Healthcare-Associated Infections Advisory Committee
December 9, 2020

Transcription provided by outside vendor
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Speaker: Hello, this is Laura with the healthcare-associated infections team. Um, I'm going to unmute all attendees. This will allow you to unmute yourself. Um, you should see the HAIT agenda for today. And then, um, I will let Rosa start. Please let me know –

Next Speaker: Thank you so much, Laura.

Next Speaker: – in the chat for questions if you cannot see or hear.

Next Speaker: Perfect, thank you, Laura. Yeah, as, as Laura just mentioned, everyone should be unmuted now, but you will probably need to unmute yourself as well. You will also need to correct, of course, to audio. Um, so I know that some, some folks are not corrected yet to audio. Um, and I know that we're all kind of trickling in as well. So, as Laura mentioned as well, if you're having any correction issues, um, with your audio, muting, unmuting, other stuff, please go ahead and put it in the chat box so that, um, Laura can help troubleshoot. Can someone just confirm that you can see the agenda and hear my voice?

Next Speaker: **** and I can see it.

Next Speaker: **** I can see it and hear you.

Next Speaker: Great, perfect. Okay, so we're gonna go ahead and get started with our call to order and our roll call. So, um, I, uh, will be filling in for our, our wonderful chairperson, um, Dr. Jenn Buser, um, again during this meeting. And because I am not a member of the committee, um, I am staff, I will ask, um, one of our members to please, um, move to call this meeting to order.

Next Speaker: Hi, this is Deborah Cutura. I call to bring this meeting to order.

Next Speaker: Thank you. Is there anyone who can second that motion?

Next Speaker: This is Wendy Edwards. I can second that motion.

Next Speaker: Thank you, Wendy. Okay, we will go ahead and get started. So, I'd like to go ahead and do a roll call. Um, this can get a little chaotic with the, with the remote meetings, but we'll just do our best. We also have your named, um, since everyone has registered for the webinar. Um, so please go ahead and let's, we'll do our best to, um, to introduce ourselves and

our role, um, on the line, and then we'll get started. Uh, I'll start us off. My name is Rosa Tammer. I will be facilitating this meeting today. Um, I am an epidemiologist, infection-control epidemiologist at the Oregon Healthcare Authority's healthcare-associated infections program.

Next Speaker: Hi, this is Deborah Cutura. I'm with the department, Oregon Department of Human Services, and I'm a member.

Next Speaker: Thank you, Deb.

Next Speaker: Hi, this is Wendy Edwards. Um, I'm a hospital surveyor for health facilities, licensing, and certification here at the Oregon Health Authority, and I am a member.

Next Speaker: Hello, Wendy.

Next Speaker: Hi, this is Pam Cortez, and I'm the –

Next Speaker: Hi, Pam.

Next Speaker: – assistant director of quality and safety at Salem Health, and I'm a member. Hey.

Next Speaker: Hi, this is Kirsten Schuti, medical director of infections and prevention at Asante, and I'm a member.

Next Speaker: Hello, Dr. Schuti.

Next Speaker: Hi, this is Amy Anderson. I am a director of safety and quality with the Washington State Hospital Association. I am sitting in for Sandra Asasnik today.

Next Speaker: Great, welcome, welcome to our meeting.

Next Speaker: Thank you.

Next Speaker: Hi, this is Shana Meta. I'm infection prevention program manager for North Lincoln Hospital and Pacific Community Hospital for Samaritan.

Next Speaker: Hi, Shana. It's, I just want to say, it's just so nice to hear everyone's voices. I feel ob, like, I want to say hi to everyone, but I'm gonna stop doing that so we can get through this, but I'm really excited to hear you all on the line, and I'm gonna be quiet and let people just do the roll call.

Next Speaker: Hi, it's Vikki Nordby with Marquee Company.

Next Speaker: Hi, this is Mesa Greenfield with Lake District Hospital, and I'm and infection preventionist and employee health RN, and I am a member.

Next Speaker: Hi, this is Elizabeth Hickerson with Pine Ear Memorial, infection prevention.

Next Speaker: Hi, Jesse. Um, this is Laura. I am going to unmute you. Give me one second just to make sure. Okay, Jesse, you should be unmuted now.

Next Speaker: Uh, my name is Jesse Kennedy. I'm a nurse practice consultant with the Oregon Nurses Association.

Next Speaker: Hi, this is Susan Diskan, um, manager of infection prevention and control for Legacy Health.

Next Speaker: Hi, this is Joseph Scarpelli, infection prevention representative for Striker.

Next Speaker: Mary Post. Infection control, employee health, Shriners.

Next Speaker: Okay, anyone else on the line that hasn't had a chance to introduce themselves yet?

Next Speaker: Hi, this is Jamie Miller. I'm the senior manager of clinical services for Cervical Care Affiliates.

Next Speaker: Hi, Jamie. I just saw your email and responded to you with the link to this meeting, so I am glad that you are here on the line.

Next Speaker: Thanks.

Next Speaker: Anyone else?

Next Speaker: Yeah, hi. This is, uh, JJ Faruno, uh, associate professor at Oregon State University.

Next Speaker: Great. Okay, thank you, everyone, for, um, doing the roll call. So, we'll go ahead and just jump right in. Um, the first thing on the agenda is the logistic update. So, I want to, um, say, you know, for those of your who aren't, um, familiar with this meeting or who are somewhere new to it, um, we have certain roles that are defined by, um, gosh, I think it is by rule, administrative rule. Um, those, uh, those formal membership roles are on HAIT, although this is a public meeting and anyone can attend and participate, and from my perspective, you know, holding a formal role certainly doesn't give your voice more weight than anyone else's in the room. Um, it is, you know, kind of an opportunity to fill, uh, or to have a formal title. Um, and, uh, some people may find some value in that. We certainly would like to have our, uh, all of our roles, um, filled all the time. Um, so all but two of your who are currently members, so Jesse and Donna, you are exempt from this, um, had your 2-year term of membership expire in June of 2020. Um, I want to say, um, I just really value everyone's participation and membership in this committee, and we want to make sure that everyone that's interested in filling a formal role has a chance. Um, I think there's some value to kind for freeing people up from their commitments, getting some new faces and names in the room as well. So, with that, I'm kind of hoping to here from folks about whether, if you are currently a member, if you'd like to continue

