Healthcare-Associated Infections Advisory Committee
March 10, 2021

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Speaker: Hello, everyone, this is Laura with the Oregon Health Authority, um, with the HAI team. Um, I have started the broadcast and unmuted everyone on my end, so you are now able to unmute or mute yourself on your end, and you should be able to talk. Um, can someone confirm that you can hear me?

Next Speaker: I can hear you, Laura. This is Erin.

Next Speaker: Yep, I can hear you. This is Jesse.

Next Speaker: Okay and can someone confirm that you can see the agenda on the, on the screen?

Next Speaker: Yes, we can see the agenda as well.

Next Speaker: Perfect, okay. Rosa and Genevieve, I can turn it over to you.

Next Speaker: Thanks, Laura.

Next Speaker: Thank you, Laura. This is Genevieve Buser, I'll be your chairperson for today. Welcome to the March 10, 2021 Healthcare Associated Infections Advisory Committee meeting. We're so glad to have you here. We have a full schedule today, so I will begin by doing roll call. We're going to do it, as I'm going to read the list of names that are listed as attendees, and if at the end, I haven't read your name, I will ask for people then to unmute and give their name. So alphabetically, we have Ann Eaves, Deborah Katora, Elizabeth Johnson, Erin Koch, Gabriella Escutia, Heather Hertzel, Jeanine Bristol, excuse me, Jean Bristol, Jesse Kennedy, Karen Kanuck, Kenan Williamson, Christy Ketchum, Lisa Barton, Megan Lender, Megan Millett, Mesa Greenfield, Pamela Broom, Pamela Cortez, Pamela Mikelowski, Pat Preston, Paul Cieslak, Ryan Grin, Simon Perrera, Sara O'Dell, Stephanie Peterman, Sidney Edlin, Therese Anthony, Valerie O'Campo, Vickie Nordby. I apologize if I mispronounced anybody's name. Um, if, at this moment, if there's anybody's name I did not mention, you please go, feel free to go ahead and unmute yourself and introduce yourself to the group. And today, we are joined by staff Brittany Williams, myself, Rosa Pemmer, and Laura Lalonde from ACDP, excuse me, from Oregon Health Authority. If you're interested in the other attendees that are here in the little option box that's part of the webinar, you can see attendees with an arrow pointed to the right. If you click on that arrow, it will drop down and show you the list of attendees if you're curious, um, which are callers that are here today. We'll do a second roll call at the end of the meeting as well.

Next Speaker: Thank you so much, Genny. This is Rosa, um. I am, um, uh, sorry, apologies. This is Rosa Pemmer. I'm an epidemiologist for Infection Control, epidemiologist in ACDP. That's Oregon Health Authority, so I'm going to do a quick logistics update. Um, first of all, our vacancies have not changed from our previous meetings, so just to kind of note what they are, our current vacancies are a hospital administrator with expertise in infection control at a facility with fewer than 100 beds, um, a consumer or patient advocate, this includes patients and family members, a health insurer representative, a representative of the Oregon Safety Commission, and a chairperson, um, Gen is our current chairperson, but I think we are in the market for someone to, um, pick up on that responsibility should anyone be interested. And just the second part of my logistics update is that last quarter, I sent out a survey to everyone suggesting that we really would like to collect some information from this group to help us ensure that everyone has an opportunity to serve in a formal role in our HAIAC, and also fill up some of our long-standing vacancies. To those who completed it, thank you, um, a big thank you, and then unfortunately, I actually failed to include any way for you to identify yourselves when I sent that survey out. I know there were a number of people who did complete it. The only way I have to identify who completed it was, sorry, looking at your IP address. So that, unfortunately, isn't gonna be super helpful to me, so I have updated the survey and sent it out again. Those of you who completed it once, um, I know that someone tried to complete it a second time and they got an error message. I think we have, uh, we have addressed that issue, um. Josh Barfield, if you're on the line and you have a chance to try it out, please let me know. Um, otherwise, go ahead and please just complete the survey a second time, or sign the first time, and if you have any technical issues, please let me know. Your responses will help us to shift things around to make sure that everyone gets an opportunity to serve on the HAIAC if they're interested. Does anyone have any questions for me on that? Okay, fantastic, and that is our logistics update. Gen, back to you.

Next Speaker: Thank you, so now, I'd like to go ahead and, uh, ask for a call to approve the September and December 2020 minutes that Laura sent out before the meeting, if anyone has reviewed them and would like to approve them. Asking for a motion.

Next Speaker: This is Jesse. I'll move, uh. The only thing that I noticed, which would be a friendly amendment, would just be that my name kind of varies from page to page, so, but, uh, I had already emailed Laura about that, also moved.

Next Speaker: Thank you very much. Is there a second to the motion to approve, and this is on the minutes for September and December 2020.

Next Speaker: This is Deborah Katora. I'll second.

Next Speaker: Great, thank you, so moved. We've approved the minutes from September and December 2020, and now we will go back to –

Next Speaker: This is Laura.

Next Speaker: – oh, yes, go ahead.

Next Speaker: Yes, I saw that email Jesse, and I will fix that and address that. I apologize.

Next Speaker: Not a problem.

Next Speaker: Okay, thank you, uh, now we'll go back to Rosa for some COVID-19 updates.

Next Speaker: Thanks, Gen. So, um, I will just, I'm gonna go through a couple of, um, data updates to start for COVID and for flu both, and then we'll cover a couple kind of discussion topics, um, before we have a break. Um, so the first thing that I will start out with are the data updates. So, um, bear with me, get this on my screen. Okay, well, there are three kinds of data reports that I'm going to verbally summarize. Um, we will include the report links in our minutes, um. I don't know –

Next Speaker: **** sorry to interrupt, Rosa, sorry, to interrupt you and Genevieve, but we're still seeing the agenda. I didn't know if you had successfully transferred –

Next Speaker: Got it.

Next Speaker: – over your screen.

Next Speaker: Yeah, we are not doing slides this meeting, so I will not be sharing my screen, um, just gonna be giving –

Next Speaker: Okay, just wanted to clarify.

Next Speaker: – verbal updates, mm hmm, yeah. Okay, so the weekly data report, the OHA COVID-19 weekly data report is what I'll start out with, um. The most recent report, um, as of today, was published on the 3rd, um, and it covers the week of February 21st through February 27th. During that week, there were 2,652 new cases of COVID-19 infection reported, that being a 17 percent, um, increase from the week, prior week's total. There had been a large increased in testing from 70,200 people or tests done to 120,678 along with a slight increase in test positivity. Um, 3.7 percent of those tested during the past week, or during that past week had a positive result up from 3.5 percent, um. Uh, and then the prior week likely represents a low outlier for testing due to fewer people, um, reaching out for testing during the winter weather event. Patients newly hospitalized with COVID-19 rose from 158 to 164. Fifty-seven Oregonians died in association with COVID-19. That's an increase from the prior week, but otherwise, was the lowest weekly tally since the week of November 9th through 15th of 2020. Then of the 155,787 cases reported in Oregon since the start of the pandemic, 2, a little over 2,000 have died, 2,212, a case fatality rate of 1.4 percent, and 1,621 were hospitalized, which is a hospitalization rate of 5.5 percent. Epi curves can also be found, um, in that report. I think, you know, I will not try to describe them verbally, but we are seeing thankfully, a pretty significant looking decline. Kind of nice to look at these reports, you know, from the past few weeks and compare. We see that, that, you know, I guess hopeful trend, um, and then the out, per the weekly outbreak report, this is a different report. Again, uh, the most recent report was published on the 3rd. Data were updated as of the 28th of February, and this report includes list of active and resolved outbreaks in care facilities, senior living communities, and congregate living

