Meeting of CRC with Provost Hu, Vice-President Shrivastav, MOTF, and PMAB Leadership
19 January 2021

Executive Summary

- Provost Hu provided a summary of the surveillance test and the supply challenges that were encountered. Access to supplies continues to get better.
- MOTF provided an update and responded to questions focused on vaccinations and DawgCheck.
    - **Vaccines** arrived on campus the week of Christmas. Dr. Russo and others led an initiative to gain hands-on experience with processing the vaccines and to refine the workflow for administering the vaccines. There has been a good uptake in participation, and more than 1400 vaccines have been administered to those in group 1A+.
    - Group 1B is challenging. There are potentially 8,000 to 10,000 individuals in 1B who will want the vaccine. We've spent the last two weeks working on identifying who those individuals are and learning what is needed to rank order them or sort them by priority.
    - A plan is being formulated based on data from multiple sources, including HR, information from the DawgCheck database, and responses to the recent survey. With relative weighting based on information about the risk level for subgroups, our intent is to identify people who are older with comorbidities, those who are frontline workers and have higher risk work contexts, and select from that body preferentially over those who are younger with no comorbidities within each of the subsequent tiers.
    - We need to wait until the state as a whole moves to group 1B before moving to that group on campus. Many things are not in our control – the frustrating issue of the supply of vaccines, the edicts of the tier structure, the need to work in concert with the community around us as we work our way through our vaccinations, and trying to be synchronized in our tier structure. **If we break those rules, we break the contract we have as a vaccine provider.** If we make policy that goes directly against the DPH, we run the risk of not getting any vaccine at all.
    - FAQs for **DawgCheck** help provide answers to questions related to who has access to the data, what data are available, how that information is being used, and how long the data are maintained. See "Information Privacy" on this page: https://dawgcheck.uga.edu/support/
    - **Testing** at Legion Field has transitioned from the nasal swab test to saliva testing. The process has been refined since returning for spring semester and is working more smoothly and efficiently now. Nasal swab testing can be requested if needed.
- PMAB reported they continue to respond to requests for assistance in determining mitigation strategies.
    - **There is significant concerns across PMAB membership about any large in-person event** that's being planned or considered that is not mission critical or critical from a programmatic standpoint for a unit. There's a lot of concern with PMAB membership about those events continuing to be planned and taking place given the current situation and positivity rates in our community.
    - Our local communities are at an all-time high in positivity rates, and a lot of the events and activities that we have that are outside of our academic setting mix those two populations. **It is**

very important to continue strong messaging about wearing face coverings, watching our distance from each other, washing our hands.

- VP Shrivastav provided an update and responded to questions related to instruction.
    - We **helped faculty transition to spring semester** with some moving online. **We added more large spaces and new technology was added to multiple classrooms**.
    - The **Consolidated Appropriations Act** has some major changes for education, particularly financial aid issues. **There's a component that is directly related to COVID relief**. We are keeping an eye on and working to address those issues and funding changes as soon as we get the green light to do that.
    - We receive questions related to why face-to-face or in-person classes continue to be encouraged, particularly with the upsurge in cases in the community as well as why there cannot be more face-to-face or in-person classes. The answer is basically the same.
        - **Why face-to face**: Wearing masks and six feet distancing continues to have the effect it was having in the fall, irrespective of the total number of cases, or even with the new variants. We've been looking very closely at the mitigation factors. As long as everybody's wearing masks and maintaining distancing, and sanitizing spaces and hands, the risk remains the same.
        - **Why not more face-to-face**: Whenever the space limitations prevent you from holding your whole class in person, you must break the class into smaller attendance sections. We've tried to find bigger spaces. We've tried to map more smaller classes into bigger rooms. Whenever space requirements permit that we've tried to do that, but it's the same six feet, social distancing constraint that limit us from both of these things.

The meeting was convened at 2 p.m.

