

Healthcare-Associated Infections Advisory Committee
December 13, 2017

Transcription provided by outside vendor
Full voice recording of meeting available through *Recording* link

Speaker: I'm currently at, uh, Providence **** pediatric infectious diseases, and we'll be, uh, chairing the HAI committee meeting today. So first of all I want to welcome you and do a call to order, and I guess I'll just begin to my left here. **** and **** on the line.

Next Speaker: Uh, **** HAI program manager here at OHA.

Next Speaker: Uh, Daniel Bruno, uh, associate professor at Oregon State **** and I'm ****.

Next Speaker: And he's, uh, retired and needs some consulting for the Oregon Patient Safety Division.

Next Speaker: Laurie, Laurie Murray-Snyder, a project manager at Health Inside.

Next Speaker: ****. I'm ****.

Next Speaker: ****.

Next Speaker: Karen Brooks, infection prevention leg, Legacy Silverton Health.

Next Speaker: This is Leslie McClain. I am ****.

Next Speaker: Debra Katur, or, um, DHS.

Next Speaker: We'll do the folks on the phone. Go ahead. Thank you Debra. Anyone else on the phone?

Next Speaker: This is Christy **** prevention.

Next Speaker: This is Marissa Hadid from, uh, Legacy Good Samaritan Hospital.

Next Speaker: Stacy Garvaski from Well Memorial Hospital.

Next Speaker: Kirsten Judisasante.

Next Speaker: Art Ashby, Lacey Good Samaritan Medical Center.

Next Speaker: Hey, Sabrina **** from Lake Fisher Hospital.

Next Speaker: Mary Poshriner.

Next Speaker: **** Legacy Manuel.

Next Speaker: This is Conrad **** Hospital.

Next Speaker: This sounds like a great phone turn out. Let's continue in the room.

Next Speaker: Lisa Takigia, **** at OAJ.

Next Speaker: Uh, Wendy Edwards, uh, client care server for, uh, OHA, helps with license and certification hospital ****.

Next Speaker: Um, Alexia John, also HAI epidemiologist with ACDB.

Next Speaker: Diane Roy, research analyst, OHA.

Next Speaker: Monica San Perry, HAI reporting coordinator with OHA.

Next Speaker: Tara Buren, office specialist with OHA.

Next Speaker: Paul Cieslak, medical director for communicable disease, Oregon Public Health Division.

Next Speaker: Rosa Tamur, uh, epidemiologist with the HAI program.

Next Speaker: Great. And we're back to me so a great turnout today. Glad to have you here with some good stuff on the agenda. Uh, so first of all we're gonna move to introductions and membership updates from Rosa.

Next Speaker: So this is really just one introduction and, um, membership updates. Nothing has really changed too much since last time we met. But, um, in the meantime we do have a new office specialist. Tara is here with us in the room. Everyone should have gotten an email with a little bit of information about her so we just wanted everyone to be aware of, you know, who sent out the information about this advisory committee and who you're gonna be hearing from about HAI program matters going forward in general so hopefully everyone will give Tara a really warm welcome. We're really happy to have her with us.

Next Speaker: Okay.

Next Speaker: And I suppose from the phone as well, is there anyone new that hasn't, uh, previously been a part of the HIA, HAI advisory committee who would like to introduce themselves or introduce perhaps a new goal that they're playing. Okay. Great. And then we do have two vacancies on our advisory committees still, um, so the healthcare purchasing

representative and the healthcare insurer representative are both vacant positions so if you are aware of anyone who might be interested in or suited for one of those positions, um, we'd love to hear from you or them, um, and in addition we're always looking to engage more patient and consumer advocates and representatives so those folks would be very welcome to reach out to me or if you would pass on some information as well, um, to me, I can reach out to them with some more information about committee participation.

Next Speaker: **** in those roles, just to get a sense of ****.

Next Speaker: Oh gosh.

Next Speaker: You know?

Next Speaker: ****.

Next Speaker: I'm not able to like dig the name out of my memory.

Next Speaker: Sorry, I didn't mean to put you on the spot. I'm just tryin' to think about like who I would like reach out to, 'cause, you know, um, our, uh, ****.

Next Speaker: Yeah.

Next Speaker: It's been a while since we've ****.

Next Speaker: When I filled the position I literally cold called like Blue Cross Blue Shield and asked for somebody who'd be interested in serving in the position. Um, we had a gentleman, I remember his last name was Mitten but I don't remember his first name.

Next Speaker: We have the –

Next Speaker: **** information –

Next Speaker: – yeah.

Next Speaker: – in our records.

Next Speaker: Somewhere.

Next Speaker: Yeah, just tryin' to brainstorm as to what that person would look like and, 'cause I have no idea by that kind of demographic description ****.

Next Speaker: You know there is, so, the way our, the way the language is written there is no, you know, kind of explanatory information about these positions so, I think my thought is if you have a significant role in healthcare per se or insuran, health insurance or **** consumer advocate then that would probably be, you know, a good fit, a good enough fit ****.

Next Speaker: Like someone that worked at like a hospital that's involved in the, I mean could that be someone who is, I mean.

Next Speaker: Ab, absolutely, yeah.

Next Speaker: Because the, the servicing, I mean, I don't know, that's why I'm asking, ****.

Next Speaker: Or who works on like for instance, there are like, um, there's the Providence Health System that had insurance **** from that side then **** for example seeing Kaiser, um.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: Okay.

Next Speaker: And it, and it, maybe this, this is Genevieve, but those are on the call.

Next Speaker: Uh, that it maybe, it may be worthwhile actually get reaching out to some of the big groups specifically and seeing if there's someone who would be available. Because it's true, I think that many of us run in the clinical rather than in the administrative circles and so may not unintentionally come in contact with ****.

Next Speaker: Thanks everyone. Okay, well with that, um, we'll move to the next item on the agenda and I will entertain a motion to approve the September 27th, 2017 minutes from the last meeting. And for that I would need to, uh, two ayes to approve, either from the phone or the ****.

Next Speaker: So moved.

Next Speaker: Second.

Next Speaker: 'Kay. We have a first and a second and we're so approved. So now we'll move on. Next on the agenda is the HIA, HAI annual report. Um, **** 16 data. We're just gonna get the slides and ****.

Next Speaker: I think everyone should have been able to access the slides on, on the web site previously. Also for those of you in the room, we do have paper copies of our 2016, uh, summary report available here on the back table. For those of you on the phone, it's available on our web site. So, jumping in, um, some of us might remember back in the winter we sought some input from this advisory committee regarding how to present our 2016 HAI data. Um, considering the context of the newly released standardized infection **** using 2015 baseline that updated, uh, target SIRs from the Department of Health and Human Services. I can kind of guide us as we considered option we had three goals in mind, um, which are listed on the slide. Clarity, utility, brevity, um, and I think we can count **** successful effort, um, so the proposal that we ended up using which should feel like a good happy medium, was to roll all these

changes out over multiple years, uh, what this looks like was that the aggregate 2016 unit includes the original SIR and HHS targets in the graphs and we just reference the new SIRs and HHS targets in the introductory text. And then the facility specific data, data tables and maps which are on our web site, um, are presented using both the old and new SIRs and HHS targets. The next time we publish some more data, we expect that we'll analyze all of it according to the new SIR, remembering that the new models can be used for data from 2015 going forward and then we'll benchmark it according to the new HHS targets which are only applicable when we're analyzing our data according to those new national baselines. So circling back around to our goals, how does this stack up? Well, our hope that this approach is allowing us to sort of ease into this new information, um, slow kind of introduction could be positive for clarity and it did allow us to keep our PDF aggregate summary report about the same length which we believe is the strength of that report while the number of maps and tables that are gonna be going up online will increase substantially. And I just want to highlight the fact that, you know, your input and feedback is really important to us. We do listen to it and we do incorporate it in our activities. So thank you very much for your participation and advice on this. So, summary report does contain aggregate data. The slide has a link. It's on our web site. Paper copies in the room once again and it includes HAI measures for CLABSI presented by adult and pediatric ICUs and wards and neonatal, nia, na, neonatal ICUs. Our CAUTI data for adult and pediatric ICUs and wards, we have surgical site infection data for six different procedures. Lab I.D. events, so these are laboratory identified events of Clostridium difficile infections and MRSA bacteremia. And then bloodstream infections and access-related bloodstream infections related to dialysis. So what is new about this report? We added an acronym glossary. You can find that on Page 28. We removed the former Appendix 1 which was location mapping for reportable HAI from Oregon. If anyone wants to hear more about the justification **** I'm happy to get into it. And then we revised our language in our, uh, former appendix to new Appendix 1, uh, which are those recommendations for patients of families to minimize HAIs. On the next slides we're gonna go through the data for each specific measure, and remember that in addition to Appendix, um, 1, each section has a set of relevant prevention measures that link to the relevant CBC page in the, uh, section of the report and we are comparing our data to two benchmarks since they are shown on the slide, uh, comparison to national data and comparison to the HHS targets. Any general questions before we jump into the actual data itself? Okay. So for CLABSI, central line associated blood stream infections in adult and pediatric ICUs and wards, you can see that represented on the graph in a clear decline from 2009 to 2014. There's a little J-shaped curve in 2015 and 2016, both showing, um, increases from the prior year but not specifically ****. So we saw 57 CLABSIs in 2016, an SIR of .41 meaning 39 percent fewer than were predicted. Um, this was statistically significantly fewer than were predicted. It was below the 2014 national SIR and it did meet that HHS target of .5. And then **** pediatric wards, sorry that was ICU data and for adult and pediatric wards we observed 43 CLABSIs in those settings during 2016 and SIR .35 which is 65 percent fewer than predicted based on national data that was statistically significant. It fall then below the 2014 national SIR and met the HSS target.