settings with three or more confirmed COVID cases or one or more COVID-19 related deaths. Outbreaks are considered resolved if no new cases are identified for 28 days after the last case's onset, and this was **** include corrections facilities as well as foster homes. So, there are currently 56 active outbreaks that meet criteria, um, for inclusion in the report. Just for fun, compared to about a month ago, that was 116, so we've seen a precipitous dip in the number of outbreaks that kind of meet that threshold. Oregon Health Authority is also aware of 221 congregate settings that have five or fewer beds with three or more confirmed cases or one or more deaths, um, and those again, are not included in that list, um, for reasons of identifiability. There has been one death of a staff person who worked in a congregate care setting from COVID-19. We don't report employee deaths by workplace for protection of patient privacy. There have been 13,362 cases and 1,210 deaths associated with congregate care settings in Oregon, and just for sake of comparison, about a month ago, that was 12,888 cases and 1,099 deaths. We also, I'll also briefly cover the most recent report published, um, of the Oregon Health Authority's flu **** data, so that report was published on, um, sorry, 3/5 and it covers 2/21/21 to 2/27/21, um. The current week of the report, that last week in February, there was actually a decrease in the percentage of ED visits for influenza like illness going from .5 percent down to .4 percent, um. Percentage positive of flu tests raised slightly from 2 percent, sorry .2 percent in the previous week to .3 percent. In the current week, one influenza associated hospitalization was reported in the Tri County area, 23 COVID-19 associated hospitalizations reported during the same period, 0 reported flu outbreaks, 0 reported flu associated pediatric mortality and no RSV activity. So, um, we are also seeing, just looking at the national picture, minimal transmission of influenza, or minimal influenza like illness activities being reported nationally, so that is very encouraging. Um, before I switch gears to some of the updates and a little bit more, um, discussion, um, any questions or thoughts from that data or questions from the group? Okay dokey, all right, so let me start by just talking about breakthrough infections. So, we do want to track and investigate COVID-19 infections among fully vaccinated folks, so we can understand patterns and suboptimal immune response to the vaccine, waning immunity, compromises in vaccine storage and shipping, coaching, and viral mutations or variants that impact accessibility to the immunity that's typically induced or thought to be induced by vaccination. So right now, those, we're calling those kind of breakthrough infections, um. It's tentatively defined as people who have RNA or antigen positive respiratory specimens collected more than 14 days after their second dose of vaccination, vaccine. This, anyone who has a prior positive test result within the last 45 days would be excluded from this, and we're asking that our facilities report these to the local public health authority or as a backup, they can be reported directly to the on-call epidemiologist in ACDP. Um, the local public health or OHA epidemiologist who you talk to, if, you know, anyone does report breakthrough infections, will probably ask the caller to hold samples from the case patients since some specimens are going to be requested and shipped to CDC for the purposes of RNA amplification and sequencing, sequencing, viral isolation, and immune characterization. Um, so one of the things that our facilities would be asked to do when reporting this is to see if there's any residual respiratory specimen available to be sent for sequencing, uh, perhaps asking the patient to have MP swab collected, um, and then finally, um, their reporting and that is that adverse event reporting system that's only required for breakthrough infections if the case died or was hospitalized. Um, so I will turn this over to the group, uh. You know, kind of wondering does anyone have thoughts on breakthrough infections, anyone would like to share experience. Are you able to sort of routinely flag these breakthrough infections if they do arrivably – they're not arriving routinely,

but would you be able to kind flag those and report them, um, and identify them? What are the challenges here, and then finally, if anyone needs the local public health authority or epi on call contact info, I can provide that too. So, I will mute myself and turn it over to the group for some conversation.

Next Speaker: I don't have any particular comment but thank you for the update. I thing OHSU's predictive, um, data mapping has been pretty close so far.

Next Speaker: Thanks, ****, that was Kenan, right?

Next Speaker: No, sorry, that was Jesse. I should've, should've said that.

Next Speaker: Oh, okay, thanks, Jesse. So, thank you, that's helpful. Um, so are folks, does anyone kind of foresee challenges in picking up these breakthrough infections or no, would those be easy to identify?

Next Speaker: This is Kirsten Schute. You know, I think one of the things that we've struggled with as we've talked about this is, um, collating that information. You know, there are a lot of questions that are asked at the time that we collect a swab already, um, and you know, relying on patients' self-report versus other information about, you know, when they were vaccinated, have they truly completed a series depending on which dose, uh, which vaccine they got, um. I think operationally, there are some challenges with connecting that data.

Next Speaker: Yeah, yeah, I think definitely, of course, like, this relies on us, you know, knowing that someone is developing illness, right. So, so certainly, that's part of the picture, um, and then I will say in terms of identifying like how, yes, I, I'm hearing, you know, having to like collate the information, finding out, um, when they actually received the last dose. I believe it is actually just 2 weeks after the last dose of any vaccine, regardless of the specific product that was, um, given, uh, so that does take some of the guesswork out of it, but yeah, I hear you in terms of telling us about self-reporting and kind of collating this information.

Next Speaker: Hi, this is Deborah Katora. Um, one of the things that I think could be problematic is, um, how to properly communicate with the nursing facilities and the CDCs that may be starting doing their own testing. In theory, they should know what vaccines their residents have received, so should know if they have a breakthrough, um, but if we could get some kind of standardized language that we could share with the facilities, um, if they identify, um, they not be able to do it. I, I don't know, but if they don't have some specific directions, then they're not likely to contact their local county health department.

Next Speaker: Thank you, yeah, I think some of this information has gone out, um, but I'm not sure. Certainly, for local public health, but I'm not sure if I can speak to how the request for breakthrough infection reporting has been pushed out.

Next Speaker: Maybe it's ****.

Next Speaker: Hi, this is Tom Rollins from Prestige. Hey there.

Next Speaker: Hi, Tom.

Next Speaker: Hey, so I actually just had this come up that we had a staff member test positive with breakthrough, and we had no idea the expectations that OHA had until the local health department sent it. So, I really think that sharing that information, again the communication piece, I think would be huge. So, we, they just don't know because they don't, until it's already upon them and then if they've got an outbreak, it already a lot of extra work anyway. So, I, I would encourage you if you have documents and stuff like that to share, that would be wonderful.

Next Speaker: Thank you.

Next Speaker: If it helps ****.

Next Speaker: No, no, that's very, this is all very helpful.

Next Speaker: Okay.

Next Speaker: Paul, are you available and on the line. Are you – I hate to always be calling you out during these meetings.

Next Speaker: I'm here.

Next Speaker: I'm wondering if you remember if and how this has been pushed out to facilities. I know local public health is aware, but, and I'm, as far as I'm aware, CDC is still finalizing the approach as well as OHA, but I don't, I will turn it over to you, if you have time to answer.

Next Speaker: No, I don't think I do. My, my understanding is that, you know, Becca and Dax were going to be, um, reaching out to, uh, long-term care facilities anyway regarding this because, uh, they're, they're doing, first of all, they've got to highly vaccinate the population and secondly, um, uh, they're testing, you know, regularly and finding cases. So, um, but, but beyond that, I don't, I don't have specifics I guess is what I would say.

Next Speaker: Okay ****.

Next Speaker: Are you able to maybe follow up with Becca and, or Dax and, uh, see what their, what their plan for communication is?

Next Speaker: Sure.

Next Speaker: Whether they can do that.

Next Speaker: And can I ask, uh, folks to address kind of a related question, which is, um, when you get either a breakthrough infection or a re-infection, you know, one of those positives that you find more than 90 days after an original positive, um, are you, are you, you know,

considering them a case? Are you, uh, checking the CT value on the PCR, uh, you know? How are you, um, how are you approaching, uh, those kind of cases?

Next Speaker: This is gonna be, uh, I can speak a little bit for Providence as a caregiver there that we, when we can, if the test platform that was used to test allows for, for us to know the CT value, usually it's the infectious disease doc, maybe infection prevention, but not just the general clinician, but usually ID that will contact the lab and see if they can find out the CT value and that can help us with a determination of, you know, other steps to take, but it's fairly limited who does that and who asks for it, and then the interpretations depends on whether the platform gave that information, and then the idea would be, then if it was, if it was positive and it was considered to be either breakthrough or re-infection, I believe they're trying to send those samples to the state to refer for variance.