in your current position, if you're wanting to cycle out, either away from formal membership or perhaps into a different role. Um, and if you are not currently a member, are you interested in becoming one. Um, I will ask everyone to just proactively reach out to me with your thoughts, but you'll probably be hearing from me as well on this. Um, those of you who have served as members, I think, can speak to the fact that it really doesn't require a lot of homework. Uh, we just ask that you participate in these quarterly meetings, which pretty much everyone is doing already anyway. Um, I think we'll continue to see really active participation from everyone who regularly attends, um, because the fact is that we really haven't seen much drop off during COVID, um, from what I know, so this group is really dedicated. Um, it's very heartening to me to hear your voices and see your names, um, even when we're all getting kind of slammed with, um, work related to this pandemic. Um, so with that all being said, um, for those of you who will be continuing in your formal roles, we'll be working on getting updated nominations paperwork in place, which will require an updated CV or resume from you and a brief paragraph stating your interests and qualifications. The process for applying for a formal role on the committee is the same. It's just a, you know, CV and a brief paragraph with your interests and qualifications. I'd like to kind of prioritize people who haven't been members before, so if I, either you're currently filling a, a role and there's someone else who is very interested in that role, I may reach out to you to discuss it. Um, I'm sure there's plenty to go around. Um, does anyone have any questions about that? Laura, any hands raised or anything? Um, questions about membership? Can folks still hear me?

Next Speaker: I can hear you –

Next Speaker: Um, yes, there's a, um –

Next Speaker: – fine. No questions from me. This is Wendy.

Next Speaker: Oh, perfect. Hi, Wendy.

Next Speaker: Thank you. This is Laura. Um, I'm sending an audio pin, audio pin to a few people so they can unmute themselves, but looks –

Next Speaker: Okay, great.

Next Speaker: – like we are good.

Next Speaker: Okay, so I'll just, as we're doing that, I just want to remember, or men, mention – Remember, goodness. Okay, that we have several vacancies which have actually been vacant for quite a while, so I would really love to see us be able to fill some of these roles. Um, everyone with their meeting materials should have gotten a one-pager that says "Bring Your Voice to the Table" at the very top of it. That one-pager is available. You can distribute it as widely as you like. You know, it's really, I have tried kind of cold calling different people to try to fill these, um, roles, which doesn't really work that well, as it turns out. So, um, you know, those of your who are already familiar with this meeting and who have folks in your network who might be a good fit for one of these roles, you know, your kind of network and outreach on our behalf is so incredibly valuable to get these vacancies filled. So, I'm just going to mention them. I feel like I

sound like a broken record 'cause these are the same vacancies that we've had for quite a while, but I think it's very worthwhile to reiterate because we would love to have a fully, you know, co, a full complement of members. So, the first role that is vacant is a hospital administrator with expertise in infection control at a facility with fewer than 100 beds. We also have a consumer representative vacancy, a health insurer representative vacancy. And finally, we have a vacancy for our chairperson, um, of course, Dr. Buser is still serving in that role, but, um, I think, you know, she has been in the role for a little while, um, so, uh, the thing about the chairperson role is that they must be a current HAIT member. You can be a new HAIT member, or you can be a member who's already, you know, in your formal role. Um, either one is perfectly fine, but the chairperson is kind of a dual role, um, and that role really involves kind of helping to facilitate these meetings and helping us to, you know, set and approve agendas for these quarterly meetings as well. So, with that being said, does anyone have any questions about membership vacancies, formal roles, et cetera?

Next Speaker: Uh, no.

Next Speaker: Okay. All right. So, just, you know, my last desperate plea, here, so please take that one-pager and distribute it around. If you know of anyone who would be a good fit for one of these roles, I would love it if you would either send me their contact information and I can reach out to them, or send them my contact information and our one-pager, and hopefully that, we will be able to get some new faces into the room as well as our old reliables here. Um, another thing I wanted to mention during the logistics update is that several folks had requested from during the last meeting to have an interim meeting, uh, between September and December HAIT to discuss flu season. And I want to really let everyone know that unfortunately, we don't have the bandwidth to bring folks together more often than quarterly because of the workload that COVID is presenting. Um, because HAIT is a, you know, public committee, um, the public has to be informed in advance of any, um, meetings that are occurring. They have to be given meeting materials. It all has to go online, um, so ad hoc discussions and meetings also are kind of not something that we're able to accommodate through this committee, so I just wanted to really explained 'cause it kind of makes me a bit sad to not be able to provide the form that was requested, um, but I just wanted to explain sort of why we can't support extra meetings at this time. But if you're looking for a specific forum or state resource on a particular topic, you're absolutely always welcome to reach out to me, and I will do my best to connect you to the most appropriate folks. Um, for those of you who are not already participating in our local chapter of APIC, um, association of professionals in infection control and epidemiology; it's the Oregon and Southern Washington chapter. That's also another great place to go to have these discussions. So, that really brings me to the end of my logistics update. Does anyone have any questions or thoughts on any of that?

Next Speaker: No, thank you.

Next Speaker: Okay, perfect. Thank you. So, with that being said, um, you know, really, I, I think that, uh, our agenda, if we can scroll down just a teeny, tiny bit so we can see the full agenda on the screen, Laura, that would be awesome, thank you. Um, I think we're gonna just kinda of have, um, our Agenda Items 4 and 5 kind of together here. Um, I have a guidance update for you all, but I think the discussion can kind of be woven in with that, um, as well. So,

I will just go ahead and, and launch into it. Um, so, uh, CDC has put out some new guidance on quarantine. And I can share all of these links after the meeting as well. Um, so many of you probably already are aware of this. So, um, CDC has kind of said reducing the length of quarantine may make it easier to adhere to, right? Uh, it can reduce the time that folks don't or are not able to come to work. And it can also sort of lessen stress on healthcare and public health systems or, uh, allowing healthcare personnel to come back to work earlier, potentially, or reducing just the burden of, you know, that kind of follow-up, um, with cases, um, especially when new infections are currently rising quite a bit. Um, CDC has said, of course, um, that, you know, local public health authorities or states make the final decision about how long the quarantine would last. Um, as everyone is probably aware, quarantine had been quite, um, clearly 14 days, right, to align with the incubation period of COVID-19. At this time, CDC has said that there are options that can be considered by local public health authorities would be after Day 10 without testing or after Day 7 after receiving a negative test result as long as the test has occurred on Day 5 or later. However, CDC is continuing to endorse quarantine for 14 days and sort of recognizes that quarantine's that are shorter than that full incubation period do, you know, post a small increased risk of viral spread, kind of against the **** for workload, um, and on public health and healthcare resources. So it is a trade-off like everything. Um, and they are still saying to watch for symptoms until 14 days after exposure, and of course, if symptoms develop, to immediately self-isolate, and we would actually add testing to that. So, um, I'm gonna just kind of editorialize a little bit 'cause that is just the CDC piece. So, um, I just want to say that kind of where we are as a state is that OHA senior health advisors are currently looking at this new CDC guidance and considering how best to implement it, and it's just not quite clear yet what decisions are going to be made and how our own guidance will change here in Oregon. In particular, um, our senior health advisors are evaluating the potential use of the guidance in congregate settings, right? Which, as you know, are some of the hardest hit, have many vulnerable residents and patients, um, plus severe staffing issues. So, one of the issues with congregate settings, um, in relationship to a decreased quarantine period is that it's often not feasible for us to kind of adjudicate when and where these exposures are actually happening when people are living together and having close contact every day, potentially. Um, it's possible that the new guidance might have some application in congregate settings. For example, in the case of newly-admitted residents or if someone was begin quarantined due to a very defined and specific high-risk exposure, like, in the case of healthcare personnel with a household contact, but for the time being, there is no change to OHA guidance on quarantine in any facility type. And then I also wanted to just clarify, um, that the discontinuation of isolation for residents and patients and the return-to-work guidance is still the same, and that would be the 10- or 20-day, um, period of exclusion or isolation, plus some other symptom criteria as well. So, with that being said, I'm going to stop and let folks, um, kind of discuss as a group, like, have your facilities been reviewing this? Any thoughts on kind of the, this new guidance from CDC, uh, stuff on, you know, what you would like to see from OHA. No, no promises on any of those, but I'll just open it up to the floor.

