Healthcare-Associated Infections Advisory Committee
December 11, 2018

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Speaker: Good afternoon everyone. We're gonna go ahead –

Next Speaker: **** discussion.

Next Speaker: – and get started. It's 5 after –

Next Speaker: And that's, so that's –

Next Speaker: I'm glad to see everyone here.

Next Speaker: ****.

Next Speaker: I can't believe it's the last meeting of the year.

Next Speaker: Oh, we don't need it right now.

Next Speaker: 2018.

Next Speaker: ****.

Next Speaker: Uh, so this is Genevieve **** for those on the phone, um, from Providence Saint Vincent's. They do pediatric infectious diseases there. Uh, so I'm gonna go ahead and start the roll call. Let's start with people, uh, in the room and then we'll go to the folks on the phone.

Next Speaker: Uh, this is Rosa Tammer. I'm the HAI reporting epidemiologist at the Oregon Health Authorities HAI Program.

Next Speaker: Hi, this is Vince Valdez. I'm the section manager for the Acute Communicable Disease Prevention Section here in the Oregon Health Authority.

Next Speaker: Hi, this is Tom Jean. I'm a deputy health officer here at Public Health Division. I'm just covering for Paul Cieslak today.

Next Speaker: Uh, Rebecca Pierce, HAI program manager for Oregon Health Authority.

Next Speaker: Dat Tran, HAI public health position for the Oregon Health Authority.

Next Speaker: Uh, Judy Guzman, pediatric infectious disease OHSU.

Next Speaker: Sally Ocampo, **** public health nurse here at OHA.

Next Speaker: Monika Samper, HAI coordinator here at OHA.

Next Speaker: Eliza McQueen, public health educator at OHA.

Next Speaker: Alexia Jones, um, HAI epidemiologist with OHA.

Next Speaker: I'm Renee Kluboski. I'm a senior at **** High School and I'm shadowing Alexia today because I'm interested in public health and I'm so happy to be here.

Next Speaker: Um, I'm Sydney Ebland with the Oregon ****. I'm the director of research ****.

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

Next Speaker: Vicky Norton with **** company.

Next Speaker: **** King, director of nursing at Marquise of Ohio.

Next Speaker: **** long-term care.

Next Speaker: Michelle Shields, um, infection prevention **** at the Holgate Center.

Next Speaker: Tara Buring. I'm the **** office specialist for the HAI Program.

Next Speaker: Diane Roy, research analyst OHA.

Next Speaker: We have also have Julie Koch from Salem here in the room, and then if we'll go to the phone lines. I just wanna encourage if, on the phones, you're just on the phone, there's also a way to join by the go to meeting webinar from the link that was in the email invitation. Um, but anyone on the phone that they could introduce themselves and where they're from?

Next Speaker: Kellie Cuevo, River Bend Ambulatory Surgery Center.

Next Speaker: Vicky **** Department of Health in Florida.

Next Speaker: Judy **** representing the consumers from Hood River, Oregon.

Next Speaker: ****.

Next Speaker: Hi, name is Rachel Ruhl. I am a clinical pharmacist that works for ALK, um, and we work to help, um, hospitals implement **** as a way to decrease their HAIs.

Next Speaker: This is, uh, Jenny Curren, also with ALK and **** in the Pacific Northwest with ALK.

Next Speaker: Okay, anyone else?

Next Speaker: This is Lisa Free – yeah, this is Lisa Freeman. I'm a public member, consumer representative.

Next Speaker: Anyone else? Well, great, welcome to the new folks on the phone and also to **** members and attendees. Uh, so right now I will go over to, uh, Tara to give us **** updates.

Next Speaker: Uh, so **** have **** for health insurer representatives and we now have an application we are doing for consumer representatives. Uh, if you know of anyone that would be a good fit for that position, just pass on the information please. Um, and then we have filled the position of registered nurse with involvement in infection control, Amy Jo Walters, and her application is currently in the nomination process. Everyone else, um, on, all the other ones **** nominations **** have been approved. Uh, and then, so we're **** meeting format to webinar. If anyone's having any issues, please just email me. I also be sending out a short survey in the next few weeks just to collect any feedback on the new webinar format. That's it.

Next Speaker: Can I make one quick exciting addition to that? Um, so Tara Buring, who you just heard make an announcement, has just accepted a job with Vibra as their infection preventionist, um, so we are very excited and proud of her and excited to work with her in a new capacity. Congrats to you.

Next Speaker: **** on a much less exciting note, this is Rosa. Um, the reason why we have added microphones and, and webinar is to help us kind of make sure everyone on the phone that's joining us remotely can hear and see what's going on, and, um, so that we can more easily track our remote participants, so if you are joining on the conference line and you have not signed into the webinar, uh, we would really encourage you to do so. It makes our lives a little bit easier. Thanks.

Next Speaker: Uh, and this is Genevieve. In addition, um, if you're online and you're having, uh, problems with the hearing or the sound's not good, you can type that in just a little message box for us to hear. Um, however, if it's questions regarding the presentation, we will ask for you to, um, join by phone and ask those live, if you don't mind, at the end of the presentation or whichever section we're on, so that's good. Okay, great, so, uh, next on the agenda is a motion to approve the **** 2018 minutes that were included, uh, in the email or in your packet. I ask for approval from the floor if anyone has **** and is willing.

Next Speaker: **** over **** good.

Next Speaker: We have a **** from the floor, is there a second?

Next Speaker: I'll second.

Next Speaker: Thank you. Okay, so approved. Uh, next, we'll move on to our outbreaks update, uh, Dat Tran.

Next Speaker: Thanks Genevieve.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: No, it's okay.

Next Speaker: ****.

Next Speaker: Okay, all right. Uh, so you can see here from this table, um, –

Next Speaker: Sorry.

Next Speaker: So, from this table, uh, I pulled outbreaks from September 1st, uh, to December 6th. Uh, so in total there were, uh, 70 outbreaks, the majority of which were gastroenteritis in nature, uh, followed by E, uh, E. Coli numbers **** and then, uh, other categories, and as usual, for the GI, uh, outbreak **** common, and for respiratory viruses or respiratory outbreaks this time Pertussis, uh, was the most common, uh, rather than influenza **** this year we haven't had much yet. Uh, and then you can see there for other, uh, **** kind of rash or **** like, uh, viral, uh, outbreaks as well. Um, and then I'll go to the slide next that focuses on the go, the healthcare associated outbreaks. You can see here that, um, for this particular period, uh, 70 percent or 49 of the 70 outbreaks, um, were healthcare associated. Uh, the majority of these, uh, DJI outbreaks occurred in long-term care facilities, accounting for 64 percent of the outbreaks, and, uh, the most common etiology, uh, and is commonly the case, **** virus, and then I provide some, uh, breakdown of the different type of facilities, un, in terms of long-term care facilities with a various, uh, outbreaks, uh, uh, accounted for, uh, during this period. So, you can see again, um, a lot of the outbreaks were in skilled nursing, uh, facilities, um, with 20 of them, and, uh, **** virus, and then the other five are distributed, uh, pretty evenly among the other, other groups. So, at this point I, I wanna highlight a particular outbreak, um, that actually did not occur in this period, but, uh, shortly before this period, and it, uh, an outbreak of **** Type 3A. Uh, in this particular **** is actually very uncommon in the United States. Uh, tend to be associated with, uh, travel or international travel, uh, so we, um, found **** outbreak a couple days after this wedding that occurred in Yamhill County on August 11th, and we, uh, were, we found reports of, uh, three attendees who were hospitalized, um, because of this particular bug with septic shock, and also an estimated 100 out of 263, uh, wedding attendees, uh, having fallen ill. So that was like a pre, you know, pretty big outbreak, so by the end of it, this is the epi curve that you can see here of all wedding attendees, and, uh, we had, uh, 198 survey respondents, um, and we had deployed a, a survey, two surveys in fact, over time, um, but you can see that the first case, um, incubation period was pretty short. Uh, within, you know, 12 hours or so, and then the last case occurred about 5 days, uh, after the, after

the wedding, uh, but the majority of the cases, uh, had onset of illness between 12 and 72 hours, as you can see there. In the terms of the survey, uh, there were 107 respondents, uh, sorry, 100, a 107 of the 198 respondents, uh, were deemed to be cases, which, which was defined as essentially, um, you know, onset of, uh, of diarrhea and, um, with, um, - I'm tryin' to remember the exact definition, like **** stools within a 24-hour period was their definition of gastroenteritis. So, you can see there's a mean age, um, a fairly young population, not unexpectedly of 37.6 years, but with a fairly large range, uh, also of not having expected it. Um, 56 percent of the attendees were, uh, female and the, you can see the symptom profile there. Again, you know, unexpected fever was a very common symptom, um, followed by vomiting and then, uh, quite a high proportion of patients having reported, uh, attendees having bloody diarrhea, and it ca, caused a lot of problems for the attendees. You can see there, you know, over half sought healthcare. Um, 9 percent were hospitalized, uh, like, like ****, none had died, and when we look at the foods that are associated with the diarrhea or loose stools, and this is just diarrhea, loose stools in general, and I'll go on to the table that focuses on a more restrictive definition. So, you can see there, asparagus had the highest **** 12.44 with, um, a range of **** 95 percent **** 4.14 to 37.36. You can also see a number of other foods that had higher, high ****, but not to the same extent as asparagus, so when you look at a more restricted definition, um, of, uh, illness, uh, defined as three or more loose stools in a 24-hour period, um, really the same kind of foods stood out, right, in terms of having, uh, an **** greater than, greater than 1 **** highest this time, 16.7 with a **** interval of 4.862 57.37. Um, I just wanna point out though that, um, this particular, um, food was prepared for multiple weddings, uh, through the same period with no other reported illnesses, so that's the challenge **** we had in terms of having a definitive, um, uh, vehicle and so, at this point we don't have a specific vehicle that we can say, you know, this is for sure what it is. This is obviously a suspicious vehicle, but that's the best that we, we can do, uh, at this, at this point in terms of identifying a potential source. Um, we did ask about, um, history of travel in, in our, um, survey and there was some, uh, a few, uh, residents who had traveled internationally, uh, but, um, we couldn't really, um, map it out very well in terms of travel and **** and, and potentially, uh, pass that on to, to this **** of, of **** attendees. So that's kind of where, uh, we're at with an outbreak. We closed the outbreak, and this is, this is what we have and, uh, a report will be posted on the OHA website, hopefully within the next, uh, week or 2, so I don't know if you have any questions **** or any thoughts for that matter.

