Healthcare-Associated Infections Advisory Committee
September 23, 2015

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Speaker: **** Kaiser **** control.

Next Speaker: And **** from ****.

Next Speaker: And who's on the phone?

Next Speaker: Hi, this is Kathy Goodes from ****. I'm filling in for Laurie Murray-Snyder.

Next Speaker: Okay.

Next Speaker: Georgia Harris, Oregon Nurse's Association.

Next Speaker: Great. Anybody else? Okay, well, let's get started then with the approval of, uh, the meeting from last month, or from, um, June, which I was unable to attend, so has everybody had a chance to review the, um, the minutes? Okay, does anybody have any changes or suggestions? Move to approve.

Next Speaker: So moved.

Next Speaker: Okay, second?

Next Speaker: Second.

Next Speaker: Okay, minutes have been approved. Moving on with the agenda. Let's go to OAR updates, Monika.

Next Speaker: Okay, we don't have as many updates as we have reminders. Um, beginning this fall in October is the first year that we're going to have dialysis facilities report healthcare worker influenza vaccination data. Since they're already on NHSN, I'm hoping it'll be a smooth, effortless reporting unlike the ASCs. We had a really hard time getting them on NHSN. There are still quite a few who aren't. It's not so much getting them on NHSN as it is getting them on HS, NHSN and then conferring rights to us, so it's, it's a double edged – it takes two steps. The second item and I was really hoping Daniel was going to be here was, you know, we like to mirror CMS required reporting and there's a new item that's coming up for long term, uh, acute care hospitals starting January of 2016 for VAEs, ventilator associated events. Obviously, we would like to change our OARs to match that, but the problem is in the State of Oregon the definition of an L-tach it falls under our definition for hospital, so I, we tried to add VAE

reporting under the hospital section of reporting requirements for the State of Oregon. Then in essence we're asking all acute hospitals to report it when actually we only want to match CMS' requirement for L-tach, so I was hoping Dana could help us with the definition. Anyone else with input – go ahead Mary.

Next Speaker: Can I just also, in our rules we treat L-tachs under our hospital rules, but CMS has licensed them as an L-tach under different regulations.

Next Speaker: Yes.

Next Speaker: Correct.

Next Speaker: Okay, yes, so it makes it confusing for us to kind of know what to do because we'd really like to see that data. I think it would be very interesting, but how do we add the rule? Can we change our rules to simply pull them out from hospital and say they fall under L-tachs by CMS definitions because that'd be the other way to change the rule.

Next Speaker: Yeah, the problem is is that it's, L-tachs are defined as hospitals under law.

Next Speaker: Yeah, ****.

Next Speaker: So we can't change the law, the statute itself.

Next Speaker: The statute, I think that might be hard.

Next Speaker: Yeah.

Next Speaker: **** I guess.

Next Speaker: So I'll contact Dana and the attorney and see what we can do because we'd really, you know, Janet also, so we'd like to be able to see that data, but any input would be appreciated.

Next Speaker: How many L-tachs are in the state?

Next Speaker: One. We don't know.

Next Speaker: Yeah, so one.

Next Speaker: That was going to be my question, so what's the big, um, urgency around –

Next Speaker: There isn't urgency, it's just, you know, we can measure it against others across the country and, you know, data is always good data.

Next Speaker: Right, and then also the legislative session it's good to have these lined up by fall, you know, early winter because people are going to legislative session because they want to make changes.

Next Speaker: Right, right.

Next Speaker: So I think that's why we're asking the question now.

Next Speaker: As far as changing the rules. Yeah.

Next Speaker: We actually wouldn't even see that data until 2017 because of the way we report, but, um, it's kind of nice to address it earlier than later, we've done in the past.

Next Speaker: This may be way out of left field, but since there's only one do you think that you could get them voluntarily to ****.

Next Speaker: That's a good question.

Next Speaker: Yeah, I think that's possible. I think that's probably actually my, that's probably the most realistic option, uh, because I can't see us changing that in statute or something like that.

Next Speaker: So their, their CEO Dave Tupper is very flexible, very amenable, very reachable. I mean I think he, he'd be –

Next Speaker: The thing is it's going to be, it's going to be reported anyways too, so.

Next Speaker: Yeah, it's a matter of us accessing it.

Next Speaker: Okay.

Next Speaker: Okay, that's a great idea. I will talk to them.

Next Speaker: Okay, anything else Monika at this point?

Next Speaker: No, thank you.

Next Speaker: **** okay, hey, the review of the 2014 long awaited HAI and **** reports.

Next Speaker: All right, um, so I thought what I'd do today is, is just go through, um, some highlights from the reports, um, give you an update on the status and kind of let you know what's, what's going on. Um, we did put together two reports, the provider and consumer format, as we've discussed in this meeting. Uh, the last two meetings here kind of how that was going to work out, so we'll, we'll show you how that ended up. Um, and then I thought as a group we could go through aggregate data trends in Oregon and also review a facility specific table because the report is not going to be released until next week. We will not share any facility specific data, but we'll go through how the tables are set up and I think, you know, everybody here at this meeting is, um, has had a role in, in, you know, either determining what type of infections are to be reported or how we report out the data and so I think, um, you know, in your respective communities you're sort of ambassadors to those people who might be using the

