Speaker: **** belabor the point that you can see that there were a lot of long-term care facilities involved voted on the right side of the table, uh, under the second column. So, if you look at healthcare associated outbreaks, uh, it accounted for 81 percent, uh, or 185 outbreaks, uh, from, for this period of time from December 1, uh, 2017 to March 22, 2018, and, um, as I indicated already, the majority of the HAI associated, um, outbreaks occurred in long-term facilities, uh, 96 percent in fact, and the most common etiologies, uh, were influenza and norovirus. And if you look at the table, um, in the third, sorry, the second and third rows, you can see that the distribution between skilled nursing facilities and assisted living facilities are fairly, uh, uh, equal. So, at this point, I just wanna highlight one outbreak, um, that we, uh, were involved in and this was, uh, a multi-drug resistant Acinetobacter baumannii complex, uh, outbreak, and this came to our attention through the, um, ALRN surveillance system and we were notified on February the 2nd, uh, of 2018, uh, some reports, uh, laboratory reports of isolates of these, um, uh, Acinetobacter baumannii, uh, isolates, um, and they came primarily from wound cultures. Actually, all came from wound cultures. There were five isolates and you can see the susceptibility pattern. Uh, they were all the same, and, um, the only one that it's sen, sensitive to is gentamycin as you can see there, but resistant to everything else, uh, that's on the list and **** to ****. Um, in terms of investigation, we identified that all of these individuals were admitted, uh, between November 20th of 2017 and February 10th of 2018 on the same floor or wing of a particular hospital. So, obviously we were pretty concerned, um, and we, um, proceeded to do some environmental sampling and you can see from this, uh, slide here, there were cultures taken from two sinks, um, on the unit. Uh, both, um, identified, um, the bau, bau, Acinetobacter baumannii complex, uh, but the **** pattern was quite different from the ones that affected the, the patients. So, you, as you can see here, uh, while slightly different, they were mostly susceptible to, uh, the antimicrobials, uh, that, to which they were tested. And then at the bottom, um, you can see that, uh, the sinks, um, had isolated some other organisms as well, uh, stenotrophomonas maltofilia, uh, on Sink 1, and then on Sink 2, that as well as the pseudomonas, uh, species. So, the other thing we're also doing is just trying to see whether, um, these are actually the same isolates, uh, in terms of not this but the, uh, the other one. Uh, this one here, uh, that were isolated from the patients, we're gonna send it to, um, uh, a lab, uh, on the East Coast just to do a sequencing, so we'll, should have that results within a couple weeks, um, to see whether it's actually, um, the same, uh, clone. Um, that's all, that's all I have, uh, for outbreaks. Any questions?

Next Speaker: John, what type of sinks were those? **** –

Next Speaker: Um, one, I mean I couldn't really tell. One was definitely at a nur, at a nursing station, and the other one, it labeled at 370 which implied it's a room, but it's probably not within a room. Maureen, do you know?

Next Speaker: I **** was in the rooms ****.

Next Speaker: Like, one of the rooms, right?

Next Speaker: Right.

Next Speaker: So, I was try, like, one clearly, it was clearly indicated that it was a nursing station type of common sink, and the other one, it just said, Label 370 and I know that, um, a couple of the, uh, patients resided in that particular room. So, and, they didn't swab every single room, you know, that all of these patients stayed in, so it was just a representative sink, I suppose.

Next Speaker: And, and just as a, this is Genevieve, as a follow up to that, sort of with, um, as far as speaking back to the facility, 'cause obviously all of those bugs are known to be, you know, be water bugs and invaded the environment and be very difficult to get rid of and potential for wound infections or respiratory infections and people acquiring lung disease, etc., so, what kind of changes did, uh, the place make or what was their, tell us a little bit about their –

Next Speaker: Yeah.

Next Speaker: Yeah, so, they were implementing a pretty thorough disinfection process right after this, so they were using EPA approved cleansers, um, at least after we checked in with them. Um, I think after this, you know, this really drove home the ability of these bugs to get into the sink and again, how hard they are to keep out. Um, we are gonna recommend they do some follow up environmental cultures on the, the other sinks to make sure though we do have some precedent that it has been hard to eradicate even with pretty thorough disinfection, so we'll have to keep working with the facility to make sure. But, I mean, our, our kind of perspective is, you know, sometimes it's a bit of a needle in a haystack finding these bugs to begin with, so if you find a couple, then that indicates it may be more wider spread, you know, um, environmental disinfection issues, so, um, we're working with them on their ****.

Next Speaker: Is there anything we could learn from their sort of wound care techniques or hand hygiene here? We're **** faucet. It's sort of hard to go from the faucet to the wound in all manifestations. Was there something – were they using water out of the tap for their wound care, which to my understanding would be very inappropriate? And I'm just wondering if there was, again, what – there are many things that we could learn from that connection.

Next Speaker: Yeah, that's a good question. So, uh, no smoking gun was the way that wound care was provided, through interestingly there is one wound care nurse for both all their outpatient work as well as, you know, so one that goes from room to room. So, you know, we didn't identify the bug anywhere specifically with the wound care equipment, but we did emphasize a bit because this is a, you know, healthcare worker that's going room to room. There's just a high potential for contamination. So it's sort of a **** to the process.

Next Speaker: Are there comments or questions from the phone or the room? They, I know that the, uh, having done this before I know there's a lot of work that goes into them and so I'm, it's always interesting to learn, see what we can learn that helps us in the future preventing this elsewhere. ****.

Next Speaker: Great. Thank you.

Next Speaker: Dr. Graham. Okay, next on the agenda we have Nicole West who's gonna give us a little in, update after our exciting influenza ****. Uh, **** – and if there's any questions or etc. that arise after these meetings, you can always feel free to contact the staff here.

Next Speaker: All right. So then I'm Nicole West and I work on the team here that, uh, manages flu surveillance. Uh, we have multiple tributaries leading into our influenza surveillance data stream, so I'm gonna kind of walk through, uh, the different systems that we use here and, uh, sort of the data that we've been getting out of them this season. Uh, this is sort of an overview of what we'll be going through. So first of all this is sort of a summary of where we are right now through the end of MNWR Week 11, which is March 17th. For those of you who received flu ****, this will look familiar with you. It's a weekly report we put together. And if it doesn't look familiar to you, then I invite you to go to our website and check it out and/or subscribe to the weekly updates. Uh, you can basically see though that all of our weekly indicators are trending downwards. Um, that, uh, for example our ED visits for IOI or influenza-like illness are down from a peak of about 5 and a half percent, um, the percentage of positive influenza tests are down from a peak of about 37 percent, and, uh, on and on, and we'll go through all of this in detail. Um, so first of all, uh, this is sort of a representation of our Oregon Essence Syndrome Surveillance System. Essence is a system that tracks the, uh, percent of ED visits in this case for IOI based on, uh, emergency department data for, um, all 60 hospitals in Oregon. It looks at, uh, codes for chief complaints in discharge and we have a query that pulls out, uh, things that look like they're gonna be influenza-related or IOI illness. So you can see how much higher, uh, that percentage of ED visits was, uh, for this season compared to previous seasons, and that we are way down, um, from about 5 and a half percent of all ED visits being for IOI down to about 2 and a half percent. But we are still well above sort of that normal baseline. Next, we have laboratory surveillance. Um, so a number of, uh, hos, uh, laboratories, hospital laboratories from across the state report to us, uh, either through NREVSS, which is the National Respiratory and Enteric Virus Surveillance System, or just by **** reports of how many tests they've conducted for influenza and other respiratory, uh, viruses, um, on a weekly basis and how many were positive and for what types. This helps us to track the, the percent of positive tests that are conducted. If people are looking like they have IOI and they're being tested for it, what percent are actually positive, uh, the proportion of Flu A versus B, and, uh, among those hospitals that do report the subtypes we can get those. In addition, the state public health laboratory conducts additional typing and lineage testing, so we can see, uh, what subtypes of Flu A and what lineages of Flu B were seen, what's actually circulating in the population, and that helps us get an idea of how well matched the seasonal vaccine is to the types of flu that are actually circulating. Um, again you can see that the percent of positive tests was way up earlier in the season, came down. We're now seeing another increase, uh, primarily because of that low peak, that late season peak of Flu B, um, but overall the numbers have declined substantially. Next, we have our hospitalized flu surveillance. Uh, this is a system called Flu Serve Net. Um, that covers the Portland tri-county area, which is about 44 percent of the state's population, about 1.76 million people, so Marion, Clackamas and Washington County. Uh, we track all individuals who are hospitalized and had a positive flu test. Um, through the end of Week 11 or March 17th we were down to 34, uh, influenza-associated hospitalizations for that week. Our seasonal total is, uh, 1,460 cases reported this season. 993 or about 68 percent of these cases were Flu A, 466 or 39.1 percent were Flu B, and one individual was co-infected with both Flu A and B. Uh, you can see the age breakdown there. Again, that's for all cases this season and about over half of all

cases are with that over-65 population, as we would more or less expect. Um, now of the 258 subtyped Flu A cases, 123 or 47 percent were the 2009 H1N1 virus and 135 or about 52 percent were Flu A H3N2. Of 72 subtyped Flu B cases, 71 or 98 percent were the Yamagada lineage and just 1 was the Victoria. Which brings us to the vaccine composition for the United States this year. Uh, you can see that the tri, trivalent vaccine contains, an H1, an H3 and 2 and then a B Victoria lin, lineage, and the quad valent, quadrivalent vaccine, uh, contains those same three, and the Yamagada lineage for Flu B. Now remember that 98 percent of Flu B cases in Oregon are that Yamagada lineage, so that's one that's not included in this year's vaccine.

Next Speaker: Or in the tri, it's just, is not included in the trivalents group? ****.

Next Speaker: Right. I'm sorry. It's not included in the trivalent, but it is covered in the quadrivalent. Yeah. Thanks for clarifying.

