Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
March 11, 2020

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Next Speaker: Can you hear us?

Next Speaker: Yes. We can hear you. We are just giving folks another couple of minutes to themselves going on webinar and phone lines, but I think we're gonna go ahead and get started. It looks like we have about 20 people on the line so that's a great turnout. Um, can someone just confirm you can hear me okay.

Next Speaker: **** can hear you.

Next Speaker: Yes. I love it. Okay, so today, because, um, we, it's a little bit of a special circumstance so we have asked, um, most of our, um, folks who aren't already in our building to join us remotely.

Next Speaker: Mm hmm.

Next Speaker: Um, just out of an abundance of caution so I just want to say thank you to everyone, and also to say, um, you know, apologies for any inconvenience if this caused any disruption in your plans. Hopefully, it wasn't too bad. Uh, we're going to move forward with the meeting in every other regard as we had planned to do that. Um, Jen Buser, our wonderful chairperson, is also on the line, but since I am in the room with the computers and the phones, I think it'll be me sort of running the show, uh, today from that perspective, so I move to call this meeting to order. Does anyone second my motion?

Next Speaker: I'll second.

Next Speaker: Any member of the ****.

Next Speaker: Sorry.

Next Speaker: ****.

Next Speaker: Thank you, Wendy. We will begin the meeting, uh, with a roll call, so we are gonna off with, um, folks on the phone.

Next Speaker: It looks like Jen Buser is self muted.

Next Speaker: Kay.

Next Speaker: There we go.

Next Speaker: Just call them.

Next Speaker: Can folks on the phone please go ahead and start going through your names?

Next Speaker: This is Jesse Kennedy. I'm here.

Next Speaker: Thanks Jesse.

Next Speaker: Kristin Denow is here.

Next Speaker: Thank you.

Next Speaker: Vicki Nordson.

Next Speaker: Thank you, Vicki.

Next Speaker: Karen Larson.

Next Speaker: Thank you, Karen.

Next Speaker: JJ Fernoncer.

Next Speaker: Thanks, JJ.

Next Speaker: Marsha Jerwoski, Comadgen Health

Next Speaker: Thank you, Marsha.

Next Speaker: Sandra ****

Next Speaker: Thank you, Sandra.

Next Speaker: And we have Yolanda from Harney District.

Next Speaker: Yolanda, are you on the line? And just as a reminder, you will need to unmute yourself before speaking, so everyone is now muted, unless you've unmuted yourself, and unfortunately, I don't think we can do that on your behalf. So please go ahead and unmute yourself if you're trying to talk. So Yolanda Rickman on the line? Anyone else on the line?

Next Speaker: Oh, John, is not on, okay? Just one second. I'm going to unmute everyone again and then they can self mute.

Next Speaker: Hey, does this –

Next Speaker: Is that Dennis?

Next Speaker: I think so.

Next Speaker: Okay. I think we are just having a little technical issue here.

Next Speaker: Okay, everyone is allowed to unmute themselves now.

Next Speaker: Okay, so everyone should now be able to unmute yourselves. So, uh, Yolanda, are you there? I'm just picking on you now.

Next Speaker: Oh, here, I'm gonna –

Next Speaker: Okay, Dennis was that you?

Next Speaker: Hey, this is Dennis Connelly Kaiser.

Next Speaker: Thank you, Dennis. Anyone else on the line?

Next Speaker: Yolanda Rickman's here.

Next Speaker: Hi, thank you. I thought you might be. Sorry for making you the guinea pig there.

Next Speaker: That's okay.

Next Speaker: Who, who else is on the line, folks?

Next Speaker: Debra Katora.

Next Speaker: Thank you, Deb. Is anyone else joining us on the call? Great we're gonna move forward with people in the room and then, um, anyone else on the call who didn't have a chance to say their name can do so afterwards. Let's start with Wendy.

Next Speaker: Yes, uh, Wendy Ethors, uh, hospital surveyor.

Next Speaker: ****, um, with ACDP.

Next Speaker: Deb Tran, ACDP.

Next Speaker: Lisa Ugi, ACDP.

Next Speaker: Maureen Cassidy, ACDP.

Next Speaker: This is Rosa Tammer, ACDP.

Next Speaker: Diane Roy, ACDP.

Next Speaker: Marla Lon, ACDP.

Next Speaker: **** ACDP.

Next Speaker: Sure. I'm Chet Bryan with Abbott.

Next Speaker: Okay, anyone else on the call that did not get a chance to introduce themselves the first time? Just as a friendly reminder to unmute yourself before speaking. Okay, excellent. Um, so we're just gonna start out with a very brief logistics update. Honestly, the only thing I really have to say is please unmute yourself before you talk. Um, we, uh, did distribute a instruction guide for using this webinar. Um, it will be in your packet of materials. So that should be helpful. Uh, we've also distributed a more updated version of our sort of HIAC one-pager. It says "Bring Your Voice to the Table" at the top. Um, so we now have several vacancies on this advisory committee, including a hospital administrator with expertise in infection control at a facility with fewer than 100 beds; a consumer or patient advocate; a health insurer representative; and a representative of the Oregon Patient Safety Commission who does not represent a healthcare provider on the commission. If you or anyone you know is interested in one of these positions, uh, please do get in touch with me. Feel free to circulate this one-pager to your networks, and if you have any questions you can get in touch with me directly. Um, with that being said, any other logistics updates that we need to tell the group?

Next Speaker: It looks like just a reminder, um, to some of you are not able to, able to talk because you were still muted on your end.

Next Speaker: Okay, so just final reminder to please unmute yourself before speaking. Um, with that being said, uh, I will put forth a motion to approve the December 2019 meeting, meeting minutes. Those minutes are in your meeting materials. Would anyone like to second my motion to approve?

Next Speaker: I second the motion to approve.

Next Speaker: Thank you.

Next Speaker: This is Josh Barfield at the Oregon Clinic.

Next Speaker: Thank you Josh. Okay, we will approve the minutes and, um, moving on to our first, uh, agenda item, which is the state HAI plan – I'm just gonna move myself over to the computer right now. Okay, so, um, as some of you might now we have a state healthcare-associated infections plan. Um, it has not been updated in a few years and one of our goals for

this year and for every coming year is to be updating that state plan, um, and part of what we want to be doing is to be making sure that the priorities incorporated in our plan are data driven, right? We wanna make sure that, um, those priorities are actually sort of indicated by the data that we collect. And we collect quite a bit of data, as especially folks from hospitals on the line will know. Um, so this will be a brief, I think, conversation. Um, the goals of, you know, looking at our data are to create a standardized way to evaluate statewide and facility-specific HAI data that are report that are reported to our program in order to identify data-driven priorities, and those priorities will inform our annual updates to our plan, and they will also inform, uh, future efforts to kind of make sure that our membership and attendees of this meeting are representative of people who have expertise in those areas. So, um, in order to identify our data-driven priorities, we are looking at these sort of measures that we, uh, collect on two different levels: One is whether or not they meet a target threshold, based on how many of our facilities met our target threshold for performance, and then the other is a level of concern, which should be sort of independent of the data and we have used sort of a high and moderate classification here. This feels a little bit abstract, um, but you'll see what I mean in a moment. The way that we have, uh, decided to kind of organize and assess our data is a tool called the data matrix. And that data matrix is basically a glorified spreadsheet and in that, um, matrix we have incorporated statewide pooled data, as well as facility-specific data. Our plan is to update it once a year in order to consistently be revisiting our priorities to make sure that our activities are data driven. They include a lot of the more actionable metrics that we collect. Um, there are tabs for hospitals that include both acute care and critical access hospitals, as well as a tab for skilled nursing facilities. And again just to revisit, um, the data matrix incorporates not only data and, you know, allows us to assess our data measures based on how well our individual facilities, or us as a state, are performing, but also a level of concern, which is either high or moderate, which is independent of the data, and should really be more about, you know, what type of infection is there and are we concerned about it. So, just for an example, if we were looking at the common cold versus Ebola, right, one might be high and one might be moderate regardless of how we're doing, right, in terms of, uh, prevalence of incidence of disease. That's not on data matrix but just a little example. So with that being said, we wanted to bring our measures to this group and talk about, um, what level of concern this group has for these measures. These are the measures that we're incorporating in our data matrix for hospitals. Um, so these are our sort of, what we feel are our most actionable data points that we would like to be assessing in this data matrix to potentially include as priorities in our state HAI plan and to inform our HIAC membership and attendees and how we kind of structure this committee and if we need to continue engaging additional folks that have expertise in areas that we aren't already. So with that being said, I just really would like to, um, you know, open up the line for discussion. We have a few minutes for this. Um, and I think we just wanna hear from you folks, you know, would you consider these without having, you know, the data in front of you. So again, thinking about them independently of data, just your level of concern associated with these types of infections or these measures, would you consider them a high priority or a moderate priority? Um, so for example, not knowing – looking at our very first one, right? That's healthcare worker influenza vaccination. So is this a high priority for us or is it a moderate priority? And I'm just gonna remind everyone once again to please go ahead and unmute yourself before speaking on the line.

Next Speaker: This is Jesse. I would definitely say on our first one that should remain a high priority.

Next Speaker: Thank you, Jesse. Yeah, let's, I mean, anyone other, anyone else have thoughts on this?

Next Speaker: This is Wendy ****.

Next Speaker: I would, I would, this is Josh, I would agree on that high on the influenza.

Next Speaker: Wendy –

Next Speaker: This is **** Jason from U.S. **** Care, um, I wholly agree with keeping that as a high priority.

Next Speaker: This is two microphones in the room.

Next Speaker: Great. And then we had a comment in the room.