Next Speaker: ****.

Next Speaker: In the neonatal ICU study we are seeing a rise so 13 CLABSI in 2016 with an SIR of .74, that's 24 percent more predicted than baseline national data but it is not statistically significant so we are seeing stable in terms of statistical significance, um, over the last few years,

actually over all years of data that we see here because the data are not large for this population. Um, our number for 2016 to fall up above the 2014 national SIR and it did not the 2013 HHS target of .5. For central line associated urinary, I mean capital associated, uh, urinary tract infections in adult and pediatric ICU wards, it looks we are seeing some movement in the right direction here, um, in the ICUs, 109 CAUTI were reported in 2016. 36 percent fewer were, uh, observed and predicted based on national data and it was statistically significant. Um, we did fall below the 2014 national SIR ICUs and we met the 2013 HHS target of .75. In wards we saw 75 CAUTI, uh, 48 percent fewer than were predicted based on national data and then that was statistically significant so that's a positive thing. Falling below the 2014 national SIR and meeting the target as well. We saw 906 C. Difficile lab I.D. events in 2016 so these numbers are high and getting a bit higher. Um, the SIR is .85, so 15 percent fewer than predicted based on national data. But this is not **** significant so really the same, right about what the national picture would predict. We fell below the 2014 national SIR numbers but we did not meet the 2013 HHS target SIR of .7. In terms of MRSA, bloodstream infections, we saw 57 in 2016 so this is staying very stable over time. The SIR is .61 so 39 percent fewer than predicted based on national data and that is statistically significant. We did see numbers below the 2014 national SIR and we didn't meet the 2013 HHS target of .75 for MRSA bacteremia. To get into the SSI, we saw seven infections following the **** in 2016, so this is a pretty compelling pattern of decline in, in my opinion. Um, the SIR demonstrated 73 percent fewer observed than were predicted based on national data and that was statistically significant so pretty good. It did fall below the 2014 national SIR and it did meet the HHS target of .75. Which I should say is the same for all SSIs. For SSIs following the **** procedure, we saw 11 infections in 2016, again we're seeing a pattern of decline over time. We saw 71 percent fewer than predicted based on national data. That was statistically significant and for these procedures, we did both fall below the 2014 SIR and meet the 2013 HHS target. For SSIs following abdominal hysterectomies, 12 infections were observed in 2016 so again, seeing that pattern of decline here, and with an SIR of .45 seeing 55 percent fewer than predicted based on national data. It is statistically significant and both falling below national, uh, SIRs for 2014 and meeting the HHS target. I know I'm going through these very quickly but this is just to give you a general sense of what's all in the report. For SSIs following colon procedures, we saw 91 infections. Again, seeing more or less stable, 25 percent fewer than predicted based on national data. Again, this is statistically significant, falling below the 2013 SIR and meeting the HHS target. For SSIs following hip, uh, replacement surgeries, there were 67 infections in 2016. These numbers are bit all over the place, um, the data from 2011, 2012, and 2016 all look kind of similar with that sort of 3-year dip 2013 to 2015, um, we saw an SIR of 1.03 so 3 percent more infections than were predicted. But this was not statistically significant. Our numbers fell above the 2014 national SIR and we did not meet that 2013 HHS target for this data. And for SSIs following knee replacement surgeries, 48 infections were reported through 2016. There was a dip in 2013 and 2014 but now we're seeing a little bit of a rise and kind of maybe some stability in these numbers. We did, um, see an SIR of .78 so fewer than predicted based on national data but not statistically significant and so our numbers did fall above the 2014 national picture and did not meet the target from HHS. And then finally dialysis of that data. We saw 39 percent fewer dialysis related bloodstream infections than the national average in 2016 and 48 percent fewer access-related bloodstream infections than the national average of 2016. So summarizing the findings in 2016, most of our reportable HAIs in hospitals were both statistically better than predicted based on national data and the national HHS targets. Um, and our dialysis facilities performed pretty

favorably. A few of our HAIs, uh, do need more attention and continued infection prevention efforts such as everything needs continued infection prevention efforts but maybe a little bit more love to **** in the neonatal ICU setting, surgical site infections following like a knee, uh, prosthesis and those C. Difficile events. In terms of the facilities, specifically under the original baseline, so we do have the facility-specific tables and maps using that original baseline now available, um, please note that after clicking on tables you would like to view, you will need to select explore data and view data in order for everything to display correctly. You're gonna see this note on our web site, you know, when you're clicking through the links to get to the tables and maps anyway, but just a, a friendly reminder, if you have problems viewing the data, it's probably due to the extra step this year. This is just an example of what our maps look like. These are customizable to a degree so that's exciting for anyone that wants to kind of manipulate the look and feel of these. And our tables are even more sort of flexible and customizable than the maps, so there are options to filter, reformat them, create visualizations and export them as well. Facilities specific data under the 2015 baseline is in progress. We have, you know, the SIRs are analyzed according to the updated 2015 baselines. We won't include percentiles on the 2014 national baselines in these new tables because we have a more updated kind of comparison that are benchmarked according to the updated HHS target SIRs which are kind of a partner to the 2015 baselines for the SIRs. Um, they do not include symbols showing SIR and HHS target progress, um, background. They do include symbols showing SIR and HHS target progress. And the data are presented in more granular categories. So for our CLABSI, CAUTI, MRSA and CDI data they are broken down by facility category and for our SSI data they are broken down into adult and pediatric data. And finally our dialysis event data will be presented as an SIR for the very first time. So, in terms of our communications, I have some minor updates to this slide so our report was published November 1st, 2017. We did email notifications to our partners. Announcements went out via List Serves for **** the health insight group and the Oregon Patient Safety Commission so thanks very much to all of our partners for helping us to publicize the report. Social media posts went up. We have, um, we have the report posted on our HAI program web site and the ACDP web site. Press releases came out both from the Oregon Health Authority and the Oregon Association of Hospital and Health Systems. We had mentions included in partnered newsletters and communications. We published an issue of the communicable disease summary recently and some press from the Portland Business Journal. We also asked much earlier this year via the **** List Serve if any hospitals had patient and family advisory committees to please let us know and the three facilities that told me that they did we sent them directly to the person who responded and asked them to share, um, you know, if there are any other folks on the line or in the room who work at a facility that has a committee like that, um, I'd love to hear about it so we can engage those groups more in our efforts so please feel free to just type up whatever or email me or call me directly. So, not sure how we're doing on time. This is a lot of information. I'd love to hear from everyone about how you heard about the report, if you got the report, if you're going to use the report and if you share it with anyone and be, or even move into that discussion for a few minutes. I just want to acknowledge two groups of people, one of which is all, of course all of our, um, facility partners who reported data, reviewed data, we know this is really hard work and it takes up a lot of time, and without you guys doing that we would not have anything published so thank you very much. And also, um, our group here, uh, um, ACDP which included Lisa, our publication group, Diane, Monica, Alyssa, **** from my leadership so thanks very much everyone who was involved, and I know

I'm missing people so apologies for that but, it's a lot of work so, yay. So with that being said ****.

Next Speaker: I think it looks, yeah, I think it looks really good Rosa. It looks really nice.

Next Speaker: Yeah, and see that, this is Genevieve, I think this is a very nice summary of everything, and it calls out, well not only work that's involved in it but you know, places for, for improvement ****. So I might have some follow-up questions on that, on that ****.

Next Speaker: Anyone else from the phone or the room that had any questions or comments regarding the report? Does anyone have thoughts about how they will use this report?

Next Speaker: So actually yeah, **** so that **** or List Serve and did a **** and it's really great that **** hospitals, uh, **** and there's **** so that, that's pretty good ****.

Next Speaker: Thank you very much for sharing.

Next Speaker: This is, I'm just, this is Genevieve, I'm curious if **** the legislature ****.

Next Speaker: Yeah, I was ****.

Next Speaker: All the work, all the Oregon hospitals are doing basically, even to.

Next Speaker: They did specifically ask about it, um, when we **** down there ****.

Next Speaker: ****.

Next Speaker: **** but, uh, said I don't know, I mean I think we should almost get a, uh, that they, um, confirmed that they received it in the exactly the right hands 'cause it was, um, uh, you know, they, they weren't exactly sure that they had received it, seemed like there was some, you know, um, so.

Next Speaker: I assume that, well I ****.

Next Speaker: Thank goodness ****.

Next Speaker: **** it's there, but is it, you know, and then **** but you know –

Next Speaker: Yeah, right.

Next Speaker: – you know.

Next Speaker: Right. And it goes through our legislative liaison folks.

Next Speaker: Right.

Next Speaker: Um, so, right, so.

Next Speaker: I, I think this year they heard, like, A. We have a new legislative liaison folks. B. I think they heard that message really loud and clear so I'm pretty sure that everyone that needed to get it got it so I, I'm ****, otherwise we'll find out next year when we ****.

Next Speaker: Any other thoughts, comments, questions about the report?

Next Speaker: I mean do you have a list pie in the sky for how it should be used? I mean is there like, you know what I mean? You can distribute it and people might get it like, **** get it and put it on my desk and pick it up. If someone has a question about something then.

Next Speaker: Hopefully it will be used to direct priorities –

Next Speaker: ****.

Next Speaker: – within the facility –

Next Speaker: Yeah.

Next Speaker: – to a certain degree. I mean I think that aggregate report is great for kind of a situational awareness of like what is happening as a state and the facility-specific data tables and maps should provide some context for an individual facility of where they kind of fall in the spectrum of other Oregon facilities. So, you know, ideally it would be used to direct infection prevention efforts.