Next Speaker: Yeah, that is what we want. I'm just finding whether you're trying to ascertain from the CT value whether a patient is going to be isolated and you know, things like that.

Next Speaker: So far, the cases I've had have been case by case, both based on the CT value, the clinical history, the patient's current symptoms, um, yeah.

Next Speaker: Yeah, this is Kirsten Schute. I would echo what Genevieve said, you know. Sometimes what we're finding, at least in the handful of cases I've seen so far, is we're picking these up on testing that was done, uh, for asymptomatic screening, for example, time of admission to like a labor in delivery unit, and then, uh, a patient who has a history of COVID a number of months ago, um, and so a lot of those are done on platforms that we don't have a CT value, um, but if we have one, we're, we're trying to follow the similar process that Genevieve outlined.

Next Speaker: Okay, thanks.

Next Speaker: This is Vickie Nordby. So, um, we're picking up a couple on, um, just a routine survey, survey that's based on CMS, um, requirements, and those that, um, we do get CT values on all of our testing, well, our TCR testing and we do look at those, um, around anyone who's being currently tested, but is not within that 90 days of a positive, um, and is, um, or, um, then we are looking at those, um, CT values and determining, um, requesting, um, variant testing if that, um, that might be indicated. All those are then isolated until we have additional information.

Next Speaker: Thanks.

Next Speaker: This is Kirsten. If I could as a question, because this came up in some of our conversations about, you know, thinking about how we would try to get information to be able to detect someone who's been vaccinated and is a breakthrough case, um. Is there reconciliation being done, uh, with like the Alertis immunization base, uh, database behind the scenes at the state level. You know, for example, we have a, a fair proportion of outpatient testing, and like I said, it, from a system perspective, unless we explicitly ask that question or we explicitly direct a staff member collecting that sample going through that process to, uh, verify immunization

records within our system, um, we're not going to be picking up, I'll just be honest, we're not gonna be picking up on every breakthrough case.

Next Speaker: Um, they, they should be, if I understand your question, you know. When we get a case reported to us, you know, typically, it comes in through an electronic lab report, right, of a positive, uh, PCR antigen test, and it gets uploaded into our database and then, uh, either at the local public health level, uh, or at the state, um, there's, there's sort of an automatic feature built in. You push a button and, and that becomes an alert query about the patient's vaccinations, and, um, and their status should be uploaded into our records. Um, the issue of course, with trying to do anything with these breakthrough cases, uh, is that, um, you know, time has gone by and then if we wanted to get a specimen and have it sent in and see whether it's a variant strain or something like that, uh, often too much time has elapsed. So, it would be nice if at least on some, uh, fraction of the cases, you know, if, um, if that's done on the front end rather than on the back end.

Next Speaker: Thank you, that's really helpful, um. I'd be curious, uh, as to what other health systems are doing, whether they're able to collect that information. Like I said, we've identified from the time of specimen collection as the easiest way to do that, rather than when, for example, the results are reported, but I don't think that we're doing that and that's worked into the process quite yet.

Next Speaker: ****.

Next Speaker: While people are thinking about that, I just wanted to say that, uh, Kenan Williamson from OHSU said they're doing a similar process, um, as was mentioned before, using the CT count. I think that's referring to the CT values plus the clinical history plus the **** times **** section, so it sounds like CT values is one of several factors. Thanks.

Next Speaker: Thanks, Gen. I think we're going to move on to another topic, um, but, you know, we do have a, quite a bit of time for group discussion, um, you know, during the other portion of the call, so I will encourage anyone who, you know, can think of any additional feedback or thoughts or questions to kind of bring them back up later on. It's all fair game. Um, does anyone have any final thoughts or questions that they want to share now before we move on to another topic here? Okay, hearing none, um, so one of the things we do want to talk about with this group is fit testing, so our program is going to be developing the materials to kind of talk, get some **** fit testing so, you know, like part of that and have this conversation, um. I just have a number of different questions for everyone on the line, and I'd be curious to know what, how folks are approaching, so fit testing, of course, is something that, or again, OSHA has kind of said that, you know, it could be suspended for the time being, uh, for those wearing respirators who haven't already been fit tested, considering, you know, the many kind of competing priorities doing on during COVID and the importance of respiratory protection, specifically, right, respirator use for known or suspect COVID-19 cases. So, you know, what we're seeing is a lot of facilities kind of building up fit testing capacities where maybe they haven't had it, um, as established in the past, um. So curious to know, you know, from the folks on the line some of the questions in our minds are, you know, who is doing this at your facility. Is that an occupational health, employee health person, a contractor, someone else, and how is that fit

tester trained, um. Who is getting fit tested, you know, is it everyone? Is it only people with direct patient care duties, um? How are your facilities kind of managing fit testing in contrast with supply shortages, right? So, are there concerns about getting consistent supplies of particular respirators? Are staff getting fit tested for multiple models, you know, to kind of accommodate for possible supply interruptions and not being able to get that same make, model, size, and style over and over again, um. Are folks using quality over quantity in testing approaches, you know. What infection control approaches are being taken to re-process fit testing equipment between uses, like hoods, for example, during qualitative testing, and then finally, uh, are you seeing that employees are failing to fit test to any N95 and how are you managing that. So just, you know, just kind of, just kind of a grab bag of questions on kind of fit testing approaches and the various challenges that have been kind of popping up. So, I will again mute myself and, and hope the group can take it away on this.

Next Speaker: Well, this is Tom Rollins from Prestige. So, all of our SNIPS and assisted livings in all of our states have done fit testing, um. We are re-fit testing now because we had allocated a large amount of N95s through 3M and so we are switching folks to that and then using the other ones as backup in case we run out of those. Um, so we are really set for N95s right now, as far as who's doing it, um. Our staff developers are infection prevention on the skills side or our executive directors or maintenance directors on the assisted living site, they do a train the trainer video on their local health care associations, and then we've really only had, I would guess, probably, I can count on one hand the number of folks that have not been fit tested, um, because they just failed the fit test, and they've failed every fit test we've done. Um, we did a, you know, we'd send them off to other folks to try to get fit tested and they just don't pass, and so then we've come to the conclusion when they need, when they're going to need to wear an N95, they are just going to have to take time off of work, and they're perfectly fine with that.

Next Speaker: Thank you, that's super interesting. So, would do you consider offering a **** respirator to those folks or is that kind of outside of the scope of your respiratory protection program?

Next Speaker: We've, you know, we've thought about that. However, in our setting, it's really hard to wear those, um, because we're, you know, we don't, a lot of places don't have central air. They're hot. They're, we have residents that yank them off their face. Like, there's a lot of, there's a lot of what ifs that go in there.

Next Speaker: Mm hmm.

Next Speaker: So we depend on the situation, especially if we're in a staff shortage, um, but, you know, we never say never to anything, just so you know, but, um, if it's just one person in a building, then it's probably a lot easier to, to have them just stay home during the outbreak or whatever that issue tends to be.

Next Speaker: Thank you and that's Tom, right.

Next Speaker: Yep.

Next Speaker: That's Tom.

Next Speaker: Appreciate it, and then in terms of the train the trainer video, is that from which organization are you guys using?

Next Speaker: We, it depends on the state, but a lot of the health care associations have shared them, um. I think there's one on YouTube you can use as well, and if I recall, OSHA has one as well, but I could try to locate that, but we, uh, we found those work really well, and we've had a lot of folks that are just seasoned at doing it because they've done it forever and in the SNIP world, we've always had the fit test, so we've just always kind of done that, but the assisted livings side has been a much different animal because they just have such a different number of staff members, and so, um, but that was, that was probably our biggest challenge was the assisted living side.

Next Speaker: Thank you and then, well, are you doing both qualitative and quantitative approached –

Next Speaker: Yeah.

