Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
June 28, 2017

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Speaker: I'm Gen Buser and I've been asked to be the chair and take over after Mary Shanks so thank you Mary again for your, your commitment to this for the past couple of years. Uh, so we'll begin today first with the call to order and then roll call. So again I'll just introduce myself. I'm Genevieve Buser. Uh, I currently work in pediatric infectious diseases at St. Vincent's Hospital with Providence. We'll go around to my left here.

Next Speaker: Uh, Judy Guzman, pediatric infectious diseases **** and, uh, part-time consultant to the HAI program.

Next Speaker: I'm Sid Spelldown. I manage the communicable disease section here at the Oregon Health Authority.

Next Speaker: I'm Rosa Tamara. I'm an epidemiologist in the HAI program.

Next Speaker: I'm Mary Post, director of infection prevention for the Oregon Patient Safety Commission.

Next Speaker: I'm Laurie Murray-Snyder, project manager at Health Insight on the HAN project.

Next Speaker: I am Thomas Stuebner. I'm the new executive director of the Oregon Patient Safety Commission.

Next Speaker: Hi I'm Rebeca Felwalk. I'm director of public policy for the Oregon Association of Hospitals.

Next Speaker: Paul Cieslak, medical director for communicable diseases of the Oregon Health Authority.

Next Speaker: Uh, Diane Roy. I work for the HAI program and I'm a research analyst.

Next Speaker: Lexi Jung. I'm an epidemiologist with the HAI program at the Public Health Division.

Next Speaker: Dat Tran, public health physician with the HAI program here.

Next Speaker: Hi, I'm Monika Samper, HAI reporting coordinator **** assist with HAI program.

Next Speaker: Thank you. So that's everyone in the room. Uh, please let us know, uh, audience on the phone how we're doing with the sound here if you can hear us all clearly. So if I could ask the folks on the phone to go ahead and introduce themselves please.

Next Speaker: This is Gretchen Cook, Oregon State Board of Nursing.

Next Speaker: Kelli Coelho, executive director **** representative for the **** centers.

Next Speaker: **** go ahead.

Next Speaker: Vicky Norbeen, nurse consultant with **** and infection control prevention corporate coordinator.

Next Speaker: Todd Preston the representative at large for long-term care facility.

Next Speaker: Chris Pecuty, medical director of infection prevention and control ****

Next Speaker: **** Community Hospital.

Next Speaker: Hi this is **** I'm with Oregon Health Authority and **** program.

Next Speaker: This is Debra Petora with, the Department of Human Services.

Next Speaker: Anyone else who just joined? It's great to hear some familiar face, familiar voices on the phone so thank you everyone for joining. So I believe the next order of business is to approve the minutes from March 2017. So anyone would like to start that out?

Next Speaker: So are there any concerns with the minutes or?

Next Speaker: Would somebody be willing to approve them? Or at least ****?

Next Speaker: Is there a motion to approve?

Next Speaker: A motion to, thank you. Is there a motion to approve the minutes out there either in the room or on the phone?

Next Speaker: **** motion ****

Next Speaker: Thank you Kelly.

Next Speaker: Is there a second? Do I need a second? Uh, Mary **** a second. Okay.

Next Speaker: ****

Next Speaker: Okay we have a second in the room. Another official number and in regards so thank you everyone. Um, and please if you didn't have a chance to look through them, um, maybe you know take a little time at the moment. I see some good stuff that was covered back then. Uh, then in regards to the membership I think Rosa Tamara here is gonna actually do some updates on the membership as part of the HAI committee.

Next Speaker: Yes. So um, we do have some familiar faces and voices and also some new ones too so I just want to say welcome to those of us who are, you know, new to the meeting. Um, I'm you know it sounds like we've had a chance to do a little introduction and because of these changes we've updated a draft version of our roster. So those of us in person here at the meeting can find a paper version of the roster at the table. And then we'll also send the draft roster as well. Um, and if you have a chance, uh, to go ahead and look at your information on the roster, for members will be on the roster and then a few of the program staff. So, um, if you do have c chance to take a look at your information and just let us know if anything needs to be updated, um, feel free to just – if you're in the room you can mark it up on the paper and give it back to any of us or leave it on the table. If you're remote, um, you can just email me, uh, so we can make sure we have all of your credentials, titles, contact information, all that good stuff. And the name change as well so if there's a name changes to be made to that, um, feel free to let us know. I know we do need to get some name change for some of us as well. Um, as a friendly reminder we're waiting for a few CVs to be submitted, um, in order to put nomination paperwork in place. So feel free to email those to me and if you're not sure if you need to get your CV to me, you can also email me and I'll let you know. And, um, finally just really briefly, we have four vacancies on our advisory committee. Um, so we're really hoping to recruit folks to help fill in these gaps where possible. Um, if any of you are interested in these positions you know you can't hold more than one formal position at the same time is my understanding. Um, but if you're interested in these positions or you can promote these amongst your contacts that would be so much appreciated. So we have, um, one vacancy for a hospital administrator with expertise in infection control at a facility with fewer than 100 beds. Health care purchasing representative. Representative of the Department of Human Services and Health Insurer Representative. So those are the four vacancies we have at this time and then, um, we are also always looking to engage additional consumer advocates and representatives so anyone who has thoughts about some of those folks who became kind of pulled in to represent the patient and consumer voice, that would be excellent too, so.

Next Speaker: ****

Next Speaker: Sure, so the four are hospital administrator with expertise in infection control.

Next Speaker: Or at least shall we say interested?

Next Speaker: **** it was interest in infection ****

Next Speaker: At a facility with fewer than 100 beds. A health care purchasing representative. I understand that one has traditionally have been tough to fill. Represented of the Department of Human Services and then health insurer representative which I also hear **** has been a

historically tough one but we do want to aim for a full complement of members. So any kind of promotion you can do. Any thoughts you have. I'm happy to reach out. You know I think anything we can do to engage these folks would be great so. And I know we often have questions that we wish we had that kind of viewpoint **** that detail especially around infection control and, uh, use of, **** and things like that.

Next Speaker: So is there a **** on the structure of the email ****

Next Speaker: Certainly you can email me, call me.

Next Speaker: What's your email?

Next Speaker: My email **** maybe my phone number is easier. Um, I can also send this out. I know I kind of listed this – oh thank you. He has this on the roster. But uh, my number is 971-673-1074 and I will also send these vacancies out in an email as well. Um, and just for the folks on the phone it was difficult to hear some of the names so if you wouldn't mind just emailing Rosa to let us know that you were a part of this call that would be great. Thank you.

Next Speaker: ****

Next Speaker: Oh yes, I'm sorry someone just – we have a new addition to our group here and if you wouldn't mind just quickly introducing yourself.

Next Speaker: Gina Ramos. I'm the **** Oregon State ****. And I'm a member of the ****

Next Speaker: Good to see you. Thank you for joining us today. So we have a lab representative for those on the phone. So anything on the updates for the minutes report?

Next Speaker: No. I think that's all I have.

Next Speaker: Great.

Next Speaker: So it looks like next we're going to hear from Alexia about, uh, 2017 conference. And while we're getting that ready any questions or concerns on the phone please let us know. Thanks.

Next Speaker: I'll tell you in advance.

Next Speaker: All right. Can everyone hear me? On the phone?

Next Speaker: Why don't you pull, take that closer to you. There you go.

Next Speaker: If you guys can't hear me on the phone please speak up now. I can get pretty soft spoken. Okay so just gonna go through the outbreaks that have been reported, um, to us ACDP - Acute and Communicable Disease Prevention program between March 1st, 2017 and when I pulled the data which was June 22nd of 2017. So since March 1st there has been 112 outbreaks

reported to us, um, the majority of which were GI in nature. So 46 of these outbreaks were norovirus and 25 of the 46 occurred in long-term care facilities and five occurred in hospitals. And then we also had a handful of norovirus outbreaks in schools and daycare centers, restaurants, others and at camp. So tis the season where we've been seeing a lot of norovirus recently. We also saw 27 unknown GI outbreaks so these are what we call norovirus-like. Um, these outbreaks usually have some sort of vomiting, diarrhea, stomach cramps and what not. Fourteen of these 27 occurred in long-term care facilities and one occurred in a hospital. And we had eight of these that occurred in schools and four in restaurants. We also saw a handful of other, uh, etiologies for GI outbreaks. We had a mixed norovirus slash salmonella outbreak that occurred at a camp-type setting. Um, we had four salmonella outbreaks one of which I'll touch base on later. Um, we had an E. coli, or two E. coli 0157 outbreaks, one in a school and one that was food borne so food related. And then we had two rotavirus outbreaks one of which occurred in long term care facility and then the other that occurred in a school. Um, I'm happy to report that respiratory outbreaks declined drastically in the past 3 months. So we only had six influenza outbreaks reported in these 3 months, all of those occurred in long-term care facilities. We did see two RSV, uh, outbreaks that occurred in long-term care facilities. And then we also had, um, four pertussis outbreaks that occurred all in school. We, we had reports of seven unknown respiratory outbreaks, um, during this time period too which occurred in schools. And then a handful in others. You can go to the next slide. Okay, so moving on to the next slide, so healthcare-associated infections accounted for 51 percent of all the outbreaks reported from March to June. So that was 57 of them. The most common etiology among the HAI outbreaks were norovirus or noro-like. And then the most common strain of norovirus among, um, the hospital associated infection or the HAI, the outbreaks that occurred in healthcare facilities were G24 un-typeable which is similar to what we're seeing, um, in other settings as well. We're seeing a lot of G24 un-typeable. And so the table on this page is showing the etiology and the long term care facility type and so, uh, facility types are memory care, assisted living facility, skilled nursing facility, uh, facilities that were just reported as nursing home, retirement communities and mixed. So these are outbreaks that, um, occurred at a facility where both say the skilled nursing facility and assisted living side were both infected by the same outbreak. And so if you look, um, across the totals, the most, the most outbreaks occurred in assisted living facilities followed by skilled nursing facilities. So, we can go to the next slide. So just a couple of outbreaks of interest, um, we did have an Hepatitis A outbreak that, uh, that happened. So what happened was that there's two confirmed Hepatitis A in food handlers that work at the same restaurant or same two restaurants. And then two additional food handlers that had symptoms that, um, were compatible with Hepatitis A but they, those two cases actually didn't meet our case definition because they both had, uh, negative IgMs and no LFTs liver function tests to confirm the cases. And so Multnomah County organized immunization efforts, um, to immunize people that might have eaten at these two facil – er two restaurants during specific time frames. Um, Multnomah County did really, really did an awesome job mobilizing 'cause they basically had like a day to get everything set up because the window for, um, providing vaccine and Ig was closing pretty rapidly. And so the, and then we had no additional reported cases, um. And then the other outbreak or I guess the other etiology that I would like to mention is salmonella and live poultry. And so, um, CDC is working with multiple states, Oregon included, to investigate, uh, multiple clusters of salmonella. A lot of these cases are reporting exposure to live poultry. Um, there's currently ten different salmonella serotypes and 18 different PFGE which is pulse field gel electrophoresis patterns, um, associated with these, this multiple cluster.