Next Speaker: **** so –

Next Speaker: Pardon?

Next Speaker: The high dose vaccine? So –

Next Speaker: Right. The high dose vaccine is trivalent, which is, um, kind of the interesting quantity that we didn't do. Uh, now early vaccine advocacy, uh, estimates from the CDC were, um, an overall estimate about 36 percent. Um, and that was about 25 percent against the H3N2 strain, 67 percent against the H1N1 strain and 42 percent against Influenza B viruses. Uh, we know that the vaccines have for the last several years done comparatively poorly against the H3N2, uh, Flu A types, uh, but interestingly the vaccine advocacy among children 6 months to 8 years old was 51 percent, so it is performing a little bit better in that younger age group.

Next Speaker: Sorry, would you like to say that one more time?

Next Speaker: Yeah. So overall the VE estimate for the H3N2 strain was, for this year was 25 percent. For children ages 6 months to 8 years it was 51 percent.

Next Speaker: Thank you.

Next Speaker: Okay.

Next Speaker: ****?

Next Speaker: Uh, so this data comes from our IOI Net Surveillance System. This is our outpatient, um, IOI, or influenza-like illness surveillance system. So, it measures proportion of outpatient visits, uh, where people are coming in complaining of IOI, and it's defined as fever of – equal to or over 100 degrees Fahrenheit and cough or sore throat in the absence of another known cause other than influenza. Uh, this includes a number of Sentinel providers as well as, uh, Essence data or that surveillance system, the Syndrome S31 system that we discussed earlier, uh, so it covers, um, about 84 reporting facilities across the state including 20 outpatient

providers, 54 emergency departments and 10 urgent care clinics. Uh, so you can see we break the data down by region. Um, you can see that, you know, the, the general trends track across regions although there are, uh, sort of differences in that percentage by region. Of course we also track influenza-associated pediatric deaths. These are nationally reportable. Uh, in a typical year, uh, we usually get between zero and one deaths. Uh, unfortunately this year we've already had three flu-related pediatric, uh, deaths. Uh, so this is just another reminder to please do report those, because we take them very seriously and do a lot of follow up. Okay. Now we'll get into the outbreaks data which, uh –

Next Speaker: Can I ask you ****?

Next Speaker: Sure.

Next Speaker: Just, uh, this is ****, 'cause I do pediatric.

Next Speaker: Mm hmm.

Next Speaker: So, here's what the pediatric deaths – uh, 'cause you do spend a lot of, you know, investigating and things like that. Um, were these children who were previously vaccinated or had underlying health conditions, or – anything we can learn from those? I know there's been a move to try to improve vaccination rates in specialty clinics where we see a lot of those kids who are at high risk.

Next Speaker: So, I have not done the follow up for those three cases. I do know that at least one of them was not vaccinated and at least one of them was vaccinated. Um, I also know that two out of three were not initially reported to us, and so we discovered them on child abuse later. Uh –

Next Speaker: So, is that something you rely upon? Like how, how would those, or how should we be reporting to, those to you as providers ****? Or is, it doesn't get picked up in surveillance or things like that, or –

Next Speaker: So hopefully we try to pick them up through our other means, but they really should be directly reported. So, do call us. Um, we do have email, but, you know, as well, but if you call we can get a lot more of the information.

Next Speaker: Okay. Great.

Next Speaker: Thank you.

Next Speaker: Nicole, what's the flu email?

Next Speaker: It is flu.oregon@dhs.gov.state. Flu.oregon@state.oregon.us. Yeah. Right. That works with ****. It's very long. Okay. Um, so, we track both confirmed influenza and IOI outbreaks, uh, and investigate them all across the state with our county partners. This chart, uh, includes both those confirmed and, uh, IOI outbreaks, and, uh, the chart is – we're actually up to

a total of 130, uh, IOI outbreaks for the year. Um, so we're goin' strong. I think last year, in the 2016 to 2017 year, which is again another H3 year, there were 157 total outbreaks for the whole influenza season and 95 percent of them were, uh, in assisted living facilities. Um, so far, as I said, we have 130 IOI outbreaks this year. 83 percent have been in assisted living facilities and 11 percent in schools. Um, there was one hospital-based outbreak, uh, back in December which you can see is the little green dot, and that was a Flu A outbreak in Marion County. Uh, we have I think 17 outbreaks that have been confirmed as influenza. Uh, 8 of those were Flu A, uh, with sort of mix between, um, H1 and H3. Two were caused by Flu B that we know of, and we had 6 influenza outbreaks where we had both Flu A and B positives come out, so there was just a lot of flu going around. Okay. So, next we have a little bit more about an RSV outbreak at, uh, Providence. I think, I don't know if you ****.

Next Speaker: I think ****.

Next Speaker: Uh, so this was an outbreak, uh, that was reported because it met criteria for, uh, a respiratory outbreak that was reported to the state. It didn't involve influenza, but because it was in a population as the title suggests for medically **** children, so these are children who require long-term care. Uh, they have, uh, you know, G-tubes for feeding, uh, you know, may have **** for, uh, for breathing, but, but need full ranges of care. Uh, and the first onset was noted in December, on December 6 of 2017 and the last case was on January 14, so over about 6 weeks, uh, that it was on, uh, and we'll talk about, I'll talk about a couple of the difficulties and maybe why it went on so long. Uh, so there were, overall there were 7 RSV cases and there were 40 residents during that time, so an attack rate about 18 percent. Four females and three males were affected, and the ages range from 5 years to 24 years. **** years. Uh, none of the staff were ill. Not surprising. RSV is, you know, is, can be a cause of the common cold in adults but most of us by this age we've seen it several times and don't, don't tend to be as severe. It's usually more severe in affected children. Um, a typical onset, you know, of, uh, may be a minor sore throat but really runny nose, cough. Sometimes it can cause a respiratory illness like, uh, bronchiolitis. Uh, and very rarely, in, I would say more rarely than influenza it can go on to have secondary bacterial infections. Uh, one of the cases was hospitalized, although I don't believe it was thought to be from, uh, bacterial, uh, cause, just a part of the RSV, in dealing with that. So some of the challenges, uh, about, about how this went on, again, the, the symptoms are very minor and so sometimes just picking up on that, on those symptoms in children who for other reasons can have chronically runny nose or have chronic coughs, um, and so knowing when to isolate them. Uh, also in, you know, after talking with some other subject matter experts maybe realizing that our, that the initial recommended 7 days for precautions may not have been long enough 'cause RSV can be shed, can be shed for longer than we think for influenza. That was one of the, the hypotheses. Uh, however overall there weren't any deaths associated or any, um, significant morbidy, morbidity, but I think what it raised was how, uh, perniciously something like this cold can go from patient to patient in these types of facilities in children who could potentially have, uh, bad outcomes from them. One of the things that makes this set, you know, this setup so different than say other adult long-term care is that these children, those who are able, they actually attend local schools and so they're bussed to school every day. Uh, they have friends there. They have, uh, peers that are there that, uh, help them with their homework or even will come back to the Province **** as to try, as The Center for **** Children, you know, visit socially with them. They have families who come and go with, uh, their siblings who, of

course, **** school system, and that's all, uh, friends and family centered care, and so immediate, it makes it very hard to protect these children absolutely from things that are in the community. Uh, if you compare that to say a nursing home where, yes, people are coming in to visit people there, but those folks aren't necessarily going ta' school settings or there's lots of, um, other, other ways to pick up stuff. Um, so what, I see the big, one of the big takeaways we're hoping to understand better is how do you do a section control in a setting that's very open like this, and how do we protect these children from something that's not vaccine preventable in the future? How do we apply, um, things like, uh, **** the precautions or contact precautions ta', ta', to really residents, um, that doesn't socially isolate them from people who need to visit them or people who come and do physical therapy et cetera? Um, so just an FYI, if anyone's interested, there is gonna be a, um, a conference in the fall. Our hope, wi, around pediatric long-term care and trying to deal with some of these infection-control situations and learn how to do that, uh, better 'cause it is different than I think our experience with adults, so, anyways, and, and I think, you know, uh, again, sort of the reporting, again, not ta', ta', to say anything, uh, the, the center did exactly what they, what they needed to do and work with infection control, and I think this is a difficult thing, but , um, you know, they thought it was important to report it as, so that you guys kinda know what's out in the community and understand what, what's going on there, so, thanks.

Next Speaker: Um, okay, and then I think we just kinda talk some, some open-ended, uh, professional questions, uh, for the group. If you guys just wanna jump in. Um, I, what I might do is, um, actually skip ahead first to our, the next slide. Um, back in, uh, September of 2017, uh, we did a sort of survey of, um, flu-related infection prevention practices as reported by facilities, um, so this is sort of what, uh, we were told was going on, um, and I think there was some interest in seeing from facility to facility how practices varied, and then even within facilities, uh, if, um, uh, either restrictions or, um, infection prevention practices in some way might be changing from unit to unit. Uh, so I can, uh, leave this up here, or we can go back to some guided –

Next Speaker: So I'm interested in –

Next Speaker: Yeah.

Next Speaker: – the mandatory, maybe you can go through each one and, and, uh, this mandatory thing. Are you saying that the hospitals are requiring the, the employees to get –

Next Speaker: So, first, uh, one, that's a great question. So the, the mandatory, um, uh, designation meant that there were systems that linked the vaccination or declination to payroll or HR records. Um, so they needed to have, uh, either proof of vaccination or declination so, um, as opposed to it just sort of being voluntary and anyone –

Next Speaker: Yeah.

Next Speaker: – wanted to say one way or the other.

Next Speaker: And for the declination, were there some reasons that were considered legitimate reasons? Was that assessed or –

Next Speaker: Um, –

Next Speaker: – because it's –

Next Speaker: – I'm not sure.

