



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

April 9 MMS /DPH Call: DPH Update and Summary of Q & A

On April 9, the MMS hosted a third COVID-19 conference call for physicians with the Massachusetts Department of Public Health (DPH). Dr. Larry Madoff, Medical Director of the DPH's Bureau of Infectious Disease and Laboratory Sciences; Dr. Catherine Brown, State Epidemiologist; Kerin Milesky, Director of DPH's Office of Preparedness and Emergency Management, and Mary Clark, JD, MPH, Senior Advisor to DPH's Office of Preparedness and Emergency Management participated.

DPH Update: Dr. Madoff provided an update on COVID-19 cases in the Commonwealth and reminded participants that the www.mass.gov/COVID-19 website is updated daily. New guidance and a link for medical professionals to volunteer to help with the state's response can be accessed through the website.

- As of April 8, there were 87,511 tests with 16,790 positives and 77 new deaths to bring total to 433 which underscore the need to protect most vulnerable.
- There are 25 labs now conducting tests, performing close to 5,000 per day. The [current Massachusetts case summary](#) is made public daily at 4 p.m. The summary now includes new information on race and ethnicity.
- To increase surge capacity, field hospitals have been established in Worcester, Boston and the Cape.
- DPH's current priorities:
 - Increasing assistance for nursing homes and LTC facilities that have been disproportionately impacted
 - Reinforcing the importance of social distancing
 - Continuing efforts to increase supply of Personal Protective Equipment (PPE) and ventilators
 - Contact tracing

DPH officials' responses to critical questions the MMS received from physicians and that were submitted to DPH in advance and answered on the call:

Surge Expectations

Question: What is DPH's current best estimate of the expected surge timing and numbers in Massachusetts?

Dr. Madoff: There are a number of models looked at, including one developed by our Command Center, based on Wuhan and these vary depending on which model you look at. The current IHME model projects a peak in bed use for about April 19. This is updated daily, and anticipates about 13,000 beds needed on peak day of April 18. Deaths are projected to increase until about April 20. This is using one model and not necessarily accurate but useful.

Personal Protective Equipment (PPE)

Question: The Bureau of Health Care Safety and Quality recently released Comprehensive Personal Protective Equipment (PPE) Guidance, which adopts a universal facemask policy for all health care workers in clinical areas and recommends that a facemask, eye protection, isolation gowns, and gloves be used when caring for an individual who is presumed or confirmed to be infected with COVID-19. With the ongoing PPE shortages, we are hearing from practices that are experiencing challenges

implementing this and other PPE guidance due to insufficient PPE and may have to close due to not having enough PPE for their HCP. What does DPH advise/recommend?

Dr. Madoff: We recognize that many providers are facing ongoing PPE shortages. I will turn it over to Kerin Milesky shortly on how we are doing our best to address these challenges. We need to be innovative and creative and recognize we need to conserve and reuse PPE. The guidance can be found on our website.

Follow-up: Do HCP returning to work after two negative tests need to wear a facemask? Is this the best prioritization/use for limited PPE?

Dr. Madoff: At this point, we are recommending that all health care workers wear a mask while in the health care setting. People who have recovered may have some degree of immunity, but the recommendation is for wearing facemasks.

Question: Can health care facilities/practices use KN95s as an alternative to N95s for aerosolizing procedures?

Dr. Madoff: Yes, they are functionally equivalent and are approved for use.

Question: What is the current fit testing guidance for KN95s/ N95s?

Dr. Madoff: Guidance on fit testing is evolving. Please stay tuned for more updates on that topic. The requirement for annual fit testing has been suspended, we advise all individuals using N95 do just in-time fit checking to ensure adequate seal. Hold mask and blow and be sure no air escapes around the sides of mask. We plan to issue additional guidance shortly.

Question: What is the latest information on N95 mask decontamination? Who can access and how?

Dr. Madoff: DPH has not yet posted formal guidance on decontamination. Some facilities have posted their own guidelines for N95 mask reuse after decontamination.

Question: Is the state tracking the burn rate of facemasks?

Dr. Madoff: We are doing our best, some facilities doing so on their own. We don't have info on every facility and how masks are being used in those facilities.