report, so my, one of the goals in this presentation is to kind of get you familiar with how the data are presented and, uh, perhaps, you know, discuss how people might use the data. Um, and then we'll have, um, some, uh, discussion about how to use this data moving forward, making it more actionable, what do we do based on what we found, and, uh, hopefully that will sort of, um, segue nicely into the presentation by **** Mary. We're going to talk about some initiatives that have been recently funded that involves some resources to really, uh, reach out to facilities and help build infrastructure and it would be great if we could use this data to help drive, uh, how we go about doing that. Um, so the revised release date is Monday, uh, 28th, so, you know, we had hoped we'd have nice pretty reports printed out for everybody here. Um, we don't have those, but we will mail reports, printed copies to everybody on the committee and we'll have sort of a limited number, so if you know of any stakeholders who really would prefer to have a printed copy, let us know and we can, we can make sure they get that. Uh, we will be printing, uh, posting both reports in PDF format on our web site. Um, there are a couple of reasons for the delay in the report. Um, I will take responsibility mainly it's my first year doing it and I think verification of the data with each facilities, uh, took me a lot longer than expected, so it's, that's one factor. Um, we have a slightly revised like approval process at OHA with **** what's going on in our, with our administration, so that, that caused a slight delay, and then another piece, another decision that we made as we kind of delayed the release of the 2014 data was we had sort of had this flu vaccination report that comes out in the fall, October, November, I think last year it came out, so, um, because Monika was able to get all of the ASC data in, uh, a couple weeks ago we said, you know what, let's just delay this report another 2 weeks and incorporate the flu vacs data, so the data that comes out will be a combined 2014 HAI report and 2014/15 healthcare influenza vaccination report, so it's all in there.

Next Speaker: Um, if you remember the flu vac data used to be a year behind in the report. Now, it's actually up to date with the rest of the numbers, which is really nice.

Next Speaker: That's right. It was like a repeat of –

Next Speaker: Yeah.

Next Speaker: – the data that you had already published and now it's all kind of new. Um, so the full provider report is, um, it's still long. I mean one of our goals was to make this report shorter, but, um, you know, I think with, with getting all of the facility specific data in there with the information that we wanted it ended up being long, um, it's 87 pages. It's in landscape orientation and that's to accommodate sort of the additional metrics link for the, the tables we have. They're sort of wide. Um, so, again, this, this report is intended for providers, uh, people who have, are savvy about the data, who understand the metrics, and really kind of want to dig in deep at each, uh, at the facility level. Um, and the large report also contains information on trends over time, so for all Oregon we'll look at from the first year that an infection was reportable in Oregon through 2014. Um, so that's all in the big reports. Um, we also, uh, have a consumer report and I'll kind of show you how that's set up too, so that's, that looks a little bit, it's, it's more, uh, it's in portrait format, the tables are narrower, um, it's only 38 pages total, it's very light on statistics. In fact, we don't, we, we don't even mention SIR, except for just in a, you know, an appendix and we reference heavily that people can go to this report if they want more statistics. Um, the only information that's in this report that's not in the full report is, um, for

each infection we have a little box that says what can, what can patients and families do to help prevent infections. They're designed for the consumers, some tips that are pulled mostly from CDC, uh, web site resources and we don't include any of the trends over time in that, so, um, and then there's the executive summary, which you all have helped, uh, you've provided input on and, um, that's also included in your, uh, meeting, um, materials and that will be in both versions of the report. So speaking of the executive summary, it's, I mean it's a little blurry here, but you guys sort of have a printed out version, um, in your, in your meeting materials. This is how it ended up. It still is probably, it, it still looks a little bit busy, um, but this is after a lot of paring down and adding in the leading, uh, information. Um, and so you can see for each of the ten infections that acute care facilities or hospitals were required to report, uh, we basically present two metrics. One, how they performed relative to the U.S. because I know that was something you guys were saying here that, uh, like Oregon stakeholders want to know how they're doing compared to the nation, so the most recent national, uh, data published, uh, by CDC that had the right information for us to compare statistically, so we needed an SI, we needed like the raw data to do a statistical comparison and that was 2013, so basically the top line for each of the infections, like performs statistically better or statistically equal to the U.S. that's comparing Oregon in 14 with the U.S. in 13. Um, and the second metric is whether or not Oregon as a state exceeded the HHS, um, reduction target, so HHS in 2009 set these 5-year targets for like 50 percent reduction by 2013 and so that 50 percent reduction basically means an SIR of point 5, so that, you know, we gave Oregon a check if as, uh, collectively the hospitals were under point 5 or an X if they didn't meet the target. Um, and so all of this combined **** take away message that, um, that Oregon met national reduction targets for bloodstream infections ****, uh, for MRSA bloodstream infections, uh, for, um, uh, coronary artery bypass graft surgeries, and, um, and for knee replacement surgeries, but for, um, you know, for a C. Diff infections, for catheter associated urinary tract infections, and for, uh, colon, abdominal, hysterectomy, and hip replacement surgeries Oregon did not meet, um, meet the HHS target. Um, so we can kind of talk about how we want to potentially use this data. I mean I think it kind of sums up how we're doing, you know, on each infection. Um, the other piece of information that's in this table that's not elsewhere in the report is like the total number of infections, um, or laboratory identified events for like C. Diff and MRSA, and I think, um, you know, I think particular, in particular some of our public heath stakeholders were interested in just seeing like the raw number of infections in the state kind of, so when we're prioritizing where we want to put resources. You know, we can see how that compares to salmonella for example and stuff like that, so, um, so that's that, and this table that accompanies the executive summary is basically presenting, um, a little bit more, uh, granular detail on the information that's on that front page, so for each infection there's a row that kind of tells you, you know, what the baseline year was for, for benchmarking, uh, what the HHS target was, how many hospitals out of our 61 hospitals were reporting, uh, whether they met the target. And, also, one thing I wanted to note here is that we split CLABSI into ICUs and NICUs here, um, which we didn't on the first page and that is significant because, um, Oregon as a whole performed better in the adult ICUs as opposed to in the NICUs. Um, any questions or thoughts on the executive summary, um.