Next Speaker: Right, yeah, I guess that's, maybe I didn't, um, I, I guess other than kind of informal feedback on how we're distributing it. Is there ways to get a better sense for its kind of penetration into policy and, um, you know, you, you add a place for like people to cite it, but I don't know where you would expect to see it cited, um, I don't know where you would expect to hear people say, well, according and we did this, and I don't know if it's worth pushing that agenda a little bit to kind of justify the, um, the, the need and the effort and all those things. I think it's a great thing, like, it's one of those things that, you know, I think that you, you want people talking about it right? Other than when you ask people if they're seeing it and if it's **** and so I guess, you know, it would be nice if there was some way to, to get it to see it cited like since where it's supposed, or maybe people are using it. I'm, I'm thinking out loud here –

Next Speaker: Yes.

Next Speaker: – it's just one of those things, you know, where like, uh, yeah, I got it. It's in my mailbox and **** thanks for sending it to me to look at it and, but, um, I'm not sure how I would cite it in my academic work necessarily, I mean maybe, if I was looking at specific disease state, we could say that this is what it is in Oregon, you know, kind of like in the background section or something, but, I'm just wondering how, uh, Samaritan would say that, what they're doing, or what, um.

Next Speaker: Well each hospital's gonna get a list of, you know, where they rank –

Next Speaker: Mm hmm.

Next Speaker: – right, in, in the state. I mean they're gonna be able to see how they compare so hopefully they'll each be taking a look at, you know, what's, what are the main things we need to work on. I, I mean I, I look at this report and I'm, and I think, you know C. Diff is a huge issue that I think we need to put resources into, you know, maybe we need to study it more, why, why have we stalled, you didn't mention, uh, CLABSIs among your, your, your big thing but we seem to have stalled on the CLABSIs, we, we had a big decline in the first year and now we seem to be level for several years, um, and hip and knee prostheses, you know, those are devastating infections sometimes and, you know, so, either we try to gather more data around why are we still seeing these infections and I, I don't, I don't know whether we have the resources to do that or whether, you know, Oregon Patient Safety Commission can try to, you know, get the ball rolling somehow, uh, uh, statewide, those, those, those thing jump out at me.

Next Speaker: Mm hmm.

Next Speaker: I think this is also one of the reasons that, um, you know, there's been some flexibility introduced into how we present and publish shared data. We talk about this last meeting but, um, our hope really is that we can get input kind of on the front end about what would be helpful in meeting **** facilities and partners and take that into our process, and we do need to focus in on issues exceeded for CLABSI in particular that we have to have the resources and the time to focus in on this ****.

Next Speaker: **** the leverage for more funding or for more, um, you know, concentrated efforts or follows the rule changes.

Next Speaker: Yes you could.

Next Speaker: Yeah. Who does that? ****, yeah, I mean sure, we could do some of that but I, you know, those, that's kind of what I'm also getting ****.

Next Speaker: Yeah.

Next Speaker: Not that the, this is Genevieve, that the right groups have it 'cause like you said, the joint **** um, jump out, has this been shared to the Oregon orthopedic surgeon blah, blah, blah, I don't know who those people are, and the NICU stuff throws out, all of our NICUs are involved with Vermont Oxford Network. Do they, are they aware of this data? You know, do they specifically have **** that of the focus and a priority, further programs, so you really coin off those key ****. Maybe having to track down the people who do something about it but that, that's the issue. What is it about being in hip prostheses that's –

Next Speaker: Yeah.

Next Speaker: – an issue.

Next Speaker: Yeah, I know we've had a couple outbreaks that have been investigated and, and had timing.

Next Speaker: Well, ri, right, and.

Next Speaker: Together.

Next Speaker: And, and, you know, now that we've identified the outcome of the concern, you know, I think then you, you go back and start lookin' at the process measures and you know, are they, are they adhering to, you know, the various, uh, recommendations to prevent those infections or, you know, so is it, is it a failure of the, of the bundle or is it that, um, failure to use the bundle in the first place? Um.

Next Speaker: **** is changing on a lot of those kind of or the things I feel like, I mean, you know, my dad had double **** and, and, um, I don't know if they do more or less of those now, you know what I mean? I mean, it, it, you know, it's, it's hard to say but, um, I, I, you know, you worry about, I, I was shocked that this guy was so cavalier about it. I'm, you know, ****, uh.

Next Speaker: And another piece I'm thinking about also is then you guys do an EGI survey thinking about, is it something about the surgeries about, uh, standardization, of say pre-op or bundling or whatever, uh, are those used throughout all hospitals? Or is there a lot of variation or, I don't know, you probably have to delve into it but I think, I guess that's how I would see this would be really nice to **** replacement, use other tools that you guys use, like survey. Um, and then my, one other follow-up question, and I, I know we need to move on to the outbreaks, but just run through that out here, some of these, uh, measurements, hospitals are doing fabulous at. Is there, uh, is there any thought eventually to, um, putting some of these measures maybe in the background and bringing on other measures. So for example, I'm now you know, doing more OB and pediatrics, uh, and looking at, um, uh, you know, Cesarean surgical site infections which has an **** definition and that kind of thing but just wondering if at some point some of these metrics will be good and stable and will solicit other opportunities 'cause as we all know, where there's certain reporting and, and need for, um, uh, responsibility then that's where ****. I just wanted to throw it out there, not **** discussion now but. Any, any comments from the phone?

Next Speaker: Yeah, this is Constance Trudy from Asante. I just want to echo what's already been mentioned, but I think it would really be helpful to try to get this information to the groups that have stakes, um, in some of the data but may not know about it, um, and it may not be shared with them readily. I know we've been working hard here to kind of implement a bundled approach to try to reduce surgical site infections, um, kind of an uphill battle, especially when we have a disparate surgical groups in the area, they're not all hospital employed, um, so I think there was information that was coming from the state to state societies, um, that could help get that message across in a different venue, um, it would also help them be a little more receptive to recognizing, you know, this is a problem that we're really as a state approaching it, not just one individual hospital and that there are certain things that we all agree are the right things to do here, to reduce those, um, reduce those events.

Next Speaker: Excellent. Great comment. Thank you. Anyone else from the phone or room? Great. Thank you. All that input has been duly noted. Uh, next we will move on to, Lexi who, uh, will provide us an update on our outbreaks in the state.

Next Speaker: Good afternoon. Um, for the people that don't know me, I'm one of the epidemiologists with **** oversee prevention, um, program ACDP. So I'm gonna give you a brief update of **** and **** September, um, had I realized earlier that this was December I probably would have done a year-end review but apparently December doesn't ring any bells to me anymore, so. Anyways, since September we have had 38 outbreaks reported to the State **** Health Departments. Most of them were GI in nature so it was some sort of vomiting, dia or diarrhea. Most of the GI outbreaks were norovirus in etiology and the majority of those occurred in long-term care facilities **** long-term care facilities. The others, uh, the other norovirus outbreaks occurred in daycare centers. That's what BCC is. And schools and then other, uh, and then we also had a **** outbreak at a daycare center, a salmonella outbreak, a sapovirus outbreak at a long-term care facility, two E. Coli outbreaks, one that happened in a restaurant and one that happened in other, in another, um, setting. I am gonna go through the, one of the E. Coli outbreaks and one of the salmonella outbreaks later on in more detail. And then we had four GI outbreaks of unknown etiology but were probably noro-like, um, and two of these occurred in long-term care facilities. We also did see some respiratory outbreaks for Influenza B outbreaks, three of which occurred in long-term care facilities. We had a pertussis outbreak at a school and a mumps outbreak in a clinic. Um, we also had a strep **** outbreak in a daycare center and then three unknown respiratory-like illnesses at long-term care facilities. Um, there were three rash outbreaks at all occurred in daycare centers, and then another outbreak that occurred in, um, ambulatory surgery centers, the ASC is, and I'll go into that, um, in more detail in a little bit. What's really interesting is that we've had 38 outbreaks, um, between, this was September 1st and December 1st and then in this past week alone we've had like 10 outbreaks reported. I think **** would know better than I, 10 or 11 outbreaks so far, so, um, tis the season apparently since this week, so, um, so looking into healthcare-associated infections specifically, um, healthcare-associated infections accounted for just about half, just over half of the outbreaks reported from September to December. The majority of them occurred in long-term care facilities, so ****, and the most common etiology was noro or noro-like infect, uh, noro-like outbreaks. Looking specifically at long-term care facilities, the majority of the outbreaks occurred in assisted living facilities, that's 9 out of 10, 6 of which were norovirus etiology. Six occurred in skilled nursing facilities and three occurred in residential care facilities, so. Alright. Going into the ****, so I'm gonna talk about a salmonella outbreak here, um, so this was interesting, this was a salmonella and **** outbreak, and of course I pulled these data back, um, a couple weeks ago so, um, there might be updates since then, um, for this one I don't think there's an, an additional update but so this is an interesting outbreak because at first we thought it was just Washington, it was a Washington outbreak but it was like 17 or so salmonella **** and, uh, **** cases in Washington but then we got involved because two cases occurred here in Oregon. Six of the Washington cases were hospitalized and there's actually one death associated with this infection in Washington. But here Oregon we had no hospitalizations and no deaths. The onset range was, um, all between the end of October and the middle of November, so 10/29 to 11/15, and Washington was actually able to determine that the likely source of this outbreak was from pre-cut fruit implicated, uh, pre-cut fruit and then went in Oregon distributor. And so they thought that this fruit was either watermelon and/or cantaloupe. I'm not sure, or at least at

the point when I did this slide, we weren't sure if it was either watermelon and cantaloupe or watermelon or cantaloupe ****. And Washington a female just were able to deduce that's the Oregon distributor was mostly distributing to, um, the grocery stores listed. So that's Fred Meyer, QFC Grocers and Central Market in Oregon and Washington. So that's, uh, Kroger brand, Kroger brands specifically, so. Um, I don't think there's been any additional, um, any additional cases to this outbreak.