CDC is calling it one cluster. There is eight current, um, Oregon cases. And so, um, baby chicks are really cute, um, but they are also as, our Department of Ag partners like to call 'em, bags of salmonella. And so when kids are picking them up and kissing them and hugging them, um, there is potential to expose yourself to salmonella because, uh, baby chicks do carry salmonella. So, um, we've been working really closely with the Department of Ag to do trace back with, um, like feed stores that sell, uh, baby chicks. They have a database in place so that when we tell them that like someone went and bought chicks at this feed store at this state and this was the breed they can go back and trace the chicks from the, um, the hatchery. So next slide. And so I just have one more slide. This is from Department of Ag the last slide. It's the salmonella prevention. It's in your hands. Um, just reminding people about egg safety, poultry handling safety meets safety so you can find more information on their web site. Um, that is all I have. Any questions? Yes, Jen.

Next Speaker: I have a question. Uh, this is great. Thank you very much. I was sort, I was curious because you know part of you were talking about that outbreaks especially in healthcare settings is to understand how we can minimize their spread. And so I'm curious if we have any data around the relative number of cases in each of these settings. Are we catching them any earlier? Are we **** 5, 10 years ago, are we limiting their spread? You know is there less, uh, fewer secondary cases perhaps. Um, and I'm curious also if there's a difference between settings or just as a hypotheses we've worked a lot with skilled nursing facilities. Are they, you know, on top of it? Or does it tend to go longer at assisting living or independent care? Just maybe give us, I don't know, looking at the data in a couple of different ways to give us some ideas of how we could, um, reach back to those healthcare facilities, say, "Hey great job," or ****.

Next Speaker: Those are great points. I am not prepared to answer that question right now.

Next Speaker: That's okay.

Next Speaker: But –

Next Speaker: No, no, it's okay. I was just kind of throwing that if may be, uh, a way to help us understand, uh, if we're making any movement.

Next Speaker: Yeah, that sounds – I don't know. Paul do you have any historical knowledge about this?

Next Speaker: Well I don't have any data, uh, at my fingertips on how long do the typical outbreaks last. My, my general sense is that you know at least the norovirus ones, uh, are ending a little bit more quickly. And also that the long term care facilities where they primarily happen, uh, are reporting them much more reliably than they were say 5 years ago even. Uh, the 112 outbreaks in less than 3 months is a huge number for us. I mean I have typically been telling people we get 200 to 250 outbreaks a year but obviously in less than a quarter to have 112 outbreaks is kind of outpacing our, our average. Part of that is due to the fact that we had kind of a bad norovirus season and a bad influenza season. So, uh, it was an H3N 2 year a lot of, uh, influenza A respiratory outbreaks in long term care facilities. And I think we're getting better at those in terms of, um, you know quickly recommending that they put everybody in the facility on

a **** inhibitor to as prophylaxis like as soon as we become aware of a couple of cases in a, in a nursing facility. But I don't have any data on actual **** or the number of cases –

Next Speaker: That's okay. It doesn't have to be right now. I was just **** generally some future ideas and are there, I mean just having done this in the past there being some barriers to actually getting **** facilities to work with the health department.

Next Speaker: I feel like there's been less resistance from long term care facilities to, we'll both call on the outbreaks and then also to take our recommendations as well. So, um, so I think it's been going really well.

Next Speaker: That was my question. Any questions or anything from the audience or the phone audience?

Next Speaker: Okay well thank you. I know there's a lot of folks on the phone too in long term care that have worked very hard to, to improve their response to, uh, healthcare-associated infections so thank you. So looks like next on our list is the ICAR update. That'll be given by Mary Post.

Next Speaker: Um, next slide. So, um, without going into a lot of details the Ebola grant again was really developed almost 3 years ago, um, to, to really focus on **** the infection infrastructure in the state and our response to, um, different emerging pathogens. And then there also was just **** we try and strengthen in general infection prevention practices across the continuum of care. Next slide. Um, one of the components of the grant was to provide, um, the ICAR consultations or ICAR – when I say consultations we have funding to provide 95, um, general infection prevention consultations over the 3-year period. Again our plan was to for better or worse, provide consultations across the continuum of care, um, so we're not just focusing on nursing homes or dialysis. It's all facility settings. Um, to date we've completed 35, we are running behind. Um, we had a different model where instead of doing, um, virtual, um, conducting the consults over the phone we actually go onsite. Takes a full day, um, to do the consultation. It involves staff reviews, audits, observations and policy reviews. Next slide please. So to get us caught up because we will deliver and complete all consultations by the end of the grant cycle, um, we are bringing on board and signed contracts with three certified infection preventionists and we'll be adding a fourth. It's summer. We will be hitting Oregon, um, focusing mostly on, uh, a lot of regional, um, outlying areas when we know the travel's better and then we'll be hitting more metro areas, um, later in the fall. Um, we will be, uh, working with HAI team to try and identify once again facilities that we'd like to offer the consultations too based on outbreaks and, um, and their infection rates. We currently are discussing trying to integrate. One of the new, um, strategies for this year's grant cycle which is to incorporate the targeted assessment of prevention strategies. And my understanding is we're required to focus on Clostridium difficile infections for that. So, um, that will really impact hospitals. Um, though it will not impact other facility settings and we will be, um, working with 11 hospitals, uh, for the consultations. So next slide please. Um, so just, just in terms of some findings from all the, uh, domains, um, and all facility settings. Um, honestly hand hygiene is something, um, that always has opportunities that sometimes lapses. Dialysis facilities are running 90 percent which is really high. And these are actual observed practices. Long term

care facilities though we're running anywhere from 20 to 40 percent. It's actually been up in some ICUs that are running around 40 percent. So again I think this shows that we have to have continual monitoring and audit in place. Um, one of the common lapses we see is people forgetting to wash their hands after they remove gloves. And this is again in all settings, all, um, staff, um, environmental services, um, etc. Um, personal protective equipment, I, I feel pretty good that most settings have it available. In long term care facilities we need to make gowns more available than they are. Sometimes unfortunately people have to run out of the building to get a gown. And I think overall that's one thing we really want to be promoting with long term care is, um, really enhancing the application of standard precautions. Um, next slide please. Um, for respiratory and cough etiquette, um, for the most part signs are available especially during vital respiratory seasons. But we see lapses the rest of the year. And you will see it especially in like some of the dialysis facilities, long term care and other ambulatory settings. So I think again this is, um, an area of focus and education that we can work on. Um, antibiotic stewardships, um, programs. The good news is, um, more facilities especially acute care settings, um, are rolling out antibiotic stewardship programs. But big lapses when you move into critical access hospitals where for instance they maybe don't have a pharmacist on staff or a pharmacy available. Um, and certainly in other settings, long term care they're just getting started. We are starting to see some reports though, some policies being put into place. They are aware that they will be required to have antibiotic stewardship programs in the future. So, um, overall I think there's a need for a lot of support for facilities, um, especially when you move outside of the larger acute care settings for, um, assistance with antibiotic stewardship programs and materials. Um, when I do do a minimum of five audits when I'm onsite and chart reviews. When I've done the audits I frequently find and again across the continuum even in hospitals that there is no indication for the treatment that's written and, uh, no date to discontinue. And one of the common workarounds I see is somebody writing continued until discontinued. Clever. Next slide please. Um, injection safety and point of care, uh, one of the kind of lapses I'm seeing, um, and again this is mostly non-acute settings are the glucometer, um, that is in use is not approved for multi-patient use. Um, or it hasn't been, um, given to specific residents. Um, a lot of times people don't know. They're not familiar with the type of disinfectant they should be using and the dwell or contact time that needs to be used with that glucometer. Um, so we have some opportunity for education there. We do have success in that I've never seen insulin pens being used. We always have, um, single use lancets. Um, and I'm not seeing in most areas multi-dose vials being shared. I will tell you in the ORs that we are still having issues with multi-dose vials being used in the anesthesia cart and then sometimes you'll see that also in the recovery room. Um, let's see, um, again lancets are observed, uh, for scrubbing the tubs sometimes in the OR, um, and then, um, also with just knowledge and again I think this is part of the learning curb. For some healthcare workers they were trained that they didn't have to, um, disinfect the rubber septum when they opened the vial. And that of course is something many of them have to unlearn. Um, and they now have to learn to do that. Um, and then again, um, across the board, um, one of the things the CDC is really trying to initiate, um, and have facilities put into place are better, um, drug diversion policies. And ensuring that there is a process in place for facilities to notify infection prevention and involve them in follow up to assess whether there is a risk with airborne pathogen transmission and if so, what type of follow up needs to be done. And there need to be stakeholder groups for that. So that's just overall again I think we can work on developing as a state. Next slide. Um, inter-facility transport communication, this group knows more than ever. We have a lot on the book. Really falls through the cracks a lot. And so I know

