



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

November 4, 2020 MMS /DPH Call: DPH Update and Summary of Q & A

On November 4, the MMS hosted its monthly COVID-19 conference call for physicians with the Massachusetts Department of Public Health (DPH). Commissioner Monica Bharel, Larry Madoff, MD, Medical Director, Bureau of Infectious Disease and Laboratory Sciences, and Kerin Milesky, Director, Office of Preparedness and Emergency Management participated in the discussion. MMS member questions for DPH officials were submitted in advance as well as answered during the call.

Commissioner Bharel provided an update on COVID-19 response efforts.

DPH is seeing COVID-19 everywhere in the Commonwealth. Not everyone can identify the source of their infection, but DPH's cluster report does show a high rate of transmissions in households. On Monday, November 2, 2020 Governor Baker announced a series of targeted measures to disrupt the increasing trend of COVID-19 cases and hospitalizations in Massachusetts since Labor Day. The changes are designed to dissuade face-to-face gatherings and disrupt rising trends so that the Commonwealth can keep the economy and schools open for residents, and to prevent the need to roll back to Phase 1 or Phase 2 of the reopening plan. Day. All of these advisories and orders become effective on Friday, November 6, at 12:01 a.m..

The new orders and revised advisories include:

Stay at Home Advisory: The revised Stay at Home Advisory is meant to ensure residents avoid unnecessary activities that can lead to increased COVID-19 transmission. The revised Stay at Home Advisory instructs residents to stay home between 10 PM and 5 AM. The Advisory allows for activities such as going to work, running critical errands to get groceries and address health needs. [Click here to read the revised advisory: http://www.mass.gov/stayhome.](http://www.mass.gov/stayhome)

Early Closure of Businesses and Activities: This new executive order requires the early closure of certain businesses and activities each night at 9:30 PM. The 9:30 PM closure requirement is aligned with the Stay at Home Advisory and together the two new initiatives are designed to further limit activities that could lead to COVID-19 transmission. Effective November 6, the following businesses and activities must close to the public each day between the hours of 9:30 PM and 5:00 AM.

[Click here to read the new executive order](#) (including full list of businesses required to close at 9:30 PM).

Face Covering Order: This revised order requires all persons to wear face-coverings in all public places, even where they are able to maintain 6 feet of distance from others.

Gatherings Order: The new gatherings order reduces the gathering size limit for gatherings at private residences: indoor gatherings at private residences are limited to 10 people and outdoor gatherings at private residences are limited to 25 people. The new order also requires that all gatherings (regardless of size or location) must end and disperse by 9:30 PM. The new gatherings order also requires that organizers of gatherings report known positive COVID-19 cases to the local health department in that community and requires organizers to cooperate with contact tracing. [Click here to read the revised gatherings order.](#)

All actions are informed by the data that we have and the science as it evolves. DPH keeps a close eye on all of the key metrics and information as they come in. With recent uptake in more communities, DPH is keeping a full court press on all of our interventions as it remains concerned about the rising numbers.

When it comes to COVID-19 testing, Massachusetts continues to be one of the top testers with regard to the number of people tested every day. DPH is continuing to work on testing to make sure we can do even more. DPH continues to share more data in its daily dashboards and the weekly public health report, that are now posted on Thursdays. This week, DPH redesigned the daily dashboard to include and highlight more of the metrics that are relevant as the pandemic evolves. It includes a new age breakdown of cases.

As we approach the holiday season, DPH put out tips for safe and healthy Thanksgiving in 11 languages. They encourage small and household-only gatherings and include other ways to limit the spread of this deadly virus. Unfortunately, these are the actions and sacrifices that we have to take until we have a widely available vaccine. Massachusetts is continuing its planning for a vaccine. The state's interim vaccination plan includes a robust public engagement component. DPH will be reaching out to all of its partners, including the MMS and other stakeholders as planning efforts go forward. DPH and the Covid-19 Command Center are also working with a COVID vaccine advisory group that's advising our state on a variety of issues, including the very important issue of equity. The arrival of a vaccine does not mean the end of the virus. Everyone will have to remain vigilant against this highly contagious disease and continue all public health prevention protocols. To learn more about the state's vaccine preparedness efforts go to: <http://www.mass.gov/COVIDvaccine>.