Next Speaker: So just to clarify, so it's, the fruit is cut up at some place and then distributed.

Next Speaker: Right. So this, the fruit is cut up at this place in Oregon which then distributes, packed and distributes to, um, Kroger brands supermarkets.

Next Speaker: ****.

Next Speaker: The FDA didn't get involved.

Next Speaker: Oh totally.

Next Speaker: Totally.

Next Speaker: Totally ****. All right. Next is this E. Coli **** by seven outbreaks. I'm really glad that's ****.

Next Speaker: **** uh, update us if things are different. So, this was interesting. The current case count was, or, were, ten different cases or 25 percent of the cases, so lots of, and lots of diarrhea here. Um, the majority or over half the cases were females with 23 of the cases being females. And age range was 1 to 74 years of age but most tended to be in the, um, young middle-age group, so 20s to 30s. And onsets ranged from the end of September to, to the beginning of November, um, though I think since pulling these data there might have been an additional couple of cases that I'm missing here in these slides. So initially what happened is that there were some females that all had this E. Coli own, O103 infection that matched like pulse field gel electrophoresis. Three of the seven cases indicated that they ate some CSA produce which is community spread agriculture from the same farm. And then in addition to that, the other four cases shot at stores that sell produce from Farm A, or that Farm A distributes to. So a epidemiologist here reached out to the farm that does this community **** agriculture to inquire about illnesses and we sent a, sent out a letter to all CSA members and that's when we found an additional 24 cases with the recent, um, onset of diarrhea. Um, because everyone basically ate everything in their CSA monthly boxes or bi-monthly boxes, we weren't able to indicate any pro, uh, produce specifically through trace back. Um, epidemiologists here, ACDP, FDA and ODA visited this farm and took samples of the produce, the water and some environmental samples of like benz and stuff like that and, um, also additional samples from produce that were sold at stores and all of those are negative to date. So, um, ****, is there anything I'm missing?

Next Speaker: No, that's ****.

Next Speaker: Great. I'm not gonna say anything so I'm moving on to the last outbreak here. So this one was kind of also, I thought was really interesting, um, so this was, uh, peptostreptococcus magnus and ACL repair. So, what happened was an **** ambulatory surgical, surgical center called her and report privations with ACL surgery sites infected with peptostreptococcus magnus, so for those that don't know, peptostreptococcus magnus is an anaerobic gram positive coccus. It's part of the normal flora of the GI tract, oral and nasal cavities. Um, if you look through, uh, if you do a lit review you would find an article that suggests that peptostreptococcus magnus is responsible for bone and joint and infections after ACLs **** back in 1998, um, and recently peptostreptococcus magnus was reclassified as this finegoldia magna which is definitely not as fun to say as peptostreptococcus –

Next Speaker: Mm hmm.

Next Speaker: – so, um, so what we know about these three cases is two are males one are females, age range is 18 to 32 years of age, and then the onsets were about a year and a half apart, or the onsets all occurred within a year and a half. So first onset occurred in April 2016 and the last onset occurred in August 2017. The cases presented with septic arthritis with fever, um, anywhere from 17 to 34 days after surgery. Um, small cases did require wash-outs and antibiotics and one patient had a graft, yes.

Next Speaker: Um, how long after the surgery until the infection?

Next Speaker: It's about 2 weeks.

Next Speaker: She said 17 to 34 days.

Next Speaker: Yeah. So about 2 weeks from surgery to onsets. Um, so these cases were otherwise healthy apart from these ACL, the ACL surgeries. So.

Next Speaker: Do you know what kind of ACL repair they had?

Next Speaker: It is, um.

Next Speaker: Two ACLs, on ACL but all went ****.

Next Speaker: Oh, okay. That'll do. ****.

Next Speaker: ****.

Next Speaker: So.

Next Speaker: **** ASC and like observed every, or observed the surgery and we have pictures from that so, um, in, in the slide.

Next Speaker: Sorry, didn't mean to –

Next Speaker: ****.

Next Speaker: I really hope not.

Next Speaker: So all three of these surgeries occurred in the same operating room, uh, at the ambulatory surgery center, um, the, the ACL surgeries are performed in all four, uh, or in all four operating rooms in this one facility but other surgeries are also performed in all the operating rooms. There were two different surgeons and no staff that were common to all these surgeries, and so it's a type of, um, ACL surgery that was done is an autologous hamstring graft and arthroscopic equipment was used, so, um, that picture that you see, uh, we're on Page 35 here, um, is the tool that was used to prepare these grafts, and so the grafts were handled by a bearded masked surgical assistant for about 25 minutes, and this is a really old school, it's about 8 years old, um, it has many dents and cuts in the metal and, um, I'm not sure if, you know, how they ****.

Next Speaker: They, um, use a, um, anosmatic, uh, disinfectant and then they place it in a high temp wash, 190 degrees, um, and then it goes into the clean room where they package and then autoclave.

Next Speaker: 'Kay. And, and then so, uh, Magdalena, who's my **** epidemiologist here learning, Cassidy, another epi and Becca McDaniels AC and they observed at least one of the operations and took some environmental samples, en, environmental swabs, and so, um, these samples went to the CBC and we're still waiting for some test results, however this is in Anrove so we wouldn't expect it to find it living on tools since **** so I guess going to come on this one. Any questions?

Next Speaker: Tell me about the **** where they, uh, hamstring site.

Next Speaker: So, yeah, they use a core exiting the **** case of the surgical wash to, it's the same surgeon that had one of our cases. The other, um, used a **** and iodine based ****.

Next Speaker: **** iodine ****, they used both preps did you say?

Next Speaker: ****.

Next Speaker: Do they have a, a protocol in place for the patient's to do ****?

Next Speaker: These patients do not. They do for their replacement knee **** surgeries. They do not have them ****.

Next Speaker: Do they have any theories about what might be happening? I mean.

Next Speaker: They don't. I mean I, I think it's hard with three cases.

Next Speaker: Right.

Next Speaker: Um, and there's a lot, there's a lot consistent about the three cases but there's also nothing, no smoking gun that's super obviously between them. Um, I think our immediate reaction was that, you know, that graft master is something that's fairly particular to these, um, ACL surgeries so, uh, you know that was our first kind of focus for environmental samples.

Next Speaker: But didn't you say it gets autoclaved after this?

Next Speaker: It, it does, yeah.

Next Speaker: 'Kay.

Next Speaker: Did you have, what did it look like when they, when they, when they were done? Was it, and was there a lotta stuff all over it?

Next Speaker: Yeah, yeah, the problem is the Teflon surface where they literally hammer out the graft. It's full of divots and it's an uneven surface. And this is an anaerobe but it is, it hasn't gone the semi **** tolerant **** situations and it can form biofilm so there is a potential that on something like that it could survive. And also you can't really see it there but one of the things they do after they kind of bash it out and sew it up is pass it through a cannulated piece of metal equipment, um, and that's always a bit of a concern. It does go through the high temp wash as well as the autoclave but, um, there's a lot of surfaces in there, so that was ****.

Next Speaker: And do they have any plans to replace it just because it is older and 8 years old and.

Next Speaker: They are replacing the, they have about six of them, um, and they are replacing the Teflon surface on all of them at least. They had also swabbed their Craftmasters but, um, one of the things we worried about is the lab that they were using for some other testing had some trouble identifying the organism in the first place and that's just, they don't do a ton of anaerobic testing I think, but, um, so, and you know, and **** maybe we wouldn't have identified it as easily ****.

Next Speaker: We, once again an astute IP. ****. Thank you for whoever reported that. Uh, so any other, other questions from the phone about outbreaks? Okay. Next on our list, um, before our break is, uh, Becca is gonna speak to us about some exemptions.

Next Speaker: 'Kay. Um, so exemptions in this case which really refers our HAI reporting, um, so one of the things that I think has been done really since we started, um, reporting HAIs to state, um, was give exemptions to facilities in two specific situations. One, um, for central line associated blood stream infections, if they reported less than 50 central line days in their facility or for a, um, specifically a procedure type, um, if they did less than 50 surgeries a year they wouldn't have to report for that particular surgery. Um, so I think, as we've kind of gone forward processing these exemptions we found that it's, it's fairly burdensome for both our facilities and, as well as on our side to kind of process the exemptions to determine whether they qualify, um, to get **** back to us, to have us maintain it in a way that's up to date, um, but also we really increasingly been talking about, um, these facilities where few procedures or few central lines

are placed and sort of challenging the notion that, um, those facilities might be lower risk and, you know, I think one of the things that we want to consider is that if the facility isn't placing as many central lines, if they do fewer surgeries than other high volume centers, we may really wanna know what's happening in those facilities. We really may wanna know how many infections they are seeing. Um, so one of the things we're kind of proposing to the group just for feedback today, is to consider removing the exemption all together. Um, just to simplify things a bit as well as to sort of make sure that we are tracking what's happening in all facilities **** central line **** are, um, there are other ways to be exact for reporting, for example if you don't have a NICU and **** NICU data, there are other ways to not report data but, um, this is one that we feel may add some unnecessary complexity, um, so we really just wanted to open that up to the group and, and see what people thought about it. This is a change that we're sort of proposing for the 2019 year. This isn't something we plan on doing overnight but, um, we, we do feel that it could potentially simplify things and allow us to have a better sense of what's going on in some of our facilities.

Next Speaker: Uh, this is Jen, just a little bit of background, uh, how many facilities are currently exempt?

Next Speaker: **** I don't know, you may not know off the top of your head but is it a, a ****?