In Attendance
Provost Jack Hu

Medical Oversight Task Force (MOTF)

- Dr. Garth Russo, Executive Director, University Health Center
- Dr. Shelley Nuss, Dean, AU/UGA Medical Partnership
- Dr. Marsha Davis, Dean, College of Public Health

Preventative Measures Advisory Board (PMAB) co-chairs

- Dr. Shelley Nuss, Dean, AU/UGA Medical Partnership
- Mr. John McCollum, Associate Vice President for Environmental Safety

Dr. Rahul Shrivastav, Vice President of Instruction
Dr. Kyle Tschepikow, Assistant to the President

COVID Response Committee

Co-Chair Janette Hill, Professor, Learning, Design, & Technology, MFE COE	Co-Chair Annette Poulsen, Professor, Sterne Chair of Banking & Finance, Terry COB
Secretary Stuart Ivy, Senior IT Manager	Asim Ahmed, President, UGA Student Government Association
Don DeMaria, Director, Washington Semester Program	Paula Krimer, Professor, College of Veterinary Medicine
Bill Lanzilotta, Associate Professor, Biochemistry & Molecular Biology, Franklin Arts & Sciences	Christine Scartz, Clinical Assistant Professor, School of Law
Cynthia Tope, Graduate University Representative, Graduate Student Association	Kari K Turner, Associate Professor, Animal & Dairy Science, College of Agricultural & Environmental Science
Janet Westpheling, Professor, Genetics, Franklin Arts & Sciences	Beth Woods, Executive Director for IT, Franklin Arts & Sciences

Dr. Tschepikow welcomed all to the meeting and expressed President Morehead's regrets that he was not able to join the group today, sharing:

As you know, the Georgia General Assembly has convened for the 2021 legislative session. President Morehead participated in a meeting with the governor's office this morning and he's participating in another state capitol

meeting right now. These types of meetings will be frequent for him during the session as he advocates for UGA budget priorities to our state leaders. You may have seen that all of UGA major capital projects were included in the governor's proposed budget last week. So that's great news for our institution. These projects include $21.7 million in construction funds for a new science building, $5 million in construction funds to upgrade Science Hill infrastructures, $5 million for a multi-disciplinary greenhouse complex among other projects. So hearings and meetings will be taking place on those projects in the coming weeks.

I also want to acknowledge that Provost Hu is joining us today. President Morehead invited the Provost to give this group an update on some of the supply chain challenges we have faced related to our surveillance testing program.

President Morehead wanted me to assure the group that as with the fall semester, the leaders across our campus who have been charged with responding to this crisis will remain focused on protecting the health and safety of our community, while carrying out our vital missions. He also wanted me to encourage you, as the spring semester gets underway, to draw on the successes of last semester, and to work together to make this one a success as well. And then he also has asked me to take meticulous notes today, so that I can share with him the comments and concerns that you raise during the meeting, and I plan to do so. I'll turn it over back to the co-chairs or to the provost. And my job would be to just sit back, listen, and take notes. Thank you.

Co-Chair Janette Hill: Thank you, Kyle, for that overview. Here's a brief recap of our activities since meeting with you.

- Our first meeting of spring semester gave us the opportunity to review comments and concerns from the university community.
- We prepared a report of our last meeting and shared it with University Council last month and we also sent that report to all of you.
- We've analyzed data from a Qualtrics survey that's been circulated to University Council members and the full university community. To date, we've received more than 1600 responses.

We're continuing to collect responses. We use the survey responses to inform our discussions with you about issues that the faculty, staff, and students would like addressed. We do have a few questions to focus our discussion today. But before we begin that, we know that there are some updates, including from Provost Hu and others.

Provost Hu: I can provide a summary of the surveillance test and the supply challenges that we encountered.

