Joint Committee on Public Health

Representative John Mahoney and Senator Jo Comerford, Chairs

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Oversight Hearing:

Massachusetts' Preparedness and Response to the COVID-19 Outbreak

March 4, 2020

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Video recording:
https://malegislature.gov/Events/Hearings/Detail/3454

Department of Public Health website for the most up-to-date information: mass.gov/covid19

Committee members present:

Senator Joanne M. Comerford, Senate Chair
Representative John J. Mahoney, House Chair
Representative Chynah Tyler, House Vice-Chair

Senator Rebecca L. Rausch
Representative Michelle L. Ciccolo
Representative Jack Patrick Lewis
Representative Andres X. Vargas
Representative Jon Santiago
Representative Michael J. Soter

Goals:

The Joint Committee on Public Health conducted an oversight hearing on the State's preparedness and response to the COVID-19 outbreak for the purpose of understanding and providing information on:

- Current efforts to track, contain, and respond to the virus in Massachusetts, both by the State government and the broader health system;
- The Commonwealth's capacity to respond to foreseeable and unforeseeable challenges;
- Any potential gaps in resources of which the Legislature should be aware and work to fill; and
- Efforts to ensure a unified response to COVID-19.

Three groups of panelists:

Panel 1: Department of Public Health

- Dr. Monica Bharel, Commissioner of the Massachusetts Department of Public Health
- Dr. Larry Madoff, Medical Director, Bureau of Infectious Disease and Laboratory Sciences
- Kerin Milesky, Director, Office of Preparedness and Emergency Management

Panel 2: Medical and academic experts

- Dr. Davidson Hamer, Professor of Global Health and Medicine, Boston University School of Public Health and School of Medicine; Adjunct Professor of Nutrition, Tufts University Friedman School of Nutrition Science and Policy
- Dr. Paul Biddinger, Vice Chairman for Emergency Preparedness, Department of Emergency Medicine, Massachusetts General Hospital
- Dr. Michael Mina, Assistant Professor of Epidemiology and Assistant Professor of Immunology and Infectious Disease, Harvard T.H. Chan School of Public Health; Core member of the Center for Communicable Disease Dynamics

Panel 3: Local and community public health professionals

- Stacey Kokoram, Director, Office of Health Preparedness, Boston Public Health Commission
- Lisa White, Public Health Nurse, Cooperative Public Health Service of Franklin Regional Council of Governments
- Carlene Pavlos, Executive Director, Massachusetts Public Health Association

Summary:

The Joint Committee on Public Health met on March 4, 2020 for an oversight hearing on Massachusetts' preparedness and response to the COVID-19 outbreak. The Committee heard from three panels with representatives from the Department of Public Health, medicine and academia, and local and community public health. Following this report is an appendix with the prepared testimony from the local and community public health panel.

Panel 1: Department of Public Health

Dr. Monica Bharel, Commissioner of the Department of Public Health (DPH), presented first. Two Department officials, Dr. Larry Madoff, Medical Director of DPH's Bureau of Infectious Disease and Laboratory Sciences, and Karin Milesky, Director of the Office of Preparedness and Emergency Management accompanied her.

Commissioner Bharel said she is optimistic that, though the risk of COVID-19 remains low in Massachusetts, DPH is prepared and continues to prepare for this potential outbreak. The Department is engaging in regular communications with the CDC and other federal and regional agencies to make sure it is sharing the latest guidance and recommendations. Commissioner Bharel noted that DPH has created a website with information related to COVID-19. The website, which is updated daily, provides guidance for groups such as schools and businesses, and contains downloadable materials for individuals, clinicians, and employers.

Commissioner Bharel noted that the risk of contracting influenza is higher than that for COVID-19. For now, 80% of individuals infected with COVID-19 become mildly sick, and the mortality rate is estimated to be around 2-3%. The actual mortality rate may be lower because the estimate is based on the number of reported cases, not the number of actual cases. Based on reported cases, children do not appear to be at much risk of contracting the disease.