Next Speaker: Yeah, a 10 percent of, it's quite a few because you can be exempt from one of many –

Next Speaker: Okay.

Next Speaker: – procedures for example. It, it is quite a few but it varies depending on the facility, how many exemptions we get or something like that but, a few ****.

Next Speaker: Hi, this is Mary Shanks and I have a question on that kind of thing so if somebody says that, you know, six procedures of a certain type and had an infection, obviously they're rate is gonna be high so, is that something that would be kind of looked at or reported out publicly? Um, because it really, it was such a low denominator, a small denominator, you get, you know –

Next Speaker: Right.

Next Speaker: – a rate that's –

Next Speaker: Yeah. Yeah, I think that's a great question and, you know, I think, um, in this case you know, we're making a distinction between reporting to us and then what is made publicly available so I do think there is reason to consider kind of on the back end of this, um, suppressing certain data when there are just really low numbers and things like SIR –

Next Speaker: Right.

Next Speaker: – becomes super uninterpreted ****.

Next Speaker: That makes total sense to me, right?

Next Speaker: Right.

Next Speaker: And this is Genevieve, is there any precedent of other states that sort of again do maybe what you were saying about, that report to HAI **** but it's not necessarily publicly available?

Next Speaker: Yeah, I'm gonna let Rosa comment 'cause I know she has experience ****.

Next Speaker: Yeah, so when I did the, did some more in New Hampshire we didn't have any exemptions at all, um, but we did center our data when we published them according to certain criteria. Uh, Connecticut also. No exemptions.

Next Speaker: Any other thoughts?

Next Speaker: Concerns about empty burdens to small facilities? I mean I don't, coming with experience from New Hampshire and Connecticut, I don't know or from someone on the line ****.

Next Speaker: Connecticut, **** reporting requirements with CMS so there are no concerns in that regard. New Hampshire has had, um, these requirements across the board for, it actually has more requirements than many states in terms of like facility types, so they have required SSI reporting for ambulatory surgery centers etc. I think it's just more ingrained there no matter what type of facility it is, they are all reporting all of the required measures so.

Next Speaker: I do know thought that Oregon requires more SSIs to be reported than CMS does.

Next Speaker: It does. So there are some facility that may see increased reporting requirements with the removal of the exemptions. And there are many facilities that would remain exactly the same. It just kind of depends on what other requirements they have. What are they doing for their own internal purposes, lots of different stuff.

Next Speaker: Right.

Next Speaker: I'm curious if Paul or anyone remembers the conversation on how these exemptions initially got put in place. I think that like right before I started so I don't, I mean, get involved with it but I didn't know like the decision making would be ****.

Next Speaker: I'm sorry, I, I don't remember.

Next Speaker: It was a grandfathered thing that came to us with the reporting program when we started it.

Next Speaker: Yeah, well, that's what I'm saying.

Next Speaker: Yeah, yeah.

Next Speaker: So that's, that's what I'm tryin' to figure out where, you know, the thinking behind that initial –

Next Speaker: Yeah.

Next Speaker: – 'cause that was like right before I was here, so.

Next Speaker: And I don't know if Brook's on the line **** but that, but, uh, the comment was that the initial exemption would grandfather in from the previous reporting system.

Next Speaker: Mm hmm.

Next Speaker: That was **** program.

Next Speaker: Right.

Next Speaker: This is Mary, and I was on the original rules writings committee or group and, um, it really was because of the concerns about the, um, statistical variation with the smaller numbers, that it would be meaningful.

Next Speaker: Right.

Next Speaker: Makes sense.

Next Speaker: This is Rosa. I'll also mention just as a side note that for all of the folks from facilities in the room, we did send out a letter or an email on November 30th I believe, um, so just asking everyone to review their current exemptions and let us know if there are any changes for 2017 and 2018 so there's no requirement to respond to it for those of you didn't respond you may get some reminders from me just so everyone remembers to do it if you want to.

Next Speaker: Well thank you for that feedback. That's very helpful. I, we do plan on kind of taking this to some of our critical assets hospitals and other facility partners and just getting **** as we go forward.

Next Speaker: We got some good stuff ahead, uh, involving animals and pets in the hospital, but before we get to that, we're gonna talk about data priority.

Next Speaker: Something much less exciting.

Next Speaker: Right.

Next Speaker: Um, so, one thing I did wanna, uh, mention first is that in relation to where we talked about at our last meetings, um, of **** proposals either Oregon **** administrative rules. Um, one of my, um, was specific to our meeting was that, um, we had, um, altered requirements

for our HAI annual report, um, this really just affected the timing and contents **** the report **** gives us some additional flexibility to report on other things, uh, as well as, uh, gives us some additional time to focus on infection prevention. So this was presented at last ****, um, there was a rules committee meeting about this as well as a hearing that took place on December 1st and I just wanted to share back with you all that there were no formal comments made, um, during that period. Um, so in relation to that, and this will really be a standing item on our agenda going forward, we want to just reach out and see if anyone, especially based on what we talked about today maybe has any thoughts about data priorities, things they'd like to see published from our program, um, and things they'd like us to focus on going forward. It's okay if there are none right now. No, no pressure, but we just wanna, we wanna put this out there and we will be kinda bringing this up at every meeting just to see if there are any suggestions or, um, things people are really feeling strongly about going forward.

Next Speaker: This is Genevieve. I'll just throw out what I said before but, um, I, I've been asked by the OB providers based upon, I think there's one or two or three articles regarding, uh, prophylaxis around Cesarean, C, so Cesarean sections, uh, for delivery of babies and typically it's just sephasm that's used like any other SSI but now there's some **** about adding Azithromycin. So, if that was, you know, alone just at Saint Vincent's I think there's about 40, uh, sorry a little over 4,000, 4,500 deliveries a year, so then suddenly adding ****, you know, and then there's only a certain percentage of those, maybe 15 or 25 percent I think. Forget what the national average. But if you take how many deliveries there are a year, the percentages of those that Cesareans, suddenly we're starting to add Azithromycin to perioperative prophylaxis. That would be a lot of increase in antibiotic exposure, um, and so one of the, the data points we were interested in and didn't have was again what is a Cesarean, uh, surgical site infection rate. And apparently there isn't an NHSN definition and it's not currently looked at in Oregon, um, but that was just something that came up where, uh, looking, you know, having that data and whether it's tracked or not may have some impact about whether there's big changes to surgical site infection and antibiotics stewardship, things like that so I don't, that's just one idea, not necessarily that it's applicable everywhere but.

Next Speaker: Maybe finding out ****.

Next Speaker: Hi, this is Mary, uh, Shanks over here at Kaiser and I know that we track those internally. Uh, we don't necessarily enter them into NHSN because of all of the data points that are required for, um, the denominator input, um, but we do track those. I bet you a lot of other places that do volume update sections track that as well, and I think that would be something to look at. I, I agree.

Next Speaker: Thank you.

Next Speaker: And we'd be willing to share our rate.

Next Speaker: Okay.

Next Speaker: That's all I have. Thanks ****.

Next Speaker: Great. Well if anyone has any, um, comments or suggestions, uh, you know, from their facilities, thinking, as you kinda talked about before is you did really well **** MRSA **** to control if there's new **** to come on board, uh, please reach out to, uh, Becca Lozak. So next on our agenda is Dr. Melida Vasquez here to talk to us about infection control guidance for animals in healthcare facilities and thank you, this is very timely. Because we've been seeing more and more –

Next Speaker: Animals.

Next Speaker: – animals in the facility. Talk about cats and things like that.

Next Speaker: Excellent.

Next Speaker: So, ****, so and then there was a lot of discussion on the **** List Serve recently so hopefully this feels like it's kind of tapping into some of the conversations that are going on, and if anyone has topics, you know, we do pay attention to what seems like people wanna hear about but in their, later on in the agenda you should also pipe up if you have anything, any ideas about future ****.

Next Speaker: All right. Um, so thank you everybody for inviting me. Uh, this is actually a very interesting topic, mostly because I think you like Genevieve said, uh, we do see more animals coming into healthcare facilities, and the question is, when is this gonna stop. Um, answering my question but it may not be everybody else's question but, you know, the question is are we really taking care of our patients, human patients, uh, when animals are brought into clinics, hospitals, nursing homes, etc. So, I'm gonna go through, I put together a few slides and information that I found on the use of animals in, in, uh, health facilities. Feel free to ask any questions as I go along or wait until the end if you have any, um, any, uh, um, questions or concerns or if you are interested in putting on some sort of program together or guidelines together I can, I'll be happy to help out if that's what you want to do so let's just go through some of the basics here that I found, uh, through lookin' at papers and I'm tryin' to understand a little bit more as to what's going on with animals in assistive facilities. So right now many hospitals and even long-term care facilities are actually allowing animals to come into their facilities. Um, based on the lack of scientific evidence I think that there's lag on what are the requirements here for these animals to come into the facility, such as things like an annual checkup, do you check the stools for parasites, you know, is that an, does that animal have any ectoparasites like fleas, you know, anything like that that could potentially be a source of infection or problem, uh, not only to, uh, the individual but also to the hospital in general. So we look at and we're gonna talk about definitions because there's multitude of them. One of them is residents that have their own animals in facilities, and those are people that go into nursing homes and bring their own cats in or which we, we saw one in, uh, when we were in, uh, Corvallis, um, at a facility. Other dogs or you know, any other animal. It could be a bird, it could be a snake, you know, it's whatever your flavor is that day or that month. And, and that's completely okay and it seems to be allowed and people do like to have their animals because they do provide, you know, that sense of being at home at a place where they **** like they're lonely and they feel supported ****. Then you have animals that are animal in a assistive, uh, activities which are volunteers and this is not related to service animals that I'm referring to by any means, but animals that are volunteers that

actually bring pets into hospitals or nursing homes, just to enhance, uh, the quality of life and socialize. And, um, they're really not tailored to any medical condition. Then you have animals that are brought in by professionals such as therapists who will bring their own dog and, and especially for kids that actually works really, really well because it gets the kids either moving or doing anything that may lead to be, uh, accomplished during that therapy during that, uh, time together and that promotes that involvement of social and physical activities, which is what the end point is. Um, so, obviously there's a lot of good things about it. And then the bigger question of the day, you know, big elephant in the room is service animals and emotional support animals, and they're really two different categories. So, according to the ADA, these animals are actually allowed and for service animals, uh, they're actually considered to be dogs and sometimes miniature horses. And you can actually have a miniature horse –

Next Speaker: Oh my god.

