Healthcare-Associated Infections Advisory Committee
September 9, 2020

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

Speaker: Hi everyone, this is Rosa Tammer. Um, can I just ask that, um, someone on the line let me know that you can hear me okay?

Next Speaker: This is Pam Bruin, I can hear you ****.

Next Speaker: Great, thank you so much. So, thank you for joining us during our September quarterly HAI Advisory Committee, um, meeting. This is, of course, our remote **** meeting, for the time being we'll be doing this remotely going forward, I think, unless, until something, um, changes kind of significantly. Um, hopefully we'll just continue to have this be, um, you know, a forum for us all to get together and, uh, talk about how, uh, things are going for us. So, um, with that being said, I, I am going to be, um, sitting in for our chair **** have on the line.

Next Speaker: Hi, this is ****.

Next Speaker: Thank you, Lisa, thank you. Go ahead and unmute yourself before you introduce yourself, please.

Next Speaker: This is Pam Bruin, uh, Director of ****.

Next Speaker: Hi, Pam.

Next Speaker: Hi, hi.

Next Speaker: Who else do we have on the line?

Next Speaker: Brian Graham ****.

Next Speaker: **** here.

Next Speaker: Thank you, Paul, and who else is speaking there?

Next Speaker: Sorry.

Next Speaker: Brian Graham from the Portland Clinic.

Next Speaker: Hi.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: Anyone else did not have a chance to mute, I, I mean to say your name, and if you have called in via phone, you may find that you need to press star, 6 in order to unmute yourself. Uh, folks who are self muted may need to dial star, 6.

Next Speaker: Hi, I'm not sure you heard me, this is Nancy ****. I'm the, um, information prevention **** from Providence.

Next Speaker: Thank you so much for joining us, Nancy.

Next Speaker: Sure.

Next Speaker: Hi, this is Karen **** am in Corvallis.

Next Speaker: Hey there, thank you for joining.

Next Speaker: Okay, I'm gonna mute, unmute everyone one more time and then after this, um, give if you **** if you can mute it'll help the feedback.

Next Speaker: Hi, this is Josh Bartfield from the Oregon Clinic.

Next Speaker: This is Tracy Ward **** Fullerton.

Next Speaker: Okay, anyone else not have a chance to introduce themselves, and I know people are typing into the chat and introducing themselves there. Uh, um, I'm not sure who all can see, um, these questions. So, um, if anyone else has not had a chance yet to introduce yourself, please go ahead and do that now, if, if anyone is, uh, unable to unmute yourself, I think Laura can assist with that.

Next Speaker: This is Sandra ****.

Next Speaker: Hi Sandra, and Sandra, you're with the Washington, uh, State Hospital Association, correct?

Next Speaker: That is correct.

Next Speaker: Great, thank you. All right, well, um, so, I think that, um, so, just, uh, as a reminder, if you're not speaking, do mute yourself. If you are signed in both via phone and your computer, it may be possible that you're contributing to an echo. I've certainly been guilty of it many, many times myself. I am hearing people say that there is an echo and for that I apologize. Um, we will do our best. Um, with that being said, I think we're gonna move on to our logistics update. Um, this information is in your meeting materials. So we do want everyone to be aware

that, um, you know, we currently have vacancies on our HAI Advisory Committee, memberships and opportunity to give your input, help **** our work and stay informed about our activities. These are 2-year terms. There's no additional time commitments other than attending the meetings whenever possible, and we are currently looking for a hospital administrator with expertise in infection control at a small facility, meaning one with fewer than 100 beds, a consumer or a patient advocate including patients or family members, a health insurer representative, and a representative of the Oregon Patient Safety Commission who does not represent a healthcare provider on this mission. We are also recruiting for a chairperson. Jen Buser has been filling the role for quite awhile. Um, so it is, uh, open for those who may want to **** to it. Also in our meeting materials as well as our, um, little flyer, uh, to bring your voice to the table and we would love for those of you on the line to distribute that out if possible to any networks you might have or any of your colleagues that might be interested. We do have our webinar quick reference guide. I want to draw your attention to that now. That is on Page 2 of 51 of the meeting materials. This gives you instructions on how to mute and unmute yourself and what kind of troubleshooting you may need to do to get into the call. Um, you're welcome to just speak up on this meeting. We're gonna do our very best to monitor questions in chat as they come in and assist with muting and unmuting. So, again, thank you so much for your patience with this, and do take a look, everyone, at Page 2. Today's agenda, um, is very simple. We will be going over the June 2020 minutes shortly. Um, I will give a brief situational overview of some of our activities and some, um, of the published data for Oregon for COVID so far, and then we will be having a discussion, and I have some great topics that were brought up to me by some of the folks on this call as well as some of our other colleagues. So, um I think it should be fruitful. Again, the purpose of this is really for it to be an opportunity to, you know, share with each other about what is going on. So, um, with that being said, I think, um, I will have to ask someone to move to approve the June 2020 meeting minutes.

Next Speaker: This is Jeff Dale, move to approve.

Next Speaker: Thank you, Jeff. The, is someone available to second that motion?

Next Speaker: This is Josh –

Next Speaker: ****.

Next Speaker: – I second.

Next Speaker: ****.

Next Speaker: Do we have a third? I heard Josh.

Next Speaker: Uh, this is Sandy Edwards, I can third.

