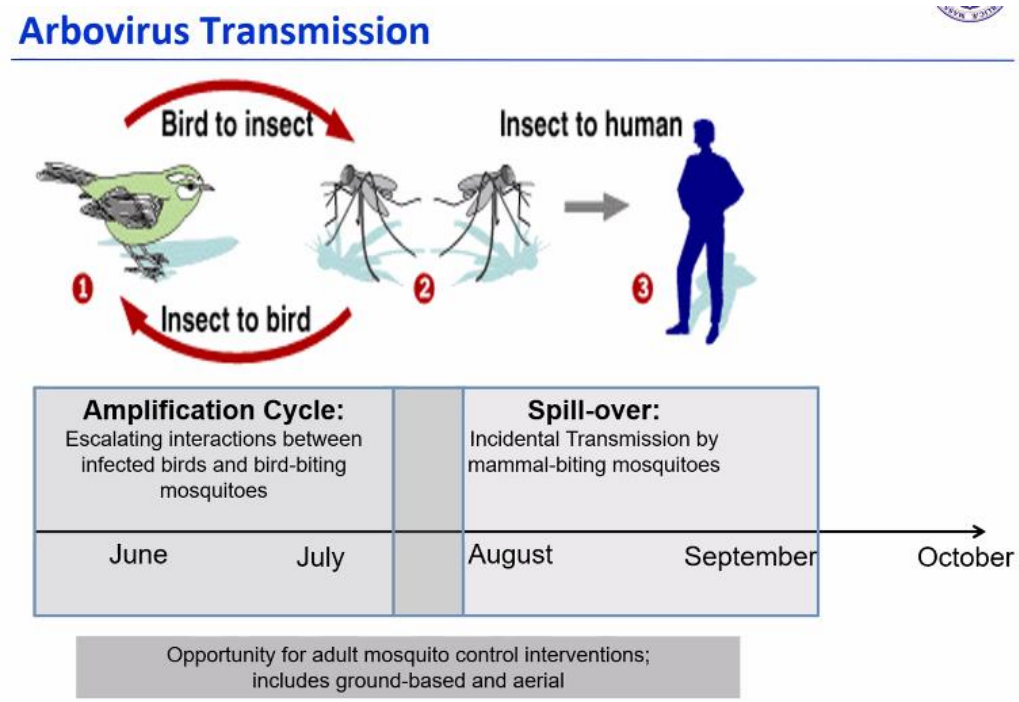
Norfolk County-8 Coalition

MDPH/LBOH Webinar 5/24/2022

Inter-agency Staff on the Webinar

- Sam Wong , Rachael Cain, Erica Piedade, and Michael Coughlin, Office of Local and Regional Health, DPH
- Dr. Catherine Brown, Glynnis LaRosa, Laurie Courtney, and Matthew Osborne, Bureau of Infectious Disease and Laboratory Sciences, DPH
- Donna Quinn, Office of Preparedness and Emergency Management, DPH
- Anne Gilligan and Anne Marie Stronach, Department of Elementary and Secondary Education
- Cheryl Sbarra, Massachusetts Association of Health Boards
- Chief Edward Dunne, Massachusetts Chiefs of Police Association
- Tali Schiller, Academic Public Health Corps/MHOA

Mosquito-borne illnesses: Matthew Osborne, Bureau of Infectious Disease and Laboratory Sciences. EEE 2022 Overview. EEE is the most severe arborvirus in the US. In MA we have EEE and West Nile Virus (WNV). EEE is rare but serious, 50% mortality and 80% of survivors are left with permanent neurologic damage. All ages can be affected, including children. Outbreaks usually take place every 2-3 years and 2019-2020 was an outbreak cycle. The purpose of the mosquito control is to reduce populations of bird-biting and mammal-biting mosquito species in order to reduce the risk of arborvirus.



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DPH surveillance: sets and collect traps from long-term sites in southeastern MA. We collaborate with the Mosquito Control Districts (MCDs) on surveillance efforts in member communities. We also provide surveillance testing in parts of the state without MCDs. We test specimens (mosquitos, suspect animal and human) for EEE/WNV infection (testing begins 6/13/2022). We identify areas at risk for human disease, communicate findings with local health agents, MCD's, and the public, and provide information to guide control actions to reduce risk of disease.

2022 EEE Prediction: Historical Indicators of Risk

- ✗ Above-average rainfall in the prior fall and current spring
- ✗ Mild winters with insulating snow cover
- ✗ EEE activity in the previous year
- Any EEE virus isolations from mosquitoes prior to July 1,
- Isolation of EEE virus from a mammal-biting species of mosquitoes
- Infection of a human prior to late August
- Higher than average summer temperatures
  - Accelerates the mosquito reproductive and development cycle
  - Shortens the time interval between a mosquito becoming infected with EEE virus and when it becomes capable of transmitting the virus.