Crisis Standards of Care Guidance (CSC)

Question: Please provide an update on the Commonwealth's CSC guidance. Has DPH communicated with hospitals directly so they are clear about the processes and requirements with regard to CSC activation/deactivation?

Dr. Madoff: The CSC guidance was released earlier this week. We have communicated with hospitals. Many hospitals were instrumental in developing the crisis standards of care. These represent guidance and are not mandatory for any facility. Activation is done at the facility level.

Ms. Clark: We are working internally on providing additional guidance and information around activation and processes and hope to get out over the coming days.

Question: Does the CSC activation include liability protections for physicians acting in accordance with the CSC guidance?

Dr. Madoff: Legislation was introduced this week around a general waiver of liability for COVID-19-related activities.

Question: What should physicians know about which patients will be admitted to ICU-level care during the surge?

Dr. Madoff: We don't expect decision-making to change for care providers. These are clinical decisions. We are hoping CSC can offer help in making those difficult decisions. DPH is working to hopefully avoid need to use them.

Question: We know Massachusetts received 100 ventilators earlier this week. Does DPH expect more from the SNS or other sources before the expected surge?

Ms. Milesky: We are working closely with partners around this issue. We received a first shipment of ventilators last weekend from the stockpile, and we are hoping for a second delivery. Our federal partners have made it clear that future decisions around ventilators are going to be tied to the daily reports on ICU bed capacity and ventilator capacity on DPH's WebEOC. We have been getting unprecedented participation to those requests, but I need to emphasize how absolutely vital that reporting is to be able to portray the need in the Commonwealth. This is the only justification the federal government is using right now for our request, is existing med surge availability - what you can bring on, staffed and unstaffed, and the same for ICU; current capacity and what additional capacity, staffed and unstaffed. They also ask questions around how many COVID-19 positive cases, how many are in ICU and vented.

Testing

Question: There have been reports across the country in disparities in testing and early access to treatment and that locally and nationally minorities and low-income communities represent a disproportionate number of cases and deaths. Other states are reporting race/ethnicity and zip code data for their COVID-19 cases. Is Massachusetts collecting this data and planning to share it?

Dr. Brown: DPH collects detailed demographic data on all cases of reportable data and complete data does include race and ethnicity. This data is often incomplete and hard to understand disparities. The Secretary has now signed an order requiring the complete report of demographic information, name, address, phone, race, ethnicity. We hope to get information out on this soon and hope to incorporate this into the lab submission reporting to minimize the impact. We need providers and the EHR to include this in the lab submission and the lab can report that to the DPH. This is a moment we can take something that has been recognized as a long-standing problem and use it to help inform response for ALL reportable infectious diseases in the future.

Dr. Madoff: There is an opportunity for providers to help and provide this information on a specimen submission form, as this is very important to us. We want to be able to provide better data.

Question: Currently, we are only able to test sick patients if they need hospitalization or fit into certain risk categories. That makes it hard for us to diagnose patients as there do not seem to be "classic symptoms" and so hard to advise families. When will DPH relax the testing parameters?

Dr. Madoff: Testing is widely available at this point through commercial and hospital labs. The state lab has prioritized testing for certain populations. You, as a doctor, can make that decision in conjunction with your patients with symptoms. There is no rule requiring certain list of symptoms or defined criteria. You as a provider can make the decision on who to test as it is now widely available.

Question: When will COVID-19 antibody testing be available? Will there be certain priority groups for initial antibody testing?

Dr. Madoff: The FDA recently approved an antibody test (Cellex) and it is available. There are a number of other tests available, although not FDA approved. The challenge is in interpreting those tests on an individual basis and results still need to be defined with good research. We are waiting for that and would not be surprised if literature is available in a few days. It is reasonable to assume that someone who has recovered may be immune, but we do not know for sure. We are beginning to see serology used and some of those results coming in to DPH.

Question: We have heard of COVID-19 patients re-testing as positive, even after seven days of symptom onset, being afebrile for at least 72 hours without taking fever-reducing medications and

improved/resolving respiratory symptoms. Are these patients still considered to be infectious? Can they leave self-isolation?