that we have some initiatives where we are gonna work on trying to improve the requirements for written communication, um, but again across the board, um, you'll see a lack of follow up for recognizing when, um, there are pending cultures or if culture results come in that people contact the receiving facility about those results. Next slide please. Um, OR observations, one of the common things I see is, um, some lapses in how the skin disinfectant should be applied especially CHG and, um, sometimes they're not following the actual drying time that's required. I will comment on the best practices I've observed with, um, OR room turnover which is somebody is actually assigned to oversee the room turnover and the disinfection and then they will come in with a lot of wet saturated, um, rags if you will with the disinfectant. Place it on the different surfaces so you can visually see the surfaces in the room that still need to be cleaned. I think that's a great, um, especially when you have 10. Nine of 10 people in the room cleaning all at the same time. It's a key way to communicate you know what, what still needs to be disinfected. Next slide please. Uh, in terms of device free processing again we see lapses in quality control, um, and documentation. Issues with brushes being used not being the right size. Um, occasionally I actually observed immediate use sterilization and have identified from those I'm watching some gaps or lapses in procedures. Um, and again any time there is a lapse, um, policies need to ensure infection preventionists are in fact notified and again in rounding **** some time when that hasn't occurred. Um, hospitals have policies in place for, um, and again we want to see the hospitals having policies and procedures in place for the stakeholders. They would convene should they have, um, lapses or gaps in, um, infection prevention practices. Who would be at the table to make decisions about follow up and communication activities. Next slide please. Um, other findings. Um, outside the acute care metro area hospitals a lot of hats are being worn by one individual, um, and you certainly see it in, uh, the different facility settings and especially critical access critical access hospitals. Um, we've identified environmental services needs to have additional training. Um, and I've listed you know some of the main strategies of things that we need to focus and work on. Dialysis issues with station disinfection in between patients is occurring. Next slide please. So what are we doing to address these gaps? One is we are rolling out, um, a series of five, um, training programs for environmental services. Um, we've developed a lot of observational competencies. There is a workbook with training materials and tools and policies that can be adapted. These are the dates and the locations. Um, we're charging $25.00 which is nominal fee for the course and materials. Um, next slide please. Um, these are the objectives for the workshop which since everybody hopefully has slide I won't go through all the objectives. Next slide please. Um, I just wanted to highlight some of the videos that we produced addressing some of the common gaps that we've identified when we are out, um, in the field. We have one, um, basic environmental hygiene. Next slide. Um, and it's also available in Spanish. Next slide. We have one for norovirus and again even though this says for environmental cleaning staff, they really are very useful I think for all settings. There's a lot of training about transmission and basic infection prevention practices that need to be in place. I've already heard this has been used for some, um, outbreaks of long term care facilities by some of the counties with ****. It's also available in Spanish. Next slide please. Next slide. We have one that we hope to get out the next week or two on CDI - abbreviation for Clostridium difficile. Next slide. It also will be available in Spanish. We, um, are just about ready to post a video of blood glucose monitoring and insulin prevention. That also will be available in Spanish. Next slide please. Um, we have one coming out on linen and laundry management. Good news for influenza outbreak management for long term care facilities which will not be in Spanish unless I hear a request otherwise. OR room turnover and

terminal cleaning. Um, dietary kitchen so believe me the food service, the hepatitis outbreak and other things really caught my attention I think. This one in looking at the script will be helpful for that. And then, um, dialysis station disinfection and I think that's pretty much. Next slide please. Um, I'm gonna skip over the partnership 'cause I think I'm over or will be over time but we have a collaborative going on where we're working with both hospitals and long term care facilities, um, at trying to build, um, partnerships and deal with issues like Clostridium difficile, antibiotic stewardship and urinary tract infection prevention. Go with that next slide please. This is a series of webinars that we've been working on in partnership with the Oregon Health Authority and Healthy Insights. Um, these were all associated with Clostridium difficile and were rolled out as part of our collaborative. Next slide please. Um, and, uh, Rosa and OHA have really been taking a lead on rolling out a NHSN **** for action dealing with the new temp strategy that we talked about and Laurie has really assisted helping roll that out with Health Insight and their teams as well. Next slide please. Um, additional grant activities, Julie will talk a little bit more about the MDRO toolkit but, um, I did wanna let everybody know that we have, um, talked with Health Insight about using some of their long term care facilities to have a long term care stakeholders group, um, and, um, we really want to ensure that the tools are useful for their studies. We received feedback last week from some of the regulatory surveyors for long term care that they want to ensure it's simple and easy to use. Um, it kind of focuses on what they need to do. Um, and then dialysis activities, um, we are a member at the commission of, um, the, uh, end stage renal disease learning action network and at the National APIC Conference, um, I participated and was a faculty member for the hands on training session for dialysis. Um, really focusing on a lot of the observational competencies and practices including station disinfection that they'd like to have in place. So, I think that's it.

Next Speaker: Thank you.

Next Speaker: Any questions?

Next Speaker: Great work. Great work there.

Next Speaker: I have a question. Uh, I was just curious if you would share those videos with CDC at this point?

Next Speaker: Um, we, we've let them have the links to some of the videos but I think we, um, I'd like to sort of do what I call a soft launch so that they're out to smaller groups and then after they're out for a month if we're not hearing you know anything major that needs to be fixed or changed, then give it to broader groups on the more national level.

Next Speaker: And the other question was whether or not, um, there's an interest in being translated into other languages besides Spanish. And I'm not sure but.

Next Speaker: I would welcome that input. Um, we, you know we always have to find somebody to not only translate, but then because we don't speak that language, we have to have somebody validate the work that was done.

Next Speaker: I can translate for Latvian if you need that.

Next Speaker: I'm sorry?

Next Speaker: I can translate for Latvian communicating ****in Polish.

Next Speaker: You're hired. So no –

Next Speaker: **** that's a good point. I don't know from the long term care but **** where there's Russian **** if there's another one.

Next Speaker: – yeah I think you know we are happy to entertain comments and ideas, um, we're in mass production right now. We still have a number of videos we're trying to complete by the end of July. But at that point, we're gonna take a breath and we have started some preliminary conversations with long term care. I think one of the videos we may roll out is dressing changes, um, since that is, um, an area that we think would be very helpful for them to have. Um, once we figure out what multi-drug resistant organism practices we'll be recommending for the different long term care settings, we'll have a video to help train. I think we'll have a very basic standard precautions video as well, um, for the long term care settings. So those are just some of the initial thoughts that we have but you know again I think these are a great way for us to address some common lapses or gaps that we see. We can work with our county health departments and other partners, um, as well to help get them resources that may help them in their settings.

Next Speaker: So this is Judy. The two that are completed, the videos, the environmental hygiene and norovirus, they're both on YouTube.

Next Speaker: Mm hmm.

Next Speaker: That's where they're posted. So I shared them at the spring **** in April because I gave a talk about infection prevention and **** limited settings. Um, and then as you know as the new ones roll out we can share those through ****

Next Speaker: I was getting questions for where they are posted or.

Next Speaker: ****

Next Speaker: It's not the Oregon Patient Safety Commission YouTube channel.

Next Speaker: Yeah.

Next Speaker: Okay and then we have the **** links playlist if you will so there's a playlist for English and a playlist for Spanish. So if you want to just go to English or Spanish you can also see all of them. But we, they're public domain. We welcome anybody who wants to link to them. Anybody who wants to use them. We really encourage that.

Next Speaker: So it sounds like for those on the **** sounds like you go to YouTube and then you search for the Oregon Patient Safety Commission YouTube channel and they're listed on that. Okay.

Next Speaker: Yes and we can send the link out.

Next Speaker: There's a short **** I think I saw it on ****. It's, it's **** training videos but it's case sensitive so **** look at your slides.

Next Speaker: And most people they're going oh I remember I heard about that and you go and then you go and look for it.

Next Speaker: Well if you have the slide deck from today on **** then you can actually link ****

Next Speaker: There'll be a live link ****

Next Speaker: And then the, the one idea you have for the one on wound care, do you do dressings?

Next Speaker: Well that, could you potentially use that for educating patients and families? So much wound care happens at home now.

Next Speaker: Yeah. No, I think the whole concept of family training, right, is something we need to begin to address and I can see a need for that as well. Yeah. Yeah. We find, there's kind of a soft spot in video ****. We ideally want to keep them like 8 to 11 minutes. After that the software **** doesn't quite work as well. But, um, we're learning. We're learning how we learned. You know there are PDSA cycles and action if you **** every time we do it we learn something different and we change our process. So, um, but I think we're, um, at a point now where, um, it's, it's getting pretty good, so.

