

**Minutes of the Academic Council
Thursday, September 15, 2022**

Erika Weinthal (Chair, Academic Council / Nicholas School of the Environment): I love how I can silence a room still. *(Laughter)* Welcome everyone to the first meeting of the Academic Council for the new academic year. I am Erika Weinthal, from the Nicholas School of the Environment, and this is my second year of a two-year term as the Chair of the Academic Council. I would like to begin by extending a warm welcome to newly-elected Council members to your first meeting – and that same warm welcome to our returning members. It is great to see so many of you today in this room. It hasn't been this packed in over 2 years. It really is just wonderful to see everyone back in person. I want to start by noting over the last few years we've had to attend via Zoom when necessary. This year we are trying/hoping to encourage more in-person attendance as we move to returning to a fully in-person residential campus. It is critical to the building of our community at Duke. Also, a number of the faculty have noticed over the last year that when we've had meetings via Zoom, that Zoom seems to reduce the level of engagement, discussion, meetings have finished a bit earlier, and there has been less query of the administration. *(Laughter)* They're [the administration] all here today. So, we hope that by being able to gather in person we will be able to have more vibrant conversations at our meetings. I also understand that there will be circumstances where people will be unable to attend and will need to be on

Zoom. For that reason, we will continue to offer the Zoom option during the fall so people can attend in ways that suit their needs at various times.

The Executive Committee of the Academic Council, otherwise known as ECAC, has been meeting in person since August 24th. I want to begin by introducing the members of ECAC, and as I introduce the members, I will ask that you stand. I'm going to begin with those who are beginning the first of a two-year term, our newest members: **Karin Reuter Rice** from the School of Nursing, **Barak Richman** from the Law School, **Deondra Rose** from the Sanford School of Public Policy, and **Mine Centinkaya Rundel** from Statistical Science which is also from the Natural Sciences & Mathematics Division. Then those from ECAC who will be joining me in their a second-year: **Keisha Cutright** from Fuqua School of Business, **Scott Huettel** from Psychology & Neuroscience, and **Thea Portier-Young** from the Divinity School.

According to our bylaws, ECAC, must select from the Executive Committee a member who will serve as the Vice Chair. I am delighted to share that **Keisha Cutright** will serve in that role this year.

I also want to introduce two very important people who play a role in ensuring that the Academic Council runs so smoothly. I want to begin by introducing Sandra Walton, our executive

assistant, and then Mariah Cooke who is our staff assistant.

Before I go much further, I also want to make our new members aware of the Christie rules, which are considered a cornerstone of faculty governance at Duke. Many of you have heard about the Christie rules before, but I will restate them. They were drafted by a faculty committee of which Professor George Christie from Duke's Law School was the chair. They were created and subsequently approved by the Academic Council in 1972. They say: "Except in emergencies, all major decisions and plans of the administration that significantly affect academic affairs should be submitted to the Academic Council for an expression of views at some time prior to implementation or submission to the Board of Trustees. The views expressed by the Academic Council should be transmitted along with the Administration's proposals when these plans and decisions are considered by the Board of Trustees." You can find the complete document pertaining to the Christie Rules in the Academic Council Handbook which is posted on the Council website.

Attendance is taken at our meetings, and you will see these sheets being distributed throughout the room. Please initial by your name and for those of you on Zoom, we will note your name via the portal. Our bylaws state that you can be removed from the Council after three consecutive, unexcused absences. So, please email Sandra, if for some reason you are unable to attend a meeting.

As I noted, this is an opportunity to be able to ask questions of those who are presenting, or of our colleagues in the

administration. When you ask a question, please say your name and school or department, because these meetings are recorded and transcribed.

Speaking of the recordings, for those of you who have been in this room before, you will note that there are mics embedded in the ceiling, but this room is old. The equipment works, but not the best. We would ask when you ask a question, if you are comfortable, please remove your mask. It will just help with us being able to transcribe later. If you would like to keep your mask on, I would just ask if you could jot down your question, and then pass it along at the end on a piece of paper so we don't lose the content of the question.