Next Speaker: Genevieve ****. Okay, were there any, um, was it prepared by a catering company and **** food preparers and was the asparagus ****.

Next Speaker: Uh, yeah, so the, um, it was prepared by a catering company. Uh, none of the, uh, food preparers reported illness, right. As you know, sometimes, you know, we always wonder well, how accurate is that reporting ****. The, we did collect stool samples from, um, really the majority of the, uh, caterers, with the exception of the one that prepared the asparagus. So that's, that's, that was kind of disappointing, right, and, and we faced, uh, challenges, you know, um, you know, with some, I guess, delay in, in getting information and, and some cooperation, but, um, uh, yeah, it, it was very, very challenging, and the asparagus was, um, was not imported. It was from the, from the United States.

Next Speaker: Hmm.

Next Speaker: **** on the phone?

Next Speaker: ****.

Next Speaker: Okay, **** outbreak, so next on the agenda is the NHSS data ****.

Next Speaker: So, hi everyone. Um, most of you are probably already aware that we published Oregon 2017 HAI data from the National Healthcare Safety Network, um, this fall, so I think we're gonna use this as a chance to go over that. Um, CDC also recently published its data for 2016, so I think it's a good opportunity to kind of look at how they're publishing those data now, and then finally, we'll just briefly give some quick reminders about the state of exemptions for HAI reporting here in Oregon. Well, this jumps right in our 2017 data are now up on our website. This is a screen shot of what that looks like and where to find it. You'll find a link for all of our facility-specific tables and maps, uh, remember that they actually include statewide numbers as well, and then we have our HAI data summary, which gives statewide performance, and we'll look at that in just a moment. And then finally, there's a third element, uh, which is new this year, and that's called About the Data. I realize this is very tiny, even up on the big screen, but everyone should have a supplied, um, and then we'll go over that. So, as a reminder all of these data for 2017 were analyzed using the, uh, updated 2015 baseline in ****. So, our data summary, um, is kind of an expanded version of the executive summaries we published for 2015 and 2016 data. The format should look pretty familiar, uh, it's a 3-page document that's divided into three sections. Um, acute care hospital device associated, and laboratory identified infections, critical access hospital device associated, and laboratory identified infections, and adult surgical site infections for both acute care and critical care hospitals. And just to cl, clarify, in this case device associated means CLABSI and CAUTI, so the catheter and central line associated, um, infections, and then laboratory identified infections refers to, um, MRSA, BSI, and, um, C Difficile infection. So, we divide our data into these sections, because if you remember, the new baseline means we have to stratify our SIR by facilities either by patient age, and each one-page section can serve as a freestanding one-page document. Each page does include, you know, a title, that image that we're all probably somewhat familiar with seeing now, um, introduction, legends, the data and the takeaway, so they can kind of be standalone if that's what serves your facility the best, or your organization. And just wanna note here that we do not report all tax data in this way, because we only have one facility of that type here in Oregon, um, so their data are represented in our, uh, tables and maps on our website, but not presented separately in one of these data summaries. And then we also do not include pediatric SSI here, because those data are quite small. So, this, these are, um, the data points from our acute care hospital device associated and lab I.D. data summary. Um, as you can see, we provide the number of infections per each measure, um, and we also provide the statistical significance and directionality compared with the 2015 national baseline, 2020 Department of Health and Human Services, um, healthy people target, and the 2016 Oregon data. Um, so there's like three points of comparison for each measure. And so, then looking at the actual data for acute care hospitals in 2017, these facilities in Oregon performed better than acute care hospitals nationally for all device associated and lab I.D. HIA metrics except for CAUTI. Um, acute care hospitals met the 2020 HHS target for Class C and **** acute setting, um, but we have yet to meet the target for the other metrics. And, again, as a reminder, we're starting here from 2015 as our new baseline,

right, so whereas in the past we would have seen a lot more kind of green arrows showing statistical significant, specifically significant decreases for, um, you know, decreases from the baseline or, uh, more, sorry, better performance on the 2020 HHS metric, but since that, also starting from scratch with the new baseline, we're just, it's normal to kind of expect to see incremental progress starting afresh. So, in terms of our critical access hospitals, in 2017 our Oregon critical access hospitals performed better than critical access hospitals nationally for MRSA, BSI, PDI and CAUTI. Um, critical access hospitals met the 2020 HHS target for CAUTI, but they have yet to meet the target for other metrics. So, really this kind looks similar to acute care hospital, just, um, we're swapping CAUTI out for CLABSI here, but, um, in general we're doing well compared to national, other similar facilities nationally, and in general we have a ways to go to meet those 2020 targets. And then let's finally look at our surgical site inspections. Remember, these are adult SSIs, and they for both critical access and acute care hospitals combined together. So, in 2017 Oregon hospitals performed better than hospitals nationally for heart, laminectomy and colon surgeries, and they met the 2020 HHS target for heart and laminectomy surgeries, and hospitals did not outperform hospitals nationally for hip, knee and hysterectomy surgeries, nor was the 2020 HHS target met for these procedure types, so we're kind of half and half ****. So, that's what our data summaries look like. Um, and shifting gears a bit, I mentioned that we have a new document called About the Data, which is posted on our website. Um, I didn't provide a screen shot of it, because it would just be a big block of tests, but, um, it's really meant to accompany the facility's specific and statewide HIA data that we publish in the data summaries that we just reviewed, and in the tables and maps that we're gonna look at in a moment. And this document includes a background of our reporting, the methods that we use to report these data, how we present the data and their usage, how to interpret the data, including an explanation of the standardized infection ratio, or SIR, the benchmarks that we use, which are national progress and the 2020, um, healthy people target, SIRs, and all those different elements of our table. Um, that document also includes a summary of some of our prevention activities, acknowledgment and references, and it can be found by following the link at the bottom of the slide. Okay, so similarly to how we publish 2015 and 2016 data and tables and maps, we've done that again this year, and just as in the past they display overall and facility-specific data for 2017 or, well, that's not last year, but for Oregon, new this year, 2017, and they're interactive, meaning you can sort and filter them. Um, and they're stratified by facility type, um, and patient age, because that's how the new SIRs are structured. Um, they are available by following that first link on the page, and just please remember that if you wanna look at data from prior years, you can absolutely do that. They're, it's all in our website, um, under a title called archived data. It's just at the bottom of that page that there's a second link to there. So, here's a sample of what our tables look like. Again, maybe not the most compelling image up on the projector. Um, this was for CAUTI and acute care hospitals. Um, our table include a title and a description. They display a number of all Oregon rows that are aggregated in certain ways that you can possibly see here on the slide. So, looking at maybe all adult cardiac ICU is on their own line. All adult cardiothoracic ICU's on their own line. All of our, um, adult and pediatric ICUs and med surg, uh, medical surgical wards combined, so different kind of ways that we have of aggregating these for all of our facilities in Oregon, so you can look at them by location type. Um, and then you can also scroll further down and see facility-specific data, it's just not shown on the screen, but it's a very long table. Um, it may also give numerator and denominator data, the SIR, the confidence interval around the SIR, the interpretation of the SIR, whether it was fewer, more or similar to the national picture, or the numbers were too small

to calculate an SIR, um, plus that statistical significance in the form of the confidence interval. And we also provide the 2020 HHS target, whether it was met or if there were zero infections, we also like to credit where it's due for that. Um, county address and HPP region, and you can actually **** it for filter on any of these elements. There's a couple of little rows or columns, I should say, of data at the end of these tables that look a little bit funny. Um, it's really just because our application changes a little bit and we didn't have a lot of control over that, so it allows us to create our maps in the way that you'll see on the next slide. So, maps really provides the same information as tables, just in visual format, um, facilities are represented by colored arrows, either up or down, depending on the directionality of the association **** a poorer or better SIR than we would expect to see or predict. Um, and then gray or green or red, um, depending on statistical significance, and then blue dot is no SIR could be calculated. And facilities are represented geographically, and there's a callout if you just click or hover over that image, um, representing a facility that provides key information from the table, and then the table's actually represented there below the map, too. So, now that we have briefly discussed Oregon's 2017 data and where to find them, I wanna make sure that everyone's aware that CDC publishes 2016 national and state HIA data, I believe back in October. So, on this line is a link to the website where you can access these data, and you can see all the different measures they are reporting out on by facility type in the imagine there. Um, their data has several components, um, which includes the executive summary, the progress report, data table, a technical connect references acknowledgments and a glossary of terms. Would it be helpful if we turned off that light over the front, do you think? Thank you.

Next Speaker: It's a dangerous game ****.

Next Speaker: Yeah, yeah. We're gonna see.

Next Speaker: All right ****.

Next Speaker: Other one?

Next Speaker: Yeah.

