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FEMALE SPEAKER: Welcome to Mayo Clinic COVID-19 Expert Insights and Strategies. The following activity is supported in part by an independent medical education grant from Pfizer Inc. And is in accordance with ACCME guidelines.

JEFF POTERUCHA: All right. I'd like to welcome everybody today. On behalf of the Mayo Clinic School of Continuous Professional Development, I'd like to welcome you to the Mayo Clinic COVID-19 Webinar Series. I'm Jeff Poterucha. I'm going to be your host today. And our topic is on responding to Workforce Management Issues in the COVID-19 pandemic. Now, a few house cleaning items as people are logging on here, this webinar is accredited by the AMA for one credit. There are no relevant disclosures for today's discussion. And of course, we'd like to thank Pfizer for their support of this educational activity.

Now before we get started, I'd like to go over just a few details that'll be helpful for today's webinar. First is, you'll be able to claim credit for this webinar. If you'd like to do that, you can see this link here visit us at ce.mayo.edu/covid0928. What you'll want to do is, when you go to this link, you'll need to log onto the site. If it's your first time visiting, we'll have you go ahead and register an account. Once you've done that with this link, you'll see there's an access code box. In that box you want to enter the access code, COVID0928. This will allow you to access the course, complete a short evaluation, and then you'll be able to download or save your certificate.

So a few things with this webinar, what you'll see down below on your screen, is you have a Chat function and you have a Q&A function. Now if I could ask, for the chat function, we'd like you to use that if you're experiencing any technical issues, so our support staff can help you. If you have questions for the panel today, we'd love to have you use that Q&A function. So as the speakers are talking, if you have a question right now, you can go ahead, open that box, and go ahead and enter your question. You'll notice that when questions start coming in, they have an upvote function. So if you see someone's asked a question that you also would like to see answered, go ahead and click that upvote. And our panelists will see that rise in the list, and we'll be able to prioritize in answering that for you.

So in today's webinar there's a few learning objectives. You'll hopefully walk away really be able to determine rational contracting tracing and monitoring processes for healthcare employees, discuss the impact of COVID-19 on the workforce, identify resources to assist employees during COVID-19 pandemic, identify permitted pandemic related medical exams and inquiries, determine pandemic related accommodations rights and obligations, and of course, be able to discuss protections for high-risk employees. So with that, I'd like to introduce our moderator for today. It is Roshy Didehban. She is the Chair of the Department of Practice Administration at Mayo Clinic, and Assistant Professor of Health Care Administration, and also an instructor in Health Care Systems Engineering. And with that, Roshy, I will pass it to you to introduce the rest of our panel.

ROSHY DIDEHBAN: Great. Thank you, Jeff.

And welcome everyone today. We're really happy that you joined us for this discussion today. Our first panelist, who I'm honored to welcome is Dr. Laura Breeher. Dr. Breeher is the chair of Employee Occupational Health Services Executive committee, as well as a consultant within preventative medicine. We also are joined by Keri Slegh, who's chair of our Division of Human Resources. As well as, Samantha Halverson, who's director of Human Resources within the Mayo Clinic Health System in Eau Claire, Wisconsin.

We also have Mark Hyde, who's the program manager for Employee Assistance Program at Mayo Clinic in Rochester, and also has significant expertise in leadership, employee motivation, as well as performance issues. And lastly, we have Dr., sorry we have Charlie Bierman, who's legal counsel and senior director of Risk Services at Mayo Clinic. And he has significant experience in employment, disability, absence management, as well as occupational health services. And with that, I'll turn it over to our first panelist, Dr. Breeher.

DR. LAURA BREEHER: Thank you so much, Roshy. And it's a pleasure to be here. I'm looking forward to discussing, just briefly, a few of the things our group in Employee Occupational Health has done in collaboration with the others on this call and their teams, to support the health care workforce. Very early in the pandemic, we identified the need to create a 24/7 call line for our health care workers. So we did this in collaboration with HR. And this call line is supported primarily by nurses, but there are options on the call line, if employees have questions about pay or other items that human resources could provide expertise on, to route them to that team.

Within our team in occupational health, the calls that primarily come to this number, are calls related to personal COVID infection, symptoms, personal exposures from household members or in the community, as well as occupational exposures. So anytime an employee had a breach in PPE when working with a patient, we would ask that they call us right away. And that 24/7 call line has continued to operate since spring of last year, and is still available to employees now. We get fewer calls after hours now, but it is still available for emergencies after hours, as well as all day, seven days a week.

The other thing that we did, that was a little bit different in response to the pandemic, was that we shifted the scope of the individuals that we serve. Typically, employee occupational health very much focuses on employees. And we identified that for safety reasons, as well as for ease for our health care workers and non-employees on campus, it was important for us to provide kind of a one stop number for them. So our Employee Occupational Health Team is serving employees, volunteers, students, contractors.