Next Speaker: Thank you. All right, great. Um, I do want to reassure those on the line that there is no external speaker near my computer, but if I am the one causing the echo, which is fully possible, I truly apologize for that. Um, what I can do is take a moment and sign off and sign back on with audio on my phone. Um, that may be the best. Is the echo pretty intense though?

Next Speaker: I'm not hearing it right now. **** delay ****.

Next Speaker: ****.

Next Speaker: Yeah, when, when anybody else speaks, we hear it.

Next Speaker: Oh. Well, it's only when callers talk. Goodness, I don't know. Don't know. I don't know. Okay. Well, –

Next Speaker: I think we can just move forward –

Next Speaker: Um, hm.

Next Speaker: – and do our best.

Next Speaker: Okay. I'm gonna try to give the situational overview, and what I'll do then is sort of flip my audio over when the discussion starts. So I will be off the line for just a few minutes when the discussion starts, but, um, I think this is the, the best way to do it unless anyone has any other ideas. So with that being said, I will jump in to the situational overview. So I just wanna review some data. This is all published data, um, available online. As of yesterday, in Oregon, we have had 28,355 confirmed and presumptive cases of COVID-19 and 486 deaths. Some big-picture kind of descriptive on this is about 22 percent of these cases are in ages from 20 to 29 and then about 18 percent of them, um, the next highest age group is 30 to 39. We have about 8 percent of our cases hos, have been hospitalized during the course of their illness. Our cases are about 40 percent white, about 48 percent non-Hispanic and about 40 percent Hispanic. About **** cases are healthcare personnel and about 14 percent of our cases are associated with congregate settings. In terms of some available capacity for hospitals in Oregon, we have 190 available adult ICU beds out of 699, 835 available adult beds that are non-ICU of about 4400. We have 47 of 323 NICU and PICU beds available at this time, and 91 of the pediatric non-ICU beds at this time of which in total there is 332. Currently, there are 153 cases hospitalized, 44 in the intensive care unit, and 22 are on ventilators. We have 778 ventilators available in the state. Um, COVID-related illness is still making up a very small percentage of ED visits, and overall, our ED visits are lower than they were pre-COVID and are pretty much stable at this time. A couple of non-data, um, situational overview points just to mention, um, so, uh, currently, um, CMS is sending, um, point-of-care antigen testing machines from BD and Quidel, um, to about 126 nursing homes in Oregon. Some have received these already. Um, these will supplement the new CMS testing requirements for nursing homes and the antigen testing algorithm for nursing homes from CDC. Um, and our program finally continues to do virtual and in-person, um, infection control assessments for COVID-19 for long-term care facilities and some other facility types like behavioral help. These visits are both, um, in response to outbreaks and are being done proactively. We're currently bringing in many new team members across the board. There will be lots of new staff at OHA, um, new faces and voices to get used to, um, but rest assured, we will continue to be here and have this meeting, um, and, uh, we are also in, in some moments available to give, um, infection control consultations for other facility types, so you are welcome to reach out to us if you feel that your

facility, um, would like to request some kind of COVID infection control consultation. And, of course, that's, uh, free of charge. So with that brief overview in place, I think maybe I will, um, just kind of start the conversation off, um, by going through one of the topics that was mentioned as kind of a priority to discuss, and then what I will do is switch my, my audio. So one of, um, our partners, um, did send in a question regarding how to handle potential – actually, let me ask. Does anyone on the line from OHA want to give any other information just in terms of situational overview or updates to share with the folks on this call? Okay. No problem. Um, so, um, one of our folks did, um, email in and ask about kind of how to handle potential COVID follow up and quarantines in healthcare settings. So some facilities are treating any contact, you know, and then I think facilities are kind of approaching this differently. Some facilities are treating any contact of within 6 feet or less for more than 15 minutes, even if full PPE or recommended PPE is, has been worn as an exposure. Um, so this is, um, when staff has a positive test but worked in the prior days before their test result was known, um, and this is resulting in a large number of patient and staff notifications and patient quarantines. Um, I think there are concerns about the resources needed to this and the sustainability of this approach especially given that, um, these individuals are wearing PPE. So, um, I wanted to just mention that there are at high levels, lots of conversations happening at OHA about this. I know recently there was a tri-city call on this. I was not on that call. Um, I believe it had a good representation of hospital epidemiologists but not a lot of IPs. Um, there is not a lot of guidance around this. Um, we, you know, of course are not always sure how well the PPEs may possibly contain, um, infection, you know, definitively, right, um, but we do believe that, that PPE is fairly protective. There may be cloth face coverings in play here for patients. We don't know how protective those might be, um, and then of course there are training and adherence questions about, you know, how closely are we following the guidance. And this question really does impact all levels of care including hospitals' long-term care. Um, of course we don't want our healthcare personnel to work while they are symptomatic and then having asymptomatic positive healthcare personnel work is a very sort of crisis-level contingency that we really don't, um, advise regularly at all, um, if ever. Um, you know, another thing to think about is the quick encounters as a contact, so how are we defining these contacts, which patients are we wanting to quarantine, how are we communicating about this. So with that being said, I am gonna go ahead and mute myself and switch over my audio in hopes of not having other people echo and let you all take it away, um, in terms of, you know, how are your facilities dealing with this, what are your opinions on how to handle it. We really wanna hear from you.

Next Speaker: Hi, Rosa. This is Kirsten. Can everyone hear me okay?

Next Speaker: Yes.

Next Speaker: Hopefully that's a yes. Thank you.

Next Speaker: Yes.