MA State Plans: DPH (outlines public health response to mosquito, animal, and human surveillance data) and MDAR/SRMCB (MA Dept. of Agricultural Resources/State Reclamation and Mosquito Control Board--outlines the response when an emergency response is needed).

2022 DPH Plan: Updates in 5 key areas.

Communications: Maximize adoption of personal prevention behaviors. DPH will initiate communication with camps, schools and sports organizations in June and July promoting the use of bug spray.

Surveillance/trapping: Drive use of all prevention tools. DPH continues to utilize expanded surveillance efforts based on new locations identified in 2020 and 2021.

Larviciding: A targeted mitigation tool. MCDs conduct aggressive, targeted larviciding operations. MDAR coordinated with several MCDs on the implementation of larviciding product choice field trials, this work supports previous field trials and is ongoing for 2022.

Adulticiding: Routine adulticiding can be targeted or a widespread mitigation tool and is ground based. If a public health hazard is declared, an application can be performed by aircraft. The response time to conduct the application can be performed quickly but must include a 48-hour notification requirement. Upon decision to spray, contractors will have assets and personnel in place w/in 3 days with 2 aircraft for over 250k acres.

Statewide Mosquito Control: Long term plan.

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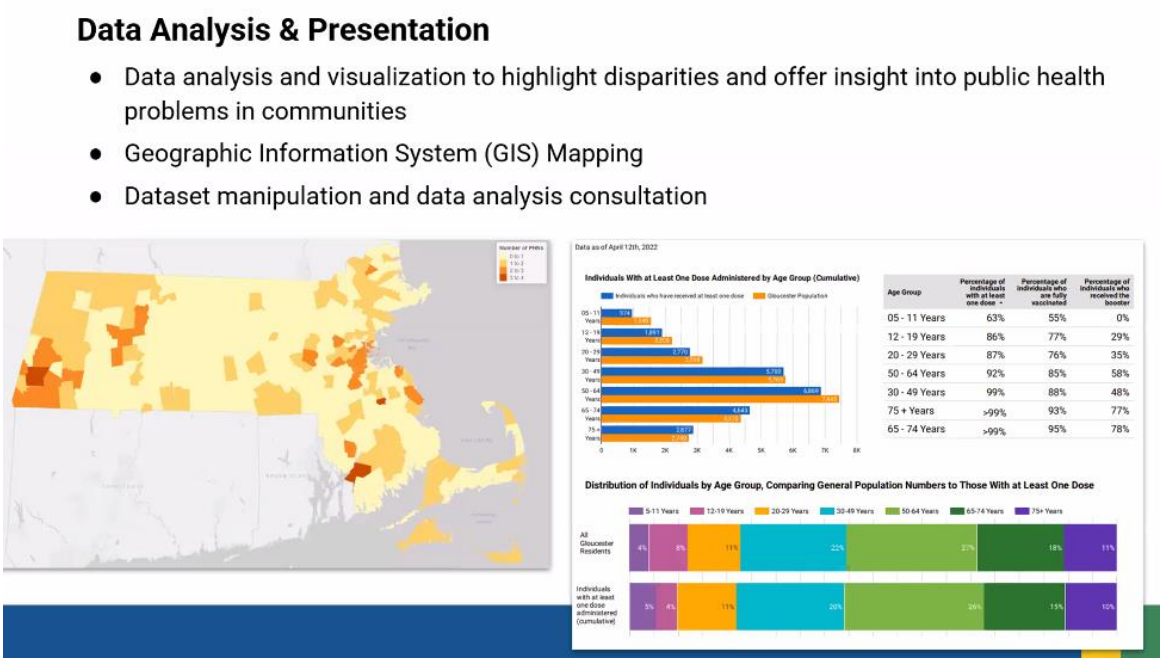
Late season EEE risk levels: September, mosquito surveillance less able to accurately predict risk. Mosquitos are less attracted to traps and normal mosquito vector population declines. Mosquito activity highly depend upon temperature, very unlikely to be active at evening temperatures <50 F. 2/43 human cases since 2000 have had onset later than September 15. If temperatures are reliably below 50 and surveillance indicates that mosquitos have substantially declines, DPH will review data and, in consultation with MDAR, MCDs, and the MAG, may reduce municipalities at high and critical risk to moderate risk after September 30.