Next Speaker: That's a great point, yeah with the families and also the patients in general if there's ****

Next Speaker: Yeah. For toileting. You know that's always the ****

Next Speaker: **** so many times ****

Next Speaker: And we talked in this, we, we kind of mentioned that it can, it's applicable to schools, camps, to health fairs as well.

Next Speaker: Yeah.

Next Speaker: So we may, you know we roll stuff out and, and, stuff like shay is I understand it's gonna come out with these guidelines for Clostridium difficile so we may have to go back in and modify later but going in and modifying and making some changes won't, I don't think it's going

to be as expansive in the future. So we just kind of have something saying we're gonna, we will address this with the next round.

Next Speaker: This is Debra Pretora.

Next Speaker: Hi Deb.

Next Speaker: One of the things – hi, one of the things that our agency will do with all these videos is we will start **** facilities and then we have a link to your link on our setting so they don't have to necessarily go to another web site **** that they're not familiar with. 'Cause they **** was going to **** each individual facility type **** web page that sits in DHS. So we have links there as well.

Next Speaker: Great, excellent. Thank you Deb.

Next Speaker: Can I ask what your target, uh, number of facilities for your multi-region infection prevention partnership collaboratives?

Next Speaker: So, um, we anticipate stable funding first off for this next year. So, um, right now and I have to go to the slide, I don't have it in front of me. My slide went blank.

Next Speaker: It's where you have three hospitals listed.

Next Speaker: We have three hospitals and what we had put in for the grant was, uh, initially, um, we would have, um, two to three regions I want to say and, um, three to five hospitals. So we pretty much hit that target. I think we, we initially depending on the part the grant said ten. This year though we really are, we're recruiting. And we anticipate funding for this next year. So we really are trying to hit ideally about 15 long term care and I'd like to see at least five hospitals. And those are kind of anchor hospitals. So we're trying to have the hospitals and the nursing facilities they frequently admit to default with the project. Um, as Laurie knows hospitals are busy. There's a lot of activities that they have going on. Um, sometimes it's been hard and challenging to engage them in this but they have given, they're conferring rights to us so we can actually monitor their community onset Clostridium difficile rates. And at least if we can engage the long term care partners with them hopefully we'll begin to see that impact.

Next Speaker: Any questions from the phone?

Next Speaker: I had a couple quick ones. Um, the health care environmental services, the practice to prevent HI sounds awesome. Who, is there a target audience that you want and how do they go about signing up for that?

Next Speaker: So if you go to the Oregon Patient Safety Commission web site events page you can actually see the registration. We have sent it out, um, in communication I think, did you guys send it out on the hand as well? It's gone out. Deb Pretora. Deb, you sent it out on, on your administrator, um, list didn't you?

Next Speaker: Yeah, what we do is we have what we call, um, provider alert, um, where we sent out the information that can be useful and then, um, in fact in July we have a news out every quarter for the different facilities. And I will also be talking about, um, these things through that video as well ****.

Next Speaker: So if you have people, we're trying to target not only environmental services but infection preventionists, quality managers who may have some oversight for environmental services programs as well. And, um, again it's, it's covering basic microbiology, basic EVS practices.

Next Speaker: ****

Next Speaker: You're **** we're coming up. And as the injection state you mentioned. I think there's injection, do we have an injection safety web site that has some of that information on diversion?

Next Speaker: We have a one and only campaign.

Next Speaker: One and only campaign ****

Next Speaker: **** moving all of our **** safety content over to that one and only state kind of partner web site. And we should definitely put, I actually wrote down, we should put the blood glucose **** video and anything else on that web site. Yeah. Looking forward to building it out but our **** coordinator is on leave right now and so some of that work has, is kind of on hold.

Next Speaker: Okay. So there is a web site the one and only. There is some if people are interested I just wanted to bring it to their attention. There is some **** around that ****

Next Speaker: **** as well on general injection safety and drug diversion too.

Next Speaker: Excellent. And I just wanted to say **** a lot of doing ****. I feel like we learn a lot from those and **** just like **** so thank you for that. Just going back and looking over what you commented on **** went back **** kept that in mind **** that would be a great ****

Next Speaker: It's a great opportunity to really teach and mentor and coach the facilities.

Next Speaker: Anyone else? Otherwise we will move on to our next ****. Okay so our next piece is, uh, from Rosa. It's gonna tell us about the annual CDC report.

Next Speaker: So I'm just gonna touch on this very, very briefly. So, um, we don't have any slides on the report but everyone got handouts and they're projected on this screen as well. So, um, the first handout is a four-page document called Data Explanation For the 2015 HAI Data Report. And just to kind of make sure 'cause there's lot of annual reports so this is the report that CDC puts out and it is reporting on 2015 data. Um, so the document, um, is 4 pages long. The first 3 pages are all really about you know what kinds of data are included in the report, what was the kind of freeze date that CDC used, **** from NHSN. What analyses are used and how to

interpret what's presented. And then if you skip to the last page of the handout exactly **** there's a screenshot that I took of the data and where it can be found on the web site. Has been published. Um, it is using the new baseline. Um, the 2015 baseline. And if you want to access these, um, you can see maybe I can sort of see this. On the left hand side of the screen there's a green bar. Um, annual reports is where you're going to click. It's in bold, uh, and that will bring you here. So just you know so everyone knows where to find it if you want it. Um, and these are all data tables broken down by facility category. And please the other document I provided today is the NHSN Version 8.7 release notes. You'll remember 8.6 was the version that was scheduled for this past winter. Um, originally, and then they have you know been kind of going through some growing pains with all the new re-base lining and the new user interface. Lots of big changes. Um, not so much on our end but on their end. So some glitches have been found. It's inevitable and they're working on that stuff. So this document doesn't you know necessarily exactly relate to the annual report itself but I think it's kind of a nice companion reference piece to have. Um, it does cover lots of changes that have been happening in the system and fixes and updates that may continue to be made. And I know many of us are probably wondering what's going on with the ****. SIR is under the new re-baseline and then unfortunately those have not yet been fixed. That I'm aware unless anyone else? Nope.

Next Speaker: I asked Dan Pollack about it at APIC. I did not get a definite update about it.

Next Speaker: I got a update that they have not been **** that.

Next Speaker: I mean in terms of a date or when it's going to be ****

Next Speaker: Oh yeah. They mentioned it was the top of their priority and I think that's I'm sure true. Okay, um, so that's really all I have on the annual report but, um, we're just coming up on our break here I think. But if anyone has any questions for me or want to chat about it I'm happy to take any questions or discussions.

Next Speaker: Any questions on the NHSN definitions etc. from the phone?

Next Speaker: ****

Next Speaker: Okay. Great. Well let's then take a break. We are, we will return here at 2:00. Okay we're good. So for the second half we're going to begin with, uh, Rosa Tamara. She's going to give us an update on the annual HAI program. Take it away Rosa.

Next Speaker: Oh yeah. I'm gonna spend a couple of minutes now chatting about the status of our annual HAI program report so what's been done, what's happening now, what to look out for in the months ahead. And then I want to spend some time hearing from you all regarding the internal validation process. So, um, again to clarify this is the report produced by us, the HAI program and it is 2016 data. So what's been done so far we've worked with, uh, several internal and external groups including this committee here, uh, to review the 2015 report and identify changes to be made, um, this time around. We've completed our internal validation process which is where we provide facilities their data and offer a review period and technical assistance before we freeze it for publication and we've solicited comments. Currently we're working to

analyze data, prepare our reports and performing quality assurance both on that aggregate data which is the PDF report. Um, and then the facilities specific data which are online only in the form of tables and maps. So circling back around to a conversation we had during a previous HAI advisory committee, there's going to be some changes to our report that we've made under the advisement of the committee and some of our other partners and stakeholders so thank you very much for your feedback. Um, some of the things to look out for is that the aggregate data in the PDF report will present FIRs under the original baseline and the decision was made to do that so that we could continue to see trends data. Um, the facilities specific tables and maps will present SIRs under both the original and the new 2015 baseline but they're going to be in separate places on the web site and I'm going to talk more about that in a second too. Um, we will mention the new baseline and the new HHS metrics for, um, HAI reduction targets, um, in the narrative of the PDF report for context. And we're going to include a link to the place on our web site where we discuss the **** activities that we support. So I want to mention that as many of us are aware and I already talked about a little bit, there are problems with the SIRs under the new baseline, um, that is the 2015 national data. So while we do expect to publish facilities specific data under the new baseline and we heard loud and clear that our partners do want access to the most, uh, recent update data, um, the publication of these may actually fall behind our projected publication date because we're waiting for CDC to fix the models. So what's next really similar to last year I believe. Um, we are aiming for early August publication date. We'll be presenting on data, we expect to present on data during September's, um, advisory committee meeting. Uh, we'll be coordinating talking points, public release of data and press communication. And facilities will have access to facilities specific data and will be notified before the publication of those data on the web site. Any thoughts about any of this before we move on to internal validation and there will definitely be time for plenty of discussion about all this at the end as well?

Next Speaker: Okay, I have a very high-level question –

Speaker: Sure.

Next Speaker: – since **** this visit being repealed or is this going away? I thought I read like **** discussion and that this report is no longer going to be required.

Next Speaker: So just the folks on the phone, the question was, uh, is the report still to be required –

Next Speaker: In the future.

Next Speaker: In the future.

Next Speaker: If that's too complicated or political.