Next Speaker: Okay. So, it's interesting how some facilities will have policies like this in place, and there are sort of legitimate declinations, religious –

Next Speaker: Mm hmm.

Next Speaker: – observant or medical contraindications versus just a straight declination, which is also, I think it's just varies by facility is what I see.

Next Speaker: Do you wanna, I, wa, I, this is, uh, this is Genevieve. I don't know if anyone has any comments on it. I, as part of the process, I know, uh, is anyone else here part of the, the discussion around this, but, uh, in particular, the visitor restriction age was a big issue last season that we spoke a lot about, and, um, trying to under, trying to be fair. I think this is, uh, possible. Our process is different in healthcare systems because there were, because of some of the age differences, um, families were choosing to go to one healthcare system and not the other healthcare system, especially in regards ta' siblings to say that we should **** admitted, sibling or children of patients admitted. Um, so I just wanna call that out as, uh, –

Next Speaker: So, I'm sorry.

Next Speaker: – having conversations about.

Next Speaker: So, you're saying that people will call ahead and go, what's your visitation policy on flu and then I'm not takin' my patient there.

Next Speaker: They may not have been as proactive, –

Next Speaker: Oh.

Next Speaker: – but it definitely caused, uh, consternation maybe if they'd been admitted at one place before, and then we're at a different healthcare system –

Next Speaker: Okay.

Next Speaker: – the next time, there was, uh, you know, the patients were like, wait a second. This other place does it differently, um, because, you know, historically children, so under 18, have not been very welcome in hospitals because they do bring, especially in adult hospitals, because they, you know, carry germs and vaccine-preventable or unpreventable diseases, um,

but, as you can see, uh, some of the, the , the, the systems, um, you know, Kaiser doesn't have any age re, restriction as far as, uh, we understand, and others go down to 12 years of age, uh, et cetera, so that, that's where some of that was in there, and I don't know if anyone has any, um, comments or from their experience with that, but that was the kind of the stuff, the big source of the conversation.

Next Speaker: I would say, Genevieve, um, Julie from Salem, of course we're not in that metro area, but, uh, and we were at 12, but we always had a caveat that nursing could override that based on the reason for the admission of the patient. Somebody might, grandma might be dying for example.

Next Speaker: Mm hmm.

Next Speaker: And we weren't going to stop some family members from coming in. I think the challenge with any of these restrictions is enforcing them. Um, I know nobody wants to lay hands on someone to let them out of the hospital, so as much as we profess we have that visitor restriction, actually, uh, being at a hundred percent compliance is a challenge for hospitals. I don't know if Mary **** about it ****.

Next Speaker: It's a big issue and, again, I think the needs of the family and patients for, for maternity **** transplants, you know, et cetera, so I know the community hospital tried to standardize and approach, and I think they just had felt they can't. Um, I know our population, we have families coming from all over, and we have family quarters as well, um, so we don't have **** restrictions for emphasizing education, um, and screening more than testing in our facility.

Next Speaker: Yeah, absolutely. So Marion Post was just talking about how to balance the family-centered care and special at-risk populations, um, and also I think Providence as well, there's different, they differentiate between less than 12 and a sibling could visit versus a non-sibling as everyone needed to be well. Um, but again, I think it's important to highlight how infectious prevention, for it to work, needs to also take into account the, the family-centered care that we try to do in all of our health care fac, facilities in Oregon and be reasonable but also protect our patients, so I think that'll be ongoing topic of discussion for many of these things we speak about, so whether it's CRV or flu.

Next Speaker: Can I ask a question?

Next Speaker: Sure.

Next Speaker: Uh, I was just curious on the mandatory versus voluntary versus ****. Have you looked at what percentages actually **** and vaccinations for each of the hospitals overall and how that reflects on ****, if, if it does at all?

Next Speaker: No, that's a, a great question.

Next Speaker: ****.

Next Speaker: We have, we have a **** may be **** talk about it.

Next Speaker: Yeah, I'm not exactly sure I understood – so you're saying –

Next Speaker: She was wondering if the, um, if I may –

Next Speaker: Of course.

Next Speaker: If that's okay, into the microphone. Um, that if the, the, did the policy difference, i.e. there's a mandatory, um, documentation versus a voluntary documentation, does that have any effect on the final percentage of health care workers who are vaccinated at that facility?

Next Speaker: Well –

Next Speaker: Does that make sense?

Next Speaker: Yeah, we collected data on this sort of thing a couple years ago and, um, actually found that the declination form does help. It's not one of the top ones. The, the more effective strategies are maybe being forced to wear masks, having centralized vaccination for your health care workers. Um, incentives weren't even that favorable. Um, yeah, the mandatory declination versus vaccination form itself was not that much of a factor in whether people get the vaccine or not, if I remember right.

Next Speaker: But we do, just to add onto what Monica is saying, we do publish annual data, um, for hospitals, skilled nursing facilities, ambulatory surgery centers, and I'm missing –

Next Speaker: Dialysis.

Next Speaker: – dialysis facilities on their, uh, health care personnel influenza vaccination rates, so we do have those data published in a report, so for every flu season we have that up on our web site, and we can send that around if folks want to see that. Um, but yeah, it is on, it is on our web site, and I think one of the things Monica says is really well taken is that even just having any kind of policy in place where they have to document, even if there's no enforcement, like, let's say there was no enforcement, and there was no, you know, there were no, there was no differentiation between what's an approved declination and what's not approved declination, just having the policy to fill out a form improves the data quality because it reduces unknown vaccination status, just as a side note.

Next Speaker: Yeah, just as a paraphrase to, from what Monica was saying is the declination form itself didn't cause a huge difference, or maybe not as much as having to mask and other strategies, like having vacc, mobile vaccine and **** a lot of **** to that, but it was one of the factors that contributed potentially to the overall ****, so.

Next Speaker: Just to add one more thing. Um, on the report that Monica works on each year and it's coming out within the month, uh, for this most recent flu season –

Next Speaker: **** this month.

Next Speaker: – previous year is that, um, you know, we compare facilities on there, health care worker vaccinations, so each facility as well as consumers can actually, you know, see how facilities are doing, all these different ****, you know, **** care or having ****.

Next Speaker: Remember, I believe you're doing another hospital survey this year? Or are you taking the year off?

Next Speaker: We are doing a long-term care survey and a lab survey. For the hospitals we're gonna be using their NHSN data for a case this present year.

Next Speaker: I think **** decided because I just think some of these questions might be interesting to ask in a survey.

Next Speaker: Yeah.

Next Speaker: Um, but well, you know, it can definitely wait a year.

Next Speaker: Yeah, **** longer –

Next Speaker: ****.

Next Speaker: – ****. Right.

Next Speaker: I mean –

Next Speaker: Yeah, and there's a, there, there are so many permutations, like Mary was saying, you know, or is it siblings or not siblings, yeah. **** the challenging question to ask ****.

Next Speaker: I was wondering what does the signage mean? What kind of signage are we talking about?

Next Speaker: Yeah, so, um, it could be, uh, I think that was, um, if there was, uh, signage for, pertaining to the enforcement of the visitor restrictions.

Next Speaker: Okay.

Next Speaker: Um, and so just sort of, like, having something out and posted to, to be a little bit stronger in the enforcement.

Next Speaker: And I think some other differences that don't come across in the back people, this is Genevieve, but just from having spoken to people is that some sit, some facilities have a focal point that all visitors must pass through so there's a very, you know, everybody gets screened at that point before going into the larger, uh, uh, larger hospital, so everyone gets funneled through

that versus other places just you can come by multiple entrances, and so there's no focal screening to people coming onto campus. Uh, some of the campuses screen, also screen all of their employees in addition to their visitors and some don't, so there's all sorts of different approaches, and, you know, all of that takes a lot of staff and resources, and I guess the ultimate question we want to know is does that actually prevent any **** influenza outbreaks or, or things like that to patients, and I think that's a harder question that hasn't been answered **** masking.

Next Speaker: ****.

Next Speaker: Oh, the masking and, and, um, screening everybody at the front door or the, the level of visitor restrictions. Um –

Next Speaker: See, the actual screening of those that could screen from a single entrance to whether or not, or what their flu rates were this year would be valuable information ****. I mean, I don't even –

Next Speaker: ****.

Next Speaker: – I don't know **** doing that –

Next Speaker: Mm hmm.

Next Speaker: – but **** as a single point of entry –

Next Speaker: Or at least, yeah.

Next Speaker: – or stamp to actual screen.

Next Speaker: And, and the, and, and sometimes, you know, the system will have it on the bone marrow unit or in, into the NICU or very, very high risk patients they will do it for ****. I think hopefully we'll learn over time how to do influenza prevention better, um, but we didn't have, there weren't that many notes, at least ****.

Next Speaker: Yeah.

Next Speaker: **** hospital.

Next Speaker: Yeah, if we just –

Next Speaker: Um, **** influenza outbreaks. I know we had, you know, we definitely had a couple cases not influenza, respiratory illnesses brought in by family –

Next Speaker: Mm hmm.

Next Speaker: – members and things like that, but yeah, ****.

Next Speaker: I think one of the, uh, challenges –

Next Speaker: Mm hmm.

Next Speaker: – that we should look at, and even go back ****, is the, um, masking and the number of masks a facility goes through.

Next Speaker: Mm hmm.

Next Speaker: Um, 'cause **** shortages periodically, and then the questions come to infection control. How long can I wear my mask?

Next Speaker: Mm hmm.

Next Speaker: Uh, can I reuse my mask when we're in shortages or, you know, our supply's not gonna come in for 2 days, things like that. Um, those are becoming real issues these days along with the IV shortage, so.

Next Speaker: Um, the staff, um, unrelated to this but just related to vaccination earlier.

Next Speaker: Uh huh.

Next Speaker: Do we have access to data of what formulations are being administered across the state **** water ****?