ECAC and I also welcome suggestions for discussion topics for future meetings. I just want to give you a sense of some of the topics that we have in mind for later this year. Jenny Lodge, who assumed the role of Vice President for Research and Innovation earlier this year, is scheduled to address the Council at next month's meeting along with some members of her team. ECAC and I have also initiated a process for overhauling Duke's Faculty Handbook, and for those of you who've served on ECAC you will know how clunky this handbook is, and a bit outdated and redundant at times. Cam Harvey, a Council member from the Fuqua School and Karen Reuter-Rice from ECAC have agreed to help, but we've also hired a PhD student from the Classics Department who will help manage the overhaul of the handbook. There are some of you in the room who will be asked to help contribute at times depending on whether the content is relevant for your part of the university. Our plan is to bring a revised version for

the Council's consideration and subsequent approval this coming spring. Fingers crossed. We also, hope to have an update this year on Duke's Global Initiatives at some point. And if you would like to suggest an item for a future meeting please send those to me, to Sandra [Walton], or to the Academic Council email, which is acouncil@duke.edu. The Council also has a tradition of submitting questions to be asked anonymously of the senior officers: the President, the Provost, or the Executive Vice President. You can do this either through our website on the contact us tab, or you can send to the Academic Council email account.

***FACULTY HEARING COMMITTEE:
APPROVAL OF NEW MEMBERS***

Weinthal: I'm now going to start with our first substantive item of business today. At each September Academic Council meeting, we approve the new members to the Academic Council's Faculty Hearing Committee. A document containing those proposed members and the continuing members was circulated with the email that the Council members received from me on Monday. This is what you should have received with the newly proposed members. [\[Refers to slide\]](#) The Faculty Hearing Committee is a subcommittee of the Academic Council, and is charged with considering complaints from faculty concerning issues such as termination of employment, violations of academic freedom, and allegations of harassment, not resolved by other university bodies. The process for issuing a formal complaint is detailed in Appendix N in the Faculty Handbook. The handbook states that the Faculty Hearing Committee will consist of up to 18 tenured faculty members, nominated by ECAC, and

elected by the Council to serve three-year terms. We received no objections or questions about the five new members proposed. But, I will pause now and ask if there are any questions. Hearing none, we will consider these new members approved. Their term will begin on October 1. I would like to thank all 17 members of the Faculty Hearing Committee for their service and future service. A special thanks to Trina Jones, from the Law School, who serves as the chair of the Faculty Hearing Committee, and is in her second of a three-year term. Trina is also a member of the Council and is here, and she has served on ECAC in the past. So, thank you for all your service, and all you do for the university.
(Applause)

***FALL SEMESTER UPDATE AS RELATED
TO THE COVID ENVIRONMENT***

I am now going to turn the podium over to Steve Haase; Professor in Biology and Associate Professor of Infectious Diseases in the School of Medicine; Carol Epling, who is Duke's Executive Director of Occupational Health and Wellness and has an appointment in Community and Family Medicine, and Paul Grantham; Assistant Vice President for Duke's Office of Communication Services. They are here today to speak about the start of the academic year. We've been doing this over the last few years with the pandemic, and they will speak about how we continue to navigate the opening of the academic year and the COVID environment.

[\(Slides used in presentation.\)](#)

Paul Grantham (Assistant Vice President, Office of Communication Services): First, thank you Erika, and all

of you for the opportunity to come and talk about Duke's COVID response as we enter the third year of this pandemic. I will say, this is typically where you would expect to see a guy named Kyle Cavanaugh. I am a little bit shorter than he is. *(Laughter)* Some of you may know, he got called up to the NBA early this spring. *(Laughter)* But, in truth I worked very closely with Kyle since January of 2020, when the novel virus didn't even have a name yet, out of Wuhan. So, we were connected at the hip throughout this process. I serve as the deputy emergency manager for Duke, as well. So, I've been closely connected to this. We've entered a new phase of the pandemic, and Steve [Haase] will go over a lot of the data that reflects that. But, we may not be in your inbox quite as often, we may not be quite as visible in ways that we were in the first couple of years of this pandemic. But I will tell you, we are no less busy, and no less vigilant in monitoring the circumstances, situations, data, and assessing the environment and how best to keep this community safe. I will just give you a sense of context of the groups that are continuing to meet, assess, and work this issue. We have weekly meetings that Steve leads with the code and modeling team to look at the science. He's going to go through a lot more information on that. The COVID task force is meeting on a weekly basis to assess what our operation issues are, and any recommendations regarding policies. The Duke University Health System, we're blessed to have such a wonderful partner and treatment options available to us. Surveillance testing that is still being done from the Vaccine Institute, as well as variant sequencing with genomic computational biology. There's just a lot of work, we have good connections, both locally with the Health Department and

the State, and at the national level with the CDC. So, we have lots of resources that we continue to tap into, as well as our Ivy peers to learn what they're doing and what their issues are. They're experiencing many of the same things. Without further ado let me turn this over to Steve, and he will walk you through some of the latest data.

