



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

September 2, 2020 MMS /DPH Call: DPH Update and Summary of Q & A

On September 2, the MMS reinstated hosting its COVID-19 conference call for physicians with the Massachusetts Department of Public Health (DPH). The calls will be held on the first Wednesday of the month through December 2020. Dr. Larry Madoff, Medical Director, Bureau of Infectious Disease and Laboratory Sciences at DPH 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.

Dr. Madoff provided an update on COVID-19 case data and testing in the Commonwealth:

- DPH tracks the numbers of daily COVID cases and is monitoring the indicator metrics very closely and those numbers can be seen on the COVID-19 daily dashboard. Massachusetts metrics have been reasonably good.
 - DPH is concerned and expressed some trepidation as we face the fall, students coming back for college and back to school, and, unfortunately, being in a country where there is still lots of COVID around us.
 - The rolling average of percent positive tests has come down in the last few weeks through the month of August and is now at 1% or less. Massachusetts is doing well compared with other states in terms of test positivity.
 - The rolling average of deaths is way down, certainly compared to our peak.
 - The numbers of hospitalized patients are also down from our high point in the spring. Currently there are about 300 hospitalized COVID patients throughout the state.
- DPH also looks at many other metrics that have to do with early warnings of a surge. For example, syndromic surveillance. We look at other test characteristics, and we look at a lot of health care consumption metrics such as ICU beds. All of them are continuing to look pretty good for the Commonwealth at this moment.
- Despite the good news overall, DPH is seeing upticks in some communities and communities have been designated higher risk, moderate risk, or lower risk. Fortunately, the vast majority of our cities and towns are in the lower risk category.
 - The Baker Administration has set up a cross-agency COVID intervention team, which DPH supports, to help coordinate local efforts to assist communities with enhanced messaging about the importance of mask use and social distancing as well as other supports for those communities deemed to be at especially high risk.
 - Wednesdays are the day that DPH posts its updated risk map, along with other local statistics that you can see on the [mass.gov/COVID-19 website](https://www.mass.gov/COVID-19-website).
- The Baker Administration is also continuing to expand its *Stop the Spread* initiative that provides free COVID-19 testing across the Commonwealth.
 - Launched in July, *Stop the Spread* is a data-driven initiative that provides free testing. Currently in 20 communities with high case rates.

- The [Get Tested website](#), shows the availability of testing sites throughout the Commonwealth. Massachusetts testing numbers have been steadily increasing averaging close to 20,000 tests per day. Over two million people have been tested to date.

Ms. Milesky provided an update from DPH's Office of Preparedness and Emergency Management:

- DPH is doing a lot of work now around PPE-demand modeling and working quite aggressively around ensuring that we have adequate supplies of PPE and supplies in the event of a second surge in the Commonwealth.
- DPH is also trying to better understand what steps those health care partners have taken to prepare themselves for a second surge so that we can also be able to support our demand modeling.
- DPH is working to bringing remdesivir into the state.
- DPH has reengaged with Dr. Mike Wagner and the working group that is supporting the framework around Crisis Standards of Care. That group is considering what updates to that framework might be necessary in anticipation of a second surge.

Dr. Madoff's responses to questions the MMS submitted to DPH in advance of the call.

Question: *Where are most of the new cases coming from? Is Massachusetts contact tracing efforts working?*

Dr. Madoff: We are continuing to see cases and we are continuing to see clusters almost everywhere that people get together. That includes daycares, restaurants, parties, and really any setting where multiple people assemble for any reason. So, there is ongoing community transmission and we are still seeing cases that we can't define. We're also seeing cases that come in from out of state. There's been a massive upscaling in testing going on college campuses, and we're starting to see those results add to our numbers. Unfortunately, we are also starting to see cases associated with college and universities to some extent. We do have good contact tracing capacity here in the state. Much of that is based in the localities and the local boards of health in each city and town, and in addition to that, we have the Community Tracing Collaborative, which is a collaboration between Partners in Health, DPH, and the COVID Command Center of Massachusetts. That organization is assigned many of the cases, and reaches out, and talks to each case, and arranges their isolation, and traces their contacts. Over 90% of cases are successfully contacted and isolated, and their contacts are obtained. That's an ongoing effort that has been successful in the sense that it's getting to the cases and their contacts, but we have not yet reached the point where every new case can be linked back to a previous case, which we would consider the end of ongoing community transmission.