- In the fall we tested more than 40,000 faculty members, staff, and students, of which 37,300 were from Legion Field. The remaining tests were the saliva-based tests from pop up sites, including on the branch campuses in Tifton, Griffin, Gwinnett, and Buckhead at their request. I believe for this semester we will reach at least 40,000 tests, perhaps we will be close to 50,000 tests, by the time we finish this semester. Looking at last week, we've had a higher rate of testing.
- As of now, we have spent $6.2 million on testing. After adding together the cost of various components of the tests, we estimate that each nasal swab test costs between $60 and $65 per test. The Vault health

saliva kits, used at the pop-up sites in the fall, were closer to $85 a kit. Then you add staff costs including additional staff at Vet Med and nurses at Legion Field, mitigation efforts, housing for isolation and quarantine, PPE, etc., we estimate that our investment for mitigating, testing, and managing COVID is about $20 million or slightly over $20 million so far.

- I want to share with you the challenges that we faced in the fall supply chain. You know, we got our CLIA certification in the middle of June, and the Medical Oversight Task Force prepared to launch our own testing, in partnership with Vet Med and the Health Center.
    - Once we started preparing, we immediately worked with USG, DPH, Department of Public Health, to deal with testing kit and other supply issues. In July and early August, many universities wanted to do testing and supply was a challenge. So that was the first challenge we experienced around the end of July and the first part of August.
    - At the end of August, we faced another supply challenge. Hurricanes in the middle of the country interrupted supply chains. We got an emergency shipment of 1000 tests kits that arrived, I think, on a Monday so that we can continue testing without interruption. So that was a Monday of the first week of September.
    - In December, we faced additional challenges. The first was the shortage of pipette tips. Vet Med reached out to mobilize all the research labs at UGA who use such tips for research. We were able to gather several 1000 in time for our testing in January, thanks to the creativity of the Vet Med staff.
    - The day after Christmas, I got a call about the supplies needed for expanded testing for the first three weeks in January. Our typical steady state test is roughly about 450 tests a day. But we wanted to expand our testing for the first three weeks anticipating that holidays, gatherings, and travel would increase interest. We thought the interest in testing would be high, which is exactly the case. So our target was 1000 tests per day at Legion Field and 500 per day through the pop up sites. So we were concerned about the increased testing and the need for the increased supply. The supplier was unwilling to guarantee delivery of needed supplies until we initiated a standing order for the product. We did so as soon as we were told about this way to procure sufficient supplies. So I think we should be able to run our tests at the increased level for January and February and into the foreseeable future.

That summarizes some of the challenges that I experienced working closely with the Medical Oversight Task Force. Supply challenges remain real. In late July, or August, I attended a meeting facilitated by the U.S. Department of Health and Human Services, and the President's Task Force, with higher education leaders on testing. At that time, due to worries about insufficient supplies for testing, they discouraged universities from testing everyone. But as testing increased, manufacturers ramped up their production. I do think supply is becoming better and better.

Co-Chair Hill: Thank you so much for that update. That’s very helpful. Are there updates from the MOTF or the PMAB groups?

Dr. Russo: I probably should give just a brief update on where we stand since we've added vaccines into the mix. We received shipments of first Pfizer and then Moderna vaccine the week of Christmas. The first set of vaccines

that we received were Pfizer. These are vaccines that require super cold storage. They come dry, they have to be thawed, and then a diluent is added. You have about six hours to use those vaccines, or you lose them. So we worked to gain hands-on experience with them before we broke for the week of break. We refined workflow around what we learned from that experience.

We were comfortable with our workflows and so, we elected to stay open through the break and administer vaccine for the Monday, Tuesday, Wednesday of that week to those defined to be in group 1A – basically healthcare workers dominated that group from our perspective since we don't have any long-term care facility residents here. We had already worked on this list in anticipation of getting vaccines for group 1A. It was nice to not have the background work or distractions of regular work during that timeframe, and it was rewarding to see the faces of people who've been eagerly awaiting a vaccine to get their first one.