Dr. Madoff: PCR is an extremely sensitive test. People very unlikely to spread the disease once symptoms have improved. Some facilities require testing for clearance. CDC added some guidance to their release from isolation. An area of active, ongoing research. In general people who have recovered are much safer than those we may not know about who are incubating the virus.

Treatment

Question: Is there any new information or data to support the COVID-19 treatments being discussed? i.e. Hydroxychloroquine, Remdesavir, and plasma donation.

Dr. Madoff: The FDA has not approved any drugs for treatment of patients with COVID-19. Hydroxychloroquine, Remdesavir and similar agents are all under study, but none have proven efficacious. Best way to use these agents would be in a clinical trial so we can learn.

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

Question: I'd like to ask about the policy to shift nursing home patients around to make one nursing home for COVID-19 patients and others for non- COVID-19 patients. Because of the inadequacy of testing, it seems to be an unsafe policy that asymptomatic carriers and pre-symptomatic patients will infect others when they're moved. Just like HIV and HCV did in blood before we knew how to test for them properly.

Dr. Madoff: Thanks for that question. I think you're absolutely right and that has been, unfortunately, what we've seen, and we've really shifted away from that policy. It is absolutely true, and I want to emphasize again in the negative tests in someone who's incubating COVID-19 is really not helpful because they become positive at any point during the incubation period, and so you're absolutely right and we've shifted away from that strategy and we're asking instead that skilled nursing facilities cohort or isolate their COVID-19 positive patients and continue to care for them at that facility.

Question: Some of the state has outdoor burning. Given the Boston Globe article this morning on the fact that smokers, maybe vapers, are at increased risk for this disease, and given the fact that outdoor burning which lasts until the first of May every year exposes people involuntarily to the fine particulate matter in the smoke, often across a wide area, is there anything that the DPH can do to ban outdoor burning, at least for the rest of this season when we have a respiratory emergency?

Dr. Madoff: Thanks, that's an excellent point. I honestly don't know anything about that. I don't know if any of the other speakers are involved in that, but I can promise to raise that with other people in the department.

Question: Asking for myself and on behalf of the MA Chapter of the American College of Surgeons and the member physicians there. There's currently a bill before the legislature to permit universal HIV testing in the event of health care exposure, and there's becoming increased concern in the care of the COVID-19 patients with the massively increased ICU capacity that these intubated patients in the absence of their family members are unable to provide consent for HIV testing in the context of a needle stick. Consent has generally been waived for other procedures except for this. And in the anticipation of the peak patients coming in the next couple of weeks, the problem this poses for critical care physicians and surgeons and other people doing invasive procedures is that in the absence of testing, they go on drugs that has a side effect that includes fever as well as the other side effects, and they are basically removed from the workforce as well as having the additional stress of awaiting a test that may never be able to happen. So, it further reduces workforce capacity. Is there anything that can be done at the level

of the DPH in terms of waiving this consent requirement or this only a legislative solution? Could you comment on that?

Dr. Madoff: That's an excellent question, and I have to say that I don't know the answer. My sense is that general medical consent is usually assumed to be adequate for HIV testing in most settings, but I think that this would be a good question for our general counsel, and I can try to get back to you with a more definitive answer.

Question: I'm familiar with contact tracing, but I'm wondering if the health department has any plans to test a cross-population such as assisted living. I'm in Framingham, and there's a senior living place called Schumann House, which has three positive case, and the question is, why not test the whole building? That's what they did in Singapore and a number of places - and isolate immediately everyone who's positive. Any plans to do that statewide?

Dr. Madoff: There have been a number of facilities where facility-wide testing has been done, and I would say when there's been widespread transmission in a facility, and to really help us gather data on that point. But the utility of testing asymptomatic individuals - and I realize that it's been done in other places - but I don't know that the utility of that has really been established. And as I say, it can be a double-edged sword because sometimes people who test negative are actually incubating the illness, and it can provide a false sense of security that this individual is negative. You can get into a situation where you have to test people every few days. But I think we may be moving to a point where rapid and inexpensive and easy testing becomes available, and we may see our guidance change on that point. I know we're doing our best to get testing done in assisted living and nursing homes and that was just launched today to include assisted living facilities among the facilities that can be tested by our National Guard unit and to do more skilled testing within a facility. But I want to emphasize that there are times when a test like that can be helpful, but overall, it has to really demonstrate its utility, because in some situations provide false reassurance about a patient not being infected.