Next Speaker: Hi, this is Kirsten. Rosa, I think that was really helpful in terms of, uh, an overview. You know, we have talked about that when this came out to try to get ahead of any, you know, questions that might be raised from our employees and staff about how this would apply. I think, you know, where we could use some potentially help in the future from OHA would be, you know, if there is any change under certain circumstances to really help define

what that looks like, um, just so that across the state, we're not kind of using different, um, not different, kind of secondary, optional criteria as opposed to the standard 14 days. Um, you know, we have applied this a little bit in terms of some cases and, and clusters we had in certain units of our facility. Um, especially with, uh, having kind of no room at the inn, so to speak, where we're at a, a real crunch for beds. Um, and looking at patients and making sure that we've gotten at least, you know, initial baseline testing and then a week, uh, of testing after the question of whether there could have been an exposure on that unit that we, we were trying to look at. So, it has been helpful in that regard. Um, but like I said, I, I think it would be helpful if we think about any changes in the future, just to make sure they're, they're a little more structured, um, so that we're all kind of doing the same thing and approaching it the same way.

Next Speaker: Thank you, Kirsten. Have other folks been applying this guidance in your facility or, or, uh, systems so far at all? Or kind of any other thoughts on, like, how we can be very structured? Like, what are some of the kind of, um, nuances here that you would want OHA to address?

Next Speaker: Hi, Rosa. This is Susan, um, at Legacy. Uh, so I mean, I think from the standpoint of, um, just, uh, it, it, there was a discussion on the, um, a noon call as well that OHA was, was on, and I, I mean, I, I have a little bit of hesitance with, with it in the healthcare setting just because, um, it doesn't really feel like CDC is fully on board. And it, it also didn't feel like, based on the call at, at, um, noon today that OHA really had its arms wrapped around it, fully embracing it either. And so, it just, um, I think from that standpoint, it still feels a little tenuous to me. I definitely feel like we're in a pinch with staffing, so I, I can see from that standpoint where it's, um, would be helpful to have a shorter quarantine, but it, yeah, it still just feels a little, um, concerning. And then, um, the other thing for us that makes it a little bit challenging is Clark County had really sort of set the, you know, a standard there where it didn't apply to healthcare facilities, kind of that exceptional risk area. And so, um, you know, we'll have to have a different standard for, um, if we decided to go with, with OHA recommendation, we'd have a different standard for our, um, hospitals in different states.

Next Speaker: Yeah, I think that's, Susan, I'm sure you're reflecting kind of what many of us are feeling, right? But does that, the, the incubation period has not changed, right?

Next Speaker: Right, right.

Next Speaker: So, what is, what is being offered here is an abbreviated quarantine period and t, typically, we do like to align our incubation periods with our quarantine periods, right?

Next Speaker: Yeah, yeah.

Next Speaker: Um, so I, I think you're correct, right, which is, and then, and I think CDC is pretty, pretty explicit, right, in, in their language, which is they –

Next Speaker: Mm hmm.

Next Speaker: – they do continue to endorse a quarantine for 14 days. And, you know, in the community, I think we can see, or at least my, my perspective, right, is that in the community, it's a little bit more kind of like, or feels a little bit more, um, feels less concerning than implementing this in the healthcare facility setting.

Next Speaker: Yeah.

Next Speaker: Um, yeah.

Next Speaker: I'll –

Next Speaker: It, it, also, I will add just really quick –

Next Speaker: Oh, sorry.

Next Speaker: – to it. It also just feels like the timing isn't great because we are in the middle of a surge. Like, I could see this definitely, if, if our numbers were down, um, you know, and we, we had less risk of, um, transmission, but with higher numbers, this seems a little, like, bad timing. That's all. Bye.

Next Speaker: This is Mary. I, I –

Next Speaker: Oh, no. I didn't mean to cut you off at all.

Next Speaker: This is Mary, and I think, um, you know, the CDC does lay out the risk. The percentage of risk, and you can clearly see at 7 days. I want to say it was like a 5 to 10 percent risk. And at 10 days, it was, um, maybe somewhere around 1 percent. Um, you know, so there is an increased risk, but I think this is in lieu of having, you know, an, an option that they're giving for crisis staffing in lieu of having people continue to work until they become symptomatic. Um, I, I personally think, again, that all the hospitals are different, and their staffing and what they're experiencing is different. So I, I think it's good to give options to facilities. Um, you know, we've been able to accommodate our work restrictions, um, but not every facility has been able to do that, and they, in fact, have had, uh, crisis staffing issues, so.

Next Speaker: Yeah, this is Kirsten. It feels to me, like, you know, one possible structure that be, could be considered would be just like we, we kind of tiered PPE use, um, in contingency and crisis scenarios that, you know, the, the real potential benefit to try to minimize the risk of taking someone out of quarantine earlier, recognizing that risk is not zero, would be when there really are crises in staffing for healthcare workers at least. Um, and trying to provide a level of comfort in that situation. And I think some of that depends on, you know, what the current practice is. You know, we've allowed healthcare workers, um, you know, with exposures to patients in the hospital that weren't high-risk exposures to continue to work thus far. So, you know, if there was a facility that was saying, you know, anyone with an out of work exposure, you know, a positive household member, something that would be considered a, a significantly high-risk exposures, was being quarantined. That might be a strategy that could be used to try to allow them to more

safely come back to work even though it wouldn't be as safe as having them out for the full 14-day quarantine period.