Question: *What kind of test does DPH recommend and what is the current turnaround time for testing?*

Dr. Madoff: Testing continues to be a big issue, and we realize how difficult, and confusing it can be. Still, eight months into the pandemic, testing is still not as easy or as readily available as we would like it to be. There are numerous new tests available, but the gold standard remains the RT-PCR tests. We're reporting 15,000 of those tests. Yesterday, it was over 20,000, so we're recording tens of thousands of tests. One of our partners, the Broad Institute, who's been working closely with us and the state laboratory, and working with colleges and universities in the state, just performed their millionth test, and so testing is widely available. Many of our hospitals and acute health care facilities offer testing on their own. Some colleges and universities have stood up their own testing capacity, and, of course, there are national laboratories that have RT-PCR testing available, including mail-in testing and other kinds of testing that are available. With regard to the turnaround time for testing, the good news is that a large proportion of our testing is done in-state, either at the Broad Institute, at the state laboratory, at our health care facilities, or at some of the commercial labs that are based in Massachusetts. About 2/3 of our testing actually gets done in the state, and our turnaround time, overall, for testing is only about two days.

Question: *Are there any changes to DPH's testing recommendation guidance for asymptomatic individuals?*

Dr. Madoff: DPH's testing guidance was put out in July and still stands. We prioritize testing of individuals who are ill, certainly the most important category of people to get tested. The highest proportion of positive tests are in symptomatic individuals. We also prioritize testing of contacts. So, any person who is identified as a contact of a known case is recommended for testing and that they are prioritized for testing.

We are still recommending testing for asymptomatic individuals. In many settings, for example, we are doing screening testing of workers, for example those who work in long-term care facilities. Many health care institutions are testing every patient who comes into the facility, and that is also endorsed in our testing policy. In addition, anyone who a provider feels is at high risk because of an exposure or because of just general risk is also authorized for testing under our testing guidance. Of course, testing for travelers from anywhere except low-risk states is required in order to avoid a 14-day quarantine on entering Massachusetts. The *Stop the Spread* initiative also tests individuals regardless of symptoms in 20 higher-risk communities, which are located all over the state. You do not have to be a resident of one of those communities to get tested. You do not need to be documented to be tested. You do not have to have insurance to be tested. Testing is free in these facilities, and the turnaround time is just two to three days.

Question: *Should individuals be retested? If so, when?*

Dr. Madoff: First of all, people who have tested positive, we generally do not recommend retesting. Clearance from isolation is based almost entirely now on duration and symptoms, so a minimum of 10 days, and one day without fever, and improvement in other symptoms. Most people are considered cleared from isolation at that point, and we think there is a very, very low risk of those individuals continuing to transmit. There are some exceptions for immunocompromised individuals or individuals who are seriously ill, requiring hospitalization, for whom a longer period of isolation is recommended. But, in general, we do not recommend retesting of those individuals. In terms of retesting asymptomatic individuals, that's a difficult question. Some colleges and universities and workplaces are routinely testing people on an ongoing basis, sometimes more than once a week. Testing in those settings is linked to the employer or to the institution. In general, I think other forms of testing of asymptomatic individuals needs to be decided by a clinician based on some perception of risk.