Next Speaker: Ewww. Thank you. Um, and then CDC provides several highlights from their acute care hospital data progress report, so looking at progress between 21015 and 2016 nationally, there was about an 11 percent decrease in CLABSI, about a 7 percent decrease in CAUTI, and about a 2 percent decrease in, um, ventilator-associated events. Um, there was about a 6 percent decrease in SSI across all the ten selected procedures that they include in the report, and then they found a 13 percent decrease in abdominal hysterectomy SSIs, 7 percent in colon surgery SSIs, about a 7 percent decrease in MRSA bacteremia, and about an 8 percent decrease in C. Difficile infections. So these are all in acute care hospitals. And this is what those interactive web-based progress reports actually look like. This is a sample of the data that just show the national picture for acute care hospitals for CLABSI and CAUTI. You can see there's a legend there up at the top of the screen, um, and for CLABSI what we're seeing in that na, in nationally in 2016 we saw 11 percent fewer infections than were predicted based on national data, and that decrease was statistically significant, um, because its represented in green. And we're also seeing that 10 percent of facilities that reported enough CLABSI into NHSN in

2016 in order for an SIR to be calculated had a statistically significantly worse SIR than the national SIR, which was .89. That's kind of a mouthful, so that's basically saying anyone nationally who did have an SIR, about 10 percent of them were, uh, worse than the national SIR. And the data that are presented here are just the same for CAUTI, um, again you see a statistically significant decrease from the baseline with 7 percent fewer infections being observed than predicted, and that just like CLABSI, about 10 percent of the facilities with an SI, SIR had a worse SIR than the national SIR, which was .93. And I provided a link on this slide to that progress report, as well. And, um, you can see that along with the type of **** woody at the top of the slide, you can select either national, which is what we're just looking at, or you can select a state, so, um, these are just dropdown lists, so this is Oregon data. So, in the progress report we can that Oregon saw 32 percent fewer CLABSI than were predicted in 2016. That's statistically significantly lower than, uh, what was predicted, and that none of our Oregon facilities had a CLABSI SIR, uh, statistically significantly higher than the national SIR in 2016. Our CAUTI data for, uh, acute care hospitals is also shown. That looks a bit different, um, we actually saw 11 percent more infections than were predicted based on national data in 2016, though that was not a statistically significant result, so our data could be interpreted as looking about the same as what was predicted based on national data, and then we did have 11 facilities in Oregon in 2016 with a statistically worse SIR than the national SIR for CAUTI, which was .93. And you can also see on the slide that Oregon facilities have statistically similar numbers for both these measures in 2015 and 2016. And then just for some context, looking at acute care hospital data for Oregon, uh, versus nationally, for 2016 Oregon's acute care hospitals saw increases from the 2015 national baseline in just two of our southern measures, and neither of those increases were statistically significant. We saw no change in one measure, and then in four of the southern measures we saw statistically significant decreases of greater magnitude than the national ****, so. The progress report from CDC also has inpatient rehabilitation or IRF, or IRF data, uh, and CAUTI for these facilities was similar to the national picture because though we did see more infections than were predicted, it was not statistically significant, um, C. Diff in Oregon was actually statistically significantly lower than the national SIR in 2016, and we observed 81 percent fewer infections than were predicted, which is pretty great. Um, Oregon looked similar for both these infections in 2015 and 2016, and then there was no enough data to determine whether ours had SIRs better or worse than, uh, national, 'er SIR for these two measures in that year. Um, just a note that Oregon does not have enough LPAC data to, um, assess performance. and the CDC does include critical access hospital data in the ****. So, wrapping up, um, I just wanna remind everyone again that our committees voted to remove Oregon's exemptions to reporting for SSI and CLABSI starting with data reported for 2019, um, and what that means, you're probably very well aware that since Oregon hospitals will be required to perform surveillance for, and report CLABSI and SSI to our agency for applicable procedures or location regardless of the number of procedures or central line-based that are observed annually, and that of course, facilities without applicable location types for CLABSI or that don't perform relevant procedures will not be required to do this. Um, we have tried to make sure everyone has the information they need to get this recording done if it's not already part of your standard processes, and to ease that along, we offer to webinars this summer and fall, one focused on CLABSI, one on SSI. They're both available on our website, which is linked here, but we're also really happy to give one-on-one technical assistance. Um, so reach out if you need help, yeah. Um, and I think at this time we can answer questions about 2017 data in Oregon, national 2016 data or exemptions, and I think we also have a reminder.

Next Speaker: Oh, yeah, I can, um, just bit of a plug on our part. We've, um, initiated again our targeted assessment for prevention project, so this is a CDC-funded project that does surveys, um, largely in hospitals now, though they are extending into long-term care facilities, as well, um, that assess perceptions and awareness of infection prevention strategies you have in place at your facilities. Um, and then, you know, we take that data, we analyze it, provide a feedback report to hospitals, and that can guide future, um, quality improvement interventions. Um, so we have done some recruitment already, but this year we've shifted our focus a little bit. Um, many of you will know it, this process focuses on the CAD, which is the cumulative attributable difference. It tells you how many infections you would need to prevent to meet the reduction goals that Rosa just mentioned. Um, so this year we focused on that, as well, but we also focused on critical access hospitals, hospitals that have previously asked for exemptions from reporting, just to make sure we're supporting the range of programs in our state. Um, so you may be receiving those recruitment emails if you haven't already, so please let us know if you have questions and we'll be following up.

Next Speaker: I've got a question. I was, I think there were a couple of surgical site infections where, you know, pretty dramatic decreases, I think abdominal hysterectomies maybe, was like 44 percent down. Do you have any sense of what that might be, like, or does anyone else here, like, what's goin' on in terms of those?

Next Speaker: Well, those are one of the nationally reported ones, so they're probably monitored more closely than the other, like colons and hysts are the ones are, um -

Next Speaker: Right.

Next Speaker: - required by CMS, so I would imagine they have had more attention paid to them.

Next Speaker: Right.

Next Speaker: But, um, they're been required to be reported for a while, and they -

Next Speaker: Right, right.

Next Speaker: - have languished in their decreases, I think, so I really couldn't. Maybe someone from that facility could offer, um, you know, are there kind of new things that, that you're seeing in terms of SSI prevention that are more, uh, or that might, that might be contributing to this dramatic **** infection.

Next Speaker: Right.

Next Speaker: ****.

Next Speaker: I think more, um, like colon issues, -

Next Speaker: Oh.

Next Speaker: - **** sorry.

Next Speaker: That's what I was worried about.

Next Speaker: Okay.

Next Speaker: Sorry, I'm losing my voice too. Um, I think it might be coline issues, coline changes -

Next Speaker: Right.

Next Speaker: - over time and once captured, anesthetics were doing those surgeries there. Um, you know, they, they're not necessarily staying overnight like they used to.

Next Speaker: Oh.

Next Speaker: Um, so they wouldn't necessarily fall under our surveillance by that definition anymore.

Next Speaker: Whereas -

Next Speaker: So there's no, like big initiatives that -

Next Speaker: Not in my ****.

Next Speaker: - I'm not aware of that I'd like to know about if there, there are, okay.

Next Speaker: What -

Next Speaker: Do you think that it may be possible that more folks are getting those surgeries, I mean, is an abdominal hysterectomy done on an outpatient basis, I don't -

Next Speaker: Sometimes, though, I think there's gonna be an interesting trend that might happen over the next few years, 'cause there was a big study that recently came out looking at, um, comparing, um, radical hysterectomy versus, um, more robotic techniques, and found some superiority with the open, so we might be seeing more inpatient procedures for these in the upcoming years, so it'll be interesting to track, but, um, I agree that we are subject to coding issues, and also we have relatively few number of SSIs over all the states, and I, I think in that sense interpreting percentage differences can be a little tricky.

Next Speaker: Oh well.

Next Speaker: Do you folks, um, redo, your, uh, billing code mapping to your procedure reporting for SSI on a regular basis?

Next Speaker: What was the question ****.

Next Speaker: So, the way that we determine what our, you know, what procedures fall into our category for SSI surveillance, right, is whether they match up with the CPC or ICD 10 billing codes, um, in the NHSN protocols, so I'm wondering if folks are routinely sort of reviewing or feel very confident that their, um, mappings are working the way that they're supposed to. I mean, ICD 10 is still relatively recent.

Next Speaker: And if by mapping, this is Genevieve, do you mean mapping to the location, whether it's an inpatient location versus -

Next Speaker: It would be like -

Next Speaker: a surgery.

Next Speaker: - that, but mapping it to the procedure type.

Next Speaker: Map.

Next Speaker: Yeah.

Next Speaker: Okay. Does it, does it matter if they come in through the day surgery and leave the same day?

Next Speaker: That would be recorded as an outpatient.

Next Speaker: Outpatient.

Next Speaker: Yeah. They have to be admitted and discharged on different calendar days in order to count as an inpatient in NHSN.

Next Speaker: I know we had some challenges with, um, coding in some cases that we had to send back for coding, recoding.

Next Speaker: Yeah.

Next Speaker: And, um, sent to some coding specialist, because they were captioned as abdominally directing me, but based on what was described in the op cell, they weren't the codes they were coded to, so they were recoded for us. So, it's, it's some challenging, um, question was where the uterus is removed from. Through the vagina, through the lap, depends on whether or not you captured ****.

Next Speaker: Other there thoughts on this?

Next Speaker: I'm curious also if there's any other like, insights in terms of any of these differences that we're seein', you know, there's the MRSA bacteremia, or the increase in, um, CAUTIs, national, or in Oregon, if there's any thoughts on what we should be doing or could be doing, or that's things that are happening that are influencing these decreases.

Next Speaker: Folks from the phone, please feel free to, uh, speak up.

Next Speaker: From any of our long ****, from any of our long-term care facilities, um, how you're thinking that the initiative set up in, you know, placed in the last few years are going, um, you know, is there a message ****, or things are going well and it's been incorporated into routine practice, are there any comments **** on that?

Next Speaker: Is that con, consistent with your internal **** or that it's somewhat ****.