Next Speaker: Um, thank you. That, that is actually a question that I think has a second part that I'll ask in a moment, but, um, you know, I, I think it can be a bit of a struggle. I mean, when we're trying to risk stratify all of the considerations you brought up need to be, you know, calculated in that equation, but hopefully as people really are following, I think the policy is that

pretty much all of us now in the healthcare field I would imagine have put in place in terms of universal, uh, source control and PPE use, even with patients who aren't suspected of having COVID **** symptoms. Um, you know, I would imagine the risk is significantly reduced unless there was something, like, an aerosol-generated procedure, uh, or other specific situations, but it might be helpful to call out. Um, so I think that's one point of this. I just wanted to make one other comment in terms of something that may help. You know, we haven't been able to get this completely operationalized throughout all of our providers and all of our different caretakers, um, but we've started incorporating a PPE use template as encouraging use at the bottom of notes. So, for example, when someone has to think back about an exposure and they have seen so many patients between now and then and they can't really remember, um, then everybody errs on the side of caution thinking that oh, gosh, I, I don't know. Did that patient take their mask off when I was in the room? Did I really make them put it back on? How long was I there? Um, and so we've encouraged documentation in our notes which allows a way for, uh, our infection preventionist to, uh, and our providers just so they have some level of comfort of saying, you know, actually, the patient and their family member were masked throughout that visit, um, you know, and here's what I was wearing as well. Uh, so I think that's one thing that may help with some of this, uh, because I think some of those other uncertainties are harder to, to resolve in terms of, you know, we try to do audit, but we, we don't know for sure that every second of every day people were following our policies and process. Um, and then after we have more discussion, I guess I, I'd ask if maybe we have a little bit of time, I'd ask what other people are doing in terms of patients who are in quarantine, you know, in the outpatient setting, um, or if they're not in quarantine, have other risk factors. In particular, travel is **** that I think we're struggling with a bit in terms of defining, you know, what's high enough risk that someone might, if they're admitted to the hospital, they could have aerosol-generating procedures, you know, at what point would we want to, to treat them differently especially now that we are using, again, universal source control and PPE and, and pretty much throughout all of our settings.

Next Speaker: Thank you so much, Kristen for, for mentioning that. And yeah, this can be a free-flowing discussion. Is the audio echo issue somewhat resolved this way?

Next Speaker: Yep.

Next Speaker: Awesome. Thank you, Paul. Um, thanks, Nicole. Yay, oh, good. Okay. I'll take it as success. Are there folks with thoughts on, um, this kind of topic of how you're handling those, yeah, those potential exposure events within your facility, both for patients and for, you know, healthcare personnel when, when healthcare personnel are wearing that full PPE? I'd love to hear from other facilities on, yeah, like, what challenges you're experiencing with this, what tactic you're taking.

Next Speaker: Can you hear me? This is Susan Diskin at Legacy.

Next Speaker: Yes, Susan. Thank you.

Next Speaker: Okay. Hi. Well, um, I missed the call Friday. Um, uh, I was on furlough, so, um, the regional call just to discuss this topic. It, um, but it did come up today on our, um, weekly call with, um, Multnomah County. I feel pretty passionate about this. I, um, on one

hand, it, you know, I, I understand the concern and trying to mitigate as much, um, risk with, um, patients and, um, just the contact tree thing is so important right now. Uh, um, on the other hand, um, I know for myself, um, Manager of, of Infection Control for Legacy, we, we have, um, we're just staffed at a, a very lean, um, level, so, you know, one person at a site, and even then, um, very low. So resources to do internal contact tracing for one staff person that may have developed symptoms, um, and trying to work through where that staff person may have traveled, um, during their shift, um, for a time period, too. It's all retrospective, so we're counting on a staff person to recollect wh, um, what patients did you see. It's not just, like, oh, I saw, um, this was my assignment for the day. It's, it can be, you know, for many, uh, like, 20, 30 patients, um, and how can they recollect the time period that they were in the room? Um, we ask patients to mask, um, when someone goes into the room, but how reliably that happens, it's, it's hard to determine as well. Um, I think, um, that's just one aspect of it. It's not, it, it would have to be, um, a detailed conversation with a staff person who's out on, on illness, you know, out on furlough because of an illness, um, and to be able to recollect what patients did you see during this timeframe. I mean, so that's one piece to it. It's also, you know, it's all retrospective. Um, so it, it could've happened, you know, that, that time period of incubation. So there's several days that, that go into effect as well. And then I think, um, from the standpoint of, you know, what we're already doing in-house, we have, um, daily surveillance of course to look for any patients that develop symptoms. This is really provider-heavy, um, to, you know, ask them to be monitoring for this and, and nurses as well to be monitoring for any changes in their status. Um, of the hundreds of patients that we've had, I mean, well, probably more than that. I mean, obviously, since March, we've seen thousands of people come through our doors, um, and we haven't yet seen any hospital onset cases, um, that we're aware of. So I think, um, it's just kind of where we're struggling with this, uh, is just, um, how to, how to make it purposeful.

Next Speaker: Thank you, Susan. Yeah, I think, I mean, I, I can only speak for myself, but I clearly have a sense of these challenges. I think it's that, um, our **** being the same kind of volume, I think **** can be, like, 20 or 30 patients that they're having that close contact with, uh, on a shift and then kind of trying to go back in time, um, are, are other people seeing those things, types of challenges with this as well, especially in the context of **** levels that I think many facility types are seeing across the board these days.