Next Speaker: Oh, I, I'm, I felt ****.

Next Speaker: Yeah, this is Wendy at Bertson. I would agree with that. I think that the influenza vaccine should remain a high, high priority.

Next Speaker: Do folks have, does anyone on the line wanna consider this more of a moderate priority? I'm just curious to hear, you know, if there's kind of general, unanimous agreement, um, and that is encouraged, right? So it's okay for you to differ from the group, the group that's already spoken.

Next Speaker: Uh, Sandra Assinic says high priority in the chat box.

Next Speaker: Sandra I think you may be possibly muted there. But we have another vote for a high priority on this. Other thoughts before we move on?

Next Speaker: Okay, Sandra is unmuted.

Next Speaker: Okay, so let's talk about our next two measures which are about antimicrobial stewardship. So this, these measure really relate to are those sort of essential elements of an antimicrobial stewardship program, um, actually being met in our healthcare facilities, in our hospitals, specifically? And we break this down into acute care hospitals and critical access hospitals, um, because they are quite different from each other in this regard. So any thoughts, um, from folks whether or not, you know, these would be considered high or moderate, and if you have a difference of opinion between the two facility types were looking at?

Next Speaker: This is Sandra at **** and, um, **** high priority. Um, but I would also ****.

Next Speaker: Thank you, Sandra. So for folks on the line that was, um, a very high priority for these. Sandra, did you have any difference of opinion between whether or not we would kind of think about acute care versus critical access in different ways here?

Next Speaker: No. I, this is, this is such an important, um, element, I would certainly not differentiate between either, uh, category of the care.

Next Speaker: Thank you. Other thoughts?

Next Speaker: Is, do you think **** aware of what these are, like –

Next Speaker: I would support that and I'm sorry I didn't get to comment on the influenza vacc, vaccination piece, but I think that those are high, as well.

Next Speaker: Thank you, Jen.

Next Speaker: And I **** I believe that some of the, correct me if I'm wrong, but if they're also C&S measures and so it, it is important that our hospitals are meeting those for other reasons besides just **** HAI work.

Next Speaker: Good point.

Next Speaker: Wendy, did you have a ****?

Next Speaker: Yeah, this is Wendy ****, and I just wondered if maybe you could just kind of go through the, what the kind of overview of what the elements are that are being reviewed or what have you.

Next Speaker: Just a few acronyms, right?

Next Speaker: Yeah, just a few.

Next Speaker: Yeah, this is filled –

Next Speaker: I have an idea ****.

Next Speaker: – it's filled with acronyms. I, I recognize that. I think, you know, our intention was kind of to go through this and sort of get the general feelings from the group. Um, uh, but what we might want to do – and I don't wanna overload anyone, so I guess let me ask the group this – is, would you like to see just a very quick Survey Monkey and respond in that way? Is that something people are receptive to?

Next Speaker: You are – this is Sandra **** - you were reading my mind. I was thinking that would be so much easier.

Next Speaker: Yeah, and that –

Next Speaker: Yeah, that would be great.

Next Speaker: Mm hmm.

Next Speaker: Okay

Next Speaker: – **** what each one is a little brief ****.

Next Speaker: Okay.

Next Speaker: I know **** maybe just clarify, do you want these, like, 1 through 15 or do you want people to say, like, 1, 2, or 3? Or just be a little bit more clear on your, um, what you want your result responses to be –

Next Speaker: Thanks, Jen.

Next Speaker: – your interpretation.

Next Speaker: It is actually just a two-part scale: 1 is high and 2 is moderate. Um, and I will include that in there. So let me just kind of go through these core elements of antimicrobial stewardship, um, in hospitals. So they are – sorry – hospital leadership commitment. Um, accountability – meaning appointing a leader or co-leaders, like a physician or pharmacist who is responsible for program management and outcomes, um, pharmacy expertise, the action, action of implementing interventions to improve antimicrobial use, tracking in the form of monitoring, regularly reporting information and providing education to prescribers, pharmacists and nurses. So when we're looking at this measure of what we're talking about is how many of our facilities met all seven of those elements. So in the interest of time, I'm just gonna kind of briefly go through the rest of these, um, verbally. Uh, we have a few more minutes on this agenda item, so I don't want to feel, anyone to feel that their voice is not being heard. So I'm just gonna kind of quickly go through them. A bunch of these are from NHSN or the National Health Care Safety Network, so CAUTI is catheter-associated urinary tract infections, um, and this is in I, ICUs and medical-surgical and medical-surgical wards. Um, CDI is clostridium difficile, actually clostridioides difficile infection in both of those unit types as well. And then we're also looking at – oh goodness, there's actually a mistake on this slide, hm – um, central line associated bloodstream infections in ICUs and those same wards. Then we'll be looking at – and please disregard on these next one – ICUs and on because these are all surgical site infections that are facility wide, so laminectomies, knee and hip replacement, heart surgeries, abdominal hysterectomies, colon surgeries, and then our final NHSN metric is MRSA bacteremia or bloodstream infections, and our final two are carbapenem producing organism presence and then the evidence of transmission. Okay? So, um, any thoughts on any of these? Do you folks have strong opinions on any of these measures?

Next Speaker: I thought we were taking laminectomy off the **** disease list?

Next Speaker: We are. This is what happens when you put slides together in **** a coronavirus outbreak.

Next Speaker: Pandemic now.

Next Speaker: ****

Next Speaker: Okay so we're gonna go with lam as low. Any other thoughts on this?

Next Speaker: I'll just throw out there that I, I think, I, I like the first two that you picked – healthcare worker flu vaccination rates and antibiotic stewardship. I don't care much about CAUTIs. Uh, and I care a lot about clostridium difficile and after that do what you want.

Next Speaker: Anyone else wanna chime in in a similar way?

Next Speaker: Okay, Jen said in the chat – "Should there be a low-priority group?"

Next Speaker: Yeah, I think our hesitance to create a low priority group is because why would be be collecting data for low priority infections and our concern about labeling an infection that has a very real impact on patients and their families as low, um, might bring an impression across that we don't really want to be espousing. It's the same reason why we've moved from expected infections to predicted infections in this work and I, I think, yeah, uh, hopefully, none of data that we're collecting is low priority.

Next Speaker: Yeah, I think in addition to that we were also trying to create a plot that would be easier to tease out and identify our priorities and having a 2 by 2 **** would be easier than having a 3 by 2 or, I mean, at one point we had a, you know, three levels of concern and that, and that the performance, uh, metric is a contingence –

Next Speaker: Variable.

Next Speaker: – and we couldn't really, um, I guess, it wasn't easily distinguishable, uh, in terms of the priorities, so we thought we'd just simplify by having 2 by 2 **** and that's, that's also part of the decision-making process.

Next Speaker: Yeah, thank you for that. And I think we'll just skip this and show, uh, our kind of goal is to create kind of a quad plot that breaks down our, um, our measures into sort of high and low pri, uh, level of concern, and then high and low performance, right? And to some degree by, like, Jen, what you're saying is a fair point. You know, I mean, there are many gradations of priorities here, um, but in order for us to kind of be able to say these are the measures that really meet the high level of concern and our facilities are performing relatively poorly compared to our other measures, um, makes it much easier for us to kind of create a discreet group of data-driven priorities. So this is what that might look like, um, you know, kind of using our current, um, level of concern that we created internally in our kind of meetings, but we really want to reach out to the bigger group to kind of say, hey, what is your level of concern and have that inform the level of concern that we use to create these priorities and to create the

final quad plot. So, I think with that, uh, we'll move on. Um, I do plan to then distribute a survey. It sounds like folks are willing to do that. I really appreciate it. I think we're just so hesitant to kind of reach out for anything else at this time. Um, if you have thoughts on the approach, I think we're open to that. If we are missing important data elements that you know that we collect because you report them to us, or that you think we should be collecting, you're welcome to speak up about that, and then, um, just as a little FYI, skilled nursing facility data will be going through a similar process and that review will be done via email, um, so it sounds like hospital folks are wanting that same kind of opportunity to think it over, sleep on it and sit down in front of it and respond, so thanks for humoring me. I realize these slides are imperfect. Um, but we'll move on. Uh, because –

Next Speaker: Rosa, um, uh, Becca asked me to do the candida auris update.

Next Speaker: Oh great.

Next Speaker: And that she said that she would, um, try to come for the COVID-19 update when she could. She got called away –

Next Speaker: Thank you.

Next Speaker: – for COVID-19 work, so. Um, this is Maureen Cassidy and um, the candida auris update is that, uh, candida auris infection colonization or isolation in a laboratory will become a reportable condition, um, in April, uh, April 6th, I believe is the exact date, and to give you a reminder, um, OHA can facilitate screening, uh, for candida auris on patients admitted to your facility and the screening is done at the regional antibiotic resistant lab network in Washington State, so we can also, um, facilitate that you, um, get set up to directly submit, um, screening samples to them. So you can contact the, um, OHA, um, HAI program, um, at any point, uh, and, um, my name is Maureen Cassidy if you want a specific contact. So, uh, screening is a good idea for patients coming into your facility if they've been hospitalized or in a skilled nursing, um, facility in areas of extensive transmission on both across the world and in the U.S. Um, out-of-country places include India, parts of Africa, Venezuela. And in the U.S., uh, New York which just had 455 cases confirmed, New Jersey's had, um, 155 cases confirmed, and Illinois 288, Florida 29 and southern California 21. So areas of C. auris transmission are on CDC's website, uh, cdc.gov fungal, uh, candida auris tracking, so that's all I have for candida auris.