Dr. Steve Haase (Professor of Biology):

Awesome to be here in front of you. This is my third briefing on COVID for this group, and this is the first time we've all been together. I think that really tells you that we are in a much better place than we've been. It's great to be here, thank you.

So, I just want to give a little context for the policies and the operations that you're going to hear about. We've been data-driven as much as possible in our thinking about how we navigate this COVID space since the start of the pandemic. Our groups actually look often at data from around the globe and I just wanted to start there and show you that what we've seen over the last greater than a month are cases dropping globally. I looked again today and we're very hard pressed to find a single country where we're seeing an increase in cases. Now, when I made this slide, we saw some surges in Japan and South Korea, and we care about those things because we are interested in whether these surges are being driven by a variant or something that we ought to be thinking about in order to plan ahead. This is one of the reasons we continue to look at the global data. And I should say that a lot of the data I'm going to show you comes from the Johns Hopkins COVID Dashboard.

When we look at national trends what we've seen since May is really kind of a plateau. We haven't seen much change, either up or down since May, except for the last four or five weeks. We're starting to see a decline in cases in the United States. And just to give you a little context of where we're sitting right now, this is the Omicron spike that we saw last January, and this is the Delta spike that we saw about a year ago at this time when we were returning to school. So, most of these cases are being driven by variants of Omicron, or mostly BA.5. I'll show you that here in a bit. These Omicron variants are highly transmissible. They see R naughts as high as eighteen. Which might be a bit of an exaggeration, but certainly this virus is among some of the most infectious viruses. As well BA.5 is able to invade immune systems of natural vaccine, this is what made it so successful during the rapid takeover. I'll show you that data here in a little bit. The good news about Omicron is we see a decreased disease severity as compared to Delta, Alpha, and even the original strain. We can see that here. I don't have the hospital data, but definitely the mortality rate has dropped substantially since the start of the pandemic and that's very good news. The news is even better in highly vaccinated populations like Duke, and we are a very highly vaccinated population. We tend to be doing even better than the nation as a whole. In fact, we'll hear a little bit about a new vaccine booster out that has components of BA.4 and BA.5 which should help things as well.

This is a county-level map of the United States and showing CDC's ideas about what the levels of risk are on a county by county basis. They divide the risk levels into low in green, medium in yellow, and

high in orange. We're seeing a lot of green on this map, which is great. We're in our seventh consecutive week of decline in high risk counties. We've seen an eight percent, almost nine percent drop in the last week for counties that are at high risk. So, the news looks really good. If we go to North Carolina, what we're seeing is Durham County, as of last Thursday, has dropped down to medium level. Some of our neighboring counties: Wake County at low, Orange at medium, Alamance at medium. We're seeing consecutive drops in a number of counties in North Carolina that were showing up as high risk. This is important and we'll talk about that in a little bit.

I just wanted to say a couple of words about how the CDC decides whether you're high, medium, or low risk because there's more to this than just counting cases. And of course, cases are important. They're telling you how quickly transmission is happening. In the first metric for this rating system is the number of cases, below 200 cases per 100,000. You go on to look at the other two metrics and above you can never be low. You're either in the medium or high. The second two metrics – the first is how many new COVID hospital admissions are we seeing? And this is really a measure of severity of disease. Are we seeing disease that's severe enough to drive hospitalization? The second metric is the percent of staffed in-patient beds that are in use by COVID19 patients. This is really a measure of how much we're taxing on the health system. We saw this in a big way last year, when we had the outbreak and our health system was being heavily taxed by a number of people who were in the hospital with COVID. So together, these three different metrics are used to

decide whether communities are high, medium, or low risk.