We've continued the process of dedicating days to vaccinating, inviting folks from the 1A group, and refining the membership of the 1A group to be as accurate as it can be. People just don't have the placard on their back that says that they are a health care worker, and changes in the definition of the 1A group to 1A+, which included 65-year old and older individual took place during this time. There are challenges in determining who has comorbidities since we don't keep medical records on our staff and faculty. The CDC appreciated this and assumed that 65 and over was a comorbidity, and, as a consequence, that demographic was added to 1A+. That has been well received. We've had good uptake in participation, and we have administered 1413 vaccine as of this week. We started with Pfizer with a 3-week break before the second vaccination, and so we've actually completed the cycle for the initial 77 vaccinees.

Next week, we'll have both Moderna and Pfizer vaccines to finish out a cycle of 2 vaccines for about 800 or more people.

The membership in the 1A and 1A+ group was intuitively defined. The definition of who fits in the 1B group is a little bit more challenging because it depends more on job description and function to the university as a critical worker. Also, group 1B is larger than the 1A group. We've spent the last two weeks working on identifying who those individuals are and learning what is needed to rank order them or sort them by priority. This prompted the survey that went out on Thursday night to all faculty staff and students who fit under our vaccination pod definition, which basically are people who are on payroll or who are enrolled in classes. The survey response thus far has been good. We will take that information, couple it with data we already have, and run queries against that to create an invite lists that is informed by logical parameters (desire for the vaccine, role risk, and co-morbidity for example).

Co-Chair Poulsen: I'd like to jump in for just a second because this has been one of the most frequent questions we've seen. To what extent will you be able to sort group 1B so that, for example, frontline workers such as custodians and dining hall workers who have constant interactions with many individuals, will be designated at the top of group 1B as opposed to those who more able to work from home or limit their interactions with others. How will you differentiate within group 1B? That's a question that everybody is asking.

Dr. Russo: The number of individuals within 1B and subsequent groups exceed the number of individuals we'll be able to vaccinate with one or two deliveries of vaccine at current rates. There are potentially 8,000 to 10,000 individuals in 1B who will want the vaccine. The recent survey is intended to sample from the full community. With relative weighting based on information about the risk level for subgroups, our intent is to identify people who are older with comorbidities, those who are frontline workers and have higher risk work contexts and select from that body preferentially over those who are younger with no comorbidities within each of the subsequent tiers. All of that technical work is being done by the Office of Institutional Research – they're the data guys. Again, the source of this information is from HR, information from the DawgCheck database, and responses to the recent survey.

Dr. Westpheling: May I may I jump in here? Dr. Russo that sounds to me to be very vague and unsatisfying. I work in the life sciences building, and the custodial workers that come to work every single day, who don't have the option of working from home or working remotely, have not received a single email about being vaccinated. And that seems unacceptable to me. There are people in Bolton Dining Hall, who stand behind a counter and serve hundreds of undergraduates every day, and we know many of the students are infected and asymptomatic. And it's not clear to me why you can't prioritize those people. This is really urgent for these people. I think the time for action has already passed. The custodian who cleaned my lab this morning can't get a vaccine.

Dr. Russo: That's not driven by our lack of desire to get vaccine to them.

Dr. Westpheling: Well, what's the problem?

Dr. Russo: We're working through a tiered structure that's imposed on us both federally and at the state level. So if I went right now, and just opened up a vaccine to let's say, the custodial workers that you're referring to, we'd be breaking the public health policy that's driving the distribution of vaccine.

Dr. Westpheling: This is urgent. People's lives are at risk. And it needs more than a kind of vague, "We're working on it." So I think we really need to have answers to this. People need to know where they stand, and how they can find out where they stand. How does a custodial staff person find out where they are in the line?

Co-Chair Poulsen: I think Jan's right; that frontline workers need special consideration. But we also know that there will be people who say that they also need special consideration due to their personal circumstances. So how do you balance that within 1B? The faculty member who's teaching 300 students at a time versus dining hall workers versus … how are you going to implement discretion within the group?