Next Speaker: Thank you, Maureen. We have a few minutes more. Um, it sounds like we may potentially have Becca Pierce to give a COVID-19 update unless someone in the room would like to give one.

Next Speaker: ****

Next Speaker: I mean, at the, at the time, I think we're at 15 cases in Oregon, and they're, they're –

Next Speaker: We just got, we just got another –

Next Speaker: ****

Next Speaker: – **** acknowledge yet.

Next Speaker: And, anyway, I think the last published data I think say, uh, 15 cases in Oregon. Eight of them were in Washington County, uh, two were in Jackson County, one in Multnomah, one in Marion, one in Douglas, and one in Umatilla and one in Klamath. Uh, of those cases I think only three had a travel history. So the rest of them were acquired presumably within the State of Oregon and, uh, they are a mixture of people who were seriously ill, ill in the hospital with what looked like a viral pneumonia but no cause identified, and so we tested them for COVID-19 and these were a lot of the sporadic cases around the state. Um, and then several of them were found based on more mildly symptomatic people who were close contacts of the cases we already identified. Um, so, uh, let's see, what else can I say about the cases? Um, you know, we're currently testing, uh, people who are symptomatic after arrival from, uh, any of the five countries that CDC has designated as, um, uh, having high-level travel warnings, and those are, uh, China, Iran, Italy, Japan, South Korea, uh, and then we're also testing, as I said, this other group of people who, um, who would likely have viral pneumonia who are hospitalized and, uh, and who, um, uh, have no other cause identified for their illness. Um, lots of discussions going on of, uh, personal protective equipment. We've certainly made some, um, some, offered some guidance, uh, about what type of personal protective equipment we need, you need, and uh, basically, we're saying, uh, droplet precautions unless you're using, um, uh, unless you're, uh, administering an aerosol **** reading procedure, like, uh, intubation or, um, or a handful of others. A question came up to as whether or not you need to collect the nasopharyngeal specimen, uh, under conditions of aerosol, uh, of, uh, airborne precautions and we're, we're saying no if you don't have the, uh, mask, an N95 mask available for someone's who's been tested. Um, you can certainly test, uh, uh, with a face shield and, um, or eye protection I should say. Eye protection and a surgical mask. Uh, testing has been a big issue. Um, the state public health lab currently has the capacity to test about 80 specimens a day. Uh, we're testing one specimen per patient now in order to maximize the number of patients we can test and also because, uh, we weren't **** when we were testing two patients, two specimens from the same patient **** so that was reassuring. Uh, in order of preference, we're testing lower respiratory tract specimens, like, bronchoalveolar lavage fluid or endotracheal aspirate. Um, and then, uh, after that, or, or sputum. After that we would prefer a NP swab – nasopharyngeal swab – and then if all you've got, all you can give us is, is an oropharyngeal test that way. Um, but despite the fact that, uh, our testing is limited, uh, lots of other testing is coming online, so as of today, I know that the University of Washington Virology Lab, Lab Corp and Quest will all test, uh, for a price. Um, so they're available. And lots of possible **** labs are coming online with their own, **** tests. Uh, I don't think any are online yet, but they're all, they're all, a lot of them are working toward it. I know Providence is. I know Legacy is. Uh, I, I can't speak for anyone else. I, I don't know, Steve, if you have.

Next Speaker: Yeah, uh, we just got off a call with the health systems, um, yeah, Providence is looking at it. Kaiser is hoping to have a test but I think toward the end of the month. Uh, **** obviously involved in all that. Even OHSU has designated some lab space that we're looking at possibly **** developing and then bring a test on, and then one of the systems **** Legacy

actually mentioned that, uh, they're hoping that when Bio – oh and Biofair, **** Biofair develops a test, they'll get that one. Um, I don't know the status of the Biofair's version of this, though.

Next Speaker: And I could also tell you guys Abbott – because it's public knowledge – Abbott is also working on a rapid, uh, coronavirus test as well, so it was released yesterday.

Next Speaker: Oh, it's out?

Next Speaker: No, no, no, it was released in the news yesterday.

Next Speaker: Oh.

Next Speaker: Yeah –

Next Speaker: ****. That, that'd be nice to have a ****, yeah.

Next Speaker: It **** against the **** now platform, so molecular. It's all rapid molecular.

Next Speaker: Great, great, I didn't know that. Um, you know, with, with it popping up apparently, uh, disconnected from known cases in several counties throughout the State of Oregon –

Next Speaker: Mm hmm.

Next Speaker: – from Klamath to Umatilla to here – uh, we're so figuring that it's out there and our, our main focus is on, um, you know, we're not gonna be able to identify every case, follow them up aggressively, like we were trying to do with the first cases, identify all the contacts and quarantine them for 14 days et cetera, et cetera. So our, our focus is really move to, um, protecting the most vulnerable. Uh, I think the majority of the deaths – and, and almost all the deaths in the United States have been up in Washington State. I think a majority are in long-term care facility residence. So we're really trying aggressively to identify and then now, you know, take measures to stop the spread within long-term care facilities. Um, so and meanwhile, there, uh, influenza outbreaks continue in these facilities that are, uh, we're seeing lots of those. Any, anything else to add?

Next Speaker: Thank you so much, Paul. I think because I know folks are very interested in this topic, I'm sure that is, includes people in this room and on the line, um, because we have some dedicated time for questions and discussion at the end of this meeting, I think I'm gonna ask that everyone hold their questions and comments related to COVID-19 until that time. Um, and then, of course, if you have specific questions and comments, you're welcome to email them to me, Rosa, directly, and I can, uh, get them to folks who can answer them, okay? Um, with that being said, we're gonna move on to our next agenda item, um, evaluation and validation of NHSN dialysis event reporting. I want to remind you to unmute yourself before speaking. If you have a question –

Next Speaker: I'm gonna unmute everyone again.

Next Speaker: – if you have a question or a comment, um, please don't put it in the chat box. Please unmute your line and speak up so we can all hear you. If you're having a technical issue with the phone or the webinar, feel free to put it in the chat box and we'll address it, but we want to hear your questions and comments from your own voice over the line if possible, okay? Um, and then, uh, I also just want to give a huge thank you to the people who made our kind of special dialysis themed HIAC meeting possible. Um, that's Lisa and Steven, who are about to speak. And then we also have a panelist of three folks who are – or Steven who is maybe gonna speak – but is in the room. And we have a panelist of three people who work, um, in the dialysis setting who are going to speak to us as well. And then, I think several more dialysis folks on the line, so just a huge thank you for taking the time out to attend this meeting, which I know is probably not part of your regular schedule. So with that, I'll turn it over to Lisa.

Next Speaker: Thanks, Rosa. Hi, everyone, this is Lisa. Um, so I'm gonna kick off, um, the dialysis portion of this meeting, um, presenting on two, um, distinct but related projects, um, that we did related to NHSN's dialysis event reporting. Um, so first I'll be talking about **** evaluation that, um, Steve Rekak, um, who is our EIS officer, um, did, and I'll be presenting his slides on his behalf because he's been very busy with the COVID-19 response. Um, but he's also here if there's any questions that, um, come up or if I miss anything. Um, and then following that I'll be talking about our external data validation that we did, um, in relation to NHSN's dialysis events reporting. Okay. Um, so, um, for those who aren't familiar with dialysis event reporting, um, dialysis events are what we consider something that is indicative of a bloodstream infection that may be associated with dialysis and, um, in Oregon, we do have requirements for dialysis facilities to report these, um, to us. So why is it important for us to measure and track these infections? Um, you know, if people are receiving chemodialysis, um, we think that they already have reduced health status so it's important for us to track infections and use that data to monitor trends and facility performance and, um, look at, you know, how can we inform prevention efforts. Um, HAIs are deemed a winnable battle. Um, we estimate that there are 37,000, um, bloodstream infections, or BSIs, per year, um, in the United States, um, with a single case that can costs, um, up to $28,000.00. So that means there's over $1 billion in excess costs to say nothing of the additional patient suffering. And so, for us it's important to measure these, and I think even, even those who, um, are on the line, um, who are in the room, um, and not part of dialysis facilities are familiar with the National Healthcare Safety Network or NHSN system. Um, this is a system that we use, um, for, uh, facilities who report HAIs to us. And I'll be talking specifically about the, um, outpatient dialysis component today. Um, within that component there is the dialysis event module and that includes, uh, three types of dialysis events that are reported to us. Um, antimicrobial starts positive blood cultures and observations of **** or increased swelling at the vascular access site. Um, we also want to note that, um, with dialysis facilities, um, many of them use automated processes to actually batch and submit these data to NHSN. And so what Steve really learned from this process is there is around 70 percent of all data from dialysis facilities come to NHSN through these automated processes rather than through manual data entry, which is a little different than what I think hospital, hospitals do. Um so really the goal of this surveillance evaluation was to identify knowledge gaps and potential for reporting errors and find out ways that we can improve the system and use, use information to create training and development resources for, um, staff at the facility, facility or patient care

level. Um, so the way that the **** evaluation, um, works is that, um, CDC kinda has this guidance document where, um, you look at different attributes of a **** system, and see whether or not they meet the needs of stakeholders. Um, and so you can see here on this slide that there are some attributes that fully meet the needs, um, of stakeholders and some that partially meet the needs of stakeholders, and so overall it seems to be a good system that had problem areas that can be improved. And this is, I think, NHSN overall, but also specific to the dialysis event reporting portion. Um, for time purposes, I'm just gonna focus on those, um, attributes that partially meet the needs and talk about where there can be room for improvement. Um, so in regards to, uh, flexibility, um, the system updates regularly, but it can be difficult to make big changes. Um, so **** get updated regularly driven by internal and external feedback, um, there is some difficulties, um, getting access to the system. Essentially you need to have, uh, a grid card through the secure access management system or SAMS, um, and it takes quite a bit of time and paperwork. Um, so turnover, if there's turnover at the facilities that can be difficult to insure there's someone that always has access NHSN. And then the interface is tailored to the current setup so that if there are any changes to definitions or if any new, um, event types are added, then there does need to be, um, changes to the interface. Um, and that will also require additional training. And so, um, that's the thing about cruise ships in relation to COVID, but, um, just to note that making changes to the **** event module is like turning a cruise ship, it can be done, but it takes time and planning.