Let's talk about trends on campus. We're kind of zooming in now. This is what we saw over the summer, which was pretty steady, very much what we saw nationally. And we're looking at faculty/staff cases in orange bars here and students in blue bars. We saw a pretty steady level of faculty and staff cases, where student cases were very low. We didn't have a lot of students on campus over the summer. Then here at week thirteen-fourteen we started to see an increase in student cases. That's primarily because students were returning to campus. So, week thirteen-fourteen we see our graduate and professional programs starting up. Week fifteen and sixteen we're seeing move ins, and week seventeen was our first week of classes. There we saw the rise. Not surprising. We have our students back, they're gathering. But, just to give you some context, this is on the low end of what we were seeing at the end of the semester last spring. What we've seen in the last week is that student cases appear to be steady, and halfway through the week and counting this week, I think we're on par for seeing pretty much a steady level of student cases. What's interesting is while the student cases are increasing, we're seeing a slight decrease in faculty and staff cases. Which suggests that what's happening with the student population is not translating into our faculty and staff. As well, we're seeing Durham moving from high to medium risk and cases are dropping fairly precipitously, suggesting that our students are also not negatively impacting the Durham community. This is all very good news.

Just really quickly I want to show you the things that we do in Greg Wray's group here at Duke. They have been collecting this data for campus but looking at the evolution of variants. This is data from the CDC. And what we're seeing since June is a pretty slow takeover of the cases by BA.5. So, right now we're about 90% BA.5, and the variant BA4.6 is the only thing that seems to be expanding as quickly as BA.5. We're watching closely, globally, and in our on-campus samples for anything that looks suspicious. This is data from campus. So, we continue to sequence every positive out of all of our asymptomatic testing that's being done on campus. And just to give you a look at what's happened over the course of the pandemic. This is Alpha right here that was taken over very rapidly by Delta last August, and then Omicron showed up in December. It took over very rapidly first with the BA.1 and BA.2 variant here and BA.5 variant here. That's where we sit right now. We're really a reflection of what we're seeing nationally. This is another reason we look at the national data as well.

With that I'm going to turn it back over to Paul and let him talk about how we've been preparing in our operations, and policies.

Grantham: Thank you Steve. So, you may not be surprised given the focus on this particular topic that we were involved in this over the summer as well. We weren't just taking a break between spring and fall. I would tell you that we had high hopes, and kind of crossed our fingers that we might be able to back out of a lot of the things we have been doing seeing the decline in the spring. But then BA.4 and BA.4 came along, and we saw a rise in trend. So luckily, we didn't dismantle that

operation over the summer. We kept the surveillance testing site open, continued to offer that testing. We required campers, and some of the other participants to come in and be tested or to come with a test. We required our students coming in for the fall semester to have a negative COVID test before they arrived on campus. So, we start off with a clean slate and kind of eliminate the mass outbreak beginning of the semester. We've also had the masking policy in place, and we'll talk about that in a minute. But to kind of get back to the fall semester we're not requiring surveillance testing but we do offer 4 sites on campus. One on East, one on West, one over in the Bryant Center, one in LSRC, and one at Washington Duke. Those are beginning to increase in usage. We're seeing more students going in and getting tested voluntarily, which is good, and the Human Vaccine Institute is processing those, as they have been throughout the last couple of years. We did move to an isolation in place policy for students this year, given where we are. We are a very highly vaccinated community, and we're now asking students to reside in place if they do test positive. Students who are high-risk, medically, who are in a room with a COVID positive student can request to have alternate housing. We've set up a convenient location at the Hilton Garden Inn just off of Main Street so that we can move students there. We had three, as of last week, this Monday we had one additional student. So, utilization has been extremely low. We started off the semester reserving 25 rooms, not sure what to expect, but usage has been very low. We had a total of four students who have relocated to alternate housing as a result of these policy changes.

