**VDH Partners Call, 23 Oct 2020**

**COVID-19 Cumulative Case Count, as of 23 Oct 2020 – James Sclater, Public Health Preparedness Training Coordinator, VDH OEP**

* Cases: 171,284 (an increase of 1,180)
* Hospitalizations: 12,140
* Deaths: 3,539

**Hot seating - Matt Lott, VDOT Emergency Planning Manager**

* VDOT is crafting guidance for winter weather operations.
* In regards to hot seating, multiple employees sharing a vehicle over the same shift, the current plan is to try to either allow the vehicle to sit for an hour fully ventilating in between shifts or if we have during the emergency, we have active precipitation and that one hour would adversely affect other lifelines like the ability of first responders to move on the interstate and we want to try to keep the plows running.
* Looking for guidance from VDH:
  + Requesting current update for the definition of close contact.
  + Looking for extra clarification and guidance on contact tracing with close contact and hot seating, multiple people in the same vehicle over the course of the day.

**Update on Airborne transmission of COVID-19 Hot Seating recommendations and CDC updated close contact definition  - Katie Kurkjian, CDC Epidemiology Field Officer, VDH OEPI**

* Potential airborne transmission updates: on October 5th, CDC updated their website on how COVID-19 spreads. Specifically they acknowledged that there is a potential for airborne spread.
* They also released a scientific brief that includes some more technical details in the list of references.
* Despite the acknowledging the potential for airborne transmission in uncommon situations, their recommendations remain the same based on the existing science and after doing a thorough technical review.
  + They recommend staying at least six feet away from others when possible.
  + Covering your mouth and nose with a mask when around others. This helps reduce the risk of spread both by close contact and by airborne transmission.
  + Washing your hands with soap and water.
  + Avoiding crowded indoor spaces and ensuring indoor spaces are properly ventilated by bringing in outdoor air as much as possible.
  + In general, being outdoors and in spaces with good ventilation reduces the risk to exposure to respiratory droplets.
  + The routine guidance of staying home when sick and cleaning and disinfecting frequently touched surfaces.
* Hot seating: we made the following recommendations regarding hot seating.
  + Consider reassigning those at high-risk for severe COVID or prioritizing those individuals for a designated truck that won't be used for hot seating.
  + We advise not to have the heater or air conditioning in the truck on recycled air.
  + Whenever possible to put the windows down temporarily between drivers or during the drive.
  + Continue the practices that VDOT was reporting and that is hand hygiene before entering the vehicle and continuing wiping in and out of the vehicle with disinfectant wipes.
  + Consider drivers wearing masks if there was frequent hot seating, like a switch every hour or potentially less.
  + If there are multiple people in the vehicle, we would recommend wearing masks in that situation.
* Update this week from CDC on the defining close contacts: This Wednesday (21 Oct), the Vermont Department of Health published a paper in CDC's Morbidity and Mortality Weekly Report (MMWR) about a correctional officer who likely became infected with COVID after having a series of brief interactions with six incarcerated or detained persons.
* On that same day when CDC updated their close contact definition, previously they had been saying that being within six feet of someone for 15 minutes or more constituted close contact but they made a clarification or change to say that being within six feet of someone for 15 minutes or more within a 24-hour period should be considered as close contact. So, they're adding, they're changing from a consecutive 15 minutes to a cumulative 15-minute period.
* VDH reviewed the CDC guidance and we are updating our materials for this revised close contact definition. Last night (22 Oct), we did post a number of materials so far including our website on what to do if you're exposed to COVID-19. We have an info graphic on when it's safe to be around others and that's been updated as well. We are prioritizing some other key documents and particularly for schools and children right now.
* Over the course of the next week or so, we'll be updating all our other websites and guidance.

