FITCHBURG CITY CLERK

Feb 07 2022 1:24 pm

Office of the

Board of Health

City Hall
718 Main Street
Fitchburg, Massachusetts 01420
978-829-1870

This was a regular meeting of the Board of Health of the City of Fitchburg held in the Legislative Building at 700 Main Street and recorded by FATV Studios, Fitchburg, on January 13, 2022. The meeting was called to order by Dr. Bogdasarian.

Present: Stephen Curry, Director; Dr. John Bogdasarian, Chair; Ian Murray, Member, Sandra Knipe, Member, Jacquelyn Wehtje, Petitioner; Matt Hughes, AKS Recycling Inc.; Mayor Stephen DiNatale; Amy Jolly, Applewild School, Head of School.

Approve Meeting Minutes:

Ms. Knipe stated on page 2 of the December 2, 2021 minutes the word" Hearing" should be changed to "Petition". Ms. Knipe made a motion to approve the minutes of the December 2, 2021 meeting as amended. All were in favor, motion carries.

COVID-19 Update: Director Curry:

Cases & vaccination: Mr. Curry stated since January 1, 2022 Fitchburg has seen 1,287 confirmed cases to date. There are 307 confirmed cases under 18 years old and 980 are greater than or equal to 18 years old. We had 3 deaths in 2022 due to COVID-19. The positivity rate is 25.2% which equates from 1,573 cases 6,236 tests from Fitchburg residents. The state rate is around 18 to 20% so we are consistently above the state rate. The vaccination rate is around 56% in Fitchburg, also below the state rate. We will be working harder to try to get those numbers up.

Booster dose percentages from age groups are 65-75 years olds are in the 50% range, age 50-64 are in the 30% range then it gets even lower under 20% from age 20-45. For some reason folks are not getting boosters and only 20% of our population has received a booster.

Mr. Curry stated in December the public schools had several clinics and each of those clinics got about 200 children.

Clinics: There will be a clinic tomorrow from 12-4 at the Legislative Building. We will be hosting an adult clinic and folks are encouraged to go on the web page and sign up for an appointment but we are also accepting walk-ins. There will be Pfizer available tomorrow. Starting next

weekend we will offer Friday (12-6PM) & Saturday clinics from 10-4pm at the Legislative building until the end of January and will work itself into February. We don't know yet if it's going to be the entire month but we are working on staffing those Friday and Saturdays up until the end of February so the availability for boosters will be there for the next several weeks.

Test Sites: Mr. Curry stated today was the final day for the test site at 49 Nursery Lane. We are moving the testing site and combining with the City of Leominster to the Fitchburg Airport. Starting next Tuesday from 12-4PM. Folks can enter from Airport Rd to Blueberry Lane to Cobbler Drive which would bring you to the old runway at the Airport. Both Fitchburg & Leominster residents are welcome to attend. Testing is (PCR) and we will continue to operate until the end of March, weather permitting.

The test sites are producing 300 to 500 tests a day depending on how the weather is and how many testers arrive. This is first come first serve and you don't need an appointment ahead of time.

Contact Tracing Staff: Mr. Curry stated he has hired 8 Contact Tracers, an Epidemiologist and Contact Tracing Supervisor and they have taken over the duties of the Contact Tracing in the Montachusett Public Health Network and will be taking over in Fitchburg, very shortly.

Dr. Bogdasarian stated at the last meeting there was a discussion about Fitchburg State University that when they reached 80% vaccination status they would be allowed to remove the mask mandate. They are currently at 90% vaccination. Mr. Curry said he did speak to the President at FSU and was told there are very strong student groups that support the mask mandate and he continually supports it himself and does not wish to have the mask mandate removed at the college. They also would call upon the BOH for assistance to enforce if necessary.

Request for Variance: <u>Applewild School request for variance of Lodging House Regulations-Amy Jolly, Head of School:</u>

Dr. Bogdasarian – Recused himself from this agenda item.

Ms. Jolly stated they are in the process of purchasing new furniture for one of the dormitories and they are asking for a variance for furnishings as listed in the Fitchburg Lodging House Regulations. The Regulations were written for the needs of adults and their students are generally ten to fourteen years old, so naturally they have different needs. Specifically the requirements include "16 cubic feet of dresser space" and 3" feet of closet rod" which is quite a bit more than the average middle school student needs and all this space is hard for them to keep clean and organized. The regulations also call for each student to have a towel rack and I would ask for a variance to allow hooks instead which are easier for students to use. Our goal is provide comfortable accommodations for our students and we plan to purchase this arrangement or similar for our students.

Ms. Knipe made a motion to amend the regulations to allow each student to have hooks instead of towel racks. Motion was 2nd by Mr. Murray. All were in favor, motion carries.

Ms. Knipe made a motion to remove the 16 cubic feet of dresser space and three feet of closet rod space from the regulations. Motion was 2nd by Mr. Murray. All were in favor, motion carries.

Site Assignment Review: AKS Recycling Inc.-review amended Conditions (Continued from Aug 5, 2021: Matt Hughes, Virtual:

Mr. Curry stated back in August we had a site assignment hearing that was considered a Minor Modification, according 310 CMR 16.0. Our original Conditions was to have municipal solid waste removed from the tipping floor at the transfer station within 24 hours. The Board in August did grant the condition to be amended to 72 hours. In that meeting we did ask for a three month review. Five months have passed so I've asked Mr. Hughes to come give a report on how things are going with the operation.