Essentially anyone who's on our campuses working amongst our teams, we want them to call us if they're having any symptoms, if they have an exposure, if they have any sort of a concern, so that we can have standard safety practices and standard restrictions for who should be on our campus and who shouldn't amongst those teams. And that's worked very, very well. And I think alleviated any confusion that could have come from disparate recommendations for those non-employees, that they may have received from others.

Another area that we were very heavily involved in was medical clearance for respirator use. And we continue to be involved in that, but the surge with clearing our employees and health care workers for use of respirators was really in March and April of this year. In a typical year, we clear about 1,500 employees. And those employees go through fit testing for respirators, like N95s. So those will be people working in high risk areas, where they may encounter potential respiratory pathogens.

This year in Rochester, on our Rochester campus alone, we've cleared nearly 14,000 employees for respirators, and 11,000 of those were in March and April. So that was a lot of work for our Occupational Safety colleagues to actually do the fit testing, but also for our Employee Occupational Health Services to review all of the Occupational Safety and Health Administration questionnaires, that are required to ensure someone is safe to wear a respirator. So we created a digital questionnaire to apply some AI behind the scenes to help us with that, and expedite that process, so that employees with no medical conditions that would prevent clearance, could get that response immediately after submitting the questionnaire.

Our team is also very focused on return to work. So anytime an employee is out due to symptoms of COVID, COVID infection themself, or if they have an exposure, we're assessing before they return to work and determining restrictions. Early on for those that had COVID infection, we were doing PCR testing. But as the knowledge has evolved and we've identified that employees may remain positive with PCR for a long time, we've shifted those practices as well in response, as several health institutions have done.

And then the final thing, that I just wanted to touch on was the contact tracing work that our team has done. So it was identified early that the need for centralized contact tracing was important. We centralized that exposure investigation process and contact tracing within our Rochester practice, in collaboration with all of our enterprise partners. And we evaluate every single health care worker with COVID infection to determine how they may have acquired that, any exposures they had, collaborating with public health. And we also do active symptom monitoring of any exposed employees, whether they were exposed in the workplace, at home, or in the community. Next slide.

The contact tracing process is one that I could probably talk about for a long time. So I wanted to share with you that we did put many of the details of our model, that we developed in writing, in a paper that was published in the Mayo Clinic proceedings earlier this summer, to share that with other health care institutions and businesses. But just like public health and other health care institutions, the contact tracing is focused on early detection, thoroughly evaluating anyone who may have been exposed, so that no one is missed, including evaluation of personal protective equipment.

And one of the things that we were very thankful that our public health partners supported us in doing, was to not only evaluate our health care workers for occupational exposures, but also to be a resource for them, and proactively in our contact tracing ask about exposures at home and at work. And by doing that, we've been able to make decisions about the safety in returning to work much more quickly than we would have been able to, had we not been delegated that ability to do that. So with that, I'm going to hand it over to my colleague, Keri Slegh in HR to talk about some of the COVID-19 workforce impacts their group has been working on.

KERI SLEGH: Thank you, Dr. Breeher. If you want to advance the slide. So my colleague, Sam Halverson and I, are going to talk a little bit about the impacts to our workforce, really starting in March, all the way up to the present. Like many employers across the country, we moved to a rapid state of remote work for many of our staff, some in nontraditional remote or telework roles. Then we went into a pay protection period for most of the month of April, where we maintained pay but also moved staff to critical areas to our labor pool and other needed roles, in order to really, one learn, and two really set us up for the future.

We deferred some work. So we had certainly priority projects and others, like everyone else who put things on pause. Beginning April 29, we implemented several actions to help secure financial stabilization for the months coming. So we looked at our workforce, we looked at priorities, and looked at what roles will be critically needed, and implemented furloughs, both fixed and flexible. Fixed meant it was a fixed period of time.

Flexible meant it might be a rolling one week on, one week off type of situation. We also implemented reductions, so reductions in FTE, or hours scheduled during that time. So that began April 29. The furloughs, which we called Workforce programs lasted up until August 31. And there was varying times. Some were a short period of time, some were a long period of time, it really depended on their role of the work they perform.

There's two pieces of that, one we continued to pay benefits. So even if they were not working, the employer paid benefits pieces we're continued. We also, did not allow PTO use during that time, mainly to maximize unemployment benefit but also to preserve cash flow for the organization. You could go to the next slide.

We also implemented salary reductions. So there was a 7% salary reduction from 4/29 or April 29 through June 23. So for about eight weeks, there was a 7% salary reduction for allied health exempt staff. There was a 10% reduction for our consulting staff. And then administration had 15% reduction. During all similar time periods, we did not impact the base rate of non-exempt staff. So hourly staff did not have a base rate or a pay reduction. They may have hours or furloughs, but they did not have a pay reduction.

