Cambridge
Public Health
Department

Cambridge COVID-19 Expert Advisory Panel
Wednesday, February 17, 2021

Meeting convened at 3:05 pm

ATTENDEES:

Panel Members
Bill Hanage
Jill Crittenden
Louann Bruno-Murtha
Chris Kreis

CPHD/City staff:
Sam Lipson
Nancy Rihan-Porter
Sammi Chung
Lee Gianetti
Dan Riviello

1) Clinical, case, and wastewater data update

Case update:
Cambridge has emerged from a period where the daily average of new cases was similar to the surge in April and May. By comparison, the state of MA overall had a surge that was about 2.5 times the rate of new daily infection experienced last April and May. Of course current case data can't tell us what to expect after the dominant variants sweep through the U.S. later this winter. As of today, MA has detected 34 cases of the B1.1.7(UK) variant and 1 case of the B1.351(SA) variant. This is certainly an undercount. One recent local study found 2 cases of COVID B.1.1.7(UK) in a pool of 30 healthcare workers.

Clinical update:
The overall situation is relatively good in CHA hospitals. The COVID patient census is down to 19 in-house COVID patients as of Feb 17th. The only concern is that the hospital census overall remains high. The healthcare system might not be able to take many patients in if there's another surge. The rapid rise in new variants case numbers in MA still poses considerable risk.

2) Policy and Administrative update

The city manager is working with Boston Metro region communities and other large MA cities to coordinate the municipal response. There is a difficult balance struck between the

burden of new infections currently measure and projected, positions taken by the Governor, expert recommendations calling for stricter measures (including this panel), and the economic realities. Along with the rest of the state, Cambridge now allows restaurants use up to 40% of seating capacity, up from 25% a couple of months ago. Restaurant seating capacity has been moved up and down by the Governor and is declared separately from the sector reopening Phases and Steps.

3) Vaccine roll-out status

The governor expanded the priority groups for vaccination as of today (Feb 17th) to include **people age 65+** along with **people 16 years and older with two comorbidities**. The State largely adheres to CDC's recommended list of comorbidities but has also added asthma to that list. Because of the large number of people with asthma, it would be expected that this will place more pressure on the vaccine supply.

Also, the State has declared that they **will not provide any more first-dose vaccine to municipally managed vaccination sites**. They have committed to supplying second-dose vaccine to cover those already previously vaccinated at municipal sites. People who need vaccinations will now need to go to the mass vaccination sites, chain pharmacies, or other retail locations like the Costco and some supermarkets. After March 1st Cambridge will get enough vaccine to administer second doses for those already receiving their first (shelter residents and some seniors). This past week, the Cambridge vaccine team was forced to use many allocated first doses as the second doses since the state did not send any new vaccines for the week of Feb 15th.

There will a separate allotment distributed for the senior housing sites and the Cambridge vaccine collaborative will continue to administer second doses in senior housing sites and homeless shelters during the weeks of Feb 15th and Feb 22nd. With these vaccine supply uncertainties, there is still a need to arrange more vaccines for some additional senior housing sites and seniors not living in congregate housing.

20 MA cities have been identified by the State as high on the social vulnerability index. This does not include Cambridge. Other than these 20 cities, no other local boards of health will receive the first dose vaccine for municipal sites, unless they can commit to a throughput of 750 vaccines per day, 5 days a week. Cambridge is capable of this based on our experience and level of organization demonstrated up until now. These regional sites would need to be open to all state residents and they add responsibility for other onerous compliance requirements. This requirement makes it very difficult for a municipal site to meet criteria unless the State eases up somewhat. Since the Governor expanded the priority groups on a few occasions recently, resident vaccine inquires have flooded in and the only realistic suggestion the we can offer is to refer residents to one of 70,000 new appointments being released this week at the big four statewide sites.

Because the City does not have alternatives to meet this surge of interest from newly eligible residents, there is understandable anxiety and confusion. Some places around the U.S. and abroad have extended the time between first and second doses to try to ease the

impact of these shortages, but the lack of certainty is very difficult for everyone involved. Cambridge has the infrastructure in place and did a lot of planning in order to comply with State mandates. It would be very unfortunate if all the mass vax planning and our excellent track record in both testing and vaccinating did not result in a major role for the Cambridge vaccination collaborative. For example, to this point, they have **not wasted or lost a single dose** of vaccine by virtue of careful organization, record-keeping and diligence.