Next Speaker: Um, I've got a question.

Next Speaker: Yeah.

Next Speaker: So I was curious did you have any sense at all and probably not, but why some of these things are not making their targets?

Next Speaker: Um, that's a good question. Okay, so I think for, um, for CLABSI and we'll kind of see this when we go through the, through all of the, you know, each infection and the summary over, you know, the summaries for trends over time. I mean you can kind of see that CLABSI has been reportable since 2009 and it just goes down each year and that's sort of the national success story that Oregon followed. Um, similarly with knee replacements where we met the target that, that's been reportable for longer than some of the other infections, so it could be, it could be an artifact. You know, we're actually measuring and we're thinking about it, um, but I'm not sure. I mean one of the things we'll also see, you can see that a lot of even where we didn't meet the targets that, for a lot of these infections were statistically equal to the nation, so I think in some cases we're following the nation in terms of these are difficult infections to address and we haven't figured out how to, how best to do it yet. I don't know, do others have thoughts about this, you guys who are out in the field and ****.

Next Speaker: I have a question.

Next Speaker: Yeah.

Next Speaker: Um, does the C. Diff lab I.D. event include culture for the organisms separate from toxin positive? Do you all know?

Next Speaker: No it's an **** lab I.D. whether it's –

Next Speaker: Culture or positive.

Next Speaker: – nobody does.

Next Speaker: One article that came out in Jama last week was doctors asking other doctors to stop ordering just a culture and go for the toxin only that they're announcing 20 to 50 percent of patients and in my field residents might be colonized and if the culture is done and if that's the lab I.D. event, we know there are regional differences and maybe, maybe the northwest has a higher incidence of colonization and subsequent culture positives which trigger that we can't meet the goal. A thought.

Next Speaker: What do nursing homes do because in hospitals we generally do BCRs and assets?

Next Speaker: It's, it is mixed, some will order cultures, more appropriately they should be ordering the toxin or all ask mail with this Jama article.

Next Speaker: I think we just got nursing home survey results about CBI practices, right? So maybe they can analyze the results of this year's survey, they can –

Next Speaker: Yeah.

Next Speaker: – cultures very, cultures rare now?

Next Speaker: Very rare ****.

Next Speaker: But it's something to consider. I think there's also, uh most nursing homes and hospitals do follow that they, the lab will not test the stool if it's formed. So you should be looking in the diarrheal stool, not a formed stool. That would be another –

Next Speaker: Variable.

Next Speaker: – another issue, of you know, if they're asymptomatic ****.

Next Speaker: We do a lot of testing obviously in the hospitals now because we want to identify it as soon as the patient has a liquid stool or one that conforms to the shape of the container, which is our criteria. And we do pick up a lot of colonized patients **** and the like, a lot of Miralax is given and stools are collected the next day. Which will pick up more of a colonized patient?

Next Speaker: Will that go into the lab I.D. Do you know?

Next Speaker: Yes it will.

Next Speaker: And regional differences between higher colonized populations may account for – I'm just throwing that at the table.

Next Speaker: Yeah. No I think it's really important to consider, especially since these laboratory identified case definitions are really geared toward surveillance rather than sort of you know, truth in the clinical sense and so I think all of these things are really important and um, to that end, you're right, they are included in the facility specific SIRs. The NHSN, when you calculate the SIR they do control for type of test used at the facilities as well as admission prevalence. So a hospital will not be, you know, it will be given a little bit of a, not a pass but the SIR will be adjusted downwards for highly prevalent communities.

Next Speaker: Okay.

Next Speaker: Now that doesn't really, that doesn't get to like how colonized population is but it's just in terms of admission prevalence which I assume would be a little bit higher in a highly colonized population.

Next Speaker: So that's their attempt to risk adjust?

Next Speaker: That's there attempt to risk adjust. So that's in part of the equation that actually generates that predicted value that is then compared to the observed.

Next Speaker: Yes, it is an interesting organism to compare and to measure.

Next Speaker: Yeah, and it's real interesting on this one and this is where, I don't know, you might get questions and people are you know, you're sharing this report with people about you know, why so we don't meet the HHS reduction target for C. Diff which is like the fourth row. But we are statistically better than the nation and why is that. And one of the reasons is that the confidence intervals are really tight because, for example, in Oregon we have all the hospitals that are reporting the denominator is all patient days excluding NICUs and well-baby units. So, you have a lot of data for that reason and you have a pretty tight confidence interval so it's going to be easier to make statements like, didn't quite meet the target and that's significant but did, you know, was better than the nation. So, that's sort of another thing to consider, especially when we're talking about data coming out of Oregon where we're a smaller state with a lot smaller hospitals.

Next Speaker: But you know, down 4 percent, at least it's in the right direction.

Next Speaker: Yes! There is, exactly.

Next Speaker: That's great.

Next Speaker: So does that mean that there is a 4 percent reduction in total number of lab identified CDI in the state?

Next Speaker: That means that there's 4 percent reduction in the SIR. So in fact when we look at rates, the rates increase slightly which is going to be an interesting methoding because part of one of our OHA metrics is looking at rates over time.

Next Speaker: Right.

Next Speaker: And you know, with this risk adjustment, there, when you're so close when you have very small differences from year to year, it's possible that we're up on one and down on the other. And that is in fact what happened with their team.

Next Speaker: Wasn't there a 10 percent increase in CDI from 2012 and 2013? Is that it?

Next Speaker: It was less than 10 percent, yeah.

Next Speaker: There was an increase. ****

Next Speaker: We have the SIR. That'll be on like another slide but yeah, we –

Next Speaker: But you know, based on what you just said Kate and Mary too, if we're looking, surveillance – if we're looking for it or we're testing more.