Next Speaker: So I can, I can speak to that. My understanding and I do want to verify this, but I think that the requirement, **** grading an annual report is not going to be in place starting next year. Uh, we can still create one but we no longer have a requirement. The reason that we are moving in that direction is so that we can focus on, so that the report, the reporting will still need

to come to us, but then we can use the data for active prevention efforts instead of, uh, creating a report that is largely redundant in the way as a lot of reports. So, um, that's right now my understanding, but I, I would like to verify that –

Next Speaker: Yeah, no, I ****, I just had a question from one of our members felt that it was part of **** –

Next Speaker: Yeah.

Next Speaker: – Yeah.

Next Speaker: I think the –

Next Speaker: Something that we may do next time in September is a little legislative update.

Next Speaker: Yeah.

Next Speaker: That feels appropriate. Um, okay.

Next Speaker: Any comments from the phone on that?

Next Speaker: Maybe just –

Next Speaker: Questions.

Next Speaker: Or questions. No, maybe just hit, hitting ****.

Next Speaker: So ba-, so basically like the datum **** would still be required to come from the state, but the HAI could be re-, be required to put out a report.

Next Speaker: Right. So that the per –

Next Speaker: Every-, everything's still remains in place. The requirement for the committee, the requirement to send data to the state, um, everything except for the requirement for us to create an annual report because there is, you know, there's the hospital Compare and other systems that meet a lot of those needs and we decided that's probably a better use of time to focus on prevention.

Next Speaker: So, one of the things that we will continue to do definitely in the coming years will be internal validation. So no matter if we're going to be producing a report that looks the same or not or publishing data on whatever schedule we do, we want to support our facilities to make sure that if we are going to publish data everyone has an opportunity to see what their data are going to look like and have an opportunity to go into the system and make any edits that are needed and get help with that. So that is the internal validation process. So, the intention was this past time around was to keep the process, you know, more or less similar to, or as close as possible to last year considering that we've had some staffing changes, **** kind of nice in, in

light of that. Um, so initially we froze the data on April 3rd. We prepared individual facility reports and sent them to the facility on the 10th. We provided 2 weeks of concerted technical assistance although technical assistance with NHSN data is **** facility partners. So you ever have questions about NHSN data or how to report, um, you know, we are definitely here to answer those questions and then we refroze data on the 24th after that 2-week review period, prepared reports and then sent them to facilities on the 9th of May, also soliciting comments at that time. So, while the intention was to keep the process close to what had been done in the past, this time around we also have some ideas about things we might change for the future. So I want to briefly kind of go over some of the thoughts that we have had since then. So, considering possibly adding some information to the internal validation report, um, possibly including things like unresolved alerts, uh, including things like data quality checks that are built into NHSN and then a number of **** quality checks that are sort of more proprietary or ones that have been developed by **** in the past. We may consider doing this type of thing on a more frequent basis. It's not that we would make the requirement to review and correct more frequent but providing **** data on an **** basis creates the opportunity to have less work all kind of stack together at one time right before the CMS deadline when everyone is kind of scrambling anyway, and giving more warning time, that, you know, here, we're going to be freezing the data at this time, so we didn't give much of warning, I think, before we initially froze it, and kind of considering there would be this review period, but I think people want a heads up in general. Um, and then the last big one is guidance, more guidance. So, I definitely heard from facilities that they wanted a little more information about what do these data mean and what to do with them. So, as an FYI we also have some maybe internal changes and we made some internal changes, ourselves, to improve our reports, and **** enormous help with all those so I want her a giant thank you, not just internal validation, but the report as well. Um, so there's **** we can explore that we might be able to do on our end but this is kind of the outward-facing ideas that we have. So, um, next, I guess, thank you, I really wanted to just keep the presentation part of this super short and sweet because what's important here is to get everyone's feedback on what we can do to make sure that this process works the best it can for everyone. Um, any thoughts you have about internal validation, um, positive feedback about what worked, constructive criticism about what we can do better next time is really, really welcome. So, with that I'll just turn it over to anyone who wants to comment. And we can go back to the proposed, yeah, if this is helpful for discussion. If anyone feels that this would be good, not good, I'm curious. You know, I think we have some hospital representatives on the line, so it would be good to get some feedback from them. **** as well, I think. Any feedback you need to send or that process or, yeah.

Next Speaker: Um, this is ****. Can you hear me?

Next Speaker: Yes, we can.

Next Speaker: **** facility **** sometimes we have **** and, um, I don't, I don't know, **** I, I shared a document, uh, with **** baseline **** for **** from **** specialized, um, from baseline. I don't know if, uh, we can actually **** specialize from baseline. I don't know if, uh, we can actually ****. **** HAI, HAI, but –

Next Speaker: Yeah, I, so, Paola's talking about the fact that critical access hospitals kind of, have a different sort of profile than traditional, general acute care hospitals and I think that resonates with many of us in the room, um, and then NHSN has traditionally, um, rolls together all of those hospitals in kind of one bucket and the baseline that they use is, you know, both acute care hospitals and critical access hospitals. However, I will say, and Paul, I did get your email. I haven't had a chance to respond to it yet, but thank you for sending that, and, I will say that under this new baseline there are going to be some SIRs that are broken out specifically by critical access hospitals. So that is an option kind of going forward in terms of analyzing data from 2015 on. But retrospectively, uh, critical care access and acute care access hospitals are lumped together –

Next Speaker: Under the original –

Next Speaker: – for baseline, they're all lumped together, yeah. And I guess that probably **** looking at that or doing ****.

Next Speaker: Well, so we're going to be, un-, when we are able to publish the, um, the facilities-specific numbers under the new baseline when all of the **** access facilities will be comparative to other critical access facilities under the new baseline. Un, unfortunately under the previous baseline if we were to change the way we compare these facilities then we would kind of lose that trend data as well, but I think that we do recognize the importance of comparing apples to apples in this context, so –

Next Speaker: Um hmm.

Next Speaker: – so having, you know, the new baseline data as really good stuff and then, you know, it's just kind of how do we move forward from here, I think.

Next Speaker: Yeah, and we're looking at it, like kind of retrospectively, if that's **** too. I think we can also consult in **** or other states and see if anyone else like what they're doing in that direction, so ****.

Next Speaker: That's good. Thank you Paola. Anything else you wanted to add? Other thoughts like an internal validation and what we can do to make these reports more useful for facilities? Okay, thank you so much. If anyone does have thoughts about this, if you want to kind of mull this over, you know, any of the suggestion on this slide, I'm happy to talk about it with any of you offline, um, if you're not quite sure. If this kinda too general what we talked about, um, or what I kind of proposed on the slide today, that's totally understandable. Um, and if you'd just rather share your feedback individually, that's fine too. So, thanks very much.

Next Speaker: Thank you. Great. Always something new happening in the NHSN, that's for sure. Uh, so, our, uh, always seeing new definition, new baselines.

Next Speaker: That's right.

Next Speaker: Uh, okay, so our next piece is going to be an NICU laboratory update from Dr. Guzman ****.

Next Speaker: Um, this is Judy Guzman. I have some slides also. Um, for those of you, if any of you also serve on the drop CRE through with our meeting, maybe a month ago, maybe 6 weeks ago and so, some of this is going to be repetitive. Um, but, uh, these are more up, updates, um, as opposed to action items. So, next slide please. So, I first, um, wanted to share with, um, everyone on the HAI, um, an update on the NICU, um, antibiotics stewardship collaborative. I think, um, I discussed this only very briefly and just mentioned it maybe, uh, last year. So, um, in 2, in, um, January of 2016, um, Vermont Oxford Network, which is a, um, national quality improvement group that focuses specifically on **** and ICU, um, shows antibiotic stewardship as, um, the, um, prime, as the, um, um, topic of a, um, national project that launched in early 2016 and it was actually in collaborative with the CDC. Uh, next slide. So, the, um, the collaborative was, um, in, uh, partnership with, um, the, with the DHQP at the CDC and two, um, physicians, um, from that group, um, act as faculty on the, um, Vermont Oxford Network, um, project. Um, Dr. **** and Dan Pollack, and, um, there's actually now 169 participating NICUs and nurseries across the country including, um, Puerto Rico. So, seven countries, including, um, Puerto Rico. 39 states are represented across the United States. And, um, it was really pretty amazing to see, um, this group of physicians and nurse leadership and all of these hospitals quickly realize the importance of antibiotic stewardship because as a, as a pediatrician, I'll tell you that, you know, when I was in my training and Jen can probably attest to this too; when we were in our training, every baby admitted to the neonatal ICU got antibiotics, just for the sake of being, and, and that doesn't happen anymore. And Mary Post can attest to that too. She was once in neonatal ICU nurse. Um, and that's the, the paradigm has switched and I didn't think it was gonna switch so quickly, so, it was really pretty refreshing to see a group outside of Infection Control and Infectious Disease and Public Health actually really understanding it so quickly. And I don't, I think it's not just because of multi drug resistant organisms; that's not as much, thank God, an issue in pediatrics because our babies are still babies. Um, but it's really also the restrictions coming out about the microbiome and, you know, how one dose of antibiotics can really affect the, uh, microcosm, um, of the organisms that live in our GI tract and how much our GI tract and, um, the, the microbiome is so important in health and in maintenance of health. So, um, because of that, five states actually were able to recruit almost all, if not all, of their NICUs, um, to make a state collaborate on top of being just a, you know, a, a single ICU in this collaborate and Oregon is one of them. And Oregon, um, plus two Southwest Washington, or, um, um, NICUs, um, join, uh, joined together to create a state-wide collaborative called the Northwest IPAS. Because everyone loves beer around here. And that's called the Northwest Improvement Priority of the Antibiotic Stewardship. Um, and so, um, I just want everyone in the HAI to know that this is going on because, um, this has really become a very focused group on, not only stewardship and they can be, um, I'm, I'm kinda trying to get the word out because I think that if you have any, you know, ICU in your hospital or in your healthcare system, they can really serve as the, the one inpatient unit that can be the, kinda your pilot to show success in stewardship in, uh, in a unit where antibiotic use used to be, you know, just part of, part of patient care for every baby. Um, next slide. So, the goal of nationally, um, the stewardship, um, program was to, a 25 percent reduction in antibiotic use. And, um, again, I, you know, when I first, when the neonatal ICU at Oregon Health and Science University were all one faculty they asked me to, to be a partner in this for the, um, for the OHSU group, I thought,