Next Speaker: Hi, this is Nancy O'Connor from Providence. I'm happy to share a little bit also.

Next Speaker: Thank you, Nancy.

Next Speaker: Can you hear me?

Next Speaker: ****.

Next Speaker: Okay, great. Thank you. Um, I, I certainly share pretty much everything that, uh, Susan, uh, just shared with us, particularly the lean staffing, um, and, you know, it's all, it's all related, um, you know, now we have some of our staff impacted by having their children's, uh, school not opening and being online, so that reduces our staff even more and, um, some of our staff had to be evacuated, so now that's impacting it. So you, you know, in addition to, to not being business as usual 'cause of COVID, there are, you know, other life factors that are playing

into it. So we are extremely lean right now. Um, and we are, uh, doing PPE auditing as much as possible, our IPs are doing that using a, a PPE audit tool that we created, um, to get some sense of, um, compliance and, uh, do any Just in Time education, uh, that they possibly can. Um, we were able to get to a place after, um, some discussions I had with Jen Vines about our patient to caregiver potential exposures, um, where we were able to, um, differentiate a little bit better by ensuring that, uh, overall there was really good compliance on that unit and that the, um, the nursing unit leader could speak to consistent knowledge of compliance on her unit or his unit, um, and, you know, Jen had said if, if you're confident in your policies and compliance with them, uh, then you'll be meeting the spirit of, you know, what the state is requiring, um, for the patient to caregiver exposures. So, you know, we felt much better about that; however, then when we started having potential caregiver to patient exposures, which we call reverse exposures here, uh, just for lack of a better term, um, that then presented a different problem. Uh, Providence, uh, made a decision to not require all patients to be masked. They do strongly encourage, uh, masking of patients, um, now I'm talking about in-patients, acute care, um, if a caregiver is entering the room. So if a caregiver's in the room, they really strongly want patients to mask unless it's a safety issue. Um, but they are not requiring it.

Next Speaker: Mm hmm.

Next Speaker: The diff, different story for patients that may be walking in through the door for an appointment or something, everyone is required to mask then. Um, we do universal masking, um, and then universal face shields for, um, caregivers, our employees. So this caregiver to patient piece became really problematic because, um, we couldn't, it, for those who have been on some of those weekly, um, calls, like the ones that Susan mentioned that just happened earlier today, um, we can't guarantee that all of those patients were wearing a mask. We can't guarantee that it was a medical-grade mask, um, if they don't feel comfortable saying we don't have to consider all of those potential exposures and then quarantine those patients, um, so at this point, until we're able to get them more data, I think that we are pretty stuck with this very, um, laborious time-consuming process that most people, this is a generality, but most people feel, um, is, is fairly low-risk and that if we have ****, we would find that there have, has been either no or very low numbers of exposures related to it. But unfortunately, we're not in a position to do that right now, um, from a resource perspective. I think it's very possible and I'd really like to do it, um, make, it almost makes me want to work around the clock for a couple of days and do it myself, but that's not realistic either. So I don't know what I added to the discussion, um, but that's kind of how it is here in a nutshell at all eight of our, um, hospitals in the Oregon region.

Next Speaker: Hi, guys, this is ****.

Next Speaker: Nancy, I think that **** a lot. Oh, Dennis, please go ahead. Thanks.

Next Speaker: Yeah, sorry. No, I mean, I just want to, totally, you know, I agree with my colleagues, uh, from Legacy and Providence completely in regards to the staffing issue. I was wondering in addition to everything that they mentioned, um, which I [dictation ends here]

Speaker: – in regard to the staffing issue. I was wondering, in addition to everything that they mentioned, um, which I think is very, very important, both of them, um, but is there, have

we looked at, you know, a potential distinction, at least, of maybe going back to the low and high-risk exposure type scenario, because, you know, really, um, if we look at, regardless of the PPE, couldn't there be something to differentiate between the two because as a true low-risk exposure and a high-risk exposure, I mean, do they both really equate and furlough quarantine, you know, massive notifications and I'm just wondering if here's a, you know, if there's a compromise here or a middle ground so that we can, you know, be honoring the struggling IP **** short staffed and, uh, low resources versus the need to, uh, with the community in ****?

Next Speaker: I would say –

Next Speaker: ****.

Next Speaker: – intent and with the intent still being, yeah, or, of course, we want to be conservative and we want to be protective but we need to be balanced and **** all these considerations out. What are some of the, um, dentists or anyone, um, on the line **** to kind of dec, decision points at which, you know, I heard you say, of course, PPE, right, is one of them but some of the other sort of decision points at which, folks on the line, what, like how are, how do people feel about kind of making decisions between lower and higher risk exposures and other than, I think, you know, we know time period, right, and then distance away, but within 6 feet and 15 minutes plus are things we're already using aside from those, what would be some of the decision points to decide whether we **** low or high-risk exposures and, you know, we just really want to, like, hear opinions, so don't be shy to just, anyone on the line.

Next Speaker: This is Mary from –

Next Speaker: Uh huh.

Next Speaker: – Shriners. Can you hear me?

Next Speaker: Hi Mary.