Next Speaker: – come into a facility and that would be considered to be okay. ****. And then you have emotional support animals, and that's even a bigger bag of problems because you can actually have snakes and you can have any other type of animal. Miniature pigs are becoming a big thing. We're starting to see in small animal practices, they're not a small animal, they're a farm animal no matter how you call it, whether it's big or small, the farm animal. But people think they're supposed to be like dogs or cats and they're not. But we do see a lot of them, um, if you have not seen 'em, there's actually a great commercial on TV and the pig is about the size of a Chihuahua, and that's how big they are. So, um, used quite a bit, poop everywhere, can bite, can scratch, you know, multiple things that actually happen so, there's a difference between service animals and there's a, and, uh, emotional support. And in terms of, uh, these animals and what you can ask people when they come into the facility, you can, I mean you have to be careful about the questions that you ask 'em. You have to be very general about what kind of service that that animals, uh, provide to that individual. So, um, it's really, uh, becoming quite a bit of concern because anybody can call any animal that they have an, a, an emotional support animal, and that, you know, if it's a, a snake for example, we all know that's how, that's how **** snakes kind of live together in a happy environment but can actually be passed on to the children, people in the hospital can, can actually cross-contaminate, uh, different, uh, work areas and actually really create a problem in a healthcare facility. So in terms of the benefits we obviously understand that there's a lot of benefits to having pets in, in therapy. We know that they allow for communication. And again children are a huge thing. They, um, inter, social interaction is humong, is huge, humongous, uh, improvement of emotional and physical health, they, they, they decrease anxiety. They decrease loneliness, especially in people in nursing homes where they're not mobile and they just have a pet, um, that they actually see throughout the day, um, sometimes, uh, reinforce, reinforces behavior in terms of, um, physical therapy, moving around, walking around, throwing the ball, things like that would actually get 'em moving. But there's also risks, much like we would have expected. Animal allergies are, are supposed to be fairly significant or we actually have figures of that. We talk about trauma including bites and scratches, especially when you bring a cat into the formula, when you bring a rabbit into a, the situation. If you have a snake, they like to bite, uh, so, a lot of things that you need to be con, con, need to be concerned. We also talk about **** infections, immune compromised patients and obviously the fact that, uh, zoonotic infections are so significant in the health. So about 50 percent of the human population is considered to be, uh, uh, uh, are allergic,

uh, to dogs and cats, so whether it's cats and dogs, there's the dander that's actually, uh, the hair of the animal that's actually creating a problem, a very significant, significant, uh, because it can lead to a pretty significant allergic reaction that we need to be managed with medication. Um, and then, um, a few allergic reactions are seen in nursing homes because of the diminished immunity and, uh, a lot these allergens, the positive things that can be managed by bathing the animal on a regular basis and making sure that that animal is not shedding hair or dander, uh, throughout the facility or what you, where it's at. So in terms of zoonotic infections, we talk about the number of, uh, infections that can be, um, passed on and the big one that we usually talk about has to do with ringworm and ringworm is a fungal infection as most of you know, and I remember, um, when I was in practice it was one of the more interesting, uh, cases that I had. This woman was in the hospital. She come back from the hospital, somebody gave her a kitten, uh, it was a little white kitten much like that one and that's why I put that picture in there. It was a white kitten, um, she held that kitten close to her all the time. She would never separate herself from that kitten. That kitten basically was her life and she brought it in to have it examined after she has had it for **** 4 weeks. I was lookin' at the kitten basically attached to the woman, I could hardly take that kitten away from the woman, which is, you know, we, we see that in practice. We know that it happens and at that point they used one of the black lights and picks up about 50 percent of fungal infections at least in animals, and I did notice that the animal lit up, um, you know, with potentially a fungal infection, and what I said to her, I said I think your kitten has, I was being very kind, I think your kitten has, you know, ringworm, she goes like, oh is that what it is and she pulled out that kitten from her chest, and her chest lit up like a Christmas tree. She was all covered with, uh, ringworm on her chest because she's been holding that kitten close to her. So, that to me was the introduction to zoonotic disease and how likely it is to have it. And from then on I realized that, um, you know, it is significant and I think people tend to forget how prevalent it is, especially ringworm and how likely and it is that it can be transmitted from animals to human. Um, so there are other reports. Uh, a lot of reports talk about campylobacter, probably one of the most significant, uh, conditions that we see in young animals such as dogs and cats. Uh, kittens are well known to be campylobacter, uh, ready and they will be ready to pass it on to any human that they can infect so campylobacter in dogs and cats are a big issue, um, young dogs and young cats so, if, if there's any take-home or take-away, uh, message here is that young animals should not be, should not be allowed in a healthcare facility. And we talk about young animals up to a year age. So they potentially can carry campylobacter and most likely will have campylobacter, um, uh, campylobacter infection, so, and that can be passed onto humans. And then we have Clostridium difficile and that's one that in which we're trying to understand the presence of Clostridium difficile in animals, especially in dogs because we do get some reports of positive cases. The question is did the human give it to the dog and now the dog is colonized and potentially give it back to the human, or is the dog really the source of Clostridium difficile and as far as we know and as far as we understand and we see is a lot of these dogs do not have any significant gastrointestinal condition that would actually, um, tell us that the dog is potentially, um, the, the source of the problem rather than it happens to be somewhere in the middle between a human being infected, a dog catching the infection and then passing it on to another. Um, we also talk about, um, MRSA and I think, uh, we, I've been asked multiple times as to the significance of MRSA in dogs and cats, we, we do, um, so dogs and cats do get MRSA. When we dig into it a little bit more, there's usually a human, uh, exposure to MRSA so animals usually are not the primary, um, animals that do carry the organism, although they could, I'm not saying that they won't, but every time the studies have

shown that if you have a positive dog or cat with MRSA and you take it away from the household that animal will clear the infection within 2 weeks. So we know that potentially humans are the source of the infection and not necessarily the animals. We talk about Clostridium difficile and the possibility of again being a pathogen that's passed on, passed on from humans to animals. We talk about other E. Coli pathogen, E. Coli strains and then vancomycin-resistance or VRE and the last one which is one of the more interesting ones is during the influenza outbreak here in Oregon, we were the first state to, uh, identify a woman who happened to be a nurse as the infection to her ferret. Uh, that would have been an influenza related H1N1 and then we had other cases of families passing it onto their cats so we have cats positive for H1N1 so that **** act, actually happened.

Next Speaker: And throcozoanoses.

Next Speaker: Right, exact, exactly. So, um, we, we're very interested in this. We've had some reports of the H1N1 has been, uh, passed on to, to dogs in, in the United States as well. A lot of reports from **** so potentially **** from animals, uh, from animals to humans but to hu, from humans to animals. And therefore potentially be a source, uh, for either hospital staff, whoever the, um, animal's visiting. Even veterinary staff in a veterinary clinic, we need to remind them that this could potentially be a problem as well. So they have done studies and these are all coming from, uh, Canadian, these are Canadian studies in which they've looked at animals, uh, in regards to positivity rates and they've found different positivity rates with, uh, Clostridium difficile, MRSA which we know is a true issue, uh, in animals and, and again we take it away from the household for 2 weeks and those animals clear up, um, the MC coli which is a, um, multitude of resistance against, uh, different, uh, prednisone, um, uh, ampicillin and, um, uh, beta-lactamase and then BRE, and then they decreased it in numbers but have been found, have been correlated with, uh, potential animal infection. Um, in terms of hospital visitation problems, Ontario, Canada has actually looked at how many animals are allowed into different, uh, hospitals and determine, um, kind of what has been, uh, screening or recommended protocols for these animals to be part of this visitation program and it looks like most people are requiring things like routine vaccination and that would be the extent for **** would be rabies, would be Bordetella which is potentially could be a human, uh, pathogen, um, you guys have Bordetella broncho septic no, you have Bordetella.

Next Speaker: Well pertussis –

Next Speaker: Pertussis.

Next Speaker: – but humans can get broncho septic.