Our current guidelines and protocols - we still require primary series vaccination, and booster vaccination for all faculty, staff, and students. And fourth series boosters for medical science students. Masking - we are still in our current masking requirement for in classrooms, for buses and vans, and for all the clinical settings on campus. We are a little outside the norm. Many places, a lot of schools have moved away from masking and are leaving masking optional. But again, Durham has been in a high risk by the CDC for the entire summer. So last Thursday we've just moved down to the medium level category, and we need to be at medium for two consecutive weeks before that masking requirement in classrooms comes down. Today, actually, Thursday - I keep hitting refresh on my phone, but Thursday afternoon is when we get that notice. If the CDC designates Durham as a medium or low risk county again today then the clock will be on week two. So, September 22nd would be when that mask restriction would be lifted. Testing, again, is optional. We stopped doing required testing of students after spring break last year. We still offer symptomatic testing in student health, and at four different locations. Isolation, again, is for five days except for health care workers have a seven-day isolation requirement. And then masking is required for ten days after the positive test.

We do stay in regular contact with our peers. We're all dealing with meeting the same issues. So, it helps to identify best practices and ideas that may have originated at other places that may be applicable for Duke. Entry testing - everyone essentially has gotten out of the business of doing entry testing and moved to a model where we're asking

students to come with a negative test and building that into the honor code. Broad surveillance testing is no longer required in most places. There are some that still require testing for unvaccinated individuals, and we have isolation in place which is now the norm across most of our peers. While masking is no longer required at most schools there are some that have required it, like Duke has been, at high risk in that category but a lot of places are mask optional now, and that's probably where we will end up going forward.

Speaking of that, I know this is probably one of the considerations at top of the mind for many of you. If the CDC comes today, this afternoon, and says that the risk level in Durham is medium or low we will then make an announcement, probably very soon. To announce that September 22nd would be the day in which that policy would change. We've talked with Sally and Daniel, and we think it's important to include some flexibility for faculty in the classroom. So, if you want to continue to require masking and request students to mask, you can do that. As you set that expectation with your students so they know that is the expectation.

We will continue to rely on the science and the data and the information that Steve is regularly pulling together to assess what the most effective course is in terms of managing through this pandemic. We have had to be previously, and we'll need to be going forward, flexible. If conditions change, if a sub variant emerges, we will have to be flexible and accommodate what the circumstances might be. We're definitely relying on our data and our constant assessment to kind of know what's

coming, and oftentimes we see it coming from other countries before it gets to Duke, so we know what to expect.

I'm going to turn it over now to Dr. Epling to go over some of the clinical data and some of our clinical practices.

Dr. Carol Epling (Duke's Executive Director of Occupational Health and Wellness): Hello everyone! This is a big day for vaccinations. Let me tell you a little bit about where we stand in terms of our immunity to COVID. We have 93.5% of our faculty and staff who have had the primary series, and 91% have had a booster. We track anyone who will report their information to us. Those who've had a second booster, now that's been indicated for everyone who's 50 years old and older, or is immune compromised. And we know of at least 5,800 faculty and staff who have been vaccinated with that second booster to date. These numbers are quite a lot higher than what we know is happening in North Carolina and nationally. This has warmed my heart. Our students are also highly vaccinated. 98% with the primary series and even though the booster is not required, except for the allied health students, we do have 64% who have had a booster. But there's even better news! We have the new updated bivalent booster that was just approved for emergency use September 1st. And we have that here, at Duke, and we started vaccinating employees on last Friday, the 9th, with our first bit of supply.

So, first this vaccine now targets the original strain by protein, as well as the current circulating strains, BA.4 and BA.5, common spike protein between the two. On this we have both the Pfizer version of this mRNA vaccine that's available for everyone 12 and older, and today or

yesterday we just received the first supply of the Moderna vaccine for those 18 and older. We know that the eligibility for receiving this vaccine is simply to wait two months since the last vaccine. A lot of people are asking the question about having had recent COVID illness, and how long to wait before getting this booster. The only rule is you have to be out of isolation to be able to safely receive the new updated bivalent booster. But, there's certainly language out to say you may consider waiting up to 90 days from the date of first symptom onset of your recent COVID illness. Of course, that's because there's neutralizing antibodies, natural immunity from your current active COVID illness in your body protecting you from transmission as those antibodies wane over weeks, so a few months, then it's time to think about getting a boost and boost those neutralizing antibodies back up. And a lot of people are just thinking about the risks and their activities that are coming up in their lives and thinking about the timing, the best timing for them personally to decide when to take this new updated booster. That being said, I don't want to upset Steve too much. I know he's thinking over there, "we all need to get this booster so that we can all do our part in reducing the transmission risk of this very slippery virus that depends on transmission to mutate." So, the next strains are going to come to us as we pass them all about among ourselves. When the FDA approved the emergency use authorization for the new updated booster the very same day they demote the EUA for the original booster. So, we had a couple of days in there where we didn't actually have a supply of boosters for folks. But now any boosters that we administer are using the new updated bivalent version.