Academic Public Health Corps (APHC): Tali Schiller, Program Manager, tschiller@mhoa.coom. APHC is funded by DPH and is funded specifically to support Local Public Health (LPH) across MA. The APHC is an internship program for public health (PH) students in schools/programs of public health all over the state. We hire PH students and assign them projects from LPH. If you need a project done, it can be done for you for free through the APHC! What exactly can these interns do for my LPH? If you've ever been in a situation where you need to complete some projects but don't have the capacity or funding for it, and you don't want to train and oversee an intern, let us know! We do all of that for you. All you have to do is request here (capitalized letters matter): https://bit.ly/APHC-Request

Services:

Communication: Examples at www.Mhoa.com/aphvc-infographics

Data analysis and presentation:



Age Group	Percentage of individuals with at least one dose	Percentage of individuals who are fully vaccinated	Percentage of individuals who received the booster
05 - 11 Years	63%	55%	0%
12 - 19 Years	86%	77%	29%
20 - 29 Years	87%	76%	35%
50 - 64 Years	92%	85%	58%
30 - 49 Years	99%	88%	48%
75 + Years	>99%	93%	77%
65 - 74 Years	>99%	95%	78%

Health Equity support: Highlighting and supporting public health initiatives that promote health equity and service minority or underrepresented communities. Community and stakeholder analysis and engagement and supporting health equity projects and research.

Research and administrative support: Planning and research, digital file organization, policy guidance.

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Q&A Session:

Questions to Dr. Brown

Q: With current suspected spike and limited data on home tests, is the CDC community level data tool the only current metric that DPH Is recommending or will there be additional guidance on masks?
A: DPH is not specifically recommending the CDC Community metrics. We encourage communities to view them as one data point and use them in the context of your own numbers (cases, deaths, wastewater, etc.) and what you are hearing/seeing from your residents. I do not expect additional guidance on masks.

Q: Please comment on the benefits (or not) that masks provide in indoor spaces (classrooms in public schools and campuses) with graduation and finals approaching.
A: Masks have been shown to be useful at reducing the spread of COVID-19. The best resource for the science behind mask efficacy is on the CDC website.

Q: Test kits. Any educational materials on re-testing using antigen vs PCR? People are saying "I heard you can test positive for up to 3 months so why would I retest at day 5?"
A: PCR test can be positive for up to 3 months in rare cases, antigen tests are likely to be positive only for a limited amount of time that someone has enough virus to be infectious. For people who are positive and testing on day 5, they should use an antigen test and not PCR.

Q: Considering lifting the 5-day isolation mandate of positive COVID cases if they are asymptomatic? We now have vaccines and medications for COVID, when will the guidelines become "if you are sick stay home" as we do for other viruses?
A: Other countries have done away with the 5-day isolation period, symptomatic or not. Haven't heard CDC talk about this. I suspect we'll get to that point some day, but many people don't actually stay home wen they're sick when we ask them do.

Q: How much longer will we need to do contact tracing? Do you still want us to prioritize our cases? Should we be making clusters for ALF/LTC facilities still?
A: Case investigation (CI) and contact tracing (CT) has been optional since the middle of December. It remains best practice but every municipality needs to make decisions about what is most appropriate for their residents balancing competing public health needs and capacity. If you identify clusters of cases, please create them in MAVEN as that information continues to be useful.

Q: Since contact tracing is no longer required, Town Managers and Boards now assume that the completion of case report forms for COVID-19 cases are no longer required. What is the expectation for the completion of case report forms?

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A: CI (including completion of case report forms) and contact tracing has been optional since mid December. Every municipality needs to make decisions about what is most appropriate for their residents balancing competing public health needs and capacity

Q: Does Paxlovid "wear off" after 10 days and then the recipients begin having COVID symptoms again?
A: Small percentage of people who are prescribed describe an initial improvement of symptoms followed by a subsequent increase once the 5-day treatment ends. Whether this is something specifically related to Paxlovid or the fact that some people have a bimodal disease course (which happens in untreated people also) is unknown. CDC has recently advised that people who experience this rebound in symptoms should isolate for another 5 days.

Q: Is there a COVID treatment recommended now for those with renal function limitations who should not take Paxlovid?
A: There is a reduced dosage recommended for patients with renal function limitations, but many can still be treated with Paxlovid at that lower dosage.

Q: Any discussion on how symptoms and duration of BA.2.12.1 or BA.2.10 might vary from Delta?
A: Not aware of any published data about substantial difference in duration. Have not heard that CDC is considering changes to isolation recommendations based on the variant. We have seen symptom profile change between the different variants, for example loss of taste and small is much rarer with Omicron than it was with the original COVID-19 virus. Since CI is limited in MA and other places, quantifying those symptom changes is challenging.