Next Speaker: **** battleship ****.

Next Speaker: ****. Um, okay, so the next attribute line to talk about that potentially meets the needs of, um, or partially meets the needs, um, of state coders is around data quality. Um, so there is knowledge gaps that can lead to systematic errors in reporting. Um, if, if an individual isn't comfortable with how to apply a definition for its dialysis events **** is unlikely to be reported appropriately. As well as we talk about the automated file. So this is, uh, CDA stands for clinical document architects, architecture files and that's the way that the, um, the system kind of batches and sends, um, data files to reports to NHSN. If there are errors in how the files are prepared, those same types of dialysis events will be routinely misreported. Um, additionally there is some data that we have in our system that merits further examination. So in 2017, um, we noted that 30 percent of facilities reported zero, um, zero dialysis events in three or more months, meaning that they had said they have no antimicrobial starts, no positive blood cultures and no pets, redness or swelling events and we question if that is true. Um, additionally, um, 48 percent of facilities, um, reported zero positive blood cultures collected outside of their facility. Um, and so just a data quality issue that, um, we, we need more examination on and I'll talk more about this in our validation work. Um, additionally in regard to Simplicity, um, there can be some issues in Simplicity. Um, there's some confusion among users, um, so some might be confused about how to apply definitions in the system, um, and how to count patients or denominator information, um, and in addition to confusion about definitions, um, if there is, um, automatic preparation of data that's submitted to NHSN, that essentially distances patient care staff from IT staff. And so there might be a disconnect between what patient, what patient care staff actually know about what's going on in the facility versus what is actually in NHSN. Uh, I forgot to do some kind of like transition, sorry.

Um, so sensitivity is, um, variable cross-event types. So apologies for the, the pictures on the slide that overlap, but I just want to show that, um, **** antimicrobial start rates are well understood, easy to document and easy to report. Um, **** any events at the **** access site is likely to be noticed, um, by patient care staff and documented in the chart notes, but, um, not a clear place to, uh, to ensure that that information gets into NHSN. And then reporting positive blood cultures from hospitalized patients is especially difficult. Um, there is quite a bit of a process there. The facility must contact the right person at the hospital to get them to send records, um, and then they need to ensure that they are reviewing that information and have that information get documented appropriately to be reported into NHSN. Um, and the last I actually wanted to touch on is, um, timeliness of the system. Um, I'm sure many of you familiar with NHSN know that, um, this is not a system that has real time data, um, it's not designated to maximize detection of active outbreaks. Um, data are typically collected on a monthly basis, um, but can be submitted even quarterly due to CMS deadlines. Um, we found that the median time between when **** this event occurred and when it was reported to NHSN was 35 days. Um, additionally obtaining information on positive blood cultures from hospitals, again as I mentioned, can take time 'cause it's a complex process. Um, and so I think that's what I want to say about the timely, timeliness, um, of the system. And then want to just conclude by saying that overall this is a good system that has problem areas that can be improved. Um, because of automated reporting that has improved some aspects of dialysis event surveillance, but it can create its own issues. Um, if there are any errors in the ways that the files are prepared, um, additionally if patient care staff aren't the ones familiar and reviewing the data, um, you know, they're not the, the experience they have at the facility may not be reflected in what is actually in NHSN. And then additionally retrieving information from providers, um, can be difficult, especially getting that hospital data. Um, there were not that many facilities who had a, a easy way like electronic access to hospital records to get that information. Um, but I think what I want to conclude with is that it's important to remember that all of this is in, is in service of protecting patients and healthcare personnel and promoting safety, quality and value in dialysis facilities. Um, so with that, I'm gonna jump right in to talk about our NHSN external data validation activities, um, which we did have in conjunction with, um, **** surveillance evaluation. Um, and I will go right into this.

So as I mentioned, um, we do require dialysis facilities to report, um, dialysis events in NHSN. This has been in place since 2013. At the time of, um, doing these projects there were 64 dialysis facilities in Oregon. We conduct internal validation on an annual basis and then we produce or publish facilities' specific data on our website. Um, what I'll say about this process is that, um, we don't get a lot of feedback from facilities on, um, you know, if they're, if they're data loos correct, um, if they had any changes and so we were wondering how, um, how many facilities or how often facilities were reviewing these reports that we were sending to them, um, to, to make sure their data were accurate. Um, additionally there were other states that said external data validation in dialysis facilities that noted some common themes of reporting discrepancies and we thought this may be the case here in Oregon as well. And so we decided to do external data validation. And **** those are **** to understand, um, what's going on with reporting with, um, surveillance practices and knowledge of facility staff with NHSN and then use that information to provide guidance to facilities and hopefully improve the quality of reporting. Um, we use a implementation guidance document developed by CVC to do external validation activities and so we also wanted to provide feedback to them about the process. Um,

so we did this back in, ****, last year 2018 to 2019. Um, we selected a subset of facilities in Oregon. Um, on this slide there is a map of Oregon, um, and the red circle is the Portland tri-county region. We limited our selection to this, to facilities within this region and we randomly selected until we had 14 facilities on board which is around a 20 percent sample. Um, our period of interest was the last six months of 2017. So for each fac, for each facility we asked them to provide us with five **** lists, um, for any patient in the study period who had received one or more, um, treatments, um, and then list two to four represent those three different dialysis events that are reported into NHSN. And so we would expect that anyone on those lists should also be in NHSN. Um, the last list was five, is anyone who was hospitalized. And we selected up to 30 patients per facility to review. Um, we also asked, um, facility staff to complete an online survey for us to assess their practices and knowledge on NHSN. Um, so we did, uh, site visits for all of the 14 facilities. It was a one-day visit. Um, we had a team of validators here so it was myself, um, Steve, and then our public health nurses Monica and Valerie. Um, we had two to three validators at each site visit. Um, I would say a chunk, a large chunk of our time was spent on reviewing those, um, patient records. Um, we had the ability at most of the sites to review both electronic as well as paper records. Um, and then we also reviewed that survey with staff, um, if they didn't complete the survey prior to us going out, we administered it onsite. And then we followed that at the end with an exit interview where we provided them a one-pager summary of our findings, um, and then we, um, sent them a longer summary report after our site visits. So what did we find from our validation activities?

So we reviewed 385 charts, um, and essentially with the exception of one facility, all of the facilities had at least one reporting discrepancy. So this table shows you a breakdown of, um, what we found in chart review versus what was reported, correctly reported to NHSN. Um, and then also reported is those events that we found, but weren't in NHSN and then over-reported is those events that were in NHSN and we did not find in chart review. And this is broken down by the three dialysis event types. Um, and so just taking a look at the table you can see that for antimicrobial start rates seems to be pretty good. We found two underreported events, but overall seems align. But I wanted to highlight that underreporting seems to be an issue with our positive blood cultures. Um, essentially half of the ones that we found weren't reported into NHSN. Um, and then a big portion too of the pus, redness and swelling events were also not reported into NHSN that we found. I do wanna highlight the positive blood cultures and this is, this information is included in our annual reports and what we found was the main reason for underreporting of events was the collection outside of facility. And so essentially, um, dialysis facilities needs to report, um, positive blood cultures that are collected like on the day of and day following hospital admission which requires them to ask hospitals for records, make sure they get those records, um, review the record for any positive blood culture that needs a definition and somehow make sure that that gets documented appropriately to get pulled and reported into NHSN. This is quite a complex process. Um, we were lucky that we had the ability to look at, um, hospital records electronically and, and finds a lot of these that were missed by the facilities. Um, and I think it kind of, I think we were able to **** that that's really a useful tool if they are able to get electronic access. Um, but again you know, there is a big proportion that, that were missed, um, in our data review. I also wanted to highlight some of the survey findings. Um, so in terms of their practices, um, most of them had completed NHSN training, but not all of them had access to NHSN. So only 71 percent even had a way to access NHSN and then, um, 64 percent did **** data entry. I think this, um, speaks to the use of automated processes as I

mentioned earlier. Um, additionally I think there was a good proportion of facilities we spoke with who were as familiar with, with the NHSN platform. Um, so only 14 percent ever generated any type of analysis report in NHSN and then less than half went to revise any kind of event record or data after that event had been reported. Um, so common themes that I wanted to, um, lead with is that the majority, so 93 percent of, um, validated facilities use automated imports for reporting. And when we look at that we can see that with this system it seems that IBM **** are captured accurately if a positive blood culture is collected at the facility then that seems to be captured accurately. It's the ones that are collected outside of the facility that seems to be, um, a issue. And then pus, redness and swelling events, um, there wasn't a standard field to document that information. Oftentimes we were reviewing nursing notes at the bedside to look for like terms like, uh, swelling or redness, um, and so there wasn't a clear field that the imports could pick up, um, to, to ensure that information gets, gets documented and reported into NHSN. Um, a lot of the facilities that we went to were part of large dialysis organizations, um, who have corporate and regional staff responsible for NHSN reporting. And I think this is really helpful for facility staff, um, because you know they wear multiple hats and they're responsible for a lot of things. So if they have the ability to have that reporting kind of taken off their shoulders, um, it allows them to focus more on patient care. Um, but I think you know, they're the mo, they're the ones who are most familiar with what types of infections or things their patients have, um, but that information with this system doesn't always get translated, um, accurately into NHSN for us to see. And then lastly again, the difficulty in accessing hospital records. Um, do you think that, you know, doing this work, um, and doing onsite visits and outreach, um, to our staff throughout the facilities as regional partners helps us better understand work flow processes, um, with the dialysis event reporting and also strengthens our relationships with these facilities. And we're working on an internal validation guidance document that is informed by these efforts and will be providing additional training on NHSN reporting and analysis. So I just want to thank those, those facilities that participated. If you are on the line, um, and, um, to, uh, our validation team here and to these other, um, jurisdictions. That is all.

