Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
June 10, 2020

Transcription provided by outside vendor
Full voice recording of meeting available through *Recording* link

Rosa: ****. Thanks everyone for bearing with us. This is, we're doing this completely remotely ****. So, um, can, um, okay. Great. Everyone should be able to see our agenda on our screen.

Other Speaker: ****.

Rosa: **** should be able to speak on the line?

Genevieve: Rosa, this is Genevieve. Yes, you can. Your screen is visible.

Rosa: Excellent.

Genevieve: Okay. Well, this is Genevieve ****. I think we'll start with the call to order and roll call. Uh, and, let's see. We have about 27 attendees online. That's excellent. Uh, again, this is, you're here for the healthcare-associated infections advisory committee meeting for June 10th, 2020, and we'll have about an hour and 15 minutes to go through our agenda today. So, uh, first of all, uh, so, I just introduced myself, and I'll be your chair for today. Uh, Rosa, how do you, do you, how do you want to go through roll call? Or should we just instruct people to look at the attendees list that's provided on the, on the right-hand side.

Rosa: I think it, it would be, I do see the attendees list. If folks are able to, um, unmute themselves and would like to introduce themselves, I think that would be great. And please, just as a friendly reminder, to unmute yourself. Let's see. I'm, manually unmuting as I can, uh, there are some of you who are self-muted. So, please unmute yourself with that little, um –

Other Speaker: Microphone.

Rosa: Green micro –

Genevieve: Okay. This is Genevieve. Uh, what I'll do is I'll ahead, while we're getting Rosa back on, online, uh, we'll go ahead and go to approve the March 2020 minutes. Uh, and if you would like to, uh, approve them, please unmute yourself and, um, give your approval. And we need approval and a second, please.

Other Speaker: Can you hear me now?

Genevieve: Yes, we can hear you.

Other Speaker: Um, so, okay. Yeah. And it said muted by organizer up until the microphone just changed. Um, so, Jesse Kennedy. I'm here.

Genevieve: Okay. Thank you. Were you also, um, able to, um, give an approval for the March 2020 minutes?

Other Speaker: Yeah.

Genevieve: Okay. Great. Thanks. Is there anyone that has a second for the minutes?

Other Speaker: This is Deborah Catora. I'll second it.

Genevieve: Great. Thank you. So, the March minutes are so approved. Uh, at this point, I'm gonna check in. Rosa, are you available to do the logistics update? Sounds like not quite at this moment. Uh, Becca, I'm gonna see if we would like to move ahead on the agenda to the situational awareness around COVID-19? And then when we have Rosa back on, we'll return to the logistics update ****.

Other Speaker: Hi, Genevieve, this is Angela. Um, Rosa just sent me a message saying that Becca is not going to be able to join us on this call unfortunately.

Genevieve: Is someone else going to be delivering the situational overview, or should we just proceed?

Other Speaker: Uh, let me check real quick.

Genevieve: Okay.

Other Speaker: Do we know if we have a quorum? Or if we have, who we all have on the line?

Genevieve: That, sorry, that was, um preempted because of, uh, Rosa, um, not, something happened with Rosa's thing. But, however, you can look at the **** in the right-hand box there, under attendees. We should be able to determine from that if there is a quorum. So, if everyone can pause for a moment, we'll just verify that before we continue.

Other Speaker: This is Pam Cortez. Do you wanna maybe just have people mute, you can call through the roll of the committee members, and then have people just briefly say they're here or not, potentially?

Rosa: ****.

Genevieve: Yeah, we have, um – just hold on one second, Rosa. Yeah, we have everybody's name. So, it's just a, it's, we can decide also if there's a quorum without everyone having to go through and everyone unmute. But, um, yes. We can also unmute you one at a time and introduce. Uh, so, give us a second. The main person, uh, was not able to rejoin. So, give us a second here while we try to organize this. Okay, everyone, thank you for your patience. Um, we're having some audio issues. There's a lot of feedback when we unmute people, so we're not gonna go down the list. But Rosa will be, uh, looking to see if there is a quorum. And that just really pertains to the minutes. So, we may have to redo that. But we'll, we'll verify that by the end. I think the main point of the, this meeting to, this afternoon was to understand, uh, in a discussion around COVID-19 what your organizations' roles and experience have been around this, uh, and to share any learnings and feedback around that. Uh, so, if you have a question, we're gonna try to, uh, we will, you know, be able to unmute you so you can share verbally. We do suggest that if you're calling in by both your computer and your phone, that that creates that feedback that we're not able to hear anything. So, if you can choose one or the other ways to communicate, that would be, uh, that would be excellent. So, one of the questions, uh, that we had to kick us off, uh, was around, um, that I had was around testing. This has been very hot, especially in long-term care facilities, around testing for residents and staff on a regular basis. And I was wondering if there's, uh, anyone here from a long-term care facility that could comment on if they've had discussion around that that, and how they're addressing it, any challenges.

Other Speaker: This is Deborah Catora. Um, our staff just yesterday received a notice that there is going to be a specific plan or testing of all staff and residents in the larger facilities. But they, it didn't contain any details yet. I certainly know, you know, individual places have been trying to do it, but I don't know what the success has been.

Genevieve: And, so, this, you're, and you're with DHS. Just a reminder for everyone of your position. And, so –

Other Speaker: Correct. I'm, I'm with DHS. I'm the staff RN consultant, um, and the liaison with the health division. Um, and we have foster home where there's not been any current efforts for testing outside of their individual position decisions. Um, and then the, uh, assisted living, residential care, and nursing homes.