DPH would appreciate physicians' continued assistance with all of these efforts. Physicians are highly trusted voices for their patients, staff, and communities. There is a need for these precautions and for assistance with combating pandemic fatigue. Anything physicians can do to help DPH in this area is needed, and greatly appreciated.

Dr. Madoff and Ms. Milesky then provided responses to questions received in advance of the call.

Question: *How the recent steady increase of COVID cases impacting surge capacity? How are MA hospitals positioned to respond to potentially more cases of COVID as well as flu and other admissions?*

Ms. Milesky: The question about surge capacity is incredibly timely. I was so glad to see it on the list of questions because yesterday, the Department did issue guidance for acute care hospitals to be able to support COVID-19 resurgence planning. As many of you will recall from the first surge, the decisions that were made around the health care system were made in a statewide manner. The approach that we're going to be following in the event of a resurgence is going to be focused more on the regional level with the goal be able to maintain Phase 3 reopening guidance throughout preparing for this surge. As many of you know, we have a regional structure with six Health and Medical Coordinating Coalitions (HMCC). DPH is going to leverage the HMCCs to be able to establish a regional planning process in order to be able to identify and address capacity constraints. The plan is outlined in a guidance document that was pushed out yesterday and is available on the COVID-19 web page under hospital guidance. It will involve a regional planning process that will include senior leaders from acute care hospitals across the state, HMCCs and representatives from both DPH and the Secretary of EOHHS. We will work together to recognize triggers, analyze capacity across the region and share real-time capacity and constraints, so that we can identify where there are issues and concerns and respond through the regional action steps and defense strategy. The meetings and this planning will be based on an established tier that each region will be placed in. The tier reflects what impact the region is seeing at the time from the COVID surge. At tier 1 there will be meetings at least every other week, and following through up until tier 4, where there potentially will be daily meetings. The plan is being modeled after an initiative that took place during the first surge within the city of Boston and are also currently developing tools that will be able to help with planning, such as a regional dashboard and other reporting and assistance tools. We anticipate that the first regional meetings will kick-off next week.

Dr. Madoff: One of the things I wanted to add is that there is a focus by state leadership on maintaining hospital capacity for dealing with other illnesses during the surge. During the spring surge, we tried to

decrease hospital use of other non-COVID-related illnesses. As cases increase, we are going to try our best to maintain other hospital activities. The undesired side effect last time was that patients with other types of illness were discouraged from seeking care either because of their understanding of the risk of going to the hospital or for other reasons. As we plan for a new surge, there's an emphasis on maintaining hospital capacity for non-COVID illnesses as well.

Question: *On Monday 11/2 DPH posted a revised COVID-19 daily dashboard that reflects new reporting methodology and categories. Please explain what's new?*

Dr. Madoff: The revised daily dashboard shows much of the same data that was on the last dashboard, but hopefully shows it in a better way. The state has received a lot of credit for the volume, amount, and frequency as well as the careful display of data which has evolved through the pandemic. It is one of the most comprehensive public data reports in the country. It includes municipal level, college and university, contact tracing data, information on clusters now in the new record, long-term care facility data. Our hope is that the enhancements to the dashboard make it easier to read and understand. A lot of the same things are there. Our seven-day average positive test rate continues to be on the low side nationally, but it has gone up from our low point in early summer. We are now seeing a seven-day average positive test rate of 1.86%. That is, strictly speaking, the number of positives divided by the number of tests that are done each day. One of the new features on the dashboard is case growth by age group, which we are hoping will help contextualize the impact of COVID on different age ranges over time. As you know, we're seeing a larger proportion of cases in younger people compared to earlier in the pandemic. The dashboard now also includes the average turnaround time for COVID-19 test results, which is really quite low. We're currently reporting a 14-day average turnaround time of 1.79 or 1.8 days essentially, less than two days. That is actually the time from the specimen being obtained to the time that data are reported to DPH. I will point out that sometimes that actually takes a little longer than it takes to get back to the patient or the provider. That low number reflects the large number of tests that are being done in the state, either by our hospital partners, by the Broad Institute, by the state laboratory, or by other in-state commercial testers. We know that some tests are still taking too long to get back. The dashboard now contains a lot more information on the Commonwealth's colleges and universities. As you know, universities have been leading in an effort to do surveillance testing. They are testing about 25,000 students, faculty, and staff daily, which is an enormous number. That is partly responsible for why we've seen very good results overall in the college and university setting here in the state, with relatively few outbreaks and a low number of cases. The dashboard now separates out now the daily positivity rate in that setting from other non-university settings in the state. Some of the other existing data points on the dashboard, including testing, deaths, hospitalization rates, have been reorganized to report on current numbers and trends over the past weeks so we can sort of see them in a larger context.