Follow-up: In a place this like they have a issued restrictions lately, but before that people paid no attention. They gathered and talked face to face and there was a lot of exposure going on, and now there's a lot less exposure, so the question like this is a little bit different because people are not exposing themselves like they did a couple of weeks ago.

Dr. Madoff: I appreciate the question. These are challenging and difficult areas. We're still grappling with the right answers.

Question: I heard a gentleman from the CDC yesterday talk, and he talked about the COVID-19 illness as Week 1 and Week 2 and emphasized that people are infectious and spreading the virus even when they don't have symptoms. So, I'm not quite sure how to address that with the patients in my practice and certainly many of my neighbors who say, "I don't have symptoms, I can go out and about because other people don't have symptoms."

Dr. Madoff: Thanks for your question. The question of transmission from asymptomatic people is an important one and clearly it an occur. There are some well-documented instances where transmission from asymptomatic individuals occurs, and there's certainly been a lot of discussion about that. It's part of the reason that we've instituted social distancing and telehealth. Most of the available evidence suggests that transmission may occur in the 48 hours prior to the onset of symptomatic infection. And that's certainly the most dangerous period. We know from long experience with other respiratory illnesses that what drives the transmission of respiratory illnesses is coughing and sneezing and that those are the most important factors in trying to really reduce as much as possible transmission. There is certainly evidence that a couple of days prior to symptomatic illness, there is evidence that transmission occurs. Again, this is the general message behind all the social distancing measures that we've implemented.

Questions: You had talked about the wide availability of testing for COVID-19. I know it's available in some of the drive-through places, especially in the eastern part of the state for people 18 and older. Unfortunately, I don't know if there's any drive-through availability for pediatric patients. We are very hesitant to do any testing in our office because of lots of spitting going on and the PPE that's needed for it. Is there any future plan for doing drive-throughs for the pediatric population? They have it in CT, lots of facilities. Just wondering what the plans are in the future for our kids, because it is really hard to get them tested.

Dr. Madoff: Thank you for making me aware of that problem. It's something I can look into. I agree with you. I don't think that the drive-through testing is at this point available for kids. It is more difficult with kids, to do the testing with kids in general. It is something that can be done in an office setting with appropriate PPE as you mentioned, but it is difficult. I guess until that time we're going to have to pursue it in an office or other health care setting for the moment, but I will raise that issue and see if we can try to address it going forward.

Question: I'm a cardiologist. My question is whether these patients who are sick with COVID-19 in the hospital are hypercoagulable or not. People have been asking me this question, and I don't know the answer.

Dr. Madoff: That's a great question. I have to say I don't know the answer, either. We know there are activation of the whole inflammatory cascade and I've read about elevation in D-dimer levels as part of that, but I don't actually know if there is hypercoagulability or not that's associated with this, so I can't answer.

Question: I'm on the Board of Health in the local community. I'm also a retired practicing practitioner, if ever there was a need for communication between providers and public health it's certainly now. We have been getting calls at the board of health. Providers are not aware of both criteria for testing and testing sites and their turn around time. The only place I could find a [list of testing sites](#) was on the FAQ list on the MMS. I need to know, and probably all boards of health in the state need to know, how are primary care providers communicated with, what kind of knowledge are they getting, and can we somehow be on the same page with that? I know that's a tall order, but I don't know what information providers are getting and how they are getting it. I was wondering if you could address that?

Dr. Madoff: Sure. I would say for sure that there's a link to the test sites that's available through the DPH website. I find the question about resources available to primary care doctors is a challenge. Actually, MMS has done an excellent job making resources available. In some ways, I have too much information available. The Infectious Disease Society and the CDC website have good information. I read the preprint survey on daily basis; there's so much new as-yet unpublished literature; most of the major journals have made COVID-19 material available freely, have collections on their websites, so there's a glut of information and difficult to sort your way through it. I'm afraid I don't have an answer to that.