Next Speaker: – or qualitative only?

Next Speaker: We're doing qualitative only, um. We do the Bitrex and banana oil and all that, depending on which kit they use.

Next Speaker: Mm hmm.

Next Speaker: So, um, that's just been easier for us especially in the, in the long-term care setting.

Next Speaker: How are you approaching the disinfection of hoods between uses or if at all, I guess.

Next Speaker: We, well, we use the un, the unlisted, um, disinfectants, um. You know, in Washington, they actually have people that will go do your fit testing for you at no charge. Um, the state pays for it, so, you know, if that's ever an option for Oregon, it would probably be super helpful, but they do, we just had it done at a SNIP in Washington at no cost. It was super fast, like come in, get it done, and move on, so.

Next Speaker: Right.

Next Speaker: Yeah.

Next Speaker: Thank you.

Next Speaker: Yeah.

Next Speaker: Appreciate that. Other folks, anyone who's kind of experienced those differences? Any feedback is helpful for our training area to develop some guidance here, and aside from just having the conversation and sharing the different approaches. I'm taking assiduous notes as we, as we talk, so I'd love to hear from others on the line.

Next Speaker: Rosa, this is Erin, um. I just had a situation with a, um, facility, an assisted living facility, and they had tried to get the testing, um, done by an occupational health provider in the area, and they only did the quantitative, and all of their, um, staff members failed that. So now they're looking at the qualitative and I don't know if, you know, something was in error, the way it was being done, but, um, that, that was just their, um, experience. I haven't heard that before. I think most of the time it's usually qualitative, um, that I'm aware of, so anyway, just an experience.

Next Speaker: Yeah, thanks, Erin. Have any, has anyone kind of seen like any patterns in folks that are failing to fit to any make or model or size or style of an N95 and kind of Tom outlined how they're addressing that situation. Are other folks, how, how are other folks managing individuals who fail the fit test to the respirator and do we have some best practices maybe for people who are doing the fit testing, know that if every single person is failing to fit test, maybe there could be something that has gone awry with the process of, of fit testing itself.

Next Speaker: This is Mary from Shriners and, um, you know, we, we've had to have a variety of N95 masks available. Um, we primarily use the 3M 1860 series, but again, those are very specific to the sizes and shapes of different faces. So, we've had to get, you know, some pleated duckbill masks, other, other options for employees. The other thing we found is we, through qualitative, we not only, uh, use Saxon, but we have Bitrex, because some people couldn't pass with one, and we had to use the other, um, and so that has helped us, um. Some employees just can't taste one of the solutions, so it's good to have an option, alternative, um, and, um, we do disinfect the hoods, uh, with a, um, COVID approved disinfectant as well, and just, um, we have to rinse with water because the smell of the disinfectant lingers, so we've had to spend a little bit more time in between people ensuring it can get disinfected and rinsed and dried. Um, and then, uh, we, um, do have PAPRs available for those who are unable to fit test, and people of course, have to be trained in how to use the PAPR as well.

Next Speaker: Thank you, Mary, and how are, who is doing the fit testing at your facility?

Next Speaker: Um, again, we've got a core group of individuals who have all been trained and people in all departments so that we have, um, the testing availability, uh, 24/7 there. Again, we have PAPRs in case somebody has not been fit tested, but, um –

Next Speaker: ****.

Next Speaker: – you know, the nurses, the nurses are primarily clinical and, um, we had, um, 3M actually has a fit testing video that we, uh, use for training and support, and then, of course, we just had people, um, you know, practice fit testing on each other, and then we did a series of observation as they fit tested others.

Next Speaker: Thank you.

Next Speaker: Genevieve, one of the audience members brought up that there could be an issue with people who have a lack of smell or taste due to a history, a recent history of COVID. So, I don't know if that's something to ask about prior to doing the test.

Next Speaker: Good point.

Next Speaker: Yeah, that is interesting. I didn't think of that, um, because it has been a while since I've gone through the qualitative method myself, but it seems like, yeah, there are individuals who have that particular, um, symptom that quantitative would be more appropriate.

Next Speaker: Any other thoughts on this, um, before we move on?

Next Speaker: This, this is Mary. I just was going to add that, um, we did send reminders out prior to fit testing that they shouldn't smoke, eat, or drink prior to coming with the hope that that will help them get through the test as well, and also we send out the, the infographic about facial hair, so that people know that again, they have to be clean shaven.

Next Speaker: Great, I'd love to see, you know, if anyone on the line is interested in sharing infection control protocols or any additional, you know, process documents that kind of incorporate infection control elements, um, love to see those or kind of best practices and strategies on how to get people fit tested to a respirator. Any of that is fair game if folks are willing to email it my way. Um, with that, we're gonna just switch gears here to a brief kind of a teaser that I have, and then we will take a break.

Next Speaker: Rosa, this is Genevieve to say that, I have a little bit of follow up on, uh, **** last question about breakthrough infections and asking about that, uh. I'm going to take that back because he had, at Providence, we use a, a nicely detailed lab order that has questions, you know, about past infection, and I'm gonna bring it to incident command and see if maybe we can request to add, you know, the data history of vaccine and see if we can get that included and if that would help us follow up, especially now that, you know, we have an opportunity, that we're looking for these kind of breakthrough infections. Thanks, and I'd just encourage other people that that might be something, um, that could be updated in your, your ordering system depending on how flexible it is.

Next Speaker: Okay doke, any other thoughts before we, uh, switch gears to a different topic and then take a break? Okay, well, so the last thing I will mental health before we do go to a break is that we are working on gathering, um, vaccination data from long-term care facilities, um, here at OHA. So long-term care facilities are working either with a, um, federal pharmacy partnership program or other partners to vaccinate residents and staff for COVID-19, um. However, the data shared about administering vaccine doesn't, isn't routinely transmitted as a proportion of eligible staff and residents and then additionally, information from these partners doesn't always capture staff or resident turnover, or things like vaccination outside of **** facility clinic. So OHA has developed some COVID-19 vaccine tracking tools, which have been adapted or modified from the National Health Care Safety Network or NHSN tools that will

automatically calculate summary data. So OHA is working with DHS to make this the standard tool that long-term care facilities will use to track that scene information and then our agency plans to collect that same summary data from long-term care facilities and, you know, as more information on reporting this to OHA will be forthcoming. This is really just a bit of a teaser, um. These tools will allow both individual and aggregate level tracking for the facility and, you know, tracking information is just important to inform outbreak response and infection control strategies, and identify, and of course, key vaccine outcomes of public health concern like breakthrough infections, as we talked about earlier, vaccination, uh, related adverse events, or large outbreaks post vaccine. So, we plan to collect summary data to calculate accurate vaccine uptake percentages, which are needed to track progress, identify gaps to allocate vaccine **** appropriately and then finally, help our agency to define next steps for reopening and infection control policies. So, any, any, I don't really have a ton of extra detail on this, since this is all in progress, um, but we have about 3 minutes before the break, so I'll just open it up to the group, um, to discuss or anything that we've talked about so far is also fair game, of course.

Next Speaker: This is Vickie Nordby. So, are you going to, um, nearing the OHA form data collection? My concern is that **** we already have a tremendous amount of reporting we're doing on a regular basis, and if you're, you know, adding an additional that is not of similar form, you know, like where we can't utilize the same data for two sources, um, you know, is, is an added, um, resource drain. So, you know, my, my request would be that it is, closely mirrors the NHSN data gathering, um, as possible.

Next Speaker: Thanks Vickie. I believe, and I don't want to overstep, um, but I believe that, you know, they are adapted and modified from the NHSN tools, so they are somewhat similar formats, um, but that, um, but that they allow for some additional information collection. So, our forms will allow both individual and aggregate, aggregate level tracking –

Next Speaker: Yeah.

Next Speaker: – possibilities to be able to track, um, individual staff and resident –

Next Speaker: But I will tell you –

Next Speaker: – ****.

