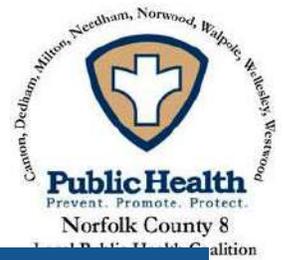


# Norfolk County-8 Coalition

MDPH/LBOH Webinar 1/29/2021

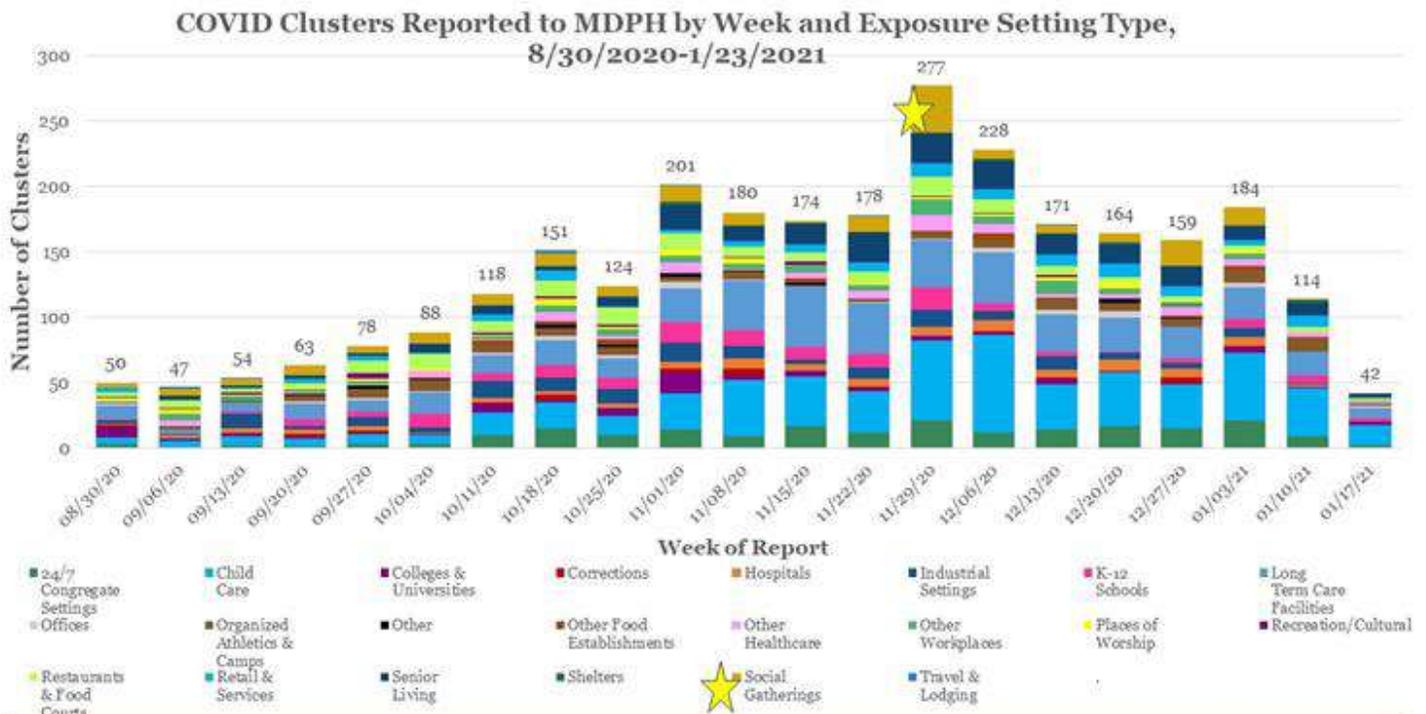


## Inter-agency Staff on the Webinar

- Jana Ferguson, Assistant Commissioner, DPH
- Ron O'Connor, Office of Local and Regional Health
- Dr. Catherine Brown, Bureau of Infectious Disease and Laboratory Sciences
- Donna Quinn and Mary Clark, Office of Preparedness and Emergency Management
- Emily Cooper, Executive Office of Elder Affairs
- Michael Flanagan and Adam Kinney, Department of Labor Standards
- Anne Gilligan, Department of Elementary and Secondary Education
- Cheryl Sbarra, Massachusetts Association of Health Boards
- Chief Edward Dunne, Massachusetts Chiefs of Police Association
- Jeff Farnsworth, Executive Office of Public Safety and Security

### Announcements:

**Data on clusters:** Multicolored slide shows different categories of cluster types we are able to track overtime. Social gathering (gold star)--we saw an increase in clusters related to social gatherings related to Thanksgiving holiday, and then from 12/27 – 1/3, week after the holidays. Child care, LTFCs, senior living, are all part of the largest categories. Slides with exposure tables can also be found on the weekly dashboard.