Commissioner Bharel emphasized that the Department of Public Health understands the concerns of the public. At the time of the hearing, there was one confirmed case and one presumptive case in the Commonwealth (As of March 10, there was 1 confirmed case and 91 presumptive cases). The Department has been monitoring these individuals who are under self-

quarantine at home and the numbers will be available on the Department of Public Health website. The Department is anticipating that there will be more confirmed cases in the coming days and the public is advised to take steps similar to those to prevent seasonal illnesses:

- Wash hands often with soap and warm water for at least 20 seconds.
- Avoid touching your eyes and face.
- Clean things that are frequently touched (like doorknobs and countertops) with household cleaning spray or wipes.
- Cover coughs and sneezes with a tissue or the inside of your elbow.
- Stay home when feeling sick.
- Get a flu shot.

Commissioner Bharel said DPH is providing hospitals and health care institutions with clinical and infection control guidance as well as supporting their existing surge protocols for beds and staffing. DPH is also monitoring the supply chains of medical supplies and personal protective equipment in the United States and providing procedures and steps to optimize these supplies.

Ms. Milesky stated that the Department has a process in place to address potential shortages of beds and other supplies by facilitating the sharing of resources at the local and regional levels.

On testing, Dr. Madoff stated that the state public health laboratory can now perform testing for COVID-19. The Department expects to receive an additional 1000 test kits from the Centers for Disease Control. Under current federal rules, clinicians who have patients with symptoms consistent with an infection and certain risk factors can contact the Department to receive authorization for testing by the state. It will take approximately 24 hours for the state laboratory to obtain the test results. Dr. Madoff added that he expects hospitals and commercial testing centers to be approved by federal authorities for testing in the coming weeks. He indicated that it would be helpful to expand testing for surveillance purposes.

Asked about patient costs for testing, Commissioner Bharel said that there is currently no cost to the patient for testing conducted by the Department of Public Health. When asked about a New York policy that waives all patient copays and deductibles for COVID-19 testing, she said the Department has not yet looked at the issue for commercial testing, but that they want to make testing as little of a burden as possible.

Commissioner Bharel stated that the State Legislature recently appropriated $95,000 for the Department's response to COVID-19 is for supplies and staffing at the state public health laboratory. As of now, the Department has sufficient funding and staff for all of its needs, including monitoring its hotline. Commissioner Bharel added that local boards of health have been advised to report any need for resources to the Department and underscored that there should be no financial barrier to preparation and planning.

A number of questions concerned the dissemination of information, including how information is being communicated to hard-to-reach populations, such as people with disabilities, people without internet access, people in nursing homes, shelters, prisons and jails; and people who do not speak English. Commissioner Bharel stated that guidance is being provided to primary care physicians, hospitals, nursing homes, and educational institutions, but it is ever evolving. She acknowledged that at the local level, it is difficult to keep up with information and that guidance has been changing frequently. With regard to reaching vulnerable populations, she said the Department of Public Health is meeting with fellow agencies, such as agencies on mental health and disabilities, to assist with sharing information with these groups. Commissioner Bharel said

she would look into the possibility of publicly posting recordings of the regular calls they hold with doctors, hospitals, and local officials. She also suggested that legislators use social media platforms, such as Twitter, to provide information to constituents. Legislators requested that the Department inform them regularly via briefings and provide information for them to disseminate.

Commissioner Bharel noted that updated Massachusetts-specific information is available on the Department of Public Health's website, mass.gov/covid19, and through their 24/7 phone hotline, at 617-983-3900.

Panel 2: Medical and Academic Experts

Dr. Davidson Hamer, Professor of Global Health and Medicine at the Boston University School of Public Health and School of Medicine led off the panel. Two other medical experts, Dr. Paul Biddinger, Vice Chairman for Emergency Preparedness in the Department of Emergency Medicine at Massachusetts General Hospital, and Dr. Michael Mina, Assistant Professor of Epidemiology, Immunology and Infectious Diseases at the Harvard T. H. Chan School of Public Health also accompanied him.

Dr. Hamer explained that during the last six to eight weeks, the number of COVID-19 cases has grown and spread worldwide beyond China, Japan, South Korea, and Italy and as a result, travel advisories exist for most of these countries. The disease has been the most fatal in vulnerable populations, such as nursing home residents.