Next Speaker: Um, sometimes. Um, so, uh, it depends on the completeness of the data that's entered into Alert, which is our statewide, um, vaccine registry. Uh, sometimes we have very complete data that we have, you know, exactly what was administered. Sometimes it's a little bit more limited, um, and then, uh, you know, for the hospitalized flu surveillance we're also checking, um, so that was the flu serve net that I discussed earlier that was just the tri-county hospitalized flu cases with those, and that is a national system, um, on certain participating sides, um, and that system, uh, does not collect that extra, uh, um, sort of vaccine, uh, type information. That's just sort of vaccinate yes/no. So we do lose some of that information at a, a national level, and then even at the state level that's kind of where we have, uh, really detailed patient outcome information, right? And we don't necessarily have vaccine type information on those individuals, but broadly we can look at the, um, vaccine administration data, um, that's entered into Alert.

Next Speaker: Are you done with flu, or can I ask a flu question?

Next Speaker: We have five more minutes to spend, five more minutes.

Next Speaker: Um, I'm just wondering what the metro area's using for calling off flu season, off visitor restrictions. I don't know if that's part of the discussion today, but I'd be interested if we have any standardization there.

Next Speaker: Barb, do you want to answer that?

Next Speaker: **** the hospital is where ****.

Next Speaker: **** the right number. Um, so I believe the, the determination, and this was for hospitals and public health, and they had some phone calls to turn on and turn off the flu season was above 10 percent, right? For at least one, I think, two –

Next Speaker: Two weeks.

Next Speaker: – 2 weeks.

Next Speaker: So under 10 percent for 2 weeks.

Next Speaker: For 2 weeks would go off, and going up it was over 10 for 2 weeks, although I, yeah, it was, when going on it was, like, you know, the angle was really steep, so they pretty much ****.

Next Speaker: They kind of went on Alert at five, and then I, I think a lot of organizations put it on at 10 percent, you know, so they were ready to go when they hit ten –

Next Speaker: Yeah.

Next Speaker: – 10 percent.

Next Speaker: 'Cause you, yeah, um, and if there was some probably minor variability, but I, again, like the angle was so intense as, as you saw at the beginning –

Next Speaker: Right.

Next Speaker: – of it, so everyone knew it was on its way up, um, and I think from the previous season they learned, you know, it, it takes more than 48 hours to get this going, so it was, to have that extra week was sort of the time that actually worked out pretty well as far as notifying units and, you know, there's even, like, cards sent out to laboring, to women who are pregnant to let them know that when you deliver there's gonna be flu restriction. You know, there's a whole bunch of things that, that, that do happen, so I believe it's gonna be 2 weeks and 10 percent, so we're still **** way. I think, I mean, just as a clinician we've seen a lot less flu here, and I think there's a couple, like the Columbia Gorge is so high. There's a couple of non-Portland areas that are still high that are gonna have restrictions on.

Next Speaker: Can we just clarify, 10 percent of what? 'Cause **** representative ****.

Next Speaker: Yeah.

Next Speaker: Ten percent positive, yeah, 10 percent positive.

Next Speaker: Yeah, of, so of, um, respiratory viral panels, or no, I'm sorry, just respiratory, of respiratory panels sent, the 10 percent positivity is what drives it.

Next Speaker: And so that would be that laboratory survey ones **** test run of how many per, what percent positive.

Next Speaker: One thing I en, encourage the **** program to think about is next year, um, we had a discussion the other January, I think ****, and when you look at the hospitalizations each week, it's just the metro area, and there were areas like Salem that had, you know, probably more, I think, than what we were seeing in the entire metro area, so you might give some thought or some discussion about perhaps doing kind of a prevalence survey, um, just to, again, ascertain how much flu, how many hospitalizations we're actually seeing and how good a monitored figure **** those three counties, tri-county area might be. Um, if you do that, um, I would recommend planning ahead of time, obviously, you know, so that, uh, hospitals can get ready to let ****. I think there, there would be some interest in trying to help **** do that.

Next Speaker: Yeah –

Next Speaker: At least there was during the discussion –

Next Speaker: That was our discussion at our **** meeting this year that, um, it is, the metro area represents what, 44 –

Next Speaker: Mm hmm.

Next Speaker: – or 45 percent? Then down by us we're another 10 percent.

Next Speaker: Sure.

Next Speaker: And of course –

Next Speaker: And –

Next Speaker: – down the I-5 corridor.

Next Speaker: And just to clarify why it works that way is because that actually is a special CDC surveillance system –

Next Speaker: Yeah.

Next Speaker: – so we're funded particularly to conduct that surveillance, um, and so we just have a little bit, we have more resources, and we have a mandate to track that. Of course, we'd love to have statewide data, um, but I think that's why we try to get a sense of the broader spectrum of disease severity and burden across the state with these other systems, um, like

Essence Survey, uh, Syndrome Surveillance, the IOI Net, Sentinal Provider **** outpatient surveillance.

Next Speaker: ****.

Next Speaker: Um, and we –

Next Speaker: **** that so –

Next Speaker: And it may be something that just understanding our methodology and replicating that methodology is **** health care systems, even if it's not **** the state.

Next Speaker: But it's great to hear suggestions about, you know, work that you'd like to see or data that you'd like to see, and we'll have another opportunity to talk about that more broadly at the end, but I just want to encourage everyone to think about what kinds of data you'd like to see come out of our program, and if we can, you know, we'll, I mean, anything's on the table, and we'll have discussions about it, so.

Next Speaker: And just as, **** and, um, I just wanna ask if there's any people on the phone who have questions, uh, and while you're thinking about that, I just wanna make a plug about, uh, some people willing to give feedback on how it was with the healthcare systems to have this on and off for the flu season, and really– 'cause I mean there's, there's definitely bringing –

Next Speaker: ****

Next Speaker: – people together so just wanna hear that that's positive, what can be done to improve that, and make this more coordinated, so –

Next Speaker: Maybe we can take screen shots of the activity , and send communication and reminders out to employees, and status them on what's happening, things like that, so it's really helpful to have ****.

Next Speaker: Thank you.

Next Speaker: Anyone from the phone who would like to– I just wanna make sure you guys have an opportunity. Again, if there's any questions, um, Blue.Oregon@State.or.us and thank you for this great conversation around flu. Um, so we're, now we're gonna break for **** –

Next Speaker: I'm gonna bring it back, um, to our meeting –

Next Speaker: ****

Next Speaker: *** yeah, as well –

Next Speaker: This was nice.

Next Speaker: Returning ****

Next Speaker: Thank you.

Next Speaker: ****

Next Speaker: So, I am the next presenter. My name is Alexia Benning. I'm with the healthcare-associated infections program with the co, communicable disease prevention and I'm gonna be talking about, um, a healthcare-associated infections and antimicrobial youth prevalence survey, which we call HAIPS, so just let me say HAIPS, instead of that really long title. Um, that prevalence survey that we've done here, um, at, uh, ACDB. So a little bit of background about ****, um, HAIPS is a project, it's a prevalence survey that we had conducted underneath our emerging infections program. This is a Centers for Disease Control and Preventions-funded grant that is, um, active in ten states across the US, ten states across the US really, which, Oregon is part of, and, um, the purpose of emergent EIP, Emerging Infections Program, is to, um, it's multi, multi-global. One is we do a lot of emerging pathogen disease surveillance, so, for example, we do our **** resistant ****, um, surveillance through EIP. We do aria bloodstream, blood, bloodstream Candida infection surveillance through, um, EIP, and these are all, uh, **** population-based surveillances. But we can also, or we also do use I-EAP, um, sites to do special projects like point public surveys, uh, in hospitals and in nursing homes, and so I'm gonna spend the next 10 to 15 minutes talking about public surveys, uh, conducted at our hospitals, and so, HAIPS, again, Health Care Association Infections and Antimicrobial Use Prevalence Survey, uh, is a multi-phase survey that began in 2008 as a pilot in one site. The first full survey was in 2011, this took place in all ten states, all ten states, and 100, at 183 acute care hospitals. We then repeated the, the survey in 2015, it was again a full-scale survey. A, again, all ten sites, and at 258 acute-care hospitals among the ten sites, and so there's a few adjust– objectives of HAIPS, um, I have listed the top three or four, um, so we, we really are using HAIPS to estimate the HI-prevalence in the US acute care hospitals. You might have seen some large papers, or papers that have come out from the survey, uh, we use HAIPS to determine the distribution of HAI **** pathogen and major infection site as well as estimate the prevalence and rationale of antimicrobial use. Um, the reason why we do HAIPS across multiple years is so that we can assess changes in HAI and, and microbial use and theology. So, um, briefly, briefly about the HAIPS protocol, we have a ten-county catchment area here in Oregon that surrounds the Portland, Salem, Salem and Eugene metro areas, um, each recruited hospital randomly selects in-patients, uh, that, that are occupying beds, on a survey date. Then, additional medical records are do–, medical record reviews, chart reviews, are done on these patients and, um, these patients are either on antimicrobials on the survey date, or are scheduled to receive antimicrobial-based, antimicrobials on the survey day, or the day before. So, the forms that we fill out for these sub-set of patients are antimicrobial use, so we capture what antimicrobials, antimicrobials they're on, plus medication, and then, um, antimicrobial quality assessment forms so this is a subset of forms, like general patient assessments, um, patient clinical characteristics, we'll capture more information if the patient is on say, Necromiasin and Chlorophones or if they have **** pneumonia or urinary tract infections. In this 2015 HAIPS, um, round, we actually applied both 2011 HAI definitions and 2015 definitions. So, here in Oregon, we had 22 participating hospitals with 1,370 eligible patients surveyed. 535, or just over 39 percent of the patients were scheduled to, uh, were on, or scheduled to be on, antimicrobials on the survey date.