Next Speaker: This is ****. We've seen a decrease in, um, as far as marketing companies, we've seen a decrease in CAUTIs also, um, primarily related to decrease in catheter usage, um, I think we've seen, um, we've also a decrease in C. Difficile with the antibiotic stewardship, um, so, um, we don't do, we don't see a lot of CLABSIs.

Next Speaker: Right.

Next Speaker: We just don't have the number of, um, cynical line. Our facilities in Nevada have seen an increase in that associated, um, for **** catheter. ****.

Next Speaker: Okay, thank you. And I think, you know, since ultimately this is about, uh, patient safety wherever they're surgerized in Oregon, just like if the fault would be in certain surgeries are gonna start, are happening in ambulatory care centers or day surgeries, you know, how does any just then sort of deal with and adjust to like new realities of healthcare and things like that, and the ultimate goal is safe for everyone, whether it's in a hospital or ambulatory surgery center.

Next Speaker: Yeah, there are some states that require their ambulatory surgery centers to report, um, on SSI data to NHSN, um, I think that NHSN has been working to bolster that part of their application, um, and I have a sense that that is the direction that more states will eventually be going in, because more and more procedures are done in those settings. We're missing a big chunk of the surgeries with that, that by focusing on hospitals only. And that's data **** that aren't very valuable, but where the care is happening is also important.

Next Speaker: Yeah. One thing I think I would just add, um, you know, I think interpreting HAI data like this from year to year gets really difficult. As I said, just because we're working with small numbers and we're kind working within the confines of the statistics the CDC provides us, so I think one thing that is really helpful for us every few years when we have some trend data developed and kind of report that back to you guys through our reports and the way we post this on line, so you can really see trends over time, and you know, I think, um, what we've seen over the last few years is that C. Diff has really been our kind of stagnance, that, we actually really made quite a bit of progress this year, um, which isn't shown here, this is 2016 data, but, um, that

has really been the one that's been tricky for us. CAUTI has kind of fluctuated a bit throughout the years, CLABSI has been steadily declining, so, um, I think next year it'll be interesting now that, then we'd have 3 years of data, we can, um, show that I think in a more consistent way.

Next Speaker: And this Genevieve. I know with the C. Diff, um, for example, Providence has recently gone back to now doing a two-tiered testing -

Next Speaker: Mm hmm.

Next Speaker: - uh, with UV, both the CR and your toxin antigen or if positive for ****, so again, as these changes come through ****.

Next Speaker: Could you **** the, um, ambulatory surgery centers, what they report right now.

Next Speaker: So, they're reporting flu vaccination data, mm hmm.

Next Speaker: But none of these ****.

Next Speaker: Any other comments or questions or clarifications or **** anything useful, or how it could be wonderful?

Next Speaker: Um, just a, just a comment with like the ambulatory surgery moving to a potential two-night stay we're likely to see more of these procedures move to the ambulatory setting, which will mean we won't be reporting 'em, so, um, because there isn't any measures to report an ambulatory surgery currently, might be somethin' this committee wants to take up.

Next Speaker: Yeah, um, thank you for saying that. I think that we will be planning to have a conversation about, general conversation about what, which of our measures are reportable here in Oregon, so perhaps there's a co, opportunity to have a broader conversation about our reporting requirements, sometime in 2019.

Next Speaker: And for, this is Genevieve, for clarifying questions, a two-night stay, is that a recent change that they're allowed now to do?

Next Speaker: Yeah, **** a different **** as you can but impact that everybody's talking about, what that might mean.

Next Speaker: Any comments from the phone? Great. Okay. Well, what I think what we're going ****.

Next Speaker: ****.

Next Speaker: **** ambulatory -

Next Speaker: **** with the acclimation of an **** care facility, so looking forward to hearing from the panel. Uh, next up, I'm gonna turn this back over to Rosa, who's gonna tell us about the

piloting **** in the county. It's exciting to see us come to fruition, but a number of ****, this was first being talked about 4 years ****.

Next Speaker: Yeah, we're, maybe we're – so, um, some of you may recall that have, um, a student who was with us finishing her MPH at the time, Rachel **** present on this project back in June with some preliminary data. I think Rachel and I actually be on the call today, um, and just be – we'll go over the data and some of our findings in detail today. Um, but I just wanted before we get started, acknowledge that this has been a long time coming and there ha, hare a lot of different folks who have worked on this project, some of whom are in the room and some of whom are not. So, just thanks everyone for a lot of work. So, um, some of you will have **** background on this project already, but as a refresher, in 2015 our division investigated a prolotherapy clinic after a case of acute hepatitis C was linked to injections received at an affiliated clinic in California, and though no cases were identified in Oregon residents, the investigation revealed that we had an incomplete understanding of what injection and needle use practices looked like in alternative settings. And for those of you who are familiar, prolotherapy is injection of bone marrow, fat, plasma or sugar solutions into the body in order to treat joint, ligament and tendon pain or weakness by stimulating a healing response. Um, at that time we received, had received funding from CDC's one and only campaign which was focused on safe injection practice, um, and a survey was developed for providers, businesses and facilities in, um, our county in which this occurred, um, that provided health-related services, the goals of the project to assess needle use and injection practice to develop resources for healthcare facilities, and to engage our healthcare personnel in educational activities. And anecdotally, you know, audience to which our staff have delivered education on this topic perceive injection safety to be a really basic fundamental skill that all healthcare personnel should already be well-versed in, making education on this topic unnecessary. Um, but the reality is that delivering injectable treatment for medications and using needles are complex competencies that require multiple skills and serious slipups or misunderstanding can cause, or a simple slipups and misunderstandings can cause serious consequences. Um, additionally, those who deliver injections self-report that they observe unsafe practices in their workplaces, um, in the form of surveys, and we also have case studies in the form of outbreaks that confirm that this does happen, and that not only does unsafe injection practice with needle use occur, but it does result in infections. Um, over a 10-year period 448 Americans were infected with hepatitis B or hepatitis C in a healthcare setting due to breaches in fundamental principles of aseptic technique and infection control, including reuse of syringes or lancing devices. Um, and we also know that, you know, there are repercussions for patients in terms of morbidity, mortality, distress, pain, um, also repercussions for healthcare facilities, providers and systems, as well. So, where are we with this project now? Well, we've done a lot, um, we've developed, piloted and finalized our survey tool. We have developed a tool kit of resources, um, on injection, uh, practice and needle use that lives on our website. We prepared a, distributed a list of 4,000, um, individual providers **** facilities, distributed the survey, collected the data, performed, um, analysis and prepared a report, um, but we are going to be doing a second round of distributions seeking more responses, so that is in progress. And then our next step will include, um, additional data collection, analysis and, uh, report preparation and then data sharing on a more wide scale. Um, and you'll get to hear all about our data analysis in today's presentation. So, this was the text at the very beginning of the survey where we explained what our goal is and who should complete it. And just really wanted to know that the purpose of this survey was to assess, um, key healthc,

healthcare providers who were involved in aspects of needle use and injections, what types of services are provided that rely on needles and injections, and the amount of education providers receive about injection safety-related issues. And the purpose of this was not to identify regulatory issues associated with injection use, which is something that gets assessed separately, either in partnership with our regulatory agencies or accrediting bodies, and through our infection control assessment. And the survey included 48 questions on facility demographics, types of services provided and types of providers employed, what types of procedures and practices regarding injection and needle-based care were being carried out, types and quantity of education received and communication. I mention the tool kit very briefly, but since it's a pretty important component of the project, I wanted to show the table of contents for the tool kit. Um, everyone who completed the survey got automatically routed to our website where this tool kit lives. Um, here is the table of contents and each subject heading, um, contains a link that directs viewers to the specific content area that they're interested in. I really encourage you to peruse it when you have a chance. It has information for patients, it has information for healthcare personnel, it has, um, information that sort of general, uh, information that's specific to setting, and information that's speci, specific to practice type or practice category. So, um, there is a pretty wide array of material there for you to look at. So, in terms of our data, um, we had 70 responses that were compete enough to include in our analysis which used Fisher's exact test to compare results by facility type. Um, the responses were divided into two categories, acupuncture setting, and non-acupuncture setting, and then our non-acupuncture facilities were further stratified into businesses and facilities that were perceived as inpatient or outpatient. Um, and I mentioned that though 73 responses were submitted, three of those were excluded from analysis, um, because we could not ascertain any business or facility category. But just of note, that all three of these **** responses indicated that they did provide any services involving needles or injections. Um, I think one of them is actually a bank, um, so ultimately we had data from 15 inpatient facilities, 49 outpatient facilities and six acupuncture facilities, and just for shorthand I may not say facilities, but really they're businesses and facilities, or individual providers who reported working at one of these types of facilities or businesses. And this table gets a bit of a further breakdown of our outpatient facility types. Um, inpatient facilities were largely hospitals, while outpatient responses were more varied, coming predominantly from dental, primary care and specialty clinics. Um, outpatient responses that did identify them fall to the specialty clinics included community mental health programs, diabetes care centers, medical detox facilities, and providing services for things like weight loss, family planning, nutrition, eye care, sports medicine, ocular surgery and general health and wellness. And while nearly 100 percent of our inpatient settings part of a larger hospital or health system, just about a quarter of our outpatient facilities were associated with both hospital and health system, and about a sixth of our, um acupuncture facilities were. Our licensed provider types and types of needle-based or injection services provided were very diverse. The common provider type that were employed, um, at these settings included, um, certified nurse -

Next Speaker: **** a system.