Next Speaker: Okay, good. I didn't know if I was unmuted. Um, it, you know, I, I agree, again, with my colleagues and, um, I, I have to say just based on experience, the amount of, you know, coworker-to-coworker exposure is next to nil, um, especially when you have, um, you know, universal masking in place and, uh, eye protection, um, you know, it's a, it's a real struggle because you deal with people who feel they need to know but realistically, you really minimize the risk in terms of risk assessments. I relied pretty heavy on CDC, uh, healthcare worker risk assessment. Again, you have to have the defined close, um, contact **** contact, um, but then they, basically, had broken down the risks as well; were you masked, you know, was the patient masked, if the patient wasn't masked, was the employee wearing face shield in a mask, um, you know; if an aerosol generating procedure occurred, was everyone in full PPE. I mean, I find using that risk assessment very helpful in, um, you know, trying to define if exposures happened ****, um, at least to our workforce.

Next Speaker: Thank you so much. Are other people using that tool?

Next Speaker: Yeah, if you're talking about the CDC COVID ****, uh, yeah, that's, we're, where we were **** and we don't ****.

Next Speaker: Correct. The, uh, we're using that too at Legacy.

Next Speaker: Um, this is Pam Bruin in Eastern Oregon and yes, we're, that's, we use that tool.

Next Speaker: Same here at Providence.

Next Speaker: And Dennis **** as well. Um, I think sometimes the challenge is, is, has already been mentioned going back and with respectively trying to determine that with the number of potential contacts involved, um, in all of these different scenarios, whether it was the patient who we think were contagious **** exposing, potentially exposing healthcare workers based on the type of treatment they were receiving or, you know, sort of control that they were or weren't wearing, um, or vice versa. All, although, I guess, I would add my perspective of, you know, I'm just as concerned about, um, our healthcare workers and their contacts with each other. Um, I, I think, people are getting tired and, uh, you know, it's easy to find examples where people get laxed because they feel very comfortable around the people they work close to day in and day out, um, and they're not having the same mindset that they are when they're going in to see a patient who they, they're caring for but they don't really know and have a personal relationship with.

Next Speaker: Mm hmm.

Next Speaker: Mm hmm.

Next Speaker: Right. Right. I think, yeah, outside of working hours, certainly, but also lunch breaks, etc., um, are other folks kind of seeing, um, seeing that same pattern **** that can, could maybe contact between healthcare personnel that might be and what risking is that kind of playing a big role in these notifications, um, in the fifth particular contact?

Next Speaker: This is Nancy. Can you hear me?

Next Speaker: Mm hmm.

Next Speaker: Yeah.

Next Speaker: Yep.

Next Speaker: Okay. Sorry, I didn't know if I had to unmute again. Um, I don't know that we can say for sure. I do know that we have had concerns about break rooms and that type of thing, and we've addressed that in various ways. Um, I don't necessarily think it's perfect but with the, um, you know, with the community transmission being what it has been, we've been feeling more like the caregivers have been acquiring the illness in the community and then –

Next Speaker: Mm hmm.

Next Speaker: – have no known they were positive, but –

Next Speaker: Mm hmm.

Next Speaker: – um, had not been tested yet, came to work, you know, did a couple of shifts and developed symptoms, were tested and were positive. Um, and thus, the potential exposure occurred. We feel more that that's, uh, problematic versus the break rooms, even though –

Next Speaker: Mm hmm.

Next Speaker: – **** risk, but I think with community transmission, that that kind of leaps to the top in our mind.

Next Speaker: Yeah and this is Susan at Legacy, I'll, it, same for us. I think, we're seeing more, um, staff who get together outside of work, um, and we've had exposures, um, and symptoms from people there. Not, uh, really, we've, we haven't seen anything happening within our walls. Um, the other thing is, uh, you know, now, we've, some kids going to, um, you know, learning centers and, and still, you know, with daycare, um, it's, it's developing other problems with staffing and shortages there, um, so we're seeing a bit more of that now too.

Next Speaker: Mm hmm, mm hmm.

Next Speaker: Mm hmm. Yeah.

Next Speaker: This is Mary and I just was gonna say, I mean, of our employees, our, our first, um, employee with COVID was way back in March and that's the only one that was an unknown source. Other than that, all of our, um, employee cases have been close, uh, contacts, usually household contacts and they've already been placed on some work restrictions.

Next Speaker: What kind of work restrictions, Mary, are you using and ****?

Next Speaker: Um, if they can work remotely and have that option, uh, they can work remotely but they are not to, um, be working at the hospital. Um, at this point in time, we have been able to accommodate staffing and coverage for people who have been on work restrictions.

Next Speaker: What about other folks – thank you so much for that – other folks from work restrictions, different options for work restrictions, what type of work restrictions or tiers of work restrictions or anything like that? I do see that as, I think, that could potentially be part of this conversation.

Next Speaker: This is Kathryn with Peace Health and, uh, we have some interesting data. So one of our hospitals in Washington is in a county where they're requiring us to notify patients, um, if a caregiver works at all during their infectious period and we have found, um, since going to universal masking that we've had, um, no transmission from any healthcare workers to patients in any of these situations, um, and we've done both, um, testing and monitoring of symptoms in

those patients. We do place the patient into the special **** isolation precautions after a known exposure just because we're testing them and, um, want to make sure that they don't end up in a shared room, etc., um, but I'm wondering, like, how much data do we feel like, as a community, we need before we can show which sit, which situations, um, is this, um, **** in and which isn't, it, because we've had CNAs and nurses both – I think, we've had 14 maybe positive since the beginning, um, and since implementing universal masking, um, and what it has shown is a, a real burden on our infection prevention teams and, um, you know, probably are scared of those patients but haven't actually yielded anything from a public health standpoint that made the community safer.