Dr. Hamer shared his frustration regarding testing protocols for COVID-19. The guidelines have been outlined by the Centers for Disease Control and Prevention, and only individuals that meet their specifications can be tested for the disease. Dr. Hamer strongly suggested that these specifications should be broadened. Since testing is currently limited, the elderly and those with underlying medical conditions should receive priority. Those with mild illnesses should stay at home to protect themselves and others. At this moment, there is no treatment or vaccine for this disease, and realistically it will be at least 18-24 months before a vaccine can be developed and tested per the U.S. Food and Drug Administration guidelines. This assumes an effective vaccine is released, which is not always the case. Dr. Hamer proposed that medications may turn out to be more helpful than a vaccine. Researchers have identified some possible drugs.

Simultaneously, companies are working around the clock to develop easy-to-use testing assays that can be mass-produced to expand testing capacities. It is expected that some of these testing kits will be ready for use in mid-April. Currently the test is fairly complex and difficult to handle. It is not known if these companies will be able to supply sufficient testing kits to meet surges in global demand. The concern is two-fold: that not all countries will be able to receive enough testing supplies and that the supplies needed to make the vaccine will be in short supply.

Dr. Biddinger noted that other major events such as MERS, Ebola, and H1N1 preparation have helped build strong response protocols. He stated that a good communication system is critical to protect our health care infrastructure.

Dr. Mina advocated for understanding the epidemiology of the pathogen as a key priority, and that this can be achieved by screening health care staff at hospitals. Staff testing can offer a baseline and help determine the modes of local transmission for the pathogens. These are other reasons to invest in screening/testing kits. Testing is also constrained by a shortage of skilled

technicians. Dr. Mina also spoke about the need for quality control as new tests become available. He suggests putting emphasis on validating tests as well as testing patients.

The panelists concluded that medical staff are tired but they will go on as long as needed. Hospitals are working on staff schedules, rotations and protocols that can help address staff burnout. Those testifying agreed that a key constraint is the limited number of available high-skilled medical technicians.

The panelists highlighted that the spread of the disease is largely based on factors outside of the control of medical providers. At this time, with no clear understanding of how long the outbreak will last, their best recommendation is to prepare for the long-term. The panel did not recommend social distancing at this time, and instead suggested extreme hygiene precautions. Most importantly, hands are the principle source of disease transmission. The panelists recommended avoiding shaking hands and suggested adopting new social gestures, such as an elbow bump, a respectful greeting without hand-to-hand contact.

Panel 3: Local and Community Public Health

The last panel represented local and community health from an urban, rural, and community public health perspectives. The panelists were Stacey Kokoram, Director of the Office of Health Preparedness, Boston Public Health Commission; Lisa White, a Public Health Nurse with the Cooperative Public Health Service of the Franklin Regional Council of Governments; and Carlene Pavlos, Executive Director of the Massachusetts Public Health Association.

Speaking about the situation in Boston, Ms. Kokoram noted that public health nurses and dispatch call-takers are working around the clock to talk to patients and answer questions. Boston has activated its Incident Command System which coordinates public health information, community relationships, and resources. The system helps prevent confusion and duplication of efforts. Ambulances are equipped with protective equipment. As of March 4th, Boston is monitoring 18 individuals for 14 days.

Ms. Kokoram said Boston is committed to stand against xenophobia and support the Asian and Chinese communities. She urged partners in the legislature to push back against racism.

The Boston Public Health Commission is working with The Department of Public Health to make sure they receive the needed resources. The Commission has updated information available via their website www.bpch.org, and they have made fact sheets in multiple languages available for the community. These materials are shared through the city and are regularly updated with new information. For more information individuals are encouraged to call 617-534-5050.

Lisa White focused her testimony on the rural communities she serves. Her service area covers 14 communities with 21,000 people spread over 345 square miles. Her activities are limited by having just one full-time public health nurse, herself, and a full-time and part-time health agent. Rural communities' public health systems are largely supported by volunteers. Even the largest community in Franklin County, the city of Greenfield with a population of almost 18,000, does not have a full time public health nurse.

Her department's ability to meet the needs of its residents is also compromised by workforce and transportation issues. Rural residents are, on average, older and more vulnerable to disease. These demographic realities are compounded by the difficulty in finding qualified staff,

decreased funding, and decentralized public health systems. Her job is to keep the community safe, a difficult task given that she oversees 50 active surveillance cases in a year as a baseline, and more when there is a spike in possible infections. One pressing concern is boarding schools. Several are in her district, and she called for the state to provide leadership and clear direction regarding recommendations for dismissals, cancellation and closures related to COVID-19. The department also has a need for supplies such as thermometers, sanitizer, and masks.