well that would be amazing if we could see that. And I'll tell you the, the stewardship, um, uh, collaborative has been successful that they actually added another year. It's continuing on until the end of 2017. It was supposed to just be a 12-month collaborative in the, um, across the country, um, the Northwest IPAS, um, their most recent calculations that cognitively have seen a 23-percent reduction in antibiotic use. So, we are one of the star states, um, in all the 39 states that are participating. Next slide. Um, and you know, as, um, as most, if not everybody, on this committee knows, um, antibiotic use and antimicrobial resistance, um, are two modules in NHSN that hospitals, um, currently, acute care hospitals can report their antibiotic use, um, through to NHSN, and which will calculate for them at SAAR, which is standardizing antibiotic or antimicrobial administration ratio, which is similar to benchmarking that we think about with, um, with centralized associated blood stream infections, catheter associated **** other devices and can benchmark unit service lines within a hospital to similar service lines in hospitals, like hospitals, um, in their region and across the country. And the antibiotic resistance, um, is basically similar to, I think, what people traditionally think of as an antibiogram, um, but kind of the big vision is if, if many hospitals of different sizes, different service lines across the country provide antibiotic resistance data automated to an NHSN, then we can actually create reg, statewide, regional and even national, um, antibiograms, and kind of compare the two, looking at antibiotic use and how that affects antimicrobial resistance, um, across the United States. So because of this – next slide – um, one of the, um, focuses of the **** program was to try to get more hospitals in Oregon to **** reporting, um, antibiotic use, so, um, Lisa ****, whose picture is there, um, and myself from **** program and, um, Dr. Dimitri Duchovny who's, um, also there – he's a neonatologist at **** - the three of us worked together to kind of – tried to strategize how we could use, um, the success and structure of the **** network in Oregon to target hospitals that would be interested in starting to report antibiotic use 'cause when this kind of – first got into this, none of the hospitals that were, um, in the **** so, um Lisa was kind enough to, um, assist the NICU's in creating and analyzing state-level **** reports. Um, the state-level collaborative has reports. They send those out to all of the, um, hospitals. Um, you know, most of these hospitals are doing this, kind of, um, you know, shoe leather on a string doing **** you know, they, they have these diligent pharmacists that are just kind enough to count up the days of antibiotics and which dose and how many doses each day for a month and put that dat- data together manually, and Lisa's been helping them. Um, this allowed us to have some targeted partnerships and incentives and we were lucky enough to get some federal funding to use to incentivize some of the hospitals to start reporting AU and, um, so we used our partnership to encourage, um, kind of the high-level, high-performing hospitals to report AU by – and our goal is, um, spring of this year so just a few months ago. Um, and then we also use some of that funding to sponsor all of the NICUs to continue to participate in the **** collaborative for 2017. The hospitals actually pay to be in this collaborative to improve antibiotic use. I mean – it's like a dream come true. Usually we're like please do this, you know, and they're like oh, sorry, we're, we're too busy, we have other priorities. They actually pay a tuition to prove to **** that they can improve antibiotic use. It's crazy. It's just –

Next Speaker: **** how committed they are.

Next Speaker: It's – yes. I mean it's really true that a heart and soul **** quality improvement ****. So, um, so we use some of the funding to say okay, you know, you guys are – have done such a great job and become such great partners for us that we'll pay your tuition. It's about, I

think like 30. About $3,200.00 per NICU for 2017. Um, and then I have stayed on **** 2017 as a faculty member and, um, this, uh CDC and **** leadership asking to stay on and primarily one of my roles is, um, that many of the other state **** want to actually also partner closer – closely with their **** some kind of help and be that bridge between the two and then I'm also serving on a, um, uh, NICU specific **** special interest group to try to improve the definitions for antibiotic use specifically. Next slide. And so, um, when Lisa and I started this we came up with a – with a spreadsheet of all the acute care hospitals in Oregon and there was only one hospital at the time that was reporting to, um, antiotic **** and that was **** Medical Center. Um, but now we have – currently have 13 **** just recently started reporting, um, antibiotic use to NHSN. If any of you were wondering - if you work in a healthcare system or in a hospital and wondering if there's a secret ingredient to reporting, it really – I'll just say – it's, um, having – what we've found, at least for the Oregon hospitals, is having Epic as your, um, electronic health record, plus the addition of Icon which is the infection control software module that is also an Epic product that you – that hospitals or systems purchase to work with their NHR.

Next Speaker: Mm hmm.

Next Speaker: And all of those – well, except for the **** - have that as their combination. That's really made it streamlined to, um, **** hospitals. Next slide. And in case you're wondering, um, about the antibiotic use, um, how many hospitals are reporting currently, this is actually from an APIC, um, from an APIC, um, presentation by the CDC, um, so just a couple weeks ago. So there are 263 facilities that are sub- have submitted at least one month of data so far. You can see the states listed and you can see some, um, just characteristics **** the bed size. And, um, more than half of them are teaching hospitals and, uh, major teaching hospitals. Next slide. **** antibiotic resistance, um, module – we do – **** we do not have any hospitals reporting AR. Um, it's, you know, a pretty small number across the whole United States. Sixteen facilities have submitted at least one AR event from nine states, um, so, um –

Next Speaker: I think it looks like a data issue, though.

Next Speaker: It's –

Next Speaker: Isn't a lot of it just having the right –

Next Speaker: Yeah.

Next Speaker: - program, that whole thing.

Next Speaker: It's, it's, the same thing.

Next Speaker: Yeah. ****

Next Speaker: It's having the right HR with a – with your microbiology data to make it work. Yes.

Next Speaker: What, what's an AR event?

Next Speaker: Oh, I – an- an- antibiotic resistant event. I think that's, um, a one-day of data of patient's information – I guess where the patient is in the hospital and the positive culture and the susceptibility of that positive culture.

Next Speaker: But can it be any –

Next Speaker: Yes.

Next Speaker: - antibiotic resistant organism?

Next Speaker: Any organism –

Next Speaker: ****

Next Speaker: They have a long list of organisms and they just ****

Next Speaker: Susceptible and resistant ****

Next Speaker: Susceptible and resistant. So, yeah –

Next Speaker: Okay.

Next Speaker: - they do have a demon- or they're planning to have a denominator and then a numerator **** yeah.

Next Speaker: So ****

Next Speaker: **** you know, **** deliver that data in a streamlined fashion.

Next Speaker: Yeah.

Next Speaker: It's really all positive –

Next Speaker: ****

Next Speaker: - all positive clinical cultures, um.

Next Speaker: So it's really a lab thing.

Next Speaker: It's a lab thing. Yeah. So it's really being able to submit that to, um, of transmit the data. Lisa, ****

Next Speaker: Oh, no, I was gonna say that, like, beforehand the vendors, um, there weren't really any vendors listed for the AR option. It looks like recently they have – some vendors have

begun starting to, um, say that they are able to actively report AR data, so hopefully in the near future we can see more facilities starting to be on board with this.

Next Speaker: So that we be the **** vendors, um, electronic vendors ****

Next Speaker: Yeah, like –

Next Speaker: Like Epic ****

Next Speaker: **** yeah, exactly.

Next Speaker: Yeah.

Next Speaker: Um, next slide. So, um, potential next steps. Um, we have some initial discussion to make with the Washington State ****, um, Department of Health and, um, to try to continue onward in efforts, um, be strategic with trying to choose a healthcare system that has multiple hospitals in both states, um, so we'll wait and see in terms of, um, what their priorities are in funding, um, over the next year to see if we're able to do that and then, um, you know, we discussed maybe trying to incentivize one Oregon hospital beginning AR, reporting to NHSN but again as we just discussed a lot of it is really just based on, um, their lab, um, interface with their EHR capabilities, so, um, just kind of waiting to hear from the few number of hospitals across the state that are reporting and what seems to be kind of that secret ingredient – like **** to see what that is with AR and then, um, see which hospitals actually will be able to based on that. **** most, you know, ****.

Next Speaker: But, but eventually you're gonna wanna get more than the, the organisms, right? You're gonna probably wanna know something about patients and clinical syndromes, because if all you wanted was the organisms it seems to be NHSN wouldn't be the way to go about it, it would be to go through electronic lab reporting which we already have, you know with all the major hospitals in Oregon.

Next Speaker: Right.

Next Speaker: Yeah. The way – how I see it is more of just an antibiogram at a large, large scale, which I agree with you – if we had some clin- you know, clinical information for these syndromes it would be much more rich in terms of the data.

Next Speaker: Mm hmm.

Next Speaker: The usability of it, I guess **** capabilities of the reports that are generated but this is **** that ****.

Next Speaker: There is the, the ****, right? Which is limited.

Next Speaker: Oh, the ****.

Next Speaker: ****

Next Speaker: Yes, yes.