Next Speaker: Hi, this is Paul ****. Yeah, thanks for the, um, uh, uh, in general, you know, our, our take is to, um, endorse CDC recommendations unless we have some data to suggest that, you know, things were different here or that, uh, you know, we had **** positive ****. Um, we're, we posed this question directly to CDC and their response was unequivocal even if both people are masked and, you know, everything was followed, if they're meeting the time and space criteria, you know, 15 minutes within 6 feet, uh, we would still consider them exposed and quarantine accordingly, um, so that's kind of where we sit right now. We saw, we did review one little paper that looked at, um, uh, a couple of hundred, uh, people, uh, **** patients in the hospital who were exposed and **** testing, I think, about 40 percent of 'em, um, probably just tested once, uh, and, I think, the only positive they found was somebody whose spouse was also positive, so that, um, that was presumably, as you all have been eluding to, are community-acquired cases, not a, not a hospital-acquired case. Um, so, you know, not a lot of great data out there and I think, it would be awesome if you all would, you know, summarize, you know, how to, how much experience you have with **** your experience with healthcare workers who prove to be positive and you rounded all the patient names and, you know, did what you do and followed them up and, and we accumulated collectively, you know, say throughout greater Poland or maybe throughout the state and, and said, you know, this just doesn't appear to be a risk, um, yeah, that would almost better to keep **** from that recommended by CDC.

Next Speaker: This is Jessie –

Next Speaker: Thank you –

Next Speaker: – with **** –

Next Speaker: – so much, Paul.

Next Speaker: ****.

Next Speaker: – ****.

Next Speaker: Hi, Jessie.

Next Speaker: Hi. Uh, so we've also heard from several nurses and received the, um, accompanying emails from the individual facilities that several facilities and healthcare systems

are, uh, chosen to forego contact tracing entirely in favor of just the universal masking, is, is that something you all are seeing or aware of?

Next Speaker: Uh, I can't say that I am. Uh, no. I mean, we, we know that a lot of hospitals and healthcare facilities are universally masking their, uh, employees but, um, but as far as foregoing contact tracing, that's ****.

Next Speaker: All right, yeah, I'm not aware of anyone – I know, I, I'm not aware of anyone kind of thinking in the, of, thinking of them as mutually exclusive –

Next Speaker: Mm hmm.

Next Speaker: – uh, practices.

Next Speaker: Thank you.

Next Speaker: Okay. Well, I have a couple more brief topics. Actually, ones are more of a media topic, um, and the other is just a brief more of an announcement and call for resources, but, um, so I will just, um, I **** very fruitful and, you know, if folks want to continue discussing this, I just want to offer another, um, question that folks might be interested in. Um, the other thing I have for our discussion here **** how people are approaching PPE purchasing, um, as the number of manufacturers rise, new info comes out about what types of PPE is and is not the most effective or appropriate, and, of course, supplies continue, supply chains continue to be interrupted. Um, you know, we know that we need to be using medical grade, um, PPE, uh, but what type of medical grade PPE can be a bit difficult to assess at this point and there are different kind of ways that PPE are categorized, uh, but for gown at least. Um, I know that there are different levels that FDA assigns to, um, masking so I know that **** Level 2 Quest surgical masks but how to assess whether your masks are that level or not can be challenging so, I guess, I just wanted to open this up to the group. Um, how are you thinking this question is true, um, at this time of, you know, how are you evaluating, um, and making purchasing decisions about PPE and I'll, um, mute myself and let you guys take it away here.

Next Speaker: This is Mary. Can you hear me?

Next Speaker: Yes, Mary, hi.

Next Speaker: Hi. Um, so this is like a real headache, um, and a real struggle, um, especially when you couple, um, PPE and try and apply the, um, OHA and, um, OSHA, um, PPE contingency grid and the different tiers that are represented there. Um, you know, it's a, it's, if I am interpreting some of the guidance correctly, um, you fall into Tier 3 if you're using any PPE that has, um, FDA emergency use approval that is international, in other words, it has international standards. Um, you know, a part of me wishes I could interpret it as just applying to, like, you know, N95 masks but if I look at the language in the documents, it appeared to, um, you know, apply to other types of PPE, such as, um, masks, um, as well and then, um, you know, we received, um, some donations of face shields, um, that came from, you know, like in the auto repair company. They were just homemade and so my interpretation of the guidance is that that

puts you into Tier 4, um, because they are, basically, homemade and locally sourced **** from, you know, various companies like Ford, um, and, you know, they were manufactured there but I can't tell you that they have medical grade claims associated with it, so we're having to spend a lot of time, you know, back tracking and really assessing, reassessing our inventory, um, to be certain that we are, in fact, staying in Tier 1 and Tier 2, um, of, of guidance for, um, PPE contingency standards and then, I think, when you apply, um, some of the guidance for extended use versus reuse that it becomes very, very complex. I am certain nobody else is having those struggles.

Next Speaker: I have a feeling you're not alone in this. I wanted to keep my, um, I just want to take a back seat here and let other people chime in on this 'cause I do not think care facility is the only one, Mary.

Next Speaker: Should I call on my fellow colleagues or will they remain silent?

Next Speaker: Does anyone **** want to reflect on this, the challenges associated with assessing medical grade claims for PPE?

Next Speaker: **** –

Next Speaker: If you are –

Next Speaker: – **** –

Next Speaker: – **** –

Next Speaker: – this is –

Next Speaker: – **** –

Next Speaker: – ****.

