

COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

MAIN CAPITOL BUILDING
ROOM 140

WEDNESDAY, SEPTEMBER 30, 2020
9:01 A.M.

PRESENTATION ON
TREATMENT OPTIONS IN PENNSYLVANIA FOR COVID-19

MEMBERS PRESENT:

HONORABLE KATHY L. RAPP, MAJORITY CHAIRWOMAN
HONORABLE TIMOTHY R. BONNER
HONORABLE JIM COX
HONORABLE VALERIE S. GAYDOS
HONORABLE DAWN W. KEEFER
HONORABLE KATE A. KLUNK
HONORABLE JERRY KNOWLES
HONORABLE CLINT OWLETT
HONORABLE BRAD ROAE
HONORABLE DAN FRANKEL, DEMOCRATIC CHAIRMAN
HONORABLE PAMELA A. DELISSIO

MEMBERS PRESENT VIRTUALLY:

HONORABLE PAUL SCHEMEL
HONORABLE SARA INNAMORATO

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*Pennsylvania House of Representatives
Commonwealth of Pennsylvania*

COMMITTEE STAFF PRESENT:

WHITNEY METZLER

MAJORITY EXECUTIVE DIRECTOR

LORI CLARK

MAJORITY LEGISLATIVE ADMINISTRATIVE ASSISTANT

ERIKA FRICKE

DEMOCRATIC EXECUTIVE DIRECTOR

I N D E X

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SUBMITTED WRITTEN TESTIMONY

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P R O C E E D I N G S

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MAJORITY CHAIRWOMAN RAPP: Good morning, ladies and gentlemen and members of the public. This meeting is being recorded, so I ask that you turn off your cell phones.

We have an interesting panel presentation this morning from physicians and organizations, medical organizations that hopefully, you know, can share with us information about treatment. We have a lot of questions from our constituents about if I have a family member who is diagnosed with COVID, how are they going to be treated?

I'm State Representative Kathy Rapp. I am the Chairman of the Health Committee. And at this point in time I will just turn to Representative Frankel for a few minutes for any opening comments, and then if the Members would please introduce yourself for the hearing.

And for the Members and the public, we will ask all presenters to go through their presentation, and we will hold questions until the end. We know that we are in somewhat of a tight time frame today, so, Members, please be mindful that we will let the presenters do the entire presentation, and then if you have questions at the end, we will try to get some questions in.

1 Representative Frankel.

2 DEMOCRATIC CHAIRMAN FRANKEL: Thank you, Madam
3 Chair. I really appreciate your holding this hearing. I
4 think we're all really very interested and anxious to hear
5 about, you know, how we're treating those who have been
6 diagnosed and infected with COVID and what the prospects
7 are down the road, so clearly, if we're going to reopen our
8 economy, you know, while we wait for a vaccine, you know,
9 the mitigation that is taking place throughout the State
10 with the masks and the handwashing, the social distancing
11 is critical but also the effective way to treat those who
12 have contracted COVID is important as well. So I think
13 everybody's very interested to hear what this group has to
14 say. Thanks so much.

15 MAJORITY CHAIRWOMAN RAPP: Thank you,
16 Representative.

17 Erika, would you like to introduce yourself as
18 the staff?

19 MS. FRICKE: Erika, Democratic Executive Director
20 of the House Health Committee.

21 MAJORITY CHAIRWOMAN RAPP: Representative
22 DeLissio?

23 REPRESENTATIVE DELISSIO: Pam DeLissio, the
24 194th, parts of Philadelphia and Montgomery Counties.

25 REPRESENTATIVE COX: Jim Cox, Lancaster and Berks

1 County, 129th District.

2 REPRESENTATIVE ROAE: Brad Roae, parts of Erie
3 County and Crawford County.

4 REPRESENTATIVE OWLETT: Representative Clint
5 Owlett. I have the privilege to serve Tioga County, parts
6 of Bradford County, and also parts of Potter County.

7 REPRESENTATIVE BONNER: Tim Bonner, 8th District,
8 parts of Mercer and Butler Counties.

9 REPRESENTATIVE GAYDOS: Valerie Gaydos, Allegheny
10 County, 44th District.

11 MS. METZLER: Whitney Metzler, Republican
12 Executive Director.

13 MAJORITY CHAIRWOMAN RAPP: We also have some
14 Members joining us remotely. If any of you joining us
15 remotely want to unmute your microphone and introduce
16 yourself, please do so at this time.

17 REPRESENTATIVE KNOWLES: Yes, Representative
18 Jerry Knowles from Carbon, Berks, and Schuylkill Counties,
19 the 124th District.

20 MAJORITY CHAIRWOMAN RAPP: Representative
21 Innamorato, is that -- I can't see that far, Representative
22 Frankel.

23 All right. Well, thank you, Members. We're
24 going to go ahead and start with our first presenter, Dr.
25 Tracey Conti, who is President of the Pennsylvania Academy

1 of Family Physicians, and, Doctor, welcome. We truly
2 appreciate you being here with us, and we're really looking
3 forward to your presentation. So please feel free to
4 begin.

5 DR. CONTI: Good morning, Chairwoman Rapp and
6 Chairman Frankel and honorable Members of the House Health
7 Committee. As I was introduced, I'm Dr. Tracey Conti. I'm
8 the current President of the Pennsylvania Academy of Family
9 Physicians. I appreciate the opportunity to come and talk
10 about treatment options for COVID with your Committee.

11 I am a Program Director at the UPMC McKeesport
12 Family Medicine Residency Program, and I practice at UPMC
13 McKeesport both in an inpatient and outpatient manner. I
14 am also the Executive Chair for the Department of Family
15 Medicine at University of Pittsburgh School of Medicine.

16 So where we were in March and where we are today,
17 while it is certainly different, there are still questions
18 about COVID, as well as our treatment strategies. There
19 are a lot of unknowns. While we have worked on making sure
20 that everyone wears masks and everyone washes their hands
21 or uses hand sanitizers, our testing and our contact
22 tracing has improved, but there are still some measures
23 that we can do. Of course, masks have become a part of our
24 daily, and we want to ensure that patients, physicians,
25 everyone in the community has access to masks, access to

1 testing, and access to contact tracing.

2 We have seen several challenges with COVID.
3 Beginning in March, it really changed the way we practice
4 medicine. We went from fully in-person to doing the
5 majority of our business as an outpatient and telemedicine
6 type of practice. And the ability for both practices to be
7 able to switch to that type of treatment as well as
8 patients has shown us differences especially with health
9 disparities that I'll talk about a little bit later.

10 For my practice in the residencies we wanted to
11 ensure that we were keeping our patients safe, as well as
12 keeping our providers safe, and so we developed ways to
13 ensure that everyone had their bubble so that we were not
14 interacting as a whole group and really breaking down our
15 practice into smaller fractions to reduce the chances of
16 our whole practice being eliminated from being exposed to
17 COVID.

18 Because we do both inpatient and outpatient, we
19 left our outpatient teams to make sure that they stayed
20 outpatient and they weren't really interacting with our
21 inpatient teams. And at the beginning before we knew much
22 about COVID and the transmission, we made sure that there
23 were gaps between the times that those practices changed
24 over to an outpatient setting from an inpatient setting.

25 Through the inpatient setting, we really depended

1 on our system, and I'm grateful to work for an amazing
2 system that developed protocols that we were able to
3 utilize as a community hospital to treat our patients with
4 COVID. In our hospital we actually developed a COVID unit
5 to ensure that everyone was maintaining proper PPE, that
6 everyone was reducing the chances of contamination for
7 other patients by containing everybody on one unit, and we
8 were able to really ensure safety for our patients and for
9 our providers utilizing that model.

10 Because we are a community hospital, we also
11 wanted to make sure that there were interdisciplinary
12 rounds so that we involved pharmacy, critical care, primary
13 care, case management, infectious disease, and palliative
14 care in the treatment plans for our patient to ensure the
15 best outcomes possible.

16 My personal story is right after I was installed
17 as the Pennsylvania Academy of Family Physician President,
18 we were thrown into this world of COVID. And little did I
19 know how much outreach our State family physicians would
20 need to be able to practice medicine and to care for the
21 patients in their communities. We did a lot with making
22 sure that our members were informed about current CDC
23 strategies, as well as legislative guidance for
24 telemedicine, as those -- that information was quickly
25 changing.

1 At the time, my father also became ill, and it
2 was at a time that we were not allowed to go and see
3 patients in the hospital when they were COVID-positive
4 because they were trying to reduce the ability of
5 transmission of disease. And so it was difficult from a
6 personal level to have a family member in the hospital
7 being cared for and not being able to see them. Since
8 then, strategies have improved to allow a family member to
9 be able to be with their loved one in order to help care
10 and help provide that care for patients.