We continue to have quite a robust resource supporting our employees here, our faculty and staff who have any COVID exposure concerns. We continue to have the employee COVID exposure hotline up and running 7 days a week, 365 days a year. We have not taken a day off at all since we put the hotline in place back in April of 2020. I imagine that many of you have made a call and gotten some assistance from one of our nurses on the hotline. We are there to talk to anyone who has questions about current symptoms, wondering about safe return to work, or assessing special workplace concerns, special questions around transmission, especially around food events. We're there to help and to gather more information whenever we need to do that.

We made it very easy to self-schedule for testing, either post-exposure testing, asymptotically or for those who have symptoms. Staying home, or getting tested right away. Going on SymMon, our colleagues at MIT created this wonderful app, hope you all use it. I had to go on and self-schedule through the connection with MyChart and the Health System, and come on in to one of those testing sites. We have the Morreene Road Clinic inside of the former credit union. We have a testing site available at the Duke Medicine Pavilion, very easy walk for us all, and the testing site is right behind the patient information desk. You walk right in the front door and go right behind there and have your test. You can do a self-collected test or we can do one for you. You can schedule ahead, and now we can do walk in. And we're vaccinating, as I mentioned, we had a full day vaccinating with updated boosters today. We're vaccinating on Thursdays and Fridays

throughout the month, all of September and throughout the month of October. We're going to watch our demand, we hope it stays high, and we will continue to be there vaccinating. There are many other places, though, if you're having trouble getting an appointment through our scheduling line. You can seek this updated booster by walking into 1J clinic, and Duke South during their clinic hours. You can go to a CVS or a Walgreens, they are by appointment. Very easy to do, readily available, and also the Duke Primary Care Clinics or the PDC Clinics have the bivalent vaccine.

Today we began the influenza vaccination campaign. This is equally important. We really think we're going to have a severe flu season. We see that that has happened down in Australia, and that can predict our season to come. So, we think it's really important to get vaccinated this season and to get vaccinated early. We launched today. Our teams packed up over eighteen thousand vaccines with the pharmacy team and sent them out for peer vaccinations. We are so lucky to have the School of Nursing partners who are coming around campus. There are schedules on the website. You can get your flu vaccine with the students who are coming to the School of Nursing sites throughout the month of October without any appointments. And then we have a variety of clinics, and you can see all the schedules online.

This is where we've been over the years. I think you can tell that in this fiscal year 12, and then 13 and 14 was the timing of the condition of employment policy requiring influenza vaccination for healthcare workers. Then we have risen all the way up over forty thousand year

before last, and hopefully we'll get there again this year.

A couple of slides about our Monkey Pox preparations. I'm sure you are aware that Monkey Pox is an Orthopoxvirus that causes a flu-like syndrome. Often it starts with the prodrome of fevers, chills, cough, headache, body aches, and then followed by very characteristic rash that's described as a pustule or vesicle over the hands, arms, legs, genital area. It will typically last from 2 to 4 weeks, and the person who has the illness is infectious from the very beginning of their first symptoms all the way through until the lesions scab over, and there are no new lesions on their skin. Antiviral therapy is available as indicated. But, the Monkey Pox virus is difficult to transmit. When we're thinking about this virus compared to COVID or flu. Monkey Pox virus requires intimate contact directly with the lesions or with objects that come in contact with the lesions or with respiratory droplets, often through sexual contact. And Steve talked about the R naught already, that's the estimated number of people an infectious individual is likely to communicate the illness to. With Monkey Pox we have an estimate of about 2 R naught compared to Delta COVID 5 to 7, Omicron COVID maybe 18, Chicken Pox 10 to 12, and Measles up to 18. Fortunately, we're seeing a declining number of Monkey Pox cases in North Carolina. I think we're up to 435 currently and about twenty-seven thousand nationally. My last line about Monkey Pox. We've seen about a dozen cases in the health system among patients. Employees who have assisted those patients contact our exposure hotline, and we risk assess them for their contact with the patient and their use of personal protective equipment. We have had a few who have