Next Speaker: Yeah, I think, you know, I, I'll just reflect that I, I, I feel like this is kind of a contingency, right? I'm not sure that it's being kind of framed in that way as, as explicitly as kind of the tiered approaches to PPE, for example. Um, uh, and Mary, to what, your point, you know, facilities do need to have options, right, 'cause everyone is gonna be dealing with slightly different populations in the community, staff, patients, and residents, et cetera. So, I'm definitely noting down everyone's thoughts on this. Other thoughts, um, on this new quarantine guidance? I certainly have more updates, so we can move on, but I want to give everyone a chance to reflect on this.

Next Speaker: Uh, this is Jesse, if I may.

Next Speaker: Yes, Jesse, of course.

Next Speaker: Hi, uh, so I guess the, the biggest concern that I've been hearing from nurses around the state is the relative inconsistency, not only from within a facility but also without a facility, from facility to facility. Um, in terms of what the guidelines are from a quarantine perspective. So, for example, um, some of our nurses are talking about a mandatory quarantine for visiting various counties within the state. Um, and then also for visiting different states within the country. And, you know, I think the biggest question I have with this update and the CDC guidance is really more of a question as to when we might actually see some guidance from OHA to solidify all of these things as, as to when the nurses really do need to be quarantined and when it, it's, when it's safe for them to go back to work. And I think that this guidance kind of came, as we've already heard, kind of at a, an inopportune moment. Uh, but at the same time, it's probably quite opportune because there are a lot of questions out right now, and it, it's a really good time to, to really answer those questions and, and, and to try to find, uh, a good space where we can kind of direct everyone to so that we don't have nurses leaving one facility to go to another facility because they have better protocols, et cetera, around whether or not they can go home to visit their relatives for Thanksgiving or Christmas.

Next Speaker: I'm happy to give my thoughts on that, but I'm kind of curious if anyone who is speaking more from, like, a health system perspective or anyone whose had specific experience dealing with that, um, you know, the kind of differences in the way guidance is applied from facility to facility has any thoughts. Okay, well, hearing no one, um, I think, Jesse, yeah, uh, we want, um, facilities to have – I think it's a balance of allowing flexibility, right, and then also having consistency in the approach. So it's certainly been a challenge across the board. Even getting up to speed on recommendations as they change, I think, has been a consistent challenge for everyone, right, as the ground sort of shifts between our feet, um, on a pretty regular basis. Um, so we, I will actually mention that, so in terms of when we're going to see guidance from OHA to solidify what we've been talking about, which is, right, the CDC's guidance on a potential application of reduced quarantine periods. With that, I can't say. Um, I know that our senior health advisors are actively, um, reviewing the guidance, but I'm not sure what the timing might be from them. Um, however, in terms of more specific questions, that actually kind of is a great segue into our next guidance update, which I'll, I'll just go ahead and get into right now,

which is that, um, you know, one of the major points of discussion that came up during last quarter's, uh, committee was how to deal with cases among healthcare personnel and associated quarantines of patients or residents and staff notification. Um, so, um, we do have, uh, many of you are probably already familiar with the OHA's document which is the clinical care healthcare infection, prevention, and control guidance for COVID. Um, a new update is on the way and will likely be posted online today or tomorrow. I don't want to review the specific in too, too, too much detail until the document is actually released, but I'll go over the major changes, and one of them is, um, you know, the clarification that healthcare personnel identified as close contacts of COVID-19 cases may work during their quarantine period as long as they remain asymptomatic and practice source control. They should observe quarantine outside of work, and, um, the document also lists high-risk exposures that are intended to help facilities guide decision-making about work exclusions. And then related healthcare personnel identified as cases, um, the guidance kind of newly allows risk notificat, or risk assessment, rather, sorry, to guide notification of contact of healthcare personnel identified as cases, provided that some strict criteria are met. I know, um, Dr. Cieslak just joined the call. Welcome. Thank you for taking the time to be a part of this conversation. Um, so anyone with thoughts on that. Paul, would you like to chime in? Or, I can also actually just kind of go into the rest of the updates in that, um, guidance document. What would be most helpful for people?

Next Speaker: I don't, I don't have too much to add to that, Rosa. I, I think you described it very nicely.

Next Speaker: Well, thank you. Anyone with thoughts on this piece of our updated guidance? I'm just giving everyone a chance to unmute if someone's trying to speak.

Next Speaker: Sorry if I was delayed. Uh, this is Jesse, as you were saying. I, I would look –

Next Speaker: Hi, Jesse.

Next Speaker: – forward to your updates.

Next Speaker: Say that piece again?

Next Speaker: Sorry. Uh, if I'm breaking up, I was just saying, I would look forward to seeing the, or hearing, I guess, rather, the continued updates.

Next Speaker: Great, okay. I will just –

Next Speaker: If there wasn't anything.

Next Speaker: – I will go ahead and review everything that's kind of being updated in this new guidance document, and then I'll just, well, we'll be able to have a discussion as a group. Um, so, okay, some of the other new updates to that document, right, which will be posted today or tomorrow, um, so essentially, some of the language around the Oregon OSHA, um, pieces have been strengthened. Um, some of the discretion was sort of removed from their administrative rule and requirements. So I guess the important takeaway here, and I'll talk a little bit more

about that in a second, is that, you know, um, anything that's kind of defined in rule and statute, those things are really nonnegotiable. And our document is really for context and, context and support for pathways going forward, but we always will have to defer right to that guidance that's defined in rule and statute. So, the Oregon, Oregon OSHA's temporary administrative rule, which is OAR437, 001, 0744, addresses workplace risks for COVID-19. Um, the requirements are supposed to, you know, mitigate COVID-19 in all workplaces of Oregon. And, um, you know, the, uh, kind of guidance in, or the language in our guidance has kind of been adjusted a bit to, again, kind of get across the point that we are providing context and direction around infection prevention and control practices, but that does not exempt any, um, facility or workplace from the provisions in the Oregon OSHA rule. In terms of our coverage of PPE guidance, um, we have linked to the CDC guidance, um, so we can just make sure that we are aligned. As everyone knows, um, you know, we do, uh, I think as a public health community at every level, national, state, local, um, and then in our healthcare systems, you know, it's very complex to make sure that our guidance is all really consistent, as it changes rapidly. Um, so we still offer our own OHA optimization guidance for PPE, but we wanted to avoid having sort of these multiple complex structures and definitions for PPE from different agencies, so hopefully, this will streamline and clarify. We have addressed facility requests to provide community spread metrics to enact CDC guidance for respirator use and eye protection for either all patient care or all aerosol generating procedures. Um, sort vis-à-vis the concepts of moderate to substantial spread. Um, and so, again, just to summarize what I just mentioned, that CDC language has been, um, sort of, or is, uh, our new guidance sort of directs, focuses the CDC language regarding use of PPE. And then it also provides these, um, metrics based on level of community COVID transmission that talks about, you know, when should you be implementing particular PPE requirements, specifically, either for all patient care or for all aerosol-generating procedures respectively when there are moderate to high community transmissions in the area. And then finally, um, the document also includes some guidance around how to pare down contact-tracing efforts when risk level is extreme at the county level and staffing can't support, um, the current level of contact tracing. So, many of you, I believe, actually might have been involved in reviewing and giving feedback on this document, so I'm going to stop talking and open it up for discussion with the group on any or all of these changes.