Question: *What is DPH's current view of antibody and antigen tests?*

Dr. Madoff: We've had several hundred thousand people in the state tested for antibody tests, but we're not entirely clear on the clinical indication for that, and it's not a test that we generally recommend. It's a test that tells you that you probably have had COVID in the past, but it doesn't say when. It doesn't indicate whether that that individual has protective immunity. We don't generally recommend antibody testing, except for surveillance purposes, and that is something that we're pursuing on a research basis in the state and DPH is looking at that surveillance to see how many people have been infected on a population basis. The newer tests that people are talking a lot about are the antigen tests. There are advantages and disadvantages to these tests. They fall into several categories as well. There are a device-based tests like Quidel's Sophia test, which has a fairly rapid turnaround time, but it requires a laboratory and usually has an institution associated with it. In general, these tests seem to have a very high specificity. In other words, if they come back positive, certainly in a setting of a symptomatic individual, they're likely to represent a true positive. Although, I have to say that in actual practice, we have seen some problems with false positives with these tests, and it's been, unfortunately, ongoing problem with false positive antigen tests. The other problem is false negatives. These tests are less sensitive than a PCR, and they probably detect better a high viral load than a low viral load. There are advantages and disadvantages and there are more data to be had. Our current testing guidance recommends confirmatory testing by PCR of antigen tests, whether positive or negative. The value of the antigen tests is that they tell you quickly if someone is positive so that they can be isolated, and they can be treated appropriately. Those on the call may have heard about the new Binax rapid tests. DPH is expecting the arrival of those in the state. The data that I've seen on these tests is limited. The FDA Emergency Use

Authorization was based on about 100 tests that were performed, both positive and negative. While they did show a high sensitivity and specificity in symptomatic individuals, it remains to be seen how these will perform in wider use. I'm certainly hopeful that these tests will turn out to be useful. I will mention that, as far as I know, the Binax test has not yet been tested in children, and so that's a limitation. Also, it is still a laboratory test. This is not a home test that can be done by the individual as a point-of-care diagnostic. It still requires a trained operator and somebody to read, and interpret, and order the test.

Question: *Colleges are testing students, should primary and secondary students returning to in-person classes be tested?*

Dr. Madoff: We have not recommended that. You're probably aware that the administration, along with the Department of Early and Secondary Education, has promulgated very granular and cautious back-to-school guidance that has now been made widely available. The state is providing mobile testing services when a cluster is found in a school, and so in that setting, we are rolling out testing to asymptomatic people in a classroom or school who are not necessarily close contacts of the case, but that is somewhat limited. We are, of course, recommending testing of anybody who is symptomatic and any close contact in schools as in any other setting. But we, along with CDC, have not recommended routine screening testing for children in K through 12 or younger who are going back to school.

Question: *Physicians are being asked to provide notes for teachers and other workers who do not feel safe returning to work, Does DPH have guidance on who can safely return to work that can help physicians when responding to these requests?*

Dr. Madoff: We don't have guidance on that point. This is an area where we feel that the provider knows their patient best, and knows their risk factors and, perhaps, tolerance for risk. This is a question that needs to be addressed on an individual basis.

Question: *Does DPH expect to see a surge this fall??*

Dr. Madoff: I'm hopeful that there will not be, but I would not be surprised if there were a surge. DPH is certainly preparing in many ways for a possible surge and we are monitoring early warning signs very closely and continuously. We are concerned about the flu season and the concordance of the flu season with COVID. This will be our first flu season with COVID, and we don't know exactly what to expect. In some places in the southern hemisphere, the flu season was much milder than usual, perhaps because of the masking, and social distancing, and hygiene measures that people are taking to prevent COVID also prevent flu. DPH is prioritizing influenza vaccination. As you know, a school mandate for influenza vaccine was recently announced for all children, preschool through higher education. We have always done very well in vaccinating children in Massachusetts, with more than 80% of our kids under 18 being vaccinated. Thanks to our pediatricians, it's been a real success story, but this year we hope to do better. I can't emphasize enough how important it is for everybody to get a flu vaccine this year. There's plenty of supply of flu vaccine. To me, it would be inexcusable for a health care worker not to get a flu vaccine, and we are certainly providing that guidance. We have more than achieved our goals for acute care hospitals for health care worker vaccination of greater than 90%, but we are less successful in other health care settings, particularly long-term care and other kinds of non-acute care hospital settings. So, again I really want to emphasize the importance of flu vaccine this year.