Next Speaker: – this is, um, this is Tom for Prestige. Our building is actually piloting the thing, and it, you need to understand it does take time away. You're talking hours per, hours per resident and the staff because you have to do two separate ones, so just, just know it does take a lot of resource.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: This is Vickie. The other thing is, um, I would hope that we're not going to go backwards to onset of vaccination, um, to gather data, so you know, that Oregon could utilize

the, um, data that's already been entered into NHSN for, you know, because most facilities have already done their initial round of vaccination and so, and those started like the third week in December, and so to ask for facilities to go backwards, um, to that and gather that information in a different format, um, that's a big ask. I understand the public health benefit, but I also am trying to protect the resources that, that are kind of slim right now in a lot of facilities.

Next Speaker: Yeah, agreed.

Next Speaker: Yeah, I definitely hear you. Um, I'm, I'm not going to, I can't myself respond to the concerns, um, as, you know, in the best way on this line because this isn't something that I have been working on personally, but if anyone on the line would like to send me thoughts or feedback. Um, Tom, I imagine you're working together with Lisa and Gucci, is that correct?

Next Speaker: Meanwhile, yeah, Lisa and Becca.

Next Speaker: Right.

Next Speaker: So yeah, so, so Lisa and Becca are the contacts, but still, anyone with questions or concerns on this, um, do know that it's still in the pilot process. Um, I think your feedback is certainly welcome and helpful. If you'd like to send it my way, I will pass it on to my colleagues who are working on this. Does that sound fair enough for the time being? Vickie, does that sound okay to you if you wanted to send that along?

Next Speaker: I'm sorry, I was responding to, um, something. Can you restate that? I'm sorry, Rosa.

Next Speaker: That's okay. So what I'm going to ask is that anyone who has feedback on this, because I haven't personally been working on it, so have them send it my way and I will forward it to my colleagues who are working on it, and with that, I think we're going to go ahead and take our break, and we will reconvene at 2:00, okay. Thanks everyone.

Next Speaker: Uh, Rosa ****.

Next Speaker: Eight minutes.

Next Speaker: Rosa, actually, this is left, um. There's one comment in the chat, um, from Kirsten, um. Thanks for that additional information. Our leaders felt that this was too unwieldy to add to the other testing questions at present, but I'll bring it up again. If this was a requirement from OHA, like there'll be data prior to testing is required, it might help uniform information about the, about this in a timely manner to be able to submit samples for sequencing. Um, so that's just the comment, but, um.

Next Speaker: Is that in, is that in regards, sorry, ****, Kristen, is that in regards to, to this data tracking or to breakthrough infections, just to make sure I'm understanding correctly?

Next Speaker: I believe, um, data. So –

Next Speaker: Okay, I think ****.

Next Speaker: – **** breakthrough.

Next Speaker: **** in regards to breakthrough infection. It was written in regards to breakthrough infection **** was asking about. It's our way to identify that this is a breakthrough infection prior to it being reported to the local health department. I think that's where that came up from, um, but yeah, Kristen's comment about extra, requesting extra information at the time of ordering COVID is very, very valid, um. The other way would be if, to help **** have a systematic way of addressing positives, the ones who tested positive, like for example, **** clinic or the employee clinic speaks to the person with the positive test, uh, to give advice that that might be perhaps a time to verify vaccine status as part of that protocol, and would be less work than our MD ordering the test potentially, but those are just some ideas to generate, uh, for that, generated back to that question about identifying earlier.

Next Speaker: Okay, um, so and just in terms of the communication, um, I'm hearing now that there is a Health Alert Network, um, message for alert plans, um, as we are finalizing our approach to breakthrough case reporting, so I will go ahead and just have us go to our break. So, we're going to take 10 minutes. We'll start at 2:05 and really appreciate everyone's participation. Hopefully, a little break will make things a bit more humane and we will come back in about 10 minutes. Thanks so much.

Next Speaker: And I'll be on the line here if anyone wants to talk to me. I'll be available.

Next Speaker: Since we're on a break, I'm going to mute everyone. I'll mute everyone just, just in case. Okay, that is done. Everyone is muted and I'm going to unmute again. So, um, they can unmute themselves, but we are unmuted on our end.

Next Speaker: Rosa, hi, this is Kenan, can you hear me? I'm trying to test my mike – or anyone.

Next Speaker: I can hear you.

Next Speaker: ****.

Next Speaker: This is Paul.

Next Speaker: Hi, Paul, thanks. Thanks, everyone.

Next Speaker: ****.

Next Speaker: Yeah, still around, yeah.

Next Speaker: Excellent.

Next Speaker: Mm hmm.

Next Speaker: Kenan, I was muted. I'm sorry, but I can hear you.

Next Speaker: All right, thanks. Uh, I have something back on the N95 testing from OHSU if you want that, um.

Next Speaker: I want to see anything, um, since we're out technically on a break right now, like let's –

Next Speaker: Yeah.

Next Speaker: – if you have stuff you want to discuss, let's save it for the group discussion. If you have protocols you'd like to share with me over email, that's perfectly fine. I just want everyone to have the benefit of hearing what you have to say.

Next Speaker: Sounds good, okay. I'll wait.

Next Speaker: All right, this is Laura, um, again, just making sure, um, everyone can hear and see the agenda. Maybe Genevieve and Rosa, can you hear?

Next Speaker: I can ****.

Next Speaker: Perfect.

Next Speaker: Okay, well, um, Gen, are you back on the line here?

Next Speaker: Can you hear me? Are you able to hear me, Rosa?

Next Speaker: Yes, now I can hear you.

Next Speaker: Yeah.

Next Speaker: Great.

Next Speaker: Okay, great.

Next Speaker: Okay, is the com, is the line open or?

Next Speaker: Yes, it's open and then can someone besides Genevieve and Rosa confirm they can hear and see?

Next Speaker: Yes, hi, this is Kenan, OHSU. I wanted to share some thoughts about OHSU's, um, N95 process and that Rosa brought up, uh, before we get started again.

Next Speaker: Go for it, Kenan. Thank you.

Next Speaker: Thank you.

Next Speaker: Yeah, sure, the, so OHSU, we have a separate infection control and occupational health program, and occupational health typically handles, um, the fit testing. So right now, we eliminated annual fit testing, but staff do need to get fit tested for our current masks. It's, we have three, um. I believe one is a Halyard, and the two others are 3M models, um, and they have a qualitative machine that does the testing in the department, but early in the pandemic when supply was very low, we, um, approved the, I guess the process for staff to do just in time fit testing if they, you know, required the use of a mask that they weren't traditionally fit for, um, and the just in time process involved putting the mask on and just checking for leaks by putting their hands up around their face and blowing or breathing deeply.

Next Speaker: So that being field checked.

Next Speaker: Right, yes.

Next Speaker: Okay, yeah, and that is something we wanted to be doing **** respirators in general. Did you say you use a qualitative machine?

Next Speaker: Uh, sorry, I think quantitative.

Next Speaker: Quantitative, okay, okay.

Next Speaker: Yeah.

Next Speaker: Thank you, that's helpful. Did you find that that machine comes with pretty, um, robust instructions on re-processing? Like, I don't personally know and I'm sure other people on the line know, like, does the tubing get replaced in between individuals, does the machine get wiped down, anything like that?

Next Speaker: I know the machine gets disinfected, but I'm not sure on what cadence the tubing gets replaced between users, um, yeah. I'm not sure about that.

Next Speaker: Thanks. I think we can turn it over to Gen, and this is a great, this is a topic that's super helpful, um, for me, so I, I, um, yeah, if anyone has other thoughts during open discussion, um, that would be great. So, Gen, it's all you if you want to take the reins here.

