Below are the main points covered on today's AHA RPB call. We were provided with a great deal of information from Dr. Bell, Dep. Dir for Healthcare Quality Promotion from CDC, who was excellent.

Comments on US situation. 32 deaths, typically individuals with advanced age and/or chronic illnesses.

CDC guidance re PPE: Dr. Bell says a study comparing surgical masks vs. N95s, has indicted that there is not a dramatic difference between the two. Therefore, where there are shortages, surgical masks plus eye protection are fine for delivering routine care, making a distinction between routine care and undertaking aerosolize producing procedures. He was very supportive of the surgical mask approach.

Carmela Coyle from CA (she used to be high up at AHA) said that the CDC's framing of the position was problematic for workers since it's linked to shortages and not so clearly what is safe. The result is also that it leads to furloughs of workers. Dr. Bell said he understood that, and said surgical masks (with eye protection) are safe for most care situations other than when there might be direct splashes. He said CDC probably would step away from that position down the road. Carmela said we are at a breaking point in terms of workforce and relating it to the PPE issue. (I think the CDC will go back and look at this one)

Other infection control matters:

- It's really about close range transmission—coughed on, sneezed on
- However, there is some localized inhalation risk, but not at long ranges —difficult to document but not large
- Really is when face to face
- In terms of surfaces, it is of course when someone touches something that someone sneezed or coughed on –so don't touch your face, etc.
- Not need for negative pressure rooms if hospital runs out---no evidence that need to keep patients in negative pressure rooms—do use for aerosolize producing procedures however

Workers returning to work: Dr. Bell went through the CDC position that workers can return to work after certain exposures if asymptomatic and are monitored for symptoms. He of course referenced a different result for high risk exposures (no PPE, high risk exposure).
See below discussion re isolation, which affects workers as well.

Removing people from Isolation: CDC is working toward a time frame based approach---number of days from symptoms, number of days after resolution, reducing number of tests required (especially when there are no tests!)

- Based on data from China—live virus exists mostly early on—as symptoms subside, there are some RNA pieces, but not whole virus.
- CDC will be putting something out about this in the next day
- I can't tell whether this will help the PPE/worker issue or just patients in isolation, etc.

Nursing homes have the biggest threat, but we all need to apply what we know we need to do re flu: environmental cleaning, and hand hygiene. It's better in hospitals than in nursing homes. Nursing homes should limit visitors, monitor staff.

In hospitals, rapid identification and placement are important. There are concerns in both directions about transferring patients (nursing homes/hospitals). CDC says better access to testing may help address that.

N**o need to move to canceling electives yet**, but limits on PPE and regional pressures may lead to that.

Regulatory waivers/flexibility---I was interrupted during this conversation but they said CMS will not enforce certain OSHA requirements. I know later they talked about expired N95s and I believe they did mention the required fit-testing intervals (when I was interrupted). BUT I REALLY CAN'T SWEAR TO THAT. There is no question they referenced this general issue in talking about regulatory waiver, flexibility. I do recognize that it is typically OSHA we would worry about in terms of this issue, but the statement was that CMS would not enforce. (I think sometimes people don't mention the right agencies.)

EMTALA guidance---Nancy Foster spoke to this, but I think we have a handle on that and I won't type it up.