had some moderate risk exposures. We have administered vaccine in only a couple. We've placed several more on surveillance for 21 days. That's the incubation time. So, we have electronic surveillance available for them to report in twice a day for any new symptom that might occur. And we have had no occupational Monkey Pox illness occur. There have been no deaths associated with Monkey Pox in our Health System, and we do, as I mentioned, have access to the vaccine. We're very fortunate for that.

That's all.

(Applause)

Don Taylor (Sanford School of Public Policy): Thank you. Just to confirm, if someone tests positive away from Duke and then reports it to the Employee Occupation Health, it shows up in our numbers?

Epling: It shows up in our employee counts. Absolutely. There's a link to be able to upload. If it's an imaging test, take a photo and upload that. That's not required for us to capture it, but it will be in our numbers.

Weinthal: We have a question on Zoom first, and then we can take others.

Cam Harvey (Fuqua School of Business): I have a comment and a question. The comment is that it seems like the data on cases is less reliable today given that many people do not report their infections. The community risk obviously is more accurate, given that it looks at hospitalizations. My question has to do with the Duke policy of a 5-day isolation. When I had COVID in May, I was told by my Duke Physician, 7 days in

isolation and 7 days with a good mask. I know that the CDC policy is 5 days. It seems to me contradictory that we require 7 days for the healthcare workers, but only 5 days for everybody else. I'm wondering if the policy has changed from 7 to 5 days, and why?

Epling: Thank you for that question. Currently, it's not very well known, I wish it were better known, that the CDC recommends the full ten-day isolation period for healthcare workers. That hasn't changed. There is a contingency plan that we are currently in due to difficulty with staffing levels. And when you're in this contingency mode, you have justification that is allowed to reduce your minimum isolation period for healthcare workers from that 10-day recommendation to a shorter period to 7 days, or to 5 days, or to 0 days, if you're in an absolutely critical staffing situation. We've been fortunate that we never got to that level and we have been able to maintain, in what we've labeled an orange level of contingency due to the short staffing. So that's why we continue on with the manageable 7 days. We haven't had enough staffing to allow us to go back up to the full 10. So, what happens is when a healthcare worker has gotten to day 7 - they are feeling better, they meet all clinical criteria; no fever, diarrhea, or vomiting for 24 hours; they can come back to work safely, but they're wearing a well-fitting mask for days eight, nine, and ten, and able to do their job. Thanks for that.

Harvey: What about the 5 days? That was my question.

Epling: 5 days for everyone else who's not in healthcare and still wear the mask. The footnote that gets lost often and

hopefully anyone who speaks with us on our hotline when we're returning you to work after day 5 and you're not in a healthcare environment, we are spending time explaining, hopefully very well, why it's very important to continue to wear a well-fitting mask for the remainder of the day 10 period, and not to take it down to eat, or when you're near other people.

Betsy Albright (Nicholas School of the Environment): There's a bit of confusion in the Nicholas School among faculty on what is a classroom, I know that sounds silly, but I was wondering if you have a definition of classroom? I know that's a silly question. But if you happen to meet in a classroom is that a classroom or is that a faculty meeting?

Grantham: If I say you'll know it when you see it, is that not enough? (*Laughter*) I think if you are gathering the students for instructional period, I think that's what essentially what we're going for. Like this is a classroom, right?

Joseph Izatt (Pratt School of Engineering): Can we get some clarity on that? So, the wording is classroom. This is a classroom, but you're not wearing a mask. Is it the intent that it's a classroom being used for a Duke class activity? Opposed to many others gathering in a classroom?

Grantham: I think that is the intent, for a class. So, this is a classroom, but you're not here for the instructional periods. So, if I was in here by myself after this meeting I wouldn't have to wear a mask. But if you were in a classroom and you were teaching, engaging students I think that's what the intent is.

Scott Lindroth (Music): I've heard from some colleagues that from getting a booster there might be a benefit to switching Pfizer to Moderna or vice versa. Is there or is that just hopeful?