Next Speaker: Thank you, Lisa. Uh, we can take maybe one minute for some questions. Uh, we're eating into our little break time, but I think that's probably okay. Uh, anyone on the line have any questions or comments for Lisa on this? And we'll be hearing more from her after the break as well, so.

Next Speaker: Yeah, sorry.

Next Speaker: Which is a good thing.

Next Speaker: You should be ****.

Next Speaker: And as a reminder, please unmute yourself before speaking.

Next Speaker: ****, so do you have a good sense of whether, um, the facilities will be able to access hospital records electronically? Will there be barriers or other plans for these facilities to try to get that **** access.

Next Speaker: Um, from what, what we've heard, **** the dialysis facilities who are gonna be presenting they have better insight. But we've heard that like there was a ESRD project that was trying to help facilities to get hospital ac, uh, hospital electronic access. Um, but it just seemed like there were just some challenges in general, um, to do this. So, yeah. I'll be interested to hear from dialysis facilities themselves.

Next Speaker: Hey Lisa, this is Jason with US **** Care. Do you foresee, um, the automated process that I know some of the companies are working towards, um, for reporting NHSN to resolve some of these, uh, discrepancies issues?

Next Speaker: I think they have the potential to resolve some of those, the issues. Um, but from what we've also heard is that it can be very challenging to change those types of you know, pro, like mec, mechanisms for reporting, um, like if, like we notice in some aspects where there could be a field that could get pulled and we were told well, at the corporate level because this is a national organization, it's really difficult to change those processes. So yes, I think it can be done, but it's something, I think it's a conversation that has to happen at a more national level or corporate level than just at our level. Yeah.

Next Speaker: Thank you Jason. We're gonna break for five minutes. So everyone please get back on the line in you know, 2:05, 2:06, 2:07 or something like that. And we will, uh, get back started. Thank you. Hey folks, we're getting started again. Um, so let me just reintroduce, uh, Lisa who's gonna be talking to us about our dialysis data here in Oregon by way of a little introduction to our panelist. As a reminder, please unmute yourself before speaking. If you have technical issues, use the chat box in the webinar. If you have a question or comment, unmute yourself and speak on the line. Thanks so much. Lisa, take it away.

Next Speaker: Thanks Rosa. Hi everyone, it's Lisa again. I promise I'll be quick. Um, so I'm excited to hear from our panelists, but wanted to kind of preface that with some, um, overview of our data here in Oregon, um, so would just want to note that I want, I want to show the picture of HAI's in Oregon dialysis facilities, um, summarize the dialysis infection prevention practices, um, from the NHSN survey, and then talk about some upcoming resources and events. Um, so this is our data from NHSN in regards to blood treatment infections in dialysis facilities from 2015 to 2018. Um, this is the dialysis DSI SIR or standardized infection ratio. Um, and with the SIR, um, uh, I guess a lower SIR is better. Um, it means fewer infections than predicted. Um, so you can see here from 2015 to 2018, um, we're seeing a decreasing trend in the SIR which is promising. Um, and that is lower than the national baseline as well as the most recent available national SIR which is in 2015 which is 0.8 to 1. I also wanna share some data about our **** antimicrobial start rates. So this data is expressed as antimicrobial starts, um, per 100 patient months and it looks like, um, from our data, at least from 2016 to 2018, it's pretty stable. Um, the **** pooled mean rate is the, essentially the pooled mean of all data that's in NHSN, um, for all facilities in, in the United States, um, which is 2.77, so pretty consistent with that old mean. Um, and then lastly, local access site infection rates. So local access site infections are defined as pus, uh, pus, redness or swelling events without an accompanying positive blood culture. And so these are again expressed as events per 100 patient months. Um, seeing a decrease, um, from 2015, um, but when we look at the pooled mean rates which is 0.47, slightly higher rate that, um, we're seeing here in Oregon.

I also kinda wanted to highlight some of the infection prevention, um, I think worker initiatives that facilities have said that they're doing based on their 2019 annual survey results. So 72 percent of our facilities say that they, they participate in infection prevention initiatives. Um, when we break down what those are and apologies if this is small on your slides, um, it is, uh, largely I think hand hygiene followed by patient education, catheter reduction. Um, there's also some initiatives with improving general infection control and cultures of safety. And then some also participated initiatives towards vaccination and antibiotic use. Um, additionally, **** notes that all the facilities responded that they do conduct hand hygiene staff audits. Um, almost all 97 percent said that they do observe staff, um, vascular access care and central venous catheter accessing practices, and all of them do conduct, um, staff competency assessments for these. Additionally, um, when asked if they follow the CC **** interventions to prevent blood **** infections, they all said yes, but there is a choice you can say yes, I do sometimes, or yes, I do always. Um, so 46 percent said yes, they do sometimes rather than always. Um, lastly, just want to wrap up by saying that as I mentioned we're developing the analysis internal validation guidance document. That's intended to assist, uh, facility staff in reviewing your, um, annual and **** data reports from us. Next month, um, we also will have, uh, lunch and learn webinar session that I'll be providing some training on to, um, provide guidance to our interested end users, um, on dialysis event reporting. I want to, uh, both review the reporting and analysis functions. Um, and I also want to announce that an interest in, um, if you are interested end user, you should have seen an email from them, I think yesterday or the day before, that they are also hosting, uh, an introduction at an advanced training webinar next month. Um, if you have any questions or, um, you can visit our website to learn more, um, to look at, um, this information and learn more about when one of the lunch and learn webinar, uh, will be. Um, so that is all for me.

Next Speaker: ****.

Next Speaker: Yes.

Next Speaker: Uh, I'm just curious if, do you, do you trust the SIR results based on the validation findings that you just demonstrated?

Next Speaker: Uh, –

Next Speaker: 'Cause I don't.

Next Speaker: – it's a, it's a great question. I, yeah, I think that's to say that one, the great results based on the validation. Um, –

Next Speaker: Right.

Next Speaker: – and I think there, you know, I think with the training and, and this information, essentially what I want to with the new reports is put in a quick check, or the data quality report that I can run it and **** says, you know, you have so many months since you, that you haven't reported a positive blood culture from a facili, from a outside facility and just be like is –

Next Speaker: Right.

Next Speaker: – this actually correct? And do a little bit more active outreach to the facilities to ensure that they're looking at their data and checking it. Yeah.

Next Speaker: And that, just to kind of shout out to internal validation as a great tool for that, you know, um, we've been working with our hospitals for the fa, past few years providing, you know, data, uh, for them to check before it gets published and providing them guidance for how to check and resolve data quality issues. What things might be a red flag and we flag those things on their behalf, and so we're, I think wanting to roll out a similar process for dialysis facilities as, which is what Lisa touched on in terms of that internal validation, um, document. So hopefully we'll be, um, kind of promoting some more active engagement from individual facilities with their data.

Next Speaker: Great.

Next Speaker: Any other thoughts or questions? And, and we're about to have, um, the next 30 minutes kind of devoted to more dialysis. So of course, Lisa will still be here if there are further questions that arise, um, during the panel.

Next Speaker: Have, have you thought about looking at all the **** claims data as a possible, uh, secondary source of these, uh, would they, would, would they have the kind of information you need to look at either, um, inter microbial starts or at, uh, blood stream infections?

Next Speaker: They, they might, I haven't looked at them yet. We don't have, we would need to get access to all of that data, because currently I can only see **** data, um, so. I think it's something that we couldn't score further, and I, I am not sure how feasible that is.

Next Speaker: I think it's more, would be more feasible for these kinds of very defined events than it is for the more complex NHNS measures.

Next Speaker: Mm hmm.

Next Speaker: Um, but I haven't seen the APAC data either that would inform us, so I don't know.

Next Speaker: Yeah, I'm just thinking you, you have different facilities involved right? You may have a, a dialysis is happening at one place and the blood culture may be happening at another place, and may, maybe APAC could pull those two things together, uh.

Next Speaker: It's possible. Yeah.

Next Speaker: Okay, thank you. So with that we will jump into our, um, panel which is focused on infection prevention in the dialysis setting. Again, I just want to give a huge thank you to our panelists for taking the time to join us today and talk about, this is so important. Uh, we really

wanna be expanding kind of the scope of this group beyond, you know, uh, we have done a lot of work with hospitals and that makes good sense, and we wanna be expanding our scope to allow facility types of all categories to join us and to have a voice, um, here. So I think we will be advancing slides on your behalf. So Karen, please take it away and, um, as you need your slides advanced, just say next slide and we'll do that on your behalf. And then, um, we'll just have our panelists talk, uh, we're having, Karen you'll have 10 minutes and then we'll have another 10-minute panelist and then we'll have 10 minutes for Q and A and discussions. So thank you so much Karen.

Next Speaker: So Karen are you there?

Next Speaker: Absolutely.