Next Speaker: Well, uh, this is Jesse again. I did have one question that is related but, uh, not one of the ones you talked about specifically, which is the Oregon Crisis Standards of Care. Um, that document, um, no longer links properly, and my understanding is that, um, OHA has since retired that document in favor of creating a new one. I would love to hear any additional information about that, as that particular document is referenced in several other current OHA documents.

Next Speaker: Yeah, this is Paul, I'm sorry. I, I don't know, um, I'm not terribly familiar with recent efforts, uh, on the crisis standards of care. I can look into it.

Next Speaker: Thanks, Paul. Thanks, Jesse. I also don't have an answer to that question, but certainly, we can, um, look at this offline and get back to the group.

Next Speaker: Sure, I mean, I, I just heard through other folks and not through anything official that the crisis standards of care were no longer an official document of OHA, which I thought

was incredibly odd since I hadn't seen anything about it, but all of the links and all of the, um, former links that used to work, um, searching, et cetera, for any new links, all come up with nothing as far as the crisis standards of care. And the links within the OHA documents that refer back to the Oregon Crisis Standards or Care are all dead. And when you click on it, it requires an OHA login and password, so I didn't know if there was any work being done as to creating a new crisis standards or care or, or what was going on from that perspective.

Next Speaker: Yeah, um, so from what I'm able to find, um, it looks like this was discontinued, um, in July or in, uh, at some point from July to September. I'm not exactly sure when it occurred, um, itself. I don't know if a new guidance document is in the works. I believe that the official word from OHA was that individual providers are intended to, you know, make their decisions regarding crisis care, uh, scenarios. Um, of course, we have crisis care scenarios for things like PPE, et cetera. Um, my understanding was this was a bit more broad in terms of who would receive care when, uh, crisis levels, uh, of capacity were reached. Um, so that is the information I have, but we will, uh, do our best to address your question, Jesse.

Next Speaker: Well, I, I –

Next Speaker: Does anyone –

Next Speaker: – certainly understand your comment and your concern, and I agree entirely. My only concern was just that it is referenced in other documents, so if there could be some sort of an updated document for the other ones that refer back to it specifically, like, the, um, the resumption of elective and nonemergent procedures refers specifically back to that crisis standards of care document that doesn't exist anymore, so if we're utilizing that as, as –

Next Speaker: Would you be able to send along, like, if you, I, I can certainly pass this along. It's very helpful to have fresh eyes on this kind of stuff, so if you could send along the documents where, specifically, you've seen it. I'm sure that folks are working on this, but, you know, again, things do tend to slip through the cracks, um, when we are all flat out, as we all are, so if there's any chance that you can pass along, um, you know what I mean? Like, the doc, the documents specifically where you're seeing that referenced or kind of the gaps that you feel that it's leaving behind, I can pass that along to the, to the right folks.

Next Speaker: Yeah, def, definitely. Sounds good.

Next Speaker: Fantastic. Thank you. Your eye for detail is appreciated here. I think, you know, we can all, we can certainly use, um, as I said, the fresh eyes and the extra help. Does anyone have any thoughts about, um, the changes to our clinical care IT, the guidance that I, that I mentioned? Okay –

Next Speaker: Hi, Rosa. This is –

Next Speaker: Oh, yeah.

Next Speaker: – Wendy Edwards. Um, I just had a question. Did you say that it was already, um, available, or it's going to be available soon?

Next Speaker: Today or tomorrow is the last word that I got. I –

Next Speaker: Okay.

Next Speaker: – if, Paula, if you have any more information than that, please chime in, but I, I just heard from Becca this morning, so I don't think I have anything more recent than that in terms of a timeline.

Next Speaker: Thank you.

Next Speaker: Of course. Okay, any final thoughts on our updates to our IPC guidance?

Next Speaker: Rosa, this is Kirsten, just a huge thank you to those who worked hard on this, and that's, that's super good news to hear about some benchmark numbers that will help us kind of apply some of these strategies, so thanks for some of those details in advance.

Next Speaker: ****.

Next Speaker: Yeah, this is Wendy. I really appreciate it too. Thank you.

Next Speaker: Yeah, I, we know that that was definitely something that our clinical providers were calling for. And, and Paul, I just saw your email and Melissa Sutton's email in advance, um, so I will just chime in, Jesse, to circle back around, um, it sounds like we do have a new guidance document, um, which is called Principles in Promoting Health Equity During Resource-Constrained Events, so I would be happy to share that with the group after this is over. Paul, anything to add on that?

Next Speaker: Uh, no. This is the first I've seen it, so thank you.

Next Speaker: Me too.

Next Speaker: Uh, I, I do have that document. I was just referring to the, the, the one, well, there's a, a few specific documents that refer back to it, so that's all I was point out. I do have –

Next Speaker: Yeah, do send those along to me, Jesse. Send them along, but it, it sounds like this updated guidance is the, is kind of what has been, what's been used to replace the previous standards of care.

Next Speaker: That makes sense. Thank you.