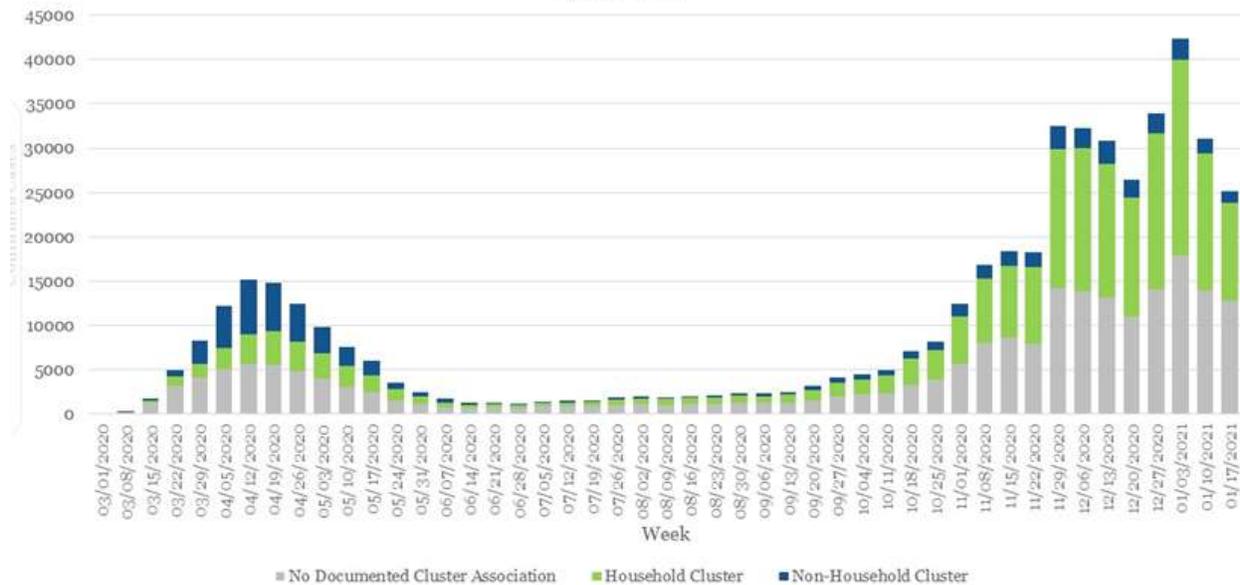
Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Long Term Care Facility Data from the National Healthcare Safety Network beginning 6/7/2020. All other data from MAVEN and are subject to change. Only clusters consisting of two or more confirmed Massachusetts cases with a common exposure have been included.

# Norfolk County-8 Coalition

## MDPH/LBOH Webinar 1/29/2021



Confirmed COVID Cases Re... Viewing Inter-agency LB... er Association, 3/1/2020-1/23/2021



Exposure Setting	Includes
24/7 Congregate Settings	Group homes, congregate housing, disabled community housing, halfway houses, sober homes, residential treatment centers, lodging and rooming houses, monasteries/convents/rectories, DYS detention facilities
Child Care	
Colleges and Universities	
Corrections	Jails, prisons, houses of corrections, correctional treatment centers
Hospitals	All hospitals, including inpatient psychiatric, inpatient addiction treatment, chronic disease and rehabilitation
Industrial Settings	Industrial settings including construction and non-food manufacturers, warehouses and distribution centers
K-12 Schools	Boarding schools, public schools, private schools, special education schools
Long Term Care Facilities	
Offices	
Organized Athletics and Camps	Sports teams, tournaments, and clubs; children's camps
Other	
Other Food Establishments	Food distributors, manufacturers, warehouses, processors, farms, and food pantries
Other Healthcare	Ambulatory mental health services, community health centers, home health, dental, ambulatory care settings, hospice, addiction treatment (non-residential or outpatient), emergency medical services
Other Workplaces	Work-related events, non-EMS first responders
Places of Worship	
Recreation/Cultural	Gyms, fitness centers, swimming pools, beaches, movie theaters, golfing, boating, casinos
Restaurants and Food Courts	
Retail and Services	Grocery stores, hair salons, barbers, other retail stores
Senior Living	Assisted living facilities, retirement communities, senior housing
Shelters	
Social Gatherings	Parties, group gatherings, weddings, funerals
Travel and Lodging	Domestic or international travel, hotels, cruise ships