Next Speaker: Oh, there we go.

Next Speaker: Thank you.

Next Speaker: Okay, perfect.

Next Speaker: I hope you can hear me okay?

Next Speaker: Yes, we can hear you.

Next Speaker: Perfect. Thanks. Uh, thank you very much for the invitation and I'm so happy to be here, uh, with this group today. I, I, um, I'm here obviously here to talk a little bit about infection prevention and, and control in the dialysis setting. You can go to the next slide.

You know, in our, in our industry, we, we talk, um, so much about infection control. And, and, and I think what's really great about the conversations that we're having today for our very obvious reasons, um, is not for the, uh, the purpose of, of the presentations, is to talk a little bit more about the infection prevention piece. So infection control, I mean that's where we're vigilant, it, it, you know, is highlighted everyday all the time. In our facilities, you know, we're, we're doing everything possible to keep an infection that we already have from spreading. And when we start talking about in, infection prevention really it, and that, and that's why I'm so excited about the, the highlight of, of this organization and, and our, our meeting today is just, you know, what can we do to keep an infection from happening in the first place? So next slide.

We probably don't have to spend very much time on this, because of information that's already been presented. I, you know, the, the ESRD population there's a huge, not only human cost, but financial burden for infections and key point, uh, from, from the CDC data about the numbers of patients that are relying now on hemodialysis in particular, uh, uh, an added concern that many of those patients, 75,000 plus, likely are receiving that treatment through a central line. We know that central lines have a higher risk of infection, but, uh, **** or a graft. And then again with those, was presented earlier, those **** treatment infection, uh, I, I think it was over a billion dollars in financial costs alone that, that's human cost of those bloodstream infections. So next slide.

So if of this, what is this **** population, you know, why, why are the dialysis patients, uh, at higher risk for, for infection? You know there, there is **** catheters. There is the insertion of needles to access the bloodstream, and, and our patient population already has a weakened immune system. They, they have other **** conditions. They have a higher incidence of, of hospital stays and, and surgeries. Next slide.

And so what are some of the, the barriers for not only infection control, but infection prevention in dialysis facilities? So, **** in a, **** facility, in a kind of a common room, uh, there is difficulty in, in isolating patients, if when we know that they're, they're contagious. Uh, patient-to-patient contact is very common. Um, I really wanna highlight the third bullet point. You know, there's, in a treatment there are over 200 individuals **** staff, and, and of those, about 25 percent of those carry a risk of contamination. You know, it is, it's the line connections. It's the, the, the skin prep, the needle insertion, the, you know, catheter care. So, so it mainly in the procedure itself is, is the potential for, uh, infection. Next slide.

So if the past few days, if not several weeks, I've highlighted this for us is that is, it certainly does take a village to, to try to, uh, prevent infections and/or, uh, control infections that have already occurred. So let's look a little bit more specifically at, at this, uh, ESRD or this dialysis population. So I'll just talk in the next few slides about what this village would look like, maybe, maybe as a key point. So if you go to the next slide.

It, it **** concurrently, however, very importantly are staff engagements. You know, having, having our frontline people, you know, they realize and, uh, offer the reminders on a regular basis, uh, there's a devastating impact every time we have a bloodstream infection, or vascular abscess infection for our patients. No that, that line is, is their lifeline and, and so it has to be the mission of the team to optimize infection prevention strategies every day, all the time. Talk about all the different procedures in a single treatment, you know, more than a quarter of those procedures putting those patients at risk. Unfortunately, for us, in this, in our ESRD workflow the CDC has been very, very helpful and in developing specific recommendations for, for how we care for our patients, or those healthcare workers. Um, due to those increased with, of infection, um, keep, keep spreading our knowledge, the best demonstrated practices for infection prevention, and there are different methods of, of analyzing and following up on that you'll see in a couple of slides. And organize all of this in such a way that, that are, are caring staff, that are the, at the point of care, that they are engaged in reaching the goals of zero infections, and, and have their participation, frontline participation in those validation processes. Next slide.

Our, our patients, uh, colleagues in this, you know, having our, our, our patients and our, and our families engaged in, in infection prevention, it starts with, in, in showing that they, they have, uh, baseline knowledge. You know, they continue to build on that knowledge. Uh, we're, we're doing much more with, with our, our patients in, in terms of quality improvement efforts. We'll talk about that in, in just a minute. Um, however, that, that partnership, uh, is, is essential in, in helping us move forward in, in the infection prevention strategy. And next slide.

We have wonderful healthcare partners. You've spoken about some of them and, and, on the meeting today, you know, NHSN, partnering with NHSN and, and reporting, educating and

reporting, uh, or, or network, uh, alliance, partnership, uh, the Oregon Health Authority, the CDC, what are **** processes with, you know, this, it's it, it's a tremendous amount of support, uh, that we can provide at, at all levels in order to improve and, and, as you know, infection prevention strategies. Next slide.

So can do better? And I think that's, that's kind of the role in, in my recommendation and if we know we can always do better. So we have a very comprehensive for the assessment and improvement program for oversight, um, infections, in infection prevent strategies. As I mentioned before, uh, you know, partnering with, uh, with our patients more. We, we do have patient representation at our quality assessment and performance improvement meetings. Coming into help us understand, uh, from their perspective what, what we can do better. Uh, have them help us spread good information. They're always talking out there in the lobby anyway, or, you know, chair to chair. Let's make sure that we're, we're sharing, uh, information, uh, accurate information. Uh, data driven, uh, we have a lot of data, **** analysis, uh, types of activities and planning. We, we have that from internally, we have it from external, so there's no lack of information in helping us understand, uh, can we do better. And then turning all of the, what this is into a ****. And next slide. That will wrap my, my ****.

Next Speaker: Thank you so much Karen. If it's okay with everyone, I think we're gonna move directly into, um, our, uh, presentation from our colleagues at DaVita. Um, Kristen Van Alan and Nancy Welder, are you available on the line?

Next Speaker: Hey, Kristin's here, Nancy couldn't make it.

Next Speaker: Okay, no problem.

Next Speaker: Okay.

Next Speaker: ****. Right. All right. Thank you. I, so my name is Kristen Van Alan. I am an infection preventionist. I do not cover Oregon, um, but I, um, I work with infection prevention **** does, and I'll, um, give you more information on that. Can you go ahead to the next slide?

All right. So obviously a lot of this information is from Ken's presentation, but this is, um, part, this is from our desk where we train, um, our new, um, our teammates. So we just like to talk about the effect, um, that infections have on our patients and our role in it. So infections are the second leading cause of death in our patients, and the number one cause of hospitalization. Healthcare workers do transmit infection, of course, as you all know, and most of these infections are preventable. Next slide.

So a lot of you, um, have been in dialysis facilities and you understand just how complicated our environment is. So we obviously have a very communal environment where the patients are right next to each other. Um, there's prolonged blood exposure and our healthcare workers take care of multiple patients at once. So therefore, we have repeated multiple opportunities for person-to-person transmission, and this could be directly or indirectly. So we have contaminated devices we need to worry about, equipment and supplies, environmental surfaces, and of course the hands of our teammates and also the hands of our patients as well. Next slide.

All right, so what is an infection prevention? So we are, there are nine of us and, uh, Nancy is our director. And we are all, uh, registered nurses and we are all either Board Certified in Inspection Prevention and Control, or we're in the process of obtaining that. Um, we are, we, I cover, me personally, I cover a little over 300 clinics. Um, so we had managers of clinical services that work with the team directly, um, but I'm the first point in contact for all things infection related. Um, so I work with those managers of clinical services and then we work with the facilities as well. Um, so we're just kind of there for an extra hand to help with all things infection related. So I deal with, on a, on a daily basis, Hep B and Hep C, TB, COVA-19, um, and, um, you know, multiple things, bloodstream infections obviously, um, and local access infections. So I service the subject matter expert city clinic and we're all like, we're all divided up into nine different palmer groups, and, um, yours is referred to a **** Escobida, and Emmy Cullen is the infection prevention, so she couldn't be here today, so I am presenting her. All right, next slide.

All right, so the key components of our program are prevention, support, surveillance, and response. So it used to be that we sent, I would say 75 to 80 percent of our time in surveillance and we did all the NHSN reporting for our clinics, and we did it very manually. And the goals of the department has to be, shift more towards prevention, which we were able to accomplish, however, if you ask me what I've been doing this past 2 weeks, I'd say 100 percent it's been on COVA-19 response and support. Um, but it's nice that we have that flexibility to spend more time there, um, because we're not spending as much time on surveillance. So if you go to the next slide it covers surveillance a little bit more.

So the infection prevention are considered the subject matter experts on NHSN reporting. So we are, you know, very, very well trained on the 21-day rule, and a lot of this is so that the reporting is consistent across our 2000 facility, over 2000 facilities. So now a lot of it, um, we did a lot of that validation, um, so that our automated reporting that came from our servers was, um, accurate. And then what we did was we created, um, it's just gonna allow all that NHSN reporting to be automatic and we do quality data checks on it with the exception of external blood cultures, which was obviously a big topic that you guys just covered. So what we did was we developed an algorithm, and when I say we, of course I mean our data analysists, not the infection preventionists. But we assisted with the, um, the writing the rules, the business rules around it. Um, so we developed an algorithm, um, with automated notification sent to facilities when an opportunity to catch an external blood culture was found. So if we saw that an antibiotic was entered for a bloodstream infection, so we didn't have a record of positive blood cultures, there's an email that goes out automatically to my facility that started the antibiotic and will say hey, it looks like you might have had an external blood culture, can you please fax that to me? Um, so that is what I spend my time now, when I do surveillance, we spend a lot of our time capturing those external blood cultures and getting that information to try and make the external blood cultures more accurate. And of course, there is always gonna be room for improvement with that, and we, we have made great strides, um, in improving that over the past 3 years. So with the automation of surveillance that's a lot to shift our focus onto prevention. So go ahead to the next slide please.