Mr. Hughes stated he went back and looked at our records as you know we report on a monthly basis, if we have any complaints. Being at the facility seeing the operation we've not had any complaints since we've gone to the 72 hours. We are able to operate just as we had before we got the expanded storage time of 72 hours so no issues.

Mr. Curry stated he does report monthly and we have not received any complaints as a result of the change of operation. We previously said if there were no concerns it would automatically become a Condition of the Site Assignment.

Dr. Bogdasarian made a motion to approve the extension of time allowed of MSW on the tip floor to 72 hours, become a permanent Site Assignment Condition. Motion was 2nd by Ms. Knipe. All were in favor, motion carries.

Petition: Jacquelyn Wehtje – Petitioning to rescind the entire BOH Mask Mandate adopted August 5, 2021 and amended August 25, 2021 or portions thereof, as outlined in the petition:

Ms. Wehtje stated that in the COVID-19 update, the Board talked about the number of cases. Focusing on cases is an outdated approach in the post vaccine world and also in the Omicron world where cases are increasingly decoupled from severe outcomes. I don't know if Dr. Gandhi is available on zoom as she said she might be able to speak to us today. I have attached an article that she wrote to the end of your packet and I believe I also sent it to you ahead of the meeting so you could read what this occurrent thinking on COVID-19 as we move to it becoming an endemic disease. **See Exhibit A**

In addition you have focused heavily on cases that have been reported in the past so you're looking backwards but if we look forward we see some very good news if you turn to pages 2-3 and four of your packet you'll see sharp drops in the level of COVID-19 in the community

wastewater in Massachusetts, from the MWR a website. I know our Wastewater Commissioner here in Fitchburg has been willing to have us do similar sampling here so we would have local data but generally we have followed the state pattern as cases rise in the state ours rise as they fall in the state ours fall so we see things are getting a lot better. **See Exhibit B**

Ms. Wehtje stated that we over the Omicron peak and there's no need to be alarmed. Another thing she wanted to address was at the last meeting Mr. Murray had criticized some data that I presented. I had showed that states without mask mandates had lower rates of community transmission that states with mask mandates. He said that's because states like Florida peaked earlier from the Delta variant, so that's a valid criticism.

For today's meeting I have on the next three pages presented data over the entire course of the pandemic showing death rates per capita by state. **See Exhibit C.**

In addition the mask mandate that you have in place is discriminatory. It discriminates against lower income people who suffer more from the $300 fine you have in place for anyone who does not comply with your mandate. **See Exhibit D**

People can't afford to pay a $300 fine if they're not wearing a mask. There is another group of people who your mandate specifically applies to which is residents of the Fitchburg Housing Authority. You don't have a mandate on people living in private apartment complexes. If they want to run down the common hallway to go out to their car and get something or if they want to go to the laundry room, these are people who cannot afford to pay a fine, but you put it on the poorest of the people in the city who live in public housing. This is a very punitive approach and there is a precedent in public health for taking a punitive approach. You need in your health department to have a substance abuse coordinator position. I would challenge you to drop your mindset of a mandate and punish and move to one of advice and support. With COVID-19 mandates there have been negative unintended consequences. Childhood vaccinations are down because people are rebelling against being told they need to get vaccines. Prior to the COVID-19 mandates there was no gap between members of political parties when it came to flu shots now members of one political party are 20% less likely to get a flu shot than members of another political party so there are negative unintended consequences when you try to force people to do things and when you punish them and fine them if they don't.

I do ask that you rescind your mask mandate and if you don't rescind it at least remove the $300 fine.

Dr. Bogdasarian asked Mr. Curry how many $300 fines have we levied since this mandate has been in place? Mr. Curry said zero. Mr. Curry stated he would hand everybody a mask before he would hand them a ticket. Dr. Bogdasarian does not feel there's been any discrimination against any particular group and everyone still falls under the same advice and that is to wear your mask and otherwise be susceptible to a fine of $300.

Dr. Bogdasarian made a motion that we continue the mask mandate as previously been in place since August of last year. Motion was 2nd by Ms. Knipe. All were in favor, motion carries.

Meeting adjourned at 5:50pm.

Exhibit A

TIME
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As Omicron Hits, COVID-19 Case Counts Don't Mean What They Used To

Dr. Monica Gandhi 2 hrs ago [December 16, 2021]

America has begun the gradual process of accepting that COVID-19 is going to be endemic—meaning it will always be present in the population to some degree—due to inherent properties of the virus (animal reservoirs, high transmissibility, long period of infectiousness, symptoms similar to other pathogens), and will remain so for the foreseeable future. However, the U.S. has an impressive suite of tools to deal with this reality. Vaccine eligibility is widening and boosters are available for all adults who want one. Two effective oral antiviral drugs that prevent hospitalizations and death in people newly infected with COVID-19 are about to be authorized. There are also monoclonal antibody treatments for people whose immune systems do not mount a robust response to infection. The CDC signaled this important and realistic shift by acknowledging that herd immunity is not achievable. With this admission from our most important public health agency, policy must shift also.