11 I also had a temperature and developed a cough
12 and was concerned that I was exposed to COVID. And having
13 to stay away from my job, having to isolate myself from
14 family members became difficult, and I was grateful that we
15 had telemedicine that I could actually visit a physician
16 online to be able to send me to testing. I was grateful
17 that I had the ability to actually drive to that testing
18 and get that in an expedient manner. However, we know that
19 that is not the case for everyone. And access to testing
20 is something that we continue to strive to provide because
21 there are patients out there that don't have the ability to
22 go to a testing site and really need localized testing in
23 their communities. We have worked with the Allegheny
24 County Health Department in my community to be able to do
25 that and to work with federally qualified health centers to

1 ensure testing availability for all.

2 Our other concern is really a vaccine and
3 vaccination especially as we move into this flu season and
4 to be able to ensure that all of our patients and all of
5 our staff are vaccinated for flu so it can mitigate some of
6 the symptoms that may cross over between the flu and COVID
7 and so that we can ensure that we are treating our patients
8 appropriately. So we really recommend that everyone is
9 vaccinated against the flu, and that will help us
10 especially with our testing with COVID and the flu. We
11 again are grateful for our system because they do have a
12 protocol of how we are going to approach testing when
13 someone comes in for flulike symptoms and what tests to do
14 versus COVID versus the flu, but having the flu vaccination
15 will help us mitigate duplicate testing for COVID and the
16 flu.

17 We want to make sure that this House Committee
18 knows that we have been active in trying to make sure the
19 public knows that the family physician offices are open and
20 that we want to care for our patient whether that be in a
21 virtual or an in-person realm, and we also want to make
22 sure this Committee understands that family physicians are
23 actively trying to get our patients to be vaccinated,
24 especially for flu in this upcoming season.

25 We continue to promote social distancing. Some

1 people call it safe physical distancing versus social
2 distancing because we still want to be social, but we do
3 want to have that physical distance, and also making sure
4 that everyone wears masks all the time when they're in a
5 potential exposure setting. And this will help us prevent
6 the spread of COVID and potentially other seasonal
7 respiratory illnesses during this flu season.

8 The scope and breadth and intensity of family
9 medicine sometimes is overlooked in moments like this. We
10 learn from these experiences how to provide the best care
11 for our patients and see the areas that need to be
12 addressed both now and in the future. In the work that's
13 being done in an interdisciplinary manner with regards to
14 COVID is really humbling. It has allowed us to face and
15 really promote some of the ideas that we felt were really
16 important to be able to care for our community.

17 And telemedicine has really shown to be a
18 valuable tool. It allows us to connect with patients who
19 are feeling ill without bringing them into the office to
20 expose them to other patients and other staff. It allows
21 us to diagnose any risked exposure. However, we do note
22 that not everyone has the ability to access video
23 telemedicine, and so it's so important for us to continue
24 to be able to provide care by phone and that there be
25 parity in payment for tele-video and telephone visits. As

1 we know that there is a digital divide in our community and
2 to address health disparities, we must be able to care for
3 our vulnerable patients that don't have access to
4 broadband.

5 We also see the need to invest in the primary
6 care workgroup and especially the family physicians of
7 tomorrow. We want to make sure and we appreciate the
8 passing of a bill in order to look at how we are training
9 our future physicians to become primary care providers.

10 We've also notice prior authorization and the
11 reforms to ease administrative burdens on the physician
12 community and to ensure that we are giving our patients
13 timely care.

14 And then lastly, as we move from this crisis
15 phase and respond to long-term patient management and
16 population health strategies, we really want to take a hard
17 look at the social determinants of health. COVID-19, while
18 it is not brought health disparities to our community, it's
19 certainly highlighted it. And so how do we as a group be
20 able to combat health disparities from multisector levels
21 because it cannot just be health and the importance of
22 providing adequate environmental programs and job programs.
23 So every sector really has to be involved. And this is
24 where we look at health in all policies.

25 So thank you again for allowing me to testify and

1 for your attention in this ongoing important issue.

2 MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

3 Are you able to stay for questions at the end?

4 DR. CONTI: Yes.

5 MAJORITY CHAIRWOMAN RAPP: Thank you very much.

6 DR. CONTI: Thank you.

7 MAJORITY CHAIRWOMAN RAPP: We very much

8 appreciate you being here.

9 And our next presenter is Dr. Neil -- I apologize
10 if I mispronounce the name -- Rellosa.

11 DR. RELLOSA: Yes, that's correct.

12 MAJORITY CHAIRWOMAN RAPP: Oh, welcome. And we
13 had your little description here. You're the HIV Program
14 Director and Attending Physician with duPont Hospital for
15 Children. And you certainly feel free, sir, to add to
16 that, but you may begin your presentation. Thank you for
17 agreeing to present to us today.

18 DR. RELLOSA: Thank you. Thank you to all the
19 Members of the Health Committee for inviting me today to
20 speak to you. As mentioned, my name is Dr. Neil Rellosa.
21 I'm a pediatric infectious disease doctor for Nemours
22 Children's Health System, Nemours/Alfred I. duPont Hospital
23 for Children. And I'm pleased to offer testimony today on
24 COVID-19 treatment and advancements as it specifically
25 pertains to children.

1 For those of you who are not familiar with
2 Nemours, we provide care to a vast area but specifically in
3 Pennsylvania to the greater Delaware Valley, including a
4 strong presence in southeast Pennsylvania. We provide
5 satellite specialty care, primary care, and work with
6 partnerships with Pennsylvania hospitals to provide family-
7 centered care to children all across the region. Our
8 partnerships include Thomas Jefferson University Health
9 System and Main Line Health in southeast Pennsylvania, and
10 we serve close to 90,000 children in Pennsylvania annually.
11 And our numbers keep on expanding as we utilize telehealth
12 and other means to reach across the Pennsylvania area.

13 I personally provide inpatient consultation care
14 for those Pennsylvania partnership hospitals, and I have
15 two outpatient infectious disease clinics in the State, one
16 being in Center City, Philadelphia. I am a Pennsylvania
17 resident and grew up in the Philadelphia area.

18 Like many healthcare systems, not only in
19 Pennsylvania but across the country and worldwide, as Dr.
20 Conti mentioned, we have been learning on the fly and have
21 really come a long way in a relatively short period of
22 time. Nemours has strived to not only be at the forefront
23 in terms of treating pediatric and adolescent patients
24 affected by COVID-19, but we continue to try to stay ahead
25 of the curve in terms of advancements, treatments,

1 technology and really be a model for other health
2 institutions in terms of treating pediatric and adolescent
3 patients with COVID.

4 While the impact in children, as many of you
5 know, has not been as severe in adults, we at Nemours have
6 seen our share of children of all ages and all backgrounds
7 affected by this disease. And we know that this disease,
8 even when one family member is affected, affects the entire
9 family. And I'm happy to share with you our experience at
10 Nemours and hopefully help you better understand how we
11 approach pediatric patients.

12 Treatment always starts with properly identifying
13 those affected and making a timely diagnosis. And at the
14 beginning of the pandemic Nemours quickly obtained COVID-19
15 testing, including securing multiple methods of testing,
16 testing that not only provided rapid results as quickly as
17 one hour but accurate results. We were one of the first
18 and still remain one of the healthcare institutions in our
19 area to set up mobile testing centers to offer testing
20 specifically for children of all ages in a safe and quick
21 manner. Testing children can be a challenging thing as
22 opposed to adults because of their age, and we were able to
23 mobilize those resources and do it effectively.

24 We are also able to offer or to perform a test
25 for every child admitted to our hospital for whatever

1 reason they were being admitted for and provide testing for
2 all of our patients prior to their surgical procedures,
3 which allows us to identify those who may be asymptomatic
4 but infected.

5 Moving forward, Nemours has secured the latest
6 testing that will allow us to test simultaneously not only
7 for COVID-19 but other seasonal viral infections such as
8 influenza, so we are able to identify truly who are the
9 patients infected with COVID and who may be the patients
10 who are infected with other infections and effectively care
11 and treat those patients.

12 Fortunately, although we have identified hundreds
13 of children infected with COVID-19, most have not required
14 hospitalization. But for those who have been admitted to
15 our hospital, there have been several who have required
16 intensive care and aggressive treatment. Again, at the
17 beginning of the pandemic, our hospital and healthcare
18 system quickly mobilized our resources, similar to what Dr.
19 Conti mentioned, to form a cohort unit to care for all
20 COVID-positive patients in one designated location in our
21 hospital. This unit had highly trained personnel, properly
22 trained in the proper isolation practices and treatments in
23 order to not only provide optimal and streamlined care for
24 those patients but to ensure safety of the families and the
25 noninfected patients and our staff who are in our hospital.

1 You know, one of the unique challenges of
2 pediatrics in terms of hospitalized patients is that unlike
3 adult hospitals where visitation might be limited, we need
4 to allow parents and healthcare providers into our
5 hospitals who might also be infected, and so our approach
6 has needed to dictate that we take the proper precautions,
7 again, to protect all of the people in the hospital,
8 including those parents who are with their child.