Next Speaker: Okay. Thank you for bringing it up. All right. Final thoughts on updates to clinical care and IPC guidance before we move on? Okay. Well, I will bring us to our next update is that, um, since our past or last, um, meeting. Of course, it's been quite a while, so

things have changed dramatically since then in many ways. Uh, um, the DHS guidance on long-term care facilities' staff testing has been, um, updated or rather released. So, I think this is relevant, hopefully, to folks in the room who touch long-term care in different ways. Um, so this is related to facility staff, right, so during an outbreak in a congregate setting, or certainly long-term care, um, our recommendation is to do COVID testing for 100 percent of previously, uh, negative healthcare personnel and staff just so, uh, and side note because I just love to make sure everyone knows this, um, non-employee staff, agency staff, hospice, PT, OT, et cetera, also must be tested at the same, um, at the, on the same, um, schedule. They aren't required to be tested by the facility, but they should submit evidence of negative test results with the same, uh, frequency as the rest of the staff who are being tested. Um, there are, um, new guidance from DHS on long-term care facility staff testing which are defined not just for outbreak scenarios but non-outbreak scenarios and are based on, primarily on the COVID-19 positivity rate in the county. So establishing, or following parameters established by CMS or looking at county needs with a positivity rate of less than 5 percent or who have conducted fewer than 20 total tests in the most recent 2 weeks, uh, we're looking at once a month staff testing at least in counties with positivity rates of 5 to 10 percent or who have conducted sort of test numbers that are in that kind of mediu, medium threshold, um, the recommendation is to test staff once a week at least. And then those with a positivity rate of higher than 10 percent at the county level, um, where, you know, testing, um, tests that have been conducted kind of are at that highest level are, we are looking for all staff to be tested at least twice a week, so this is a, um, change from, you know, kind of previous guidance which sort of only, um, would recommend once per week for staff at the most. Now, we're looking at sort of really allowing our community, um, numbers, our county numbers to drive, um, these recommendations. Um, so, uh, currently, DHS is saying that either numbers, so both OHA and CMS, provide, um, the data that would, you know, be needed to determine what category a county falls into. Um, we're currently, I actually just reached out to DHS this morning regarding their preference in terms of, you know, what should be done right if the two numbers disagree. Do they have a preference? Well, they continue to allow either. They don't have an update on that, although there may be folks on the line, I suspect, who have more, um, thoughts or reflections on that, but I will say that many of you probably know, um, that, um, sorry, I'm just trying to find the email right now. Um, that the way that we are calculating, um, and publishing our data has changed. Um, so if you would not mind bearing with me, we have actually switched to, um, test, or, you know, previously, right, looking at kind of numbers, um, from a, uh, person-based perspective rather than a test-based per, perspective. Um, our data should be aligning much more closely, um, between the two agencies so that, um, I will just actually include our tableau, uh, data link when I send out the minutes. Um, so hopefully, we should be getting, those numbers are going to be more aligned both, from both agencies. I feel like I'm rambling here a little bit, so I'm just gonna stop talking and see if anyone has any thoughts. Especially our partners from DHS on the line, if you have any thoughts to clarify my ramblings here.

Next Speaker: So, this is Deborah. All I know is that it's being discussed, and communications are going out, but I don't know any of the details. I'm sorry.

Next Speaker: No, no need to apologize. I, I think it's, that that's the latest I've heard as well. Anyone else with thoughts on, uh, long-term care facility staff testing? Pausing for folks to unmute. Happy to hear about challenges, you know, successes, um, questions. Yeah.

Next Speaker: Rosa, this is Vikki Nordby. When will that, um, your guidance be posted? I'm seeing the latest, um –

Next Speaker: So –

Next Speaker: – for long-term care, um, 10/22.

Next Speaker: So, let me. I'm sorry. I just need to open the document to check the date. There's no update that I'm aware of, so this is the long-term care facility testing plan dated, oh, my goodness. Well, I'm looking at June, but I'm not sure if that's actually the most recent one. Um, but I am not aware of, uh, awaiting more updated, you know, a testing scheme. I think, um, the thing that, you know, this, this has changed, um, since our last meeting, just the additional, right, requirements for staff testing based on community –

Next Speaker: Okay.

Next Speaker: – percent positivity, yeah.

Next Speaker: Okay.

Next Speaker: Sorry for any confusion. I'm not being –

Next Speaker: **** very well.

Next Speaker: – clear.

Next Speaker: That's right. And –

Next Speaker: Um, yeah, but no, no updates in progress. Just kind of, uh, working through the questions, right, because currently both CMS and OHA data can be used to determine the testing frequency, and I think we'd love to see consistency, um, wherever we can.

Next Speaker: That would be wonderful. We would so appreciate it.

Next Speaker: Okay. All right. Um, well, Vikki, since you're putting yourself out there, maybe I'll, I'll pick on you a little bit. How, have you been using, at the Marquee facilities, um, have you been using, uh, numbers from CMS or OHA or a little bit of both? And how are those decisions made? If, if you don't mind me putting you on the spot.

Next Speaker: We're using CMS data, yeah. Yeah, so, um, we have someone who manages the, you know, testing supplies and, um, and they are monitoring, um, that CMS data, um, to determine, you know, when facilities need to increase or decrease their, um, their testing.

Next Speaker: Gotcha. And you're doing CMS at all facilities, then?

Next Speaker: Correct.

Next Speaker: Anyone else on the line have experiences with making these choices? I'm just so curious to know how they, how the decisions regarding which numbers to use are made, and are people, you know, are the discrepancies between the data, which hopefully, are getting a lot fewer, um, is that causing problems? Okay. All right. Well, then we'll just move on. Um, so I think one of the things that was definitely brought up, um, previously was flu season, right? So, um, we do have an OHA clinical consideration for testing document. I'm gonna just send out. We'll send out an email after with, with all the links, um, relevant to this discussion, so everyone will have what we're talking about in your inbox. Um, basically, the guidance says that providers might want to test when there's enough information to say flu is circulating, but if any point, a provider thinks the disease that is in front of them could be flu, that they should go ahead and test at their discretion. Um, increasingly, there are more and more, um, you know, combined flu and COVID testing options, which should be super helpful. And then, of course, as everyone on this call is very well aware, um, flu is treatable and vaccine preventable, so we really want to be able to use our antiviral and our vaccination, immunization tools to cut down on healthcare and public health burden, as we are seeing, um, you know, tremendous number of COVID cases. Um, I think one of the things that we worry about is, you know, coinfections and comorbid outbreaks, um, so I'll just highlight a couple of, um, pieces of guidance. In addition to our OHA clinical considerations for testing, we have our OHA weekly flu surveillance report, which is Flu Bites. Uh, CDC has issued some new guidance, um, one, one of them is, um, on, uh, uh, testing and management considerations for nursing home residents with acute respiratory illness symptoms when SARS-CoV-2 and flu viruses are cocirculating, talking about testing placement, treatment, um, and then also, guidance for other health settings as well, so I will share those. Um, you know, currently, I think in congregate settings, at least at OHA, uh, we're basically saying that if you know flu is circulating in your facility, our recommendation would be to start routinely testing everyone for flu in addition to COVID. Um, there was also a recent SOQ webinar on management of COVID during flu season, and I know that we have many folks on the line who are probably interested in talking a bit about flu, um, and who know far more about these updates than I do, so I will just pause and open it up to the floor. And, Nicole, if you have any thoughts, I'm sure we would love to hear from you, but no pressure. And to get us started off, how are folks handling this? Is anyone seeing comorbid infections, comorbid outbreaks? Thoughts on the testing resources that are needed?