We also paused 403b and 401k match contribution during that period. And that was just restored, just recently. We also paused our tuition reimbursement. So we did not expand or pay any tuition reimbursement during that time. All of that was then reimplemented as our finances stabilized. And we can project out that those types of actions could be unpaused. And we are now in a period, where all of those actions have been restored. And we're actually looking at now going back, particularly the salary reductions, and paying those back, if you want to call it that.

We're also making some changes to our pension program, particularly the 403b and the 401k match to return those, and look at a whole year of contribution. So if someone stopped contributing during a furlough, for example, obviously they're not getting paid, or reduced hours, they have a chance to contribute more this fall in order to get that maximum match. Can go to the next slide.

A few other things that we implemented in order to help hardship for employees, so we were balancing not only financial stabilization for the organization, but looking at financial stability for our staff. So our paid time off program, currently, we allow staff to go into the negative or borrow against future accrual, typically they couldn't go below zero in their bank. We do allow that for any COVID related absence, or if there's staffing, low staffing needs and they want to use PTO, they can use our flexible PTO program. We have a Spirit of Caring Fund, where staff can apply for a grant of dollars from the organization. The fourth would be 401k withdraw.

Those we're allowed up to 100,000. That was really across the country, that wasn't necessarily Mayo specific, but we did amend our plan to allow. Short-term disability benefit, COVID as of itself is not a serious health condition. However we did allow short-term disability to be used, and we waive the waiting period. So if someone went on leave due to COVID then tested positive, they could use their short-term disability benefits, without a waiting period while they were out. I'm now going to hand it off to Sam Halverson, who is going to talk a little bit about accommodations and other things that we've been doing for staff.

SAMANTHA HALVERSON: So beyond the financial hardships that employees may have experienced, we wanted to use our values to guide us on helping employees through some personal challenges. We had employees who were pregnant, or had serious health conditions, or maybe had a family member with a serious health condition that could be complicated by COVID. We instituted, in partnership with leadership and our legal colleagues, what we called a C-19 requests for accommodation. We did this at the onset of what we were experiencing in our geographical areas of COVID, and stopped it, we did a recall of employees come June 10.

So while we were accommodating employees, who had those serious health conditions, in many cases we were allowing them to telework, to stay outside the environment, we redeployed them to areas, work units that maybe didn't experience as many COVID-positive patients, or we approved them to be on a leave. And then, if we had employees who didn't want to go home after caring for a COVID positive patient, we provided respite housing options, so that they didn't feel like they were bringing home anything that they were exposed to, into their family or homes.

And then once June 10 came, we felt we were in a better position. We knew enough about COVID to have instituted some protocols in our environment, such as robust cleaning, masking, screening of patients and visitors and employees, that we minimized our workplace exposures and felt like it was safe for these employees to return. So we did a recall. And then if we had employees who remained concerned about coming back into the workplace, we did an ADA assessment and worked with them through that formal process, that we had pre-established.

As employees were experiencing some school changes for their children back in March, we had many schools go 100% virtual and then this fall many of our employees' children are returning into a blended school situation, where they're half virtual and half in person. And so we grouped together to try to support them with their newly experienced child care needs. We increased our backup daycare options. We connected employees to many community resources. We helped to support community resources, such as Boys and Girls Club, YMCAs. And we provided some sitter, tutor matching programs by enhancing some of the daycare, childcare options that we had in place. Next slide.

And then our workforce reactivated quickly, and this was a good thing. So we started to recall our furloughed employees early. And then because obviously, our financials recovered as our practice reactivated, we were able to restore those pay and benefits earlier than we had anticipated. And Keri had spoke to those individually. That said, I'll turn it over to our next presenter, Mark.

ROSHY DIDEHBAN: And, Mark, you may be on mute.

MARK HYDE: Thank you for that. The Employee Assistance Program here at Mayo, we provide short-term guidance and counsel, problem solving counsel for employees, a wide variety of family life, emotional concerns, substance, any issue that impacts any one of us in the community or in our work environment. So we provide swift access to people.

So during COVID, we saw a number of interesting kinds of trends. The one thing that we saw prior to COVID, was all the issues that we normally would have, people coming in whether it's an EAP or a community counseling center, they come in primarily with family relational issues, large in volume, followed usually by emotional mental health concerns, anxiety, depression and then a wide variety of work concerns, maybe performance, or career.

And there's a lot of subcategories in each one of those dealing with substance abuse issues, dealing with grief, loss issues. And most EAPs across the country, colleagues that I've talked with and others, the same kinds of issues that we see for many decades. After COVID hit, in the early stages of COVID, we saw an awful lot of increase, and our primary is anxiety, so emotional mental health became one of the primary concerns late March all the way through April, that people were seeking some short-term counsel, some help or medication with the anxious physiological and emotional issues.