Next Speaker: - no, um, D.O.s, uh, LPNs, M.D., uh, nurse practitioners, physician assistants, R.N.s and licensed acupuncturists. Um, and then common service types that they reported providing included biopsy, blood draws and phlebotomies, chemotherapy, CT and MRI scans, dialysis, endoscopy, injection, intravenous infusion, pain management, point of care testing

involving finger sticks, specimen collections from sterile body sites, surgeries, transfusions and acupuncture. And these were all common service types that involved **** or injections. We asked a number of questions about injectable medications and treatments, so all of our inpatient respondents stated they did give injectable medications or treatment, while about 90 percent of outpatient facilities said that they did, and about 50 percent of acupuncture facilities said that they did. Um, outpatient facilities reported mean number of patients or clients who get at least one injection of any type per day, and inpatient facilities reported the highest mean number, and then acupuncturists settings kind of fell somewhere in between the two. Um, just a little comment here, that the higher number of maximum, um, injections per day in an inpatient facility probably reflect the relatively high patient, you know, census, or facility capacities, and, um, acupuncture having that minimum of above zero is kind of interesting, so both inpatient and outpatient facilities said that they had a minimum of zero, so it could be that zero patients would receive an injection a day, but acupuncture facilities didn't have that. Their mean, or their minimum was above zero, which I kind of leaves me to wonder, you know, are they counting acupuncture procedure as injection, but that's the question we may never know the answer to. Um, and then finally some of the common, we, um, administered medications or treatment by injection or infusion that were mentioned included antibiotics, fluids, anesthesia, pain medications, sedative, insulin, anticoagulants, vaccines, all really all over the ****, birth control, steroids, vitamins, hormones, all kinds of things, really reflecting the type of service that they're providing. We looked at a number of different practice duties by different types of healthcare personnel, um, and we looked at several groupings of provider types or three groupings of provider types here. So, the first grouping was nurses, the second group, grouping was, um, physician, physician assistants and nurse practitioners, and then the final grouping was other, which included dental hygienist, dentist, medical assistant, pharmacist and any other response that they gave. And just to call out a few interesting points here, when we asked who administers injections, um, outpatient facilities were more likely to say that the other category performs this task than inpatient facilities, so said that nurses or the physician P.A. or N.P. group would most commonly do that, or would do that. And then when we asked who administers the majority of injections, which is different from, you know, which staff would ever administer an injection, inpatient and outpatient facilities looked very similar, except for looking at the nurse category there, um, so in, nurses are statistically significantly more likely to be delivering the majority of injections in the inpatient setting, than they are in the outpatient setting.

Next Speaker: Okay, uh, just a clarify question. So, other, that would include anyone else, so anyone else who wasn't in, either a nurse or a ****.

Next Speaker: Yes. So, inpatient facilities were also statistically significantly more likely than outpatient facilities to use safety syringes. Um, and they also gave more injections involving blood or body fluids, like blood transfusions, platelets, plasma, etc., and facilities commonly reported giving medications or treatment at the intramuscular, intravenous and subcutaneous levels. We also asked several questions about compounded medications. About one-third of our inpatient facilities administer compounded medications and a bit less than a quarter of our outpatient facilities do, and very few acupuncture facilities appear to do this. Um, and facilities that do give compounded medications are most often both kind of compounding their own medications, as well as getting them from an out type source, like a compounding pharmacy. We have lots of questions on our survey about medication administration, so none of these

results on the slide were statistically significant, but we do see some patterns. So, more inpatient facilities reporting mixing or reconstituting medications or treatment less than an hour before administration. More outpatient facilities reported drawing up medications or adding them to bags less than an hour before administration, and more inpatient facilities have a two-step process for checking injectable medications or treatment than outpatient ****. I realize there's quite a bit of data here, so we're just kinda, kind of go over it in broad stroke.

Next Speaker: And, and just as a clarifying question.

Next Speaker: Yes.

Next Speaker: The assumption is, is that best practice is to mix things **** before you give them, or very soon before you give them and not to mix them hours before.

Next Speaker: And hour, the ti, the cutoff point that we're kind of hoping to see, um -

Next Speaker: Should be within the hour.

Next Speaker: Yes.

Next Speaker: Gotcha. *****.

Next Speaker: Okay, so in terms of how medications are packaged when they arrive at facilities, there was no clear pattern by facility type. They do come in a variety of different types of packaging, including, um, infusion bags, manufactured, pre-filled syringes, multi-dose and single dose vials. Uh, when we asked if vials of medication were used on more than one patient, we didn't specify type of vial, um, both inpatient and outpatient facilities most commonly reported never doing this, um, but outpatient facilities were statistically significantly more likely to ever do this, than were inpatient facilities. Um, and we also saw that most inpatient facilities administer anesthesia, while most outpatient facilities don't. And going back to administering multiple doses from the same vial, we did ask a qualitative question that said, you know, give us an example of this practice, and most of them described drawing doses of a medication or a treatment, like a local anesthetic or a vaccine from a multi-dose vial. We also wanted to ask about services that involve needles without injecting anything, like acupuncture, and we saw relatively few facilities reporting doing this except for acupuncture settings, and I will just mention that the reason for only 50 percent of our acupuncture settings reporting do this, I believe was because 50 percent of our respondents kind of dropped off the survey by this point. Um, alcohol was the most common form of skin prep that was reported, chlorohexidine and betadine were also popular, and just as a reminder, there is no skin prep rec, recommended for acupuncture. This was kind of new information to us. Um, we also asked for descriptions of how sharps were disposed, and how environmental cleaning was performed. That didn't seem to differ by setting type. And if you'll remember, one of our goals was to use these **** to improve our educational efforts around needle use and injection practices, and we just wanted to assess what was already going on in the facilities. Most inpatient and outpatient, uh, folks reported that they got education on this topic at work at least once per year, while most acupuncture settings did not. Um, facilities got a wide variety of topics and types of materials

would be useful, including guidelines and recommendations, one-on-one trainings or in-person site visits, peer review journal articles, posters, printed materials, videos and webinars, all talk about the topics they were interested in on the next slide. And every interesting result here. While about half of inpatient facilities provide training about drug diversion, very few outpatient or acupuncture settings do this, and inpatient facilities were statistically significantly more likely to offer assistance to stop with substance abuse issues. Here are some of the topics that facilities mentioned they would like to hear more about, but just calling attention to these two sort of crisis events that were particularly of interest, um, which are how **** these transmission related to injection practices, including kind of the outbreak scenario, and then also needle stick injury. But some of the lower numbers are informative as well, because elevated percentages, um, as were seen here might indicate, um, oh, sorry, lower percentages of people indicating these topics or interests, might indicated like a lower level of comfort or awareness of those topics, for example, compounding. So, if you're not quite sure what compounding is, you might say, you know, no, that's not something that applies to me. Um, we often don't know what we don't know, right? So, we might be less likely to ask for information that we know very little about, um, so that's where we can come and help out. Okay, and then the last slide on results here, inpatient facilities most often reporting getting general information about clusters of disease, um, outp, outbreak or injection, or needle-related patient or client notification. Um, and when asked where information about needle use and injection practices came from, facilities described a variety of sources at work, like training and messaging, as well as external sources of information, like manufacturer instructions, local, state or federal agencies, drug and equipment manufacturers, journals and textbooks and professional societies. Um, an outpatient facility is more often described receiving information from external sources and inpatient facilities most often describe just getting this information primarily at work, so it seems that in the outpatient setting, some of this kind of situational awareness or self-guided professional development is happening, um, independently. So, what's next? First, our tool kit has been viewed 586 times by 444 unique users from May 2018, which is very exciting for us, and we're continuing to expand it to add new information, and we'll be reviewing it and updating on a recurring basis. One of the things that we did include there in our tool kit on our website is a very, very short, um, feedback evaluation survey, just a couple of questions. Um, we have not seen any responses to that yet, so that's something that we're see, seeing, or hoping to see change in the future. We're also working to develop, um, new materials and encroaches, or approaches to **** training that we do already on safe injection practices and needle use. And finally, as I mentioned, we're working on that second round of data collection now. So, we really could not this presentation without asking you all to partner with us and sign up to join Oregon's one and only campaign. This is something we manage internally here, um, in our agency. We have 31 members so far. Everyone is welcome to join. All you need to do is send us an email address. Um, this could be like a general email address for your facility or, you know, your personal email address, if you just really can't wait to get to work and read all of our updates, or it could be your work email address, and you'll just get periodic updates, news and resources from us regarding safe injection practices and needle use. Um, really all we're asking in exchange, um, is that you, as you become aware of information or resources on this topic, that either you think we should be aware or that you get information from us that you think your colleagues and peers should be aware of, that you just help to distribute the messages. And, we're not gonna be, you know, asking you to sign a, an agreement or a contract. It's just kind of hoping that, you know, as we send out this information that you folks will see that where it has a good application and distribute it as you

see fit, really. Um, we'd also love to see more evaluation of our tool kit and make sure everyone is aware of it, um, so please do check it out here. The link on the slide, and if you yourself are willing to fill out our very brief evaluation survey, we would love to see any kind of feedback on it, good, bad, ugly, whatever we can do to improve it. It's really there as a resource for everyone, so without having folks looking at it and telling us what work, what works and what's missing, um, it's hard for us to continue to improve it. So, if you are interested in signing up to join our campaign, you can just email me and my email address is here, or you can call me, or you can tell me at this meeting, will you sign me up, and I will put your name on the list. And then you will get, you know, periodic, it's not gonna be, um, an overwhelming amount of information, yeah. Um, so, I'm not sure exactly how much time we have for this discussion right now. I think maybe not too much time for this discussion. Um, but I just wanna throw out some questions that we have for this group. So., hopefully, you know, if you have thoughts about these data, I mean, we can take a couple minutes to kind of reflect now, but, um, you know, what should our priorities for education, outreach and engagement be, right, based on what we're looking at today? How can ensure our tool kit makes it into the right hands, um, so maybe we can give it like 2 minutes, and the move on to the next agenda ****. So, thanks again for everyone who worked really hard on this and thanks all for listening.