Genevieve: And do you expect that, um, that long-term care facilities will need to come up with their own plans? Or do you expect that there will be some, some, uh, guidance along how and how often and this kind of thing? ****.

Other Speaker: ****. Based on what the memo, and it was a pretty brief memo, but based on what the memo said, um, it sounded like that we are working with the health division on guidance. So, my expectation is that there will be some, um, specific guidance on how it will work.

Other Speaker: Yeah. This is Tom Rollins, and we, we keep being told there's a plan coming, but there, there's just, we're lagging behind most other states with a plan for testing. So, we're just waiting for, for guidance from OAJ on what, what that entails. Because the

recommendation has been only test symptomatic, not just test blank slate. So, we're just kinda curious what the plan is, because we haven't received anything yet.

Genevieve: And, um –

Other Speaker: And this Deborah again. I, once I get the memo with the, you know, with more specifics, I'd be happy to forward it, you know, so it can be shared with the group.

Genevieve: Great. And, um, I'm sorry, it was, uh, who, who was speak, **** someone that was speaking? This is Tom Rollins that was speaking from, uh, long-term care. Uh, are there part, is there, like, particular areas of concern, uh, that you would want addressed in, in guidance? Uh, I know that we've had to do some testing around positive case, uh, of both staff and residents and, you know, logistical, etc., uh, challenges. You know, some healthcare workers work at multiple facilities, etc. I was wondering if there was any particular pieces that you would like to see addressed in such guidance?

Other Speaker: Well, testing, the number of tests, getting testing, and it varies from county to county, which we've noticed. Some counties tell us they have no tests. Some counties have tests, but they only do it if they're asymptomatic. The guidance is supposed to be that, to test all residents and staff on a routine basis. We don't know what that looks like yet. Um, we're trying to scramble to try to find places to test en mass. We don't know if it's coming from the state, if the state's gonna offer that. My understanding is, is that's the, the route that we're going. But we just don't know. We, we just need some guidelines, like, or to hear something. That would be great.

Genevieve: And I, I know that they're working on that and working out the details on that. Do your facilities in general have someone with the ability to collect samples in house? Or are you –

Other Speaker: Yeah. We're ****. We're a nursing home. Mine is pers, preliminarily, or primarily, uh, nursing homes. I mean, that's the guidance is for nursing homes and assisted livings. But we have an, we have multiple nurses and all that that can do testing. So, it's just, we just need the kits. In Washington, they're providing all the kits for all the staff and residents. So, we just, we don't know what that looks like from Oregon. Do we need to get our own? Is Oregon supplying them? Who's paying for the staff? Is the state paying for that? 'Cause the staff, that's a huge burden, cost on, on the centers and I'm sure in adult foster homes as well, and all that. Who's gonna pay for all that?

Genevieve: Yes, these are all the questions **** too.

Other Speaker: Yeah. Okay.

Other Speaker: Yeah.

Other Speaker: Well, good. I'm glad I'm not alone.

Genevieve: No, not at, not at all. Not at all.

Other Speaker: And if you're working, how often are you expected to be tested?

Genevieve: Correct. And there have been, yeah, different, um, and maybe some of the other healthcare systems can, can chime in, but, um, if they've had outbreaks. But **** have talked about, you know, is that **** depend upon the prevalence in the community of that particular nursing home. So, it may be different if you're a nursing home, um, in Hearney County versus if you're a nursing home in Multnomah. So, **** as well.

Other Speaker: Hi, this is Delia Murphy. Um, I'm sorry ****. Oh, okay. Um, so, um, **** situation, we were able to secure tests from the county, um, to ****, uh, employees because of, um, you know, this, um, situation. We, we did, um, **** able to secure tests privately or, um, ****. The whole, you know, in that situation, there was a delay in the ability to test. We would have preferred to test much sooner, but not having the availability of the, um, testing materials, um, as was mentioned, um, prior. And as we move forward, um, you know, even to secure tests for ongoing, um, testing of our staff and, um, that did test negative, um, trying to, you know, how is that gonna happen? We're still scrambling, um to try and get plans in place for that. And, so, with the, um, the re, the memo that just came out, you know, having that information, um, as soon as possible would be really beneficial, um, as we try and secure test materials.

Genevieve: All right. Thank you. Yeah, I know even the healthcare systems have had to **** the test materials. Other comments regarding that or ****? Um, it's helpful to hear this, um –

Other Speaker: I, my name is Kelly Quaylo, and I represent ambulatory surgery centers. I'm from, Eugene/Springfield area. In our community and our center itself, we are testing a hundred percent of our patients. We do PCR testing when time allows, with test results to come back within, uh, 3 to 4 days. And then for cases that are added on that are emergent only, no elective cases, um, we are, we have rapid kit testing that our nurses do. We don't allow any of the patients to enter our center before the testing's done and the results are back. Um, it's been a challenge to get the results back from where we do the PCR testing, because it's going to Bellingham, Washington, and the turn-around, just getting access to them and the report back has been our biggest challenge. But if we don't get them back, we don't do the case unless we have a negative result.

Genevieve: And, um, is it, this is Genevieve, **** okay with that?

Other Speaker: Pardon me?

Genevieve: **** have patients been, um, with, with doing the testing, any refusals, or is it, is it ****?

