January 18, 2022
MMS/DPH Call Summary and Q & A

On January 18, 2022, the Massachusetts Medical Society (MMS) held an informational call for members with the Massachusetts Department of Public Health (DPH). Kevin Cranston, MDiv, Assistant Commissioner and Director, Bureau of Infectious Disease and Laboratory Sciences, Larry Madoff, MD, Medical Director, Bureau of Infectious Disease and Laboratory Sciences, Catherine Brown, DVM, MSc, MPH, State Epidemiologist and State Public Health Veterinarian, and Kerin Milesky, Director of DPH’s Office of Preparedness and Emergency Management participated. DPH officials provided updates on the Omicron surge, changes to DPH’s hospitalization metric, oral therapeutics, and booster intervals. DPH officials also responded to member questions asked in advance and during the call.

COVID-19 Case Update
Dr. Brown and Dr. Madoff:
- Almost all COVID-19 in Massachusetts is due to the Omicron variant.
- Massachusetts case numbers have been trending down for at least a week. DPH is interpreting these declining case numbers with caution because so much of COVID-19 testing is shifting to at-home antigen testing. At-home antigen test results are not reported into DPH, and therefore are not included as part of the dashboard numbers. DPH’s other data sources do seem to suggest that this decrease in case numbers is real and not just an artifact of the shift in testing setting. Wastewater data has also been trending downwards recently, and for the first time today, in quite a while, DPH is reporting a small decrease in hospitalizations as well.
- DPH remains cautious as Massachusetts case numbers are still much higher than they were at any other part of the pandemic. For the first time since November, it looks like maybe cases are trending downwards instead of upwards. This is consistent with the modeling work that had been done at CDC, and in other locations, which suggested that the Omicron surge would peak at some point before the end of January. It is difficult to say exactly how rapidly case numbers will fall off. Cautious estimates are that perhaps a month of a downward case trend will get us back to numbers that we are more comfortable with, but there are no guarantees.

Hospitalization Metric Update
Dr. Brown:
- New hospitalizations metrics are coming later this week. Through combined efforts of several hospitals and the Executive Office of Health and Human Services (EOHHS), DPH will be using dexamethasone administration (whether or not dexamethasone was administered to that patient) as proxy for COVID-19 hospitalization. DPH recognizes that dexamethasone is not a perfect indicator, but it does have a decent correlation. Dexamethasone administration was chosen as a relatively simple data point that...
hospitals could report on and that might start to give us a better idea of what proportion of our total COVID-19 hospitalizations are actually hospitalized due to COVID-19 (primary COVID-19) or if they were hospitalized and incidentally tested positive for COVID-19 (incidental COVID-19).

- DPH will be reporting those new data for the first time on Thursday, January 20, 2022. Hospitals have already been reporting this data to DPH for a little more than a week, but it has taken some time to work through all of the quality assurance issues that we needed to with the hospitals to make sure that when we report the data it's as accurate as it possibly can be.
- Those data do suggest that a significant proportion of our current hospitalizations are incidental COVID-19 as opposed to primary COVID-19, but we need to wait and see what the numbers actually show.
- DPH is not minimizing the impact of patients who are hospitalized and have incidental COVID-19. We know that it also consumes resources, it requires some isolation and extra work on the part of medical personnel and hospitals, but the new information does help DPH gauge severity and get a handle on what's going on in hospitals.
- It is difficult to introduce a new metric as you don't necessarily know what things looked like previously, but DPH is hopeful the new metric will help track when and where we are seeing increases or decreases in disease severity related to COVID-19.