Dr. Nuss: You're bringing up some really good questions. They're hard questions and moral and ethical questions in many ways. If you had a 41-year old professor with morbid obesity, diabetes and hypertension who is teaching in-person classes, should that person go before a janitor or a food worker that is healthy with no comorbidities? That's what we're struggling with every day when we meet. There is a lot of opinions on this. Some people will say, well, I'm sicker than them. I should go first. It is very complicated. And I appreciate what you're saying, Janet and Annette. It is complicated. We wrestle with this at all of our meetings, multiple hours

through every week to try and come to the correct conclusion. The survey is going to give us more information about comorbidities of individuals. That's what Garth was talking about. We hope people fill it out, honestly, because there's no way to prevent people from saying that they have all of these comorbidities when they do not. There was a disclaimer on there that we hope people will fill it out honestly. As of now, we have no data about the health conditions of individuals at the university unless they're a student that has visited the Student Health Service. So you can see that it is complicated. You could come up with many scenarios of how to allocate the vaccinations within group 1B. You each have your own philosophy, and I bet if we queried all 10 of you, you would have a different opinion on this exact topic. So as a physician, I know I have my own ideas and Garth's would be different than mine. That's where medicine is not an exact science, unfortunately.

Dr. Westpheling: I'm not morbidly obese, and I don't have any existing conditions. And I've been vaccinated under state guidelines. The custodial workers in our building, some are overweight or have heart conditions. They can't get a vaccine. That doesn't make sense to me. We need a resolution to this; we need a plan forward. And we need to get shots in the arms of these people. And so whatever that takes, we just need to do it.

Dr. Nuss: I hear you. And there are stories like this in every state, and every Health District.

Dr. Russo: We need to wait until the state as a whole moves to group 1B before moving to that group on campus. We are being told that we will move as the state moves, so we will not get out of sequence.

Dr. Lanzilotta: To consider this in a different way. These frontline workers are at the point of service. And we've heard from the state and the Board of Regents that they really want to get us back to in-person instruction. So it seems to me a priority would be to make sure that people who are at that point of service, who are dealing with a large population of asymptomatic people, get the vaccination. Let's make sure the point of service people are vaccinated. And one other comment, why are we relying on a survey when much of this information can be pulled from HR?

Dr. Russo: The survey is about as scant as it can be. We are only asking for information that we cannot otherwise get from HR or other places, especially medical information. We know who the frontline workers are. We have an absolute commitment to do our very best to protect them, just as if they were our own families. There is no attempt to try to sort the order of importance on other things than the front line. I understand that as well as the rest of you do. I truly understand that. In every conversation that we've had regarding who we worry the most about being underrepresented, are people who don't have access, don't have privilege, and must work in situations where there is inherent risk by just sheer numbers of exposures. There is absolutely no lack of empathy for those people and their need to have a voice.

Dr. Poulsen: Dr. Russo did you have any additional comments before moving on to Mr. McCollum for a report from the Preventative Measures Advisory Board?

Dr. Russo: The issues you've shared are frustrating to me too. But we are part of a public health effort and with that comes the compromises and inanities that come with averaging everybody's experience over the whole and not being able to distill things down to an individualized basis. I've done my very best to keep myself open and

accessible. So every email that's gone out, every invite that's gone out, has come directly from me, and you could reply to me directly. I've done my very best to respond to every single individual. I will not be able to do that when it becomes 10,000. I have absolute ownership over how important this is and that there needs to be individual attention that people can feel in the process. I have great respect for that.

Many things are not in our control – the frustrating issue of the supply of vaccines, the edicts of the tier structure, the need to work in concert with the community around us as we work our way through our vaccinations and trying to be synchronized in our tier structure. I'll just say this, because it really is important to understand. **If we break those rules, we break the contract we have as a vaccine provider, we lose the stewardship of the vaccine and we only hurt ourselves.** So we have to be very careful to follow the rules as best we can. There's some wiggle room in there but in general, if we make policy that goes directly against the DPH, we run the risk of not getting any vaccine at all. And that, that at the end of the day, is the epic fail. I'm not going to let that happen.