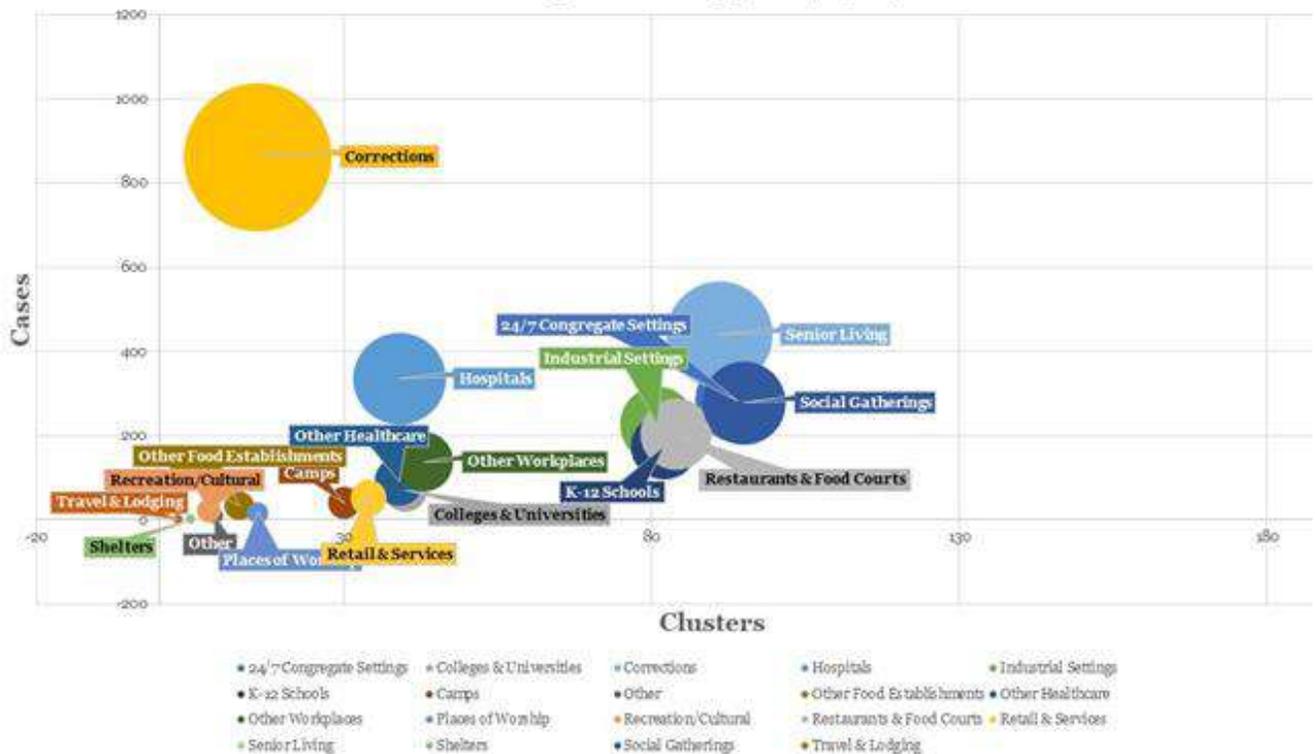
# Norfolk County-8 Coalition

## MDPH/LBOH Webinar 1/29/2021



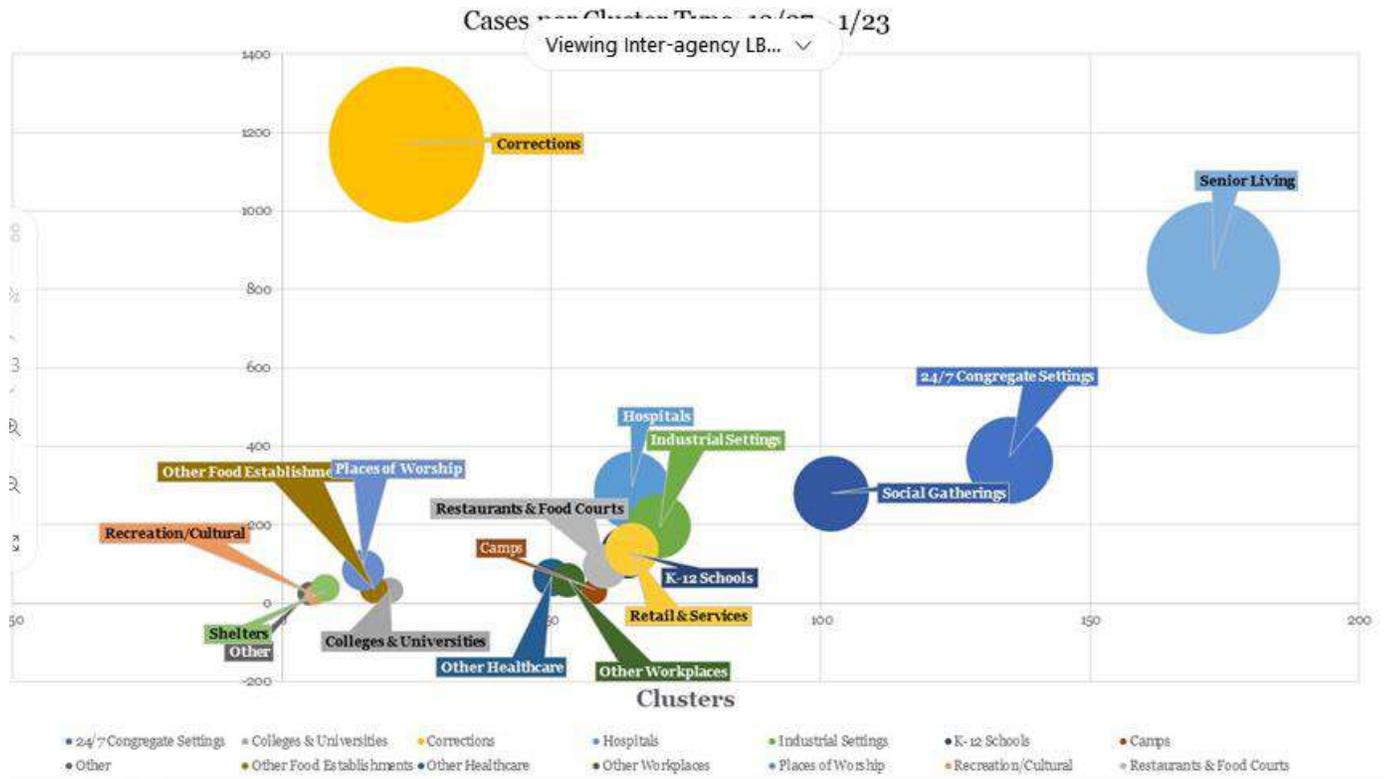
Exposure Setting	New Clusters (Identified 12/27 - 1/23)			Ongoing Clusters (Cluster Identified Prior to 12/27 But Not Meeting Criteria for Closing)			Total		
	Clusters	Confirmed Cases	Close Contacts	Clusters	Confirmed Cases	Close Contacts	Clusters	Confirmed Cases	Close Contacts
24/7 Congregate Settings	47	263	50	88	101	21	135	364	71
Child Care	139	434	587	264	184	269	403	618	856
Colleges & Universities	8	31	21	12	2	.	20	33	21
Corrections	5	48	9	18	1,122	61	23	1,170	70
Hospitals	16	91	95	49	197	100	65	288	195
Household	22,544	57,981	---	27,314	8,130	---	49,858	66,111	---
Industrial Settings	12	77	41	58	120	38	70	197	79
K-12 Schools	20	87	66	44	43	50	64	130	116
Long Term Care Facilities	74	870	---	268	2,795	---	342	3,665	---
Offices	4	20	1	15	10	23	19	30	24
Organized Athletics/Camps	29	99	279	29	26	76	58	125	355
Other	1	6	.	4	20	22	5	26	22
Other Food Establishments	4	15	.	13	22	5	17	37	5
Other Healthcare	16	47	18	34	19	19	50	66	37
Other Workplaces	9	32	8	44	26	15	53	58	23
Places of Worship	2	17	1	13	67	88	15	84	89
Recreation/Cultural	1	8	.	5	13	4	6	21	4
Restaurants & Food Courts	15	61	13	45	33	24	60	94	37
Retail & Services	20	73	36	45	64	28	65	137	64
Senior Living	39	233	33	134	622	156	173	855	189
Shelters	3	23	8	5	16	41	8	39	49
Social Gatherings	35	245	95	67	35	18	102	280	113
Travel & Lodging	.	.	.	2	.	.	2	.	.
<b>TOTAL</b>	<b>23,043</b>	<b>60,761</b>	<b>1,361</b>	<b>28,570</b>	<b>13,667</b>	<b>1,058</b>	<b>51,613</b>	<b>74,428</b>	<b>2,419</b>

Cases per Cluster Type - 11/15-12/12



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MDPH/LBOH Webinar 1/29/2021



Bubble charts are not surprising, but it's still interesting to see how the cluster types change over time. In the recent surge, it's been more difficult to identify the non-household cluster. We don't really know why, but maybe we aren't reaching out in time and do investigations.