9 Drawing from the expertise of our multiple highly
10 trained specialists in emergency medicine, intensive care,
11 infectious diseases, we also developed treatment protocols
12 for our infected patients who were hospitalized and really
13 looking at the latest established therapies for the care of
14 these children. As many of you might know, medical
15 advances, medical research usually lags behind in
16 pediatrics as compared to our adult counterparts, and so
17 it's a big challenge in terms of making sure we have the
18 latest and most up-to-date scientific information to be
19 able to treat our patients.

20 We work very closely with our local health
21 departments and FDA to obtain antiviral medication such as
22 remdesivir, which has been shown to be the most effective
23 treatment when it comes to severely affected patients, but
24 also we have in the context of clinical trial and sound
25 medical science research used other therapies such as

1 convalescent plasma and other anti-inflammatory medications
2 to successfully treat the patients that we have had in our
3 hospital. And I'm proud to say that we have had no deaths
4 associated with COVID-19 in our hospital.

5 We continue to stay informed and look to see what
6 are the latest treatment options and participating in
7 research to be able to contribute not only to the field of
8 pediatric medicine but to help us move forward in terms of
9 treating our patients.

10 One of the unique areas of the pandemic in the
11 field of pediatrics has been the identification of an
12 entirely new disease entity associated with COVID-19
13 infection called multisystem inflammatory syndrome in
14 children, or MIS-C. For those of you who are not familiar
15 with MIS-C, this is believed to be a post-infectious
16 inflammatory condition that can affect children weeks after
17 their acute infection and can severely affect multiple
18 areas of their body, including their heart. It can cause
19 pediatric patients to be severely ill. And although this
20 is a relatively rare disease entity, we at Nemours have
21 seen several of these patients, mostly older children and
22 adolescents.

23 We again have taken a multidisciplinary approach
24 to treating these patients, utilizing the expertise of our
25 specialist physicians, including cardiology, rheumatology,

1 critical care medicine, hematology, and infectious diseases
2 like myself and have devised protocols to not only diagnose
3 but treat these patients. We have used combination
4 therapies to treat these children with MIS-C, including
5 using a medication that we use for other inflammatory
6 conditions called intravenous immunoglobulin or IVIG, which
7 is unfortunately in short supply here in this country as it
8 stands, along with using other therapies such as steroids
9 and anti-inflammatory medications. Again, we have been
10 successful in getting these patients better relatively
11 quickly and without mortality, and we continue to actively
12 research and study these patients in order to become more
13 adept at the care of these children.

14 Although we have learned a lot, as I've pointed
15 out, and have been successful in treating children, there
16 is still much we don't know and especially in terms of the
17 long-term effects of both COVID-19 infection and MIS-C in
18 children. And part of our treatment is not just in the
19 hospital but to continue care once those patients are
20 discharged from the hospital. Those patients that are
21 severely infected will have follow-up care long-term with
22 our cardiologists to monitor for lasting and chronic
23 problems as it pertains to the heart, and it's an ongoing
24 vigilance in terms of making sure that we are identifying
25 and caring for those patients long term.

1 For those pediatric patients that are not
2 requiring hospitalization, Nemours has trained our primary
3 care physicians and our frontline providers to educate
4 patients and their families on supportive care at home and
5 advised them how to reengage in terms of returning to
6 social activities and how best to prevent the spread of a
7 disease in accordance with the latest scientific knowledge
8 and current recommendations from our local and national
9 health institutions.

10 As Dr. Conti also mentioned, we have utilized
11 precautions in our outpatient clinics, including really
12 expanding our child health capabilities and providing a
13 safe environment for patients to return to our inpatient
14 offices and clinics.

15 Additionally, echoing the same sentiment that Dr.
16 Conti mentioned, too, we've encouraged during this period
17 of time for families of patients to keep up with their
18 childhood vaccinations, which has been a problem that has
19 plagued us additionally during this pandemic and definitely
20 going into this season encourage and mobilize our resources
21 to make sure that all of our patients receive influenza
22 vaccine, which is important to have during this period of
23 time.

24 We've also remained vigilant in terms of
25 monitoring and quickly acting to treat our most vulnerable

1 children who may be at greater risk for COVID-19 infection,
2 including our cancer patients and transplant patients and
3 those patients that we have who have chronic problems with
4 their heart, lungs, and immune system.

5 Additionally, although transmission of COVID-19
6 from mother to baby is uncertain and at least very rare, we
7 have worked with our local birthing hospitals and centers
8 to ensure safe and optimal care for those babies born to
9 COVID-19-infected mothers.

10 Lastly, similar to the observations that we've
11 seen across the country in our adult patients and that Dr.
12 Conti also mentioned, we have a disproportionate number of
13 children of lower socioeconomic status and children of
14 color, including Black and Latino patients, who have been
15 affected by COVID-19. And Nemours has worked diligently to
16 continue to search for ways to bridge that gap to continue
17 to provide high-quality care for all of our communities'
18 children.

19 I just want to again say thank you to the
20 Committee for giving me the opportunity to share what we've
21 been doing at Nemours and our experience through this
22 unfortunate and troubling time. While we at Nemours are
23 uncertain when this pandemic will end, we are certain that
24 the work that we've been doing, the hard work of all of our
25 staff and providers and administration and frontline people

1 have been helping. We hope that we can count on
2 Pennsylvania for continued support and future assistance
3 with resources and allow us to continue to treat with the
4 great care the children and families of Pennsylvania.

5 And I'll end there. Thank you for your time.

6 MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.
7 Will you be able to be available at the end of everyone's
8 presentation for questioning?

9 DR. RELLOSA: Yes, I can stay on.

10 MAJORITY CHAIRWOMAN RAPP: Okay. Thank you so
11 very much. Then we will see you back in a few minutes.

12 DR. RELLOSA: Great.

13 MAJORITY CHAIRWOMAN RAPP: Our next presenter is
14 Dr. John Goldman, who is an Infectious Disease Specialist
15 at UPMC Pinnacle Health. Dr. Goldman, nice to see you.
16 Thank you for being willing to present to the Health
17 Committee today. And, sir, you may begin.

18 We do not have sound from you right now, Doctor.

19 DR. GOLDMAN: I always forget to turn off my
20 mute.

21 MAJORITY CHAIRWOMAN RAPP: There you go. Now we
22 can hear you. Thank you, sir. You may proceed.

23 DR. GOLDMAN: Thank you. I'm John Goldman. I'm
24 an Infectious Disease Specialist at UPMC Pinnacle here in
25 Harrisburg. I've actually been leading some of our

1 response to COVID.

2 What I would like to stress is that we've had
3 incredible what I believe is success with dealing with this
4 disease. We've learned a tremendous amount about how to
5 treat it. I believe that we've actually seen a decrease in
6 mortality. We've learned a tremendous amount about how to
7 keep people safe. We've seen basically no transmission of
8 COVID within our hospitals.

9 And I think I want to stress how the frontline
10 workers truly stepped up. You have to remember that this
11 disease first appeared on this earth in December. In other
12 countries there were a large number of healthcare workers,
13 doctors, and nurses who got sick and the simple bravery of
14 the physicians, the simple bravery of the nurses really in
15 stepping up and taking care of very sick patients when it
16 was not clear that it was always safe.

17 We initially had our spring surge, nothing like
18 what we saw in other parts of the country. I think in our
19 seven-hospital system we saw that had a maximum census of
20 about 60 patients. We had many more patients initially in
21 the intensive care unit, and we had many more patients who
22 passed away, especially early in the pandemic.

23 We fortunately always had enough personal
24 protective equipment. We relatively quickly figured out
25 that we needed to mask basically all of the healthcare

1 workers, all of our employees. And, as a result,
2 initially, we saw some transmission, though none from
3 provider to patient, patient to provider, really more
4 provider to provider since we've been masking patients,
5 masking everyone. We have not seen any transmission within
6 our hospitals. In addition, we obviously screen people.
7 We obviously discourage them from coming in when they're
8 sick. We've essentially been able to keep the hospitals
9 very safe.

10 If you go to our intensive care units, right now,
11 we still have several COVID patients, and you'll see the
12 ventilators outside of the door. You'll see any drips that
13 they need outside of the room. You'll see that we really
14 have through what I consider to be ground-level creativity
15 had figured out ways where we minimized where providers
16 would have to go in and out of the room. We maximized the
17 safety. We also rapidly switched to telemedicine. We can
18 actually do telemedicine within the hospital for some
19 specialties, for some consults, and within a period of just
20 a couple of weeks we went from 5 or 10 percent telemedicine
21 visits to I believe close to half. We went from a couple
22 hundred to a couple thousand.

23 During the course of this time, we also have
24 learned a tremendous amount about treating the disease. We
25 very widely use steroids, which have been shown to decrease

1 mortality 20 percent in patients with mild disease and 30
2 percent in patients with severe disease. And we've also
3 been using remdesivir, which is the drug that has been
4 shown to decrease length of stay. It hasn't as easily been
5 shown to decrease mortality, but our clinical impression is
6 that using the combination of steroids and remdesivir
7 greatly reduces mortality. We've in fact seen fewer
8 deaths. We've in fact seen fewer people end up in the
9 intensive care unit.