Co-Chair Hill: Dr. Russo, we appreciate the hard work that all of you are doing. We know these are very difficult decisions. We also just want to make sure to point out a compliment before we move to Mr. McCollum and his report from PMAB that we have heard from the university community regarding the vaccination process, especially for those in group 1A in terms of getting assistance and getting registered for the vaccine, and then the vaccination process itself. We have heard from many, many people about how safe they felt when that happened, how professionally it was handled from the time they checked in until the time they walk out the door. So a lot of praise to the UHC and you in your leadership role there for making that happen. Because I think it's really reassured the people that have received the vaccine so far, that this is a good process and one that they know that they can trust and rely on. So thank you for that hard work. Mr. McCollum?

Mr. McCollum: PMAB continues to respond to requests for assistance in determining mitigation strategies. We meet two times a week for about 90 minutes each time. It takes that long for us to work our way through the requests of the week and provide the appropriate types of responses for those requests for assistance. We've seen an increase in the area of special events – activities that came to a screeching halt back when the pandemic started. We're beginning to see a lot more requests to provide assistance and information recommendations to those groups.

There is significant concerns across PMAB membership about any large in-person event that's being planned or considered that is not mission critical or critical from a programmatic standpoint for a unit. We're getting a lot of requests for assistance regarding social-type of events. There's a lot of concern with PMAB membership about those events continuing to be planned and taking place given the current situation and positivity rates in our community.

So our primary message is to remind everyone that consistently implementing our preventative measures is still the best defense against the spread of the virus. Our local communities are at an all-time high right now with positivity rates, and a lot of the events and activities that we have that are outside of our academic setting mix those two populations. It is very important to continue strong messaging about wearing face coverings, watching our distance from each other, washing our hands. Those are still our best protections and despite all

the excitement about vaccines; we really need to continue that messaging. When you are out in the community, you see the great difference between campus compliance and community compliance when it comes to those basic protective measures. The mitigation strategies are our real primary defenses until the vaccine is widely available. So until we get to that point, which is still potentially several months away, those protective measures are very important. So we just want to be sure we're keeping that message out in front of everybody.

Shelley, do you have anything to add? Shelley, by the way, is co-chairing PMAB at this time.

Dr. Nuss: We're really concerned with the positivity rates in our surrounding communities that have been at all-time highs. Our area hospitals have been stressed with capacity issues that did get some relief here over the past four or five days, and we're hoping these are positive trends. UGA's positivity rate is about where we were pre-holiday. As of now, we have not seen an increase since arriving back to campus. We don't have a full week of classes yet though, although testing was available from January 4 on.

I want to reiterate what Janette said. I've heard nothing but outstanding things about the process going on at UHC in terms of receiving the vaccine, getting your follow up appointment time, etc. From the time you go in, it moves very smoothly and everyone feels very safe about it. They worked really hard to operationalize this in a matter of a few days from Christmas Eve until the 28th to get people in there so that we can start getting our campus safer. Every time we put a vaccine in someone, it is a safer campus.

I do want to point out, although we're a closed pod at UGA, there are 50,000 people here that are over the age of 18 at UGA. Oconee County probably has 30,000 people, maybe 25,000. We have to do more than all of Oconee County combined at UGA. And so it's the vaccine's limited availability that's driving some of the issues with getting the vaccine out quickly. We depend on Pfizer and Moderna and we are at their whim really when we receive the vaccine. If we get 10,000 vaccines next week, Garth has a plan to get them into arms as rapidly as possible, but we're not getting 10,000. We get a little here, a little there and that's a challenge. Hospitals are where most of the vaccine is going at this point. The Piedmont System (not just locally) has put almost 25,000 vaccines into people at this point. The hospitals are getting more right now than universities.

