MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

MMM and Mass. DPH call summary

On Thursday, March 26, the MMS held a second COVID-19 conference call for physicians with the Massachusetts Department of Public Health (DPH). Commissioner Monica Bharel, Dr. Larry Madoff, Medical Director of the DPH Bureau of Infectious Disease and Laboratory Sciences; Dr. Catherine Brown, State Epidemiologist, and Kerin Milesky, Director of DPH's Office of Preparedness and Emergency Management joined more than 700 MMS members for the one-hour discussion.

Commissioner's Update:
Commissioner Bharel thanked the MMS for being an invaluable partner during the outbreak and she expressed her tremendous appreciation to her physician colleagues on the frontlines and shared the following updates:

- The current Massachusetts case summary is made public daily at 4pm. The summary now includes additional information including age, sex, hospitalizations, exposure, and commercial and hospital laboratory testing results. As you will see in our report the individuals, who are most at risk for severe disease and death are those older adults and those with underlying medical conditions.
- DPH's current priorities:
    - Increasing capacity for testing for clinicians and providers, patients in the hospital and those who are severely ill.
    - Obtaining the needed Personal Protective Equipment (PPE) and other supplies for the healthcare workforce.
    - Contact tracing. Currently, Massachusetts is on a steep increase part of the curve and expects to see increasing numbers.
    - Increasing surge capacity within hospitals and alternate care spaces.
    - One of the most important things is social distancing, which is needed to slow the spread of disease and reduce transmission. Social distancing is critical to give us the time we need to increase capacity.

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

Allocation of Scarce Resources/ Crisis Standards of Care
Question: We are hearing from physicians across the Commonwealth who are in urgent need of uniform and ethical guidance on the allocation of scarce resources as they are facing very difficult decisions about ventilators and about which patients are admitted to ICU-level care. What is happening on these fronts? When can physicians expect guidance?
Commissioner Bharel: One of the things I want you to all be aware of is that this is something that we are engaged in. I was on a call with all the health offices in Washington State who gave us their guidance they have prepared. New York is also developing guidance and, as you may know, they're being developed in other countries, as well. One of our key priority areas is to make sure we do that work here. We have old versions of the Crisis Standards of Care (CSC) from DPH. Many people at hospitals working on this, as well. One of the COVID-19 Response Command Center Advisory Board members,

Michael Wagner, MD has convened a CSC workgroup to develop a statewide approach to allocating scarce resources and that group is meeting this evening. We realize there is a need for guidance and, like you, I hope that we do not need to use them.

Personal Protective Equipment (PPE)
Question: There is not enough PPE**.** How do hospitals, facilities and those in practice request the PPE they need and are there assurances that it is being equitably distributed? Please walk us through what is happening and the process for requesting and allocating supplies.
Ms. Milesky: DPH is aware of rapidly expanding need for PPE, including masks, gowns, eye protection and other items. We are deploying all resources to increase supplies through all avenues: federal Strategic National Stockpile (SNS), working with local partners to acquire excess inventory as well as sourcing supplies from new manufacturers.
DPH's SNS request was sent on March 5. We amended the request on March 7. On March 12, DPH received 7% of what was requested. The second request brought us to 17% of our original ask. By the end of day today (Thursday), DPH will have pushed out supplies to 105 hospitals, medical offices, community health centers and others. The current priority for the SNS assets is those medical facilities with less than a 5-day supply. DPH is bridging them until they are able to source materials.
Private physician practices, hospitals, community health centers and long-term care, who cannot source through normal supply chain, can request PPE through 1 of 6 regional Health and Medical Coordinating Coalitions (HMCCs). *See resources below for HMCC contact information.*

Testing and Exposure
Question: What is the status of testing for COVID-19?
Dr. Madoff: Testing is much more available. Five thousand have been tested at state lab. Many thousands more have been done by hospital and commercial labs. Testing really now can be based on clinical indications, what you see in patients, rather than on strict cut criteria. The state lab is emphasizing testing with the greatest public health significance: health care workers, first responder testing, seriously ill patients.

Question: If we do swab for COVID-19 and the COVID swab comes back as positive, would the person who did the swab without an N95 mask and/or gown be considered to have been at-risk and therefore need to self-isolate for 14 days?
Dr. Madoff: Detailed guidance from the CDC is available on testing. If a health care worker is wearing a surgical mask (not N95), eye protections, glove and gown, that is considered a low-risk exposure. That would not require the health care workers to be quarantined or off work.

Question: Do health care workers, either positive or exposed, need to be re-tested before returning to work?
Dr Madoff: If the health care worker actually has symptomatic disease with COVID-19 there is now two types of clearance for the health care worker, or individual in general, that has tested positive to be cleared – a test-based strategy, which does involve obtaining serial specimens and requires two swabs and a symptom-based clearance for people who have tested positive for COVID-19. Individuals are advised to self-isolate and can leave self-isolation after these three things have happened: no fever for at least 72 hours (that is three full days of no fever without the use medicine that reduces fevers) AND other symptoms have improved (for example, when your cough or shortness of breath have improved) AND at least seven days have passed since symptoms first appeared.

We believe the people who have recovered from COVID-19 are likely to have an immunity, yet to be demonstrated in any clinical trials, but a logical assumption. At this point, wearing a facemask at all times while in the health care facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer is recommended.
Under certain circumstances where the capacity is stretched thin and other measures have been exhausted, they're allowing health care workers to continue to work after an exposure while asymptomatic. The health care worker should monitor symptoms with taking their temperature twice daily and wearing a mask during patient care activity so that is something that we're recommending.

Question: Test sensitivity? What is the likelihood of false negatives?
Dr. Madoff: We really need a gold-standard diagnostic test to assess the PCR against, in order to get true sensitivities and specificities. The other variable that impacts our ability to answer the question is that there is not one single PCR test for COVID-19. There are multiple tests now, many of which are laboratory-developed tests and these tests are all currently being used under what is called an Emergency Use Authorization, which means that while some data has been provided to the FDA, it is not as complete as to what is required for full FDA licensure. The documentation for the PCR test that we know the most about is the CDC-developed test, which is what most state public health laboratories are using, says that sensitivity and specificity will be determined later using an FDA-developed protocol. Having said that, when this test is done on appropriately symptomatic patients during the acute phase of the illness, sensitivity and specificity are thought to be above 90% and likely above 95%. There has only been a couple of incidents in the state lab where it's been negative, and someone subsequently tested positive out of thousands of tests being done there.

Question: Is the self-testing available in the Commonwealth?
Dr. Madoff: Self testing is not currently available. We are hoping that as new testing modalities become available, it will be.

Treatment
Question: Is there any data to support the COVID-19 treatments being discussed? i.e. hydroxychloroquine, remdesivir?
Dr. Madoff: There is currently no US FDA-approved drugs for treatment of patients with COVID-19. Clinical management involves infection prevention (isolation) and supportive care, such as supplementary oxygen and mechanical ventilation when needed. Early mechanical ventilation appears to be helpful. Quinine derivatives, antiviral (remdesivir) are being looked at.

Resources:
- **DPH State Epidemiology Lab: (617) 983- 6800 for clinical or epidemiological questions.**
- **Statewide 211-line questions from the general public. Dial 2-1-1 Press 2-6 for coronavirus.**
- **Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings**
- **DPH PUI Criteria**
- **DPH Guidance on Strategies to Optimize PPE and HMCC Contact Information (contains HMCC contact information)**
- **Information and Guidance for Persons in Isolation due to COVID-19**
- **Information and Guidance for Persons in Quarantine due to COVID-19**