558, or a fifth, just over 40 percent of patients were on, or scheduled to be on, antimicrobial, antimicrobials on the, the day before the survey date and we had a range of 30 to 50 patients among the hospitals that were on antimicrobials. Um, I'm gonna pause because I realize I forgot to mention that those that are on the phone actually don't have the slides in front of them, um, mostly because these slides were not, um, up for, we were not going post these slides on the web site, so apologies for that. Those with us in the room, I apologize 'cause that means I'm going to be reading a lot on the slide aloud. So going through patient clinical dem–, demographics for the Oregon site, so this is just listing what we saw among our patients. So 45 patients, or about 3 percent were ventilated. 266 patients, or about 90 percent, were, had a urinary catheter, and 191 patients, or just under 40 percent, had a central line. Among those, 191 patients, 21, had more than one central line, and we saw 45 patients, or 3 percent, that died. The main length of stay, um, among our patients was 9.9 days with a range of 1 day to 379 days. So, uh, the next few slides will cover antibiotics, or antimicrobials use, HAIs, and also pathogens. So starting off with antibiotics, we saw 56 different antibiotics administered, or scheduled to be administered, among our patients. The top 20 antibiotics counted for 90 percent of ****, antibiotics prescribed, and the top 4 percent accounted for 49 percent of antibiotics prescribed. In this table below you'll see the indication for use, um, so this, these indications were all gleaned from chart reviews, so keep that in mind. So, uh, 70 percent, or 723 of the antibiotics were prescribed for treatment of **** induction, that's followed by medi–, medical prophylactics, which is 17.9 percent, and then followed again by surgical prophylactics, which is 10 percent. Yes, **** –

Next Speaker: Makes sense for, um, for **** period versus definitive therapy?

Next Speaker: I'm sor–, I'm getting over a cold, and I can't hear –

Next Speaker: Um, is there, uh, I, let me talk normally –

Next Speaker: Are we, I'll repeat the question for the people on the phone –

Next Speaker: Okay.

Next Speaker: So the question, uh, Dr. Brenner was asking whether, which percentage was for impure treatment of infection versus definitive treatment for infection, i.e., you had the culture and you're, you knew what you were treating exactly. Is that right, did I understand it?

Next Speaker: Yes.

Next Speaker: Yes, we didn't capture that information in this round of, we just captured it if it was treating of an active infection, because it was indicated that there was infection present, and that was in the clinician notes.

Next Speaker: And it would be a suspended **** and I think there's a period it's, right?

Next Speaker: It would depend on what state, at what point, right, 'cause this is the point –

Next Speaker: Right.

Next Speaker: – it's kind of like so it would be at what point you captured it.

Next Speaker: I mean to say it's an active infection, do they have to have a, a culture ordered?

Next Speaker: No.

Next Speaker: Okay.

Next Speaker: Right? ****

Next Speaker: We did collect culture data –

Next Speaker: We did, but –

Next Speaker: **** –

Next Speaker: **** –

Next Speaker: – part of the definition of when we –

Next Speaker: So how did you determine –

Next Speaker: So usually in the chart it says, you know, antibiotics are ordered for infection.

Next Speaker: Right.

Next Speaker: Like it's part of the pharmacy order, they had to put indication for –

Next Speaker: For any –

Next Speaker: – **** chart –

Next Speaker: Anywhere on the chart so, um, and either the doctor notes or the pharmacy notes. It was some sort of indication that these antibiotics were prescribed or administered for treating of an active infection ****

Next Speaker: All right, I have a question about the, the **** that died. Was that, I can't remember how that worked, was that during the time when– in that stay, or the time of chart of review, or what– like how was that determined? What steps? Like, I just– I should know this myself –

Next Speaker: That was in the –

Next Speaker: – but I can't recall.

Next Speaker: Did we go back after the fact?

Next Speaker: Yeah. We went back after the fact 'cause 90 days –

Next Speaker: What?

Next Speaker: 90 days? 90 days after the survey date?

Next Speaker: I can't remember.

Next Speaker: Usually –

Next Speaker: I ****

Next Speaker: It was after the fact.

Next Speaker: Yes.

Next Speaker: *****

Next Speaker: We will get back –

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: Yeah. We –

Next Speaker: Oh –

Next Speaker: – we **** to back records.

Next Speaker: Right.

Next Speaker: Yeah, we did, okay, and that's **** on the phone said the deaths are matched to death records, and then, uh, since we're talking about this whole –

Next Speaker: Mm hmm.

Next Speaker: – one more question. Was that 11, was that 11 percent? Oh, it's 11 percent of 190, happened more than once.

Next Speaker: Yes.

Next Speaker: Okay.

Next Speaker: Is this going to be repeated?

Next Speaker: I will get to that.

Next Speaker: Okay.

Next Speaker: Yeah. But yeah, **** is, yeah, okay.

Next Speaker: People are listening to you, like –

Next Speaker: ****

Next Speaker: Um, and okay, so coming back to indication for its static use, we had, uh, 103 that was, uh, indicated for surgical prophylaxis, 18 that had, didn't have any documentation of why there was antimicrobials being prescribed or administered, and eight that were not infections. So, um, this slide is showing the top 15 antibiotics, antibiotics prescribed, or scheduled to be prescribed, um, administered, and so you'll see the top four is **** Magnamycin, Sethtroaxin and Heptaso. Um, and the numbers drop off pretty significantly so we had 161 on Cefoperazone, 132 on Magnamycin, 107 on Sethtroaxin and 103 on Heptaso and then the next, No. 5 was Metronidazole and we dropped that at a 52, it was administered or scheduled to be administered 52 times. Uh, what was really interesting is we just recently co–, we just recently, um, created hospital-specific reports, health **** specific reports, and it was really interesting to me because I do this spread of antibiotics or what antibiotics were used for this different amount of health systems and I think that's probably due to different policies in place on what antimicrobials to be used as frontline assault, so that was really interesting.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Moving on to HAIs, so, again we use applied 2015 definitions while, um, looking at HAIs. There's a total of 47 HAIs found when applying 2015 de– definitions, uh, the majority by site was pneumonia and surgical site infections, which both have 18, which is 38.3 percent. Followed by GI gastrointestinal at five at 10.6 percent, and then bloodstream infections had four, and then two urinary, two urinary tract infections. Uh, the table on the right is the HAI type and so that breaks down the HAI site a little bit more and so we had 14 pneumonias that were clinically defined and then eight urban spaced surgical site infections, six superficial incisional surgical site infections, uh, four pneumonias that had laboratory findings, four clustering, but still infections, four deep incisional surgical site infections, two lab-conformed–, confirmed, bloodstream infections and two mucosal barrier injury lab-confirmed bloodstream infections, two systematic urinary tract infections, and one intra-abdominal not specified. That's part of the gastrointestinal infection HI definition.

Next Speaker: Question.

Next Speaker: Yes.

Next Speaker: When you say pneumonia laboratory findings, you mean, what does that mean? Usually you have to **** urologic findings but **** definition.

Next Speaker: I think there was laboratory, there was some sort of culture done, taken.

Next Speaker: What about ****

Next Speaker: ****

Next Speaker: **** culture for **** DTS **** –

Next Speaker: Sorry.

Next Speaker: Like a culture from an ETS merge or something.

Next Speaker: Right, I don't know, ETS is not an appropriate definition for pneumonia as far as I'm concerned. But I, I mean –

Next Speaker: It was in the protocol –

Next Speaker: I've been just interested in kind of this adequate **** pneumonia **** –

Next Speaker: Right, well I think it's a clinically defined probably means that there weren't –

Next Speaker: There was no additional –

Next Speaker: – **** –

Next Speaker: – there were no **** cultures, no bloodstream, no –

Next Speaker: But urologically –

Next Speaker: Uh –

Next Speaker: – that'd be –

Next Speaker: Yes.

Next Speaker: Clinically –

Next Speaker: Yes.

Next Speaker: – greater –

Next Speaker: That was the first criteria for both types of pneumonia was an extra ****.

Next Speaker: In a laboratory as it, like a culture of a, **** –

Next Speaker: ETT –

Next Speaker: BAL –

Next Speaker: ET BAL yeah.

Next Speaker: ****

Next Speaker: You were using the ventilator associated, um –

Next Speaker: Are you using the NHS **** definition –

Next Speaker: No, no.

Next Speaker: No.

Next Speaker: It worked –

Next Speaker: No.

Next Speaker: – were, sic, similar –

Next Speaker: Similar but no –

Next Speaker: No.

Next Speaker: They're not the same.

Next Speaker: **** but –

Next Speaker: Okay.

Next Speaker: But that.

Next Speaker: Thank you.

Next Speaker: Can you remind me the, the ones that were definition, what was the total end of these four ****?

Next Speaker: There was 1,307 patients surveyed.

Next Speaker: Approximately **** patients and 47 –

Next Speaker: Yes.

Next Speaker: – had HAIS.

Next Speaker: There was a lot, there was a lot more that, you know, had signs and symptoms of infections but only these were the ones that met the definitions that were in our, internal house dec–, operational manual, so, so, um, next we're gonna look at what happens when we apply 2011 definitions to the same population. Um, so, again, I just reported out 47 injections using 2015 definitions. When we look at the same population, and apply 2011 definitions, there were actually 54 infections so that's an increase of 7. So this table, um, on the left-hand column, that is the 2011 definition, that is what the HAI would be if we're applying 2011, '11 definitions. If we're looking at the middle column, that's what the HI would be if we're applying 2015 definitions, and then the last column is the number, or the times that that happened. So you'll see that there's three, um, HAIs that would've been classified as gastroenteritis, uh, as in gastroenteritis under 2011 definitions is, but we're using 2015 definitions we, that they are reclassified as clustridial patissial infections. There were three, um, HAIs that were bronchitis or other types of bronchitis, that, um, fell underneath the 2011 definitions which actually were–, did not meet any 2015, um, HAI definition. Other infections that didn't meet 2015 definitions but met the 2011 definitions was Skin, Skin, which is soft skin, soft tissue infection that was involved with the skin, a deep incisional infection, a symptomatic UTI, and a soft-tissue infection.