As time has gone on, it's become kind of a mix, because everything shows to be interdependent. So we see so many different life challenges now, that everything is kind of mixed together. So what we see is, of course prior issues to COVID, the issues just became more severe and complex once COVID hit. So if you had a relationship issue, a parenting issue, finance issue, dealing with grief, bereavement loss, or any emotional issue, it became much more severe and complex because now we added on a number of things, could be financial issues. It could be the daycare issue. Incredible strain over daycare distance, setting up initially for employees, across the country of course.

And so we saw too many issues merged together at once and people really feeling kind of paralyzed, where to go. So the EAP tried to provide short term guidance and problem solving, for each piece at a time, that we could. So normally, you see one, two issues that stand out. Now you have three, four, or five. A day care issue, emotional issue, maybe a substance issue, maybe a work change issue, and very unsecure about the new kind of task or role that they're playing. So we to try to provide services in all those areas, individually, with people in a week to week basis. In some cases, for brief check-ins, 20, 30 minutes even, to try to do something a little different than a traditional hour session to try to hit the most acute issue.

Another area, the third bullet, those in management and employees, a tip for the workplace is really important here. That if you're in management or an employee, we must move from, why the change. There've been so many changes, and sometimes we have different views about those changes, very diverse ideas about different roles, different tasks, different hours and shifts. At some point after we've tried, all of us to give the best explanations, we have to move either as a manager or as an employee, to how to be effective or efficient in whatever the change or the task is that I'm doing now.

So for leaders, it's wonderful when they can move beyond the why discussion, and move into, we have to do this. But here, here's what I can do to help make your job even a little more easy, or at least less complicated. Kind of remove unnecessary barriers that are preventing employees from doing the job, is effective, the right task, and efficient, doing those tasks with least amount of disruptions. And when employees make that changes as well, they can get stuck with the, why. And it's really good for our mental health to be able to in the midst of that crisis to change to, how can I do this in the most efficient way possible with the least problems for me and others.

And the last thing that I'll say is, this is for all of us, what we find, our staff, and we work with hundreds of employees a month, and we talk to people outside of organization as well, the key is really how to manage and adapt. Really comes down to for me, a couple of things. We have to have expectation flexibility, people support, and problem solving.

The expectation flexibility means in this new time that we're in, we almost have to expect to get that phone call like many have recently, that your school is going to be quarantined, pick your child up, and you must figure out how to do distant learning starting tomorrow. So we have to have this new mindset, this new mental model, that doesn't become shocked and overwhelmed, but goes into problem solving mode. And expect that today it could go this way.

The only way that people do that with relatively effective kinds of solutions is when they have people support. So I'm trying to provide as much support to our employees in the workforce as we possibly can. But they need people support to help them think through all of these various struggles. We need neighbors, co-workers, family, friends.

And then the key to all of our quality of life, is really problem solving. And as EAPs move to even a stronger problem solving, where can we guide and think out loud with people, how to solve that day care issue. What are the services by the employer? What are services in the community? How can we help them address a short-term financial? What do they do with their relationship issues, that have really taken a hard hit during this time? Trying to solve so many issues all at once, creates many more challenges. And certainly domestic issues for all. So problem solving is just the key to be able to see something in the future. And having somebody come alongside, be someone in the workplace, or a friend, or family member, or an EAP counselor, or a provider in the benefits program, to help people think through how to solve a number of these issues, or at least start to have the steps involved in trying to solve.

The last thing I'll say is, the issue that makes all of our emotional lives more challenging, is when we don't see an end. And so COVID has been very unique in that aspect, where we normally can go through a week, two weeks, a month, two months. But now all of our key categories, sometimes about even our job roles, to our day to day structure at home, day care issues, online learning, shift changes, many people just don't seem to have an end in sight, especially with some of the school issues, on top. So that makes it harder. And we must have the small wins daily, with people's support, and some joy that people do daily, in order to manage, when we have an indefinite kind of-- Even though it's not, it looks like it's indefinite, indefinite kind of end to the stress of all these different juggles, that people are trying to juggle in life. I will end with that and turn it over to Charlie.

CHARLIE BIERMAN: Thanks, Mark. And my topic today, is the impact of COVID-19 on the Americans with Disabilities Act. The Equal Employment Opportunity Commission oversees that law. The Americans with Disabilities Act is a federal law in the United States, and addresses employees with disabilities. What are their rights? What are the employer obligations? And the pandemic had a pretty large impact. In this area there were some many unanswered questions. The EEOC, very early on, reissued its pandemic guidance from 2009, but that didn't answer everything.

There have been several sets of Q&As that have been issued to help guide employers, to remind them what their obligations are, and to address the few issues that are new. And a big area, and the first slide addresses it, are permitted medical exam and inquiries. Under normal times, there are certain things we can do during the pandemic, that we normally wouldn't be able to do. And the EEOC has recognized they need to give employers some flexibility, given the public health issues, and the need to develop infection control standards, especially in a health setting.

