example, how much asymptomatic disease there is, and the fact that even individuals who are asymptomatic can shed. I think what would be reasonable, and this fits within our guidance, is to use droplet precautions, a kind of an expanded droplet precautions for routine patient care as we are still seeing large numbers of COVID patients in the community. There still is evidence of a community transmission, albeit declining, that makes it prudent to use droplet precautions, meaning a face mask, a surgical mask, or equivalent during routine patient care. Gloves and eye protection if someone is coughing, or sneezing, or there's likely to be aerosolization in that environment. We would also urge you to use source control whenever possible. Certainly if somebody has respiratory symptoms, asking them to wear a face mask as soon as they get to the office or get to the waiting area, but certainly at any time possible during a patient encounter to have the source patient wearing a mask also greatly reduces the risk of transmission. That would be our guidance at this point.

Question: *Does it make sense to wear lab coats or some other covering over clothes when you're seeing patients? If yes, are there any special recommendations about how they should be cleaned?*

Dr. Madoff: Again, part of enhanced droplet precautions, certainly in a health care facility, would be the use of a gown. I think other alternatives to a gown, including a lab coat or other cover-all would be appropriate in the practice setting. There's no special guidance around laundering of lab coats or other types of garments. I think washing those daily would certainly be reasonable.

Question: *In the outpatient setting, is the only time that an N95 mask would be recommended is if there was an aerosol-generating procedure being done. Is that correct?*

Dr. Madoff: CDC guidance on this actually indicates that for a known or suspected COVID patient they recommend the use of an N95 mask with surgical mask being an acceptable alternative. That's how we would phrase it at this point.

Question: *How is DPH addressing supply chain issues? Is there anything DPH can do to help? Are there burn rate calculators or other tools DPH can suggest to help providers in determining what is an adequate supply?*

Ms. Milesky: The supply chain has been a constant issue throughout the pandemic. Though, I am happy to say that we are starting to see some easing of those items that have been particularly difficult to get, such as gowns and N95 respirators. Dr. Bharel had mentioned the reopening web page, and I would certainly suggest that MMS members look at the resources that are provided on the reopening web page, both in terms of readiness to reopen your practice and resources that are available are around procurement of PPE. There is also an area for those manufacturers that have pivoted their businesses to producing PPE, and a resource based on PPE item, where you can look and see what might be available from those new and pivoting manufacturers. Of course, I would suggest that any health care entities and clinical practices aggressively work with their vendors, because again, we are starting to see some relaxation of the supply chain. I wanted to mention that, while we do have our emergency stockpile, we have pushed out more than 6,000 orders to health care entities since we stood up our warehouse activities in mid-March. The warehouse really is for emergent and urgent issues. So, it is not available to be able to supply any entities around reopening, but

as there are emergent or urgent issues, certainly requests can still be made through the Health and Medical Coordinating Coalitions and they will advance them to us for consideration. We will, going forward, be asking for a demonstration from the requester that they have pursued vendor options. For example, providing information about a cancellation of an order or a delay of an order, to be able to demonstrate that the emergency stockpile was not the first avenue being pursued. As it really is the last avenue, because like all of you, we need to ensure that we have that stockpile in place in the event that there is a second wave. There was also a question about if there was a burn rate calculator for PPE. I did share with MMS a CDC tool that is available that can be provided to anyone who is interested. That tool can assist in determining, what is an adequate supply, and what should physicians have on hand in their practice. I want to share that the Department had originally posted comprehensive PPE guidance for health care in early April, and that was just updated on our website on May 21.