Next Speaker: Yes we are.

Next Speaker: So, it's just like when you're reporting ****. You expect the number of reports to go up. So, um, you know, I think you just need to provide appropriate context.

Next Speaker: Context, yeah.

Next Speaker: We do have a fair number of facilities though that have really spent a lot of time and effort trying to prevent and changing their methodologies. In fact some I think are culturing earlier, especially like in an emergency department.

Next Speaker: Oh really.

Next Speaker: Yeah. Just to again, try and not ****

Next Speaker: It's a quality measure, so obviously we want to identify it. We even have pop-ups if somebody documents a liquid stool in the media alert, there is a screening for the ED diarrheal **** 24 hours **** boom, they're in isolation and they're getting a stool specimen if they had diarrhea. So we're trying to identify it earlier to reduce the risk of transmission in the house. But we're also finding more whether it's colonization versus infection.

Next Speaker: That's sort of an, we're finding that in our CDI validation as well. Going out to facilities there are a lot of um, tests run out of the ED but the flip side of that is that having more of those tests mean that if a patient has CDI present on admission then the hospital will not be counted as having a hospital onset. Which is where all these statistics are based on, hospital onsets? So you're also that, that enhanced screening should actually help also enhance like the validity of what we're looking at. Um, so this is sort of, you're not expected to read this but this is just kind of to orient you to the new report. So with each report, with each infection we have sort of a summary page that has a brief summary of the HIA. Some text that actually describes organs' performance and what their P values and it talks about the HHS metrics and all of that. And then the trends over time. So this is, I apologize, this seems a little bit blurry, but, so this is CLABSI and we'll look at the actual slide that's not blurry. And then so we report, we show this report, share **** organs and do 2014. For each one we have national benchmark so there's three, see there's like a purple line, a green line and then an orange line. So we look at the national baseline which SIR is always 1 for that national baseline year and that's sort of marked in these graphs. The 2013 national SIR which you can see like for CLABSI was way low, you know, it's a .5, just below .5 and then the HHS reduction target. So that's, and then, there's a little box, what can providers do to prevent HAI. So this is, we'll kind of go through for each infection, the trends over time. So CLABSI, this is the same graph that we just saw but a little bit bigger and again, just kind of following the success story of the nation but I think Oregon can say, you know, even, we actually look even better than the nation that's come down, it's reduced CLABSI SIRs by 50 percent and the nation has met the HHS target and we've actually even reduced by 50 percent from that target, so, that's a big success story.

Next Speaker: I've got a question. Do you know if, we did the CLABSI validation for last year, do you know if they ended up actually correcting their data?

Next Speaker: To my knowledge they corrected it. I don't know if Jen has a better sense.

Next Speaker: Jen, do you have a sense on that?

Next Speaker: Corrected which?

Next Speaker: The CLABSI data.

Next Speaker: Because what we saw, you know, in 2009 was that it went out fairly dramatically after we did our validation and so I was just curious, like if you had a sense of **** incorporate that and that's great if it does.

Next Speaker: ****

Next Speaker: Yeah, I mean this poll is –

Next Speaker: Corrected, that's what that says.

Next Speaker: – yeah.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: It's this summer that we pulled it again so hopefully.

Next Speaker: They were directed to make those corrections.

Next Speaker: Yes they were. That's the thing.

Next Speaker: Yeah, right.

Next Speaker: So I don't know if we, the thing is in the, we were more understaffed recently so I wasn't sure if we've actually been able to follow up on that or not. That's kind of what I'm checking on before we definitely check on all those cases.

Next Speaker: Yeah and I think you also have to take into account that the, reasons for **** etcetera, all that ****

Next Speaker: Yeah, yeah.

Next Speaker: And then again we were just validating the subset of the total so the entire state may not ****

Next Speaker: Yeah, I know.

Next Speaker: May not change very much.

Next Speaker: Yeah.

Next Speaker: The entire state **** just that subset where there was an adjustment.

Next Speaker: Yeah, and in 2009 we did do the entire state, so.

Next Speaker: Right.

Next Speaker: So here as I mentioned in NICUs we didn't, you know, the pattern isn't as, there's not an obvious decline, but again you can see the wide confidence intervals and so this year, I mean, actually, the data weren't even below the national baseline. So for those of you on the phone you have like CLABSI and NICUs and then this next slide is a mistake, it's just a repeat slide of, I guess we were so excited about the rates going down we put it in twice. So now if we look at CAUTI in adult and pediatric ICUs, um, this is the first year that it was, you know, officially reportable by Oregon facilities. And so you can kind of see here that you know, we're over the baseline, our SIR is 1.1 meaning there's 11 percent more observed CAUTI infections than we would expect based on the baseline rates collected nationally in 2009. Um, you know, interestingly we also, the nation as a whole is also, is almost a SIR 1.2 so we're just below the national, and obviously both the nation and Oregon are far above what HHS had hoped for everybody by 2013.

Next Speaker: So what I hear based on this is that because there's such a huge push to decrease utilization, so you want to get rid of those catheter days.

Next Speaker: Yeah.

Next Speaker: And so then, you know, that is going to impact your rate.

Next Speaker: Yes.

Next Speaker: Every state is struggling with this.

Next Speaker: Um hmm.

Next Speaker: You're then left with really the population that is even more prone to **** UTI.

Next Speaker: You know, do you feel like the policymakers and whatnot are aware, are they aware of that thing that you're just talking about? I think that's important and is there any way, have you figured out how it messaged them?