Ms. White requested that their local boards of health receive more support by the state through funding and detailed guidelines on isolation and quarantine. She stated that the Department of Public Health funding has been significantly cut over the last decade, and yet the need for its expertise and leadership for Eastern Equine Encephalitis (EEE), vaping, and COVID-19 response show how important it is to have a strong DPH given our decentralized public health system. Saying we are at serious risk, Ms. White emphasized that Massachusetts is one of the few states without state standards for local public health workforce and without state funding for local public health functions. She recommended passage and funding of the State Action for Public Health Excellence (SAPHE) Act legislation, H. 4503/S.1294. This bill, which passed the House in February and is now pending in the Senate, would facilitate municipal service-sharing and promote regional approaches to local public health.

Carlene Pavlos expressed her concern for populations that are often neglected and overlooked. Not everyone is equally at risk for the serious health consequences of COVID-19 and equity must be central to preparation and response efforts, she said. Existing inequities will disproportionately affect vulnerable groups. A widespread outbreak of COVID-19 has the potential to be devastating to these communities. These communities need access to real and usable information and resources to enable them to take recommended actions such as buying cleaning supplies and non-perishable foods. For low-income people, staying home when sick, taking care of a child should schools be closed, or caring for a quarantined family member will be difficult or impossible without losing a job or critical income.

Ms. Pavlos added that policies around paid sick leave and family medical leave laws should be revisited. Paid sick leave should be viewed as a public health measure. She also discussed expanding funding for food pantries and loosening time restrictions on assistance from Massachusetts Emergency Food Assistance Program (MEFAP).

Additionally, when discussing solutions all vulnerable populations need to be accounted for and represented. This includes caregivers, and people in nursing homes, shelters, prison, jails and boarding schools. It is the state's responsibility to find ways to communicate with these communities and provide them with all resources available.

Ms. Pavlos echoed Ms. White's call for enacting and funding the *State Action for Public Health Excellence* (SAPHE) legislation. Finally, she called for this outbreak to be used to prod us to plan for the long-term. She reminded the Committee that after the threat of COVID-19 has subsided, there will continue to be other new public health threats. She urged the state to prepare through the creation of adequate infrastructure, staffing, policies, and critically, funding for a quality public health response. The COVID-19 outbreak instructs us to create the robust public health system we need and which will live on after it is no longer a headline.

Appendix

Prepared Testimony from Local and Community Public Health

Stacey Kokoram, Director, Office of Public Health Preparedness, Boston Public Health Commission

The Boston Public Health Commission is the health department for the City of Boston, with the mission to protect, preserve, and promote the health of the over 675,000 residents of Boston, especially the most vulnerable. We are currently in a dynamic, evolving situation with much still to learn about COVID-19. We are confident, however, that the Boston Public Health Commission and the City of Boston will be ready for a safe and effective response as the situation develops.

First, the basics: there has been only one confirmed case of COVID-19 in the City of Boston. The risk to the general public remains low, because there is no evidence of community transmission in Boston. As of March 2nd, Boston is monitoring 18 individuals which means that they are monitored for 14 days, and then cleared if they present no symptoms.

The Boston Public Health Commission, Boston EMS, and Mayor Walsh's administration have been taking extensive steps to prepare for a potential outbreak of COVID-19 since January. We are well-trained to respond to infectious diseases and in the past have successfully stood up heightened awareness, monitoring, and response approaches for SARS, MERS, and H1N1 flu. Our preparation efforts will continue to be adjusted and escalated if needed.

The Commission activated our Incident Command Structure in January. This is a structure that ensures that we are performing critical functions, including surveillance and monitoring, public health information and clinical guidance, communications, relationships with communities and sectors, and resource management. It also prevents confusion and duplication of effort and is designed to allow us to sustain the effort over a long term – and we assume that we will be experiencing COVID-19 for a while.

Vital work is being carried out 7 days a week by the Commission's Infectious Disease Bureau. Our public health nurses have been very busy: providing contact tracing and follow up support for our one confirmed case, responding to requests for patient screenings, and supporting healthcare partners in screening and evaluating potential persons under investigation.