Next Speaker: – unmute yourselves. Hey Pam, I'm gonna mute myself.

Next Speaker: Hey. Yeah, uh, we had our PPE committee meeting just this morning and we're having this very same discussion –

Next Speaker: **** just have another –

Next Speaker: – because even –

Next Speaker: – question.

Next Speaker: – the goggles, it's required that they have marked for medical grade and, you know, early on, we were sourcing, um, just about anything that met the criteria for being, um, good protection, um, and the, the face shields, same thing, we got them from a number of

locations and so, um, we're, we're trying to do the exact same thing that Mary mentioned is, is either repurposing or trying to figure out how we meet the criteria for the tiers.

Next Speaker: Yeah, this is Kristen, I'll add to that. I, I think it's a challenge and we've had our materials management folks trying to source anything that meets medical grade criteria. It wasn't helpful with the face shields when that EUA was removed, um, as well. Um, so that made it even more difficult, I think, at, in terms –

Next Speaker: I **** –

Next Speaker: – of –

Next Speaker: – remind us about the EUA, if you don't mind.

Next Speaker: – yeah, so there was an EUA that was out in terms of, uh, face shields and essentially, you know, because, again, it's more of a, just a physical barrier that has to be cleanable and, uh, I think, they required a, you know, a fire resistance and you had to have companies say what it was made up of, so, you know, what chemicals went into it, um, but otherwise, it, uh, it allowed us to use some local manufactured equipment, um, and that was removed and I, I think, it, I haven't heard a recent update but, you know, the last word that I got when we had been working on this for months is there's really nothing out there, um, that's easy to find and then we have staff members that were working with our, our, you know, PPE committee as well, the, the one that was just established, but, you know, staff members complaining then, from what we can source in terms of their ability to do their job and ****, um, and wanting to bring in their own equipment as well, and, and I can tell you, I, you know, while I understand we need to have standards and certainly that's where we'd all want to be, it's challenging when you have, you know, a provider or someone else who has sourced their own, you know, eyewear that from a, you know, from a protective standpoint in terms of protecting the eyes, it meets the physical criteria we'd be looking at but we don't have the bandwidth to try to do any research to say yes, that works; not, that doesn't; yes, it meets medical grade criteria; no, it doesn't. You know, if that information was even available, um, so I, that's my main concern that we've been having with this is, uh, it's face masks, um, because we're also having difficulty with that trying to make sure that they meet, uh, all of the filtration standards, um, as well as the fluid resistant standards and what happens if we can't force that and how far do we need to go, um, and, and to making compromises in terms of what we're purchasing now, so we have a fallback plan if we can't source something that we like better and feel is better quality and more clearly meets the, the standards that normally we would expect and the materials we would purchase.

Next Speaker: Thank you, Kristen. Thanks, Pam and Mary. Anyone else thoughts on this? I knew it. It's a challenge. We have been hearing that, so I want to give everyone the opportunity to share your thoughts with us during this call. Okay. Hearing none, I'm gonna switch gears to another brief, brief, uh, announcement/discussion point. Um, I think we will probably have a little extra time to discuss, um, you know, in the public comment period and we also really, really want to hear from the group on what you folks want to discuss in December. I know it's looking ahead a little ways and with things changing rapidly, it's hard to kind of imagine what

will be open for **** on our minds then, but we might have some ideas to plan for and we will keep it flexible, so with that, the last kind of piece I wanted to offer during this discussion portion was we had a lot of questions about whether or not we will be rescheduling our IT fundamental offerings so this was a multi-based training program that we had planned for the very beginning of April. Um, we did have to, um, cancel that offering due to COVID, um, at the time, 'cause there aren't many people who would have been contributing to that training on today's call, um, we felt that the resources needed to put on an overview of the **** infection prevention would just take, pull a lot of people away from the COVID response, which was just beginning to kind of unfold or ramp up at that point. Uh, we've had a number of questions. I do want to say that at this point, we do not have, um, the capacity to begin planning that course again. Um, I do know that there is a lot of interest in some kind of training of that, of that type, um, kind of a basic fundamental **** infection prevention training because I'm guessing so many of our facilities are bringing on new staff. Um, I do want to, you know, apologize. I wish I could say that I knew when it would be happening or when we would have the, the bandwidth for it but at this point, I don't. Um, what I will say is that, you know, we are continuing to be available to work with you and offer answers and support around all types of HII topics, including COVID infection control, including flu outbreaks, multidrug resistant organisms, etc. so for, um, those kind of one-off questions or scenarios that you'd like to discuss with us, we continue to be available and really look forward to hearing your questions. Um, we do not have a lot of resources for general training. I know, you know, APIC has offered things in the past and for long-term care, there are web-based trainings online from CMS and CDC, so I thought I would ask the group if folks have, how **** been approaching, um, training for your new ****, particularly, for any new staff that might be doing infection prevention work, what resources you might be able to, um, kind of suggest to colleagues on the line, anything of that nature.

Next Speaker: Rachel, this is Pam Bruin. I did get a, uh, save the date from UCSF and they are having a live stream conference, uh, Friday, November 5th, um, for UCSF advances and COVID-19 update for clinicians, and, um, I just wanted to make my colleagues aware of this. It's for advanced healthcare practitioners. It's about $250.00 and, um, they're gonna be going over vaccination, long-term consequences, optimizing diagnosis, cases across the spectrum in special populations but it's very specific to COVID, not, not necessarily addressing your question of fundamentals.