Sports clusters: Last two columns are one week periods. First column, cases from 1/10-1/16.

Viewing Inter-agency LB... AVEN\*

	N	Cases (Confirmed & Probable)	Contacts	% Change in Cases <sup>1</sup>	% Change in Cases <sup>2</sup>
Hockey	109	426	1,188	+ 100 %	- 100 %
Basketball	25	78	189	- 23.0 %	+ 180 %
Soccer	11	36	96	No change	No change
Dance	11	43	10	+ 800 %	-100 %
Gymnastics	9	54	74	- 100 %	+ 200%
Baseball	5	10	86	No change	No change
Football	5	31	48	No change	No change
Swimming	4	11	45	- 100%	No change
Lacrosse	3	13	6	No change	+ 100 %
Cross Country	2	2	17	No change	No change
Bowling	2	12	1	No change	No change
All Others	5	20	35	No change	No change

\*This table represents total clusters, confirmed & probable cases, and contacts among ALL sports related clusters

<sup>1</sup>Percent change between one-week reporting periods showing the increase (+) or decrease (-) in the number of confirmed and probable cases. Above we compared the number of cases from 1/3-1/9 to the number of cases from 1-10/-1/16

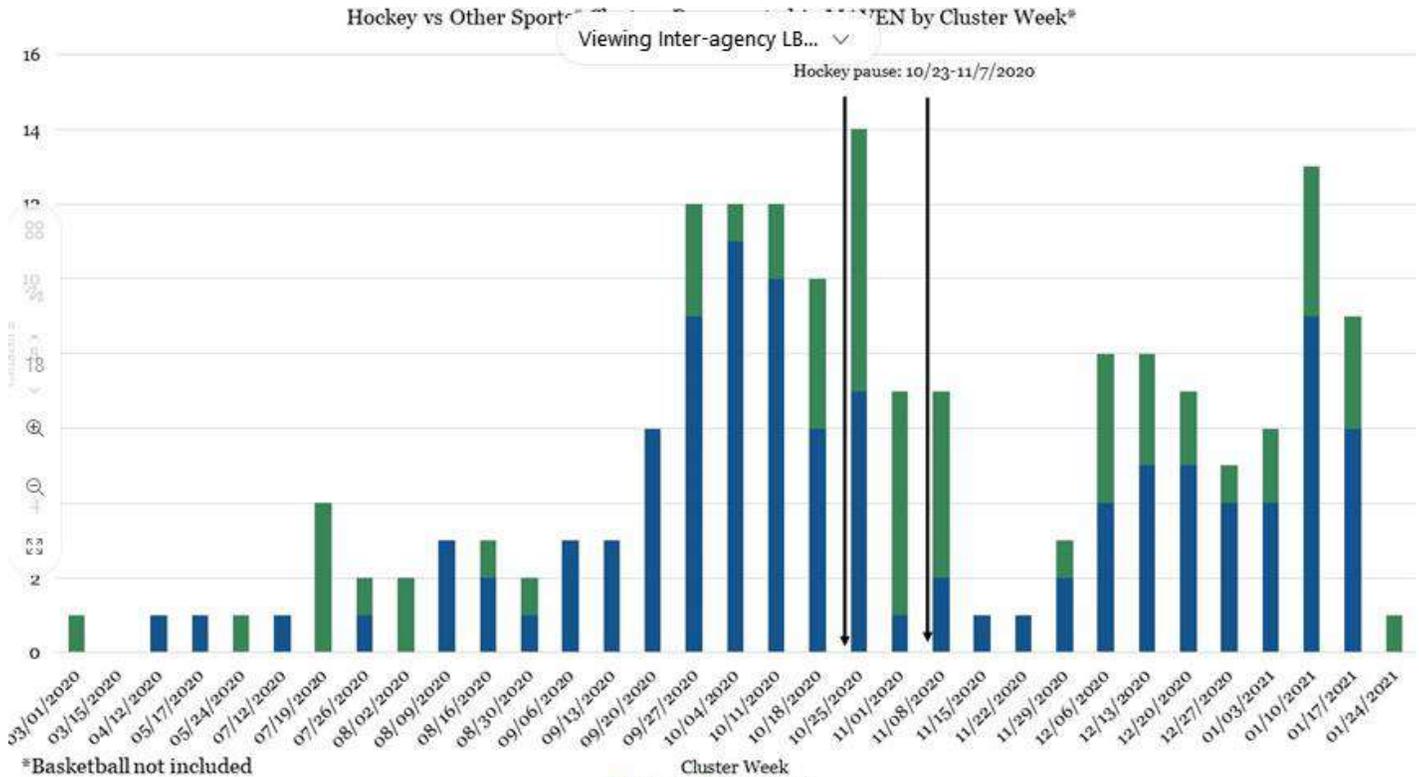
<sup>2</sup>Percent change between one-week reporting periods showing the increase (+) or decrease (-) in the number of confirmed and probable cases. Above we compared the number of cases from 1/10-1/16 to the number of cases from 1-17/-1/23