So now, during the pandemic, we can ask employees do they have any symptoms associated with the virus. We look to the CDC and our experts in our health to come up with that. And we can restrict employees from working. We want to err on the side of caution. In normal times, you can't take an employee's body temperature before they report to work. But this is new, during the pandemic, you can do that. Some employers are doing that, and their employees, their body temperature is taken before they come on-site. I remember some of the meatpacking facilities when they had big problems early on, they quickly implemented that.

Another new item is COVID testing. You can test for the active virus as a condition of coming into work. What you can't do is require the antibody test. They've been very clear on that. But testing for the active virus, before someone's allowed to come back to work after they've been out ill with symptoms associated with the virus, that's OK. Next slide, please.

High risk employees was a big, big topic early on. Sam already covered this. Mayo early on, went beyond what the laws required, for three months or more, in terms of what do we do with the high risk employees. And by high risk I mean, three of sub-bullets on this slide address the high risk areas, potential high risk areas. And when I say high risk, I mean an individual has an underlying medical condition, or even their age that they place them at higher risk, should they contract the coronavirus. That's what we're talking about with high risk individuals. We got this question early on, the first bullet. Can we refuse to allow high risk individuals from working? Can we just put them on leave, paid leave? And the EEOC says, no. If an individual wants to work, if they're 70 years old and they want to work, we can't bar them from working.

The other issue that has come up though, is even though the individual may have disclosed to you they're at high risk or you know they're at high risk, you can ask whether or not there's a reasonable accommodation they need. So teleworking, moving a lot of employees to teleworking early on, was a way we dealt with this situation. And many employees were required to telework. But when we reactivated all of our services, the issue came up about certain individuals. Can they continue to telework? Can they get an accommodation in that regard? The issue is, can they perform all the essential job functions? Next slide.

There's just general pandemic related accommodation issues. And early on, the questions came up whether or not an individual at high risk, even though an employer can be more generous than the Americans with Disabilities Act, the question came up, what are we legally required to do? And the EEOC, in some of its subregulatory guidance, indicated that, if an individual has an underlying medical condition that places them at high risk, you do need to consider accommodations. So again teleworking, is one of the obvious examples. Certain individuals asked to not do hospital service. They wanted to just work in the clinic setting, or they wanted to work in telemedicine more. And we've worked through all those issues as best we can, balancing the rights of the employee.

Yet, we do need to keep our doors open. On a temporary basis, you can eliminate essential job functions. But the trick with the pandemic was four months ago, five months ago, we realized this could go on for a year or two. And what are we going to do when we struggled with those issues? And as Sam indicated earlier on in this presentation, for about three months we went way beyond what the law required. Come June, we started to get more in line with what the law sets forth. Because again, we reopened our doors, and we were back up running the business, a little in more normal times, with obviously the use of PPE and all the other safety measures.

One issue that's come up is the individual employee is fine, but they have a family member at home who has a high risk medical condition. Under the law, under the ADA, we are not required to accommodate them. We did have a program, where we could help the person find different housing. Across the nation, employers in general, if the individual has a high risk family member at home, the employer has no legal obligations. Teleworking is an obvious accommodation choice by employees at high risk, but that raises new issues for employers.

Normally, you don't want to say, well that's going to be too expensive. But with the economic devastation that the pandemic has caused for a lot of employers, providing certain types of accommodations to employees, the economic factors, it might be a basis to deny a certain requested accommodation. And you can always try other things. But it's one thing that employers need to keep in mind, that the economic impact of the pandemic can be considered. And that's all I have, and I'll turn it back to Roshy for the Q&A session.

ROSHY DIDEHBAN: Great. Thank you, Charlie. And Thanks to all of our panelists for really that incredible information, getting through a very difficult time this year. And it's really incredible to see the summary points of the decisions that had to be made and how we manage through this complex period. I'm going to welcome everyone joining to please use the Q&A function on your screen to either add questions for our panelists today or to upvote the questions that are already there. Maybe we'll go ahead and get started with our first question. How do we differentiate, assess, and classify risk of other emergent diseases against the severity of COVID-19 in patients, when they come into the ER or the outpatient setting? I'm wondering, Dr. Breeher, if you could comment on this. And you might be on mute Dr. Breeher. No. Maybe we will go on to--

DR. LAURA BREEHER: Oh, I figured it out. I bumped it on my handset. So I'll answer that. So one of the things that we have done is, we've put precautions in place so that all of our health care workers are protected, regardless of whether we know the patient has COVID-19 or not. All of our health care workers working in direct patient care wear face masks and eye protection. If an aerosol generating procedure is performed, they wear a respirator. And we also have testing processes in place to test our patients before they come in for surgeries or procedures.

However, I think that this question is alluding to the fact that when someone comes into the ER, there's not that time to test them ahead of time. So we do have all of those precautions in place. Our health care workers have been trained to suspect that anyone could have COVID, even if they have no symptoms at all. So from that standpoint, we feel like our workforce is very protected.