We have reached a point in the pandemic where policy should no longer be based around the idea that we cannot resume normal life until case numbers are below a particular (arbitrary) level. One reason is that those levels were set before vaccination, and have not been adjusted accordingly, even though a large proportion of cases, in part due to the growing proportion of cases that are breakthrough cases, are now mild. Another reason is that these metrics were set at a time where policy makers were scrambling to set thresholds to open and close social institutions in the absence of robust data. Setting thresholds for activities according to cases no longer makes sense, but U.S. states and counties are still reporting daily case numbers and fluctuations as though policies should revolve around these numbers.

In a recent article about Oregon's COVID-19 restrictions, currently the strictest in the country, the state epidemiologist said that in order to ease restrictions, "We need to see cases going down and no resurgence of disease." But hospitalizations have fallen 57 percent in Oregon since

their peak in late August-early September 2021 and have been flat for the past three weeks. Oregon has a low daily new hospitalization admissions rate of about three per 100,000 people down from five per 100,000 people in August 2021, meaning the vast majority of cases are not resulting in serious outcomes. It no longer makes sense to assume "cases" equate to "disease" in areas of high vaccination coverage and this misguided equivalency can have negative consequences.

These negative consequences of mitigations is why Marin County, California, did not re-impose masks recently even though their cases had crept back up into the CDC's recommended masking zone. The county simultaneously had zero Covid-19 hospitalizations. Marin County's public health officer recently noted that hospitalizations were at a four-month low, and explained that going forward mask mandates would depend largely on hospitalization and vaccination metrics (instead of case counts) because in areas of high vaccination rates, hospitalizations became largely uncoupled from cases during the U.S. delta variant surge.

In light of the properties of the virus, vaccines and emerging therapeutics, the CDC should stop basing guidance on when to unmask on case counts. In November, Montgomery County, Maryland, dropped indoor mask mandates based on the CDC's case count guidance for metrics of transmission, then re-instated them a week later. This kind of whip sawing decreases confidence in public health institutions, sows confusion, and does little to nothing to meaningfully prevent the transmission of COVID-19.

Relying on case numbers as the key metric to decide whether COVID-19 mitigations are needed will trap us forever in mitigations aimed at, well, controlling cases. These include long term mask mandates in places where they are not necessary due to high vaccination rates; quarantining healthy children; disrupting school to prevent tiny numbers of COVID-19 cases spreading to other healthy children; and sending college students to remote learning and shutting dining halls, as Middlebury College announced they were doing in early December due to 50 positive COVID-19 tests among their 2580 vaccinated students. Cornell University banned all in-person student social gatherings for the remainder of the semester, though all cases among students were mild. Meaningless mitigations such as these do not substantially slow the spread of COVID-19, may deter people from vaccination if they signal that vaccination does not mean a return to normal life, and take a toll on students' mental and emotional health. Removing social connection from already struggling cohorts of vaccinated students who are extremely low risk for a severe COVID-19 outcome defies common sense.

Focusing on case counts also creates the misperception that vaccination is not effective, because the proportion of breakthrough "cases" is going to grow as the number of vaccinated people increases. However, the vast majority of breakthrough cases do not result in hospitalizations. Oregon's most recent breakthrough data from December 9th indicate that, to date, "4.4% of all vaccine breakthrough cases have been hospitalized and 1.2% have died. The average age of vaccinated people who died was 81." Oregon data also show that, for younger adults, unvaccinated people are hospitalized with COVID-19 at 15-20 times the rate of vaccinated people. For those over 80, vaccination is four times as protective

Another reason it's important to rely less and less on the metric of cases is that measurement of case positivity is becoming increasingly inaccurate. At-home COVID-19 tests, which the Biden Administration said are about to become much more available, mean that more case data (both positive and negative tests) will not be recorded by health departments. This means that reported case numbers are going to diverge even more widely from actual case numbers. Additionally, as mitigations drag on, the extreme consequence of reporting a positive test result, both for the person tested and for close contacts– which can include exclusion from school, sports, and social events for lengthy periods of time—are becoming a large disincentive to test at all. If case numbers are highly inaccurate, what is the point of using them to determine whether masks should come off, or whether to cancel elective surgeries, as New York did this month?

Florida is currently reporting half as many new daily cases as California (7 per 100,000 compared to 13 per 100,000). Is this lower case count real and due to higher natural immunity (the two states' overall vaccination rates are very similar), or are lower cases an artifact of less testing, lower test reporting, less breakthroughs due to later vaccination, or other unmeasured factors? No one knows. This uncertainty argues strongly for looking at the more reliable and much more important metrics of COVID-19 hospitalizations and deaths, not cases, even if both are artificially inflated by people hospitalized who happen to have COVID-19 on routine screening (COVID-19 nasal swabs are generally performed for all hospitalized patients for infection control purposes). Hospitalizations for versus with COVID can be inflated by up to 25% to 40%. The relationship between hospitalization and deaths has changed also. With treatment, people who are hospitalized with COVID-19 are less likely to die from it than they were at the start of the pandemic.

So, what should we do instead?

The U.S. needs to transition to dealing with COVID-19 the way we do other endemic viruses such as the flu.

First, health departments should monitor COVID-19 *cases* the way they do influenza cases. Flu monitoring happens at two levels; by the CDC's influenza surveillance network, keeping track of percent of positive tests, peaks during certain times of the year and, importantly, variants of concern, and by state and county health departments, who are largely trying to make sure influenza hotspots are not developing and are reporting potential concerns to the CDC. In addition, at certain times of year when county health officials know that flu is circulating in a particular area, they will make sure antiviral treatments such as oseltamivir are available to clinics.