Boston EMS has implemented screening during the 911 call-taking process: dispatch call takers will ask specific questions based on Centers for Disease Control and Prevention criteria for COVID-19, including recent travel. All our ambulances are equipped with necessary personal protective equipment and standard cleaning solutions to sanitize the ambulance after transport.

Not just the Boston Public Health Commission, but the whole City of Boston is preparing. We have been engaged in extensive coordination with other City departments, including the Health and Human Services Cabinet, the Office of Emergency Management, Police and Fire, and Boston Public Schools. We are working to ensure that not just our 1,200 Commission

employees, but also the whole City workforce, have the training, resources, and information that they need to respond appropriately.

The Commission is in constant communication with the Centers for Disease Control and Prevention and the Massachusetts Department of Public Health. This is a multi-agency response, and we want to thank our state and federal partners for their ongoing partnership and support. We are advising key partners across the City on best practices for precautions, including hospitals, health centers, schools, and local universities. We operate the Stephen M. Lawlor Medical Intelligence Center (the MIC), which functions as the multi-agency coordinating center for public health and healthcare organizations for the City of Boston and its partners in surrounding areas. The MIC provides both virtual and face-to-face centralized coordination and management and is an important information-sharing system.

Because we have our response structure in place at the Boston Public Health Commission, we are prepared if this situation escalates. We have handled infectious diseases like this in the past, and we will use the lessons learned from those to continue to develop our escalation plans.

One of our most important responsibilities is communicating with Boston residents and the general public. We know that providing accurate, timely, and actionable information builds public trust and mitigates fear, leaving us all better prepared to respond to whatever developments may come. You will find attached here some examples of our communication materials. We maintain a blog, updated daily, at www.bphc.org. You can also find these fact sheets and posters on the website, available in English, Chinese, Haitian Creole, Portuguese, Spanish, and Vietnamese. We have shared these fact sheets widely throughout the city. These communication materials are continually updated as more information becomes available or to be more directly responsive to community questions and concerns. We are also encouraging residents to call our Mayor's Healthline (617-534-5050) or 311, the City's main information line, with questions and concerns.

People often ask what they, as individuals, can do to help. Our public health messaging for preventing the spread of COVID-19 is simple: wash your hands often with soap and water, stay home when you are sick, and cover your cough or sneeze. These are simple, but very effective, actions that all of us should be taking.

We have been dismayed to see some use this outbreak as an excuse for racism and xenophobia. In Boston, we are committed to preventing discrimination and we encourage everyone to stand with our Chinese and Asian-American neighbors. Mayor Walsh and other City leadership have been vocal in denouncing discrimination, and have been making public appearances in Boston's Chinatown. We hope that all of our partners in the Legislature will continue forcefully pushing back against this kind of racism in our communities.

We would also like to call your attention to the need for personal protective equipment for our public health nurses, first responders, and healthcare workers generally. The World Health Organization is warning that there is mounting disruption to the global supply. We would ask that you work with both industry and the federal government to boost production, and to secure allocations for our healthcare workforce here in Massachusetts.

As the situation continues to develop, we would encourage you to consider the resource needs of local health departments like Boston, which are on the front lines of this response. We would further encourage our policymakers in state government to work with insurance companies and

drug manufacturers to ensure that both testing and care, including a vaccine if developed, are accessible to all. Finally, looking further down the road, we would also encourage you to think about social and economic support to help impacted communities, especially the most vulnerable.

On behalf of the Boston Public Health Commission and Mayor Martin J. Walsh, thank you for your ongoing attention and support to the local public health response to this outbreak.

Lisa White, RN, PhD, Cooperative Public Health Service of Franklin

It is a pleasure to appear before you today to share a rural perspective of how towns are preparing for COVID-19. My name is Lisa White, and I am the regional Public Health Nurse for a regional health district called the Cooperative Public Health Service in Franklin County, the most rural county in the state.

When formed in 2012, the district consisted of 4 towns. Today we serve 14 towns covering an area of 345 square miles, but with a combined total population of 21, 419 – a typical size of a single large town in many parts of MA. How rural are we? Within that area, there are just three traffic lights! In Massachusetts, 170 of the 351 cities and towns are rural, defined as 500 people per square mile or less. Our district has an average density of 62 people per square mile, for comparison.