All right, so what we have been doing is working on ways that we can drive improvement remotely. So obviously I, I cover, I have clinics in ten different states and any probably has at least, I think, four or five. So we can't obviously do a lot of in-center visits. Um, so what we did was we developed a tool for in-center dialysis and also for peritoneal dialysis to provide trends of data to guide our improvement efforts. So we have these dashboards, we worked with data analysts again to develop dashboards that, um, present the data to us in a way that we can focus on and see where our different, um, different areas that we need to focus on are. So I can, um, look at my rate by group and by division and by region. I can also look at my rate stratifies I asked **** as well. Um, I can look at organism data, and I, so I can look at grand positives, I can look grand negative, and I, I can dial everything into everything that way. We also have, um, we're working, we do have an antibiotic stewardship protocol and we do have a tab that would allow us to, um, review a lot of antibiotic starts, but, um, we haven't spent a lot of time on that yet, but it's something we're gonna be looking at and doing, um, and spending more time on then. So now that we, we have this data and what we do is we work with our MCS, the manager at clinical services team. They are our boots on the ground. They are our eyes and ears. So if I say hey, I noticed that this clinic has three bloodstream infections last month and they were all staph ****. I, I will communicate with that manager of clinical services and I'll communicate with the facility as well, and some things I can do is I can ask for their audit, um, from the last month. I could get on a call with them and ask for more details on the actual patient, um, information so we can discuss if there's something different we need to do with that patient. Um, I can ask my manager of clinical services to go in and do an audit themselves. Um, so it, it's just looking at the data allows me to understand where I need to focus my efforts remotely, and then involve my local team. Next slide please.

All right, so basically this is, this is all I have, um, because we, so Emmy, um, again is your infection preventionist and she, she's a little busy right now, um, helping some, uh, clinics out with the COVA-19 response. Um, but we're open, like we would love to work with you guys on anything that you need, um, any data you want. I've still got anything, um, any suggestions, we'd love if you guys go into clinics, like we partner with a lot of state health departments on I cards and they, they've, uh, met with us and, and said these are trends that we noticed in center. And we do, um, a lot of improvement projects that way. Is that, I need to make sure, is that my last one?

Next Speaker: Yes.

Next Speaker: Yeah, okay. They took, they took slides out. I didn't notice, but I have the other, um, thing I had, um, was, um, I talked about programs that we've tried to drive improvement, and, um, I was going to say we developed a lot of new programs. Um, we rolled out Clear Guard in 2019 to help out with BSI reduction, and then, uh, we have a grand negative process that we do, um, in response to the walboc, um, being a source of infection, we work with facilities when they have grand negative infections and we do environmental audits and, um, have been doing in-center, and we talk about the results over the phone. Um, and then we also do things like develop home lessons on, uh, specific infection control topics for education, and then we also developed a showering protocol for our CBC patients, and we work with the CDC to develop them. Sorry about that.

Next Speaker: No, problem. Thank you –

Next Speaker: And that's all I got.

Next Speaker: – so much Kristen. So –

Next Speaker: Sure.

Next Speaker: – Nancy and Kristen, we just, I mean sorry, Karen and Kristen, uh, thank you, you know, so much for preparing this for us and being willing to speak. Um, I know that we have several other folks on the line from dialysis studies and I'm hoping that we can just open it up for some questions and comments at this time. As a friendly reminder, once again, please unmute your line, um, by pressing the button that looks like a telephone receiver on your webinar control panel. It's around button. It has a picture of a telephone receiver in it. If you are muted it will be red, and it will have a line through the telephone receiver and if you are unmuted it should be green with no line. So go ahead and unmute yourself as needed and we do have plenty of time for, um, kind of discussion, questions on this topic and we may bleed over into other topics as well. So, um, I think we'll just open it up and, and don't, Lisa is still here as well, so don't be shy if there are questions on the data. Well I just want to start off by saying, you know, I really appreciate seeing the mention of, um, the patient and family advocacy work included in some of this. Um, that's an area where we have, um, you know, not had a great deal, as much, I guess I should say, um, of engagement as we would, would like to. So any, any kind of lessons learned on patient engagement or family at, patient and family advocacy in the dialysis setting specifically. Either for our presenters or for folks on the line from dialysis settings.

Next Speaker: Um, well this is Karen again, and I'll maybe just highlight, uh, uh, I mentioned on, on a lot of my slides. You know, this **** our efforts to, to engage our, uh, our patients and some of our process improvement efforts. And, you know, uh, a **** meeting is referred to **** meetings, uh, you know, once upon a time seemed to be sort of this, you know, big, I don't know, big secret meeting, you know, once a month all these people get together and get up, go in a room and close the door and, you know, have this meeting and, you know, whatever, whatever happened, happened. And it is really, um, just putting more visibility to it, inserting our, our patients' partners, you know, they, you know, they're there, they are, they are seeing our efforts, we're seeing their efforts, we wanna hear their voice. And it's been very helpful, was typically our, our process like how at the very beginning of a meeting, **** there was sometimes some, some, some sensitive information that is **** during the meeting, so we have to be very cautious about that. Um, but we do invite them to the beginning of the meeting and, and we talk about what our goals and our objectives are, and we, we ask them, you know, for their opinions and, and just, you know, how can we help and each other? Uh, it, it's been very, very, uh, it, of how you're walking into, have the time to put this in place, a little bit of trepidation. It's been sort of like not really know, you don't really know what to expect and it has been largely, largely very, very ****.

Next Speaker: Thank you for that. Um, are there specific, uh, initiatives you've been able to work on, um, with those patients and families? Or, uh, Kristen, have you folks had any, uh, kind of good experiences engaging your patients and families as well?

Next Speaker: Um, well I, we do have a specific for **** work on, um, empowering patients and change, I believe it's called Epic. Um, so I know we have the social workers involved in that, but I, I don't have personal experience of that, but I can say that we are currently developing patient education, um, to be, from our department specifically, because we want them to hear the message in several different ways, because we know, you know, that's how long it takes to sink in. Um, but, in, it's actually, um, been, uh, really fun to work on and we're really enjoying it. We're kind of making our, um, uh, new letter for them to be published quarterly, but I, I'm, I apologize, I cannot speak about the other DaVita programs that exist, but I do know there are several.

Next Speaker: No problem. It's just good to hear that there's that kind of push going on in general.

Next Speaker: Yeah.

Next Speaker: Uh, this is Mori from OHA. I have a, a question about, um, cultures. Um, when you, uh, collect cultures in your dialysis facility, do you send it to like a central lab that's associated with your, um, system? Or do you use local or regional laboratories?

Next Speaker: This is DaVita –

Next Speaker: Oh, go ahead.

Next Speaker: Oh, I'm sorry.

Next Speaker: – uh, DaVita –

Next Speaker: **** who's on the phone?

Next Speaker: – DaVita does have a central lab and we use, we utilize them, I would say 90 percent of the time, but we have certain areas where, um, we have Kaiser ****, their lab, um, so we'll send it to a regional lab when we have Kaiser facilities. And occasionally if it's a Saturday, we may, we may send it to a local lab as well, but mainly they're done through the DaVita labs.

Next Speaker: Okay. Um, –

Next Speaker: Yeah, and, and this is Karen, I'm, it would be very, very similar for us as well. Uh, primarily a central lab location and then the occasion where, um, when that's not feasible it, it might be local.

Next Speaker: Okay. And then if, if you, um, have an organism that's part of the reportable conditions of a state, are you reporting to the states?

Next Speaker: Yeah, the lab, the lab does those. Um, most of them, um, but yes, occasionally when we, when the facilities are **** reporting it, yes.

Next Speaker: Okay, but, uh, –

Next Speaker: **** – I'm sorry, yeah.

Next Speaker: – you're understanding is that your laboratories are reporting all these to us if we, if you have any? Is that right?

Next Speaker: Yeah. Yeah. They have the different reportables for all the states. Um, and same for us, it's, uh, for the, the required reporting status facilitated by the lab.

Next Speaker: Okay.

Next Speaker: However, I guess we, we, we might need to jump in depending on whatever the situation is.

Next Speaker: Okay. Thank you.

Next Speaker: Any, um, any other questions from folks on the line? Thoughts or comments? I think I had an additional question, which was the, you know, um, two of our panelists and our dialysis partners, was the kind of information that Lisa presented about, um, the communication of positive, but blood cultures from external labs or that were collected at different facilities than your own. Um, any reflections on that? Has that come up for you folks in your kind of surveillance work? Or infection prevention work?

Next Speaker: Yeah, so, so this is Karen and, and she was **** from, from my point of view and, and my support, um, of the facilities that I represent. Um, these, you know, it's really, it is the obtaining, uh, information from visits to, you know, the, the hospitals in that required timeframe for reporting. Uh, I think we're, I, I think, based on, um, the information that I have and the follow up that I have, is we've, we have pretty good mechanisms for that follow up. Uh, there is room for improvement. Uh, the external sources and, and the, the sharing of this, the timely sharing of this information, uh, can be challenging. Still working on this. It is a work in progress, and it's an active work in progress. Uh, more access to, more direct access to those records to, to improve the, the, beyond the, the timeline from obtaining that information.

Next Speaker: Thank you.