Counties and states are not publicly reporting daily case counts of influenza, nor do they pivot what they are doing on a dime when cases reach some arbitrary number. One of the major elements of influenza tracking is monitoring for variants because of the potential of flu to switch *from* endemic *to* pandemic. With COVID-19, we are going the opposite direction—from pandemic to endemic—and we need to get to where influenza monitoring starts, which is very

different from what we are doing with COVID-19 cases, where every uptick is seen as a cause for panic.

Even though the Omicron variant will likely drive up cases, initial evidence is that it may cause milder symptoms than delta and so far it is not causing higher hospitalization rates, though it is at this point not the dominant strain in the U.S.

It's time for the U.S. to stop worrying so much about cases and redirect our energies to reaching the most high-risk unvaccinated people, a number we conservatively estimate at 10 million people, but which could be as high as 20 million. These extremely high risk people are unvaccinated retirees, people 55-70 employed in small companies that are exempt from mandates, and people on disability, half of whom do not work and who often have multiple chronic conditions. Finally, in addition to not targeting our most important metric, hospitalizations, these restrictions have a cost. The most recent Surgeon General's report on the mental health crisis among young people tells a warning tale of the price of ongoing restrictions in their lives.

In light of the transformed landscape COVID-19 vaccines and treatments bring, shifting metrics to guide COVID-19 mitigations from cases to hospitalizations is not only good public policy, but good public health.