Next Speaker: ****

Next Speaker: And then moving on to pathogens, uh, only 26 of the 47 infections used in the 2015, uh, definitions, had an associated pathogen. This is because some of the definitions actually don't require that a pathogen, uh, require a pathogen to consider an HI. The most common pathogens that were recorded, or were found, was soreness, **** e-Coli and asp epidurals. We also found one each of a long list of other, um, infections, which is, let's see here, so, next steps. We're gonna take a deeper dive into this data. I, I mentioned that we looked at those, um, a deeper dive at those that were on **** hormones, and Magnamycin, and looking at those that had community associated pneumonias and UTIs, and so that's, uh, in the works. Um, and then we're also planning for the next survey, so currently we're working with the CDC to determine if we want to do the next survey in 2019 or 2020, um, that's not decided yet. And then the other question that we have is which HAI definition do we use. So in 2015 we used the current definition, but current definition has changed since then, and so if we, in 2019, or 2020, use the current definition, then we're, we no longer be able to compare across the years, and so the question is do we use 2011 definitions only or do we use both current, whatever the current is in 2019, 2020, and also 2011. And then there's also, um, thoughts of adding, uh, doing the public survey in long term care hospitals as well in 2019 or 2020. So, um, any questions? I know that was a lot of information in a very short amount of time. Yes.

Next Speaker: So, how does this compare to the previous survey ****. Do you remember? No. Okay.

Next Speaker: No.

Next Speaker: I'll ask you –

Next Speaker: We're gonna be taking a deeper dive into our data –

Next Speaker: Okay.

Next Speaker: – and that is one of the things we'll be looking at.

Next Speaker: So in doing **** –

Next Speaker: Mm hmm.

Next Speaker: – are you comparing them across the ****?

Next Speaker: Yeah. So one of the nice things about, um, the EIP, is that all ten sites do the same project at the same time with the same protocols. That allows us to compare, um, **** against **** and, uh, we only have one here but a lot of sites have a lot of them, um, so in the June meeting I'm gonna be talking about our nursing home pu–, public survey, so.

Next Speaker: Before we wrap up, are there any major takeaways? You mentioned the point, like looking at different healthcare systems at different –

Next Speaker: Mm hmm.

Next Speaker: – types of antibiotics **** provider formularies or, I don't–, any other, like, **** takeaway points, 'cause this is an immense amount of data –

Next Speaker: Yeah.

Next Speaker: – and work and just, I think said, it's probably due, I don't know, I don't know if we can stop at this –

Next Speaker: Yeah.

Next Speaker: – I **** if you will.

Next Speaker: I, I ****, I'm kinda surprised by how few **** like actual HAIs were found. We, I can't say, we, because Monica and Valerie did all the chart reviews, but there was a lot of data collected and very few HAIs. I think we find, we've had that feeling, um, with the, **** survey as well, so I don't know if that's, I don't know. That's always a takeaway for me. It's always interesting that how to view, actually meet the definitions. Do you have any?

Next Speaker: No, I agree.

Next Speaker: Yeah.

Next Speaker: I mean are you saying that you think there might be more that somehow aren't really accounted for in the definitions, or are you just kinda surprised by –

Next Speaker: Or you're doing a job –

Next Speaker: Yeah.

Next Speaker: No, or that we –

Next Speaker: ****

Next Speaker: We're gonna back –

Next Speaker: We have a lot of questions at this –

Next Speaker: Or we –

Next Speaker: Yeah.

Next Speaker: I think I'm surprised that we're doing a good job.

Next Speaker: Mm hmm.

Next Speaker: Well so –

Next Speaker: That that should be surprising, but I mean, you know, that there's few, and there would be interesting –

Next Speaker: ****

Next Speaker: Yeah, exactly.

Next Speaker: So really, hopefully like for example when you look at say, UTIs, we see that we did a total 69 chart reviews for those that had, um, any antimicrobials given for a treatment of active infection for UTIs, so right off the bat, that's already more than our definitions, and so it'll be really interesting to look at, for example, the UTI, um, population and the, and the community association, you know, the population compared to the actual pop, the popugate, population **** that's periodic so –

Next Speaker: And, and, I mean, and I want that, and I think that, like you said this **** sites that are collecting the data so the, the function and the idea of the study was to look at all ten sites –

Next Speaker: Right.

Next Speaker: – together and that's the way you're really be able to draw some conclusions looking at one state. You know it sounds like a lot, still but relatively small amount of data so you'll need to look at that full amount –

Next Speaker: Yeah.

Next Speaker: – if you're ever gonna draw, kind of figure into conclusive, HAIs or any **** –

Next Speaker: Yes.

Next Speaker: And it's really interesting seeing trends across the, the U.S., um, between 2011 and 2015. It looks, for example, there's a huge push to reduce **** associated **** infections. We actually saw a decrease to 2011, 2015 surveys, so –

Next Speaker: And the **** that are used to –

Next Speaker: Yeah.

Next Speaker: – see the specific –

Next Speaker: So a lot less urinary catheter use. Is that what you?

Next Speaker: Yeah, I –

Next Speaker: You would see the same, yeah, yeah, chronic.

Next Speaker: As to those questions, you would be in a **** those decisions –

Next Speaker: Yeah.

Next Speaker: – those decisions came out of decisions going to be made or are they associated with key facts on the **** sites or are they just gonna tell you what the different coding.

Next Speaker: And we have a call in a couple weeks.

Next Speaker: Yeah. They, they, uh, CBC, does take our feedback and they'll incorporate into their decisions so, um –

Next Speaker: I think the majority rules so, so it's, if all the sites think that we should be collected or whatever a majority of voices think that we should collect. Both definitions, for example, then we probably will collect both definitions.

Next Speaker: Yeah. I mean, I don't want you to go there obviously **** but, yeah, there's a reason why the definitions change and, and then, so, just to, just to collect antiquated infection

definitions so we could, that's the only logical– it seems counter intuitive to, um– I think we should close for a better **** of the, in a lot of data –

Next Speaker: Yeah.

Next Speaker: – to, to say something's a treated and, and active infection when we know that a lot, so many **** or, are used uniform greatly. I mean, look at the data, at least from a **** time, and we know that –

Next Speaker: Mm hmm.

Next Speaker: – active infection, suspected infection, I mean, you know, um, and everything in between, um, is, there's a lot, I mean, so if they ordered a culture, you know, and they're important for th****ings that you should be, ought to order culture for, um, you know, we'll give you some indication that they really think someone has something, um, you know, did they, you know, those kind of things, I mean, um, I think are pretty kind of – well, we'll certainly help you interpret the data a little bit.

Next Speaker: Yeah, especially 'cause **** antibiotics 'cause there were some **** so first generation ****, third generation ****.

Next Speaker: ****.

Next Speaker: Yeah, those three, the third generation of ****, those are all, those are empiric. Those should not be ****.

Next Speaker: **** in the hospital you, you know, and they basically start him on ****, you know, and then it's like okay, what can we do now to kind of, you know, to scale it back, right, so that's what you worry about, right. Exactly that's, that's –

Next Speaker: Cool, great. Well, awesome discussion. Any more questions you can, uh, email the state and ****. Um, okay, next on the agenda is Becca who's gonna talk to us about 2016 data and exemptions.

Next Speaker: Yes, thank you. Um, so I first **** about the 2016 data that are 2016 HAI data under the new baseline, so this is the 2015 re-baseline process. **** is now post-data on our web site, um, so that's again available by facility, and um, it's been **** for about a month now. Um, so I wanna transition into, uh, a conversation and voting for, um, a proposed exemption policy. So um, please interrupt me while I'm speaking if you have questions while I'm going through this, but um, you know, we introduced this a bit at our last meeting. There is a proposal on the table to, um, change the way that we handle exemptions at the state. Um, so I think, you know, I hope everyone has seen the exemption FAQ material that went out with all the meeting materials, but uh, I just wanted to give a bit of background, um, as to what we are proposing. So as a reminder, um, Oregon hospitals are required to report six, um, surgical site infection types, central line associated bloodstream infections, catheter-associated UTIs, **** events and MRSA lab I.D. events, um, to the HAI program here at OHA. Um, currently the HAI program offers

two exemptions from reporting either central line associated bloodstream infections or surgical site infections if the, um, following criteria are met. So for SSIs, um, an exemption could be given if a facility performs fewer than 20 procedures of a given type annually, and that's in a previous year of reporting, and then for CLABS use if a facility observed fewer than 50 central line **** again in a previous year. Um, so what we are proposing is to eliminate these exemptions, um, and we're doing this for a few reasons. So, um, we're proposing to do this for a few reasons. So first and foremost, we really are doing this to protect patient safety so, um, you know, our mission is of course to prevent healthcare-associated infections and though a small number, a small denominator, can maybe impact the degree to which our HAI metrics are interpreted, um, you know, we recognize that one healthcare-associated infection can be life changing for a patient or their loved ones. Um, so for that reason it's really important for us to know where our healthcare-associated infections are happening, um, and this is really to, you know, further the collaboration between our facilities and the HAI program to improve our ability to track the trends, uh, and then to identify targets for HAI prevention and quality improvement initiatives at the state or regional level to help us target our resources a bit. Um, it also will improve our data generalize ability. Uh, because of the current exemption criteria, we feel that our HAI data, uh, may be a bit more reflective of the experience of our large healthcare facilities here in Oregon, um, and we believe this change will make our ****. Um, and finally, we wanna continue to meet our legislative mandate, so the way it's written in our statute is that we are to provide useful and credible infection measures specific to each healthcare facility to consumer. So we wanna continue to do this, um, to, to, you know, ****. Um, a few things to keep in mind throughout this change. Um, so this is a proposed change that would go into effect for 2019 data, so this is surveillance that would be done during 2019. Um, facilities that have not claimed an exemption will see no change to their reporting. We have many facilities who meet these requirements but still report to us voluntarily, so, um, there won't be a change to any of those facilities. Um, facilities that, um, never perform certain surgical procedures or do not have applicable location types will still not be required to report data, of course. Um, so of course, if you don't have a NICU, you're not required to report NICU ****. None of that is changing. Um, facilities that have never performed surveillance for these type of measures will, um, potentially need to build some capacity to do so. So what we really wanna emphasize here is that we do not expect facilities to do this alone. Um, we're gonna offer a webinar, one for CLABSI and one for SSI, **** for infection prevention as needed, and then we are always available for one-on-one technical support as needed. You know, we know our facilities have been already focusing a lot of attention on this, but to the degree to which they need our help, we are there to help. Um, and then in terms of what data will be published, um, most facilities won't see any change in how their data has gone published. Um, we do have a preliminary censorship policy that says we will not present any data for any **** is insufficient to generate stable measures, so if there's lots of variability in the measures, um, and we also will not report facility, uh, specific data, uh, if denominators are insufficient to generate a predicted number of infections or standardized infection ratios. Um, and we're happy to, you know, hear any feedback from ones you have about that censorship policy, but that's really just a starting place for us.