10 We are actively awaiting further treatments. We
11 are actively awaiting vaccines. We are trying to vaccinate
12 as many people as possible for the flu specifically so we
13 don't have to figure out whether they have influenza or
14 whether or not they have COVID. We plan to be much more
15 aggressive about vaccinating people for the flu than we
16 have in previous years.

17 I do think that we need continued support of the
18 community. Fortunately, in our area we haven't seen the
19 kinds of surges you've seen in other parts of the country.
20 In the State we're seeing 600, 800 cases a day. In Dauphin
21 County we've kind of seen 20, 30 cases a day since the
22 spring. We do feel that social distancing, we do feel that
23 masking helps prevent that spread.

24 I would really give the message that we have been
25 able to learn a lot about this disease. I believe we've

1 been able to decrease the mortality of this disease. I
2 believe that we've been able to keep our hospitals be
3 extremely safe. Despite at times having a large number of
4 COVID patients, there's been basically no transmission. I
5 tell people that I actually feel safer in our ICU where we
6 have very sick COVID patients than I often do out in the
7 community.

8 And I think I really want to credit the people
9 who stepped up, the physicians, the nurses who were
10 extremely dedicated, extremely creative in both figuring
11 out how to best treat this disease, how to best keep people
12 safe, and I believe acted with true bravery. Thank you
13 very much.

14 MAJORITY CHAIRWOMAN RAPP: Thank you, Dr.
15 Goldman. Again, we were waiting till the end of all the
16 presenters before the Members ask questions. Will you be
17 available with us around, let's see, around 10 o'clock
18 to --

19 DR. GOLDMAN: Yes, I will.

20 MAJORITY CHAIRWOMAN RAPP: Okay. Thank you so
21 very much. I'm sure we'll have some questions for you.

22 So our next presenter is Dr. Derek Angus -- I
23 think I'm pronouncing your name right -- who is the Chief
24 Healthcare Innovation Officer for UPMC. So, Doctor, you
25 may proceed with your presentation.

1 DR. ANGUS: Thank you very much. Thank you,
2 Chair Rapp, Chair Frankel, and honorable Members of the
3 Health Committee for the opportunity to testify before you
4 today. As Chair Rapp just mentioned, my name is Derek
5 Angus. I'm an intensive care physician, a researcher,
6 healthcare administrator and my current title is, in
7 addition to Chief Healthcare Innovation Officer for UPMC,
8 I'm the Associate Vice Chancellor for Healthcare Innovation
9 at University of Pittsburgh. And I'm also Professor and
10 Chair of the Department of Critical Care Medicine at the
11 University of Pittsburgh and Physician Director of UPMC's
12 ICU Service Line.

13 I've spent 25 years studying critical illness and
14 in particular studying sepsis and pneumonia. I'm also
15 Senior Editor at *JAMA* and I've been actively involved in
16 the evaluation of potential therapies for COVID-19. I
17 currently serve on the steering committees for the NIH
18 PETAL Network, which is a clinical research network engaged
19 in several of the Operation Warp Speed active programs and
20 of the REMAP-CAP network, an international clinical trials
21 platform.

22 I want to say that I have enjoyed greatly
23 listening to the three prior experts, and I would say I
24 agree with all of their sentiments. There's a couple of
25 small clarifying points I might make, but in general, I

1 would also say that it's been an inspiring time to work
2 with my Pennsylvania clinician colleagues in the response
3 to this threat and to see the way in which people have
4 stepped up.

5 I'm going to offer comments on COVID-19, on
6 current therapy, and on some promising avenues of research
7 related to future treatments. It's important to know that
8 COVID-19 is absolutely still a raging global pandemic. The
9 rate of new cases worldwide is actually still increasing,
10 so the rate at which the number of people are being
11 diagnosed is continuing to grow. And furthermore, as we've
12 noticed, many regions in the United States and many
13 countries around the world are actually going into second
14 waves, so there's recurrent waves. This is unusual in
15 comparison to, say, H1N1, influenza epidemics where a place
16 tended to see a wave and that was it.

17 Among those tested, the mortality rate is ranging
18 between 2.5 and 5 percent. There are, however, many
19 individuals who have mild or asymptomatic infection and are
20 therefore not included in the denominator if they're not
21 tested. The actual mortality rate is therefore probably
22 about tenfold lower.

23 The general strategy for the development,
24 evaluation, and administration of treatments for COVID-19
25 is to think about agents that target the virus directly,

1 agents that attempt to manipulate the body's own immune
2 response to the virus in part because that immune response
3 is not effective in fighting the virus or because the
4 immune response is injurious to the body itself, a bit like
5 an autoimmune disease where essentially the body is harming
6 itself through friendly fire from its own response. And
7 then, finally, a third strategy is to think about general
8 supportive care for the body functions that become
9 compromised such as supportive care for respiratory failure
10 or for cardiovascular shock.

11 For patients who are mildly ill and do not
12 require hospitalization, there are currently no therapies
13 that help either by reducing symptoms or by avoiding
14 disease progression. All the effort thus far has been
15 therefore focused on patients who are hospitalized. For
16 patients who require hospitalization, the primary approach,
17 as alluded to by the prior speaker, has been to provide
18 supportive care, and in particular cornerstones of
19 treatment have included provisional respiratory and
20 ventilatory support as needed ranging from simply putting
21 on supplemental oxygen to invasive mechanical ventilation
22 and even in some rare occasions placing patients on a
23 device called ECMO or extracorporeal membrane oxygenation
24 that's essentially an artificial replacement for the heart
25 and lungs.

1 Broadly speaking, hospitals here in Pennsylvania
2 and worldwide have reported improvement in patient outcomes
3 over time. There are multiple reasons that might explain
4 why outcomes are improving, but one plausible explanation
5 suggested by the last speaker with which we concur is that
6 clinicians have become more familiar with the disease and
7 therefore are likely anticipating instances where patients
8 might experience precipitous declines and are deploying
9 supportive care more wisely and efficiently.

10 Moving from supportive care to antivirals, there
11 are several antiviral therapies that have been tested or
12 are being tested in clinical trials. We now know that
13 agents such as hydroxychloroquine and the HIV drug Kaletra
14 have not been shown to be effective.

15 The only antiviral thus far that has been shown
16 to be potentially effective is remdesivir. One NIH lab
17 trial suggested remdesivir could shorten the need for
18 hospitalization from 15 to 11 days. However, importantly,
19 not all patients benefited in that trial. In particular,
20 the sicker patients did not appear to get benefit. And
21 subsequent clinical trials, including a recent clinical
22 trial supported by Gilead, the makers of remdesivir, either
23 failed to show benefit or reported mixed results.

24 Nevertheless, remdesivir is available. It's in
25 an intravenous formulation, and it's available under an

1 emergency use authorization from the FDA. Though there
2 were initial shortages, including here in Pennsylvania,
3 there is now currently adequate supply to meet demand in
4 Pennsylvania and is being used both here and across the
5 country.

6 Importantly, at UPMC our perspective is that more
7 clinical trials are necessary for remdesivir. We do not
8 believe that we know the exact correct patients in whom to
9 use it. Nonetheless, we totally agree that the results are
10 promising, and if our physicians want to prescribe
11 remdesivir, we're typically administering it as a five-day
12 course for patients with mild oxygen requirement because
13 trials suggesting patients with no oxygen requirement maybe
14 didn't benefit, maybe they did, and patients who are sicker
15 were not shown to benefit in the NIH trial. There are no
16 other antiviral agents approved, and notably, because
17 remdesivir is only available as an intravenous formulation,
18 it has no immediate practical role outside the hospital.

19 The most compelling advance in treatments so far
20 is manipulation of the body's own immune system with
21 corticosteroids. Following an initial report from the
22 United Kingdom suggesting that a short course of
23 dexamethasone improved mortality among hospitalized
24 patients who had respiratory compromise, several other
25 trials in the same types of patients have found similar

1 results not only with dexamethasone but even with other
2 corticosteroids, and so it is now standard of care to give
3 a course of steroids to all patients with COVID-19 who
4 require at least significant oxygen or invasive
5 ventilation. That's our policy at UPMC. That's endorsed
6 actually across the world and has even been recently
7 incorporated into a WHO standard of care guideline.

8 However, there is no benefit to use of steroids
9 in milder disease and indeed in a very large British study
10 there was no obvious benefit in the hospitalized patients
11 who didn't at least require oxygen.

12 Now, corticosteroids dampen the immune system,
13 which presumably is beneficial when the body's own response
14 is so bad that it's compromising breathing functions in the
15 form of friendly fire. However, the same dampening effect
16 may have no net value when there is less harm from the
17 body's immune system, i.e., in milder cases.