Next Speaker: I think it um, message frequently. I, it has been messaged but you know, with turnover and all that kind of stuff I just think it needs to be part of the conversation whenever you talk about CAUTI data.

Next Speaker: Yeah.

Next Speaker: I just was going to say that I think though there's a similarity to the CLABSI as well because they're trying to get those catheters out. So as they get the central lines out, again, you know, have fewer lines so, so you can't totally explain it away. It certainly is a contributing factor.

Next Speaker: Right.

Next Speaker: But again, I think we have to keep learning everything we can to get it to zero.

Next Speaker: Right. Exactly.

Next Speaker: Well I think this population too really represents those patients who are more at risk because most patients who have urinary catheters will have them taken out within two days and you don't have a CAUTI unless it's been in two days. So these are the people that have the longer **** times.

Next Speaker: And, you know, I think obviously getting catheters out and ensuring they're necessary is critical but there are other interventions too. So, not looking for UTIs unless you know patients really are having symptoms of UTIs is an issue I'm seeing. Sometimes they're just culturing and if you culture you're going to get a positive result in many patients.

Next Speaker: That's asymptomatic, unless there are symptoms. Wouldn't be a CAUTI with no symptoms.

Next Speaker: That's true. For the surveillance definitions in acute care.

Next Speaker: Yeah.

Next Speaker: And there are some big changes in the surveillance definitions as well so in addition to this issue of you know, people decreasing the denominator, it's also since 2009, I think CDC and probably many researchers around the country have discovered that the way that the surveillance definition was being applied was highly variable so not all labs use the same cutoffs so there's a new CAUTI definition in 2015 where the definite cutoff is 100,000 CFUs. Also nothing but bacteria will be counted. Previously um, fungi, yeast was all counted. So there's been a real effort and there are a number of, there's a whole host of changes. There's like five different categories. You know there's big, there's like a YouTube video that actually nicely lays it out online about the changes and the CAUTI definition. But those are all designed to sort of standardize and decrease the noise that we're seeing. So a lot of this, you know, yeah there's the denominator problem, there's the noise going from facility to facility and I'm sure from state to state. Comparisons are not ideal. And, um, also so basically 2015 with the new definition is going to be the new baseline year. So that, all SIRs from 16 on and even 15, um, after we complete 2015 hospitals will be able to benchmark their data against 2015 data. So, I know Diane and I could talk about this a lot because it's a big issue.

Next Speaker: Right.

Next Speaker: Um, so that's something to kind of keep in mind in terms of context. I mean, I think it's, this is interesting and um, you know, some of it probably represents a real effect that we should pay attention to but also just know that there are a lot of changes underway with the definition. Um, so next, moving on to C. Diff lab I.D. events, we talked about this briefly. Again, you can see sort of those **** intervals around each of these SIRs over time and there was sort of that, as Mary mentioned, the increase from 12 to 13 in the SIR and then we see the slight decrease in 14 but those are all within 95 percent competence intervals so you know, I don't think we can read too much into those small percentage increase/decrease from year to year. But here you can see we're very close to meeting that HHS target unlike you know, the nation is up at .9 but we still have not met it yet and they're still a lot of C. Diff in the state. Um, the next slide is MRSA blood stream infection so again this is, these are also laboratory identified bloodstream events and yeah, the states, we were below the HHS target, below the national 2013 baseline. And I actually don't have a great sense of why this is, I don't know if people in the room, if this is also related to our CLABSI decline or you know.

Next Speaker: I think a lot of MDROs is they're really kind of regionally based and when we compare the northwest region to like mid-Atlantic states to other regions we tend to have lower rates to begin with.

Next Speaker: Yeah.

Next Speaker: That's my guess.

Next Speaker: Because like Baltimore would be in our baseline.

Next Speaker: Yeah, that's you know I was going to say, and I don't think we've had that much of a chance to do this yet but looking at a lot of this information regionally, I think would be actually pretty interesting.

Next Speaker: Yeah.

Next Speaker: It's nice to **** intervention ****

Next Speaker: Um, the next slide is SSI following coronary bypass graft which CBGB means there's been both a primary donor site incision so from 2009 to 14, you know we've seen some decline certainly if we look at the 2014 SIR, that's the lowest that we've ever seen it, um, and it was almost significantly better than the nation. I mean the P value I think is .08 you can kind of see that, the upper competence interval just barely peaking above that, the national SIR. There were also very few of these – oh, and I should mention because I think we had this conversation before everybody showed up. But, these SIRs are for deep incisional and organ space infections only. So they do not include superficial SSIs. You can actually calculate SIRs based on superficial surgical site infections but the CDC is now recommending against it because of the variation in how these uh, the superficial infections are tracked. So Mary Shanks and I were talking about how Kaiser is this closed system and she gets these flags as soon as the patient gets an antibiotic, so it's like very intense surveillance will lead to identification of more. But the idea

is that with these deep incisional organs based infections detected within the same admission or upon readmission to the same facility. The definition? Um, that those would be more standardized across. So that's the case for all of these infections that you see, they're all deep incisional organs based infections, SIRs. Here's laminectomy, um, again, you know Oregon it looked like there was a, uh, little bit of a spike last year, again, kind of big confidence intervals based on there is 22 hospitals that reported this infection, um, and not a ton of these procedures in the state but, but looking good compared to the national baseline and the, uh, HHS targets. Um, next is colon surgery and, and you know this is sort of, it looks like a, a steady rise, um, again, some of that is just noise. You can see the confidence intervals, um, but really we haven't, I think it's safe to say we haven't gone at all since, um, since this was made reportable and you can also see how close that, um, national SIR is to the national baseline. So, um, these baselines were collected in 2006 to 2008 and the nation really hasn't budged, um, much. And I, I think there are probably some, some legitimate reasons for this. I know that these are very difficult infections to prevent but also there hasn't been a ton of, uh, there hasn't been a lot of focus specifically on this, relative, like you know as opposed to say CLABSI, um.