Next Speaker: That, that's great, Pam. I think, we know, there may be all kinds of training needs at this moment. I'm not as inherently familiar with what they all might be, um, so, you know, if anyone wants to mention verbally on the line other community opportunities, we can try to kind of collate them and send them out. Anyone else have anything at the top of their head? Otherwise, you can just feel free to send them my way, you know, and I'll incorporate them into, into minutes, uh, into meeting materials of some kind and, and share them with the group. Other training thoughts other than that – Pam, thank you so much for that – um, before we shift gears to our next agenda item? Okay. If anyone thinks of things, please do send them my way. You know where to find me. You can send stuff to me at any time you want. Um, I like hearing from you all, so with that, I think we'll just switch gears. Um, in terms of what we want to be discussing in December, I think one on the top of my mind topic is, uh, the influenza season. Um, we will know how that is going when we get there. Um, I'm, just any kind of, I think, we may **** public comment and our discussion for future meetings here. Um, any thoughts from

the group at all on what you would like to hear about in December, speak about in December or a public comment?

Next Speaker: Rachel, this is Pam Bruin, again. I, um, am thrilled to talk about the flu, because that was on my mind as well and I'm wondering if there could be a, um, something sooner to be able to share best practices or how people are doing with the patient with COVID and the flu or, um, increasing vaccination rates, uh, right now, if we could do something like that in November to kind of get an idea of what people are doing before we get to December, and I don't know if that's on a, a possibility for both.

Next Speaker: Thanks, Pam. Um, you know, I know there are other groups that deal with **** more closely than this one, so I, I'm not sure whether **** on. I need to discuss this, you know, ****, um, in the meantime, Paul, I think we still have you on the line, any thoughts on when a appropriate forum might be? Sorry to put you on the spot.

Next Speaker: Yeah, ****. So **** forum for what?

Next Speaker: So, so we're hearing –

Next Speaker: ****.

Next Speaker: – **** interest in kind of the intersection between COVID and influence, and, I think, some folks might be wondering if there's an opportunity for them to kind of convene in November, um, to discuss best practices and approaches.

Next Speaker: Well –

Next Speaker: **** –

Next Speaker: – in –

Next Speaker: – **** –

Next Speaker: – in addition –

Next Speaker: – ****.

Next Speaker: – to this –

Next Speaker: ****.

Next Speaker: – meeting ****.

Next Speaker: ****.

Next Speaker: Yeah, in, in addition to this meeting, um, you know, our immunization program is gonna be out there, uh, so that, that might provide, that might provide a venue for discussion, um, but other than that, I think, we could either, Pam, use this meeting or call an ad hoc meeting.

Next Speaker: I'm taking some notes here. Thanks, Paul and Pam. Much appreciated. Um, other topics that we want to hear about. Um, we'll keep you guys posted, for sure, on, on that and other topics that we might want to hear about, um, in December, looking forward to our next quarterly meeting.

Next Speaker: ****, um, long-term medical consequences, uh, I think that we're gonna start seeing people that could potentially have long-term complications from their initial COVID illness and then get readmitted for something related to that and how are we gonna deal with that and understand what those long-term complications are. We don't have a lot of long-term data right now, but in December, we will have some more ****.

Next Speaker: **** Tammy.

Next Speaker: Yeah, exactly. Thank you so much. I think that is something at the top of many of our minds these days as what we're gonna be seeing unfolding one more time.

Next Speaker: Other specific topics in December that people are wanting to share about. Are there more, kind of, um, specific areas within kind of that co, uh, connection **** that and COVID, uh, you, that people want specifically to make sure to touch on. I mean, I think, I can kind of **** strokes of the, the interest might be but if anyone on the line has a particular area they want to make sure we touch on during that meeting or during an interim meeting, if we're able to schedule that, it would be helpful to hear ****.

Next Speaker: I would really like, at some point down the road, to be able to talk about some sort of a more cohesive pandemic planning system within Oregon.

Next Speaker: Is that –

Next Speaker: Pandem –

Next Speaker: – ****.

Next Speaker: – pan, yeah, sorry, pandemic preparedness not to, not, not planning a pandemic but preparing how we deal with pandemic.

Next Speaker: Thank you, Jessie. Appreciate that. Anyone else on the line want to give a shout out to something for December or any public comment to share at all with the group? Okay. Well, with that being said, I think we will wrap up. I think **** give our final roll call since we are, we are on **** so we know who is here. I don't think we will miss any of you, um, in our minutes and I do want to say thanks for taking the time to join this abbreviated meeting. Uh, hopefully, we are still finding this to be useful. Um, if anyone has any feedback that they kind of think of after the fact, want to share with me **** this meeting can be more useful to you all,

um, just don't be shy, um, let me know what we can do for you **** and, um, also, I just **** stressful times, there's a lot of going on out there in the world and I hope that, um, everyone here in Oregon, um, that's being affected by the fires currently going on is safe and wishing us all the best of luck going forward for the next few months until we talk again. Um, just appreciate your continued commitment to this group and your presence here today with us. So, um, with that, I will move to adjourn the meeting and **** like to second that motion.

Next Speaker: I'll second it.

Next Speaker: **** second, thank you everyone.

Next Speaker: Thank you so much, everyone. Take good care and don't be afraid to reach out to me at any time. We're gonna be ending the call now.

Next Speaker: Goodbye.

Next Speaker: Bye, folks.