Other Speaker: We've had one, we've had one patient refuse just because they did not want the, it was **** to determine whether they could, had to comply with the rules and stuff. But everybody else, they've given us some resistance, but they have to. We just tell them that it's

really for our safety and theirs. We're doing procedures, we're intubating patients, and for areso, aerosolizing procedures, for the safety of our staff and the anesthesia providers, it's really a requirement. We can't move forward unless they agree to testing. The biggest challenges for us have been patients who are in the Roseburg area, mainly, and then, um, on the coast, just organizing them to get to a site where they can test. Coos Bay has, um, we send those patients if they can't get testing in their community, we send 'em to Florence. Peace Health has a hospital there, and they're doing PCR testing. And then, um, just different areas, just tryin' to figure out where in their community they can get tested. If not, they have to come here to Eugene/Springfield area. And our hospital, Peace Health, is doing PCR testing at their urgent care sites, and they have a 72-hour turnaround. And then McKenzie Lynn Hospital is doing PCR testing. It's a drive-up type testing, and they can have results within 24 hours, which has been really helpful. It gives us different options.

Genevieve: That sounds great. It sounds like you've really come up with a good system. Does it change your PPE at all that you use during surgery? Or do you –

Other Speaker: Yes, we ****.

Genevieve: ****.

Other Speaker: They wear N95s during intubation and extubation, and then they allow 20 minutes for our room, um, air exchanges to allow for anything that's airborne to be removed. But we've relaxed that since we've had a hundred percent testing in place. Now we just do a regular 15-minute turnover, because everybody has tested negative.

Other Speaker: So, this is Dan Sirbisa from Kaiser. We also have three ASCs. I'm wondering, do you, so, even with the negative tests, you're still wearing the full PPE?

Other Speaker: We are. Our staff is just more comfortable with an N95, because the patient's reporting self iso, isolation up to 3 to 4 days, and there's no guarantee that they're being truthful. Not that we expect that they're lying to us, but there is potential risk, and some people can show now symptoms and still have, um, pretty good viral load. So, you know, there's **** anywhere from 3 to 4 days since their test occurred.

Other Speaker: We're doing the same in long-term care, per OHA ****.

Other Speaker: Yeah.

Other Speaker: ****.

Other Speaker: We can't really get our –

Other Speaker: **** with the various tests ****.

Genevieve: And, uh, Dennis, ****, Dennis **** saying. Are you managing your surgical patients differently for positive or negative in your ORs? Or in your A, ASC?

Other Speaker: Yeah. In the ASC, you know, since the majority of those are elective, we are not, um, we're not proceeding with surgery. We're holding those off if they do test positive. Although I don't think we're had any positives yet. And, so, um, otherwise no. We, we're proceeding, uh, with the case if it's a negative.

Genevieve: Like, are you using N95s for intubation, extubation, ****?

Other Speaker: We are not using our N95s with intubation or extubation.

Genevieve: Are there others **** that would like to share their experience ****?

Other Speaker: So, this is Kirsten Chudy. I don't know if you can hear me. If somebody could give me some, uh, feedback if you can, I'd appreciate it before I keep talking.

Genevieve: Yes, we hear you. Go ahead. Thank you.

Other Speaker: So, okay. Great. Sorry, with the audio difficulties here. Um, has there been any thoughts or discussion as a state about helping provide a framework with, um, kind of threading the needle of testing, um, and preserving testing in the setting asymptomatic, pre-surgical, or admitted patients as well as PPE conservation? Because I, I think what we're struggling with and the framework we're trying to put into place which various societies and various, uh, organizations and certifying bodies around the country are all coming out with different guidance that kind of takes into maybe their either local situation or worst-case scenarios that doesn't really apply to us currently with our low prevalence in southern Oregon. Um, you know, we're trying to put in place a process that at a low community prevalence when the negative predictive value of the test is very good for high-risk procedures that generate aerosol, we test. If the test is negative, we move towards normal PPE use, normal turnover. At an intermediate prevalence, I think, and, and that's where we could use some help defining that, and making sure that we have the data we need from the state and at a regional level to help inform that. Um, but at an intermediate level, then maybe **** 'cause, uh, you know, what everyone's coming up with, aerosol-generating procedures intubation/extubation may be riskier than, you know, heavy breathing or exercise, which has also been classified by some groups as aerosol-generating. Just say if you're a high-risk aerosol-generating procedure, you know, maybe then we use some extended PPE, um, even if you test negative, because, again, the positive predictive value of the test isn't as good in that setting, and we expect we may get some false negatives. And how many do you feel comfortable letting slip through the cracks? Um, whereas in a, uh, high-prevalence setting we move maybe even away from testing, um, it, unless it's for reporting purposes, if we're not going to manage the patient differently and say, you know, we don't feel comfortable that our test gives us, um, a good enough answer, and that if they're testing negative they are truly negative and not contagious, and maybe we need to be using higher level PPE in that setting. So, has there been any thought about kind of risk stratifying based on community disease prevalence?

Other Speaker: Um, this is Marian. I can just, I, I know, and just supporting what you're saying. We have looked at the same issue, because I would say we're more moderate risk, and

there's not, no clear guidance on what to do for moderate risk. So, um, we just opted instead of requiring N95 masks, um, for the aerosol-generating procedures, to go ahead and, um, you know, have, uh, full face shields, um, surgical masks and, uh, gowns and gloves for those scenarios as kind of the middle of the road.

Genevieve: And Mari could you, this is Genni, could you clarify, is that for patients who test negative prior to procedure?