According to the Massachusetts Rural Policy Plan, rural residents are older than urban residents, making them more vulnerable to a disease that is primarily dangerous to those who are old, weak, and otherwise already unwell. Combine this demographic with the decentralized public health system in Massachusetts, and the fact that we are one of the few states without state standards for local public health workforce and without state funding for local public health functions, and we are at serious risk. The ability of rural Massachusetts to meet the primary health needs of our residents, particularly our poorest residents and older adults, is challenged by a lack of health care providers and transportation. We rely on a system of community volunteerism and leadership from our local boards of health to address many community health functions.

Our health district consists of one full time nurse, one full time and one-part time health agent and administrative staff support from the Franklin Regional Council of Governments. As Public Health Nurse, my work includes communicable disease investigation and follow-up to keep the community safe when one of our residents is diagnosed with Hepatitis, Whooping Cough, Influenza, and possibly soon, COVID-19. I also work closely with school nurses, educate residents on Lyme Disease prevention and chronic disease self-management, hold regular clinics for residents in need across our region, and manage over a dozen flu clinics each fall. I should note that among the 12 remaining non-district towns of the Franklin County Region few have dedicated nursing staff, and there remain a number of towns that have no hired staff assisting locally elected and appointed Boards of Health to meet their vast duties. Even our largest community, the City of Greenfield, does not have a full time public health nurse.

What we are doing to prepare

Our preparation within the health district has included regular email updates to all boards of health and selectboards, encouraging LBOH participation in DPH-led conference calls; ensuring

my contacts for boarding schools, public schools, and nursing homes are up to date and checking in with many of those folks to assure our coordinated action as needed. Last week I presented to our district's Oversight Board on novel Coronavirus status, our preparedness, what their role might be and what they can do to prepare, and shared resources for staying updated and communicating with residents. I have provided the Committee with a copy of that presentation.

We are preparing local response to any person who is screened as having or being exposed to COVID-19 in one of our towns. We've received some basic information in conference calls from the Mass Department of Public Health on how cases will be managed and how reporting will be completed in the MAVEN database we already use for infectious disease surveillance. We understand our response in coordination with DPH and providers may include developing systems for daily monitoring of temperatures of quarantined residents, investigating contacts, and conducting clinical investigation and reporting for individuals who have tested positive for COVID-19. In a true pandemic, one public health nurse serving 14 towns will be inadequate to provide these services. Our district is working to build additional depth into our systems for case management in this public health emergency, and keeping member Boards of Health closely informed, as they are with any active infectious disease investigations now.

We are working to provide factual clear and consistent information regarding COVID-19, our anticipated response and resident's access to information in relationship with the Local Boards of Health. As in the 2009 response to Novel H1N1, Local Boards of Health in the last weeks have organized under the Mohawk Area Public Health Coalition, the Local Public Health Emergency Planning Coalition for our region, to form a Joint Information System sub-committee. We are providing assistance to that effort with the FRCOG's Emergency Preparedness staff. They are now meeting weekly to assemble and distribute timely, accurate messages for the public which are sent to all towns in the region for local publications and postings. This is an essential role for our local boards of health and they need the support and tools to do this well.

What are the challenges rural communities are facing as they gather to prepare for COVID-19?

1. **As noted before, many towns do not have access to public health nurses or any professional staff to assist with response to COVID-19.** They are not required to have one by state law or regulation, and receive no stable funding from the state to ensure these protections are available to every Massachusetts resident. Poorer rural communities often are not able to afford this kind of public health protection without sharing services, something that takes a long time and significant seed funding to plan and build. This means that if a town is going to prepare for a pandemic, the volunteer board of health members or part time health agent might be trying to do the work I just described. Boards of Health served by the Franklin Regional Council of Governments benefit from the fact that our agency has an emergency preparedness program and we manage Homeland Security funding which gives us more regional expertise and information than many other rural regions have.

2. **Outdated and unpracticed local emergency plans.** The Mohawk Area Public Health Coalition conducted an exercise earlier this week with our nine regional Emergency Dispensing Sites focused on communication and planning several months ahead of the distribution of vaccine. The exercise, which was planned well before what is now known

about the spread of COVID-19, says volumes about the type of preparedness our region has worked diligently over the last years to develop, it also provided evidence that such planning continues to be a great need.

I was also asked to speak to my experience of the state's response thus far.

Through online resources and several conference calls specifically for local public health, the state Department of Public Health has provided accurate information and guidance prevention and management of potential COVID-19 and other respiratory illness.