Dr. Davis: Yes, the MOTF has talked about a plan that can move staff from surveillance testing onto vaccination quickly when needed. We have talked through scenarios of this once we have more vaccines on how to administer it quickly. We have talked through those contingencies.

Co-Chair Hill: That's really helpful, thank you.

Dr. Westpheling: If you have a plan, could you articulate that plan? There is no plan understood by the faculty, students and staff of the university. If it's still in progress, that's fine. But if you in fact have a plan, it would be good to articulate that.

Co-Chair Hill: Thanks, Janet. We do want to move on to another set of questions that we have. So we do have several questions that came in about DawgCheck. This also relates to the refresher course that we are all doing by the end of January. Language in the refresher course implies that you must use DawgCheck before coming to

campus and you must check the box that you will comply in using DawgCheck to have the training counted as completed. Would it be possible to have some kind of FAQs updated to indicate several areas of information related to this, such as who has access to the data, what data are available, how that information is being used, and how long the data are maintained? We've received several questions from people when they're taking the class and all of a sudden, in order to, to confirm that you have completed the class, you have to agree to comply with using DawgCheck. But then they have questions about the data, as noted above. We can send you those specific questions, if that would be helpful.

Dr. Russo: I see no reason that we could not put the FAQs together for that. We can queue them up, answer each one of them. That'd be great.

Dr. Hill: That would be fantastic. Thank you.

Co-Chair Poulsen: There remains tremendous concern about why can't we have mandatory testing. However, we know President Morehead has answered this question in multiple settings. Nevertheless, we want to reiterate this concern amongst many in the University community.
In a related question, how has the transition from the nasal swab test to saliva test been going at Legion Field? We understand there are startup costs, but we hear concerns about, for example, that the test takes longer for the individual than the nasal tests. Are the new tests going smoothly? Will the changes in the testing methodology have an impact on participation? Overall, how is the new process working?

Dr. Russo: Anytime you change a process, you find out things you didn't anticipate. It does take a little longer to do the sampling piece. A nasal pharyngeal swab in skilled hands takes about 10-15 seconds to complete the sampling. It takes longer for an individual to obtain a saliva sample. The methodology in terms of the kit that collects the sample is one that can be optimal or not for the user. How to accommodate the variations and number of people who are acquiring saliva, while still continuing the process as a workflow step has been refined over the course of this last week.

There has also been concern that the straw used to collect saliva in this particular kit is difficult to handle. It's hard to know how much saliva has been collected. We have looked into this and acquired different sample kits that work a little bit more easily – like a funnel rather than a straw. That should make the process of acquiring the saliva specimen a little bit quicker.

So over the course of the last couple weeks, a lot of a lot of changes have occurred to refine that process and to care for the individuals better. In addition to those noted above, managing the space that's available and keeping six feet of distancing between people has been an issue. We are using pylons and putting up extra tents to cue people to go to spaces that are more distant apart. We have improved signage. The commingling of the older Vault kits with new saliva methodology created some confusion. The methodology at Legion does not require any fasting while the Vault kits did. You just go up, give your saliva, move on. We are not commingling the two types of kits anymore. I think the steps that have been introduced will leave us with a much better smoother steady-state, time from start-to-finish or maybe just a tad bit longer. The overall orderliness of it, and

the understanding of how you build a line and build an exit that are in balance with one another, there's a lot of learning there.

Also, this is a time when we challenged ourselves to have a significantly larger number of tests per day. But to be quite honest with you, we're not meeting our capacity there as much as we would want to with the testing. So there are lots more opportunity to get tested than what has actually occurred.

Co-Chair Hill: Thank you so much. We have we have heard even as early as this morning, that the process is smoother than it was earlier this month. So congratulations on getting some of those kinks worked out.

Dr. Russo: It's not acceptable to invite people to a place where they can't keep distance and get their tests processed quickly. We get that.

Co-Chair Hill: We appreciate that. Provost Hu, you wanted to add to this?