Other Speaker: That is for, um, aerosol generating procedures. Um, –

Genevieve: Yes.

Other Speaker: – ****, um, I will tell you our anesthesiologist in particular, and it sort of depends on the anesthesiologist, but they certainly are feeling more comfortable having N95 masks even with negative, um, pre-op test results.

Genevieve: And does, this is Genni, I don't know if someone else who could comment on that or on Kirsten Chudy's comments. I did wanna call out if you're not already aware the, um, OHA does publish, uh, case counts and deaths of positive/negative tests, uh, and count per 10,000 by county, which isn't as granular, of course, as a locality, but, um, maybe a way to, to, you know, um, at least understand the different prevalence across the state and how that might affect your pre and post test screening. And I did wanna bring up that, um, in the comment box is a good comment that the rapid tests, uh, having a false negative rate between 18 and 46 percent and, uh, and there's quite a large range, but in general the laboratory community agrees that the rapid tests have a higher false negative rate than the PCR testing, uh, when it's well done. Hence, the, the general preference. Are other systems using testing to change the level of PPE for aerosol generating procedures? I'm also thinking, uh, might be for ENT settings or –

Other Speaker: Okay, this is Susan from Legacy and I did share a little bit about what we've done, um, for our AGPs and, and testing as well. So, we have a document in which we've categorized things. We've found that not only do we have to tell people what an AGP is, but also what's not an AGP, so we've, um, categorized as a high risk AGPs, low risk AGPs and then not an AGP. And then within the document we've also stratified, um, when you would use PPR or fit tested N95 air, essentially airborne in contact, and those are any person under investigation, or lab confirmed COVID-19. And then we have, um, moved through with asymptomatic or a negatives, so, um, may have been COVID screened, so they weren't tested, but they, um, um, don't have any signs or symptoms per a screening. Um, and that so recategorize for anyone who's doing a low risk, um, aerosolizing generating procedure, again we have a list of those. They're in droplet contact, but they, if they're doing a high risk one, um, then we do a PPR with a, um, fit tested N95. We have, um, anyone who's asymptomatic in negative screen, negative test, um, then we just do standard precautions. And that includes any AGP. Um, we've worked considerably hard on this and, uh, we pretty much got pretty good by it. You know, there's always one or two physicians or nurses that kinda push back, but, um, for the most part it's worked really well. And really spelling out, like, and kinda holding firm to this, so we had a really good group of anesthesiologists and **** physicians and, um, intensivists and hospitalists that worked on making this document succinct for, um, our staff. We also, um, do test prior to

surgery, so that that, um, any elective surgery should say, so if they're planned, then we'll do, um, testing ahead of time. If they're an unplanned, urgent, trauma whatnot, we'll try to do the express test as much as possible, um, to get some information ahead of time. Um, but we tend to err on the side of, you know, we got a high risk AGP, they'll, they'll, um, wear N95s or PPRs. Hope that helps

Other Speaker: So we should be all good now.

Other Speaker: All right. Bob **** listening in.

Other Speaker: Thank you Bob.

Other Speaker: Oh.

Other Speaker: I'm sorry –

Rosa: That's okay.

Other Speaker: – I didn't mean to interrupt anything.

Rosa: No, very good. I was just making sure. Okay, we can go back to our discussion.

Genevieve: Great. Thank you, ladies. This is Genevieve. So, Susan, thank you for sharing that. Um, I, uh, question, to follow up on your AGP list, I don't know if other people have this question, but I know this has been a hot topic as well for Providence, is your list of AGPs is that, you know, the OA, the high risk is that mostly the OHA list, or have you had to entertain a lot of other questions like, uh, laboring women, this kind of thing? And Susan if you're trying to respond, you will need to unmute yourself.

Other Speaker: Yup, there. Thank you. Gosh, that was, um, yes. We do follow the OHA document, um, but we have had to take into consideration some of the, um, professional organizations that have written in their own, um, and again that was sort of reviewed really closely. But found that for the most part, um, what we got from OHA was, um, was right for what we did. We, for, um, second stage of labor we do have an opt in for N95s, um, for the provider. So we have a few little, um, allowances here and there for things like that and we still get challenged on things, um, but for the most part, yeah.

Other Speaker: ****. We've had a lot of questions about this, as well, and rather than trying to deal with this as a warn off, we've tryin' to compile a more comprehensive list. Um, I can send it out to the group, but the best one that I came across a couple of days ago was from Mayo's ****, um, on their ask mail expert website, and so they've kinda created a spectrum, where they extend from high risk to intermediate risk to low risk, and also, um, they reference what PPE are using at each of those levels in their current disease prevalence, um, I know how things change in the future, about changes, and they've also created a list of outpatient procedures as well as inpatient procedures that they require testing for prior to, uh, undergoing a

procedure. So I thought it was very helpful in regard to working to get our, our policy in place with kind of that robust information.

Genevieve: That's very helpful you did, is that on the Mayo website or like ****.

Other Speaker: It's through Ask Mayo Experts, so I'll, I'll send out the link. I don't know if it would be easy to search for. It was posted in one of the, uh, Society of Healthcare Epidemiologists of America list serves, um –

Genevieve: ****. That'd be great, thank you very much. Other challenges, comments around AGPs, that kind of thing? And I do see there's other questions in the chat, question box that are, um, coming up too, but I just wanna see if there's any – they also like to share their experience around and how it affects PPE use? And if not, I'd like, uh, I see that Jesse Kennedy has, uh, would like, would be happy to share about, um, ONA's role and experiences, uh, so I don't know if you would like to go ahead and unmute yourselves and share? That's be great, thank you.