4) Planning for a "variant surge"

Only the B1.1.7(UK) variant is now present in the U.S. at levels that we need to worry about right now. It is now clear that B1.1.7 is roughly 50% more infectious and also causes more severe disease in higher risk groups. One estimate of the overall risk of death from this variant is 30-70% higher than from the previously dominant version of the virus. The California variant could be mildly more transmissible, but not to the extent of the B1.1.7 variant. We observed the speed of B1.1.7 spread in UK late in 2020 and it is now the dominant strain. When considering our risk of a variant-driven surge, it's reasonable to measure beneficial seasonal trends and growing vaccine-induced immunity against the rapid spread of variants that probably began earlier in the U.S. than we realize. All things considered, there may be local outbreaks and a bump overall in transmissions in April, but probably no major local surge (probably no 3rd major wave). One EAP member asserted that they are reasonably confident that the mRNA vaccines (Moderna and Pfizer) will be "effective enough", even against the most important new variants. If the B1.1.7(UK) variant has already been in the U.S. for some time then the 3-month surge we just came through reflects much of the added transmission caused by that variant. That means we've cooked in much of the new variant risk. We don't really know, but it seems clear that B1.1.7 has been around the U.S. for longer than we first thought. But this is a foot race and we have to keep getting better and faster at vaccinating as many people as possible.

** changes in PPE guidance:*
We probably are seeing the appropriate guidance, at last, on mask type and use. Even with the risk of the variants coming , it's probably pretty good, as long as people are actually getting the message and doing something about it. CPHD and the City have definitely upgraded the mask selection (which types are worth getting) and use guidance (e.g., snug fit, multi-layer, medical-style and hifi design over cloth) and using excellent infographics developed by CDC. There is still a lot about masks that causes confusion (e.g., double masking) but there is a lot that is not confusing and the City and CPHD have raised the emphasis on better masks. CPHD and City staff will work with Cambridge DPW to update "mask-up posters" from last year that promoted subpar face coverings. These would be pushed out to businesses to replace the earlier posters that are still often seen around town.

* *lab surveillance (capacity for genomic sequencing)*
It was mentioned that the Broad Institute is increasing its capacity for sequencing and the goal is to sequence 5% of the total received samples. EAP couldn't confirm that this was their target, but Broad is very keen on increasing genomic surveillance.

Since the testing samples are collected across the region, Broad staff are subsampling to better reflect to overall population of the state.

* *contact tracing (impact on infectious dose, exposure time for significant contact).*
B.1.1.7 has a longer duration of infection, which appears to result in a longer and more drawn-out surge in the virus load. Its impact on the symptoms over the course of infection is unclear, but this might imply that the contact tracing timeframe will need to expand (i.e., how wide/long is the infectious window for people infected with B1.1.7?). The fact that B1.1.7 is more contagious means that contact tracing criteria might also need to be reconsidered (duration of exposure likely to cause a transmission). Though there's only one case of B1.351 and no P1 (Brazil) case so far, it's worth considering stricter contact tracing standards for when those more transmissible variants are found. At some point stricter contact tracing criteria will make it impossible to keep up, so the current practices might not be changed for practical reasons.

** how to communicate this looming risk*
As people are comfortable with a certain level of risk of being infected, the situation might change due to the variants. In other words, if people become even more lax and engage in risky behavior, then the impact of the variants could be quite bad. We'll have to wait to find out. A better way to communicate the risk is to explain that in order to maintain the same risk level people have right now, more precaution needs to be made.

* *how to respond quickly if surge arrives/CPS decision matrix?*
In the next phase we would expect that wastewater data will predict increases in transmission (likely caused by the spread of B1.1.7). Therefore, the wastewater data could be an early warning system for the schools to determine when stricter safety measures should be implemented, ex: better mask. But it's important to focus on transmissions within schools more than other community trends in the short-run. If schools can limit transmissions then they should probably remain open. B1.1.7 is more transmissible in schools and among children simply because this variant is more transmissible among <u>all</u> people and kids are no exception.

<u>5) Administrative: Reschedule EAP meeting times</u>
Adjust meeting times to coordinate with members' availability. Starting March 10, the meeting will be held from 2 pm to 3 pm on the 2nd and 4th Wednesdays of each month.

Adjourned 3:58 pm
Notes respectfully submitted by Sam Lipson on February 21, 2021.