# Norfolk County-8 Coalition

## MDPH/LBOH Webinar 1/29/2021

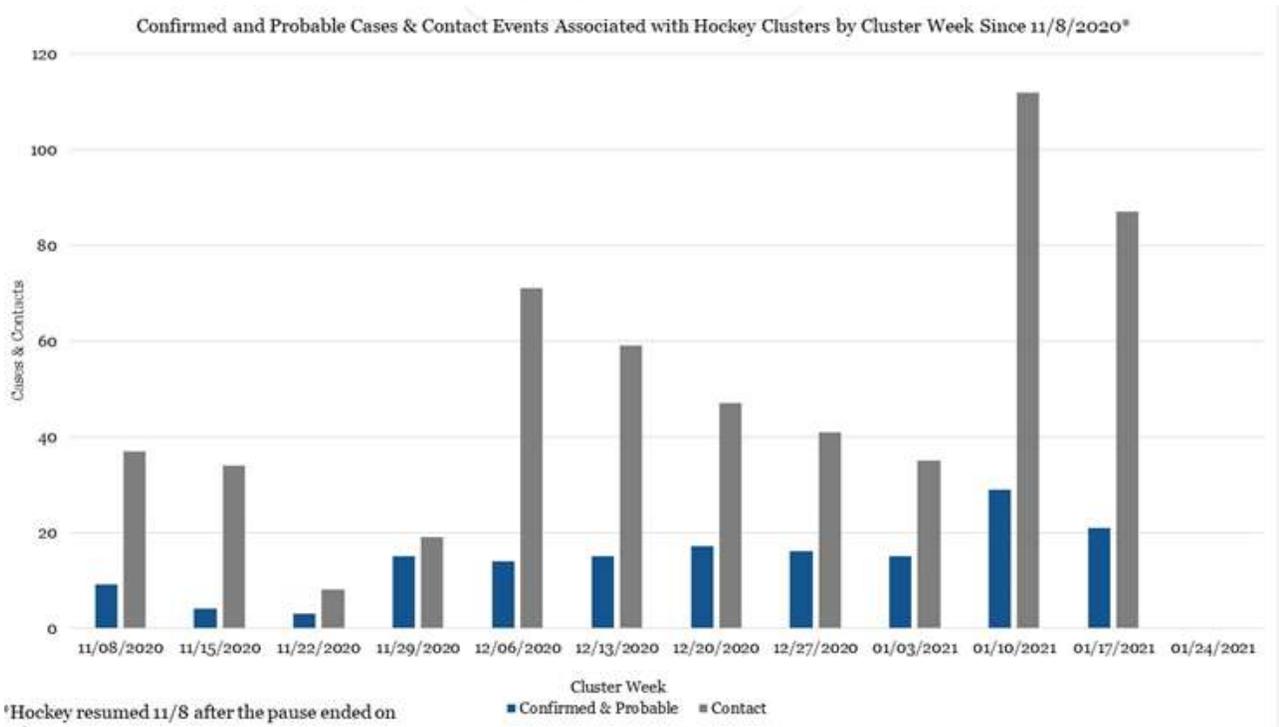


Second column, cases from 1/17-1/23. Clusters significantly increased during this time period.



\*Basketball not included

**Hockey:** Clusters are in blue, other sports (not including basketball) are in green. This isn't necessarily that people are doing anything wrong, but we have a lot of COVID floating around still. Some policy decisions have led to quarantining entire teams as close contacts. We have data to suggest that hockey is higher risk and it explains why we have taken a more cautious approach. We want hockey to keep going, but it means we have to be careful.



\*Hockey resumed 11/8 after the pause ended on

■ Confirmed & Probable ■ Contact

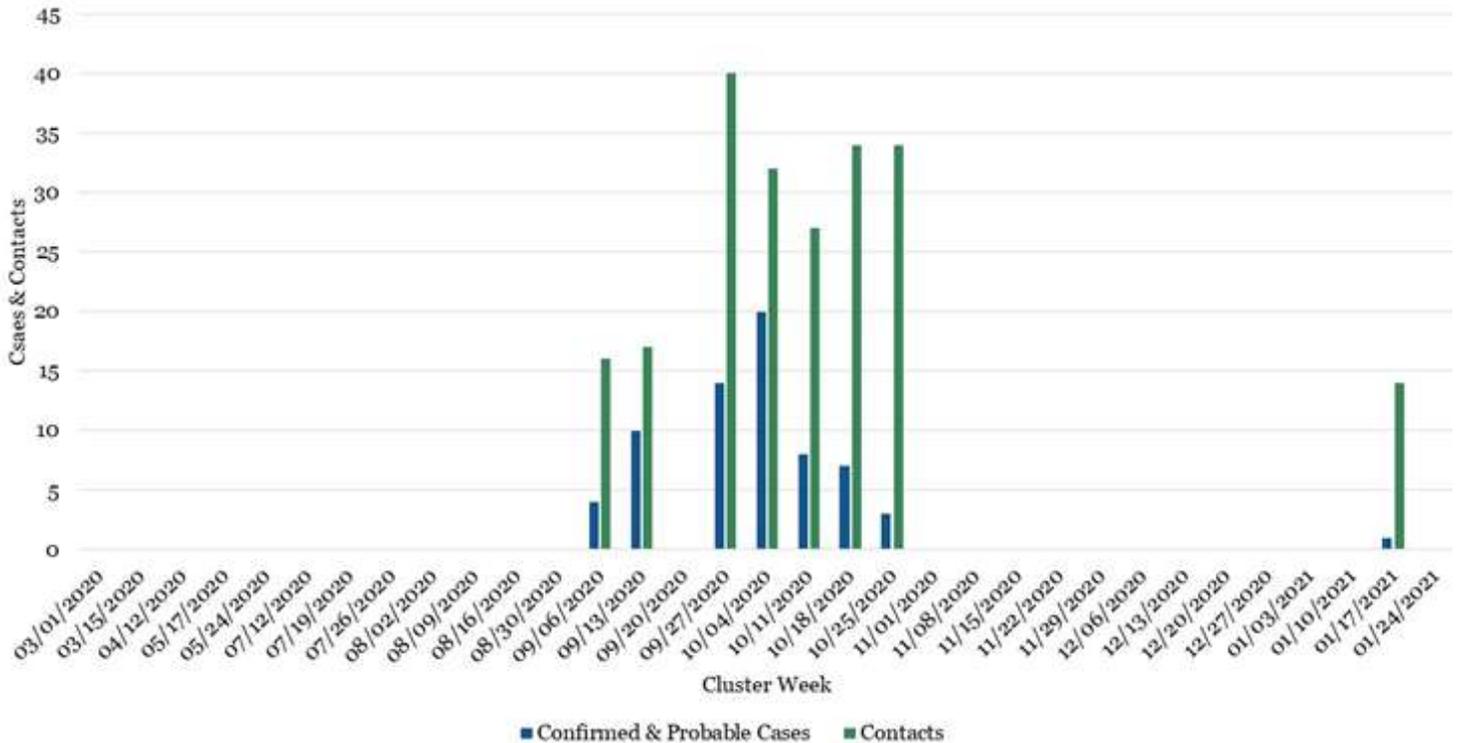
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## MDPH/LBOH Webinar 1/29/2021