Next Speaker: Great work, yeah. There's a lot of, lotta data to collect, but I think also it's something that is not an area that's not well known and not ****, so this ****. Any suggestions from the group or -

Next Speaker: And I see as being more of you're talking about, um, moving certain, uh, medical procedures out of hospitals into other settings. **** for surgery, I feel like again, like **** are done in smaller settings than I ****, releasing issues or in, um, in ambula surger, ambulatory surgery doing, or other settings, clinics, doing studies like, um, you know, um, GI studies or things like that, is where the kinda outbreaks have been and ****, parallel studies*.***.

Next Speaker: Yeah

Next Speaker: Melissa?

Next Speaker: Yes.

Next Speaker: Um, I missed the very beginning of this, but did you tap any of the tattoo parlors?

Next Speaker: So this was just for health-related services.

Next Speaker: Okay.

Next Speaker: So, we kind of used a broad definition of that, um, but I think we do –

Next Speaker: And we had a recent outbreak ****. I think it was Florida had some ink or something?

Next Speaker: It would be so interesting to see that.

Next Speaker: ****.

Next Speaker: And I think it's really hard, because our funding is for healthcare settings, right?

Next Speaker: Can't really, uh, connect that to ****.

Next Speaker: But, yeah. But, but **** the audience sees the tool kit.

Next Speaker: But the, the, the route of transmission is similar, right? And I think that we also see this happening in the community where there are injections that are occurring that are not in a healthcare center, but the route of infection is also the same. So, it's a very fair point. It's very well taken.

Next Speaker: Yeah.

Next Speaker: And I think one thing this could help us with – we talked a lot about it actually, 'cause it was super tempting.

Next Speaker: It's so on the list of ****.

Next Speaker: Not to, 'cause we have – right. And we could potentially get that information, but I think it'll be helpful to see as we collect more data on this, some trends and more kind of alternative clinics and things like that. And we can develop the same kind of training materials from tattoo parlors that we would for them and send it out. Um, we may not be able to interact with them the same way we do with healthcare settings, but, um, it doesn't seem too much to ask to, you know, remind them about skin prep and, you know, aseptive technique and, and cleaning. So.

Next Speaker: We're naturopaths?

Next Speaker: Yeah.

Next Speaker: We skipped naturopaths.

Next Speaker: They were included?

Next Speaker: Those included?

Next Speaker: And –

Next Speaker: Yes.

Next Speaker: Yes.

Next Speaker: I remember **** it.

Next Speaker: Yeah. Yeah.

Next Speaker: Great. Thank you. Well any other comments, um, that might be a good **** is to go just check this out and see if any pieces of it apply to the healthcare facility that you are currently working in and provide some feedback to the toolkit. That'd be awesome.

Next Speaker: Yes, please **** the sides, please check out the toolkit, evaluate it and, please, please, sign up to get our Injection Safety Quarterly newsletter, I think is what we'll, this will equate. Um, we just would love to have more folks getting that.

Next Speaker: **** saying we should make sure our safety committees **** if you directed it to hospital safety committees.

Next Speaker: You're welcome to send me someone else's email address. I'll just click on the links. I'll just **** get a link for a new hire, you'll put a new hires ****.

Next Speaker: **** materials in there too.

Next Speaker: Yeah.

Next Speaker: You know?

Next Speaker: Yeah. We have some –

Next Speaker: ****

Next Speaker: – good, the toolkit has some really great kind of fundamental resources, lots of checklists, things that we think will be kind of nice to use in a facility setting.

Next Speaker: But, that's helpful to know that we could direct it if we wanted to send some general information to facilities, we could direct it to safety committees. That's useful. Thanks.

Next Speaker: Yeah and because they'll have clinics ****.

Next Speaker: Great, great.

Next Speaker: Great.

Next Speaker: Thanks everyone.

Next Speaker: Thanks for the feedback. Okay. We're gonna move onto our next panelist here, um, from Marquis and I don't know if you, if, uh, folks would like to come up here and sit here and drive the slides and be next to this microphone if that, do you feel comfortable doing that?

Next Speaker: So I can just give a little bit of, um, –

Next Speaker: And ****.

Next Speaker: – kinda general introduction to this topic. So, um, I think, as many of you know, 'cause we've talked about it at previous meetings, um, one of our charges this year is really to improve healthcare worker vaccination in a variety of healthcare settings and a lot of that focus has been on long-term care facilities 'cause we're still hovering around 60 percent, um, vaccination for that, that setting and it's, it's lagging quite a bit behind, in general, some of our other healthcare facilities so one thing we did this year is kinda reach out to all of our skilled nursing facilities, send down some resources and just have a conversation about any challenges and things like that and in doing so, we really talked with a few facilities that stood out as really high performers in this and had done some really innovative things, um, so here with us today, um, is Kirsten King and Michelle Shields so, um, they're gonna share a little bit of their experience and the wonderful things they have done, so thank you.

Next Speaker: Well, thank you for having me.

Next Speaker: Um,****, here I am. I'm Kirsten King. I am the director of nursing services at Marquis Silver Garden in little Silverton, Oregon. Um, I have been here now for – oh, man – uh, 2 years and 5 days and just to give you a lit, a little bit of background about us. Um, we are a very small facility. Um, our average census is anywhere from 17 to 23, um, but the thing about that is, I don't have one person that sets me a little bit, you know, higher than everybody else, to have the fact that I really liked having a hundred percent this year, um, but that one person last year set me at 2 percent behind and then, 67 percent, um, was what they had prior to me coming there. Um, we decided at the DNS meeting with Vicki, um, to put in a masking policy and we talked about it and said what if we all, at our all staff in September, make everybody wear a mask. What do you think's gonna happen? Well, to give you a little bit about this. We ended up going over a policy, which Vicki sent out to us, and we reviewed this policy. I handed it out to everybody and the first thing that they said is, "That's the flu season?" I said, "That's the flu season." During, um, our all staff, we required everybody to wear the masks. It ran about an hour and a half. Um, we had a presenter there. Lexi came and actually spoke about the flu vaccine and what are common signs and symptoms and basic education. They can listen to me all day long, I'm a broken record, but when it comes to listening to everybody else, they tend to perk up a little bit and listen to the details better. Uh, we went over a lot of myth versus facts. People don't seem to understand how it starts at the front line, um, and it's not just the CNAs. It's housekeeping, it's dietary, it's, it's all of us. Um, it's walking in the front door, um, and, you know, meeting somebody and seeing one of our hand hygiene's patient there, um, and educating from thereon forward. So but putting it in laymen's terms, I think, was really important. Um, we had Lexi speak to back to the basics. What actually is the flu? People don't really know. They interpret it differently than, they say oh, you know, I, I have diarrhea, that's the flu. Well, let's talk about this. Let's really talk about this. Um, so does the flu shot not work? Uh, will it make me sick? If I get the vaccine, does it, you know, it, it doesn't work or whatever the case may be. Well, after going through all this and posting these up all over the facility, we started getting a lot more responses, better responses and more questions, um, so that was a big positive thing in our building. At the front door, when you walk in, we have a hand hygiene station, which you'll see a slide later but we have the cover your cough, which we promote, um, huge throughout the

facility. I have it posted in every hallway. At the front door, at the back door and also in, um, the staff break room. So we decided to partner up with Salem Hospital as well and do a hand hygiene, um, which has been really exciting. Um, it's a, a little bit of extra work but it has really paid off for us in the long run. Uh, we came up with some things that we noticed were, um, some barriers. We had five hand sanitizers, um, outside in the halls and so we decided to up the ante. We looked at our fire codes and we looked at how many hand sanitizers we could place down every hallway and we staggered them throughout so now, there is hand sanitizers throughout every hallway. There's one in every resident room close to the door. There's also one in the dining room, independent and the people who also need help assisting and we've now put 'em on the carts. Um, that was a huge deal. You, when you're passing out trays and picking up stuff, the convenience of it, that made, like, all the difference. Uh, so we figured out that when you can increase all this and have literally one soap or hanitized, sanitation dispenser per every resident, uh, it kinda made things a little bit better. Uh, I spoke to our house MD, who has, he is, just so we're all on the same page, he is a very old school doctor, which I love about him, but he is, um, he is really the one who's been hand in hand with me on this. We sat down and talked about how can we increase the flu vaccine and help our, uh, staff understand the importance of this and it really starts with them, um, and so he gave some major incentives. We decided that if 80 percent of staff, uh, were to get the flu vaccine, he'd give a hundred dollar Visa and anything 90 percent or above, he would give another hundred dollar Visa. That was a big deal. Um, when they see these incentives comin' around, it was like what? Okay, well, I want that. Um, and then, I went to the DNS meeting and Marquis also, for our facilities, gave us more money to hand out and a small little building like this with 43 employees, when you're handing out that much money, it's kind of a big deal, so that was great. And, as you can see, we also handed out, I got my shot, my flu shot for us. They thought that was a lot of fun. People ask 'em about it, uh, families, you know, even the residents, um, and so it just made them a little bit more aware and they were proud to say hey, look at me, this is what we've done and that's, that's that. So is there any questions?

Next Speaker: Hi there. Um, and, as, um, Becca noted, I participate some of those interviews, um, of the various **** homecare facilities so for Marquis, was this specific to this location, um, or was it, a, an enterprise wide initiative?

Next Speaker: No, we actually did it facility wide. Um, we just wanted to see an increase in starting from the very beginning, down to the basics, to help prevent our residents from getting the flu, you know. Um, we do a huge education. I do. I know that a lot of the other DNSs do and Vicki gives us educational stuff to hand out all the time on it's, if we're not taking care of ourself, we're gonna get everybody else sick, um, so for them to understand the importance of that, we talk about in servicing - we talked about this at the director of nursing meeting - you know, helping them understand that we all have families, so what if you take it home to your family? It's nothing different, right? So if you have that one person and you take it home, in especially a small setting, and some of our buildings are small. There are 54 beds. That's pretty small compared to 150. Um, it spreads like wildfire if you're not careful. So we actually saw the statistics go up greatly, which was, which was really good.