Next Speaker: This is Pam Cortez from Salem Health. Um, we certainly have been doing testing, and we have some of the combined testing to look for, um, you know, more viruses while we're looking for COVID, but we have seen almost no flu, um, in our organization at all so far this year. So, and as we've heard on some of the calls, that seems to be the case. I, I would be interested in hearing what others –

Next Speaker: This is Shana from Samaritan, um, we are not seeing flu either.

Next Speaker: Anecdotally, is, are folks seeing increased uptake for flu vacs either among pa, patients or staff or both or neither?

Next Speaker: I, I wish I could say we were seeing – This is Kirsten from Asante. I wish we could say that we were seeing an uptake in flu vaccine from staff, um, unfortunately, I don't think that's the case. Uh, you know, we, we had just implemented a, you know, vaccine or masking, one or the other, policy for those who chose not to be vaccinated for flu, um, 2 years ago. And it's, uh, it's interesting to be able to compare how well that strategy worked with what we're seeing this year so far in the midst of a pandemic where everyone is required to wear masks. Um, so we've, unfortunately, seen a drop-off in, in our numbers of vaccinated staff. We'll see how things look at the end of the month, but so far, it's flat.

Next Speaker: Interesting, very interesting. Are other folks seeing the same thing as well? I really want to hear from someone that you're seeing better uptake. I may be asking for something that no one can give me.

Next Speaker: Well, it's, it's interesting because statewide, uh, in October, which has always been our biggest flu vaccination month, uh, we were quite a bit ahead of previous years. Um, it was really encouraging looking, so I guess I'm sort of surprised to see maybe the opposite trend among healthcare workers.

Next Speaker: Yeah, I think it will be really interesting to see where the numbers ultimately end up in terms of looking at direct impact of different strategies to try to do that since we can't mandate, uh, vaccinations in Oregon for the flu amongst our healthcare workers. I, I think I have seen, at least anecdotally, in my patient population I have seen that, you know, those who were kind of somewhat on the fence, um, or who normally do get the vaccine, got it early and earlier than they might otherwise have. Um, but I, I'm still seeing plenty of patients that are just not interested as well. Um, and like I said, I, I think the, the carrot and the stick approach, you know, with the stick being the mask, previously, that you'd have to wear it all flu season if you chose not to be vaccinated, that's no longer, uh, a stick. So, I guess our, our carrot of incentivizing, which we have done incentivizing flu vaccination as one of our, our metrics for which employees will get a bonus if we reach the same vaccination threshold, um, that we set of greater than 90 percent in prior years. That carrot doesn't seem to be enough to, uh, to, to really get people to, to get the vaccine, sadly. Will be super interesting to see, I think, what the numbers look like at the end of the flu season in April. Interesting that the dynamics are different between staff and, and patients, though. Any other thoughts on flu season at all? Okay, all right. Um, so we will just go ahead and move into just our last, um, agenda item, so, you know, I think we can discuss topics for future meetings and public comment together. So, anyone have any either public comment or things that they would really like us to be discussing next time?

Next Speaker: Rosa, this is Kirsten. I think it would be nice to have an update, um, on kind of the status if, if there is any information available about kind of statewide trends and national trends for other HAIs. Um, you know, while we're trying to, to pull ourselves out of COVID, you know, I keep seeing some reports in various areas. And, you know, I know there was a study looking, I think it was, at St. Louis, uh, um, facility in St. Louis as well as, gosh, I want to say, maybe Massachusetts in terms of what they thought earlier on in the pandemic. Um, but, you know, I think I can at least speak for us to say we're, we're down a couple of our infection preventionists who have retired or left. And with the volume of work related to COVID, it's

been really difficult, um, to try to keep, uh, everything together in terms of not just where we're at making forward progress and, and improvements in terms of our HAI initiatives across the board, so I'd be really curious to see how that's impacting, um, us as a state and then on the national level as well.

Next Speaker: Thanks, Kirsten. I think that's very timely. Um, I'm just gonna, um, say that recently, there was a, in the – For those of you who get the Shay, um, Journal Club, um, emails, they recently reviewed, um, an article, uh, called *Looking into the Crystal Ball: How COVID-19* – And this is, yeah, this is the McMullin study, so, uh, looking at NYC and St. Louis hospitals, the bill is *How COVID-19 May Impact HAIs*, um, and they talked about, you know, decreases in overall senses at the beginning, um, you know, uh, driving down device utilizations, um, with the most sick are the only ones being hospitalized, kind of leading to increased rates. Um, at least, you know, and that is sur, surveillance wise, right? A bit, of, um, um, I mean, it is a true increased rate, but in a sense, it is also a bit artifactual, I think. Um, the factors that have led to increased CLABSI rates may also **** rates. Um, they also, um, suggested in the article that, um, decreases in surgical procedures would probably limit initial SSI rates but maybe an increase after, um, you know, nonemergent surgeries kind of went back up could also cause just, like, a lot of fluctuation. Um, and they had also hypothesized that C. Diff and MDRO rates would decrease with, um, more focus on hand hygiene and environmental cleaning, but I think, if I'm remembering correctly, had also seen, um, some new data suggesting that MDROs are actually on the rise. So, I think there's, uh, some pretty complex dynamics here, um, certainly worthwhile to talk about, um, during our next meeting, so thank you.

Next Speaker: Just a, a quick query, if I may. Are, are, is anyone seeing, um, more cases of carbapenem-resistant Enterobacteriacceae?

Next Speaker: This is Kirsten. Paul, I, I want to knock on wood before I say anything, but at least at this point in time, no.

Next Speaker: LOL, thank you.

Next Speaker: Ro, Rosa, this is, um, Wendy Edwards, um, I was wondering if maybe, uh, we have time, I could just spend a couple minutes and talk a little bit about what the hospitals can expect, kind of with the survey processes that are happening with respect to COVID-19 and what we're doing?

Next Speaker: Wendy, I would love it.