**COVID-19 Therapeutics Update**

**Dr. Madoff:**

- The presence of the Omicron variant has implications for the therapeutics.
- DPH issued new [COVID-19 therapeutic guidance on January 12, 2022](#) that provides information on a number of the therapeutic agents.
- Monoclonal antibodies (mAb):
  - Bamlanivimab, etesevimab, and the Regeneron combination monoclonals do not appear to have activity against the Omicron variant. DPH is not recommending the use of those agents except in some very limited circumstances (when you can actually identify that someone might not have an Omicron variant infection). Essentially, DPH is only recommending and providing the mAb sotrovimab at this point.
  - Sotrovimab supply continues to be quite constrained (see Therapeutics Availability Update below) and the supply isn't sufficient for the number of cases/patients who meet criteria.
- Remdesivir:
  - Remdesivir is another option for patients. It prevents progression to severe disease and is more available, but it does require intravenous infusion over 3 consecutive days.
- Oral antivirals:
  - Paxlovid, Pfizer product in clinical trials was highly effective. The major limitation right now is availability. The other complexity with Paxlovid is the drug interactions. There is online guidance which spells out the drug-drug interactions. Because it's given over a five day course, there are workarounds in many situations. See the [fact sheet](#) for Paxlovid to see the numerous drug interaction profiles and contraindications.
  - The state has started distributed Paxlovid to some of the mAb infusion sites (those operated and funded through the state) In Massachusetts, DPH has contracted with Gothams to facilitate seven sites for monoclonal antibody therapy and oral antiviral therapies for high-risk patients who have been exposed to or have COVID-19. They will begin offering the oral agents along with the monoclonal antibodies this week. The [Gothams referral form](#) is online.
○ Paxlovid is also going out through community health centers. Those allocations are primarily intended for the patients that are part of the community health center panels. There are not open to outside prescriptions.

○ Some of the larger hospital systems are beginning to get limited allocations of Paxlovid. Those sites are trying to offer Paxlovid both to their own patient populations and through their outpatient clinics.

○ The state guidance includes treatment recommendation tiers to prioritize individuals for receipt of these scarce, but highly effective agents. The tiers are based both on immunity, vaccination status or immunosuppression, age and underlying medical risk factors. At the moment, we are recommending Paxlovid and sotrovimab primarily for those in Tier 1 of that prioritization scheme, recognizing that there's room for clinical discretion in the use of these agents.

○ Molnupiravir is the other oral antiviral that is currently available. It is similarly indicated for mild-to-moderate COVID-19 in patients at risk of progression to severe disease within five days of disease. It has lower overall efficacy, estimated around 30% compared to the 80% plus/90% of the other agents. It does carry precautions around pregnancy and also around people who intend to parent, including men. The use of birth control is recommended for three months following the use of molnupiravir because it is a nucleoside analog that does have interaction with mammalian DNA. It is meant to be used in patients who would be indicated for antiviral treatment, but for whom other antiviral treatments including monoclonal antibodies and Paxlovid aren't available.

**Therapeutics Availability Update**

**Ms. Milesky:**

- The vast majority of COVID-19 therapeutics are coming into the state via allocation from the federal government. The one exception to that is remdesivir, which is available on the commercial market.

- DPH receives a weekly allocation of monoclonals, both sotrovimab and for the pre-exposure treatment, Evusheld and a biweekly allocation for the two oral antivirals, Paxlovid and molnupiravir.

- All of the therapeutic agents are extremely, extremely scarce in supply. It has been signaled to us from the federal government to anticipate that scarcity will continue for the coming weeks, if not the next several months. As an example, Massachusetts biweekly allocation for Paxlovid last week was 85 boxes of 20, just over 1,700 courses to be utilized for two weeks across the Commonwealth. It is incredibly challenging to ensure fairness and equity. DPH is working to target this limited supply of therapeutics most appropriately.

**COVID-19 Vaccine Update**

**Mr. Cranston:**

- Over 13 million doses of COVID-19 vaccine have been administered in Massachusetts. Over 5.1 million individuals are fully vaccinated, and 2.5 million individuals have received a booster.

- Massachusetts has rolled out a new way for residents to access their COVID-19 digital vaccine card and vaccination history. The tool, called My Vax Records, allows people who received their vaccination in Massachusetts to access their own vaccination history and generate a COVID-19 digital vaccine card, which would contain similar vaccination information to a paper CDC card. The COVID-19 digital vaccine cards produced by the system utilize the SMART Health Card platform and generate a QR code that can be used to verify vaccination.
COVID-19 Hospitalization Update

Ms. Milesky:

- The last two weeks in terms of hospital capacity have been fairly grim. All hospitals continue to be in Tier 4 of the Commonwealth's COVID-19 Resurgence Guidance. DPH is working daily with hospitals around resource coordination and load balancing to try and identify available beds. ICU beds have been the most challenging for many of our hospitals to identify, and really working very closely with them to be able to support that.
- There was a slight decrease in COVID-19 hospitalizations over the weekend. Today, DPH is reporting 3,192 hospitalizations - a decrease of 114 hospitalizations. 466 patients are in the ICU.
- Hospital capacity in the Commonwealth is at 92%. Overall ICU capacity is 86.8%. DPH is very cautiously watching the numbers and hoping that they begin to plateau from the increases seen in the last couple of weeks.
- The Commonwealth did put in place a number of public health orders and guidance documents and measures to try and assist through this surge.
- This week, an additional 500 personnel from the Massachusetts National Guard will be deploying, bringing their support to health care to up over 800. They are deploying to hospitals, emergency medical services (EMS) nursing homes, dialysis centers, and the like.
- The Commonwealth opened a third isolation and recovery hotel on Friday of last week, which increases the number of beds by 88 that are available across the Commonwealth. We have about 360 beds that are available right now. Referring entities and organizations, such as homeless shelter providers may contact the intake line below to ensure eligibility, register the individual for the program, and get the individual placed and transported to an Isolation & Recovery site:
  