Next Speaker: Great, so bring us back from our break. Thank you everyone for rejoining. Uh, now on the agenda, we're gonna move on to some discussion around approaches to COVID-19 and try to share some experiences and get feedback, uh, on what's being done across the different systems, uh. We will begin with, uh, Rosa would like us to discuss on the new guidance from CDC regarding double masking with, and how different systems are approaching that, um. Rosa, do you, I feel like just started doing popcorn a little bit, but would you like to kick off with that one first, and then we can go to the others?

Next Speaker: Yeah, and I'm not, I – Gen will lead this part of the discussion, but I'm just going to kind of give a brief overview of CDC's recent recommendations regarding – it's actually, uh, double masking and then other strategies to improve the infiltration of respiratory protection. So, um, there are, um, some – there is **** our guidance from CDC fairly recently that talked about, you know, layering, um, cloth face covering, um, over, um, medical-grade masks and then the use of a tucking and tying strategy, which is to tie a knot right at the base of each earlobe on a medical-grade mask and then tuck in the excess, um, you know, fabric or paper, I guess, to kind of create a closer fit with fewer gaps around the sides and some of the other options being, um, the use of mask clips behind the head to hold ear loops or straps more tightly around the head, to take off pressure from the back of the ears, and then, finally, there are mask, um, fitters, which kind of, uh, fit over the top of the respiratory protection and help the mask seal more closely to the face, so those are some of the kind of options that CDC has sort of put out there in the world regarding how to improve mask, um, fit infiltration. So, um, one of the things we really wanted to hear, and we are working here at OHA to, you know, incorporate, um, and tell – and figure out what strategy we're gonna be recommending, um, for healthcare settings, specifically, um, but yeah, that – this is something we are very curious to hear about how our facilities are approaching. Have you look at that guidance? Do you like it? Is there parts of it that you'll be incorporating? What are the challenges that you foresee? All of that good stuff.

Next Speaker: Hi, this is Kenan from OHSU. Um, the, the guidance came out, and whether I liked it or not, a lot of the staff, you know, showed it to us, um, you know, really saying why aren't we double masking, why aren't we encouraging these kinds of things, um, and that started a lotta conversation, you know, not just at OHSU, but I believe during the, uh, Wednesday calls as well. Um, what OHSU eventually decided on was, you know, we, we want you to have a, a well-fitting mask, so, you know, do what you can to make that happen, but we aren't encouraging double making.

Next Speaker: Thanks, Kenan. Are you allowing your – oh, I'm sorry. **** I didn't think to take it over for you. Just curious, are you guys allowing your, your staff to wear cloth-based coverings under a medical-grade mask, in the building?

Next Speaker: No.

Next Speaker: I mean over, rather.

Next Speaker: No. We, we're not allowing that. Um, they would have to, you know, maintain cleanliness on those things, and – yeah. If it's patient facing, then it should be our approved hosp, hospital-approved mask.

Next Speaker: Uh, and this is Genevieve following up on that. Um, are – do you find staff are using two hospital-approved masks? Uh, for example, I do see in the clinical care units, uh, using N95 with a disposable mask over that.

Next Speaker: Yeah, I, I have seen that as well, but the – that isn't a part of our official recommendation.

Next Speaker: This is Vickie Nordby. Um, so we've, um, uh, taken that, um, CDC information, and that's for public use, and shared it with them for their use in their personal time, um, but we continue, you know, to not have any, um, cloth masks, double masking, um, so again, we just stressed that that was for personal, um, public use, um, and not for healthcare.

Next Speaker: This is Kirsten. We're currently considering what some of the options are for, um, groups that are dealing with lots of patients, where, uh, our, our burn rate would be very high, if we followed kinda typical practices of dedicating single respirators to patients, um, with a higher level of respiratory protections that we've been considering, uh, use of our surgical masks over N95s, but we have had serious concerns about, you know, using any kind of cloth mask over, um, a procedural mask, to try to get it to fit more tightly to the face. You know, we don't have a lotta control, then, over what people are doing, in terms of laundering, washing, so we've taken some of the same approach, in terms of saying that's not appropriate for a healthcare setting.

Next Speaker: And this, uh, Genevieve. I'm speaking for Providence. Uh, we have a similar approach as OHSU, in that we, uh, you know, ask that caregivers use a well-fitting mask but not double masking. If they need to use the little straps around the back of the head, or there's like little different clips that make it more comfortable and well fitting, I, I think that's then okay, um, but still just using the hospital provided, and the other piece is that we are, based upon our current supply, considering, hasn't become official policy, but considering returning back to the single-use N95, um, because we have good enough supply right now, so, again, not advocating for, you know, using a surgical mask over an N95 that's being used from patient to patient, trying to get a, get away from that, as we can.

Next Speaker: This is Rosa. That's definitely in alignment with what we wanna be seeing, just as a sidenote, which is that, you know, wherever possible, we wanna see facilities returning to conventional PPEs. We know that's still a big list, depending on the setting and what's going on in that particular facility and, uh, all of that, um, but yeah, when, when we can be returning back to conventional capacity, that's what we would like to see in that burn-rate calculator, as recommended from CDC, as a way to kind of help inform those decisions, and I'd be curious if, you know, other, Genevieve, and other non-hospital settings, uh, how are you, um, – uh, has that been an issue, just given that, you know, I, I know that sometimes that PPE, uh, is harder to come by or supplied, et cetera. Have you had any pushback from staff or had to address their request to have double masking?

Next Speaker: Uh, this is Josh from the Oregon Clinic. We're following a similar – um, we're not requiring double masks, but we're rec, strongly recommending, um, and then kinda following up on the last thing, we're not at the point for single-use N95s yet.

Next Speaker: And the double masking, are you, is that, are you having them use two, uh, medical, or two masks that you provide that are medically appropriate? Are you allowing, uh, them to mix with cloth masking?

Next Speaker: Um, um, so most of it's been providers that are doing double masking, and they're using, um, the clinical grade. Um, I haven't – I got 56 offices, so I haven't been to most of them, obviously, but, uh, we will allow the cloth with the surgical.

Next Speaker: Mm hmm. Great, thank you, and I guess, uh, we should mention that this is in the context of sort of extended use, or whatever, you know, the standard masking protocols that have become part of our just everyday life, um, as different than if you are go, you know, going into a COVID-positive room, et cetera ****, of course, addressing the, the daily use. Great. Well, Rosa, um, you know, if there's some – anything else that comes up or other questions you have on that, but it sounds like, at least from the folks on this call, that most, um, facilities are, um, at least not mandating double masking, um, but either not encouraging it or leaving it as an option. So, some of the, the other, uh, that **** other questions, uh, or next – were there any other comments before I move on to ask another, uh, input? Sort of the next piece we wanted to, we were gonna ask about, and this kind of dovetails with what Dr. Cieslak had asked earlier, uh, is anybody know if their lab is performing sequencing on COVID tests **** in health, or are they just using or just referring those all to the Oregon, uh, State Public Health Lab?

Next Speaker: This is Vickie. We use, um, Caution Clinical Laboratories, and they're doing, um, select sequencing, so if they're, in certain situations, they're not sequencing all, but, um, they are doing select specimens.

Next Speaker: And which system is, are you with?

Next Speaker: The Marti Companies.

Next Speaker: Okay, and so do you think that they're just doing like a ran, uh, sort of a random sampling surveillance?

Next Speaker: Um, and if there's indication based on, um, vaccination, um, CT, um, value, um, so there's a few, um, situations in which, um, those specimens have risen to be, um, sequenced.

Next Speaker: Okay, great, and which lab did you say that was done with? Sounds like a reference job.

Next Speaker: Caution Clinical Labs.