Exhibit B

Wastewater COVID-19 Tracking

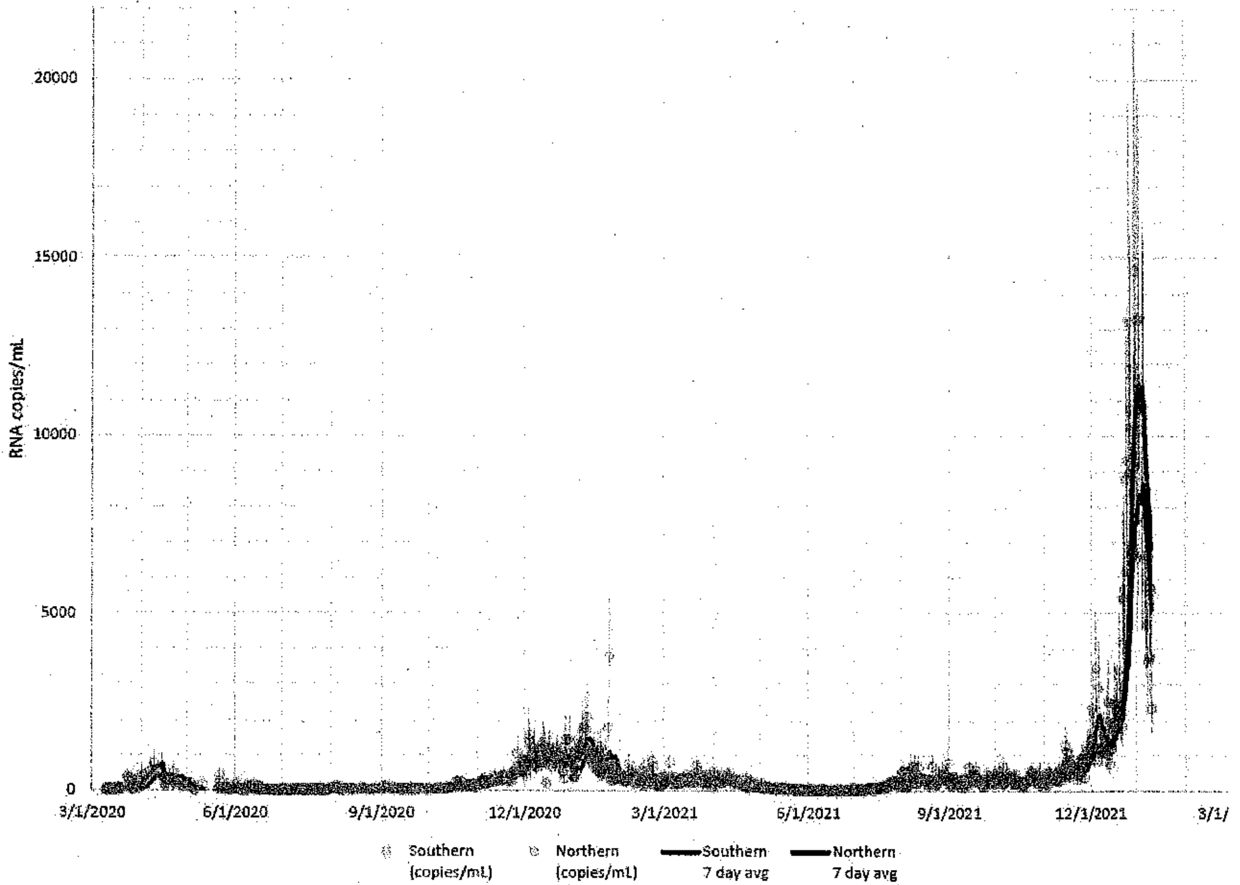
Massachusetts Water Resources Authority

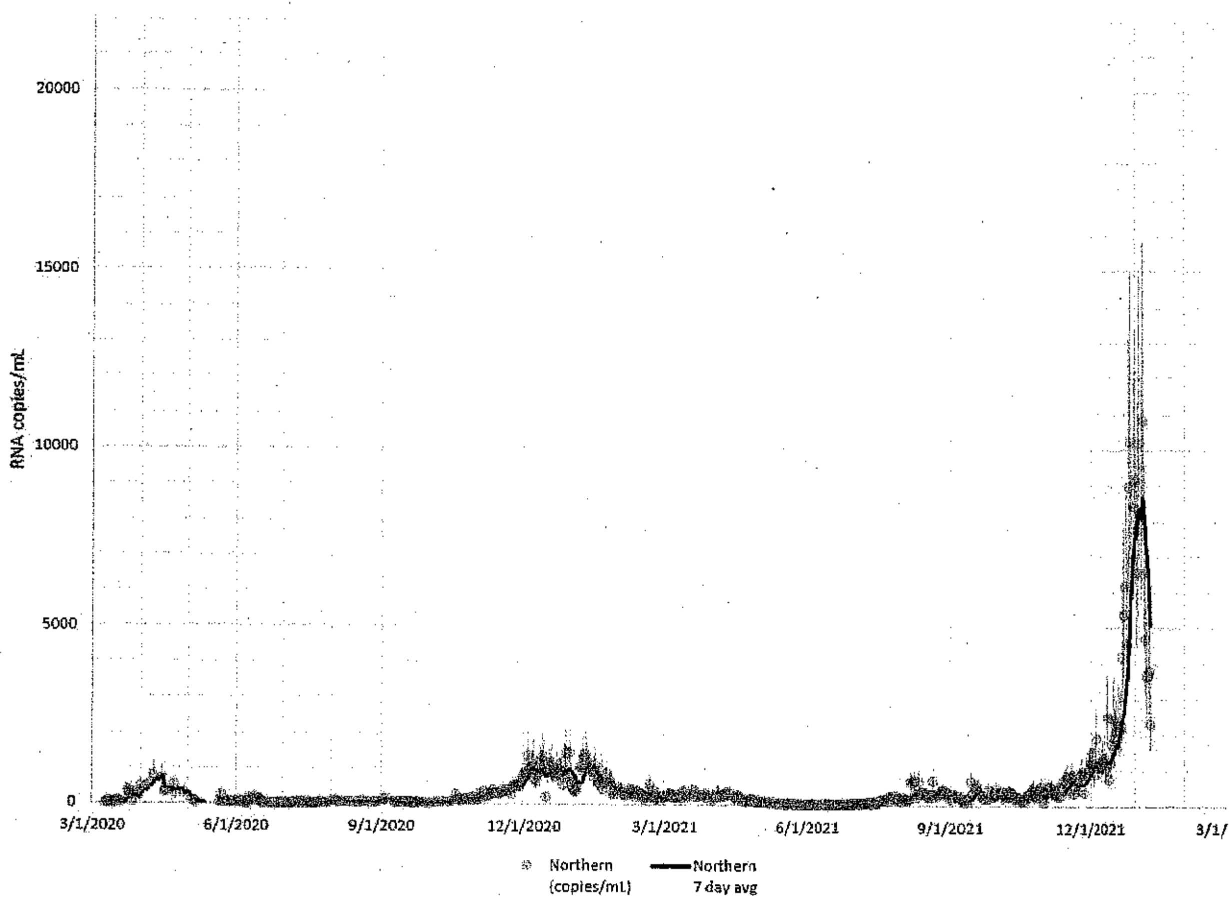
Test results from MWRA's pilot study to track wastewater at the Deer Island Treatment Plant for indicators of COVID-19 infection are posted on this site.

Samples are currently taken 3 - 7 times a week and analyzed by **Biobot Analytics**, a wastewater epidemiology company. Data are updated as received by Biobot fc an internal review process. Please refer to the **Mass DPH website** for information regarding current cases of COVID-19 in your community.

Biobot Data - samples submitted through 01/10/2022

The Omicron variant was detected in a 12/09/2021 wastewater sample from Deer Island South and in a 12/10/2021 sample from Deer Island North.