Next Speaker: These are very infection prone procedures.

Next Speaker: Mm hmm.

Next Speaker: Simply because of the nature of, of the anatomy and you know the, the likelihood of abscess formation. So they're –

Next Speaker: There's, there's been some good work though. I think, um, we, I know we had some facilities here in Oregon that really tried to work on colo, uh, rectal surgical procedures, and uh, you know, have put into ****, tri bundles. Kaiser I think published a, a paper on their bundle I think.

Next Speaker: ****

Next Speaker: Yeah, and **** Valley sent a lot of work with their surgeons –

Next Speaker: Yeah.

Next Speaker: – on this as well.

Next Speaker: So it could be we just don't have our fingers yet on the right bundle nationally.

Next Speaker: Yeah.

Next Speaker: And they sell ****.

Next Speaker: I believe so.

Next Speaker: They were. I don't know how sustained they've been. Um, you know, because of the host factors that, uh, and are the ****.

Next Speaker: Mm hmm.

Next Speaker: And again, these are just for SSI. These SIRS are adjusted, not perfectly of course, but they are adjusted for, um, patient level risk factors so that the predicted number is actually based on, um, a lot of factors that are entered into ever, for every procedure, uh, that's done, um, the IP **** like the data has to either fill in or import a bunch of, um, you know, patient specific data. Um, but, but again, yes, it's not perfect. Um, and this is a big thing what Mary said. This is kind of a plug for getting our, um, prevention inventory together as one of the, one of our efforts. In the coming years is to get an inventory of all the prevention activities because I think it would be really interesting to look at how those hospitals that did implement the bundle did relative to the other ones.

Next Speaker: Yeah ****. They've really been working on those low-hanging fruit now for a long time. What's left is really very technical.

Next Speaker: Yeah.

Next Speaker: And review of procedures and ****.

Next Speaker: Um, hysterectomy, sort of you know like colos, it looks like the nation. Um, you know, its .91 is the, is, is our Oregon SIR in 2014 and the national SIR is .86, so, um, tracking pretty close to the nation but, but not a lot of budging and, um, I don't know do you, do you guys have thoughts about why this might be? Are these similarly complicated? Um, I mean? There's not the gut flora but.

Next Speaker: What about, yeah, what's, what was going on in 2012?

Next Speaker: You know, what happened was there was a recall of the most common prep used.

Next Speaker: Oh.

Next Speaker: For, for this type of surgery. Um, that may, I don't know.

Next Speaker: Yeah.

Next Speaker: I don't know.

Next Speaker: Interesting.

Next Speaker: Because then there was a big, um, discussion about what is safe to use if we can't use CHG –

Next Speaker: Mm hmm.

Next Speaker: – on mucous membranes and what is it? So soap and water was used.

Next Speaker: Yeah.

Next Speaker: So there's, uh, I think there, there may be –

Next Speaker: Yeah.

Next Speaker: – you know an issue with that.

Next Speaker: Interesting.

Next Speaker: Yeah, so it's a pretty huge change there.

Next Speaker: ****

Next Speaker: The national **** would be ****.

Next Speaker: And then, uh, so for SSI following hip prostheses, um, I guess um, potential trending down but, um, but really kind of not. Still not meeting that target and, uh, and it looks like for Oregon we're above where the nation was in 2013. And not significantly lower than, than that, the baseline.

Next Speaker: Are you going to talk about the CADS?

Next Speaker: The CADS?

Next Speaker: The California ****

Next Speaker: Yeah, yeah.

Next Speaker: Okay. So ****.

Next Speaker: Well I just was curious you know because sometimes this variation could potentially be associated with like one facility that maybe had a cluster issue and so that's where again I think it's helpful to look at the aggregate but you also sometimes have to –

Next Speaker: Yeah.

Next Speaker: – look at individual facility. Yeah.

Next Speaker: Yeah definitely.

Next Speaker: And here with **** again, you know, I think I mentioned we're below, met the target so it looks like there's been **** drop in the last couple of years. But this isn't, you're right, this isn't, uh –

Next Speaker: ****

Next Speaker: – it's a Center Cross Facility. There, uh, there still are **** facilities that, um, are high. And you know that's another kind of metric that we, that you would be interested in reporting out. I mean there are so many numbers here and things we could report but maybe the number of facilities or the percentage of Oregon facilities not meeting the target or, or that were higher than the nation. You know, those are the, those might be interesting metrics to report out too, so. Um, in terms of, so we're kind of shifting gears now. This is blood treatment infection and outpatient dialysis clinics. Um, we don't have the same type of SIR data so basically, um, the way that the CDC recommends reporting this item is also the way CMS advises. They, they require facilities to report out as part of their quality reporting program is to look at the, um, number of blood stream infections over the number of, over per 100 patient months. Um, and so that's what, that's what this is. We, I just did some kind of very basic comparisons. If you look at that top line of the table it shows that, um, you know the Oregon mean, uh, you know, mean number of BSI's per 100 patient months was .5 and the national pooled mean was 1.3. So, um, you know, Oregon appears to be doing better than the nation across, and that, that goes across all access types except for the non-tunneled CBC. So, because of the differences in underlying patient risk depending on type of dialysis access, um, CDC also recommends, um, in addition to reporting all BSI to also report out by, uh, access type. And so that's another difference between the provider and the consumer report. In the provider report we see it stratified by every access type which is like 13 pages of table and in the, in the consumer report it's just for each facility. You just see all, um, BSI, and so that's like, reduces it to like 2 or 3 ****.