Next Speaker: ****

Next Speaker: Yeah, they ****

Next Speaker: **** NHSN data ****

Next Speaker: Yeah, so, that is true. Yeah, there is **** that's active online right now. It's pretty swift. It's, uh, **** and you can click on a state and then you can hover over, you know, the state and see their, you know, incidents of specific MDROs and, um –

Next Speaker: ****

Next Speaker: - I think also, a lot of NHSN data ****

Next Speaker: Yeah **** exactly.

Next Speaker: **** yeah.

Next Speaker: Okay, so it's – yeah. **** that are submitted as part of other **** definitions so MRSA, **** such like that and a patient ****.

Next Speaker: ****

Next Speaker: Yeah. And ****

Next Speaker: But it's – yeah, I mean it's, it's actually a pretty nifty tool, especially if you're admitting a patient who's had six weeks of long term care facility **** another ****

Next Speaker: ****

Next Speaker: **** understand what's going on **** so there's ****

Next Speaker: Um, next slide. Um, so, you know, a couple questions, I guess a question that I could pose to the committee members is, um, if, um, you know, any ideas to encourage more facilities to report or again, if there are any facilities, um, that are represented that actually moved us up higher on either AU or AR reporting – higher on the, um, on their priority list, um, you know, for example Samaritan Health, I think has purchased – we know that they have purchased the software. They're just, um, just starting to, to get it loaded up and, um, to do their, um, quality checks. Um, that, um, we can help to be a direct line to NHSN, um, during the onboarding process if there's any, any problems with the initial reporting phase.

Next Speaker: I'm curious about, yeah. It's just in follow-up in terms of, you know, potential incentives or whatnot, you know, software or, you know, what we can potentially do **** support facilities that might motivated to do this kind of work.

Next Speaker: Any comments from the phone?

Next Speaker: I was wondering if any of this counts for **** use because that is, that is a big, um, I'm getting nods from the heads at this – this desk.

Next Speaker: AR, yeah.

Next Speaker: Yeah.

Next Speaker: The, the AR AU.

Next Speaker: It certainly does.

Next Speaker: It counts for **** electronic data –

Next Speaker: ****

Next Speaker: - 'cause I – I know that's a big ****

Next Speaker: Yeah. So the, uh, AUR module is an option **** H3 **** public health registry reporting but you need to have both AU and AR implemented. You can't just have the AU module. It has to be both, um, but that's kind of one – I guess – incentive idea that CC is trying to promote **** to, you know, increase update of both the – the AUR module, um, and I think that's why there's an increase in, in vendors coming on board now because, um, the **** Stage 3 is gonna be an option for 2018.

Next Speaker: Any other questions or comments? Um, next slide. Before I move to the NPR **** toolkit I also just wanted to mention that, um, the CDC is also **** and how Lisa and I structured the use partnering with an acute structure to, um, to communicate with the hospitals, um, uh, with – about AUR, uh, reporting so the CDC sent contractors from public health **** to Oregon **** and they met with several of us who've been working on, um, on antibiotic stewardship and, uh, with – you know, all sorts of antibiotic stewardship work. **** in here **** what we were doing and sought to understand the connection between public health departments and CDC providers, vendors, um, to **** antibiotic use and, um, also **** antibiotic surveillance. Next slide. And that – um, eventually that visit culminated into this nice one-page handout that they brought to ****.

Next Speaker: **** CTSD.

Next Speaker: Thank you. CSTD. Um, and this was, uh, kind of a one-page summary of Oregon's journey to reduce antibiotic use and **** so they're helping us to, **** um, spread the word of how good this has **** for us. Next slide. Um, the MDRO – so I'm just gonna give a

very quick MDRO toolkit update so, um, the MDRO toolkit is gonna – is similar – the vision of it's similar to the **** toolkit, um, and it's a user friendly infection prevention, um, guidance document for healthcare facilities caring for patients with MDRO infections or colonization so it's kind of just, um, um, a very quick records guide for, um, what to do with patients who may have an MDRO type of colonization and the goal is not for this to only be for acute care hospitals similar to the **** toolkit and our, um, we also have **** a goal to harmonize all **** procedures across the state. Um, next slide. So, this is just to refresh your memory of what the, what the CRE specific toolkit looks like. First published in 2013 and updated 2016, um, and, um, led by, uh, Chris Piper and **** Maureen, um – thank you, Cassidy. Uh, next slide. And, um, you know, this is what it looks like for, for the user. So, this would be, you know, what to do when CRE is identified at your, um, at your **** and so, um, someone – a staff member could quickly, um, refer to it and know if the person should be in isolation or not and how the health department, um, could support them in the management of that patient from an infection prevention and decreasing transmission perspective. Next slide. So, um, we, uh, a few months ago planned to, um, kind of brainstormed what pathogens should be in a overall toolkit to try to – try to provide guides for, um, the vast majority of **** multidrug resistant organisms so this is what we envision will be all of the components eventually of the toolkit. Um, we'll start with, you know, how different settings impact the approach to MDROs, general principles and definitions and then you can see here a long list of different multidrug resistant organisms plus, um, **** to provide guidance. Uh, next slide. And, um, this is just a list of the facilities that we're hoping to, um, include in the guidance. Um, we're not quite sure yet about ambulatory clinics. That's why I put in there it should, it should be in scope or out of scope. If anybody has any strong feelings about that, we'd love to hear. Um –

Next Speaker: Um, I was just gonna say I know that APIC group really felt that it needs to be in scope ****

Next Speaker: Oh, okay.

Next Speaker: **** and I would agree. I think, you know **** I get calls on this all the time, so.

Next Speaker: Yeah.

Next Speaker: I think it would be helpful to us ****

Next Speaker: Great. Thanks. Next slide. So, um, and, and this is the format that we're – that we're planning for each infection or pathogen and again if you feel like there's something that's missing, in terms of what should be discussed within the, uh, toolkit, let us know. So there'll be some general info and epidemiology about the pathogen, some definitions, um, especially if there's, um, any, if there's any, uh, problems in terms of controversies, uh, definitions related to that pathogen nationally, or – and the literature. We'll talk a little bit about laboratory info, testing methods, um, and, um, tips on interpretation but that part will be very brief, again because really the, the goal end user of this are people that are working at the bedside who have to make those decisions for isolation and, um, what level of isolation precautions that **** infection. Um, cleaning and, cleaning and disinfection will be included in there **** um, in terms of is this

a pathogen that's found in the environment or not, what are the recommended cleaning methods such as bleach versus regular disinfection, and then related regulation rules or requirements we thought was important to add, so, um, are there other stakeholders that are keen or very interested in specific pathogen, like CMS, NHSN, direct ****, um, interfacility transfer rules, etc. that may apply and then we'll give the recommendations. Uh, next slide. So – sorry this didn't project very well for everybody here in the room – um, so you can it from on the slide upside down for those on the phone, um, so we'll be giving suggested isolation precautions, when to initiate isolation precautions, and when they can be discontinued for each of the pathogens and each of the different types of settings. So there'll be a table, a kinda summary reference table at the end. Uh, next slide. And so, this is a timeline of what we've done so far. I, I modified it because we have – so the one thing that I think was pretty exciting that this happened with the- with this work is we had a statewide hospital epidemiologist and medical director of infection prevention meeting, um, in late April and this was the first time we were able to get all of these physicians together on one phone call to talk about the same thing. And, um, you know, with all the busy schedules across the state – and, um, it was a really great way to, to kind of kick this off. We had, um, representation from the Oregon Health Authority, the VA, OHSU, um, Providence Healthcare Systems, Assante Healthcare Systems, Kaiser Permanente, Legacy, and ****. Um, we shared with them kind of our – you know, every – all the slides Lisa and I just showed you in terms of what we plan to do. After a long discussion though it was clear that, um, we thought we should go organism by organism through this. Of course it's – Lisa's not gonna – we're not gonna have this done by the end of the summer because we're gonna go bug by bug and everyone clamored for MRSA to be first. And for those of you who haven't been reading literature, there has been a lot of discussion – just really in the past year – of should we really be having patients colonized with MRSA in contact professions. Is that effective and kind of balancing, you know, the, how – how that decreases risk of transmission versus other impacts, like, the, you know, the impact on patient care, direct patient care, the number of people going into the rooms, um, the, the cost of the, the PPE, um, a lot of other kind of independent consequences that can happen. And there have been some studies, you know, this – from an epidemiology standpoint, **** hospital to do a really good big study to answer those questions. Um, a study came out of University of Maryland in the past year or two that showed, um, there were like over 500,000 contact precautions events, like a person going into the room **** gloves to prevent one MRSA transmission and not every MRSA transmission is gonna lead to infection.

Next Speaker: Could you repeat that again, 'cause that was a really big number?

Next Speaker: Over 500,000 contact precaution events.

Next Speaker: ****

Next Speaker: So, somebody having a glove, gown, go into the room to prevent one MRSA transmission.

Next Speaker: And this is NICU care.

Next Speaker: In the NIC- in an ICU setting.

Next Speaker: In an ICU setting?

Next Speaker: How, how many events were there **** on average, for a single patient? Do you know? 'Cause, 'cause there's probably a lot –

Next Speaker: Yeah. Right. There is. ****

Next Speaker: ****

Next Speaker: ****

Next Speaker: Maybe, maybe ****

Next Speaker: ****

Next Speaker: Yeah. **** big number needed to treat ****

Next Speaker: Were they **** that was because it's not readily transmissible and, or because the contact precautions aren't effective?

Next Speaker: Oh, no, I think it's that, um, um, it's like a number – it's like a, another ****

Next Speaker: Right. ****

Next Speaker: Exactly.

Next Speaker: But what's the base on MRSA **** 'cause that effects your transmission rate, too.