North System RNA Signal by Date
RNA copies/mL
20000
15000
10000
5000
0
3/1/2020
6/1/2020
9/1/2020
12/1/2020
3/1/2021
6/1/2021
9/1/2021
12/1/2021
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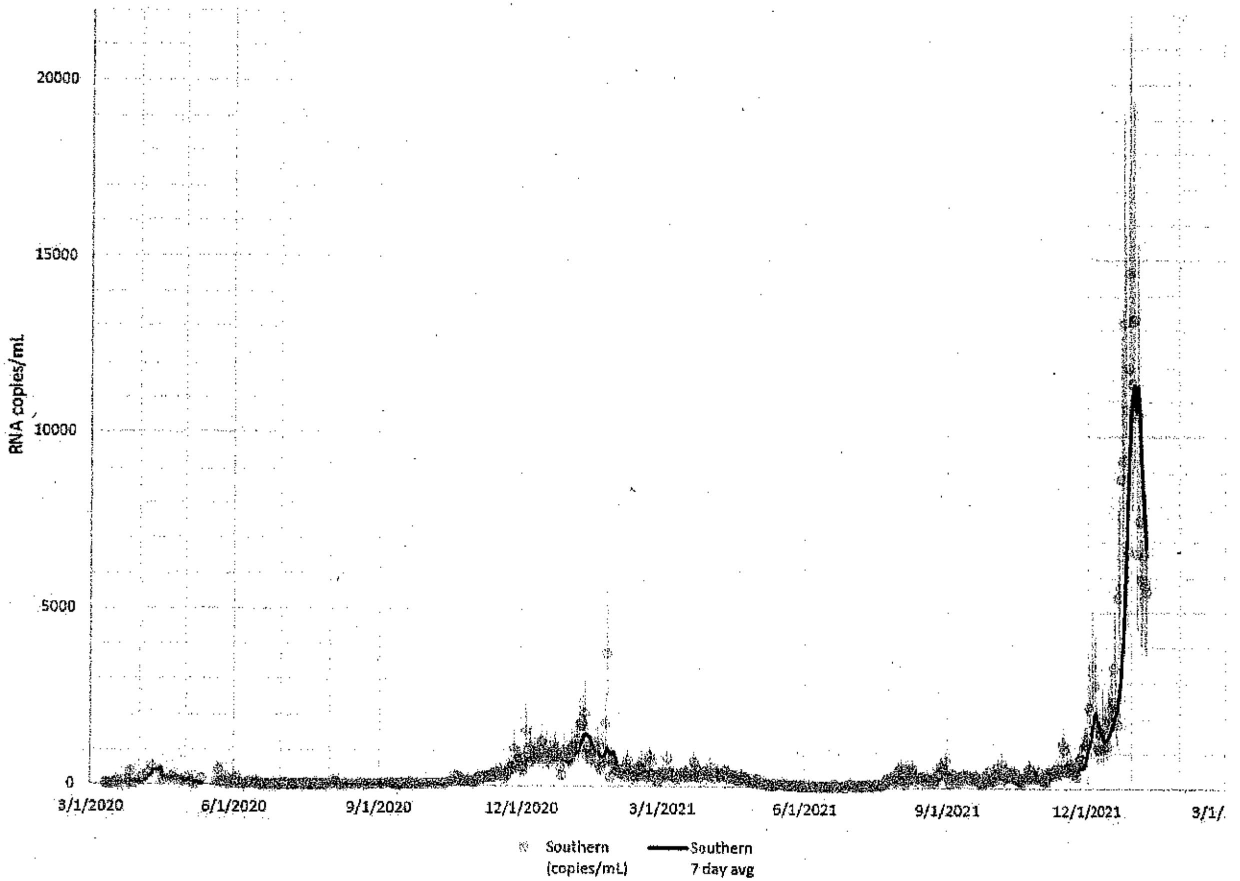
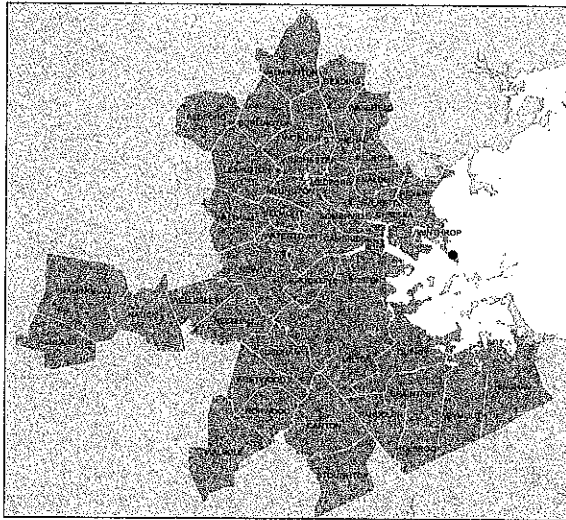
Northern (copies/mL)
Northern 7 day avg



The graphs include error bars which represent the range of result variability caused by laboratory processing.

- The graph with the green dots and error bars represent the North System
- The graph with the orange dots and error bars represent the South System.



To view the data behind the graph, **click here** (PDF).

The data tables include screening results for the B.1.1.7 (UK) variant that Biobot provides **(Biobot has temporarily suspended the variant reporting as of 06/03/20 order to develop updated protocols).**

Additional information regarding the presence of SARS-CoV-2 genetic material in wastewater is available from **EPA** and **CDC**.

Previous charts produced with the former data analysis methods have been ***archived.***

Exhibit C

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Source: https://www.statista.com/statistics/1109011/coronavirus-covid19-death-rates-us-by-state/