Question: *The CDC recently updated its definition of a close contact to "Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated." Please explain the PPE implications of that definition for health care workers in the clinical setting. Does this change which individuals should wear a N-95 mask in a clinical office setting? (MD/RN/MA/Front Desk as patients can be asymptomatic when visiting a physician's office?)*

Dr. Madoff: We define a close contact as someone who has been within 6 feet for 15 minutes. The CDC recently clarified their definition as including the 15 minutes which can be non-consecutive or not continuous 15 minutes, but any 15-minute period over 24 hours. That did not change how we at DPH have been defining close contact. For some time, we used the same concept because the risk of transmission from someone who is infectious to someone who is susceptible is proportional to the amount of time of exposure and it doesn't need to be a continuous period of time that that's occurring. We had been using that for some period of time, although we had defined it as over several hours or over the course of the day, but I think we are adopting the CDC criterion for 24 hours during that time. One of the questions was how that affects health care workers in

the clinical setting. I want to clarify that for a health care worker who is wearing appropriate PPE in the health care setting, and that really boils down to a minimum of a face mask and eye protection, unless there's an aerosol-generating procedure, which changes the equation a little bit, a health care worker is not considered a close contact as long as they are wearing that minimal PPE, at least. Anything greater than that also minimizes the risk of exposure. An N95 mask, while it's the preferred PPE for treating a COVID patient or when in a room where aerosolizing procedures are carried out, the simply the use of a face mask and eye protection does allow the health care worker to be counted as non-exposed during that period of time. Clearly, we still want to caution you all and your co-workers to be extremely vigilant and to, of course, wear the appropriate PPE in the workplace and recognize that many people with COVID are asymptomatic and may not know that they have COVID at the time that you encounter them. So, it is quite important that PPE be worn during any public patient encounter.

Question: *What are the current indications for COVID testing? Has anything changed regarding clearance (considered no longer infectious) for individuals with known exposure who are symptomatic or asymptomatic? We continue to hear about the barriers to testing including ability to make appointment and turnaround time for test results. Do you have plans to expand testing, including the Stop the Spread campaign?*

Dr. Madoff: We have not updated our testing guidance in almost two months now. The testing guidance is still very broad. Any provider can test a patient for essentially any reason that they think necessary. Obviously, someone who is symptomatic and has symptom signs compatible with COVID, any close contact of such a patient should be tested. Other asymptomatic testing can be ordered by a provider for any reason that the person thinks that the patient is at risk from COVID, be that through exposure or potential exposures in the workplace, public transportation, or other types of risk. The question about clearance for a patient who has tested positive for COVID has also not really changed very much. We still allow both a symptom or time-based clearance mechanism, whereby someone is deemed non-infectious after 10 days from their onset of symptoms or positive test result and as long as they are free of fever for more than 24 hours and have had a reduction in their symptoms. They don't have to be completely free of symptoms, but have improvement in their symptoms, be afebrile, and have made it to the 10-day mark. There are some exceptions. Those include immunocompromised patients, patients who are severely ill and hospitalized. In these cases, the window is extended to 20 days. By and large the time-based strategy is the most successful one because many people remain PCR-positive for considerable periods of time, even after they are no longer ill and are, importantly, no longer contagious or shedding viable virus. RT-PCR is very sensitive and can remain positive even when there's much less virus present and viral detection by culture is almost zero. You can also still clear somebody by two consecutive negative RT-PCR tests obtained greater than 24 hours apart in a person who is afebrile and has improvement in their symptoms, even if it's less than 10 days. But we recommend using the time symptom-based approach for clearance from isolation. The question mentions the barriers to testing. We recognize that those are still there, and we are continuing to roll out more testing. In the last couple of weeks, we've opened a mega test center, Project Beacon, at the Old Suffolk Downs site in Revere. It's a drive-through testing site by appointment with the capacity to test up to 1,000 people a day free of charge. The turnaround time is rapid. Results are reported typically in 24 hours. It is a good site for people who are in that geographic area to get tested. The website also has links to many other test sites and the Stop-the-Spread sites will continue at least through December. We lead the country in a per-person testing rate and are way ahead of many other states in the country. I understand there are still barriers or times when it can be inconvenient or difficult to obtain testing. That especially applies to children, although the Revere site that I just mentioned is open to anyone over 12 months of age. We're doing our best. It is a challenge, and we recognize that.