Other Speaker: Sure, thank you.

Genevieve: ****, you and I have talked a little bit about PPE over the last couple ****.

Other Speaker: Yeah, definitely. Um, I think, so as, as far as ONA's role has been regarding all of this, um, I have been scouring all of the ONA CD, 'er sorry, all the OHA, CDC and WHO sites, um, daily, several times a day to try to, uh, compile what the guidelines say en masse, so try to make sure that everybody is on the same page. Um, I would say as far as the challenges go with that, there are a lot of variances, as I'm sure everybody knows, uh, but I think the most difficult variances to account for are, um, the varying guidelines from individual documents, individual document, whether we're talkin' about CDC or OHA or WHO, but just that one document might say one thing in big terms, while another document from the same group published at about the same time says something a little bit different, so it's been really difficult to provide concrete guidance to all of the nurses and other healthcare workers' compensation throughout the state, uh, regarding what the current guidelines are. I would say that there has been also a lot of variance within the individual facilities, as, as far as what those guidelines are interpreted as, um, for example, some facilities are still utilizing facility disaster plans, while resuming the non-urgent and non-emergent or elective procedures, which doesn't align with what's going on, and I think there's definitely a lot of work moving forward for all of the facilities to be aware of what the guidelines are to be able to provide the appropriate protections for our nurses and stuff like healthcare workers. I think, um, a lot of work on individual level to help bring, uh, facilities into alignment, uh, but overall there's a, a large amount of variation as far as what is acceptable, um, and a, a lot of variation as far as what facility, disaster plans include and so it's, it's been a lot of work to try to figure out what the responses are within the state, so I think moving forward it would, it would be fantastic to be able to have some, some better work groups to really sit down and talk about what disaster planning looks like if, if we are going to have this second surge, this fall surge that coincides with our influenza surge. Um, it would be really helpful if we could get all of the facilities and, and folks here and, and people throughout the state to sit down and talk together about what it would look like if we do see that surge, so that we can anticipate it, because right now we're still

kind of limping along, most places are getting by pretty well right now, uh, but as we all know we're already seeing a, a pretty big surge in, in many states, Arizona, California, Texas, um, and those are mostly related to the reopening, but as we reopen and get closer to the influenza season, it, it would be really beneficial to ****, uh, the public within our state, as well as folks that are caring for the public to be able to sit down and make sure we all have a comprehensive plan about what is we're going to do when this comes back, because I'm sure everybody is, is renewing some of **** and so it would be good to make sure everybody's on the same page, so that we know what we're talking about, we all know what the, the most appropriate PPE is, um, and we are all working together towards the same goal of protecting our citizens and our healthcare members.

Rosa: Thank you Jesse, this is Rosa. Um, you know, I think that this is something that we all, you know, we want to see, um, across the board, and I don't, you know, I mean, I don't wanna speak to **** details, ****, we, um, sort of know, know the, the way to kinda bring folks together, but maybe, so Paul is on the line. Paul, do you think there is, you know, what, like is there a way for, would you, um, first to kinda facilitate some feedback or discussions, um, amongst our, our various state ****, or, um, would you suggest a particular way for them to out if you're on the line, Phil?

Other Speaker: Um, well, I mean, I, I

Rosa: ****.

Other Speaker: Yeah, I, I would think this would be the right group, no?

Rosa: I, I would think so, yeah, and certainly we'll be passing along the kind of, the conversations that are being had during this meeting, right? So I think is, uh, one opportunity to kinda of talk about what we would like to be seeing in our facilities or among our kind of constituents, Jesse, in your case, of, of working at the ****. I think that, you know, just **** generally on this, I think that, um, you know, there are still shortages of PPE and we don't know, you know, what we've gonna be seeing in terms of, um, cases rising or declining **** in coming weeks, so I think that at the very least to some degree we're gonna have to continue with, you know, for PPE optimization, um, at least for the time being.

Other Speaker: ****. I know we're not entirely out of the woods yet. I just wanna, I would really appreciate the ability to work together to work towards a framework for the future should this happen again, because we do know that PPE is still short right now and it's been, facilities are following the PPE optimization guidelines, hopefully not following, following into that ****, uh, area, but I just wanna make sure that as we are talking about this that we can anticipate some of those things. I mean, I was on the Ebola response force when that was big thing, and we had several meetings, uh, we trained several nurses in the state, designated what was gonna happen, what sort of PPE was **** be held between different facilities, so I would just like to see, um, something, whether it's our group, which I think would be entirely appropriate, or an additional group to come and find what those appropriate interventions would be should we start to see what we're hearing we probably will see.

Rosa: So I just wanna say that just because I think we need to, that, um, because this was a public, um, meeting, and this is a, you know, an advisory committee, um, unfortunately, um, any kind of convening of this group together needs to be a public meeting, as well. Um, so I'll just say that, but I think now is a good time to have some of these conversations or during subsequent staff meetings, and then, of course, anyone can shoot back directly with them.