The state also has shown responsiveness through the 24/7 state epidemiology phone line, and guidance for individual questions. We understand how essential that connection will be in the management of any confirmed or suspected cases of COVID-19 and for the monitoring of symptoms of at risk individuals.

The state has also connected local boards of health to translation services and the promise of DPH payment for invoiced services.

What more can and should the state do?

1. We need the state to assure local boards of health are supported to manage cases and provide appropriate case management to persons exposed to or ill with COVID-19. Detailed guidance, including formatted notices for isolation and quarantine, material support for supplies needed to implement community-wide Non Pharmaceutical Interventions and access to supplies like thermometers, sanitizer, and masks are needed.

2. Just as we are concerned with our local capacity during this public health emergency we are very concerned that staffing of DPH be maintained at an appropriate level so that they continue to provide our towns a high quality of assistance. The Department has been significantly cut over the last decade, and yet the need for its expertise and leadership for Triple E, Vaping, and Coronavirus show how important it is to have a strong state DPH given our decentralized public health system.

3. We need the state to provide leadership and clear direction regarding recommendations for dismissals, cancellation and closures related to COVID-19. We work very hard to maintain open communication between local public health, health care providers, care facilities, elder services and housing, schools and other community partners. We need clear directives and professional assistance when it comes to assessment and enacting specific community measures to slow the spread of illness.

4. The Legislature can support towns to create and maintain health districts like ours -- through the State Action for Public Health Excellence Bill, H.4503, and funding it in the budget. Municipal service-sharing is a top priority of the Rural Policy Advisory Commission, and an emergency like this shows why. 38% of local health departments in MA reported not having a public health nurse in a survey conducted by the special commission on local and regional health last summer. This means that many communities in Massachusetts do not have someone in my role preparing for COVID-19,

and while not all those are rural communities, it is likely most are.

5. Finally, we need the state to assist planning and material needs for Emergency Dispensing Site (EDS) distribution of COVID-19 vaccine if it becomes available. With DPH guidance our health district has transitioned to pre pay with reimbursement model for the dozen or so flu clinics we hold within the region annually serving about 1000 residents. Our clinics are no longer at the scale needed to support innovative and prevention focused delivery systems like the "drive through" flu clinics serving up to 700 in several hours that the Frontier EDS group in our district successfully ran in the years following Novel H1N1. We need continued state support to practice and prepare multi-sectoral teams in planning pandemic responses at a community level.

Carlene Pavlos, Executive Director, Massachusetts Public Health Association

I have four key points to make this afternoon.

1. **Science is Real** and that is true of public health science. This needs to be said because we are living in a time when there is pushback against scientific truth. The chipping away of the public's confidence in the truth of science and the word of our state and national public health experts endangers all of us. Our safety in times of a disease outbreak is dependent on following the guidance of public health experts. In Massachusetts we have experts at the state and local levels that are world-class and we have health care providers that are well-versed in emergency preparedness. Our role is to pay attention, follow their advice on the best way to slow the spread of this virus, and do our part in amplifying the messages of experts.

2. **Local public health *exists*.** I say this in jest because for many, local public health is invisible or poorly understood. In each of the 351 cities and towns across Massachusetts, **local boards of health and health departments are the first line of defense when it comes to prevention and response of disease outbreaks**, like the coronavirus. Local health has statutory responsibility to address infectious disease through local prevention efforts, treatment, follow-up when that's required.

   What that looks like on the ground includes any case investigation, quarantine (which we hope is voluntary, but may include involuntary quarantine), as well as reporting to state public health officials.It also involves extensive communication and coordination with local hospitals and clinics, emergency response units, law enforcement, and schools. This is a particularly heavy lift in communities that lack dedicated public health staff. And that is an issue:

   - **Inconsistency across municipalities.** With no recommended funding levels, municipalities with the same population have widely varying levels of staffing and quality of services.
   - **Small towns struggle with lack of staff to meet their statutory responsibilities.** Of the 105 towns with fewer than 5,000 residents, 78% lack full time staff and 58% have no health inspector. (Of western Massachusetts

communities with little or no staff, 22% don't keep records of reportable diseases, compared to 1.6% of metro Boston communities.)