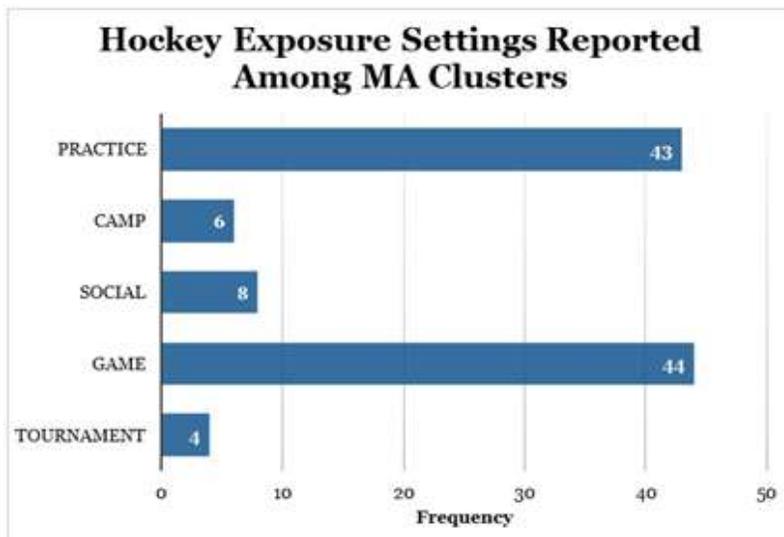


Big contributor was the eastern hockey federation. Brought people from all types of communities together and did interstate competition.

Confirmed and Probable Cases & Contacts Associated with Eastern Hockey Federation (EHF) Teams by Cluster Week



People also asking if it's the sport itself, or is it the activities of people getting together before and after games etc. It's difficult to tell, but from what we do know, it really suggests that most transmission is occurring during scrimmages/games and not the social part of hockey.



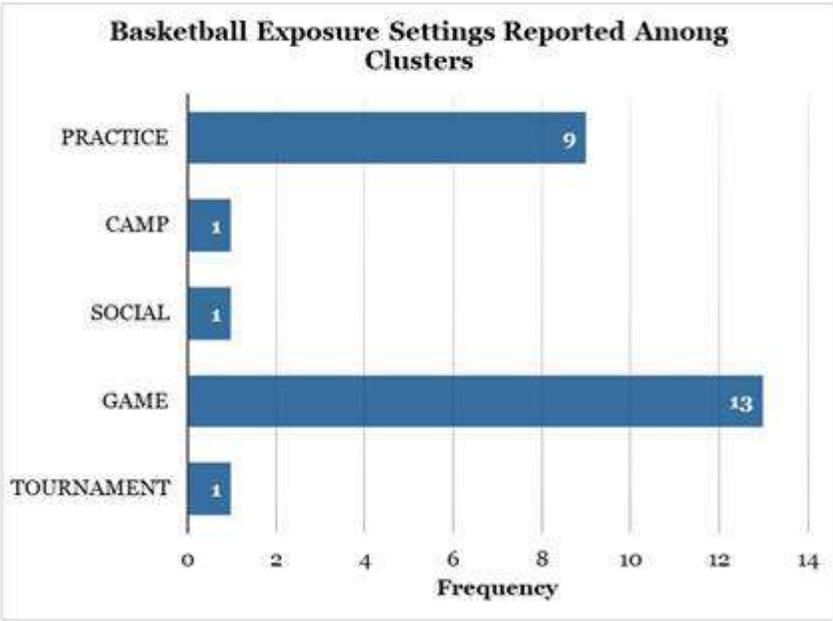
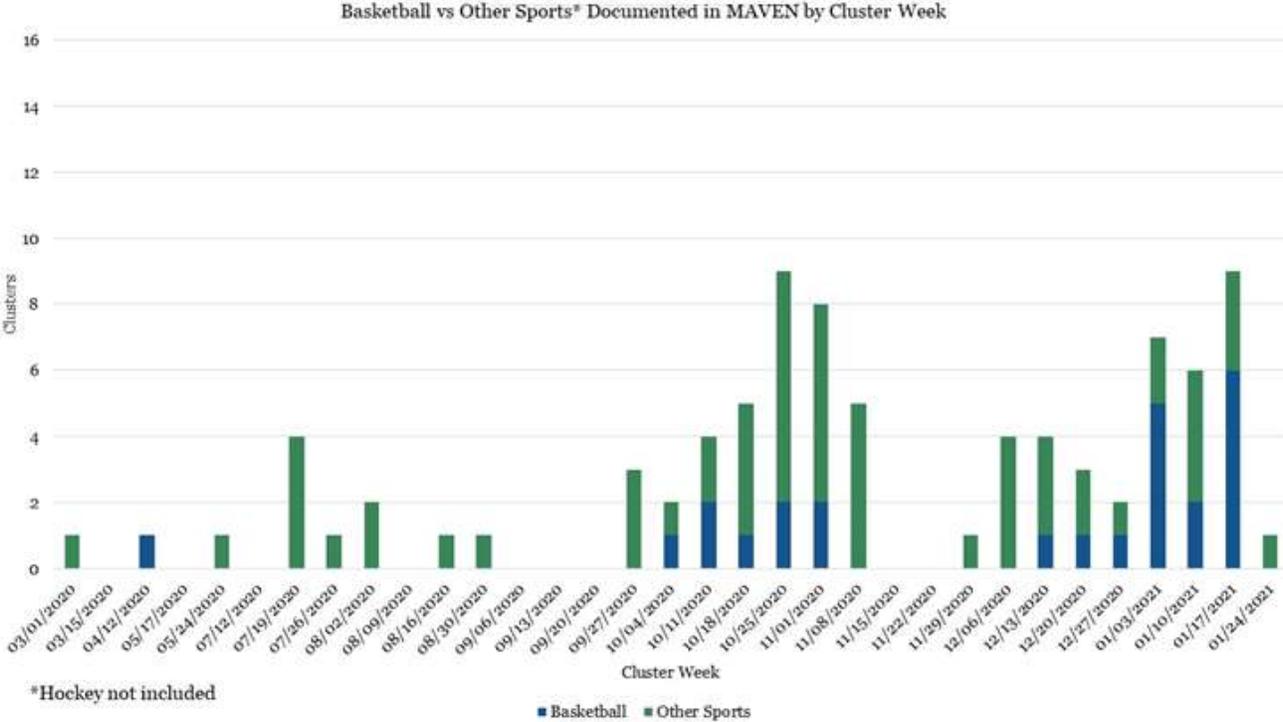
- Exposure setting unknown for 27 cluster events
- Among the remaining 82:
  - 63 (76.83%) report one exposure setting
  - 17 (20.73%) report two exposure settings
  - 2 (2.44%) report three exposure settings
- Locations
  - In state 90
  - Out of state 4
  - Unknown 13
  - Missing 2