  **Intake Line:** 617-367-5150

  **Hours:** Monday-Friday between 9:00 am and 5:00 pm/ Saturdays: 10:00 am to 2:00 pm

  For any questions, concerns or issues accessing the State’s I&R site, please contact Josh Cuddy (josh.cuddy@mass.gov) at the Executive Office of Health and Human Services.

Responses to questions provided in advance of the call:

**Question:** What should physicians know about changes to mRNA vaccine booster recommendation intervals?

**Dr. Madoff:** These have fortunately been simplified to some extent. Boosters are now recommended for either mRNA vaccine after five months. That boosting can occur with any of the available vaccines. CDC has prioritized the recommendation for the mRNA vaccines over the Johnson & Johnson vaccine at this point. Patients who received the Johnson & Johnson vaccine are eligible for booster after two months and that can be done with an mRNA vaccine as well. There is good availability and I just want to remind everybody about the importance of boosters. They really do enhance the protection against COVID-19. We see that in our vaccine breakthrough numbers. Vaccine breakthrough is much less likely to occur in boosted patients and that includes during this current Omicron surge.

**Question:** MMS is receiving emails from practices about My Vax Records. Physicians have received numerous calls per day asking about updating of demographic information in MIIS. How can physicians direct/ handle such queries?

**Mr. Cranston:** We have been signaling for several months now to anyone who's administering vaccine to please try to keep your demographic information as up to date as possible. One of the reasons for that, beyond the accuracy of our overall data, is that knowing that those data would form the basis of people being
able to access their QR code. We're seeing great success with the accessing. Over half a million individuals have accessed the My Vax Records website and 2/3 of them have been successful in getting their vaccine records. Over 75% have been successful if they put in their cell phone. I would say if there's any one thing a provider can do to improve the demographics, beyond having accurate name and date of birth, is to see if you have records containing cell phone numbers. That is the most efficacious way for people to self-serve on our My Vax Records website and get the QR code as a verifiable and useful record of all their vaccinations. This record is becoming more and more important. I live in the city of Boston. Boston has mandated that a broad range of venues to require evidence of vaccination. Even gyms are requiring that evidence, so it's not surprising that people are out looking for this record, and it's handy to have on your phone, whether it's in your Apple Wallet or it's a photograph or in another area on your phone. Individuals who are unsuccessful getting their QR code from the website do have options to request directly from the MIIS and to update their vaccination record. It does require them to submit a number of different documents verifying their identity and record of their COVID-19 or other vaccinations. They may be turning to providers for a letter or other documentation. So, I'm afraid that even the self-service process doesn't necessarily absolve clinicians and other vaccinators from perhaps having to provide supplementary records. We do recognize that is a burden. Do ask your patients to first try the self-service process and visit the My Vax Records FAQ page. It doesn't necessarily require a clinician's letter if they have other documentation in hand of their vaccine. All that information is on the help page on the My Vax Records website. So please urge your patients to try this. One of our goals with this system is to relieve the burden on clinicians to provide extensive vaccination records for all their patients for their various needs.

**Question:** Vaccination rates for Massachusetts children, ages 5-11 vary considerably depending on the town in which they live. Is this due to access or vaccine hesitancy among parents, and what can be done to increase pediatric vaccination uptake in these communities?