Next Speaker: Gotcha. Thank you. From, either from the Providence side, as far as I know, I know there's some question around, uh, research, and, uh, Rosa, if you needed a contact for that question, I think Dr. Justin Jin knows more about that, um, at PPMC, whether they're doing any, you know, research, but I think, otherwise, if **** did identify someone at risk, it would be going to the state lab. **** on that, uh, one of the questions that, uh, has been discussed, I know, on the Wednesday calls a little bit but wondering about, uh, beyond the hospitals, are folks moving to universal testing on admission. I know some of the long-term care facilities are, they have already been doing this, um, but wondering where different systems stand upon that, and, uh, is there – um, are you using DC, uh, antigen testing or the full PCR testing? What's been your experience with how that's done? Is it done in the ED or on the floors? Do you, um, – are you, you know, waiting for that result prior to placing them in rooms? Um, if they don't otherwise have, uh, COVID symptoms, COVID-like symptoms, what's been your sorta positivity or any, uh, lessons learned from that?

Next Speaker: Hi Genevieve, Kenan here. Um, OHSU is not doing universal testing, um, but we are, you know, doing routine testing for anyone who might be on, uh, **** generating proce – be getting **** generating procedure or, um, being admitted into the ICU or any of our ICUs, so that would be routine testing every 3 days for up to 14 days, um, and it's a PCR.

Next Speaker: Have you found that – I mean have you had any surprises or found that it, um, assisted or helped or changed your infection prevention or maybe prevented something, uh, more – an unintended exposure?

Next Speaker: Yeah, there, there have been surprises for sure. Um, the – and they were always within the asymptomatic population, and in that regard, it's been a relief that, you know, we were doing the testing, because anyone that's getting the testing is, therefore, put on appropriate precautions, um, so we've seen that exposures were limited or none at all in those regards.

Next Speaker: This is Vickie with Marti. Um, so we are doing, um, testing upon admission and 7 days after admit. Um, we're doing both the antigen and a, um, PCR, so we have been antigen for potential ****, um, information and then following that up with the PCR, so – 'cause those will take us about 24 hours to get back. We have identified some positive, asymptomatic positives upon, um, admission, and so in that regards, it's been, um, it has been helpful.

Next Speaker: Have you noted a discrepancy between your antigen and your PCR testing?

Next Speaker: We kinda – uh, like we've done a tremendous amount of antigen testing, and, um, just, uh, you know, off the top of my head, I would say we've had less than ten that there's been a discrepancy, and we've done, uh, we've done hundreds if not thousands of antigen tests.

Next Speaker: Mm hmm, and I guess the discre – just to be clear, the discrepancy where you had a, a negative antigen and a positive PC, PCR?

Next Speaker: It's actually the opposite, a positive antigen and negative PCR.

Next Speaker: Okay, so no one, no one that has, uh, that you would've cleared but then was a surprise positive on PCR? That, that's good.

Next Speaker: We have a – well, I take that back. We've had a couple – you know, I'd ha – uh, you know, you'd have to go back and look at the, the actual data, but it's not been a tremendous number.

Next Speaker: That, that's good feedback, um, yeah, because definitely different in timing and, and, uh, what you do with your in, your infection control, you know, as you're waiting for those, so thank you. Any other, um, systems that are considering going to universal testing on ****. Uh, Providence recently adopted this, um, so I, you know, we don't have any, uh, you know, feedback at this time, and I'm probably not the best person to speak with that, but I knew that is something that, that's recently been started, so still working the kinks out. Great. Um, some of the other topics that, uh, people were curious about is, are there differences in visitor

management, and are you changing any of those, um, – your, uh, your approaches to visitors, uh, based upon, um, the current, uh, vaccination, uh, status, um, and sort of where are you with that now? Is it – are you still at your similar or you, have you loosened kinda those visitor restrictions recently?

Next Speaker: Visitation at OHSU is, um, still the same as it were 6 months ago, during the pandemic. Um, the patient gets one, one visitor a day, and they – if the **** through, then they rotate through on a daily basis. Um, patients are, or visitors are – go through checkpoints, where they're asked if they're symptomatic, and they're given a mask if they don't have one already.

Next Speaker: This is Mary, and I know there's a lot of pandemic fatigue, and people really wanna roll back, uh, the guidance. Um, enforcing it can be a challenge, like not allowing people to bring siblings in is often frustrating, um, but I just, you know, I just keep reminding people, No. 1, the state has not changed it guidance. Um, 2, most people are still not vaccinated, um, out in the community, especially pediatric patients, and, um, you know, some of the restrictions are to allow us to continue to have physical distancing, um, while people are in the building, so it's, it's too soon, I think, to be making changes.

Next Speaker: And in regards to – uh, there were some questions recently amongst, um, um, Providence – this is Genevieve **** colleagues around different practices for the different labor and delivery units around, uh, the cities, um, that there was, uh, some places were allowing two, some were still allowing one, and that that was causing some, um, sort of negative experiences for patients that they were actually going to different systems to deliver, and I didn't know if that had come up, um, for people who were thinking of changing, so it sounds like at least – anybody on the call that's doing something less stringent than what's, uh, recommend – what currently OHA is recommending? Sounds like – okay, great. Um, the – I think there's, there's one more question about –

Next Speaker: ****

Next Speaker: Go ahead.

Next Speaker: So, I just need to say – this is Laura. Just friendly reminder. If you're having any audio or unmuting issues, I am tracking, um, the question in chat. You – we'll address any of those.

Next Speaker: So, I think at this time I wanted to see if there are any other questions that people had or concerns that they've come across on **** COVID-19 in their own facilities; if they were interested in getting information from what others are doing in their facilities. Around the isolation, AGP, uh, that kind of, um, those kind of questions. Do people have, um, you know, difficult situations that they've come across, uh, recently that they would like to get some input or feedback on what others are doing in their institutions. That.

Next Speaker: I think – This is Kirsten, I'd be curious to know what people are doing in regards to, um, leaving for example operation, uh, operative rooms closed and surgical areas closed after aerosol generating procedures, uh, in folks who, uh, aren't expected to have COVID or maybe

had a negative test on admission, but in a high prevalence area, um, since the, uh, change in OHA guidance to be more similar to the CDC guidance. Maybe I should clarify that. You know, if, if folks are undergoing, uh, a surgical procedure that's expected to generate aerosol or an aerosolizing procedure, um, in a high, higher COVID prevalence area, are you guys using respiratory, uh, protection, N95s or equivalents and then are you leaving the, the rooms closed for a period of time?

Next Speaker: At OHSU if they're undergoing an aerosolizing, aerosolized generally, uh, generated procedure, excuse me, um, we're following airborne precautions for that patient. Um, they are tested prior, but they are still following airborne precautions.

Next Speaker: So even for people who don't have symptoms and have tested negative for COVID-19?

Next Speaker: Right.

Next Speaker: The same's happening at, uh, the GIs at the Oregon Clinic.

Next Speaker: This is going to be a follow up, but especially in the outpatient settings are you, are you amending any of your practice so if they are negative to maybe not do the full expected room turnover, or do you wait that entire time even if people use AGP protection during the procedure? Do you make any amendments –

Next Speaker: There's –

Next Speaker: – based upon patient testing?

Next Speaker: The only amendment we make is some of our rooms are negative air pressure so the time's different. Other than that, the rooms that are not negative air, it's the same, it's the guidance.

Next Speaker: Okay.

Next Speaker: That, that would be the same for OHHC's ambulatory settings, um, if there is an AGP done then an hour until the room gets, has enough air exchange.

Next Speaker: Thank you. And Jamie, just a follow up on that because this question, uh, came to me, uh, just in the last day or two, um, the pediatric ENT clinic was wondering if that could be amended say based upon age of less than a year or less than 6 months. Um, if anything would change because of the age of the, of the child and the ability to transmit even if they were positive, although they are currently all being tested right now. If anybody makes the amendments by age. If there's anybody out there on the call that has, that's also dealing with pediatric patients, I'm curious about that. That's ****. So just to follow up on the comments on that, Genevieve to ask, going forward, what would, I mean given that this is a complete change of practice from what we've been doing forever in these clinics, uh, you know, the question is, is this going to be our new future and norm? I'm curious to know what would need to be in place,

whether that's community prevalence or vaccination or testing that we could, uh, return to where, you know, if a test was negative and our healthcare givers are vaccinated, and, uh, that, that we would be able to, you know, decrease, either decrease the room turnover time, um, not have to do pre-procedure testing, you know, this kind of thing. How people in different systems thought about this or are looking for guidance on, on what, um, goals need to be in place in order to step back a little bit. Is this anything anybody wants to change or are people, or are providers very comfortable with that level?