**Health Equity - Sable K Nelson, Acting Director, VDH Office of Health Equity**

* How Health Equity Working Group is making sure that we apply a health equity lens to our COVID-19 response and to let you know about some resources that you may find helpful and activities that may be going on in your community that we want to make sure you're aware of and connected to.
  + We were established right at the very beginning of our COVID-19 response. We held our first meeting on March 11th, and we are positioned at the senior level at the unified command. We have been reporting directly to the unified command leadership including the health commissioner and the State coordinator and the purpose of our group is to serve as a bridge between state agencies and the local communities that we serve.
  + Our larger health equity working group has over 120 members and includes staff members from the Governor's office. We have various state agencies staff, representation from the advisory boards that serve all of the government agencies within the Health and Human Services. We also have a wide variety of organizations, community leaders, as well as a diverse connection of interfaith leaders to ensure that health equity is central to every decision that we're making.
* One distinction to lay out is the difference between equity and equality. Often times these are terms that are used interchangeably, but it's very important to understand that equity is not the same as equality.
  + To demonstrate this distinction, equality is a one-size-fits-all approach. You give everyone the same thing regardless of their needs and ability versus equity on the other hand which is a tailored response meaning you give people what they need when and how they need it. And, it makes sure that those coming into a situation with a little less, they would need a little more in order for things to even out at the end of the day.
* What the group has been doing since we have been working since March: It falls into three buckets primarily. We do community engagement. We look to make sure that there's strong internal collaboration. We also are working to make sure that we have a training mechanism. The health equity team has lead trainings for the MRC volunteers and a great deal of community engagements through virtual meetings where we reached over 25,000 people from across the Commonwealth. We've been supportive making sure that vulnerable and marginalized in rural communities understand how to use the COVID wise app.
* In the next couple weeks, we're going to be launching a fall and winter resiliency campaign. COVID-19 has exacerbated concerns as it relates to anxiety and depression, people feeling overwhelmed. We know that substance abuse has been increasing. Overdoses have been increasing. We are going to be launching right before Thanksgiving a six-week series letting people have a place where they can get skills and tools and resources to help them through the fall and winter which are already difficult months for a lot of people.
* We will be sure to share once we get our confirmed list of speakers and dates, that information with you all so you can share it with your partners so we can talk about how to build resilience, make sure that people have connection to resources should they be in need and to have a little bit of fun and learn about different ways about how we can connect each other and still be emotionally close and socially close even though we're physically distanced.
* Highlight the hallmark of the way we do our community engagement is make sure we are inclusive and affirming and that we represent and demonstrate the diversity of our Commonwealth:
  + All of our activities have CC captioning.
  + We have interpretation to languages so that people know when they can register.
  + As a resource for you all and the individuals on this call, I'll make sure that the call organizers get this information.
  + We have a couple of helpful things that may help you all when you are developing your communication to make sure that they are implemented with an equity lens and especially for those who are affiliated with state agencies or have connections to different community groups.
    - We have a step by step list of how to develop communication tools and programs that it's helpful in the COVID moment but also we're hoping that organizations and private businesses and other partners will be able to leverage this information in other contexts as well. I'll be sure to share out that health equity communications tool.
    - We will have a health equity guide book. It was designed primarily with districts and community partners in mind, specifically as they look to develop community testing events and also to encourage individuals and help to demystify this concept of contact tracing. We want to make sure that you all have access to the current version of the document and also to let you all know that we are in the process of adapting the document as we prepare for the COVID-19 vaccine and making sure that its messaged and understood and that our community partners know how to talk to their colleagues and their friends and their family about what this vaccine is and is not and where to access it.
* We've been leveraging a data-driven approach with our health equity work. As you all will see when you get access to the resources, you will see a listing of some of the information that's on the website as it shows the demographic break down as well as like the geographic hot spots. We encourage you to continue to incorporate that information and think about how you can tailor your activities to ensure that those with the least get the most support especially during this critical time.

**PPE source - Virginia Industries for the Blind - Matt Koch, Deputy Commissioner VIB**

* I wanted to take the opportunity to thank many of you for shopping with Virginia Industries for the Blind.
* We have 175 people who are working hard to provide PPE for state customers as well as federal and commercial customers. You will see in the material the price list that we have out there. The pricing list can be found at this url. <https://www.vdh.virginia.gov/content/uploads/sites/8/2020/10/VIB-COVID-19-Price-Listing.pdf>
* Also, you can go online to [vibonline.org](https://vibonline.org/shoponline.htm). Our price list is updated each week, at least each week.
* We have over 24 product types that we offer. We have historically provided exam gloves and sanitizers to the State. We are a mandatory source but better than that, I believe we're your best source.
* We employ Virginians who are blind in quality jobs and providing quality goods and services, and we demonstrate to the State buyers every year with a comparison of our prices verses the open market.
* Products are all sourced from quality countries, the vast majority are Trade America Act-complaint. They're coming from Thailand, Taiwan, Switzerland, many places in the U.S., Korea.
* We have a robust supply chain, and we're able to respond quickly.