Next Speaker: Yes, it's just seeing the CBC difference between, in the national, uh **** CBCs I would imagine.

Next Speaker: Yeah, I, I was going to comment, because we've had our, um, our dialysis **** infection prevention collaborative with, um, kind of first the state in the northwest areas –

Next Speaker: Yeah.

Next Speaker: And the one thing we really picked up, and you can kind of see it in everything, but our, our rates, um, in terms of getting, uh, patients to fistula or graphs and not having any type of central line compared to national was substantially lower –

Next Speaker: Mm hmm.

Next Speaker: – so I'm surprised to look and see that we actually went up in non-tunnel CBCs, um, because that, that, you know, to me that's a change from the trend –

Next Speaker: Mm hmm.

Next Speaker: – we've been seeing in the prior peers, and it would be interesting to kind of drill down a little bit to see if we could figure out why, you know?

Next Speaker: Mm hmm.

Next Speaker: So, basically you're saying the number of, we're seeing less **** or the number of people switching from the catheter to the fistula or –

Next Speaker: The number of **** infections is up –

Next Speaker: Oh. Okay.

Next Speaker: – there, because –

Next Speaker: Oh, it's up.

Next Speaker: – we're so good. Oregon historically has done a great job –

Next Speaker: By giving people an option.

Next Speaker: – and, and compared to –

Next Speaker: ****.

Next Speaker: – other regions –

Next Speaker: Okay.

Next Speaker: – we tend to move patients away from central lines.

Next Speaker: **** see of having an outpatient with a non-tunnel CBC would be a temporary one, because they've got some issue or they're waiting for, um, the graft to be ready or a fistula to be ready, um, that they probably have a fistula or a graft.

Next Speaker: Did you, is, why was **** included again?

Next Speaker: Um –

Next Speaker: We, we think –

Next Speaker: ****.

Next Speaker: – we can look at that afterwards.

Next Speaker: Yeah, okay. ****.

Next Speaker: I'm just thinking that –

Next Speaker: ****.

Next Speaker: – if they are, that might be –

Next Speaker: That might be –

Next Speaker: – an issue.

Next Speaker: Okay. Yeah.

Next Speaker: **** why do you say per 100 patient ****. Is that just under 700 ****?

Next Speaker: Yeah.

Next Speaker: **** patients.

Next Speaker: What is that about? So that's –

Next Speaker: So, that's like the months that they are –

Next Speaker: Yeah –

Next Speaker: – **** you can see –

Next Speaker: Well, see this, their, their –

Next Speaker: ****.

Next Speaker: – yeah, their module is –

Next Speaker: ****.

Next Speaker: – is has similarities to, like, the MDRO lab I.D. –

Next Speaker: Okay.

Next Speaker: – so, they really tried not to have a lot of timing spent by facilities doing the surveillance. So, um, first off, they're require to report any positive blood culture –

Next Speaker: Sure.

Next Speaker: – and any antibiotic start and any redness, pus, or swelling, um, at the sight. So.

Next Speaker: Yeah.

Next Speaker: And then there's the point where, um, all they do is they indicate if they, um, you know, think it was associated with an access site. So, if you know it was a blood culture, but the patient had pneumonia, we would mark that. So, you don't do a real thorough chart review to

ensure they meet criteria. The other thing, in terms of patient months, is the denominator data for them is only collected during the first 2 days, the first 2 working days out of the month, and that, then, becomes your denominator for the month –

Next Speaker: Oh, wow.

Next Speaker: – if you will.

Next Speaker: Okay.

Next Speaker: So, um, again, it's a little different rate and, and different methodology.

Next Speaker: Okay, so. ****.

Next Speaker: Um, so, and then, so here's our, in the summary of healthcare worker influence **** vaccination data, um, so the, the last cluster of columns is the, the, the new data from '14/'15, so you can see that we're, for every category, um, the rate has gone up, although it's, you know, it's inching up slowly compared to last year, but still in the right direction, um, and hospitals who were the, you know, first group of facilities to meet that 2015 healthy people target, uh, you know, they, they seated it again in '14/'15, but we still, still skilled nursing facilities and ambulatory surgical centers are, uh, below that target, and next year we'll see, for the '15/'16, we'll see four bars, because we'll be looking at dialysis **** as well. So, let's kind of, to unpack this data a little bit, this table, um, the next slide, which, um, sorry, this also looks a little blurry up here, but, the main, um, this is, this is going to be in the report so you can look at this when it comes out next week, but I, my main point here was just to show that the way that it's reported to CDC is stratified by healthcare worker type, so those healthy people goals are for all healthcare workers, whether, uh, whether it be an employee, independent, uh, licensed practitioner or other contractors, or students and volunteers, um, but I, I like, sort of, you know, once you kind of look at the aggregate rate, it's nice to see, you know, where these different types of facilities are having, are seeing the lowest rates, and so this column here, you know, this is, you can see the percent, so there's 79 percent overall for hospitals and, like, um, you know, employees obviously have the highest rates, which makes sense, but if you go down, you know, 39 percent for other contractors, that's, that's the area that's right for improvement, and the other reason I think this table is particularly important is that we look at the, um, the, the aggregate rate of unknown vaccination status. So, uh, in NHSN, if you don't know the vaccination status of an employee, they're considered unvaccinated ****. It's like the way we think about animals and rabies. If we don't know that they've been vaccinated –

Next Speaker: Oh.