18 There does remain considerable interest in other
19 more targeted immune system manipulation, and many groups
20 here in the U.S. and around the world are evaluating a huge
21 number of immune modulator drugs that have narrower effects
22 than the broad effects of steroids targeting currently
23 hospitalized patients but looking at milder hospitalized
24 patients, as well as severe disease. However, although
25 they are under trials, nothing has clearly been shown,

1 published, or made available to be incorporated into
2 treatment guidelines.

3 Another key manifestation of the body's response
4 to COVID-19 is a proclivity to develop potentially life-
5 threatening thrombosis or clots in blood vessels. And we
6 have many drugs already typically called blood thinners
7 that can prevent clots, but these agents themselves carry
8 the important side effect of potential life-threatening
9 bleeding or hemorrhage. And an open question therefore is
10 the optimal timing, dosing, and indication for use of blood
11 thinners in COVID-19. This question is a key priority for
12 the NIH and for other groups around the world.

13 University of Pittsburgh is actually the
14 coordinating center for ACTIV-4, one of the Operation Warp
15 Speed programs that will be evaluating the role of heparin,
16 a very common blood thinner, in COVID-19 hospitalized
17 patients, as well as in outpatients as well, and several
18 clinical trials will be rolled out in the coming months.

19 Finally, an alternative solution for targeting
20 the virus directly is to use antibodies directed against
21 the virus. Now, the most crude approach to find and give
22 these antibodies is to administer the plasma from
23 convalescing patients who developed their own antibodies to
24 the virus. And many tens of thousands of patients in the
25 United States have actually received convalescent plasma,

1 and that led to a recent EUA or emergency use authorization
2 by the FDA to give convalescent plasma. Notably, however,
3 none of the convalescent plasma was tested in randomized
4 trials, and so many groups, including the NIH and UPMC,
5 believe that convalescent plasma should not be used outside
6 clinical trials. We have it available under the EUA, but
7 we would prefer to see convalescent plasma tested in trials
8 first.

9 Another approach is to manufacture antibodies,
10 and there are multiple different ways to construct such
11 therapies, and this has been a major activity in the
12 biotech and pharma industry both here in the United States
13 and worldwide, and there are actually hundreds of
14 antibodies under development. Among the many hundreds of
15 choices, some of the most discussed because they're the
16 furthest down the road in evaluation include an antibody
17 developed by Eli Lilly, a combination antibody being
18 developed by Regeneron, and an antibody being developed by
19 GSK. There are of course many other such antibodies
20 including, for example, a novel small antibody developed by
21 my colleagues at UPMC and Pitt.

22 Now, some of these antibodies themselves, unlike
23 the other drugs, are being tested in milder patients,
24 including in outpatients with the goal of avoiding
25 progression of disease, and a preliminary report from Eli

1 Lilly actually in just the phase 1 study suggested that use
2 of antibody could avoid need for hospitalization. However,
3 none of these agents have yet been shown in definitive
4 large-scale trials to be beneficial. If one is successful,
5 it is likely that the earliest clear evidence, the very
6 earliest would be the end of this quarter and more likely
7 sometime in 2021.

8 So in summary, there is an intense worldwide
9 effort to develop and evaluate treatment strategies for
10 COVID-19. At this point, however, the only clear
11 demonstration of benefit has been for a course of
12 corticosteroids in the most sick patients. There is mixed
13 evidence suggesting that remdesivir may also help, but we
14 would like to see more trials. There are many ways to
15 potentially use antibodies, and there's a strong scientific
16 rationale for such an approach, but we will not likely have
17 any specific therapy that is both proven and available for
18 many months.

19 Having said all of that, however, healthcare
20 systems both here in Pennsylvania and around the world are
21 absolutely appearing to get better at caring for patients
22 with COVID-19 already. And part of that appears to be due
23 to experience gained from treating many patients already in
24 particular with supportive care.

25 And with that, thank you very much.

1 MAJORITY CHAIRWOMAN RAPP: Thank you very much,
2 Doctor. Will you be available in a few minutes if we have
3 time for questions?

4 DR. ANGUS: Yes.

5 MAJORITY CHAIRWOMAN RAPP: Thank you.

6 Our next presenter is Dr. Joseph Zawisza -- I'm
7 sorry if I'm mispronouncing your name -- who is the
8 President-elect of the Pennsylvania Osteopathic Medical
9 Association. Doctor, please begin.

10 DR. ZAWISZA: Thank you. And that was perfect,
11 and I appreciate that pronunciation.

12 Good morning, Chairwoman Rapp, Chairman Frankel,
13 and Members of the House Health Committee, and thank you
14 for this opportunity to provide testimony before you on
15 treatment options for COVID-19.

16 As you stated, my name is Joseph Zawisza. I'm a
17 Doctor of Osteopathic Medicine, and I'm born, raised,
18 educated, and currently live and practice in a rural
19 primary care setting in Schuylkill County, Pennsylvania.
20 I'm part of a small group practice of three primary care
21 physicians who collectively see about 3,500 patients per
22 year. And I did my training at Geisinger Medical Center in
23 Danville in internal medicine and pediatrics [inaudible]
24 medical school in Philadelphia and my undergraduate degree
25 at Mansfield University in Tioga County.

1 I'm not an infectious disease expert. As I said,
2 I'm a primary care physician, and I'm not on the frontlines
3 of developing a vaccine [inaudible] and just as important a
4 role in this fight and would like to give another
5 perspective and ways to help control and defeat this
6 pandemic.

7 I see over 1,000 patients a year in rural
8 Pennsylvania, and what I can tell you is that from my
9 experience many patients over the past eight months have
10 come to my office confused, scared, worried about things
11 that they saw or read on the internet, heard from news
12 sources, saw on Facebook, or just heard from talking to
13 other people. These outlets have told my patients what
14 they should take or should be doing to help prevent or
15 treat COVID-19, and some of this information is good, but
16 some of it is not so good. And many of the concerns
17 expressed my patients are not supported by scientific
18 evidence.

19 As one patient recently put it to me, although
20 more colorfully, we don't know what to believe. And
21 another stated to me, trust your doctor. That's the only
22 person you know that you can trust.

23 What I tell my patients is what I'm going to tell
24 you right now, which is that to date there's not one
25 treatment that is recommended exclusively or preferentially

1 for COVID-19. While scientific and medical information,
2 data, resources, and guidelines should always be used to
3 make the best possible decision for each patient's
4 treatment, the importance of each patient's specific
5 clinical condition can never be understated. So
6 understanding that COVID-19 is a disease unlike anything
7 the medical community has seen previously, treatments
8 should be based on the most current medical and scientific
9 information and data available.

10 Due to the rapidly changing nature of COVID-19,
11 information that osteopathic physicians use to guide the
12 treatment of their patients may not always be of the same
13 rigor generally expected of evidence-based medicine.
14 However, the Pennsylvania Osteopathic Medical Association
15 encourages osteopathic physicians to seek and employ
16 recommendations that have been most appropriately
17 determined. With information changing so fluidly, it seems
18 inappropriate to mandate that all physicians treat all
19 patients with a specific treatment that has not been proven
20 to be the best therapy for all patients.

21 Throughout the course of this pandemic, medicine
22 and politics have intertwined because each affects the
23 other, but neither is the master of the other. Elected
24 officials like you, I understand, are charged with
25 representing the people who elected them, and you have an

1 extremely difficult job during this pandemic. I know
2 you're all doing your best to provide your constituents
3 with information that will better their lives, and knowing
4 the questions that I get in my office, I can only imagine
5 some of the questions that you get in your offices.

6 As I shared previously, we are constantly
7 learning about COVID-19, and we're advancing our scientific
8 knowledge daily towards better treatment and ultimately a
9 vaccine. My advice for you as you talk with your
10 constituents who have questions about treatment for COVID-
11 19 is to encourage them to talk with their primary care
12 physician, ask them to trust their doctor.

13 To that end, the position of POMA, as well as my
14 personal opinion, is that osteopathic physicians should be
15 the primary source of information for their patients and
16 consider all aspects of a patient's condition and all
17 appropriate medical and scientific information when
18 treating patients with COVID-19. I tell my patients all
19 the time that Google is designed to treat 7 billion people,
20 but I'm designed to treat you.

21 I thank you for inviting POMA and myself to
22 testify this morning, and I'll be happy to answer any
23 questions that you may have. Thank you.

24 MAJORITY CHAIRWOMAN RAPP: Thank you, Doctors. I
25 truly appreciate all the testimony this morning. And if

1 there's one thing I have to take away from this session,
2 this hearing, is how we in Pennsylvania are obviously very
3 blessed with the level of expertise in our medical
4 profession, including being part of Operation Warp Speed,
5 which I didn't know till today. But I do believe that just
6 from what I've heard that the level of expertise that we
7 have in Pennsylvania surely is outstanding in this Nation,
8 and we certainly appreciate all of you and all of the
9 facilities, the nurses being on the frontlines in the midst
10 of this pandemic.

11 And it's amazing sitting here and hearing the
12 progress we've made and actually some people think it's a
13 long time, but it probably is truly in your eyes a
14 relatively short time considering all the research and
15 everything else.