Q: It would be helpful to understand DPH's plans concerning daily counts and when do you envision stepping back from that data?
A: We will keep you updated as these conversations develop and decisions are made. CDC has not discussed stopping case vaunting.

Q: We are seeing dramatic rise in COVID cases at our day care center and in-home day cares. In helping our owners and parents navigate the guidance, we noted a discrepancy that we are not sure how to deal with. EEC guidance on slide #29 states: vaccinated persons with an exposure to someone with COVID-19 are not required to quarantine if they meet all of the following criteria: are fully vaccinated which means its been more than 14 days since they received two doses of the Moderna, Pfizer or one dose of J&J COVID-19 vaccine and have remained asymptomatic since the most recent exposure to COVID-19. DPH guidance states that you must be "up to date" and that's a completed primary series of Pfizer, Moderna, or J&J AND a booster

OR completed primary series within the last 5 months OR completed primary series of J&J within the last 2 months.

A: Unfortunately, this type of discrepancy between recommendations has occurred throughout the pandemic and is just a reality. Different priorities and different risks occur across various settings and that has resulted in the development of different guidance. It is truly challenging and complicated to explain but is not new.

Q: If an antigen test on day 5 or later is positive, do we tell them to isolate until antigen is negative? If a positive case tests negative after day 5, can they transmit the virus?

A: Correlation between a positive antigen test and transmitting the virus is not a 1-1 correlation. Antigen tests have a lower sensitivity, and based on what we have seen of people testing positive with antigens and PCR, suggests that the time when people test positive on antigen tests it is approximately correlated to when they are most infectious. This varies by the antigen test, the health of the person, among other influences. You need to be careful making these broad generalizations. The recommendation for someone who has tested positive for covid should isolate for at least 5 days, if their symptom have improved and are fever free for at least 24 hours without fever-reducing medications, they can stop self-isolating on day 6 but need to wear a mask whenever they're around other people. No standard recommendation on day 5, but if they test and are still positive it is probably best practice to stay isolated.

Q: Monkeypox information, now that 200 MGH workers have been exposed due to the case in isolation?

A: It is a virus that is related to smallpox and other viruses in this group are racoon pox and cowpox. Monkeypox causes less severe disease than smallpox, and it occurs naturally. It is endemic to countries in West and Central Africa. The virus probably exists in wild, small rodents. It can occasionally spill over from those rodents to primates, including humans. Periodic outbreaks occur in West and Central Africa. Most cases in the US, prior to May 2022, were a result of travel to places where Monkeypox actually is. There is a low level outbreak of monkeypox in Nigeria that has been going on for several years. More recently, we have seen this pretty significant and relatively rapid increase in cases outside of Western and Central Africa. These cases are not travel associated. A majority of the cases have also reported MSM behaviors. This is definitely a global concern, people are concerned that it's spreading differently than it has before, however, 1) monkeypox does not spread very efficiently person to person, the most effective way it spread is animals to humans. Person-person transmission is most likely when they have the monkeypox lesions on their body and when the vesicles and pustules are evident, they are extremely contagious, the fluid enters broken skin and mucous membranes. This can result in exposure to the non-infected person and eventual transmission. There is some evidence that the virus may be present in throat (lesions) and may also be present in large respiratory droplets. This is NOT similar to COVID. It requires prolonged close

contact for this type of transmission to even be possible. There can be contact with contaminated fomite (bed linens and the fluids from their vesicles and pustules) and the virus can spread. Close contact for respiratory transmission is 6 ft for 3 hours or more. The staff at MGH might not fall under the description of high risk. They'll probably have to monitor themselves for 21 days, don't need to quarantine but you need to monitor daily for symptoms like fever, chills, swollen lymph nodes, rash. Testing has to be done through the public health system. The preliminary test goes through state lab and the confirmatory test goes through CDC. If we had a preliminary positive test on somebody who has the right clinical symptoms and right exposure history, we will probably start a public health response. At least 8 cases identified at this point in the US and over 130 globally, outside of Africa. The association with people who report MSM behavior, is not about this being a sexual transmitted disease, but the type of close direct contact during sexual activity is the way monkeypox spreads. You can also get monkeypox without sexual activity. All lesions will resolve in 2-4 weeks and they must be isolated until they are no longer symptomatic and all lesions need to be recovered before they are considered non-infectious.

June 14th next webinar. Webinars are held the 2nd and 4th Tuesdays of each month.

Webinar ended at 4:02 pm.