Other Speaker: Uh, this is Deborah Catora with DHS. One of the things that I hope that we, um, focus a little bit on is some of the things that we're seeing in our ****, um, aside from whether or not there's enough PP, PPE available, is failures in, and this is a licensed staff, failure of washing your hands. Um, when they were using, not using it properly or not, you know, um, removing it properly. And I think that that's, you know, just as important as discussing how to manage the PPE, because if you're not doing some of those other basics, um, you're, you've got gaps. And I think the other issue that always faces any kind of large, um, crisis like this, is, um, a, a PPE, um, oh, I lost the word, basically people becoming tired and sorta cutting corners, fatigued, that's the word I wanted. Um, to address the fatigue of, you know, the PPE, um, so when people were trying to do it right, um, but they had, you know, heavy workloads, um, working long hours, that kinda thing.

Rosa: I think one of the things that we've been kind of atrophying, I don't wanna, you know, I would love to see if some folks have been doing this, is that, you know, ongoing, um, education and training for staff is just so important, even if it's just a couple of minutes every once in a while. Um, you know, because I think there are a lot of facilities that sending information out, um, doing on line trainings, and I think that sometimes that that personalized, um, sort of one-on-one verbal and participatory element of education is also really important, but I'm curious to know. Thank you for saying that, I'm curious to know if other folks have been seeing that same issue.

Other Speaker: I would agree with that entirely, and also even add to that from the perspective that it is incredibly beneficial when we can provide that continuing education in a format that provides continuing education credits for our nurses that are looking to get certifications and, and raise their level of professionalism within the profession. And so I would greatly appreciate any sort of movement in, in that direction as far as continuing education for infection prevention, um, but also continuing education professionalism related to infection prevention, epidemiology and all those similar out, avenues.

Other Speaker: All right. This is Paul. Um, Jen and I were having kind of a side conversation in the chat box. I, uh, Jen, are you available to talk? Can you talk?

Other Speaker: Yes, I am, I **** you can be unmuted.

Other Speaker: Okay great. Yeah, I was not, not exactly understanding what you were sayin', but I, I was, uh, saying that regarding, uh, PPE, you know, there's, there's a couple of resources out there, one is that, um, CDC has offered guidance on, you know, what is conventional, uh, you know, what to be used in, in conventional circumstances, that is, you know, when there's no shortage, and contingency circumstances, and then, uh, crisis circumstances, you know, any port in a storm kind of, if all you've got is a cloth mask, use it kind

of crisis, uh, setting, but, um, but this stuff is also tied into the reopening phases for the various counties, so that the PPE is in, you know, if there's dire shortages, then, uh, presumably you'd be back to a different phase of, uh, COVID-19 reopening. Um, and then, uh, Richard has his, uh, his, um, crisis care guidance, and I, which I think may have touched upon this, but he, he works with a medical advisory group and so I was thinkin', well, maybe that would be a good group to get engaged if you had more specific questions about PPE.

Rosa: And Paul, I can, um, make that connection via email with Richard and Jesse now or soon.

Other Speaker: Yeah, so Genevieve, I wasn't quite understanding what you were sayin' in the chat box.

Genevieve: Well that's what I was referring to, because there has been, uh, actually quite a lot of work, um, with the healthcare systems and public health regarding the different levels for contingency versus normal functioning, and how that, how that, uh, relates to use of PPE, visitor restrictions and other, other details like that, so I think maybe we just need to get you, um, uh, get you into, 'er, get you associated or introduced to that group, um, where those conversations have been, have been going on. Um, there is all, always going to be differences at the level of the individual healthcare system and facility because of differences in supply chains, uh, and, um, you know, what, what they're doing, um, so some of that exists, and then also some healthcare systems have, uh, also, you know, interstate systems that complicate things, as well, um, but these are all great questions. Anyways, that was, that was, I was tryin' to figure out the name of, remember the name of that committee with Paul. I couldn't figure out what was the name of it, but I think it is the, the Medical Advisory Committee, uh, and another thing. And also through the Tri-County and, and county health departments too, have, we've had a lotta discussions around that.

Other Speaker: This is Josh from the Oregon Clinic Supply Chain Manager. Kind of in line with what you just said about going down to the county individual hospital level, um, that would be nice, um, when some of these recommendations are coming out. I know, like when Governor Brown mentioned a couple weeks ago that PPE was in ample supply, that just wasn't the case for facilities that didn't have allocations. And yeah, we were able to get PPE from the county, but unfortunately, it comes, you know, it's not guaranteed you're getting, you know, a thousand of the 1860s or, or of the death bills, and our staff was only fit-tested for certain ones, so that we had to re-do fit tests, which they led into, um, shortages, uh, trying to find the items to be able to do fit tests, um, so I had a lotta doctors comin' where, well, the governor and the state's saying PPE is in ample supply. Well, technically you could say, but it's not, it's not a one size fits all model, so I mean, that caused a lotta heartache for, uh, the supply chain team, at least for us.

Other Speaker: This is Sandra, um, speaking from Worship. Can you hear me?

Genevieve: Yes.