Next Speaker: I think at OHSU there, we would like to make it less stringent, uh, but I, I, I feel like we'd be looking towards state guidance on, you know, what it would be, and I assume it would be community pressure, vaccine uptick, etc. Um, yeah.

Next Speaker: At the Oregon clinic it would be the same. We're relying on CDC and state guidance. Um, I know I, I know our providers are, let's get those rooms in and out and get those patients in and out.

Next Speaker: Well, thank you. Um, I'll just, um, any other, uh, recent scenarios that people would like to ask about?

Next Speaker: Jenn, I have one, um, OHU recently had a neutropenic patient who, after 90 days was tested positive again. Um, and then had a subsequent negative; I'm not sure why that patient was tested. And then several days afterwards, positive again. So, um, what Dr. Towns and infection control have done, we put the patient on precautionary, uh, precautions, treated it as a, a new infection, um, and after the clinical team made their evaluations, um, and assessments, the, we de-isolated the patient after receiving, um, a, a negative PCR that had, you know, I mean it was negative so the CT value, you know, was above 40. Um, the, what was questioning about the whole situation was, um, the positive that result, that came after 90 days had, uh, a CT value that was in the 20s or high teens. Um, so, I, I think we did the right thing in treating it as a new infection, but it, it just, you know, it was, it's the fact that the patient was neutropenic, you know, compromised, just seemed to kind of muddy things up in regards to the isolation.

Next Speaker: Absolutely. And so, did you report this then as a new infection? As far as the surveillance? And was –

Next Speaker: I –

Next Speaker: – the, was this in islet that was, and maybe Rose ****, but would this be an islet that would qualify for sequencing or further testing? And that would be something just because of the amount of immunosuppression? I mean there are reports of people who are immunosuppressed having prolonged positives. So, wondering if this patient had turned negative or had ever been tested between the prior infection and then the new, you know, reportedly or supposedly new infection. If he had gone, become negative, um, and then if he had never, if this is, um, one that might be amenable to testing.

Next Speaker: So, I guess what I'm hearing, Genevieve is if we come across this again then reach out to state public health on possibly sending it over for a sequencing or?

Next Speaker: Uh, I guess that's my, that's my questions to the state. Or is this the kind of, um –

Next Speaker: Situation?

Next Speaker: – the, yeah, situation that they would want, that they would want to go back and look and see if this is something different or determine that it was the same one, uh, or not? And I don't know if someone can, wants to comment on how they would have managed the isolation, uh, and, you know, one, is this a new infection; two, is this an immunocompromised patient, so would you do like a longer time base of 20 days versus 10 days? How did you kind of come to that conclusion based upon this patient's status? I'm sorry, Ken, I guess this is a question for you, did you guys use the 10 days or the, for like a longer 20 day isolation? You might be muted. It looks like we lost him. I don't know, Rosa, can you comment on that? Would this, is this the kind of case that the, that infection, that they should call the local health department and talk about for their testing?

Next Speaker: I'd have to hear the details again, I'm sorry, Jenn.

Next Speaker: Okay. But, um, I think from, from intents and purposes because of the, the new positive after 90 days, and the low CT count, so suggested, you know, an infection with replication where it could actually lead to transmission, that that would be appropriate to, that this patient be isolated and then determining, you know, based upon the, usually the current time base, although that is more complicated when there is severe immunosuppression.

Next Speaker: Right, so, so, I'm not, I didn't catch all the details of this, but anyone who has a new positive after 90 days would be considered a new case regardless of their immune status. But are there other details that I missed there?

Next Speaker: Nope, that's it, that was the –

Next Speaker: Yeah.

Next Speaker: – that was the main thing as far as a new case, and that perhaps his duration of isolation would change because of his immune compromise status.

Next Speaker: Right. Right. Uh, the duration of isolation would change, um, based on kind of a clinical decision making, so the, the standard baseline for someone asymptomatic would be 10 days after their first positive specimen was collected and then that, you know, plus the additional criteria, right, um, regarding resolution of symptoms. If the person does have symptoms and then if someone's considered to be severely immunocompromised or have severe to critical illness, both of which are laid out pretty clearly in the CDC guidelines with immunostandard definitions, um, then, uh, the recommendation is to look at 10 to 20 day period. And then of course I think, you know, based on clinical judgments, um, facilities can choose, you know, whether to take a more conservative approach. Um, I think what we're looking for is them to kind of adhere to the CDC guidance for discontinuation of isolation and precautions, um, or for, you know, return to work for healthcare personnel who are ill, um, to use those, you

know, minimum standard, um, and then to kind of make decisions based on what the clinical picture looks like. Um, if longer isolation periods are needed, but yeah, you know, after 90 days from the last onset or last positive specimen collection we would consider it a brand new case. Um, of course if it's 20 days, I'm sorry, 2 weeks after a second vaccine dose that's considered a breakthrough infection. I hope that's how it's clear.

Next Speaker: Yes, thank you. Um one of the other questions that came up was how different facilities are if they're incorporating healthcare worker vaccination status on whether or not they need to be quarantined after an exposure. And I'm just wondering, especially like in long-term care facilities where you may not have the depth of staff, if you're making any changes to what you do with your staff after an exposure, uh, if they do have a history of having completed the vaccine series and more than 2 weeks out. If anyone's making any adjustments to that. And I also see that we're coming upon the end of our time, so maybe what I'll do is I'll just, uh, transition to asking for any, um, suggestions on topics or future meetings and report. And it does not have to be COVID related. Uh, if there's any **** would like to suggest to the planning team. Okay, not hearing any, uh, just going to move to the public comment portion of the meeting. If there's anyone that has anything to say or would like to add to the minutes or comment on publicly we'd appreciate that. Also, if you have anything not, uh, that, uh, you'd like to just email directly to Rosa Camera, please feel free to do that. I'd also like to move just to make sure if there's anybody else who would like to announce their presence as a second roll call if they were not announced in the beginning. We do also have a list of names of people who joined, um, **** one and two. To do that, now is the time, thank you.

Next Speaker: Yeah, this is Josh Birdfield from the Oregon Clinic, sorry I was late.

Next Speaker: No problem, thank you for joining.

Next Speaker: And before we adjourn –

Next Speaker: ****. Oh –

Next Speaker: No, no, Christina, please.

Next Speaker: I'm just saying that I missed roll call in the beginning, that I'm on the line.

Next Speaker: Thank you.

Next Speaker: Thank you.

Next Speaker: If there anything else we need to cover for this meeting or are we good?

Next Speaker: I just wanted to say, you know, thanks again to the, to you, Genevieve and to this whole group for just continuing to hang in there and, um, attend these meetings and give us your feedback and participate. You know, I know that this is a rough time, to understate it, I think hopefully we're seeing some light at the end of the tunnel but there will be lots of shifts and changes that happen and, you know, that, that your continued participation at this meeting is just

something that we really, really appreciate. So thank you and welcome back, Jen and, um, please guys, please fill out your surveys, um, if you can, and that will help me kind of like look at the big picture of who is currently in formal roles, who wants to continue in those roles, who'd like to make a shift, um, and, uh, if you're interested in serving formally on the committee, uh, in the future, even if you aren't right now. So, I encourage everyone to fill out the surveys and again, just a big, huge thank you for your, for your time.

Next Speaker: Thank you, Rosa; thank you, Laura, and, uh, thank you very much and we will see you again in, next quarter. Take care.

Next Speaker: Thank you.

Next Speaker: Thanks.

Next Speaker: Thank you.