From the patient standpoint, this is one of the things that we're looking at as we're approaching flu season, because COVID-19 symptoms overlap with so many other infections. And so for our upcoming flu season, we're developing and implementing some protocols, such that patients that had symptoms that are very characteristic of both COVID-19 and influenza, would receive a swab. And it would be tested for both diseases, as well as evaluation for other diseases that also overlap in symptoms like RSV. So I think that, that's likely the background of this question.

But the other thing I want to mention is just that, early on in the pandemic, we found that people weren't coming into the ER with diseases that weren't related to COVID. So someone might have a bowel obstruction or symptoms of a heart attack, and they wouldn't come in because they were worried about exposure to COVID. And that I think had a pretty significant impact on the health of the population. So we did a lot of things to try to encourage those people to come in, reinforce the safety precautions that we have in place, which are very strong. And I think that, that helps too with some of those emergent diseases that are not COVID-19, because those things keep happening during a pandemic.

ROSHY DIDEHBAN: Thank you, Dr. Breeher. That's very helpful. And of course, we want to continuously encourage both our staff, as well as our communities to get the influenza vaccine this year, as a critical step to try to maintain the safety across health care organizations and communities. I think the next question also relates to contact tracing. The question is, how large is the team at Mayo Clinic in Rochester? And how many exposures are they able to handle per week? And it might also be interesting just to hear, kind of the ebb in the flow that we went through during the pandemic, and where we started, and where we are today.

DR. LAURA BREEHER: Absolutely. So the size of the team also kind of ebbs and flows in response to what we're dealing with. I think one of the great things about the model that we put in place right now is, I do feel like we could expand that to be able to serve any number of exposures that would come our way. We have a pretty big trained panel of providers.

We have over 20 providers right now, that are trained to do some of these exposure investigations, calling employees to do the risk assessments, a large panel of nurses to assist with restrictions and symptom assessment. I think, the last numbers that I heard were that we had over 130 people across all of our multidisciplinary teams, but that is ebbing and flowing. And we're constantly looking at, how do we use those resources very efficiently, looking ahead to what the models may be.

In terms of numbers per week, I think that the biggest numbers we had were actually very early on in the pandemic, before implementation of universal masking and then eye protection. Because we do have patients that don't have symptoms at all that we don't suspect that they could have COVID, and then they would later test positive for COVID. And so that was during those early times, when across the nation and across the world we were learning about COVID.

And there were a few surprises in patients that had been cared for. I think that our peak, we evaluated 50 exposures per week. But those may be anything from an individual PPE breach, where someone wasn't wearing a respirator in an emergent situation like administering CPR, to a larger exposure where there may have been a patient that had COVID. It wasn't known and people had been taking care of that patient for a day or two.

So I do think that one thing that's important for us to know, in terms of our contact tracing, is actually that we have many more nonoccupational exposures than we do occupational exposures. The vast majority of our employees are being exposed outside of work. Well, we aren't doing the frontline contact tracing for those if their source was not a Mayo employee. Our contact tracing team is involved in collaborating with public health very closely on that.

ROSHY DIDEHBAN: Thank you Dr. Breeher. I'm going to go to two of our other panelists, Keri and Sam. The question is around tuition reimbursement, how it will be restored for employees. And I think it will also be helpful to hear how we're thinking differently about tuition reimbursement as we look to the future, potentially.

KERI SLEGH: Yeah. So this is Keri. I could take a shot at that one. So the pause was fairly short, and so staff were able to go back and request reimbursement. It just essentially was delayed. So they're still able to get reimbursement for courses that they took this spring. We are pausing on any new programs going forward, because we want to put more emphasis on developing careers, especially in critical areas. And to have tools kind of at the ready for staff to use, versus maybe going into a career that isn't necessarily something they would do at Mayo in the future. We've had a fairly open process and a fairly open benefit. I'm trying to refocus that going forward.

ROSHY DIDEHBAN: Thank you, Keri. Sam, anything you'd like to add?

SAMANTHA HALVERSON: No, she said it very well. Thank you.

ROSHY DIDEHBAN: Perfect, thank you. Mark, I'm wondering if you could share with us, what kind of increase we've seen in EAP utilization since the start of the pandemic. And you're on mute. Sorry.

MARK HYDE: So we were extremely busy prior to COVID and kind of maxed out with our capabilities just about. When COVID hit, the numbers dropped for the first several weeks, two to three weeks easily, because of probably the acuity in people's lives and trying to readjust. And so they came back up about three weeks later, four weeks later it started to come back. We're at the full range. So I don't think we really had the capacity to do much more of an increase, but now we're back to where we were prior to COVID. So what we tracked was, not only the volume. So the volume's back to what it was before, extremely busy, probably just about 5% or 10% more, than we were before COVID. But of course, the severity is what we've been tracking. The severity of the issues dramatically changed, per our counselors, kind of quoting on that.