Provost Hu: If I can make one comment about the difference of the two methods. It's only in the collection of samples that the nasal test and the saliva test are different. The diagnostic lab testing is identical. Between swab and saliva, the swab has to be a sequential process, where professional nurses are doing the swabbing. So it has to be sequential but with saliva under our current process, once the individual is given the sample tube, he or she can either stay in the tent or go outside and into a smaller tent. So overall throughput can be much higher, as opposed to the sequential process. Even though each individual may spend a longer time, overall throughput will be much higher.

Co-Chair Hill: Thank you, Provost Hu. We do have some questions related to instruction. I apologize, Dr. Shrivastav, for not inviting you to give an update at the beginning of the meeting. We jumped into questions and that sent us down a path. But before we ask our questions about instruction, do you have an update that you'd like to provide for us about where things have been the first week of classes?

VP Shrivastav: From what I've heard, things are off to a reasonable start. We spent much of late fall and into the break doing two major things. One was helping faculty transition to spring semester. Some needed to move online. That process has worked out as we expected. We also added more large spaces like I shared last week. New technology was added to multiple classrooms. That was going on all the way into Tuesday night, early Wednesday morning. But all the classrooms that we're scheduled to be updated, were updated, so that part has gone well. The other big job we've done, which mostly remains hidden, is to manage enrollment. That's critical for a number of reasons, so there was a lot of effort, but those numbers have worked out as we had hoped for. So that part is done. A third big thing that happened was the Consolidated Appropriations Act, as you may have seen, which has some major changes for education, particularly financial aid issues. There's a component that directly related to COVID relief, and then a lot of larger, longer term changes, many of which had to be put into play almost immediately. We are still waiting for some clarifications from the Department of Education on that front, but we are keeping an eye on and working to address those issues and funding changes as soon as we get the green light to do that. So those were the big three things on my part, in the last month. I'm happy to expand on any or take your questions.

Co-Chair Hill: Thank you so much. We have received, we have continued to receive a lot of questions about why face-to-face classes or in-person classes continue to be encouraged, particularly with the upsurge in cases in the community. A lot of people that have given us that question. Do you have any remarks in that regard?

VP Shrivastav: Wearing masks and six feet distancing continues to have the effect it was having in the fall, irrespective of the total number of cases, or even with the new variants. We've been looking very closely at the mitigation factors based on DPH, or CDC or the MOTF guidance and nothing has changed from that perspective. As long as everybody's wearing masks and maintaining distancing, and sanitizing spaces and hands, the risk remains the same. And that's basically the reason why our preference to do instruction a certain way has not changed.

Co-Chair Hill: Another question that we've received is why not more in person? What if we want to fill the classroom? Why aren't we allowed to do that?

VP Shrivastav: The answer is the same. Whenever the space limitations prevent you from holding your whole class in person, you must break the class into smaller attendance sections. We've tried to find bigger spaces; there's five or six new, bigger spaces. We've tried to map more smaller classes into bigger rooms so that you have more options for everybody in the classroom at the same time. I know a lot of faculty prefer that over hybrid or even online. So whenever space requirements permit that we've tried to do that, but it's the same six feet, social distancing constraint that limit us from both of these things. So unfortunately, same answer for both those questions.

Co-Chair Hill: Understood.

VP Shrivastav: I can tell you, when I finish this meeting and go back to my email, I'll probably have one or two complaints about why aren't we more online and one or two complaints about why aren’t we more in person.

Co-Chair Poulsen: Thank you. I believe we've crossed the hour mark. We have a couple of points on communication that are relatively short. I think it might best to send those to you for responses as appropriate. We want to take the opportunity to say thank you. All of the leaders that are here are contributing so much to the UGA community and we appreciate it. And we really appreciate the opportunity to talk with you and that the answers we get when we ask questions are straightforward and to the point. Thank you very much for working with us. We're doing our best to get voices from the UGA community to you and to get your voices back to the UGA community.

Co-Chair Hill: Thank you so much. I'll echo what Annette said. Thank you everyone.