Next Speaker: Can I ask a question?

Next Speaker: Yeah.

Next Speaker: ****. Is that censorship, is that something you determine after you have the data?

Next Speaker: Yes.

Next Speaker: And you do the calculations and then you say okay, this doesn't meet ****.

Next Speaker: ****.

Next Speaker: Okay.

Next Speaker: Yeah, that's a good clarification. So one of the things we really want is to be able to see what's happening, even if we determine that, you know, that's not a number that the public would be able to interpret easily. So, you know, we wanna be able to target our resources. If a facility has two central line **** and they have one CLABSI, I'm still pretty concerned about that CLABSI, right? So um, that may not be something we report because the DSAR wouldn't really make sense, um, but we still think from an infection prevention standpoint knowing about that one CLABSI is important. Um, so I kinda wanna just open it up to some feedback. Um, you know, we're hopefully gonna be voting on this in a second but, um, I wanna give the opportunity for anyone to weigh in and, um, give us any thoughts they have about this process, but we do believe this is an important step for HAI prevention. Yep.

Next Speaker: Do you, um, what proportion of facilities are currently exempted and, um, and act on that extension?

Next Speaker: Yes, glad you asked ****.

Next Speaker: ****

Next Speaker: Um, so, so this is, um, not entirely easy to interpret data, right, because there are many HAI types, and this is just a matter of did the data facility require an exemption for any of those. So, um, I think that it probably does but, um, so for CLABSI in the ICU, uh, 4 of our 35 acute care hospitals claimed an exemption, um, and 14 of our 25 critical access hospitals, um, for CLABSI in general wards, we have 7 out of 25 critical access hospitals that claimed an exemption and 3 out of 35 acute care hospitals claimed an exemption. Now, this doesn't tell us also if they reported to us voluntary, voluntarily anyway.

Next Speaker: Awesome.

Next Speaker: So, um, we still might've reported on the **** but this is just what was claimed. Um, and I have, um, quite a few numbers for surgical site infections. Um, but for facilities that aren't doing these as much, I'll just give an example. So, uh, for hysterectomy, 15 of our 25 critical access hospitals claimed an exemption, and 4 of our 35 acute care hospitals claimed an exemption. So just to give you an idea.

Next Speaker: If, if based on your boarding in 2019 and their numbers are way higher than the exemption numbers, is there gonna be like an issue?

Next Speaker: If there numbers are –

Next Speaker: So say like if they're 20, right, so 20 was the numbers, and they're reporting that they did like 50 or, I, I mean –

Next Speaker: No, no, what, so that might happen, and one of, um, one of the issues with the way we're currently doing exemptions is facilities who might not have the opportunity to do exactly what you're saying. So if they're not performing surveillance for central line associated blood stream infections in their general wards for example, they might not know their central line exemption.

Next Speaker: Right.

Next Speaker: And, and that in and of itself is an important piece of information for us and them, but also it doesn't allow them to assess their, um –

Next Speaker: Exemptions.

Next Speaker: – that they're meeting requirements of **** –

Next Speaker: Right.

Next Speaker: – so it's a little bit circular.

Next Speaker: ****

Next Speaker: Um, and it's, it's one of the major kind of logistical reasons why we don't really think this is a good idea.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Wouldn't they come, I've stubborn recently –

Next Speaker: Yes.

Next Speaker: – is that, um, the less you are categorized as a surgical, less surgical or medical ward for pediatric or adults, your data is not being picked up, um, and I don't know how many, um, specialty wards are impacted by that, but I found out we are categorized as pediatric orthopedic ward, so our data stopped being picked up. I'm sure there are other specialty wards similar, like **** –

Next Speaker: You're right.

Next Speaker: – uh, or they have been categorized as orthopedic.

Next Speaker: You know, we have the specialty units oncology, tonometry, neurotrauma, none of those are picked up, so, uh, I think they are an ****, can we use that database in that chart with similar sites –

Next Speaker: So, we –

Next Speaker: – ****

Next Speaker: – will want for, so for device-associated infections being CLABSI and CAUTI, we align our reporting requirements. Those, so those are lo, that's location-based reporting.

Next Speaker: ****

Next Speaker: Um, as opposed to like the lab I.D. measures, which are kind of whole house, eh, surgical site infections, same thing, but the, the device-associated infections are reportable by location because location has so much impact on patient risk for the development of the device-related infection. So we align our reporting requirements in terms of the locations with those of CMS, and, um, most states do that, um, for CLABSI and CAUTI because it helps to A, reduce the burden on facilities to do additional reporting beyond what CMS requires, but also because those locations are considered especially risky for patients. Um, so we have no plans to implement additional reporting requirements for locations that are outside of the firm UF CMS surveillance, but we think that surveillance for these infections in other location types is super useful for facilities to have, and if you, you know, if you are a facility that's doing that kind of reporting, we'll still support you, you know, just because I personally can't see your data in NHSN doesn't mean that I'm not still available for technical assistance. Um, and additionally, just like as a little side note, we understand that there are probably issues with the way facilities are mapping or have historically mapped, is a better way to put it, locations in NHSN were also kind of thinking about maybe some validation work around that and how we can support facilities to maybe be evaluating how their locations are mapped for accuracy, um, because it does impact the risk adjustment, and we want facilities to get credit for the work that they're doing, the good infection prevention work that they're doing, um, so, yeah.

Next Speaker: This, um, will it stay for inpatient, not ****

Next Speaker: Just inpatient.

Next Speaker: So, so all of the, the way that you apply the NHSN protocols will remain the same. It's just what it is reportable to us. Um, and there was one other thing I was gonna mention, for facilities who are wanting a little bit more specific clarification, Mary mentioned that she had been aware of how sort of narrow the facility location maps that actually correspond with the reporting requirements are, and they are quire narrow, so it's very, like you would think that a neurosurgical location would be a surgical location, but the, it's not, um, for the way, and

it, for, for the purposes of the, of the reporting requirements for us and for CMS. So, for those of you who have questions about that, please feel free to reach out to me and **** on the phone, and I'm happy to talk to you about that in great detail.

Next Speaker: I think it would be valuable to offer assistance for location mapping 'cause I would eventually guess all of us in the state are still using slightly different methods to, um, map. Um, I know, um, CMS recent training suggest not using manager of that unit, uh, what type of patients are you getting here and rather do some objective data like look at your billing data of whether or not you're billing for intermediate care or a med surg or whatever that is, um, so guidance would be helpful to align us better.

Next Speaker: Maybe we can talk about that offline. I'd be really curious to hear, um, like more specifics about what you've gotten, and I, as much as we can standardize it, I mean that's what we're aiming for.

Next Speaker: I think the other big message that people need to understand is if they change their locations so **** what their impact will be on past data and some strategies for how to save some of those data trends, um, for comparative purposes 'cause apparently once you change your map, you lose that data.

Next Speaker: You can have it changed ****

Next Speaker: So to clarify, to change the mapping, so if you had entered data into a particular location, and I don't wanna stray too far away from the exemptions topic, but if you were to find that your location was mapped incorrectly and you had reported data to that location, what you would need to do is remove the data from that location, reenter it into your newly mapped cur, accurately mapped location and inactivate the old location, and it does change the risk adjustment, um, because data are risk adjusted based on location and that's why mapping is so important. So –

Next Speaker: Although if you're pulling data from when it was on the other unit or whatever, you need to reactivate it to get your data. So, it's very –

Next Speaker: It will still come out in the reports –

Next Speaker: – complex.

Next Speaker: – but you can't enter data into that location anymore it's I believe how it works, but I wanna turn it back over to Becka for more exemptions.

Next Speaker: This is a really important conversation –

Next Speaker: But that's –

Next Speaker: It really, really is.

Next Speaker: We've been talking about it a whole lot internally, and, you know, this is an important time because we are resubmitting one of our big federal grants right now, so, um, communicating these priority –

Next Speaker: Yeah.

Next Speaker: – **** this has come up is really important at this stage, and we have brought this to the CBC's attention quite a few times and remember that, um, grant folks we work with are often separate from NHSN but mapping was not an issue that was on their radar before we started, you know, talking about it. So I think it's, um, it's really important that we, we plan to focus on this.

Next Speaker: Yes.

Next Speaker: So thank you for those comments. Um, I think at this point I, I can hand it back over to Jen to lead a vote. Is that okay? I don't know –

Next Speaker: Sure.