Other Speaker: Hi. So um, I kind of shared that, uh, since we had the **** a little bit before, um, it's hit Oregon. Um, we may be able to share some information and some lessons

learned with you. I've been working, um, every week on an IP forum, the Infection Preventionists, many from, uh, Oregon and some from Alaska to join us on phone calls to kind of like the polls from the IP perspective. But along with that, um, we also work with, uh, the Healthcare Emergency Coordination Center and they have been doing a really good job. They were created, uh, also like, um, with the Ebola funding. And, uh, what they did, is they track, um, each of the different, uh, districts according to what the space is, what the staffing is, what the supplies are so that they can be managed really easily, um, between the different groups. Uh, the Governor of Washington also has, um, an admiral coordinating the COVID-19, um, work at the, through this office, which has been very helpful. Uh, the, uh, Admiral Bono has, uh, weekly phone calls with WISHA staff and other leaders throughout the state in terms of managing that. In terms of, um, so for the PPE, and I'm hitting some broad things, but we have a lot of information that we could potentially share with you. Um, so like in terms of managing PPE, uh, we obviously have some shortages. Uh, we had shortages of pills. We needed to figure out what to do. We went through figuring out if, um, the uh, oh, what is it called? The, uh, the Zyrtec, I don't know. That's the allergy medication, but something tech outfits that, uh, some emergency responders wear that that's not good to wear as a replacement because people can sell them. Uhm, in fact, we learned that for each different type of, uh, N95, whether it's N95 or a KN95 or whatever, there has to be unique fit testing with all of those. We ran out of some of the testing solution for the K95 fit testing. Um so, so there's an abundance of information that we could share. We also learned that, you know, for some of the rural hospitals, or the ones that were particularly hard hit, were those that service migrant and seasonal farmworkers and, uh, Latino populations because of different cultural issues. And, um, so we also had to deal with some language problems, um, cultural issues, things like that. So, I can just say that there's a wealth of information. One of the things that WISHA has me do, is each week have to work on compiling on what happened, because there's such a wealth of information out there. Some of the areas that I first started out focusing on were any changes with the CDC, WHO, um, with regard the PPE, uh, with regard to environmental cleaning, uh, with regard to, um, other types of shortages and anything that I saw that looked like it might impact, uh, the work that we're doing. So, I don't know if any of that can help? Uh, but certainly, Oregon is still, um, welcome to, uh, participate with us on the IP forum. Did you hear me?

Genevieve: Yes, we sure I did and I was, and also following up if there's anything, resources you'd like to be able to share with the group, go ahead and share those with Rosa and she'll be able to, um, uh, just to share them with the fuller group. So yeah, thanks.

Other Speaker: Certainly.

Rosa: Thank you, Gen, that's a great idea for those folks who do want to share thing, um, you know with, with your colleagues. I can compile them and send them out. And then I think, you know, we'll be sending out meet, meeting minutes as usual. Um, and I think just the topics that are coming up on this call are really, uh, crucial.

Genevieve: Yeah, because some of them are –

Rosa: Um, so thank you very much –

Genevieve: – to share as well.

Rosa: – for sharing all of that.

Other Speaker: You're welcome.

Rosa: ****.

Other Speaker: You're welcome. Um, also some of the things that you may be, uh, come across to deal with is a shortage of vendors. So, we actually had people in China on the ground go and vet some of our supplies and we've had WISHA staff go out and deliver it to hospitals too.

Genevieve: Yes, thank you. I know and the previous speaker too had mentioned, uh, the supply chain issues. Uh, and you know, even the healthcare systems have dealt with, uh, faulty different supply chains and having to, uh, pull those back after receiving them, because they were a poor quality.

Other Speaker: Yeah.

Genevieve: Uh, if anything can be done to vet that before you receive.

Other Speaker: Yes. Yep.

Genevieve: Are there other comments or questions around supply chain? Challenges? Um, comment again, on the PPE, um, but Mari had a question, uh, wondering how many facilities are moving to universal eye protection for front facing staff? Uh, and if anyone's like to comment, if you could clarify. Are you using goggles or face masks, uh, you know, are you reprocessing them, duration of wear, things like that?

Other Speaker: This is ****, I have a ques – or sorry. Oh, this, uh, to piggyback off of that, if there any kind of lessons learned regarding best practicing for storage of **** plus eye protection, um, you know, we kind of the paper bag model for our N95 but I think these **** codes are slightly different but a ****, so I'm just curious if anyone has any **** on that if not what?

Other Speaker: Well this is Tom Rollins for ****. We, in our center, long-term care centers, we are using face shields. First of all, they're more comfortable on staff than goggles or anything like that, um, and they seem to last longer and don't fog up as much, obviously, um, and then as far as storage, what we do, is when they come out, they, we have little, um, cubbies outside of each room with, um, disinfectant in them and then they disinfect and throw them into a bend, um, after disinfection after, of course, after hand bagging and all that stuff but, um, that helps us with the reusable ones. We also have disposable ones but we don't like those as well, um, the foam doesn't last and doesn't hold up. Yeah, for EPG and long-term care, we are having to go to contingency and crises conservation much more frequently, probably than hospital are at

this point. It's, were using cloth downs, we're using facemasks for a whole shift. I mean, trying to get by EPG dress has been a very difficult, um, endeavor, for sure.

Other Speaker: This is Sandra from, uh, WISHA again and, uh, you know, using those cloth down seem to be like a really great solution and, uh, Washington because you could launder them and that gets rid of the COVID virus so, uh, that's, that's really useful, um, way to go, yeah.

Other Speaker: Yeah, we're, we're using that. The only issue is, is we're getting mixed messages about reuse so it's after each use, you have to launder it, is what the state is saying. Not already health authority necessarily but, um, it's been very difficult. We're getting many mixed night surveyors verses Oregon Health Authority verses the website but we, that's where the problem comes in for us because we're so heavily regulated that we just, we're getting lost into what, what's the right, I just want us to do the right thing. I, I can deal with regulations and stuff later. I just want to do the right thing that keeps our folks safe so, um, you know, were told we can reduce swap downs and hanging inside the room and then wonder at the end of shift for, for an aide or a CNA but then we have surveyors that come in and say you have to launder between each use and which then we don't have the supply of cloth downs. It's like we don't have thousands of them sitting in buildings waiting to be used and laundered.