Next Speaker: Are you able to comment on how other facilities within the enterprise performed, um, –

Next Speaker: Vicki can. We asked her about it today so I know she can talk to it.

Next Speaker: Okay.

Next Speaker: So we had, um, of the 18 facilities, we had eight that were, um, um, 90, over 90 percent so far. Um, what was interesting is we had made the recommendation that all facilities, at their all staff in September, have everyone wear masks, um, and it was optional whether the facility chose to do a mandatory masking or not; however, a majority of 'em chose to do so. The one facility that chose not to do the masking, um, wear the mask for the, um, meeting, they're at 20 perc, 27 percent, –

Next Speaker: Mm hmm.

Next Speaker: – um, and that, the next, um, is at 67 percent and so, um, it, it really did have some positive impact.

Next Speaker: **** say something.

Next Speaker: Oh.

Next Speaker: Oh.

Next Speaker: ****.

Next Speaker: To speak to that, just so, em, and I'm gonna throw Lexi under the bus here 'cause she was actually there giving a presentation. We made every single person wear a mask when they came to the all staff meeting. Within 20 minutes, we saw at least a third of our staff start to take 'em off randomly. Uh, 40 minutes into it, we saw over half of them have 'em down on their chin and by the end of it, we had maybe, you know, a little handful that still had it on so it really played a big role in this is what you will be doing anywhere from 8 to 12 hours out of your day, depending on are you a nurse, are you housekeeping, are you dietary? That was the realistic, I think.

Next Speaker: Yeah, I was gonna comment to that. I just think that making them wear a mask like that for just even that short period of time, is a phenomenal idea. As a nurse, you tend to wear 'em before, you know, in, in the healthcare setting. You know, it is miserable breathing through those masks and I think, um, that was probably the smartest thing you could've done is make 'em wear it and make them realize how awful it'll really be.

Next Speaker: Uh, we had one lady who had not had a flu vaccine. Um, she was the one, my one last year, that did not get it, um, and did not have a flu vaccine for the last 6 years, um, and when we put the mask on her, she said I can't do this. I just can't do it. Fine, give me the shot. You know? Um, and so helping them understand also that it doesn't make you sick. It does protect you but it doesn't just start there, um, which Lexi really helped a lot with that and so I think that was just the, that was the kicker, was that mask thing.

Next Speaker: I was, I was curious how much of an factor this, it was like a hundred dollar incentive, is that the you provided? And I'm also kinda curious how often do other facilities do that, if both of you from kinda like your experience directed with this one ****.

Next Speaker: When we did our research and we, we used to ask the question from facilities, what incentives do you use when you, um, offer the flu vaccine and incentives was one of them and it was used frequently but it wasn't found to be effective so I'm glad that it was effective. Like you said, in your small facility, the odds of winning that hundred dollar gift certificate are a lot higher, I think, than, you know, in a Saint Vincent or –

Next Speaker: Right.

Next Speaker: – something like that.

Next Speaker: Well, the other thing that we talked about was breaking them up into $25.00 or $50.00, you know, increments or whatever. Um, I can tell you that Dr. Grady, um, also bought a TV one year and gave that. So, I, I think it was just, it, you know, between those, those things are –

Next Speaker: Right, right.

Next Speaker: Yeah.

Next Speaker: – big things to CNAs. Those CNAs, man, they work their tails off, –

Next Speaker: Right.

Next Speaker: – you know, and they need to see that and they're 90 percent of our prevention on the floor and so I advocate for them. I know what it's like. I've been there, I've done it. I still get out there and help so being there to help them get that, it was, they still talk about it. I mean, just, it's still the you'll never believe that I got a TV, you know? It was a 30-inch TV but to them it was everything.

Next Speaker: Mm hmm.

Next Speaker: So, so doing those little things. We didn't ask what they wanted. It was, you know, our physician and Vicki and myself and the administrator, we had sat down and just decided, you know, let's just do this. This is what we are gonna do, um, and then, we'll go from there. The other thing is, we do infection control and we do hand hygiene things and, and that's also played a big role in it and so we do pizza parties and stuff like that. You know, that's a few bucks here and there. Go to Little Caesar's, it's $5.00, right? But that being, it, I, that, for us, –

Next Speaker: Right.

Next Speaker: – has just been the saving grace. It really has. It had a positive, positive reaction.

Next Speaker: Well, thank you so much. I'm gonna, um, pass it off to Miche, or, um, Michelle but then, I think we can circle back and ask both our panelists some additional questions, if there are any remaining.

Next Speaker: Hi, my name is Michelle Shields and I'm the infection preventionist for The Whole Gate Community. Um, so this year, for us, it was, we started off in June, per, end of June, first of July, having made a list of what all of our goals were and what we wanted to do. It's still on our board, um, and we started off with our masking policy and really educating all of our staff throughout our whole campus on, um, the expectations for our mask and this is the first year we had a, a legit masking policy and for us, this worked more than anything else we'd done before. Our staff is not mo, motivated by money or gifts. It was, it was purely inconvenience of wearing a mask for, um, you know, for the whole entire time and we are the one, uh, skilled nursing facility that had the outbreak this year so, uh, we got to put everything to test really quickly and it worked. It really worked. Uh, we redid our, um, declination forms. Um, we just kind of went through like ordering our vaccine and everything. We did stickers this year, which I think helped, um, a lot, um, recognizing like when, um, management and other staff are in the hallway. You know, oh, you don't have a sticker. Where's your sticker? And, um, I think that motivated people to get it as well and it wasn't fun when we had our outbreak and everybody, I think we saw like a 22 percent increase when we had our outbreak, of people getting the flu vaccine and we have 147 employees –

Next Speaker: Yeah.

Next Speaker: – at Friendship and we're at 85 percent, uh, right now. Um, and we did have Lex come and she, she spoke and I think that made a huge difference. That's the first time we've had somebody outside and, uh, like Kirsten said, you can talk all day long but when you hear it from somebody else, I think it has a different impact than hearing it from somebody that you see every day. Um, the one thing that we will do different next year is, um, this year we immunized all of our, um, employees first and then we did our residents and this year we're, next year we're gonna do 'em at the same time because I think that, that impacted us having, uh, a potential outbreak like we did so. And I spent a lot of time, um, doing one on one, um, in servicing and education with, um, our staff, where English is not their first language and really kind of going over those fears and, and, um, concerns that they had and that bumped it up a little bit, um, but even having, you know, a department of four and getting two people vaccinated in it, I thought was a great improvement than what we've had in the past and we never stopped talking about our vaccine, um, that we have it, that you can, if you don't have it, you could still get it. We're constantly bringing up our rates in every meeting that we're having, in our all staff, I bring it up in new hire. I talk about who hasn't had a flu vaccine in new hire, uh, because if we can get 'em, you know, early, I think that's important and, um, so we talked about it constantly. I think there was, you know, when we had our outbreak in October, you know, there was a big flourish of education, information. It was the hot topic. But then, when it was over, I could see it was kind of, the topic was kind of dwindling down so we, I just bring it up every chance so to keep it in everybody's mind because it, you know, it could happen again so. Um, we spent like a hundred bucks on 200 flu stickers, which looked really great but I will not waste our money next year doing that. I will just make some kind of happy faces or some kind of cute sticker. Um,

everybody loved 'em but I think it was just like a huge waste of money so I wouldn't, I wouldn't advocate for that. Um, we stayed in close contact with our flu vaccine vendors. We've had an issue the year before and so we didn't have that issue this time 'cause we really stayed on top of it with phone conversations and emails, um, and all of that and then, when we did our flu vaccine, uh, stickers, I found it interesting kind of as a side note, to find out how many people actually weren't wearing their badges or had lost their badges. That was kind of a nice little – yeah, figuring that out. Uh, people were sticking it like on the back of their phones and stuff like that so we kind of rectified that situation very quickly and, um, I think that like 25, 30 people went and got new badges so, um, that was a bonus. And our masking policy, it's, it's, it's no exception. If you, for whatever reason, you cannot get the vaccine or chose not to get the vaccine, um, you have to wear a mask and we, uh, do, I, uh, so if you got your vaccine and say we had the flu outbreak 2 days later, we still pe, make people wear a mask for 2 weeks after getting the vaccine and I think that really helped prevent a lot more of our employees from getting the flu. I think so. I don't know for sure but I think it did and then, we're constantly doing, um, spot checks. We're keeping track of all our contracted staff, students, instructors, volunteers and getting, uh, flu vaccine information on them as well so we could make sure that they are wearing the masks when we have, uh, mask on. That's it.

Next Speaker: And Michelle, do you wanna talk a little bit about the mask on, mask off –

Next Speaker: Oh, yes.

Next Speaker: – that ****.

Next Speaker: So, um, when we had our flu outbreak, I posted signs, sent out emails to all the managers and posted signs everywhere – in the elevator, um, employee lounge – letting them know that we were officially on mask on and what that meant and then, when we came off of, um, our outbreak, then I posted a sign and sent out an email that just said mask off and that was just a great way to kind of make sure everybody got the information. Um, so it worked for us.

Next Speaker: Cool.

Next Speaker: So, I'm sorry, I just want to clarify. Are you saying next year, you're not gonna do stickers at all?

Next Speaker: No, we're gonna do stickers –

Next Speaker: Okay.

Next Speaker: – but I'm not gonna spend a hundred bucks on them.

Next Speaker: Okay.

Next Speaker: Uh, I'm just gonna make some, some sticker.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: No, 'cause I think the stickers are effective and –

Next Speaker: Oh, yeah.