16 I just want to make sure that all of our other
17 physicians are online. I see two. And I am not going to
18 ask any questions. I'm going to ask Representative Frankel
19 if you have some comments or questions, but I am going to
20 leave the rest of my time for the Members to ask questions.

21 Oh, okay, after Representative Frankel --

22 DEMOCRATIC CHAIRMAN FRANKEL: Thank you.

23 MAJORITY CHAIRWOMAN RAPP: -- and Members, then
24 after Representative Frankel we will be taking questions.
25 My thanks to all of you presenting today. I myself learned

1 very much about treatment and what's going on in
2 Pennsylvania. Thank you for all that you do.

3 Chairman Frankel.

4 DEMOCRATIC CHAIRMAN FRANKEL: Thank you, Madam
5 Chair. And let me concur with Chair Rapp, this was a very
6 informative hearing, listening to the testimony. I
7 certainly agree that, you know, we are blessed here in
8 Pennsylvania to have the expertise that we heard today and
9 are encouraged, I think, by many of the things we heard
10 both in terms of the progress that's been made in terms of
11 treatment and mitigation and in research that you all are
12 engaged in.

13 Let me ask you, you know, one of the things that
14 I think has been of concern even before COVID was the
15 increasing skepticism and opposition to vaccinations
16 generally. And now we are faced with, you know, Operation
17 Warp Speed, which, you know, God willing, will provide us
18 with an effective vaccine. And we're also faced with the
19 issue of making sure that we get broad-based flu
20 vaccinations done throughout the State of Pennsylvania, all
21 this in an environment I think where, you know, the issue
22 of vaccinations generally has become politicized but also
23 now increased skepticism even among those who were not
24 skeptical about vaccinations before, because of the issue
25 of trying to rush a vaccination for preventing COVID. You

1 know, how would you build confidence in vaccines in this
2 environment?

3 DR. RELLOSA: I'm happy to answer that question.
4 Again, this is Neil Relloso. And one of the pediatric
5 infectious disease doctors. You know, vaccine hesitancy
6 and refusal is a major issue that we face in pediatrics
7 almost on an everyday basis, and, you know, again, during
8 this time period not only thinking about the future with
9 COVID-19 vaccine but also during this period of time and
10 keeping up with already-established routine childhood
11 immunization, it's been difficult.

12 And I think at least when I try to approach it in
13 terms of talking with families and patients about their
14 hesitancy to receive immunizations, I think there's two
15 things that we need to draw on that have been emphasized
16 during this hearing this morning. One is the science,
17 really going to -- even for laypeople to help them
18 understand that these vaccines have been vetted and have
19 been trialed on multiple levels not only from industry but
20 also at the government level in terms of that and then in
21 the academic science realm to really emphasize that and
22 give them that.

23 And then the other thing is really having a good
24 established relationship between the medical provider and
25 the family and cultivating that trust that they have, as I

1 think our last speaker said, in terms of that, you know, we
2 are here to take care of you on a one-to-one basis, and
3 having trust in us. And that's incumbent also of all
4 medical providers being well-versed in vaccines and
5 immunizations and helping families to understand.

6 DR. CONTI: I also agree with trust and
7 establishing that trust not only with your direct patients
8 but in the community, and that takes community engagement,
9 so working with partners who are doing education in the
10 community, who are addressing issues of health equity, and
11 actively addressing the mistrust in the medical community
12 and specifically targeting those communities to be able to
13 educate about all vaccines but especially in relationship
14 to a new COVID vaccine. That relationship between a
15 provider and patient is of utmost importance. It has to be
16 valued, but also that provider's relationship within the
17 entire community, and so working with churches or social or
18 community organizations to be able to go out and provide
19 the education for members.

20 MAJORITY CHAIRWOMAN RAPP: Is that all,
21 Representative Frankel? Thank you. Thank you, sir.

22 DEMOCRATIC CHAIRMAN FRANKEL: I may have another
23 question, but I'll allow other Members to weigh in, and if
24 we have time --

25 MAJORITY CHAIRWOMAN RAPP: Thank you, Mr.

1 Chairman. Our first question comes from Representative
2 Knowles, who I believe is joining us remotely, virtually.
3 Representative Knowles, do you want to unmute your
4 microphone?

5 MALE SPEAKER: It looks like he actually logged
6 off.

7 MAJORITY CHAIRWOMAN RAPP: He logged off. All
8 right. Representative Jim Cox.

9 REPRESENTATIVE COX: Thank you, Madam Chair.

10 I heard I think it was just one testifier that
11 even mentioned something we've kind of heard about in the
12 news for a number of months. I've had constituents contact
13 me about it, and it's still an ongoing question in regards
14 to its accessibility, and that is the use and/or
15 recommendation of hydroxychloroquine.

16 Back in May I think it was there was a doctor out
17 of Yale, Dr. -- I think it's Dr. Risch if I'm pronouncing
18 it correctly. He issued a study or had a study published
19 at the end of May. Since that time, there's been seven
20 other studies that have followed up on it and have further
21 validated his study, his report, including four studies
22 that were done in the United States in nursing homes and
23 clinics.

24 And so as my constituents and others around
25 Pennsylvania have looked at this, it seems as if

1 hydroxychloroquine has been another one of those highly
2 politicized things as well. We heard about the health
3 risks, and yet, as my constituent who contacted me and even
4 someone I'm very close to in my district has told me
5 they've been on hydroxychloroquine for other purposes for
6 years, and these side effects are not as dangerous or not
7 as prevalent as some people would like to say.

8 So with all that said, I'd like to ask the
9 question, you know, have you reviewed the studies by Dr.
10 Risch? Have you personally look through and analyzed it or
11 has it been one of those things where the CDC came out and
12 said we're not recommending it, and so you set it aside?
13 What has been your personal experience and your personal
14 delving into those studies on an academic level?

15 DR. ANGUS: Sure. So I think I was the person
16 who mentioned hydroxychloroquine. This is Derek Angus
17 speaking, so perhaps I can go first. So the study from
18 Yale and a number of studies have reported using so-called
19 what's called an observational design that patients treated
20 with hydroxychloroquine appeared to fare better, but the
21 potential study weakness in that design is that you may
22 have given hydroxychloroquine to patients who were always
23 going to fare better. And so that's why the standard
24 evaluation that's used around the world to really prove
25 drug efficacy is traditionally a randomized clinical trial

1 where then the two groups really would have the same
2 outcomes unless the drug was making a difference.

3 In the randomized trials of hydroxychloroquine,
4 there are now several randomized trials in hospitalized
5 patients that have overwhelmingly shown no improvement with
6 hydroxychloroquine. There were several thousand patients
7 randomized in the recovery trial in the United Kingdom.
8 There's been a large Brazilian placebo-controlled study
9 published in the *New England Journal of Medicine* about six
10 weeks ago. And we in the PETAL Network conducted the
11 ORCHID trial, which enrolled many patients in Pennsylvania,
12 and that trial also found there was no benefit.

13 You are completely correct that in the randomized
14 trials there wasn't a major safety signal.
15 Hydroxychloroquine in a subset of patients can cause
16 problems, but of course it is a drug used widely and has
17 been for decades, and so it can be used moderately safely.
18 And it just simply has been -- there has been no
19 demonstration that it improves the course of disease in
20 hospitalized patients.

21 Now, you also mentioned what about giving it to
22 patients, say, in nursing homes at risk. And the answer is
23 we don't know the answer. There are no large-scale
24 randomized trials in at-risk populations. There had been a
25 desire to do some, including, for example, in healthcare

1 workers, but those trials have had trouble recruiting, and
2 some of them are now pivoting or abandoning those trials.

3 REPRESENTATIVE COX: Okay. You mentioned
4 hospitalized patients and you kind of circled back around
5 and mentioned a couple of times about patients that had
6 been hospitalized, so that's pretty far along in terms of
7 care. What Dr. Risch has advised repeatedly and those who
8 also support the approach, he talks about the immediate
9 early use. That's a common phrase --

10 DR. ANGUS: Yes.

11 REPRESENTATIVE COX: -- that he utilizes
12 repeatedly. And those local doctors I've talked to, those,
13 you know, my constituents are hearing from, it's that
14 immediate early use perhaps at the first onset of some of
15 the symptoms, et cetera, that he's kind of focusing on
16 saying, look, this is an early treatment that we can get
17 out there and we can do a lot of preventative --

18 DR. ANGUS: Yes.

19 REPRESENTATIVE COX: -- medication if you will.
20 What are your thoughts on that?

21 DR. ANGUS: Yes, so it's an entirely legitimate
22 possibility. People's enthusiasm for this potential role
23 dropped when there was the lack of benefit shown in the
24 hospitalized trials. But you are accurately pointing out
25 that early prevention, it could be effective even if it

1 doesn't work at treatment. The answer is from our position
2 that ought to be tested in a trial. We would still be
3 nervous about widescale deployment outside a clinical trial
4 in this clinical setting. There had been an intent to do
5 prevention trials, including funded by the Federal
6 Government. There's a large study called the HERO study
7 coordinated out of Duke and funded by PCORI that was going
8 to try to recruit, for example, healthcare providers who
9 would be at risk of getting COVID and seeing whether they
10 could take hydroxychloroquine as a type of early treatment
11 and/or prevention, but it has had trouble enrolling.