Question: *Please update us on the distribution plan in Massachusetts. Does DPH have more information about expected vaccine availability timeline and/or immunogenicity at this point?*

Dr. Madoff: We are still awaiting data on the effectiveness and safety of the vaccines. We've heard some preliminary positive safety data that at least the first two vaccines that are in the pipeline, which are the RNA

vaccines from Pfizer and Moderna, have a very favorable safety profile. We're still waiting for efficacy data on that vaccine. Distribution planning has been moving forward. The Commissioner mentioned the external advisory group. I attend those meetings, and it's a really interesting and engaged group that includes a representative from the MMS. It's a little early for vaccine planning. DPH has submitted an initial plan which is publicly available. The plan is subject to public commentary and stakeholder input, and we are continuing to refine and build on it as we learn more about the availability of vaccine. We all think that health care workers, those who are likely to be treating COVID patients, are in the first group that will receive the vaccination. Frankly, we also look to our health care workers to be an example for receiving the vaccine, and we hope that their acceptance of the vaccine will be an example to the rest of the community around the safety or endorsement of vaccination as a way to tackle this problem.

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

Question: *My question is about what level of testing, beyond what we have right now, is needed in order to create some sort of return to normalcy?*

Dr. Madoff: I don't think we know the answer to that. We have seen some examples. Some cities in China, for example, have tested the entire population over a period of time. I don't know if that's a desirable or feasible approach for us, but it is something that we think about. There have been different responses and different models that have looked at the question of how often, and with what frequency, do you need to test people and with what kind of test. Another question that frequently comes up is around antigen tests. There's a relatively new BinaxNOW rapid point-of-care test that has been rolled out. It's been purchased by the federal government, and it's being rolled out to the states. We are in the process of initiating some pilot use of that, perhaps in the school settings, in the K through 12 settings. All of the output of Abbott tests were purchased by the federal government and allocated to the states. We received a portion of those tests. There are unanswered questions about these tests, simply how sensitive and specific they are. The FDA, actually just yesterday, released an advisory about the specificity of false positives occurring with some of the antigen tests that have been deployed. We are evaluating that, and we are actually doing a study right now comparing the BinaxNOW antigen testing with PCR. The availability of that kind of testing at point of care could supplement the numbers that are available. If a home version of that were developed in a self-test version, that could also have important implications for wider-scale testing. Then there also the question of the resources that need to be devoted to testing, and just how much can be done. Another approach has been to use pooled testing which has limitations in that it slows down the process because if the pool turns positive, you're going to have to go back and identify who in that pool is positive. It also lowers the sensitivity of the test because you're diluting the sample out, but it's another approach that's being explore. I would just say, we are open to ideas, and we'd love to hear from you all.

Question: *I have two questions. One is, about the new dashboard. You've taken out the daily census of hospitals and medical centers. Is that in a place I can't find, or is that something you can put back online? Second question is the RT-PCR testing. I called Abbott, and they said that the optimal day for testing is eight days after exposure?*

Dr. Madoff: I believe that the information about health care facilities will be in the weekly dashboard if I'm not mistaken. The timing of testing relative to an exposure is challenging. There's a 14-day incubation period. Within 14 days, more than 97% of cases will occur. The actual time that virus is first detected after exposure ranges from about two days to probably 12 days or so. You're right that at the end of a 14-day period, although people who are infected may continue to shed virus, not everyone will, so you would miss some people. Unfortunately, you: miss people regardless of when you test. We know that it's rare that someone would turn positive in less than two days. The timing of the travel restrictions is somewhat arbitrary and obviously doesn't catch everybody. The idea is to make people think about it, to perhaps discourage travel and to at least get a point in time. A test is only valid for a point in time. The optimal time to test somebody would

be to test them soon after they're identified, within a couple of days, so that you can use that information for contact tracing. Then to clear somebody, I would test them at probably between a week and nine days, which would maximize the likelihood of finding somebody who is going to turn positive within an incubation period.