Next Speaker: Okay. Um, so this is Wendy Edwards. I'm one of the hospital, uh, surveyors for health facilities, licensing, and certification. And so, we, we conduct surveys of hospitals, um, throughout Oregon for compliances with the state licensure, licensing and CMS certification requirements. And, of course, I, um, you know, I've come in contact with quite a few of the individuals who are, are on the, the call, or the, the meeting. Um, but just a couple things I just wanted to mention just so you might have an idea, you know, what are we doing for surveys and things like that at this time and a few changes. And probably a lot of this, you already know, but I thought it might be a good opportunity to bring it up. Um, we are continuing to conduct

surveys in hospitals, um, primarily remotely. Um, as long as it's permitted, um, by CMS. There are some certain surveys that we are required to go on site, um, at this time. For an example, if there's a concern that comes into our office, um, that is a potential immediate jeopardy, um, situation or a potential condition level, uh, um, noncompliance in the area of infection control. And, Rosa, can I just ask you, is my volume okay?

Next Speaker: Your volume is great for me.

Next Speaker: Okay. Um, and so, um, so that was one thing I just wanted to, to throw out there and let you all know, that primarily, we are conducting surveys remotely still. Uh, and the way that we go about doing that, generally, if we need to kind of announce that we're gonna be having a survey is that we'll send the hospital administrator, um, an email announcing that we're, we're now starting a remote survey, and then the process carries on from there. Um, so that was one thing that I just wanted to mention. The second thing, um, again, probably most hospitals are aware of this, but, um, CMS has initiated – Hold on just one moment, please. C, CMS has initiated a, um, focused COVID, uh, survey process and a tool that we are using to conduct surveys. And these are surveys that are, um, when we do go on site, then we are also required to conduct one of these focused COVID surveys as well. So, ex, except for in some particular situations, uh, there are just a few surveys that we wouldn't be doing that. So, for example, if we had to come in, come into your hospital for a potential immediate jeopardy or for the potential condition level deficiency, um, uh, and do an on-site survey in a circumstance where we couldn't do it remotely, we would also be having to do once of these focused COVID surveys at the same time. So, I wanted to share that with you, and probably, most of you, as I mentioned, are aware of that already, but that is continuing to, to carry on at this point. Um, and those focused surveys have a number of topics that we review, in, including PPE and, you know, screening of, of patients and visitors that are coming into the hospital, and so it's a big, long checklist, and of course, it's available on the CMS website. Uh, the next, um, item, I just wanted to go over quickly, and I, I'm not going to talk too long, but, um, in sitch – And this is, this is kind of really a, a new process that I have not seen our office do, um, in the 10 years I've been doing this work. And that is, in situations where our office receives a complaint, and this again, is all about hospitals, um, that has to do with, uh, COVID and personal protective equipment and their lack of, we are, we are, and it's just a sta, you know, potential standard level. You know, maybe there's just a complaint about one or two people not wearing masks or something along those lines. Um, then what we are doing, rather than, uh, necessarily going out and conducting a, a survey or what have you, we are actually contacting the hospital's administrator, um, by, I've done it a couple different ways, but by phone or email. And I'm setting up a time to talk with them and an infection preventionist at the hospital about what the actual concerns were that came through our office. For example, we had received a complaint in our office about, um, you know, staff in the, uh, you know, triage area weren't wearing, you know, masks or something along those lines, whatever it may be. And we'll actually tell, tell the, the infection preventionist and the administrator what the, the complaint was, and of course, we don't divulge who the complainant is, um, and then we'll provide some resources to them, um, for, from CMS, OHA, and CDC. Um, and those are just designed to, you know, give them the information that they need so that they can actually evaluate their own practices and then implement corrective actions as determined necessary. And then once that phone call is completed, there's a follow-up written notice that's sent to the hospital with all of that information, a kind of recap of the phone call, so

just kind of a follow-up co, correspondence with the, uh, that's sent to the administrator and also requesting that they please forward the information to their infection preventionist once again. So, I just wanted to, to share a couple of those, those kind of, um, um, uh, kind of, uh, processes that are happening in the, in the, the regulation and compliance, uh, area in our office, health facilities, licensing, and certification. Certainly, if anybody has any questions about any of that, you can always email our, um, our office. They may **** –

Next Speaker: Thank you, Wendy.

Next Speaker: Thank, thank you.

Next Speaker: Do you have, can you, um, email any, uh, documents or links you'd like me to share, uh, with this group, um, after the meeting is over? And I'll make sure everyone gets, gets that all.

Next Speaker: Sure. Yeah, I can, I can, uh, make sure that they, um, I get the, the, um, CO, the focused COVID tool, the CMS tool. Um, again, it's, it's readily available on the CMS website, but I can go ahead and get that to you. And I, I so appreciated the information, Rosa, that you mentioned about the updated, um, guidance that's coming out as well 'cause we want to make sure when we're, when we're providing, uh, information to the hospital from these various sources, that we're providing the most current information too, so you betcha I'll do that.

Next Speaker: Great. Well, I think I'll just, um, allow, like, another minute or two if anyone has any final thoughts. We're a few minutes over time, so I want to be respectful of everyone's schedule. Okay, well, I think we will wrap up since we are a little bit past, um, what we had – Oh, anyone? Do I hear a, a voice? Okay, so I think I'm hearing things. I will send out links and information on what we discussed today. Um, please don't hesitate to reach out to me via email if you have thoughts, um, on how we can best utilize our time for our next quarterly meeting. I'd love to hear about it. Um, and then, um, if anyone has strong opinions on the length of this meeting, so typically, we do have 2 hours set aside, and we've been doing an hour and 15 minutes because everyone is maxed out, I think, right now. So, um, if anyone has strong opinions on whether to keep it at this abbreviated time, you know, as long as we're kind of dealing with the pandemic or as, as the pandemic is affecting us as much, um, in terms of workload and time, or if folks would like to have a lengthier, um, meeting, uh, in the spring, I'd just love to hear about it so, you know, we can accommodate, um, your preferences as well. So, with that being said, um, will one of our members move to adjourn our meeting?

Next Speaker: This is Deborah. I move to adjourn the meeting.

Next Speaker: Thank you, Deborah. Can anyone second the movement, motion?

Next Speaker: This is Kirsten. I'll second.

Next Speaker: Thank you. Thank you for bearing with us, all. Thank you for your patience. Thank you for continuing to attend this meeting, and thank you for your extremely hard work. Um, this is not easy, so having you all join us, um, and continue to do the incredibly important

work you're doing is just, you know, uh, I think it's a true, um, it's a true glimmer of hope, um, for me personally, so I will just end us off on that. I hope everyone gets a little bit of time over, um, the upcoming week to have some moments of respite. And do not hesitate to reach out to me at any time, okay? Okay, we will go ahead and end the call. Take good care, everyone.

Next Speaker: Thank you.

Next Speaker: That sh –

Next Speaker: Thank you, Rosa. I can end the Webinar now.

Next Speaker: Thank you.