As we face coronavirus, many local health departments will rely on the state health department for information, support, guidance, and additional response capacity. But this is an opportunity to recognize the inconsistencies between municipalities and begin down the road of strengthening public health at the local level by passing legislation that will support local public health.

MPHA's first priority is passage of the State Action for Public Health Excellence or SAPHE Bill. I want to thank this committee for already having reported this bill out favorably and the House for having passed it unanimously.

This bill was drafted and is being championed by MPHA and our allies because it supports more effective and efficient delivery of services that meet local health's many statutory requirements. It does this by incentivizing health departments to share services and to adopt other best practices around workforce standards and data reporting.

MPHA stands ready to work with allies in the Senate to get this bill passed.

Additionally, now is the moment to fully fund the provisions of the bill, which would be a relatively modest $1.715 million.

3. Equity must be central to our preparation and response

At this moment in time, it is inevitable, our state's existing economic, social and health inequities will create inequities in how vulnerable communities are to coronavirus. This is particularly true for communities that experience racism, anti-immigrant hostility, and poverty.

So, while everyone is at risk for contracting coronavirus, not everyone is at equal risk for serious health consequences, including death. We know that older adults, and those with underlying health conditions such as cardiovascular disease, diabetes, chronic respiratory disease, high blood pressure and cancer, are at significantly higher risk. Because of existing health inequities, these conditions are already concentrated among low income residents and people of color. This means an outbreak could be particularly deadly for these communities.

To help mitigate this, we must assure that communities already experiencing inequities have meaningful access to information and treatment and that we consider ways to support individuals, families, and communities in accessing resources necessary to follow recommended guidance

Let's take information access first:

Local and state health officials must continue and expand efforts to partner with community organizations and leaders trusted in their communities to provide up-to-date science-based information on how to prevent the spread of disease and how to access treatment. Without the partnership of community leaders, this information is unlikely to reach marginalized communities.

These efforts must be both aggressive and humble if they are to be effective.

We have examples of excellent partnership, including the emergency preparedness work of the Boston Public Health Commission, and this work can represent a model for public health more broadly.

In terms of access to the resources that make compliance with prevention recommendations possible, we at MPHA are thinking about a couple of examples:

We have already seen recommendations to buy extra food and certain cleaning supplies in the event that an epidemic becomes severe. That is simply not a recommendation that poor people can follow – since such purchases require extra money.

Additionally, low wage workers, especially service workers, may have few or no benefits, so things like staying home when sick, taking care of a child if schools are closed, or caring for a quarantined family member are going to be difficult or impossible without losing income or job security.

Addressing these challenges will require leadership from employers and business associations – both large and small – to ensure all workers are being treated fairly. This is not just a matter of fairness for individual workers, as important as that is – it's also a matter of community-wide prevention.

We need to identify strategies that take a step to creating options for such workers - perhaps permitting our state's relatively new Paid Family Medical Leave law to be used in cases of coronavirus.

I will add that if we take a long view, we can see that paid sick leave is not only the right thing to do for working people and their families, it can be an important public health measure.

We may need to get creative and we certainly must expect that employers, local government, state government, medical professionals, -- and really, all of us – take responsibility to assure all residents of Massachusetts are safe.

As a state, we must assure that our preparation and response focus on keeping us all safe, not just those that are easiest to reach with prevention and response measures.

4. We must use this potential outbreak as an opportunity to plan for the long term

As we prepare for the potential impact of coronavirus, which will hope will be modest, we must remember that after the threat of coronavirus has subsided, there will be another public health threat after that. We don't know exactly what it will be, when it will be, or how severe it will be, but we know it will come.

Infrastructure – staffing, policies and structures – are essential for quality public health.

As I noted above, many of our state's municipalities do not have adequate infrastructure to meet their existing responsibilities. And while the Massachusetts Department of

Public Health is strong, it relies on infrastructure - such as our state laboratory - to maintain its high standards and quality work.

I want to be clear: Infrastructure requires adequate funding.

The daily work of state and local public health is largely invisible – because it is effective. But these daily efforts protect all of us from very real threats: TB, foodborne illness, and lead poisoning and promote health and wellbeing for all MA residents.

Let's use this moment to ensure we are preparing effectively for coronavirus, but also to recommit ourselves – and our resources -to a strong public health system that each our residents expects and deserves – even when there are no headlines.