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

Question: *The case fatality rate in Massachusetts continues to perplex me. You report 22 deaths today. We average between 10 to 20 deaths a day. At the CDC calculation for case fatality rate of .65, that translates to roughly between 1,500 to 3,000 cases a day. Are you concerned that we are missing cases in the state? Second question comes from a physician colleague who's head of her clinic. We test every patient who comes into the system. Should we be testing and screening physicians also?*

Dr. Madoff: I think that the answer to the case fatality rate is not really yet known because we don't know what the rate of asymptomatic infection is and how much of that is out there. I'm sure we're missing some cases in the state. The other thing I was going to say, that is, of course, deaths is a lagging indicator, so a death today might reflect disease that was acquired weeks ago. As we have dramatically increased the amount of testing that we're doing, we're not seeing a dramatic increase in the number of cases, and so I don't know the answer to your question about where, if we are missing cases. Our other indicators of cases are also showing pretty level trend. Our syndromic surveillance, for example, our rates of influenza-like illness, our emergency room reporting, our hospital record reviews don't show increasing numbers of cases. So, you're right, though. The number of deaths is perhaps a little bit higher than we'd expect, and I don't know exactly how to explain that. Nationally one thing that we're seeing is an increased number of cases in young people, who are less likely to die, and we're also seeing improvements in medical treatment for COVID, which are reducing case fatality rates. It's certainly something that we will continue to monitor and look at. The other questions was about routine testing of health care workers, and it's something that we do in long-term care facilities. We have not seen, likely because health care workers are routinely using PPE, routinely masking, are perhaps better than average in monitoring their symptoms, and temperatures, knowing when to be off work, we have not seen much transmission from health care workers to patients. That's one argument against the routine screening of health care workers. It's more likely, unfortunately, for a sick patient or even an asymptomatic patient to bring it into a health care environment than for a health care provider to bring it in. That doesn't mean that it can't happen, and it doesn't mean that it might not be a reasonable policy decision, but we have not felt the need to require testing of health care workers outside of long-term care facilities at this point.

Question: *Patients are asking us about the timing of the influenza vaccination. There's a concern that the vaccine, if given now that it may not last through the entirety of the anticipated flu season. Others are suggesting that we do it now because we don't know when flu season is coming, what is best?*

Dr. Madoff: It's a complicated question and one for which there is not complete data. I want to mention that there are some new vaccine formulations that are available this year, including high-dose and adjuvanted quadrivalent vaccine. The position of DPH's immunization division is that vaccine should be available to any patient for whom it's indicated. We don't express a preference for one particular formulation for, for example, elderly patients or immunocompromised patients. On a clinical level, the idea of using these high-dose vaccines or adjuvanted vaccines in those who might have a less robust immune response are reasonable and something to consider. We expect plenty of flu vaccine this year. Manufacturing ramped up, and we're not aware of any shortages. The timing of vaccination is always a trade-off between trying to get the most people vaccinated and trying to get the timing optimal. You don't want to risk not vaccinating somebody because they're sitting in your office today, and you may not see them again until next year. I think a reason to vaccinate is having an arm in front of you and the vaccine in hand, which may be now. That being said, there is evidence of waning vaccine immunity, even during a single flu season. That's particularly true for older adults, and so the optimal time for getting a flu vaccine is probably two weeks before you're exposed to the flu to give yourself time to develop immunity from the vaccine. Our flu season around here typically starts elevating in December, so the optimal time to give a flu vaccine is probably October. While there's evidence of an optimal time to give it, I wouldn't waste an opportunity when you have a good chance to give it to a patient.

Question: You mentioned adjuvanted and high dose influenza vaccine. We're familiar with high-dose and the typical recommendation based on age. I wonder if you could tell us, or give us a reference to the best resource to read about, when adjuvanted ought to be considered and what, besides age, we ought to use as criteria for high-dose administration of flu vaccine?

Dr. Madoff: I don't know off the top of my head the specific guidance around that, other than to say that DPH is neutral on the formulation of vaccine. I can try to look into that more and get something back to the Medical Society.

Question: My agency's having a lot of trouble finding reliable testing within Massachusetts, and one issue is whether certain labs have had some problems with contamination and been taken offline. Is there a list that DPH has, which shows labs that have been recertified after being decertified because of contamination?

Dr. Madoff: I don't think any labs fall into that category in Massachusetts. I think that any place that's available to do testing is valid for testing that is approved for testing. I don't have any reason to suspect any currently available labs that would be functioning less than very well.