**Vaccination Tabletop - Bob Mauskapf, VDH OEP Director**

* We completed our vaccination plan and submitted it to CDC about two weeks ago. They're doing a review of it. They don't do an approval, just review and make some comments and recommendations that they might have.
* Once we submitted that, we conducted a seminar across the State. It was a state-level virtual seminar and included describing the plan to all the participants (approximately 130 participants).
* The plan was rolled out to them. There was an active dialogue going on, both in the chat and questions being asked during the seminar. Following the seminar, we took the plan back based on the issues that were brought up during the seminar and updated the plan.
* A week later we put together a tabletop exercise with the same participants.
  + We had one local emergency manager from each of the seven regions and one local health district director from each of the five VDH regions participating as well. Along with all of our state partners, we had federal partners in an observation role.
* Following the tabletop, we looked at the plan again and updated it based on lessons learned from the tabletop and rolled it out to local health districts for their review. The plan as it stands right now is online on our COVID website. It's public-facing.
  + It can be shared with whomever wants to take a look at it. It's a live document. It's a document that will change weekly or monthly as we learn more about the distribution mechanisms coming from the Federal Government about new partnerships with pharmacies, new relationships with long-term care facilities who have been offered Walgreens and CVS participation in their vaccination programs.
  + Updates to the prioritization from the Federal Government and updates on the vaccine availability are still areas that will be key elements, essential elements of information in our planning. We will continue to track them and update the plan with each change.
* Lastly, I'll point out that we intend as we get to implementation to develop regional exercises and are bringing in the education unit for putting together what we call a tabletop in a box for local health districts to work with their local jurisdictions to make sure that they're ready.
* We continue to feel as we have every year for the last 10 years or so, doing mass vaccination exercises in each of the local health districts. This vaccine was purchased by our grant and distributed to health districts and health districts annually review their mass vaccination plans. This year, the big difference is to do this in a COVID environment. So the separation, social distancing, and other requirements in a COVID environment have been applied to each of these exercises. The lessons learned shared among and with us have been great. We will continue to update the plan. The plan will continue to be posted publicly, and we will continue to review all as the significant changes take place.

**Q&A Session:**

Question1: Matt Lott: Katie you specified lowering the window and/or the doors and venting between drivers, again, pertaining to the hot seating question could help us limit exposure. I would need in my guidance to try to specify statewide for everyone what the amount of time would be that would be safe for us to do. In regards to us doing some amount of time less than the truck sitting one hour, if there's a shorter amount of time, if the windows are open, the doors are possibly open and we're running the AC or heat on high, how long could we do that before we rotate in the next driver?

Answer1: Katie Kurkjian: Thanks, Matt. The short answer is, I don't have a specific time for you right now. I think I would have to take it back to the group and see if we can come up with something. I think having a truck running for an hour with the windows down, that might be on the order of a little excessive. So I think if it's okay with you, I would like to consult with my colleagues on that.

Question2: Steve Pincus, Virginia Peninsula EMS, I was curious as to what the status is of the flu vaccination across the State. Just for a little bit of an example, I went into Rite-Aid and the person who was administering the shot said that they are running short on their supply. I was wondering what the status is across the State to assist with our messaging out to our community.

Answer2: Bob Mauskapf: We have not received information about any widespread shortage of flu vaccine. There are occasional local or regional supply chain slow downs. But, we have not noticed a very large update in flu vaccination. A lot of our messaging has been directed toward making sure you're getting a flu shot because some of the symptoms are similar to COVID. But to your specific question, we haven't seen any widespread shortages for flu vaccine and we don't believe that we'll be seeing that during this season.

Question3: Joe from VA Beach: This was going to be in reference to the vehicles, particularly in the spacing of the drivers. Our city actually has a policy. We have a no idling policy for vehicles when you're out of the vehicle, you have to turn it off. Is there any way that some of these things can be looked at where it wouldn't force us to violate those or rewrite those policies?

Answer3: Katie Kurkjian: I think the key here is having the windows down so we're trying to get dilution of the viral particles with some fresh air coming in or out. I think that is the key component of this.

Question 4: Joe from Va Beach: And that would apply equally to emergency vehicles as well as non-emergency vehicles? The reason I ask is because in emergency vehicles typically anybody in the vehicle could be driving it at any given time. It won't be just one driver in, one driver out type of situation.

Answer4: Katie Kurkjian: I think if you consider the inside of a truck or a car as an enclosed space, the whole goal is to try and get as much air outside air coming in and circulating to dilute those particles. So, I think it could be regardless of the type of vehicle or the use of the vehicle. Now, I don't think we're coming out and saying all cars in Virginia need to have the windows down at all times. That's not what I'm saying. But, the situation where you have shared vehicles or multiple people in the vehicle for an extended period of time, windows down is going to help.

Matt Lott comments: If I could piggy back on that one more time, I am willing to suspend or recommend suspension of the no idle policy for us so we do have the option or you could include if you wanted the option to continue to ventilate using the AC or heat for us.

**Next Call:** Friday, Oct 30, at 10:00 am