Next Speaker: Right.

Next Speaker: Yeah, and they ****

Next Speaker: ****

Next Speaker: Oh.

Next Speaker: Yes, I know. It's a complicated discussion, which I didn't mean to ****

Next Speaker: ****

Next Speaker: ****

Next Speaker: But, yeah, no. We'll **** study.

Next Speaker: ****

Next Speaker: So, but, um, it's just one of many studies that **** that doing this, a good, very **** study by experts in the field is, just feels near impossible. You get the data and then you're like, okay, well, now I **** you know, 'cause you can look at it so many ways. Um, and so, you know, there are many big institutions across the country that actually have already, um, stopped doing contact precautions for patients that **** multi drug resistant organisms. Um, and so, um, so luckily we have John Townes at OSHU who, um – he has been heavily involved with a lot of **** studies of MRSA so, um, he and I and Chris Fifer are kind of re-reviewing all of the, all of the data and kind of seeing what other states are doing and what other, um, hospitals are doing and planning to do. We're collecting policies from other hospitals and then we're gonna, um, come up with kind of a – a list of suggested, you know, of suggested, um, ways to, um, to manage MRSA or, you know. And that will be kind of our first step in towards the **** toolkit. We have our next meeting scheduled already in, on July 24, um, so that's when we'll be reviewing, um, kind of our recommendations and rationale behind those recommendations at a state level. Of course these aren't gonna be, you know, it's not gonna be a mandate. It's gonna be a toolkit so it'll just be, you know, suggested ways to approach MRSA in your patients in your facility.

Next Speaker: Very cautiously.

Next Speaker: Very cautiously. Right. So, um, so that's, that's kind of how the toolkit is going to be written at this point now. Um, after, um, a really nice discussion with the stakeholders, um, at across the state. **** oh, and just while I have everybody's attention, I just wanted to mention very briefly – the CDC contacted SHEA, the Society for Healthcare Epidemiology of America, to create a training program to teach, um, hospital epidemiologists. So this is really primarily, um, physicians who do infection prevention and control in hospitals and, um, how to manage an outbreak because, um, the Ebola, you know, the Ebola, um, outbreak in 2014 15 really showed that there's a lot of, um, education that needs to happen so, um, this is just a snapshot from the website. Um, for those of you who may work with a hospital epidemiologist or an ID physician who may be interested in this free training program, um, you can check it out. I, I'm, I am their, um, honored to serve as the, um, the chair of the advisory panel for this, um, program, um, and there's, uh, a lot of free, um, a lot of free, um, workshops, webinars and other tools, um, that provide guidance and education. Next slide. Um, again so again the goal is to train hospital epidemiologists to effectively respond to infectious disease outbreaks and ****. Next slide. Oh, **** gonna skip all this although ****.

Next Speaker: Upper right.

Next Speaker: Upper right. He's ****. He also is serving as the, um, co-chair of the education panel of this outbreak response training program. Uh, next slide. You can skip that slide. We can skip that today, 'cause I'm not – I didn't. Um, the first, um, training, uh, conference, which was free, was, uh, just last weekend and there's one coming up in January – again free, in Los Angeles, California. It's a two-day conference. Okay. Any questions or comments about what Dr. Guzman just presented, or on the **** collaborative or MDRO toolkit?

Next Speaker: Okay. Is the list of organisms kind of already set at this point, or – I'm just wondering about **** or, NCR2, ****

Next Speaker: It is not set.

Next Speaker: Okay.

Next Speaker: Um.

Next Speaker: ****

Next Speaker: ****

Next Speaker: ****

Next Speaker: Right. Right. So Candida, Candidaoris is a newly identified strain of Candida. It's a yeast that inherently is very resistant to, um, to the antifungal agents we usually use to treat patients with fungal infections, um, and it's, uh, ****

Next Speaker: Oh, I was gonna say ****

Next Speaker: And it – yes. It's a –

Next Speaker: ****

Next Speaker: There's a lot of –

Next Speaker: It's a scary bug.

Next Speaker: A lot of **** hospital ****

Next Speaker: Um, yeah. We should add, I mean we should at least –

Next Speaker: ****

Next Speaker: - add candida.

Next Speaker: ****

Next Speaker: So we don't even actually have a fungus on this list.

Next Speaker: **** just both of those **** 1 and 2 –

Next Speaker: 1 and 2.

Next Speaker: - one category.

Next Speaker: Mm hmm.

Next Speaker: And **** candida ****

Next Speaker: Yeah. No, that's a great idea. Okay. We'll add that. Thanks for that.

Next Speaker: Any suggestions for other organisms that might be important that we didn't – aren't included? Like, I don't think, we don't – there's none of the vir- the, no viruses, no viruses are in there. ****

Next Speaker: ****

Next Speaker: Yeah. Yeah. So ****

Next Speaker: Okay.

Next Speaker: Uh.

Next Speaker: **** for the MDRO toolkit, is there a plan to do some ****, uh, facilities to see ****

Next Speaker: Oh, you know what? **** discuss that. That's not a bad idea.

Next Speaker: ****

Next Speaker: So ****

Next Speaker: Mm hmm. Mm hmm.

Next Speaker: ****

Next Speaker: Make a ****

Next Speaker: Yeah. Uh, with good connections ****

Next Speaker: I, I think **** it's gonna look different. Um, 'cause they, they really want – they'll, they will tell you they don't wanna have to read a lot. They really want something more visual and something simple that doesn't necessarily have all the description on the background but it is more focused on what they have to do, I think.

Next Speaker: Well, Lisa has a page they can turn to ****

Next Speaker: Right. Right.

Next Speaker: **** have to do ****

Next Speaker: Yes.

Next Speaker: I think the intent is to have it be used also in –

Next Speaker: Mm hmm.

Next Speaker: - in long term care facilities.

Next Speaker: ****

Next Speaker: But **** they can skip the background and they just go to –

Next Speaker: Yeah. And what, what we've talked about is –

Next Speaker: ****

Next Speaker: - is, because **** has, um, a hundred and how many facilities **** a lot of long term care facilities **** into, I think, um, their process of structuring and find some ****.

Next Speaker: Yeah. Great.

Next Speaker: Yeah, I think once we – I think the most important page of the toolkit is gonna **** be the recommendations **** so then people can refer to them. They can even print it out and post it somewhere and they can so oh, it's this organism – does the patient need isolation or not, yes or no, what type, when can they come out of it.

Next Speaker: Yeah.

Next Speaker: And are there any other special **** that we need to know about. Um, so I think once we have our, our first draft of that, then we should share it with stakeholders of all – from all of those different types of facilities and see if they feel like it's global and if they have questions or if there should be other details kind of in that indexed table, that can help them ****

Next Speaker: Okay.

Next Speaker: Any other comments? I'm gonna – in regard to these two topics? Otherwise I'm gonna come, um, to our last, uh, portion here **** comment regarding any concerns, questions regarding anything that's been mentioned today or other topics that you might like to see for future advisory committee meetings.

Next Speaker: And I'll just jump in that we're planning to present on our annual data. We **** list of updates, sounds like it might be of interest and, um, I don't know what else **** they have on the docket so if there's anything anyone wants to bring to the committee or anything the committee wants to hear from us, I'm hearing maybe critical access hospital is something that we

wanna talk a little bit more about, um, so Paul, if you're still on the line I'm – I'll reach out to you and any other topics at all **** entertain?

Next Speaker: I have one. Sorry, I just have to mention it. Um, going back – being back in clinical practice, I, I think one thing I've come across is that I feel like NHSN has been around long enough that everyone's teaching to the test and only worried about the numbers and sometimes overlooking when there are key issues.

Next Speaker: Mm hmm.

Next Speaker: So even if that central line infection doesn't meet criteria, it's like suddenly it doesn't become important to our, uh – if a surgical site infection with a strain as part of the outbreak strain doesn't meet the deep organ NHSN criteria then it's suddenly not so important. So I was just kind of wondering if that might be like a general topic to, to – I mean maybe these are things you come across in your, um, **** assessments **** visits and things like that but just sort of wondering where are the blind spots of NHSN and how our facility is using this data in a useful way and **** analysis or **** these cases now because they are more rare, um, so those are just like a general **** how to ****

Next Speaker: Now on the other side of the NHSN data, so. Anyone else?

Next Speaker: This is Vicki Orby. Um, I was wondering on the MDRO guidelines, have you considered including the assisted living facilities?

Next Speaker: Uh, I think –

Next Speaker: I thought they were in there.

Next Speaker: - yes. Yes, definitely. They will be included on there.

Next Speaker: Okay.

Next Speaker: Yeah. I think **** similar to the **** toolkit where nursing homes **** were broken out from assisted living facilities, um –

Next Speaker: **** assisted living, independent living –

Next Speaker: Yeah.

Next Speaker: - was apart from –

Next Speaker: Yeah. The **** surgery centers were in a different category, so.

Next Speaker: Separate from the nursing homes precautions?

Next Speaker: Yeah. They, they were more standard precautions in those settings **** so.

Next Speaker: Okay.

Next Speaker: **** okay. Great. Okay, well everyone have a great summer. Stay safe. Wash your hands.

Next Speaker: Yeah.

Next Speaker: Uh, don't eat oysters. I don't know ****

Next Speaker: ****

Next Speaker: No **** cupcakes ****

Next Speaker: No **** chickens. Cook your meat. ****

Next Speaker: **** river ****

Next Speaker: It was, uh, great to have you all on and have a good summer. We'll see you in September.

Next Speaker: Thank you.

Next Speaker: Uh.