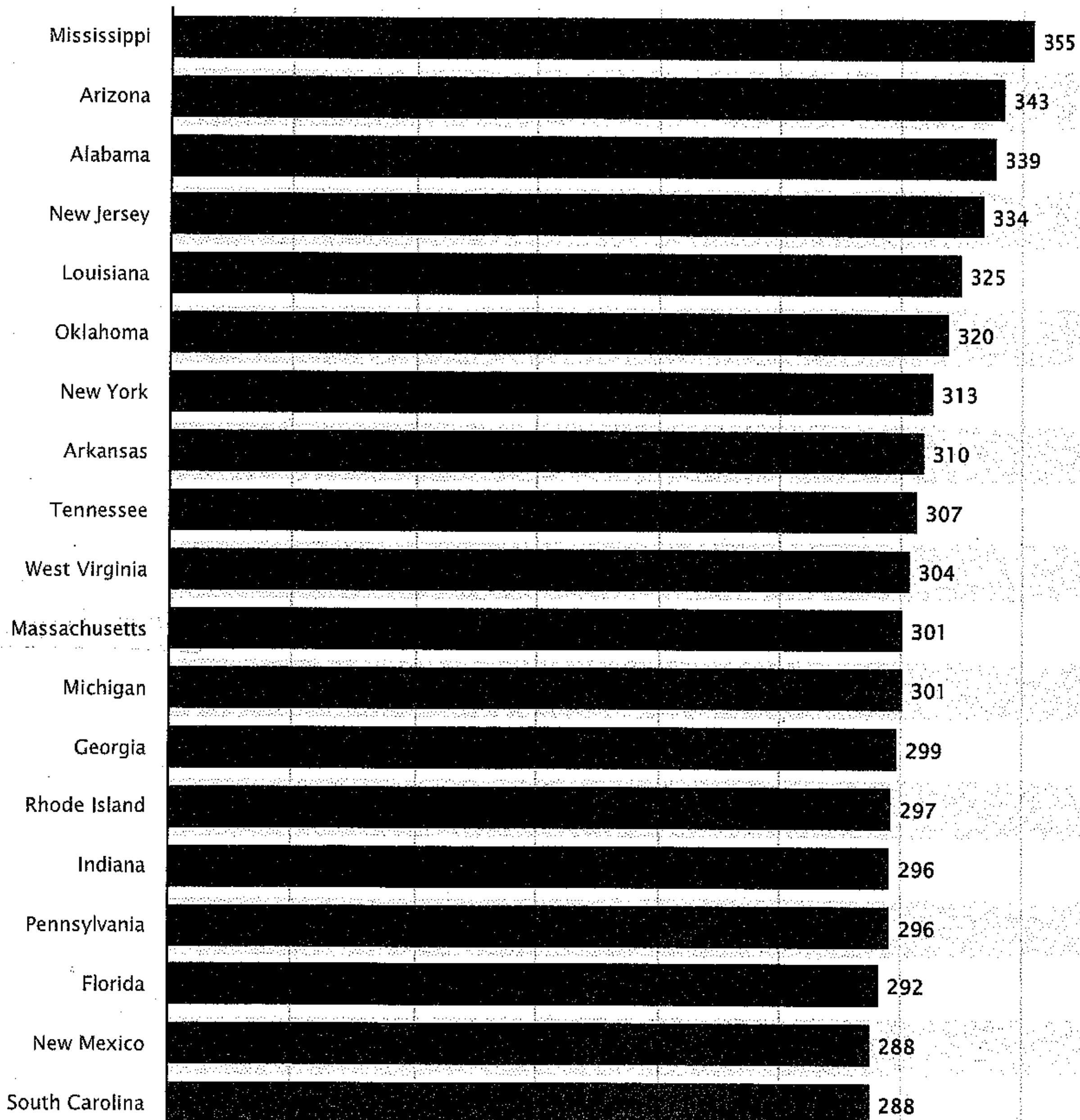
COVID-19 death rates in the United States as of January 12, 2022, by state

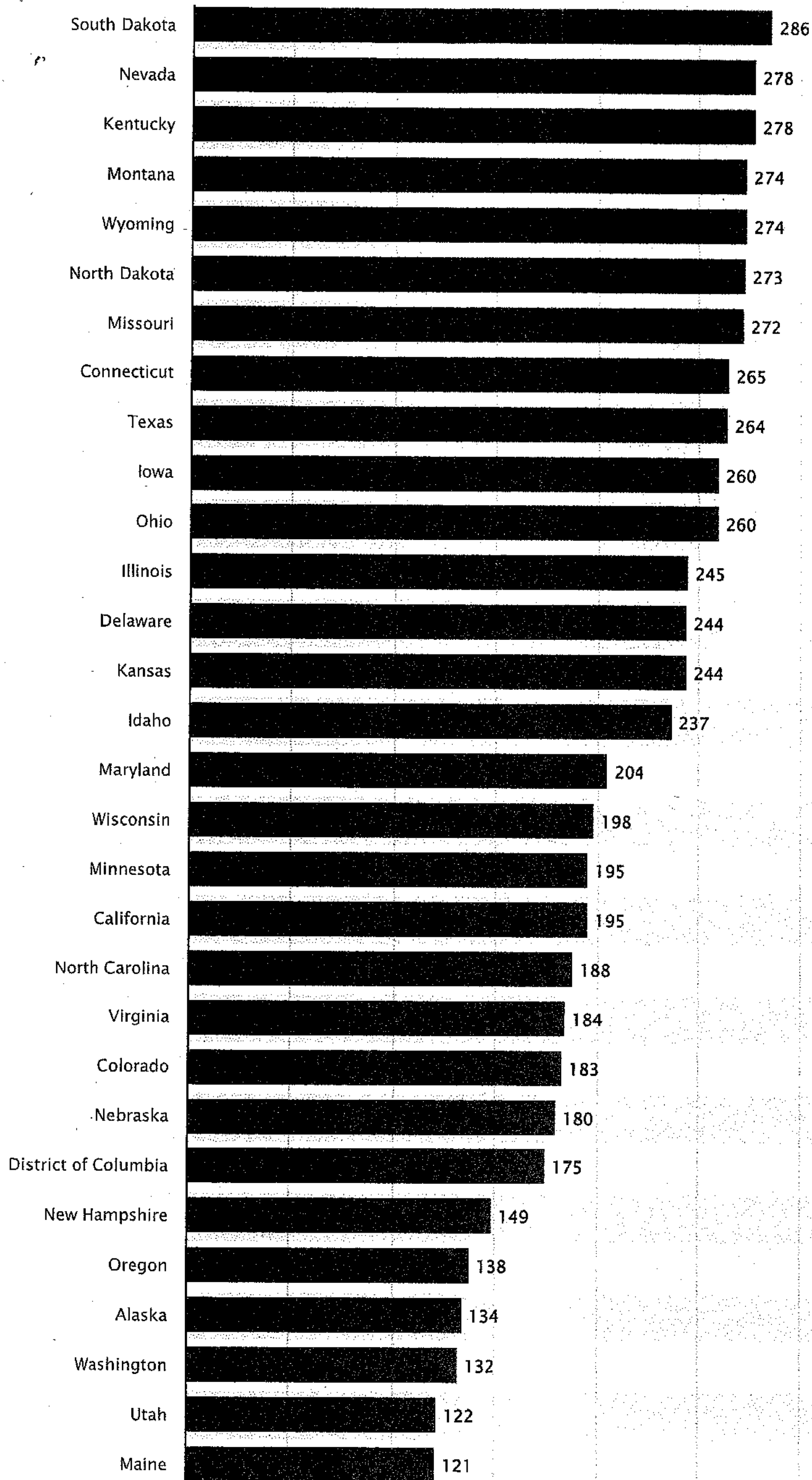
Published by John Elflein , Jan 12, 2022