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## MDPH/LBOH Webinar 1/29/2021



**Basketball:** Fewer cases is basketball compared to hockey, but in more recent weeks basketball has seen a increased proportion of clusters happening. Particularly during the games and practices, and because it is indoor. It is a higher risk activity, although right now it doesn't look like it's in the same league as hockey. Basketball—practices and the games are probably the problem.



- Exposure setting unknown for 6 cluster events
- Among the remaining 19:
  - 15 (78.95%) report one exposure setting
  - 2 (10.53%) report two exposure settings
  - 2 (10.53%) report three exposure settings
- Locations
  - In state 18
  - Out of state 3
  - Unknown 2
  - Missing 2

# Norfolk County-8 Coalition

## *MDPH/LBOH Webinar 1/29/2021*

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Where we are with basketball, it has contributed to a larger proportion of sports related clusters since the beginning of January. It doesn't mean the cluster numbers are huge right now, it means that they are a higher proportion. Good news—cases seem to be on the decline in MA, maybe we are coming off the second surge, and many schools will be participating in the pool testing initiative that we hope will serve to ID cases early and take them out of the school setting.

**Q:** Does k-12 data come from MAVEN, or is just being reported from the school districts?

**A:** k-12 data we are showing here come from data, but we watch what's being recorded by school district as well.

**Q:** cluster charts—are these available to be presented to the public?

**A:** Working on the interactive dashboard part 2. Right now, the data is shown in tabular form. If any of you share that you would recommend to show it in a different way, please reach out.

**Q:** Child care clusters—are family members included?

**A:** No. child care clusters only children and staff at the centers. Household clusters are different. We do not double count people. A child who is part of a child care cluster and household would not be counted in household. Lots of this data are super intertwined, and these are some artificial distinctions but this is how we are choosing to show it.

**Q:** Are players from opposing teams considered contacts, or just teammates?

**A:** Gong to get back to people about this.

**Q:** Should close contact hockey players still need to quarantine for 14 days?

**A:** The option for reduced quarantine is available to everyone except those in LTCFs.

**Q:** What are the implications of the data to allow hockey and basketball to continue?

**A:** With hockey, as we know, there was a pause to control transmission. They are still continuing, and they are not at the level they were before. Basketball is obviously having clusters, but the idea is that we need to acknowledge that sports like these are high risk.

**Q:** Child care clusters on the bubble not included?

**A:** There are a lot of child care clusters, but not a lot of transmission in child care in solid numbers. The bubble would be to the right of the senior living in the right hand corner, couldn't fit it in due to formatting issues.

**Q:** Student who tests positive and comes back from isolation and participates in aerobic gym classes?

**A:** Once they have completed isolation, they are not at risk of transmitting the disease. And the question about aerobic exercise, this should be sent to the individual's physician.

# Norfolk County-8 Coalition

## MDPH/LBOH Webinar 1/29/2021



**COVID-19 variants:** Lots of media coverage of this topic. COVID-19 is an RNA virus, and these constantly change through mutations—can evolve and disappear or evolve and persist. Ones we are talking about are the ones that have persisted and have some evolutionary benefit and are more commonly found in the populations they are identified in. Many variants right now, not just the ones in the news. Only some are/turn out to be clinically or epidemiologically important.

Genetic analysis—as part of surveillance to predict and understand the impact of certain mutations. One focus is on mutations that impact virus binding. We care because mutations can change disease characteristics, make viruses less detectable by current tests, increase reinfection frequency, reduce efficacy of vaccinations, and/or reduce efficacy of therapeutics. Just because it's a mutation does not mean all of these things will happen.

B.1.1.7 variant (found in UK, probably emerged September 2020): No data that UK variant causes more disease but there is good evidence that it is more transmissible. Question as to whether it causes more severe disease. This is likely to be prevented by current vaccines. Misinformation about current PCR tests not detecting this variant, but the CDC PCR test shows a particular pattern of results that shows up, and indicates this is a sample that could have the UK variant in a S-gene drop out pattern. You will still test positive on the current PCR test.

B.1.351 variant (South African variant, around October 2020): 3 protein mutations (E484K) that involve the spike on the coronavirus which impact binding with the cell, no evidence that it causes more severe disease, but there is limited evidence that it can reduce the effect of current viruses/monoclonal antibodies, just that their efficacy can be slightly reduced. First two cases identified in the US in South Carolina, with no travel history.

P.1 variant (Brazilian variant): Found in Japan in travelers from Brazil. 20 mutations—3 that impact binding. May be more transmissible, and there is some evidence that both vaccines and prior infection may provide less protection. If you were infected with the original COVID-19, you may have some susceptibility to this new variant. 75% of population infected by mid-October, found in 42% of cases that have occurred in Brazil since late December.

B.1.1.7 more widespread.

Surveillance in MA—up to 100 samples a week. Since 1/1/2021, done 373 samples. Broad Institute wants to do 1,000 / week. Academics labs also scaling up in MA. LabCorp and Quest (sending samples to Helix/Illumina for sequencing) also working with CDC. This is how B.1.1.7 case was ID'ed in Massachusetts. To date, 3 B.1.17 travel-associated cases in MA, no evidence of widespread community transmission.