ROSHY DIDEHBAN: Thank you. Dr. Breeher.

DR. LAURA BREEHER: One thing just to add to that, and to sing the praises of EAP a little bit from an occupational health standpoint. They've also worked with us in OHS to develop some resources for employees, that we're proactively sending out to every single employee, who is put on isolation due to COVID infection or quarantine due to any exposure, so that they have all those resources right in front of them. So I think that impact from EPA to support those employees, even before they develop those issues or concerns, is important. We noted that employees were seeming a little bit more anxious and having some questions, so we reached out to EAP to see what they could do. And they developed this fabulous resource.

MARK HYDE: Thank you for that. I also want to add there's so many rich resources at Mayo. There was a well-being group and a focus that did incredible amount of work across our institution, enterprise wide, providing a number of resources, and trainings, and phone lines to our employees. So we certainly were fortunate to have so much rich response to help our employees, internally, from a wide variety of groups.

ROSHY DIDEHBAN: Thank you. I do think it's incredibly powerful to really be proactive in recognizing the challenges that employees are going to have, especially when they're isolated or put on quarantine. And how can we help them through that period of time and make sure that they feel supported. Dr. Breeher, the next question is related to those quarantining guidelines. What are our current guidelines for quarantining employees that are exposed outside of work?

DR. LAURA BREEHER: So we are facilitating quarantine for 14 days from the last known date of medium or high risk exposure outside of work. We do ask that our employees call us to assess that exposure, because we assess for things like how close they were to the other individual, for what period of time were they both wearing masks, or were they unmasked, to ensure that we're quarantining appropriately but not quarantining people unnecessarily. And we've worked with our public health partners to ensure that, that aligns with their recommendations as well. So one of the things that we do is, we do monitoring for symptoms of our quarantined employees, so that if they develop symptoms we can assist with testing right away to ensure they don't have COVID.

ROSHY DIDEHBAN: And a related question, Dr. Breeher. Are we returning exposed employees back into the workplace during the quarantine timeframe? And under what conditions would we do that?

DR. LAURA BREEHER: Yeah. So this has been a topic that we thought very closely about, as did other health care institutions across the nation. And we are returning some employees during COVID with safety precautions in place. So this happened first on our southern campuses, when there was a surge in those states, and the risk benefit of keeping asymptomatic employees out of work, versus having those employees there to care for the patients. We really didn't want to put our patients at harm by not having enough staff there, so we did start allowing those employees to return.

As long as they had a negative COVID PCR test, and they were asymptomatic. And then we do serial testing multiple times throughout the quarantine period to make sure that they remain COVID negative. That in conjunction with the safety precautions we have across all of our practices like universal masking, we have not seen an uptick in transmission of infection across our campuses with that. And in the Midwest, we're doing that on a select basis if there's a critical health care staffing issue, with those same precautions in place.

ROSHY DIDEHBAN: Thank you. Charlie, I'm wondering if I could ask you the next question. It's around ADA requirements. The question is, I have had a patient tell me that the ADA requirements cannot require a mask. He was a bit belligerent about it, and wanted an excuse to not have to wear a mask. Can you speak a little bit to an organization's ability to require masking in the workplace?

CHARLIE BIERMAN: So I'll admit my area of expertise on the ADA is employer, employee law, Title I under the ADA. This is a Title III ADA question, public accommodations. One of my colleagues handles those issues. I will say for employees, we can require them to wear a mask. And if they can't, we treat that as an essential job function now. And they are not allowed on site. And hopefully, we can accommodate by providing teleworking or some other means.

My understanding is in effect, the same rules apply to our patients. And they can seek health care elsewhere. Maybe there is some type of other accommodation like telemedicine appointment. But generally speaking, given the public health hazard, individual's rights are subject to the public policy issue. So I think in general, we can require the mask. And that's just the way it is right now.

ROSHY DIDEHBAN: Thank you, Charlie. And I don't know, Dr. Breeher, if you also maybe want to add the guidance we've provided our physicians, when they're asked to provide a reason why an individual doesn't need to wear a mask. I know our guidance has been very limited in that regard.

DR. LAURA BREEHER: Yeah, so these questions do come to our providers in clinic from patients asking not to wear masks. And that was one thing that we felt very conflicted about, because from a public health standpoint, and even protection for that patient, if they have a medical condition like a pulmonary condition, that may make it difficult for them to wear a mask. It's also putting them at risk not wearing that mask. So we have very much focused on connecting our patients to treatment that would allow them to safely wear a mask.

And we've found that with our employees too. Early on, we had several employees that reported that they had claustrophobia or anxiety with usage of masks. And so we worked with our psychology and psychiatry department and helped those employees, essentially desensitize themselves by starting to wear masks at home and on leisurely walks around the neighborhood.