As of January 12, 2022, the death rate from COVID-19 in the state of New York was 313 per 100,000 people. New York is also one of the states with the highest number of COVID-19 cases.

Death rates from coronavirus (COVID-19) in the United States as of January 12, 2022, by state

(per 100,000 people)




South Dakota
286
Nevada
278
Kentucky
278
Montana
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Wyoming
274
North Dakota
273
Missouri
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Connecticut
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Iowa
260
Ohio
260
Illinois
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Delaware
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Kansas
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Idaho
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Wisconsin
198
Minnesota
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North Carolina
188
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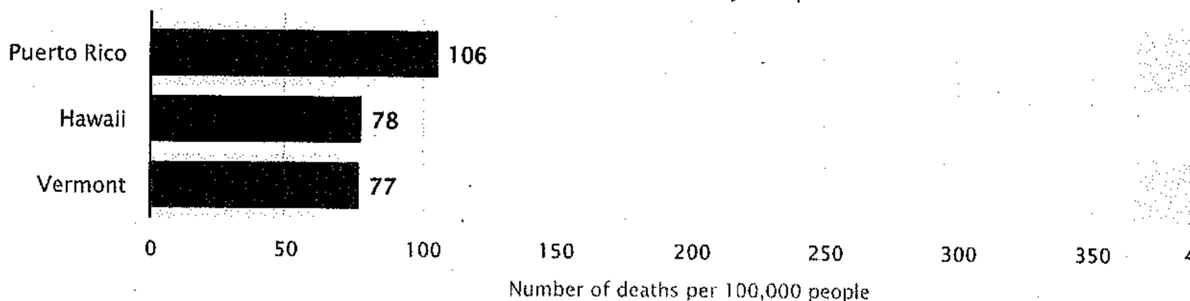

Additional Information

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January 2022

Region

United States

Survey time period

as of January 12, 2022

Supplementary notes

Data are based on reports by states and counties at the time of publication. Local governments may revise reported numbers as they get new information.

For further information about the coronavirus (COVID-19) pandemic, please visit our dedicated Facts and Figures page.

Statista's COVID-19 content is compiled from various sources. Although all of these sources are reliable, this may result in discrepancies in figures among different statistics, graphs, and charts.

Exhibit D

Fines for not wearing masks are discriminatory

- The $300 fine mirrors the one that was in place when we had a state mandate
- But according to the US Census Bureau, Fitchburg is much poorer than the state average.
- Massachusetts median household income $81,215 vs Fitchburg $57,207
- Massachusetts per capita income $43,761 vs Fitchburg $27,007
- Massachusetts poverty rate 9.4% vs Fitchburg 15.7%
- Fitchburg is in the 10 poorest cities in the state for 2021

$300 is a lot of money to a lot of people

- "A large number of Americans have less than $300 in savings, an amount lower than in previous years – reflecting the toll of the pandemic on people's financial health. A new GOBankingRates survey finds that 40% of Americans have less than $300 in savings. This is a drop compared to the pre-pandemic figure of $400 in savings used by the Federal Reserve as a gauge for measuring households' financial well-being."
- Source: GoBankingRates.com

- Homeless people, who often go to the library when the weather is inclement, are also unable to pay a $300.00 fine.
- There is a growing movement to remove financial impositions on people even in criminal matters (such as removing cash bail) – yet you are imposing a penalty for a civil offense that many in Fitchburg cannot afford.