Epling: We don't have solid data on that. There's definitely discussion, lively discussion, around mixing and matching. We don't know yet.

Nicole Larrier (School of Medicine): I think supply chain is probably not going to be the answer. But, as a healthcare worker and somebody who is not on a team, but I work on a phone. Scheduling has been a bit of a question for the new booster. I have physically not been able to find an appointment within Durham, even at CVS and definitely not at Duke. I have colleagues that are out with COVID. And then I hear Thursday or Friday I saw that email last week that seems to have come through the university side, but not through the Health System. And I've been looking but you can't get appointments.

Epling: You know the scheduling link will...

Larrier: Yeah, that was what was sent out and we click...And we had this conversation with some School of Medicine faculty last night, like is the link working for us or not. We click and you don't get any options.

Epling: So, first question you are asked is, "What are you looking for?" So, if you are clicking booster only, then it'll ask you location, and there are currently available appointments at the Duke Medicine Pavilion, we were able to load additional appointments, as we were able to secure a larger site and some staff to administer them. That's been our difficulty in getting

our appointments loaded in and updated. They also added Morreene Road appointments to it today.

Larrier: I'll send an email to folks to look again. I think the frustration is, people have literally been stopping work trying to find appointments.

Epling: I would encourage you to consider the 1J clinic where you can walk in very easily during their hours, and we're keeping an eye on their supply and making sure that there is supply. There haven't been long lines there. So, that's a walk in Monday -Friday available option for you.

Mohamed Noor (Biology): I just tried it right now on my phone and the problem is you have to click select the site first.

Larrier: Yeah, we weren't even getting any site options.

Epling: So, I'm sorry that there's so many challenges. You're feeling my pain, and I'm feeling yours. We have had the challenges of finding staff to vaccinate, having space, having vaccine supply, but the good news is on the spot we got a wave three supply in yesterday, so that doubled our supply, and then we fully expect by the end of this month there will be no further, any pinch on the supply. So, that will be great.

Larrier: Thank you.

Weinthal: Any other questions?

(Applause)

Weinthal: Thank you for such thorough and in-depth presentations. I would also recommend the walk-in clinic. It's very

convenient. Before we end our meeting, I believe Provost Kornbluth would like to say a few words.

Sally Kornbluth (Provost): Even though Erika cited at the beginning that shorter meetings were a sign of an issue, I don't plan to filibuster for about a half hour.
(Laughter)

I'll just say very briefly - thanks to all of the team for their great presentation, and also doing incredibly great work through the whole pandemic. I think, Carol slept a half an hour in the last year and a half. So, thanks very much.

I just wanted to say a word in light of all of this. And Erika mentioned a little bit at the beginning of the meeting, which is, we're at a point where we're really learning to live with this virus. It's likely to be with us for some time to come. And I think we really have a challenge in rebuilding community. I think particularly for graduate students, we've seen real distance from the faculty in some departments. We've seen junior faculty who come in, who have never really interacted much with their senior faculty colleagues. And believe me, I'm someone who wears my mask all the time, et cetera, I understand concerns about contagion. But I'm actually here to sort of plead a little bit with faculty to say, "Try to come in and come back to the campus more!" I really understand that working at home can be convenient. I understand people have been teaching in person, but there are still departments where there really just aren't many faculty around. We have staff who have been coming in throughout the whole pandemic, and I just really hope that we can start populating the campus a bit more for our students. It has been brought to my

attention, we discussed this a little bit at ECAC. Faculty are often really in need of good staff support. I realize, because of talent shortages, and hiring problems in some of our units, that even when you come in you may not be getting all the support that you need and are looking for. We're really working hard on that. This is sort of top of mind. So, I think we really have a challenge of rebuilding all aspects of the community, having a vibrant life on campus and being there for each other and for our students. So, I wanted to mention that, and I will not take up the remaining 31 minutes.

Weinthal: We are going to keep a tradition that was started last year of finishing a bit early. But before people head out, if you haven't signed the attendance sheets please come down and sign in. I really want to thank everyone for coming out today and being here in person. It was wonderful to see everyone, even if you're masked, especially if you're masked. Our next meeting is on October 20th, and I hope everyone has a good evening and weekend.