12 So science is not meeting your needs, sir, in
13 that we have been unable to generate the evidence one way
14 or the other. And the problem is there are so many things
15 to test and there's only so much time and energy and so
16 many patients. So it's a fair question, and we don't know
17 the answer.

18 REPRESENTATIVE COX: Okay. The reason I'm
19 focusing on it is I had a constituent that had talked about
20 heart disease and how his family had heart disease for
21 generations and his doctor put him on I guess it was
22 aspirin as kind of a preventative measure. And this
23 particular constituent kind of tossed out the idea of, you
24 know, if I get these types of symptoms, I'd like to have
25 something that could potentially prevent me from

1 progressing rapidly. And if this is such an inexpensive
2 medication with what you've already described and others
3 have described as a relatively rare risk, there's a subset,
4 as you mentioned, but by and large it's something that's in
5 wide use and has been for a long time, quick thoughts on
6 that sort of approach as, again, more of a preventative
7 measure? With such a low cost, what do we have to lose?
8 It seems like we only have room to gain.

9 DR. GOLDMAN: This is John Goldman. I would also
10 point out that four randomized controlled trials that show
11 hydroxychloroquine doesn't work, including postexposure
12 prophylaxis, including in mild disease. There's really no
13 reason to give a drug without evidence, especially to a lot
14 of people. And I think it tells you something that when
15 you try to enroll healthcare workers in trials, they're
16 passing on it.

17 I personally have a lot of experience using it in
18 hospitalized patients. We used it early on, and it really
19 didn't seem to have much of an effect. The trials have
20 supported that. But every trial, every controlled trial
21 that has looked at hydroxychloroquine has shown that it
22 doesn't have an effect, so I don't know anyone who has --
23 it is something we used very early on. I think we had
24 evidence that it didn't work, and I think most of us have
25 stopped using it. There isn't any good evidence-based

1 medicine that this is an effective treatment. Thank you.

2 MAJORITY CHAIRWOMAN RAPP: Thank you,
3 Representative. Thank you, Doctors. I know a lot of us
4 see a lot of things on the news, as one of our presenters
5 alluded to, so it's something we hear from our constituents
6 all the time. I really appreciate your answers on this,
7 but I don't think this is an issue that's going away.

8 But, Representative Knowles has joined us.
9 Representative Knowles, do you have your question, sir?

10 REPRESENTATIVE KNOWLES: I do, Madam Chair. And
11 I apologize for any confusion I may have caused in
12 participating driving down Interstate 81. I apologize for
13 that.

14 And thank you, Madam Chair, for calling this
15 hearing. I think what I've heard is going to be very
16 helpful to me in the future.

17 And certainly, Dr. Joe, I have to say hi to my
18 friend Dr. Joe, a Schuylkill County guy.

19 DR. ZAWISZA: Hello.

20 REPRESENTATIVE KNOWLES: Good to see you, Doctor.
21 I have one question. None of us, with very few exceptions,
22 have taken this pandemic lightly. You know, it's been
23 something that we've never had to deal with before in our
24 lives. But I heard about people whose health was neglected
25 because they were not given a test or maybe not seen by a

1 doctor or, you know, that they just weren't seen as a
2 priority. And you hear stories of people who have
3 continued to have health problems and whose health problems
4 have worsened because they weren't able to get in to have
5 their problem dealt with. So I would wonder if you could
6 comment on that.

7 And the second part of my question would be if we
8 would have a major wave, what effect do you believe it
9 would have on our healthcare system if we were to go into
10 such a lockdown mode again in terms of treating people who
11 have serious health problems that need to see a doctor?

12 DR. ZAWISZA: If I could speak from the access
13 standpoint, the first part of the question, you know, one
14 of the problems that we saw in our primary care office
15 early on was patients weren't coming in, and that was not
16 unique to myself. That was a problem that was happening
17 nationally. You know, one of the questions that I got
18 commonly is what do I do if I need to go to the hospital
19 and there's no hospital beds? And in my area of the State
20 and in many areas of the State there were plenty of
21 hospital beds. I know, you know, several hospitals in my
22 area laid off employees and closed floors, so I think that
23 goes back to misinformation, bad information. I'm not
24 saying that that was the case everywhere, I understand
25 that, but I think that's where we all have a responsibility

1 to make sure our patients, our constituents, the public has
2 accurate information.

3 Certainly, there were days in the beginning where
4 we were in our office, we had plenty of appointments, but
5 everyone was scared to come to the doctor, and I think, you
6 know, that's something that we need to make sure it doesn't
7 happen again if we get a second wave, knowing when it is
8 safe to go to your doctor, when it's not, allowing doctors
9 to screen patients appropriately to make sure that we are
10 bringing patients into a setting that is appropriate to
11 handle their condition while not endangering the rest of
12 the public.

13 So, again, I go back to my main point, which is
14 trust your doctor, talk to your doctor. They're the ones
15 who know exactly what's going on in your community.

16 DR. RELLOSA: This is Neil Rellosa again. I
17 would say again in terms of talking about access, it has
18 been mentioned a number of times during this hearing about
19 telehealth services. While telehealth services are not a
20 substitute for in-person visits and in-person care, I think
21 it has been a vital part of how all of us have been able to
22 approach and treat patients, triage patients, and do all
23 that.

24 And so opening up avenues, especially
25 administrative avenues in terms of flexibility for medical

1 providers in terms of licensing, in terms of access, in
2 terms of all those things that the State can help provide
3 to be able to serve our patients and do it safely, do it
4 remotely, do it by telehealth, whatever means that we can
5 do I think is an important part of the conversation.

6 DR. CONTI: Our organization has -- well, let me
7 take my mask off, sorry. Our organization also has had
8 access as a key issue, and we actually launched a campaign
9 across the State to let patients know that family physician
10 doors are open, and in the information page it talks about
11 we're open in a variety of ways both in-person and through
12 tele-video and telephone. And I think that's important
13 just to get the message out to patients that their primary
14 care physicians want to see them. We are practicing safety
15 and have adequate PPE to ensure patients feel more
16 comfortable, but it goes back to that trust issue again and
17 ensuring our patients have a trusted provider that they
18 know that we are looking out for their health.

19 DR. ANGUS: Yes, I would say that this is
20 definitely an important concern, and there are some
21 emerging studies absolutely that suggested that other non-
22 COVID diseases potentially suffered at healthcare systems
23 in the midst of COVID surgings. I want to reassure you
24 that at UPMC this has always been high on our mind, and
25 even in the midst of when we were preparing for a potential

1 surge back in March and April, part of the reason for
2 thinking about telemedicine, PPE, and so on was not simply
3 so that we could provide best care to patients with COVID-
4 19 but so that we would continue to be doors open whether
5 in reality or virtually. We would provide absolutely the
6 care we seek to always provide, and that would be true even
7 in the middle of an epidemic. Should we get another major
8 surge in Pennsylvania, we hope we do not, we fully intend
9 to both handle the surge and be able to continue providing
10 all other aspects of care for all non-COVID disease.

11 MAJORITY CHAIRWOMAN RAPP: Thank you, Doctors.
12 Thank you, Representative.

13 Representative Tim Bonner.

14 REPRESENTATIVE BONNER: Thank you, Madam Chair.

15 And thank you, physicians, for your great work
16 and for appearing here today and providing your testimony.

17 My first question, have we seen any increase in
18 the infection rates for school-age children or staff since
19 the reopening of schools?

20 DR. RELLOSA: So this is Neil Rellosa again. You
21 know, it's still early, and we're still gathering data, so
22 it's hard to absolutely say. I think the issue surrounding
23 reopening of schools is a complex one and really is maybe
24 individualized in terms of specific regions, specific
25 school districts, and specific schools, so it's difficult

1 to say. We know in general that more so than we expected
2 in the beginning of this pandemic that children are not
3 symptomatically affected as much but they can be
4 asymptomatic carriers and definitely contribute to the
5 transmission of infection.

6 That being said, we also know that if strategies
7 are in place, we can mitigate that somewhat and be able to
8 in some instances have children return to school, which is
9 an important part of their development. So I don't have an
10 exact answer in terms of rates, but I think it's something
11 that we are continuing to monitor and see.

12 REPRESENTATIVE BONNER: Can you also comment on
13 why minority children or adults are being infected at a
14 greater rate?