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

Question: *My organization has several staff who have repeatedly tested positive over six weeks for COVID. Mostly because primary care physicians have kept ordering tests. Is there any data to show whether or not someone who tests positive for six weeks, even though are now asymptomatic, is still shedding virus?*

Dr. Madoff: As you know, the diagnostic tests, the viral test that is in wide use, and there are a number of variations on this, all use our RT-PCR, reverse transcriptase real-time PCR, and they are extremely sensitive in the detection of viral RNA. There's accumulating evidence, pretty abundant evidence at this point, that while viral RNA can continue to be detected from people who have COVID infection as you indicate, even for several weeks, typically even for a couple of weeks, and often for much longer, that this doesn't correlate with the ability to actually detect viable virus, for example, by viral culture. Nor does it seem to correlate with the ability to transmit the infection. DPH guidance, actually CDC guidance, offers two mechanisms for clearance for release from isolation of patients who have COVID infection. One is a time-based strategy where someone who's 10 days out or more and has been free of fever and has had improvement in respiratory symptoms for at least three days of that minimum period. That that's adequate for release from isolation in the vast majority of patients who, for example, don't have an underlying compromising condition or other reason to think they could have prolonged viral shedding. The other strategy, the test-based strategy does require two negative tests greater than 24 hours apart in someone who is also free of symptoms. What we're learning is that that can be a very long time for some people. The accumulating evidence is that if people are free of symptoms and satisfy that time-based strategy, that they can safely go about their business and they're not at risk of transmitting the virus to others. We are continuing to learn about this virus all the time, but that does seem to be one of the lessons that we've learned is that people who recover from infection are dramatically decreased in their rate of infectivity.

Question: *Our organization is grappling with what to do regarding double occupancy in patient rooms, and how we handle visitors to those rooms. The concern is that even though we may very well know the status of COVID for the patients in the rooms, we don't know the status of the visitors. The concern would be whether or not the visitors might transmit the virus to either the other visitor or to patients even though they're asymptomatic, since there is data around people who are sort of pre-symptomatic and shedding virus, and infectious. What are your thoughts about that?*

Dr. Madoff: Those are really difficult and challenging questions. At the moment, as you know, inpatient visits are not allowed in general at health care facilities. So, in terms of the rules around that, we're simply just not allowing visitors in the health care facilities at this point. As we move forward, we are going to have to develop guidance. Certainly, we are all being asked to wear a face covering. The idea that visitors would wear face coverings and asking visitors to maintain safe distances from patients regardless of the configuration of the room would be something that we would consider. We're going to need to develop further guidance on this.

Follow-up: I mean in pediatrics, which is where I work right now. We allow one parent visitor per pediatric patient. I know that in OB they allow at least one laboring partner per mother. So we've we're already sort of in this morass as we speak.

Dr. Madoff: Good point. I didn't address those specific situations. Visiting is allowed in certain circumstances. I know end-of-life and compassionate visits are permitted. I think we need to approach this very cautiously. The use of face masks will help, and social distancing will help. We may be in an environment where we'll be testing more people, certainly, potentially inpatients, and perhaps visitors in the future. These are all tricky problems and I understand the issue.

Question: *From the perspective of behavior of the virus, I've read a report that indicates that for the first four or five days after one has been infected, that the virus remains relatively stable, and then only after that period of time does it sort of almost explode and really start to cause devastating effects. Since many patients don't even present for the first four to five days after they're symptomatic, and then they have to get tested, this may negatively impact some of the experimental early treatments, or experimental treatments that are being utilized. Should be more aggressive about treating people with symptoms while we're awaiting the test? Have them come in earlier, start to treat them with one of the experimental treatments while awaiting the test, and treat it somewhat similarly to the way we treat influenza, where when patients come in with symptoms early we put them on Tamiflu.*

Dr. Brown: One thing I would say is that in addition to possibly considering as we move forward, whether or not it's appropriate to, once there are treatments that we know work, whether we need to consider early treatment. The other thing that is really important for us is ensuring that as we increase testing capacity, that the turnaround time actually gets shorter instead of longer, because I do think that that is one piece of what you're talking about. We really need to make sure and build a laboratory testing system, not necessarily just Massachusetts, but build a testing system that can handle the type of volume of tests that we need to do in order to diagnose everyone we need to. The other thing that I would say is this is precisely one of the reasons that we have made this recommendation that all close contacts, regardless of symptoms, should be tested, it's not just about getting them into isolation. Obviously, that's an important component of it, but it's also making sure that we're catching people early in the disease process.