So that they weren't isolated in their home, unable to go to the grocery store, to health care, to work, to restaurants, and things throughout the pandemic. So if we do end up writing something for the employee, it's an accommodation suggestion to periodically allow that patient time in an environment, where they can safely remove their mask for a bit, where they're far away from others, rather than just a blanket restriction that they couldn't wear masks.

ROSHY DIDEHBAN: Thank you. Keri and Sam, I'm wondering if you could speak to the next question around teleworkers. So have all teleworkers returned to normal pre-COVID setup? If not, have you needed to implement new policies for the longer term? Maybe I'll just to start it off, state that from a practice perspective, we've found that getting individuals off of our campuses have really allowed us to reduce kind of the people density within our buildings.

And we believe, that's really critical to ensure that we can continue to support social distancing and make sure that our lobbies and other areas are not overly full. And so from a practice perspective, we've really considered it a priority, that if staff can work from home, they do work from home. But, Keri, Sam, what would you add?

KERI SLEGH: I would add that most of our telework staff are staff that moved to telework are still teleworking. There are some exceptions to that. But to your point, Roshy, it's where they're really needed to be physically in the building, in order to support the practice. But we've rapidly, whether innovated, learned new tools, in order to work with each other in a virtual state. And we're now moving into a new phase, where many of our administrative support, our shared service organization, will continue to telework or work remotely for the foreseeable future.

And we're making investments and changes in policies to support that, along with expanding technology options for those teleworking. So many of our staff who are teleworking today, will continue to telework with the option of coming back on campus, when needed. If the work dictates them to be there, they need to be collaborative in a collaborative space that they can't do virtually. But they still have the opportunity to do that. Sam, anything you would add?

SAMANTHA HALVERSON: The only thing I would add, it's just information that my facility colleagues have said, that individuals who are returning to the environment, they're really trying to focus on the social distancing. And they are putting up more cubical walls, just to again have more barriers. So similar to how frontline staff are using shields, those that are behind the scenes have more cubical walls just to keep that space and distance.

ROSHY DIDEHBAN: We have maybe just one minute before we turn it back over to Jeff to close our session. I'm going to put our panel on the hot seat a little bit, and ask each of you to tell us, what was either the greatest lesson or the greatest challenge you overcame in the last several months? And how has that shifted the way you think about health care moving into the future? Dr. Breeher, would you like to start?

DR. LAURA BREEHER: Sure. So I think that probably the biggest challenge that we have overcome was, the need to think differently. We had done a lot of planning for a pandemic, specifically Ebola, and had a lot of processes and protocols in place. And when COVID hit, and it ramped up significantly, it was humbling. And we realized that the plan we had in place, that was very much people power, us making phone calls to every single one of our employees when they were exposed to notify them, wouldn't work with these volumes. And we really needed to think differently. So fortunately, we had resources in place to do that. And I think that it's turned out really well, but that was a little bit surprising.

ROSHY DIDEHBAN: Thank you, Dr. Breeher. So perhaps in quick succession, Sam.

SAMANTHA HALVERSON: Yeah. I would say, the need for communication, strong communication remains very important. We had so many workplace impacts that were happening to keep employees aware of that, instituted a lot of Q&A sessions, the use of different technology so that people could ask questions anonymously. And we have answered questions over and over again, which has provided the opportunity for employees to really understand where we're headed and how they're being impacted by all of this.

ROSHY DIDEHBAN: Great. Thank you. Charlie?

CHARLIE BIERMAN: Yeah. Probably the most significant issue, is the high risk workers. You feel for them. They have a medical condition, their age accommodation. And just, they're your co-employees. And I've taken a few calls from individuals. They wanted Mayo to do more for them. They're just hard discussions to have, balancing the employer's need to get through this, and the individual, who may have been up here, a long career at Mayo Clinic. It's a hard discussion to have.

ROSHY DIDEHBAN: Thank you, Charlie. So sorry we can't get to Keri or Mark. But I want to thank our panelists. Again, this was a really exceptional time together. And thank you for sharing all this incredible information. And with that, I'll turn it back over to Jeff.

JEFF POTERUCHA: All right. Thanks so much, Roshy. I'd like to thank our panelists for joining us today. As well as you all, for being a part of this discussion, on how Mayo Clinic is responding to workforce management issues during this COVID-19 pandemic. Want to make sure that, if you enjoyed this webinar and you're interested in joining us again with our COVID-19 webinar series, on October 14 we're going to have a discussion on COVID-19 vaccine development.

What's happening with that, and what that looks like. And then of course, if you are interested in claiming credit for today's webinar, you can go to our website ce.mayo.edu/covid0928. You need to go ahead and log on to the site, access that code box, and put that COVID0928 into that access code box. And you'll be able to complete this course and get your certification.

So once again, like to thank you for joining us today. And we hope you can join us for our upcoming COVID-19 webinars. Have a good afternoon.