15 DR. RELLOSA: Again, I think this is a complex
16 issue. I think, as I believe Dr. Conti first talked about,
17 the disparities that we see in health, you know,
18 specifically towards underrepresented minorities and those
19 in socioeconomically lower status are not new but are just
20 more obvious and more augmented during this pandemic. I
21 think it's complex in terms of a lot of the issues, again,
22 we've already talked about in terms of access to care,
23 technologies that are available. But it's a real issue and
24 a real issue that we all need to think about and how best
25 to address it.

1 REPRESENTATIVE BONNER: Then finally, why are
2 there far less hospitalizations now than in the early days
3 of the pandemic if there are no effective medical
4 treatments for those who never enter the hospital?

5 DR. ANGUS: Yes, so, that's a great question.
6 And again, people can only hypothesize. One of the things
7 that people throw out is that the virus is changing, and I
8 would say to that that all viruses do change. They undergo
9 almost constant genetic mutation. Having said that, we're
10 not sure that we've seen compelling evidence that the
11 underlying genetic mutations have had any major functional
12 change in the behavior of the virus. So while it's
13 possible, we have not proven that it's the virus itself.
14 It's probably more likely that this is an artifact of both
15 who we're recording as cases because of changes in the way
16 we're testing and changes in behaviors among human beings
17 such that it's a different type of patient who's getting
18 infected.

19 So right off the bat, for example, some of the
20 surge was among younger, healthier people. And younger,
21 healthier people, when they get infected and then infect
22 other people, can quite quickly create a large population
23 of relatively healthy people with disease. Relatively
24 young, healthy people with disease will keep spreading it
25 until they touch populations who have a higher likelihood

1 of having a worse course such as elderly patients or
2 patients with underlying comorbidities. You will see a big
3 spike of the disease without too many hospitalization. The
4 poster child for that was the outbreak on the U.S. aircraft
5 carrier where actually a huge number of young, healthy
6 sailors became infected but I think only one person got so
7 sick that they required hospitalization.

8 REPRESENTATIVE BONNER: Is there any thought that
9 we're much quicker to hospitalize in the early days of the
10 pandemic than we are now?

11 DR. ANGUS: I think it's highly likely that our
12 thresholds for who we test and when we hospitalize changes
13 over time, but it could be changing in that both the
14 threshold is lowering or going up. It's hard to know. One
15 of the big problems about understanding any of this is the
16 actual denominator every infected patient has been
17 constantly shifting sands. With the absence of totally
18 broadscale ability to efficiently and easily test everyone,
19 we're constantly never too sure about who the total
20 population is that's being infected.

21 And so you are asking incredibly insightful and
22 thoughtful questions, but for every question you ask,
23 there's at least two or three plausible answers, and we
24 can't tell you which one is more true than the other.

25 REPRESENTATIVE BONNER: All right. I appreciate

1 your appearance today and your testimony and your great
2 work. Thank you.

3 MAJORITY CHAIRWOMAN RAPP: Thank you,
4 Representative.

5 Our last question will be from Representative
6 Valerie Gaydos.

7 REPRESENTATIVE GAYDOS: Hi. And thank you all
8 for making your presentations. I think this was incredibly
9 insightful for all of us to hear from you in the different
10 health systems.

11 Secondly, I'd like to thank all of you, the
12 frontline workers, for handling this for us. We really
13 appreciate that.

14 And one of the things that we in the legislature
15 tried to do is put a lot of funding towards making sure
16 that you get the PPE, masks, gloves, gowns. I know that
17 you had mentioned that some of you said you had enough.
18 I've heard some places don't have enough. You know, what
19 can we do to make sure that those allocations that we in
20 the legislature put forth get to you and down into the real
21 frontline workers?

22 MAJORITY CHAIRWOMAN RAPP: Anyone, I guess --

23 REPRESENTATIVE GAYDOS: We want to help --

24 DR. ANGUS: I think it's --

25 REPRESENTATIVE GAYDOS: You know, we want to

1 help, but we want to make sure that it's getting to those
2 who need it the most.

3 MAJORITY CHAIRWOMAN RAPP: I guess the question
4 is is the PPE and other items that we've been told are
5 really needed, are they getting to the facilities that need
6 them? And maybe the Representative is asking is there a
7 specific barrier somewhere that we need to help with in
8 removing barriers to get the supplies that your facilities
9 need?

10 DR. ANGUS: I think, broadly speaking, healthcare
11 settings were petrified back in March and April about
12 having potential crisis supply-chain problems. And between
13 the procurement officers working for those healthcare
14 systems and the legislature, Pennsylvania totally got
15 itself ready. And I think few healthcare systems in
16 Pennsylvania are feeling particular crises right now for
17 the supply of PPE in the healthcare settings.

18 I think there has been a residual concern about
19 the degree to which PPE is available in other frontline
20 settings that are not acute-care settings, and I've
21 certainly heard that, but I'm not sure if we are the best
22 experts to speak of that, the availability in nursing
23 homes, the availability in other frontline settings that
24 aren't healthcare settings. And it is important to make
25 sure that we have adequate PPE that all interface and to

1 think of frontline workers as broader than just frontline
2 healthcare workers.

3 But I think for acute inpatient settings, for
4 example, we currently feel that we have got on top of most
5 of our supply-chain problems and in no small part help from
6 the legislature, so thank you.

7 REPRESENTATIVE GAYDOS: Thank you very much.

8 DR. ZAWISZA: If I --

9 REPRESENTATIVE GAYDOS: Go ahead.

10 DR. ZAWISZA: May I speak to that?

11 MAJORITY CHAIRWOMAN RAPP: Yes. Yes, Doctor, go
12 ahead.

13 DR. ZAWISZA: Representing primary care and again
14 working as a small group of three doctors and representing
15 POMA, which is largely composed of independent or small
16 group of doctors, I think the best thing is if we had some
17 kind of specific contact that we could make when we need
18 something. You know, when you work in a large health
19 system, it's a lot different than when you're a solo doctor
20 or even a small group. So if there was, you know, a phone
21 number or a website specifically to reach out to say here's
22 what I need, if you're in a practice that has 100 doctors
23 and 500 staff people and there's an exposure, that's a lot
24 easier to deal with in many ways than myself. If one of my
25 doctors and three of my staff get exposed, that shuts down

1 a practice. Again, that's, you know, 3,500 patients
2 without a doctor. And I'm not a unique story. That goes
3 across the State, so --

4 MAJORITY CHAIRWOMAN RAPP: Yes, Doctor, I believe
5 we were just chatting amongst ourselves that the people
6 that you would want to talk to is PEMA. They are the ones
7 to call. Certainly, you can call Representative Jerry
8 Knowles and ask him for the PEMA number. I'm sure he can
9 provide that to you. But thank you.

10 We've certainly enjoyed this presentation.
11 Representative Frankel, before I close, do you have any
12 closing remarks, sir?

13 DEMOCRATIC CHAIRMAN FRANKEL: Thank you, Madam
14 Chair.

15 Again, this was really helpful. I still have a
16 number of questions. You know, one of the things that --
17 and I won't ask them now, but I think things that we might
18 be able to talk about through this Committee in the future.
19 I mean, one of the things that some of you touched upon
20 that concern me are the long-term health effects of people
21 who have contracted COVID, particularly, you know, dealing
22 with the healthcare disparities that we see in our
23 communities and also in an environment where the Affordable
24 Care Act and the coverage for pre-existing conditions is in
25 jeopardy, and particularly given the fact that we look at

1 this disproportionate impact of COVID on these communities
2 of color, communities who don't have the resources to maybe
3 practice all the mitigation. So, you know, lots of
4 questions still. This was really valuable, and I want to
5 thank Chair Rapp for putting this hearing together, and
6 hopefully, we'll have other opportunities to explore some
7 of these issues. This was an outstanding panel, so thank
8 you so much for participating.

9 MAJORITY CHAIRWOMAN RAPP: Thank you,
10 Representative Frankel.

11 And again, I just want to repeat what I said
12 earlier. We are truly blessed in Pennsylvania to have
13 physicians like yourself with the expertise that we
14 probably -- we think about it, but then to hear from you
15 and your level of expertise, we are truly blessed in this
16 State to have you. And we're always trying to acknowledge
17 our first responders, our physicians in this State, but you
18 have shown us today that we truly do have outstanding
19 people here today.

20 As usual, hearings like this, we sometimes leave
21 with more questions than what we had when we first arrived,
22 but this is a Committee that does have frequent hearings,
23 and if you are willing, we may be calling on you again to
24 follow up. It doesn't appear that this pandemic is going
25 away, and certainly the vaccine issue is a huge issue that

1 we've talked about. We've been kind of hesitant about
2 doing a hearing on vaccines, especially now that the
3 Capitol is open, but certainly this is an issue that we do
4 absolutely need to follow up on.

5 And I want to thank you for taking time out of
6 your very busy schedule to address this Committee today.
7 My thanks to each and every one of you, and thank you,
8 Members. Thank you.

9 (The hearing concluded at 10:39 a.m.)

1 I hereby certify that the foregoing proceedings
2 are a true and accurate transcription produced from audio
3 on the said proceedings and that this is a correct
4 transcript of the same.

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