Prevention: same prevention measure—masking, multiple layers of cloth, fit to face. Social distancing, hand washing, avoid large gathering, stay home when sick, get tested, cooperate with isolation quarantine and contact tracing. No way to predict if/when a variant will become widespread. This is another reason for people to adhere to same prevention measures.

# Norfolk County-8 Coalition

## MDPH/LBOH Webinar 1/29/2021



### ***Vaccination initiative for public and private low income and affordable senior***

***housing:*** Large webinar yesterday with housing people, and we know they reached out to you. This past Monday, Governor Baker bumped up the 75+ up the list. The group of public private of income/low income are next on the list.

Public and Private Low Income and Affordable Housing: Any residential premises available for lease by older or disabled individuals which is financed or subsidized in whole, or in part, by the state or federal housing programs established primarily to furnish housing rather than housing and personal services. Public housing properties are designated primarily for older adults that are owned/operated by Local Housing Authorities. This includes those public housing properties owned by a Housing Authority but managed by a private company. Privately owned rental properties designated for older adults that are financed in whole or in part through resources made available from DHCD, MassHousing, or the U.S. Department of housing and Urban Development, and in which the majority of units are restricted to residents earning less than 80% of area median income. The property must be “age restricted” and cannot be an ALR, CCRC, or licensed/certified by the state. Separate initiative for congregate care setting licensed/certified by the state. If you have any questions if this building meets these criteria, and the owner/manager has not been responsive, let us know.

Initiative funded and administered by the CDC to provide CVS/Walgreens vaccination clinics onsite in specific settings: Nursing facilities, rest homes, assisted living residences, continuing care residential communities, housing funded through the HUD Section 202 Supportive Housing for the Elderly Program. Per the CDC, other low-income senior housing were excluded from the FPPP. Clinics began on 1/11 and continue into February/March. MassHousing/CEDAC have been reaching out to designated properties to see if they need any assistance. List of FPPP facilities/properties: <https://mass.gov/info-details/long-term-care-facility-covid-19-vaccine-guidance#list-of-ltcf-participating-in-the-federal-pharmacy-partnership-program>

Properties not enrolled in the FPPP should begin exploring options now to be ready to start vaccinating residents and staff once activated by the Governor. State agencies are prepared to assist with:

Reviewing options, providing resources and templates, helping to identify potential local partners, assisting with vaccine allocation (if needed), answering questions and helping troubleshoot.

Option 1: Leverage existing pharmacy partnerships or other medical provider relationships. Housing owners or property managers may have existing partnerships with local pharmacies through regular flu vaccine clinics and/or with local hospitals, health care practices, community health centers, university health centers, ambulance providers, or visiting nurse agencies; these partnerships may be leveraged to administer COVID-19 vaccines. Owners/managers are encouraged to contact existing health care partners to determine if these partners have the capacity to operate a vaccination clinic on-site at the housing property

# Norfolk County-8 Coalition

## *MDPH/LBOH Webinar 1/29/2021*

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or the ability to arrange for a special vaccine clinic for your residents at a mutually agreeable location. If you identify a clinical partner, your company/housing authority can work with the state to factor these needs into your partners vaccine allocation.

Option 2: Partnership with LBOH. Some LBOH will be organizing clinics to immunize people in Phases 1, 2, and 3. Important to understand how the LBOH operates the clinic and if there is capacity to come onsite to administer vaccines or for the LBOH to dedicate part of a scheduled clinic for your residents. Separate allocation, more than LBOH are receiving per week because this is a particular priority group.

Option 3: Accessing Public Vaccination Sites. Residents and staff may schedule an appointment at a provider, pharmacy, or a mass vaccination site. Additional sites are being set up each week. Online attestation to sign up for an appointment and documentation provided to get the vaccine. Owners/managers provide a letter verifying that individual is a resident or a staff member. Templates available online.

Brief online form to be completed as soon as decisions have been made about partner agency and approach being used. This included basic information about the building. Information about planned approach will included onsite clinic, offsite clinic, directing residents/staff to community vaccination sites. Information will be collected about healthcare agency partner, estimated vaccine need, and type of vaccine to be used. Start collecting required paperwork from the staff and residents and start planning for how to operationalize an onsite or offsite clinic. This information is critical to ensure your needs are factored into the partner agency's vaccine allocation.

Hosting a clinic onsite may carry the following responsibilities for the housing owner/manager (if you are working with LBOH, you would be the one that would be sending the survey):

→Identify a LBOH, CHC, pharmacy or other health care provider to partner with who is available to come onsite to officer the clinic for both doses—spaced at least 3 weeks apart.

→Work with residents and staff to share information about timing of clinics and to distribute available materials about the vaccine and what to expect.

Specific webinar related to accessing these vaccination sites scheduled for Feb. 3<sup>rd</sup>, 10 am – 11 am.

→Assist with gathering required paperwork from residents such as consent forms and other documentation required for the clinic.

→Responsible for providing adequate space for immunizations and post-immunization observation.

→Responsible for logistics, scheduling, and resident flow on the day of clinics, ensuring appropriate social distancing while people are waiting. Also, accommodating those residents

# Norfolk County-8 Coalition

## *MDPH/LBOH Webinar 1/29/2021*

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that may be frail or unable to leave their apartment for medical reasons.

Service coordinators, COA, and ASAP may be able to help.

For more information (resources, templates and sample documents, FAQs, links to other useful information): <https://www.mass.gov/info-details/covid-19-vaccinations-for-senior-housing-settings>

Point of contact: [seniorhousingvaccine@mass.gov](mailto:seniorhousingvaccine@mass.gov)

Next webinar: COVID-19 response command center briefing on mass vaccination sites for senior housing Feb. 3<sup>rd</sup> 10 am – 11 am. Registration information to be posted online.

**Q:** The housing facility must be designated as senior housing?

**A:** Need to be certain age or older. Building needs to be eligible, and then once everybody in the building can live there regardless of age.

**Q:** How to differentiate housing allocation and local allocation?

**A:** If you submit 400, I need to know what you're doing so I can send it out.