Next Speaker: – if there are formal voting procedures here, but…

Next Speaker: Okay, if you're **** what's the, what are we voting on ****

Next Speaker: So, uh, we are voting on the proposal to remove the exemptions for CLABSI and SSI for organ facilities. So this includes acute care hospitals, critical access hospitals and our LTAP. Um, and we are just voting in favor or not in favor of the proposal.

Next Speaker: And I'll just, um, clarify that, um, the only folks who can vote on this are our members. Um, so if you are not sure if you are a member, um, if you're here in the room, you have a green dot on your name tent, and, um –

Next Speaker: Oh, ****

Next Speaker: – actually, why don't I just read –

Next Speaker: Yep.

Next Speaker: – yeah, we can, should we do it one by one or?

Next Speaker: Then you can say aye or nay.

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: Okay, okay, so do I call out myself? ****

Next Speaker: Aye.

Next Speaker: Yes.

Next Speaker: Deborah Catora?

Next Speaker: I think she's on the phone ****

Next Speaker: Deb Catora, are you on the phone still for voting regarding the removal of exemptions?

Next Speaker: Yeah, 12 ****

Next Speaker: Um, Kelly Klaylo?

Next Speaker: Aye.

Next Speaker: Wendy Edwards.

Next Speaker: Aye.

Next Speaker: John Bruno.

Next Speaker: Aye.

Next Speaker: Vicky Norbi.

Next Speaker: Aye.

Next Speaker: Lori Pulno.

Next Speaker: Aye.

Next Speaker: Tom Scooter.

Next Speaker: Aye.

Next Speaker: Dede Vallier, Valliet.

Next Speaker: And then maybe, Deb Catora, was Deb Catora, did she come back on? I think what, what we'll do is we'll tally, we'll tally and we'll, we can check in with those other members.

Next Speaker: And, and Dede are you on the line still? Bummer.

Next Speaker: Okay. And **** So 7 of 15. Do we still have to have ****

Next Speaker: Mm hmm.

Next Speaker: ****

Next Speaker: Yeah, we did.

Next Speaker: Oh, we did?

Next Speaker: Mm hmm. So 7 of 15 say aye, so it's like one person short.

Next Speaker: Did someone just join back on the line?

Next Speaker: Yeah, this is Deborah Catora. Sorry, I couldn't figure out how to get back to my screen so I could take myself off of mute.

Next Speaker: No problem.

Next Speaker: So, um, I, I support the choice. Aye.

Next Speaker: Great, thank you. Okay, I think we've met our, we've met our quota to carry, to **** and we will **** of members. Um, yeah, I hope that this will help us understand each idea throughout the state in the various sites and facilities, so thank you.

Next Speaker: This is Rosa. I just wanna say thank you. I think this will really improve our data quality, and it will actually simplify a lot of pieces of this reporting in the long run. So…

Next Speaker: And hopefully it will be, you know, also give important information back to our smaller facilities as well, so, okay. Uh, okay, so, uh, thank you. So now we are at that topic for future meetings and reports and public comment. I think I will sort of that, I'll, I'll just kind of ****, uh, I just wanna call a couple things that we spoke about before. Um, there were some questions back around flu vaccine, like understanding what types of vaccine. Was it the trilena **** valence, uh, we had questions around for the, uh, lexis project around if we can understand the **** antibiotic treatments, uh, and we're seeing more about that. Um, we have questions just right now about NHSN mapping locations. Uh, I just also wanna make sure to reach out like other, like, um, for, uh, nursing homes, long term care facilities, I know, I think just tends by nature to be more hospital-centered but wanna make sure that we're hearing from our long term care facilities for topics that they have that they're interested in, um, that we should be addressing and, and maybe give, help provide data for, so.

Next Speaker: And I'll mention dialysis as well.

Next Speaker: And dialysis as well, so I just wanna put that on there.

Next Speaker: And this is Rose again, I just wanna give, uh, just encourage you to let us know, I mean for reports and topics for these meetings. The reason why we brought, um, Emilio Tobas

to our meeting last time to talk about service animals and the infection prevention is because of the fact that we heard from, you know, the **** group and this group and kind of what's bubbling up and what's on people's radar and that's true of the influenza topic, and I think those topics always end up being sort of the juiciest ones of the agenda that are sort of the most broadly of interest, you know. Um, so those topics come from you, not from us. So please tell us what you want to hear about, and we will do our best to address it.

Next Speaker: Oh, there's also something about, um, hospitalizations for influenza for non-metro ****.

Next Speaker: So do you want, uh, so one thing that we have kind of talked about internally to mention today and we'd like to continue to mention at all our meetings, so we talked a little last time about our reports that we're doing each year. So, you know, this year we'll reporting data at our facilities for their HAIs, but we haven't been more flexibility on what we can do or focus report on. So, you know, we've kind of been asking you guys to communicate back to us if there are particular areas of interest that you could like us to focus on, um, and one of the things that we've really been talking about, not just within the HAI program but for **** in general is, um, the need to not only be reporting **** data, but to be talking about what we're actually doing to prevent these infections and some of those in collaboration with our healthcare facilities and our other, um, healthcare partners. So, um, you know, one example might be to, you know, do a CDI report where we report on our CDI measures, but we also talk about stewardship in our state and we can use our survey data amongst other things to inform some of that, and, you know, to talk about other kind of CDI prevention measures, maybe laboratory mechanisms facilities aren't using, put some of that data all into one report so, you know, not only we can, to get a sense of where we're at, but, you know, the direction where we'll begin to highlight some of the work that our facilities and, you know, our partners have been doing. Uh, so, you know, we don't have to necessarily go into details on this today. I don't wanna put anyone on the spot, but if you do have thoughts about what would be helpful, please relay that back to us 'cause we are in kind of planning stages for our extra **** at this point.

Next Speaker: One comment, um, I think it would be very valuable to hear and find best practices in stewardship. Um, and it would be helpful if there's bandwidth to actually take the CMS study that some of us participated in and was shared today, uh, of what opportunities were found there, kind of bring those together, um, 'cause that would impact our **** across the state and wanna make sure we got **** from that.

Next Speaker: Yeah, just 'cause, uh, I was looking t Lexi's slides here, like, she, it mentions on that review **** appear that of the 69 chart reviews with a urinary tract infection, almost **** –

Next Speaker: Borderline ****

Next Speaker: – of UTI, so, um –

Next Speaker: There's an opportunity there.

Next Speaker: – yeah, there's an opportunity there, so, yeah.

Next Speaker: And I think, I think also we need in, in the next, I don't know if it's next meeting or following meeting, you may be hearing more from that MDRO collaborative, this idea of having standardized and best practices in the multi-drug resistant organism infection people, so, um, I can't remember, is that next or?

Next Speaker: Yeah, we will have a report out on the MDRO toolkit about our next meeting along with nursing home prevalence study, um, an update on our ICAR, infection control assessment and response visits. I know those things are on the agenda.

Next Speaker: One, one of the hot topics right now is **** in, in nursing homes.

Next Speaker: Mm hmm.

Next Speaker: Um, especially given now the CMS requirement is, is live, right?

Next Speaker: Mm hmm.

Next Speaker: So –

Next Speaker: About having a ****

Next Speaker: I think you have to have a certain program –

Next Speaker: ****

Next Speaker: – and getting to be reviewing, yeah, **** get live descriptions, um, so that went live in November, and, uh, I've been looking up the data from the, um, long term, last long term care survey, we just, you know, I mean, it, it, **** but just looking at kind of infrastructure for readiness to meet those requirements, but, um, I, I think we need to kind of see how we're supporting our facilities here and making sure that they're meeting those requirements and seeing what kinds of things that they might need, um, you know, do they have, um, you know, my specific **** research **** care, um, but, and, I know that's gonna really impact a lot of 'em, um, but I think it's really important ****, um, hopefully **** by me, um, but I think the, uh, you know, there's just lots of other things in **** capacity, right, um, for types of, uh, kind of **** platforms that are using, um, the lab resources, um, **** biogram, clerisy, those types of questions.

Next Speaker: Are you volunteering to present?

Next Speaker: I'm not, when is the next meeting? That way ****

Next Speaker: June, June 28.

Next Speaker: Late June. That's better. You know, I mean I could potentially do that. I could certainly show those data if people are interested in those data.

Next Speaker: Maybe like put together like kind of a –

Next Speaker: Yeah –

Next Speaker: – ****

Next Speaker: If people are interested in this topic, um, I can certainly, um, you know, I could talk about it.

Next Speaker: I think you bring, you make a really good point is that in supporting the facilities, uh, to do the work that we focus our –

Next Speaker: Right, that's what, that's –

Next Speaker: – **** yeah.

Next Speaker: – what we should be, I mean I think that's what our, our goal should hopefully be is to, is to help the facilities with what they need, and if there's, if there's a obvious opportunity, um, for us to lend expertise, um, then, then I think that's what we should be doing.

Next Speaker: Great. ****

Next Speaker: **** talking about **** we work with long term care so **** survey centers but the needs are different.

Next Speaker: Mm hmm.

Next Speaker: And it's one thing to have to add is that it's really important and informs us why we should do what we should do, but then how do we take that data and how are we communicating it **** doing a report, but what does it mean? What does it mean in our requirement? Then getting back this, this whole issue, what kind of resources beyond, uh, **** what we, can we provide the facilities? Uh, just going in and looking at, we've been looking at the chart that was up there on the flue and one of the hospital's the volunteer and mandatory policies. Well, even that, is, are there resources for helping people, um, develop policies. So, those kinda resources, so what's out there to help me do my job 'cause that's what's facing those **** at the front line. I wanna know, like get something to help me do a better job.

Next Speaker: I like that. It's great. Thank you. Okay. Well, everyone, thank you very much for your participation today. Thanks everyone who's on this from the phone and we look forward to seeing you in 3 months and happy ****. Happy Easter.

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