Next Speaker: Yeah. And broncho septic is usually in animals so there's a potential for human transmission. Um, a lot of them do require these animals to go, uh, through a behavioral assessment which I am very much of a proponent because all of these animals are not necessarily well-behaved, especially as it relates to service animals and emotional support animals. Um, 18 percent require an annual, uh, annual checkup for parasites and based on the studies that I have done in dog parks and, and the feline studies, these animals carry up to 25 percent, uh, giardia and other parasites do potentially be transmitted, uh, to humans, um, as well. And only

2 percent actually had a routine deworming, uh, program which is even more concerning because doxycare for example, um, is a parasite that can actually affect especially children and be quite a bit of a concern. In my fecal study I think about 10 percent of the dogs in a dog park were positive for doxycare, so it is prevalent. It's not something that is, uh, animals get routinely dewormed for or treated for and it should be part of the routine process. Um, in terms of what was allowed, uh, where they had dog to human interactions, 79 percent allowed for the dogs to lick the patient. Bad idea. 7, 73 percent permitted animals to jump in their beds, even badder idea, um, and then, um, you know, the more interesting thing is that none of the healthcare workers actually wash their hands either before or after touching a dog, uh, which, you know, speaks to, to the likelihood of potential transmission just by using their hands as a **** and not necessarily, uh, paying attention to either the animal or the human patient. They talk about, uh, **** animals they did a survey of 102 dogs that came into hospitals and they looked at, uh, Clostridium difficile, giardia which is actually pretty prevalent. They think that the Pacific Northwest is a little bit of, um, um, you know, we're in a little bubble because we do have a lot of giardia and we see a lot of giardia throughout the year, um, uh, they extended **** coli, roundworms and hookworms, salmonella and ringworm, and I'm actually surprised that ringworm was so low but, you know, it's just a single study. I think we'll need to ****. So, one of the things that we talk about in therapy dogs is a lot of people love to use raw diets and the answer is probably this is, uh, the most horrible idea anybody can come up with, and I would be horrified, much like a ****, um, in regards to feeding raw diets and the reason why is because multiple studies have been done by the CDC and FDA and **** Oregon is one of the, um, states that is participating in the retail meat study in which dogs, when you go out to the supermarket and we buy the chicken that you buy, so we can actually test it for salmonella, campylobacter and E. coli, um, we realize that both chicken, ground turkey, um, ground beef and pork chops do carry a number of pathogens that will be, uh, present when you feed raw diets and then will be present in the intestinal, gastrointestinal system of those animals that then can lead to human infection. When we do tell people in clinical practice that when you do feed a raw diet you need to be very careful about handling the stool because as you can see campylobacter is significant as well as salmonella. So, if the animal is on a raw diet do not take that animal into the, uh, into a facility because it's really, can create a lot of problems. So then, uh, guidelines for animals assisted intervention, uh, that's about mostly the temperament of the animal doing that, the behavioral assessment of the animal, animals that will tend to, want them to lick, animals that wanted to bite, animals often jump on somebody that's frail and knock 'em out, animal that's not going to scratch, you know, those are things that you need to really pay attention to. We talk about hand hygiene and we know that that's horrible in hospitals. It's even more horrible in veterinary clinics and we need to remind people to be highly aware of the potential for disease transmission. Um, we talk about you know, patients, patient's beds being, um, dealing with a family, a family member only. Staff pets should not be allowed unless they're certified, and certified is really, you know, a black hole in there and we'll talk about that in a little bit. Shelter animals, bad idea. OHA, uh, animal, uh, OHS, um, the humane society should not be bringing either a shelter or a stray animals into these facilities because those animals have not been, um, assessed for parasites or any other disease well enough to be taken to a healthcare facility. Adult animals are usually recommended so we do want an animal that is 3 or 4 years old, that it has a better temperament but is not considered to be a **** that could potentially scratch or bite somebody ****. And then obviously health screenings are significant. Rabies vaccine, external and internal parasites, huge issues, especially after learning about the quantity and, of the, quantity of parasites if we

can find dogs at a dog park in the State of Oregon. Um, so, uh, obviously the guidelines, uh, talk about not visiting while the animal is ill. You will be surprised how many people take ill animals to different areas such as Home Depot, dog parks, um, anywhere, and this ill animal could potentially be a source of infection for anybody else, um, if the person is being treated with antibiotics that's a big no no. If the animal is being fed raw diets, we talked about what a horror that is and should not be allowed. Um, and then screening for MRSA, we do have a method of doing that in animal medicine. We actually take an oral swab and a rectal swab, uh, for MRSA and that has proven to be the most or the best way to actually, uh, screen for those animals, um, as well C. Difficile. And then obviously keeping those animals vaccinated. We now know that there's a potential for canine influenza to be transmitted to humans, especially if that individual is affected with influenza so I am, my recommendation would be there's a **** vaccine for canine influenza, use it, and I think we should be, um, asking for that more than ever before. Mostly because Oregon is one of the very few states in the U.S. that hasn't had a huge outbreak. Maybe one out of four or five, so we're very much due for a canine influenza outbreak. Especially where there's significant movement, movement of animals from state to state and all these animals that are coming either from California or other states. So, uh, the guidelines for, um, usually also call for, um, animals, uh, pa, patients that are under, uh, contact precautions should not be visited by, uh, pets. Patients that are, uh, eating or drinking should not because animals are obviously driven by food. Animals think about two things. One, the owner and the one is food and sometimes food is about the owner so if there's food in room they'll jump for it. They'll go for it and then we, uh, prevent licking, uh, no High 5, no shaking because that obviously has contact with the paw of the animals has basically been anywhere and potentially source of infection. Treats should be, um, used with a spoon or some sort of other device and making sure that the that it's disinfected and then provide a barrier because sometimes that's usually the best way to protect the patient. Um, that's about it for me. I mean I think we all agree that there's a, a risk for, uh, zoonotic disease transmission, um, obviously the rear end being the most significant point. This is the end of the presentation but, um, if anybody has any questions feel free to ask.

Next Speaker: I have a question.

Next Speaker: Yeah.

Next Speaker: Uh, thank you for the presentation. Um, what about trans, like do we have that on transmissions? Are there any studies that kind of indicate how often this has happened or?

Next Speaker: No, so one of the key factors is that transmission of anything?

Next Speaker: From animals to humans in healthcare centers.

Next Speaker: No. So that's what is creating a problem. Canada I think is leading the way in terms of learning more about these animals **** but we haven't done that in the U.S. ****. So the study that we saw was, is a study that they've done in Ontario, Canada hospitals. But beyond that I have not been able to find ****.

Next Speaker: And then the other thing, is have you given this talk to APIC or to any of the long-term care facility organizations or whatnot 'cause it seems like it –

Next Speaker: No.

Next Speaker: – a great, to me I'm guessing, I don't know, Ann or Mary or what do you guys think? Would that be a good audience or not?

Next Speaker: Well, um, I visited quite a few long-term care facilities, uh, this year, and almost all of them have a cat, it's usually a cat not a dog, that's in the facility and kind of belongs to the facility and, and wanders around. But I have been impressed that even though it's elderly and sometimes they have, um, you know, health problems, I haven't seen anybody particularly sick. But you know maybe that takes more longitudinal time to spend with them, but it's very common to have a cat that just lives in the facility and visits everybody and gets on their bed and hangs out.

Next Speaker: And I'm not opposed to it, I'm just saying we need to be very cautious –

Next Speaker: Cautious.

Next Speaker: – and very clear about what the guidelines are. Behavior is one, that's a huge, I think it's above and beyond any other one, then, and then things like checkups. We recommend check the stool sample at least twice a year, we check, you know, for fleas and parasites. There's a number of things that you do, and there's not a barrier, it's just a way of protecting, uh, you know, barrier against having an animal in that facility, just a way to protect an individual that's being visited by that animal ****.

Next Speaker: At the hospital that I retired from, they, uh, had a policy, well actually the last two hospitals I worked at had a pet visitation policy, and I grant you most of the things that you've mentioned, I don't remember the stool sample being part of it but, um.

Next Speaker: Yeah, I got to mention that. And I don't know that any place actually does it. They do specify that, uh, the therapy dog, uh, would be, uh, regularly seen by a veterinarian but I don't know that they specify how often and what needs to be done.

Next Speaker: Yeah, **** basic vaccinations and, uh –

Next Speaker: Right.

Next Speaker: – bathing within 24 hours and that kind of stuff –

Next Speaker: Mm hmm.

Next Speaker: – but you know the nursing staff is just terrible about sneakin' animals in but I know, the person's own animal's not quite as, um, risky as just a general animal that comes and visits everybody. I've seen 'em via, I was just telling, uh, Laurie that there was a, uh, I walked into the ICU and here were two big, uh, Great Pyrenees walkin' around, in the ICU, and I was like holy.

Next Speaker: Oh yeah, we've had dogs with the patients and, um, pre-op areas too, so, ****.

Next Speaker: That's.

Next Speaker: So, you know, the, the, the key about parasites is it's really comes from this study that I did at dog parks and I, I basically, you know, went to dog parks and collected poop, uh, by myself and I was pickin' up poop from dog parks and, and one time a woman saw me and she gave me a dollar, she was really horrified that was collecting good poop, and at the dog park ****.

Next Speaker: Homeless guy ****.

Next Speaker: ****.

Next Speaker: She said you poor dear, and she gave me a dollar and she turned around and walked away. I don't think she ever saw my face or ****. And I'm thinkin' oh, this is my cup of coffee today, I'm set up.

Next Speaker: Oh, so funny.

Next Speaker: And somebody else offered me food, **** she offered me food, she said ****, I said no, I think I'm okay but thank you. Anyway, the point is is that I collected over 400 stool samples.

Next Speaker: Oh my lord.

Next Speaker: And really a quarter of them, like one every, in every four dogs was positive for giardia, was positive for **** and bitter, but we don't know where the crito, you know, based on the, you know, uh, different, uh, –

Next Speaker: Species.

Next Speaker: Species.

Next Speaker: – species would actually be pathogenic to humans but those are, that, that's huge and about 10 percent of them have some sort of doxicare for example, which is a pathogen that can be transmitted to, to humans and then that's all amazing information that we need to have that can guide how we treat animals or we look at animals, especially in healthcare facilities.

Next Speaker: And as a point of clarification, the giardia and influenza, those are both species that can go back to humans.

Next Speaker: Right, so with giardia, giardia is divided into what they call assemblages **** divide into like A1, A2, B, C, D, and only two of them share, uh, that type of human, so, you know, it's considered to be like, somebody came up with a 14 percent of the GI to have potential

to be transmitted to humans. The question is you don't know which giardia you get right so you always need to be careful about how you, you know, which, the stool sample and the potential for transmission.