Next Speaker: – especially if you have 147 employees, you're never going to be able to keep track –

Next Speaker: Exactly.

Next Speaker: – of whose got it. Okay.

Next Speaker: Yeah. Great, great idea and we will continue to use it. We're just gonna be creative and make our own.

Next Speaker: I got a question for either, any of the panelists, which is, uh, do you feel that there's, um, a difference in the kinds of misperceptions or reasons for hesitance in healthcare personnel that you're educating about the flu vaccine versus the general public?

Next Speaker: Um, I, you know, we, since we don't vaccinate the general public in our building, of course, –

Next Speaker: Sure.

Next Speaker: But you might hear something –

Next Speaker: Uh, right.

Next Speaker: – I don't know.

Next Speaker: Um, I don't think we got as many, um, excuses or reasons for not getting their vaccine as, um, in previous years, as it's gonna get me sick. Um, I think we had one off-the-wall, uh, person, who unfortunately, English wasn't their primary language, who thought that if they got the flu vaccine, that they would get an STD. Uh, so that was re-education on their part. Um, a lot of the reasons for declin, declinations are, uh, cited as religious purposes, uh, rather than just saying I choose not to vaccinate myself, they're saying well, it's for a religious reason. Um, and I know that there are other facilities and hospitals that don't allow religion as a reason to, to refuse the flu shot, uh, but I don't know how we're going to address that in, in the future. I mean, everybody's got a right to choose, um, and those people are very well aware that if we, uh, have active cases of flu in the community, uh, that they're gonna have to wear that mask, um, until the active cases are resolved, whether it's in our building or, um, in the surrounding community and hospitals.

Next Speaker: Thank you.

Next Speaker: I have a similar question. Have you all seen more hesitancy in years following a season where the flu vaccine wasn't at its most effective, so a season like last year?

Next Speaker: Right now. That was, that was our biggest thing.

Next Speaker: Hmm.

Next Speaker: Well, it didn't work last year.

Next Speaker: Um, we hand out a lot of education, I hand out a lot of education that's handed out to me because I want staff to be, you know, aware and understand what's going on, um, but I think that was the biggest, that was our biggest thing this year, uh, was the staff said well, it didn't work last year. It was not effective last year and I said well, regardless, 10 percent and 30 percent is effective than 0 percent.

Next Speaker: Mm hmm.

Next Speaker: So there is something that's a little bit different. So when you, you know, kinda throw that information back at them to say you not getting anything is a 100 percent of you not, you know, or having the availability of getting infected a hundred percent, versus having that 15 percent chunk or 30 percent chunk or whatever the case may be and then we talked about how the possibility of the flu vaccine this year has been a little bit more positive, you know? You take those few wins, um, and we gave a little bit more education and then, you know, we educate the staff when they come in and we keep giving the flu shot and just or you hand out the mask and that was probably the biggest thing, was handing out that mask. It's, nobody wants to wear it all day long, not talking on the phone. I wear glasses. Who wears glasses and they're, you're fogged up all day long because of it and I'm like oop, can you hold on a second, okay, let's talk. Right?

Next Speaker: Right.

Next Speaker: Um, talking on the phone conversation and yes, can I help you today and they're like what?

Next Speaker: Mm hmm.

Next Speaker: Uh.

Next Speaker: You know, I think things were a little different over at the Whole Gate Center. We had our last flu outbreak was in 2016 –

Next Speaker: Mm hmm.

Next Speaker: – and it, I think it went through our building two times.

Next Speaker: Yeah.

Next Speaker: Uh, it was pretty bad. Um, and I think our staff vaccination rate, um, was roughly 6, I wanna say 63 to 65 percent that year. Um, last year, our vaccine rate, I think we got up to 70, 75 percent, uh, but it was a lot of education that, yeah, so last year's vaccine didn't work so great but, you know, they're taking it from the southern hemisphere, where they all had the flu and saying this is gonna be their best bet so you should get the flu shot because you're not only protecting yourself but you're protecting these people that are stuck here, uh, and I think that helped a lot better than, than, and then people saying, uh, well, it didn't work so I'm not gonna do it.

Next Speaker: And I think when you came, you really, really explained it really well and I think that opened a lot of people's eyes to why, why it works, you know, why, if it didn't work last year, why I should get it and so I think that was amazing and I think that really increased our rates a lot and then, we just took your message that you gave and we just keep repeating it so, thank you. And I love the idea, which I didn't think about, I love the idea of putting the, um, handwashing thing on the dining cart. I think that's brilliant –

Next Speaker: Uh, –

Next Speaker: – so we will definitely be going back and doing that.

Next Speaker: – that actually was huge from, um, **** Salem Hospital **** hospitalizations and handwashing, uh, and the CNAs love it.

Next Speaker: Mm hmm.

Next Speaker: And so I don't care, as long as they're pumpin', you know?

Next Speaker: Yeah.

Next Speaker: And doin' whatever. Um, but the other part is, uh, Vick, like Vicki and I were just talking, we also talked about re-hospitalization rates and how, you know, it, when somebody gets a flu vaccine, there's a 50 percent, right? Less chance that it decreased, whatever it was that I passed out, it was that –

Next Speaker: **** that it decreased the severity –

Next Speaker: That's what I mean.

Next Speaker: – of illness and decreased, uh, eh, um, ICU stays.

Next Speaker: And we have a lot of, I mean, our **** in our building is super, super high. I, everybody has it, um, but that was very important to a lot of the people who, we have a lot of long termers that have, are very medically compromised, um, especially when you have somebody who has ALS, that's a big deal. Um, but I, I think that it just goes back to basic

education when you really start there. It wasn't just this. It was basic education, working together, talking about it all year, getting geared up for it, explaining that it's this time to this time. Um, people think that the flu lasts only a certain amount of time and it's maybe a couple months and it's, when you throw out November 1st to April, they're like what? Okay, that's a game changer. So I don't know. Hopefully, hopefully, we keep seeing the rates increase, like we have and it just takes a team effort and everybody being on board. It's selling it. That's the thing. If everybody's on board and they have a positive attitude, they're gonna pass it on, positively, you know, say hey, I got mine. You should get yours. And we have an open f, I am very proactive about please call. If you feel sick and you think that you have the symptoms of the flu. Call me. I don't want you to have it here. I don't want you to. It's okay to be sick. We figure it out. So talking about it and then, making sure it's documented and doing all the things that we need to do.

Next Speaker: Well, I just wanna thank you all so much for coming and really commend all the work you have done. It's incredible and we can pass this information off to other facilities and it's really exciting for us. I just wanna give a round of applause ****.

Next Speaker: And I thank you for showing us it really takes a community to do that and, um, I think also for, just to feedback a few things, I'm hearing some messaging that we put out ended, our end, or public health's end, about what does it mean when it's not effective? We'll talk about actually, they're looking at medicalization for flu but there's probably even better percentages for just not being so sick that you have to go to the hospital or even getting sick in the first place to even have to miss work, which is always a huge thing so that kinda mess, I, uh, you, it's helpful, I think for major seasons to really qualify what we're talking about so, so thank you for sharing and all your work with that. Uh, so now, we're gonna just switch to, uh, the end of our meeting and right now, uh, request any topics for future discussions and, uh, that might be a suggestion as follow up from anything that you've heard here or anything that you're experiencing and we, we talked about ****, we talked about like new centered locations for medical care. Anything else that folks would like to bring to the table for, uh, the HAI group to work on, bring back to you. And this could be something like, um, you know, us recording out or giving information to the group but it could also look very much like this kind of panel. We had a panel last time that I thought was successful as well so if we can be kind of a forum for facility folks to speak to one another and share experiences, we definitely want to do that. I think that's been like well received, um, so if you have that kind of idea as well, don't be shy.

Next Speaker: Julie, um, just a couple things. I think it's a good idea to still go after location mapping this year. I don't know if that was in your plans **** reporting because, um, I don't, and I don't know if it's happening in other places but in our facility, we're, uh, practicing care in place, which means someone may be in a step-down capacity and then, they're on bed **** and they're in the same bed so, how do, you know, we're having challenges but **** location mapping without being a mixed ****, which won't give us much of anything, a benchmark. Um, anyway, you think about that one.

Next Speaker: Thank you. Is there anybody from the phone? Okay, finally, I will just open up for public comment, if anyone has anything that they would like to bring before this group, um, questions, considerations, concerns, either from the phone or in the room.

Next Speaker: Just, uh, uh, you may be already aware but the Oregon, uh, Association of Hospitals and Health System and the Washington State Hospital Association have combined in a, uh, regional quality committee, uh, which a number of the topics are around, uh, infection, uh, prevention. Uh, Alaska has a couple of facilities within the coalition as well. Um, Washington's really been leaning for a lot of years around that and so this joint committee, uh, may have some significant power and there's only two Oregon hospitals that have onboarded so far but I am sure it will, uh, move across the state fairly, fairly well and, um, we have experienced the first visit from the coalition and they were a wonderful group and bring with them some expertise as well out of the Seattle University of Washington, in that area, and so it's nice to just keep hearing different, um, perspectives but that's something moving in the state right now.

Next Speaker: All right. Thank you for sharing **** that. Anything else?

Next Speaker: I think in, um, another area, uh, with the pending, uh, revision in the NBROO guidelines for Oregon, um, I know long-term care is going to need assistance with that, um, especially with the recommendation of that, of a year from the last, um, you know, negative culture on some of those, um, when you have people who are living in the facilities, um, for a long time so, you know.

Next Speaker: Hmm.

Next Speaker: How does that, once those are approved and you go out, you know, the education and resources available, um, ****.

Next Speaker: Great, thank you.

Next Speaker: Mm hmm.

Next Speaker: Okay. I think I will call to adjourn this meeting and wish you all a very happy holidays. Be safe and, uh, I'll see you next year.