**Mr. Cranston:** We are seeing actually a very substantial uptake statewide in the 5 to 11 age group and beginning to see, for some of the older individuals, the adoption of boosters as well. Our read on pediatric vaccine hesitancy is that it tracks relatively closely to vaccine hesitancy at the community level. We are making great strides, particularly in our equity communities, expanding not only vaccination access, but confidence amongst parents and adults in our equity communities. This appears to be having a secondary effect on their willingness to seek vaccination for their children, particularly their younger children. I want to urge pediatricians to use the same techniques you use for other vaccines. To say to parents and patients, in the words that you choose, that it is time to get vaccinated, and state eligibility and timing of the COVID-19 vaccination as matter-of-factly as you would any other vaccine in the pediatrics series. Also, to the degree that your practice, particularly pediatric practices, can expand access and make vaccination more convenient for parents, we urge you to do that. We recognize that it poses staffing challenges and an additional burden on your practice. There are also other vaccine access opportunities in the communities - through our mobile providers, through our high-throughput providers, through pharmacies, and through community health centers. DPH has been providing additional support, including the National Guard for community health centers, to support this vaccination effort.

**Responses to questions asked during the call:**

**Question:** Because the oral antivirals are so scarce, I'm wondering if there's any effort to sort of try to really prioritize those for patients who can't actually get to an infusion site. For example, people who might be home-bound, or in a nursing facility, or something along those lines?
Dr. Madoff: It would be nice to have some kind of a home-bound program. Our Gotham sites all have community access teams that can go out to facilities, but not specifically to patients' homes. We have addressed some outbreaks in skilled nursing facilities and other locations like that. Our hope is that as the oral therapeutics become more available, that there will be some systems in place for actually being able to deliver some of those medications to patients in their home. I believe some of the health care systems are working on those kinds of processes as well. It's a good idea, and it's something that I would hope to be able to do once the supply loosens up.

Question: I have a question about KN95 masks, since now everybody's recommending them. Every commercial, and newspaper has ads in that they have the best KN95s. Unfortunately, NIOSH doesn't test KN95s. Can the Commonwealth or the CDC test KN95 masks from companies like 3M and let us know which KN95 masks work?

Dr. Madoff: I don't know that we can answer that, to be honest. It's a good idea. As you indicated, the problem is there are literally thousands of different kinds of masks that are available out there. Even if you test a batch, it doesn't necessarily mean that the next batch will be the same, or that the suppliers are reliable. Also, many of the suppliers are not U.S. based so it's very challenging. There are some websites that I'm aware of that they at least claim to have reliable information on different suppliers that would appear to have massive higher quality. It's a very challenging issue, and I don't know that we're going to be able to solve it right now.

Question: If someone is fully vaccinated, but then gets COVID-19, is there a time period they should wait to get a booster?

Dr. Madoff: There are sort of two answers that I would give. The first is our guidance and the CDC guidance, which suggests that as soon as you are done with isolation and can be out and about -the new isolation guidance requires you to be isolated for five days and then in a mask for an additional five days, assuming that symptoms resolve and you're afebrile - I would say it's fine to get a COVID-19 vaccination. The vaccine has been used extensively in people who have had COVID-19 and there does not appear to be any increase in adverse events associated with it. We also know that vaccination adds to the immunity, that immunity from infection is variable, and that some people develop high levels of neutralizing antibody following infection, and some less. Vaccination is very predictable compared to infection. I think any time following infection it is fine to get boosted as long as you're outside of that isolation period, so that you're not exposing others during the vaccination process. If I were to put on my clinical immunology infectious disease hat for a minute, there might be an optimal time that might be to wait maybe two or three weeks following an infection to get that booster vaccination. I don't think this has been well-studied. There is some thought that one might get an additional kick from a booster if you were to wait a little bit after the recent infection, but there's really no reason to delay, and I think any time after the isolation period has ended is a good time to get vaccinated before you forget. Supplies are good right now, and I would just go out and get the vaccine.

Question: Is it OK to get the COVID-19 booster while someone is receiving radiation or chemotherapy?

Dr. Madoff: There's no precautions or contraindications for getting the vaccine for patients who are receiving radiation or chemotherapy. Of course, the response to vaccination may be lessened by different types of treatment, but there is no reason not to get the vaccine in those circumstances. There may well be substantial benefit in those cases as obviously patients who are getting radiation and chemotherapy are at increased risk from COVID-19. So, that's a good reason for those folks to get vaccinated. We didn't touch on the use of the combination long-acting monoclonal antibody product from AstraZeneca that's called Evusheld. This product is recommended for people who have moderate to severe immunosuppression and might not respond.
adequately to a vaccine. This is given as two intramuscular injections and can be given any time. It is immunization in a sense, with a duration estimated to be around six months. It is a good product to use in immunocompromised individuals, whether or not they have been vaccinated. We've gotten a couple of thousand courses in the state. It's being made available primarily through academic medical centers, so patients who have immunosuppression can operate through those channels to get that product.