Other Speaker: Yeah.

Other Speaker: It's too difficult, you know.

Other Speaker: Yep, yep. We were really lucky, we had some, um, people make cloth gowns for some of the long-term care facilities and then I believe it was also some of the aprons that are used in the kitchens with the long sleeves, they were, worn backwards as a potential solution too.

Other Speaker: Yeah, we've, we used lots of several different like painting, coveralls, those, the staff really liked those 'cause they cover everything, um, and they have hoods, so it protects their head. They kind of thought those were pretty cool but in Washington, we've had, we have a center in Washington too. It's been very, a, a much different experience from this prospective, cause they're, they're given ****, the same guidance. Like yep, you can do this and we're just getting mixed messages in Oregon so.

Other Speaker: Oh, I'm sorry.

Other Speaker: Yeah, no, Washington's been great, so, I just, if we could get some the same guidance in Oregon, that would be super great.

Genevieve: This is great everyone. This is Genevieve, uh, thanks for all the questions and comments so far, uh, we are coming up on our last, uh, 5 or 6 minutes of the, uh, uh, of the meeting today so I do want to move us to our next item of future topics and public comment and Rosa has a quick update. I would like to suggest that if there are questions that come up, uh, and challenges, I'd like to encourage you to email them to Rosa, uh, she can share them with the

group, um, if, and that might be one form to get, uh, some responses from your colleagues, uh, whether long-term care facilities or healthcare systems. Uh, so, uh, that, that might be possibility if we can get to everything today or if there are issues that arise. Rosa, is that okay and appropriate. Sorry to put you on the spot.

Rosa: It's absolutely perfect, yes, and this is a shorter meeting than our normal 2 hours. We wanted to really focus on preventing a forum here for people to chat with one another and, um, we also, you know, recognize that **** can **** to who on this call are, um, a really crucial, uh, **** of our infection control infrastructure here in Oregon and Washington. So, um, we didn't want to, you know, absorb too much of your time, um, if, please send me any thoughts, questions, comments. We will do our best. Resources we will share, um, I just wanted to briefly, briefly mention, that we do still have several vacancies on our advisory committee. Um, I can't say I've been doing much outreach recently trying to get these vacancies filled considering, um, it feels, um, like there are other things taking precedence at the moment, but to this group, I will just remind that we are still looking for, um, a health insurer representative, a consumer or patient advocate, a hospital administrator at a facility up here at 100 beds and a representative of the Oregon Patient Safety Commission. If you happen to know of anyone who is interested, I think everyone received in our meeting materials that bring your voice to the table, one **** of like how, um, the basic info about ****, my contact information on it so hopefully, we can, you know, hopefully we will have more opportunity to get those vacancies filled, um, going forward so if anyone is able to, to pass on ****, an internal print package review.

Genevieve: Great, thank you. Uh, so went over a lot of things. I think, we definitely, just to summarize **** and **** around, uh, some clear guidance on, uh, PPE levels and crisis contingency. How testing might change PPE. How to, uh, be very clear with recommended PPE in, uh, through non-hospital settings, long-term care facilities. Uh, so, you know, these are suggestions, thank you, that we can call somebody back to the groups, a lot other groups that are working on those questions. So thank you. Uh, so next I'd like to turn for, uh, any topics for future meetings or reports that people would like to hear about. Our next meeting, uh, will be in September. Just to give you, to remind you of that. Are there any **** folks would like us to address, thank you.

Other Speaker: Yeah, yeah, this is Dennis, **** from Kaiser, um, you know, we just had an ASC survey conclude today from Triple AFC and I'm still really interested in our comparison amongst the ASC's in Oregon for some of our ATI's. Like what SSI's are we following that are similar and if there's any learnings we can get from organizations that are doing well. Cause I know that we post that across the board for hospitals and long-term vaccination rights but then, he has **** like, it would be really be nice to have something like that.

Other Speaker: Dennis, can I ask, um, and then just off the group, you know, we did have a dialysis theme meeting, um, in March and we could potentially think about having, uh, put in our meeting where we do, a do some extra engagement of our ASC, um, colleagues. Um, we have some folks from ASC too. We really, really appreciate hearing from because it's a fact that we don't get to get out much of, um, so I don't know if folks want to think that's a good idea, of course. I mean we're wanting to be really, um, responsive to the situation as it unfolds, right,

cause that's reason why we're kind of doing a little bit of a, unusual meeting this time. Um, but, we, it's something we can consider for September. You can email your thoughts as well.

Genevieve: Great suggestion, uh, anybody else? **** and you know good things coming to mind again, you can always email Rosa, uh, finally, uh, I, I need to leave the, uh, it open to any public comment. If there's anything else that folks would like to say in regards to the HI adviser committee suggestions, etc. This is your time. Okay, with that in our final minute, uh, I just want to thank everybody for bearing, uh, with us during our technical difficulties and, uh, staying engaged and sharing your opinions and questions and we look forward to seeing you in September. Thank you very much.

Rosa: Thank you, Gen. Thank you so much -

Other Speaker: ****.

Rosa: - for **** in this discussion.

Genevieve: Thanks.

Rosa: You're very welcome. Be well everyone. Thank you.

Other Speaker: Thanks.