Next Speaker: I have a question. Uh, so this is Lisa. Uh, so **** is there's something else that I'm interested in is kind of a stewardship and Kristen and I think mentions that a bit on your slides. Um, I'm just curious though, you guys, um, following the CDC guidelines for **** limitation and outpatient settings, or is that a, do you guys have like **** stewardship of guidance **** more by the DaVita or Precidious **** entities?

Next Speaker: Um, we have a protocol that was developed by our chief medical officer, and, um, in consultation with, we have an infectious disease doctor that we, um, that can **** with us.

Next Speaker: Mm hmm.

Next Speaker: And they develop a protocol, um, you know, for recommended **** therapy, and then, um, you know, the steps to, to take based on the results. And, and we put it out there, um, and we have the report and we can see a lot of the actions, but the problem that we're having is I can't get the data fast enough to follow up on any disconnects. You know, where, where the doctor isn't prescribing how the protocol recommend. So that's gonna ****, but, um, you know, so we're trying to figure out how to make that more real time, but, um, it's been going really well, and you, you can see when, um, like I can see when things are being followed per the protocol, and, um, it's, it's gone really well, but we definitely, we need the, to find a way to make it more real time, and then a need to get the capacity to be able to follow up on it, is the trouble that we're having.

Next Speaker: Got it.

Next Speaker: So we also have a, an antibiotic stewardship, uh, protocol, um, developed by our Corporate Medical Advisory Board. Uh, if we're, we probably all have similar, uh, components of that and, and again, it's is, uh, the implementation, I think that's been in place for probably a lot of last year, and we're still getting information from the system, you know, from the data entries, uh, data analysis, but, uh, really it has, it has really, um, advanced or reduced, uh, the turnaround time from, you know, uh, culture to the, uh, action to a result to an action. So it, it, it's been very, very comfortable.

Next Speaker: Great. Thank you.

Next Speaker: Are there other questions in the room? Or on the line regarding our dialysis content today? Okay, well thank you so much to our excellent speakers. Um, your contributions are very much appreciated. Um, we hope you'll be joining future meetings and promoting our meeting with your network, so that we can have more dialysis folks at the table on a regular basis. Um, with that being said, uh, does anyone on the line or in the room have any suggestions of topics for future meetings or reports from our program? Okay. We have some time for public comment or any questions that have arisen throughout the course of this meeting.

Next Speaker: I did have a question early into the COVID, uh, –

Next Speaker: Yeah, is this Jason?

Next Speaker: – presentation earlier. I'm sorry, this is Jesse.

Next Speaker: Jesse. Hi Jesse. Okay, um, –

Next Speaker: Hi.

Next Speaker: – what we can do is we'll, you know, we, some, we may be able to answer your questions in the room, but, uh, more than likely what we will be doing is taking down your question and kind of triaging it to the right person. So go for it.

Next Speaker: Okay, um, so it was mentioned earlier the recommendation from RJ was to treat it as job **** and then **** procedure. Um, my question is mostly related to the varying, the variances, the WHO or something similar. CDB says something similar, but then also it says that if, uh, facility has ****, to, to you treating, uh, known or suspected COVA-19 patient, uh, with a respirator and airborne ****. The question is mostly related to what is the best guidance required at facilities when there seems to be quite a bit of, um, variances of, obviously a lot of it is, is related to **** E, because they do get a lot of facilities there, **** saying that they have and a PBE to provide extra precautions, but should we be telling them that when they do have, and a **** to follow the CDC recommendation, to use a respirator, and everyone precautions or what?

Next Speaker: Uh, Jesse, it's a good question. I know that there's a lot of facilities that are ha, well first let me offer, is there anyone in the room who'd like to **** this other than me? Okay. Um, so, you know, I think it's a good question. I think you all make a good point, which is that, uh, guidance is slightly different between WHS, EEC in our state. Um, that is in part because they have slightly different approaches, but it's also in part because it takes quite a while to, you know, update materials in an everchanging situation. Um, I would say to you, you should continue to follow the OHA recommendations. Um, especially in light of the fact that there are limited supplies of PPE and many facilities are experiencing shortages and difficulties getting the supplies that they need, as well as local public health departments. But what I can do is forward your question along to, you know, our person who is on call today. Is that something you would like me to do?

Next Speaker: No, that would be very kind of eating, drinking, sleeping, living ****, so all of the using variances are kind of confusing when at first they're giving, you know. I read an email today with questions and didn't really answer.

Next Speaker: Jesse, I think we can all relate to your pain.

Next Speaker: Jen, this is Jen. I just want make sure, um, that I was gonna note that there are, um, public health calls, uh, that might, or they should be able to answer that question, but on the public health call today, um, we were supportive of the enhanced droplet contact with eye protection for non-aerosol generating procedures with patients in Oregon. Uh, so, so following WHO, following Washington, but we do recognize that there is some **** challenges with exact interpretation with CEC, so.

Next Speaker: Thank you Jen.

Next Speaker: **** where you're **** the area.

Next Speaker: Yeah, that is super helpful. Thank you so much Jen. Uh, I know that, you know, one of the things that sometimes we miss when we are wearing droplet precautions is eye

protection, and that's being really emphasized as an important element of PPE, uh, the use of goggles or a face shield, um, can go a long way. Uh, it is possible to become infected through, I think any mucus membrane, or that's our, that's our working assumption right now.

Next Speaker: Rosa, yeah, thanks for pointing that out, that's why we're calling it special droplet contact, and it's important, so really the most important thing is to mask the patient, um, with respiratory symptoms. I can't emphasize that enough, because you're really halting the spread of those droplets, uh, before they get out.

Next Speaker: Mm hmm.

Next Speaker: Exactly.

Next Speaker: And can't ****.

Next Speaker: Yes.

Next Speaker: And all your, you, **** typing, et cetera.

Next Speaker: Thank you.

Next Speaker: Jesse, does that resolve your question? Or should I also forward it along?

Next Speaker: This, this is Jen, there's probably more specific for dialysis units I think that we need to address. Those are just some general **** that, if you don't, I think it would be great to have **** weigh in on that.

Next Speaker: Other questions and comments from folks on the line? Okay. Well I think we'll give everyone a couple of minutes back. Uh, before I move to adjourn, um, actually let me say this. Uh, was there anyone on the line you did not have the opportunity to say their name during rollcall? Okay. Well, um, before we move to adjourn, I do want to just reiterate that we have people on call to assi – oh.

Next Speaker: Oh.

Next Speaker: Hold on.

Next Speaker: We do have people on call to assist you with questions regarding reportable disease, and Corona virus questions as well. Uh, we are getting a large volume of calls from our providers, or the health departments and healthcare facilities. Um, we are here to answer your questions and help you deal with this, uh, stressful situation. So I would just, if you do have questions please call the on-call epidemiologist at 971-673-1111. I wouldn't normally promote that on the line, but I think the circumstance is, uh, suggest it might be useful to folks. So 971-673-1111 is our on-call, for our on-call epidemiologist. You'll need to select that option. Um, and, you know, we will assist you as much as possible.

Next Speaker: Please stop messing with Josh's thing.

Next Speaker: Is, okay, with that, I'm gonna, uh, move –

Next Speaker: Wait, okay, Josh, Josh if you hear us, you can mute, unmute yourself now. There we go. Hi Josh.

Next Speaker: Yeah, sorry, sorry I was having trouble unmuting. I had a quick question and a follow up on the N95 mask. Um, with the CBC and the FDA giving **** certain industrial A95 masks to be used? Uh, has anyone heard if OSHA is gonna waive the fit test requirement? **** because they're busy with all of this ****?

Next Speaker: Uh, that's sounds very unlikely to me. Um, just, I, but I don't know the answer to that question. I don't think we can, um, we can't, uh, sort of project on behalf of any other agency, um, so I wouldn't be able to say what OSHA is planning to do. Although I would really caution against, and I think we are cautioning against the use of a N95 mask without being fit tested. Since, um, fit testing a N95 mask is really the only way to ensure that they're working properly, and an improperly or unfit tested person wearing a N95 mask may have a sense of security from that piece of PPE that isn't actually going to serve them, and I would also say that, um, you know, we need to make sure, of course we're all talking about the healthcare setting now, but I think, um, waiving that requirement might encourage sort of more people in the community to be wearing those masks and purchasing those masks. So we wanna be keeping supplies available for those who need them most. But it's possible, anything is possible. Again, I can't, uh, sort of project on behalf of another agency though.

Next Speaker: Um, really –

Next Speaker: ****.

Next Speaker: – and **** Oregon Chapter for the OSHA thinks there is a state level that might be, um, –

Next Speaker: Jen, that's a great idea. Josh, you might want to, uh, take a look there.

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: I think there's an Oregon –

Next Speaker: We can follow up via email too.

Next Speaker: Okay.

Next Speaker: We do not see any issues with the webinar or any questions now.

Next Speaker: Okay. Great. Well then, I will move to adjourn. Does someone want to second my motion?

Next Speaker: Well I think the second –

Next Speaker: **** second.

Next Speaker: – ****.

Next Speaker: And I second.

Next Speaker: ****.

Next Speaker: **** motion.

Next Speaker: This is one day I can second the motion to Jen.

Next Speaker: All right. Thank you, with that we'll adjourn. Um, we very much hope to be able to meet in person. I just wanna say that I think we have almost 40 people, um, in the room and on the phone for this meeting, so I really just wanna kind of give you kudos for making the time for this. Um, thank you for your continued interest in the topics that we're covering during these meetings. Please contact me directly if you have thoughts for our next meeting and it is my sincere hope that we'll have, um, our wonderful Chair, Jen Busser, back to facilitate this meeting when we next meet, um, in June. Thank you so much everyone.