Next Speaker: And the canine influenza, that's like a, like an H1 and it's, it's for –

Next Speaker: The H1N1 is –

Next Speaker: – it goes back and forth, wow.

Next Speaker: – ****, yeah.

Next Speaker: Okay.

Next Speaker: The H1, H1N1 would, and the canine influenza which is a H3N2/H3NH actually we just saw an article but I **** and **** the potential for human transmission.

Next Speaker: Okay.

Next Speaker: That's really great. Any questions from, uh, from the phone or anyone about like questions they have in their policy? It sounds like policies have some stuff but not everything.

Next Speaker: This is Dr. Legasigasamon, we have a policies in place but they're kind of difficult to enforce and frankly they're becoming real, this is becoming a huge, huge problem with just anybody walking into the hospital with their companion pets, especially and giving you a really hard time if you say anything about it so people are really reluctant to confront people about their companion pets that they bring in their offices, not really, uh, uh, therapy pets of any kind and so it would be really nice to have some sort of guidelines that we can point to that it's not just our policy.

Next Speaker: Yeah, no, we've been, you know, we can come up with, I, I have a lot of good information that I can share with you or even come out, come out and talk to you about it and go through it, um, but we can come up with something that will work for you and, you know, hopefully we'll be, uh, you will, you'll be able to teach the staff about it and make sure they ask the questions that are necessary.

Next Speaker: I, I.

Next Speaker: That's very good.

Next Speaker: Yeah, it's Genevieve, I agree. I think a lot of it is just that even you, how do you even identify and ask them that, there's a lot of sensitivity around that.

Next Speaker: Yeah, there's a lot of sensitivity.

Next Speaker: And there's ****, and then there's a therapy dogs and ****.

Next Speaker: So just so you know, there's no such thing as a service animal or an emotional, uh, support animal certification problem. Anywhere.

Next Speaker: Huh.

Next Speaker: Anybody can buy a little jacket that says service animal, um, I'm a service animal. It's got a little smiley face that says service animal. Anybody can buy one.

Next Speaker: I know, I know so many people that do that.

Next Speaker: Yeah.

Next Speaker: So.

Next Speaker: Just so they can take them to restaurants.

Next Speaker: Yeah, so there's no certification at this point, so anybody that says that, you know, they need to say well, you know, I'm so glad you have it and then you can ask questions like is the animal being, you know, seeing your veterinarian or you know, there's gotta be guidelines that need to be set forth so these individuals understand that not just animal can come in. And I think I got a phone call from somebody, might have been 2 or 3 years ago about bringing a, a little horse into a hospital, and I say well, what are you gonna do with it and she's like, what happens if the animal happens to poop in the middle of the room, you know, she goes I don't know ****. You need to be prepared, you know, right? So, um, there's things to think about.

Next Speaker: It does seem like we can come up with a list of, um, documentation someone would have to show. I mean you have to show documentation to get your pet groomed so –

Next Speaker: Yeah.

Next Speaker: – it seems like, you know so, show documentation to a hospital when you're bringing it in that your animal's had vaccinations, it's had fecal tests, things like that and, you know, consider it case by case, but my, my guess would be that if that was a requirement very few people would be bringing their pets into the hospital. 'Cause it's kept me from getting my pet groomed.

Next Speaker: It's **** story.

Next Speaker: Yeah, so, you know, I can come in and help you out or we can look at it together, I would be happy to do that.

Next Speaker: I think this would be a great topic for a APIC meeting and if you had, um, a hand plate or something that at least it has the, the specific things that, you know, be healthy and say need to be taken care of, that would be a huge step forward I think the hospitals ****.

Next Speaker: It would Ann. And you know, we had a big problem with this, um, at Providence when I was working there with Nancy Church. And, um, they came up with one that they had to run through legal and everything because patients could be so adamant about having their pets with them, even though it's totally inappropriate, so even, you know, suing the hospital because of, um, not letting the animal in, so I think it would be nice to have a community space approach to this.

Next Speaker: Yes.

Next Speaker: So that hospitals can adapt something that is very similar and including the fecal test. I, I kinda like that. Now obviously in times of, uh, extreme situations where somebody is, um, in an ICU setting and not likely to survive unless they see their pets, that's certainly something we could make allowances for but, um, so many therapy animals that are the, the people that are there while with their animals coming in and out, because sometimes you'll see that once, some animals come in and then next door neighbor, um, patients want to bring theirs in and then the next thing you know you've got a ****.

Next Speaker: It create a, a community standard if we all did it together.

Next Speaker: Yes.

Next Speaker: Yeah, that, that, that sort of method was very helpful with the influenza season, like **** season **** the influenza season that ****.

Next Speaker: Mm hmm.

Next Speaker: Suggestions, any more from the phone ****? Specific questions? And if you need to, if you af, after if you have any questions you can always shoot those to Rosa and she'll get them ****. Unless you know how to contact her directly.

Next Speaker: You guys ****.

Next Speaker: Rosa, we'll give you, if you have any questions that come up or something. So, okay. Excellent. Well thank you so much for joining us. We appreciate it, appreciate that.

Next Speaker: Well thank you.

Next Speaker: Thank you.

Next Speaker: Uh, next on our agenda is to move to discussion for themes and topics for future to **** meetings. Uh, and while you guys are thinking about those, uh, I just wanted to point out, I was given an update that, um, in regards to our announcement at the beginning of the, of the meeting where we talked about needed to recruit person HAI advisory committee vacancies, specifically in the insurer and you know the purchase, uh, part, and also for, uh, patient advocates, uh, Alyssa will be sending out an email to all of you that will help you then send that to the person you might know that'll be a helpful invite and you can share that with those people

and their network so kinda making, am I saying that right? About helping to, helping help you reach out to people who might know, um, having a nice introductory, introduction with HIAC is and, um, how we would love to have their help so, look for that in your email, email boxes. So opening up the floor again to any themes or topics for, uh, future meetings and our next meeting is going to be in March of 2018. Oh, and just that while you guys are thinking, just to make a plug, Shay is in Portland April of 2018 so I hope you guys will all be there for that. I think early registration's by February for the little bit cheaper rate, 'cause no ideas right now, you can always forward anything on to Rosa as things come up. Again, just like with the pet therapy and things like that, if there's any timely that you're seeing an issue with, probably other people are having an issue with that and somebody can maybe, um, bring someone to talk about it and have some ideas. So finally we'll open it up to public comment. Again, over anything we discussed about earlier, uh, for instance any other ideas on maybe how to use HAI annual report data going forward, uh, stake holders to conclude, uh, metrics, anything like that. Other concerns. Um, I have this question for the state people. Is any, any big legislation coming up for HAI that we should be aware about in 2018? 'Cause I like on our, we just out, like there was some hearing screening ***** virus screening that just came up and nobody knew about it so the hospitals now have to get in line, you know, figure out how to screen for CNB after hearing lots of ***** so I was just wondering if there's any like legislative things we should be aware of, any bills that passed or are gonna be put forward for the next year?

Next Speaker: I hadn't heard about that one.

Next Speaker: Yeah, that's, either did I, either did I. So, uh, I didn't know if you –

Next Speaker: I've, I've heard very little about the upcoming legislative session and, um, usually the even numbered year session is, is pretty brief. I mean they're supposed to be focusing on you know, really key issues like budgetary, you know, is our projected budget gonna carry us through the biennium and things like that and, and they really try to limit you know, extraneous issues to a minimum so, um, it's typically a much shorter session like a 2-month rather than a 6-month session. And so I'm, I'm not expecting a lot but something could always get dropped but I, I haven't seen anything, uh, any other bills *****.

Next Speaker: And no, no bills from 2017 that are gonna take effect in January, for, uh, in regards to HAI or, or public health or anything that we should update the group about?

Next Speaker: Well, there's the, the topic that we discussed the last time the changes to the HAI report, um, so again I gotta change the language to, um, now specify as, um, explicitly be, um, timing and nature of the HAIN report, and some of that was to again, ***** flexibility but also because it's somewhat duplicative of what's available via CMS.

Next Speaker: Also, we will still have a committee in 2018.

Next Speaker: Okay. Great.

Next Speaker: Because it was scheduled to sundown but they –

Next Speaker: And we got rid of it.

Next Speaker: – they pulled out the sundown clause.

Next Speaker: 'Kay. You guys are all committed to be here in March.

Next Speaker: That's good to know. I've got a question for Alexi, and regarding your, um, presentation you did, um, with the instrumentation and the ACLs, are they, um, arthroscopy repair, um, will you kind of keep us posted, uh, to see if we do get some positive, um, culture reports from the instruments, 'cause I'm looking at, uh, older instruments here and that we, and there's really no, um, standardized approach to when to retire instruments and how old they can be, especially orthopedic instruments that get a lot of pounding hammering, uh, just to see, you know those divots and cracks and, and little areas where you know, the naked eye cannot see what is really there and, um, until they get horoscoped and it's like, you know, it would be good to know if anything is isolated from that instrument that's been autoclaved.

Next Speaker: Uh, yeah, that sounds good. I think we'll use the APIC platform to probably update, um, in the future so you don't have to wait until March so if anything comes up we'll bring it up at one of the next APIC meetings during our ****.

Next Speaker: Great. Thank you.

Next Speaker: Well cool. If any thoughts arise, uh, please, uh, send them on to Rosa, uh, and I think with that I will entertain a motion to close this meeting. Anybody ****?

Next Speaker: So moved.

Next Speaker: So moved.

Next Speaker: Second.

Next Speaker: Everyone have a fabulous holidays and we look forward to seeing you in the new year.