Dr. Madoff: You raised excellent points. We don't know yet enough about the clinical course of illness, not just for treatment, but for prognosis, and who is it safe to send home, and who needs to be more carefully monitored, who needs to be admitted. These are all questions that we haven't yet answered. You raised them completely appropriately. The one drug for which there are some data supporting the benefit is remdesivir. In those scarce, but available, published data remdesivir seems to be most effective in patients who are moderately ill or who haven't advanced to severe illness. I think that supports the idea about early treatment being perhaps more important. Excellent points. Sadly, I don't have the answers to the questions that you're asking.

Question: *We're approaching summer and things are starting to reopen. If summer camps are opening, should parents feel comfortable sending their children to camp?*

Dr. Madoff: The summer camp question is a difficult one and it's one that our leaders are dealing with. At the moment, we're seeing declines in our rates of new cases and in all of the metrics Dr. Brown outlined. I think that's really important and good news, but we aren't yet at a phase where we would reopen schools or camps. This is something that we're just going to have to wait and see how we do. Certainly, these decisions will be made with public health input, but will not be made by public health alone. These are our whole of society questions and it's too soon to say.

Question: *When is reuse of PPE permitted and under what circumstances?*

Ms. Milesky: The one thing that I would note is that the Battelle Decontamination System has been established in Somerville with the partnership of MGH and the Brigham. Battelle does contract with entities

that wish to send their N95 respirators for decontamination. I certainly would encourage any individuals that are interested in partaking in that to go to Battelle.org for information on how to do that. In this time of conservation, N95 respirators has been one of those items that has been in great scarcity. We wholeheartedly support using the Battelle system to any extent possible. The other item that we have worked with a number of facilities around is gowns, because they have been so scarce. For those entities that have access to cloth gowns that can be washed, I would certainly suggest that as a good alternative, particularly since disposable gowns have been so difficult to be able to source.

Question: *I have a question about the exam rooms, and Dr. Madoff was talking about routine cleaning between patients who are not thought to be infected. My question is about equipment and supplies that we keep clean but not sterile, typically, such as clinician gloves and containers for things like alcohol wipes, etc.. Do you recommend that all of those items be put behind closed doors or be more protected than they have been previously so that nothing is in the way of the cleansing wipes?*

Dr. Madoff: It's a very good question. I honestly don't know the answer to that. Just on the face of it, it doesn't sound like something that we would routinely recommend.

Question: *I have two questions on data. The first question has to do with the number of reported tests. Does this include only COVID PCR antigen testing, or does it also include antibody testing? The second is on the number of reported deaths. Does that include only individuals who died as a primary result of COVID-19 infection, or does it also include patients who were COVID-19 positive, but whose primary cause of death was a direct result of another condition, to the extent that they can be separated?*

Dr. Brown: On the dashboard where we have total number of tests performed, it is only the molecular tests. At this point, we are not including serology testing in the data, although we have proposed that and anticipate being able to move to that soon. When we do that, we will not be combining the results. We consider the use of molecular tests to have a different role right now than then serology does, so we would be making sure that we separate those out. With regard to the second question, in this moment, the way we're counting deaths has to do with a surveillance case definition which is not as nuanced as perhaps it should be, and as the question indicates. Right now, people who have a confirmed diagnosis of COVID, meaning they have a positive PCR test, within 21 days of death, those are definitely counted as COVID deaths, regardless of what is included on the death certificate. For people, whose date of death is further out from their testing date, we're trying to look at those a little bit more carefully and make some judgment calls. The other group that is not counted right now, but will be, is individuals who have no test results at all, but have COVID as one of the causes of death listed on their death certificate. We are certainly hoping to be able to dig a little bit deeper into the death certificate data to get at some of the nuances that you are talking about in the near future.