Next Speaker: – they're unvaccinated. So, um, that's kind of like the same, um, you know, mindset, and so and, I think you can kind of see when we're thinking about the skilled nursing facilities that had, uh, you know, 50, 57 percent rate, if you look over at 26 percent of all healthcare workers in skilled nursing facilities had an unknown vaccination status. So, you know, um, we talk a lot about promotional campaigns and education, and I think all of those are, are important and, you know, we've done some analogies to look at which strategies lead to

increased rates, but I think a huge place to start particularly with these, uh, skilled nursing facilities would be documentation of rates. Um, you can see that three quarters of all students or volunteers, um, had no documented, uh, influenza vaccination status, so. Um, and so, um, the next, just switching gears slightly, I'm just going to walk through, um, in the remaining time, just like how these facil, how, um, the facility specific data is laid out. You can we've re, we've redacted the hospital names here. This is just kind of a random hospital that I, I picked. Um, but the, again, this is the provider report, so this is the landscape version, lots of data. Um, the denominator is published there, so the facility could potentially calculate their **** out of it that they wanted. They could do this NHSN too, but this is readily available. Um, observed infections, so there's, the pred, and then the predicted number, so in this case, this hospital had zero central-line associated bloodstream infections. The predicted rate was 1.5. Their SIR was zero. Um, when **** SIR zero, there is no lower confidence interval published. Um, sort of a little foot note there, and then the upper confidence interval is over 1. So, that's why our little, so then the next column is, do they meet the HHS target, which is an SIR .5, and yes, they did, because their SIR is .0. Um, and then the next column is sort of interpreting that SIR, so, they had fewer infections than would be predicted, because they had 0 versus 1.5, but, um, their confidence interval includ, was, was more than 1. The upper confidence interval was over 1, so that's why there's sort of the gray ****. Um, the next, the second to last column is, is, um, something new on this report. It's where this facility would fall on the, the most recent national distribution published. So, like I said, CDC, you know, publishes facilities, fac, uh, facility specific distribution, and that's in the top right corner, which is kind of faded in this slide, but it, it won't be faded in the actual report that's published, um, but you, that's actually the distribution for the nation. So, each facility can look at their own SIR, and see where it falls, and, um, so this is, we can, we can provide a range for them. This isn't as interesting, since they had zero, so, of course, they're zero to 10th percentile. Um, here's, like, another example of a facility that had two observed infections, but their predicted was also 1.5, um, so their SIR was greater than 1, so they didn't meet the HHS target, and they had, you know, more infections than, than would be predicted, but their lower confidence interval was below 1, so they have the gray triangle, and they were, you know, on the distribution of all facilities in the nation, they were between, you know, 91 and 100th percentile. Um, you know, here's an example of another facility with zero infections. Um, and then here's a facility. I wanted to show an example of a facility, um, where the number of predicted infections is less than one. So, whenever the number of predicted infections is less than 1, um, CDC recommends that we don't calculate an SIR, because it's just too unstable. Um, there are just too few, uh, denominator, uh, central line days here. Um, so we can't calculate an SIR, which means we can't compare to the HHS target, but as we had discussed at previous meetings it's, still, we have a lot of small hospitals in Oregon, and it would still be good to be able to kind of give them some credit for having zero infections, or, you know, um, also, it, not give them credit if they have more than zero infections. So, we have, this green check is meets the HHS target, or zero infections. So, in this case, we have a lot of hospitals that had zero ****, and so those guys get this checkmark here, but there's no other information. We can't compare their SIR to a national distribution or look at ****, so, that's at least one piece of interpretive data that we're giving to these hospitals that we haven't in the past. Um, and then here's a big hospital where they had, you know, enough central line dates to, um, you know, have statistically fewer infections, and, um, so even though they had more than one and they're in, between the 26th and 50th percentile of the nation, they had significantly fewer than would be expected. So, it's just a little bit more information on each facility, and it kind of pulls in some of

the factors that matter, like number of denominator days and ****. So, we'll see, um, you know, I'm interested in any feedback you guys have on this, and this may be, like, way too much information, not helpful, or maybe people like one piece but not the other, but, um, you know, if, once this comes out you guys ****, we'd be really interested in feedback. So, um, this is an example of kind of how the dialysis facility data is broken down by table, so each facility in the provider report, you can just see all of their, you know, their, uh, the number of patient months, number of BSI, the rate per patient month, and then how that compared to the nation, uh, or the pool of mean for the nation. So, you know, it really kind of breaks it down, and you can see where, if you have statistically more or fewer where, um, you know, where the problems or where the good ****. Um, and then for healthcare worker vaccination for each facility, um, we publish the number of eligible, healthcare workers eligible for vaccination, so this is all worker categories combined that did not have a medical contraindication, and then the rates, um, and then we also, to kind of provide context for that unknown vaccine status, we posted the rate of declination versus the rate of, uh, unknown vaccine. Um, the other interesting, we also published for, this is considered for the facility, so, you know, they probably want to know if they meet the target or not. The H, uh, the Healthy People 2015 target of 75, um, and then the, the Healthy People 2020 of 90 percent, which is top and not that many facilities actually met that, and the final column is something new we're just kind of experimenting with. It's sort of almost like a number needed to treat type of statistic. Like, how many additional healthcare workers would you need to vaccinate to reach that 2020 target, because we're in 2015 now. Everybody should be aiming for 2020 targets.

Next Speaker: I like that ****.

Next Speaker: Um, so this is, quickly I'll kind of go through, here's kind of what the consumer report looks like, just sort of a dissection of that. Um, there's a brief summary of the HAI, again, and it's, um, our publication staff here has edited this to be, to try to make it comprehensible for, uh, for public consumption, so, um, simpler language, um, and then there's a gray box for each infection type. What can families, patients and families do, so things to look out for, um, and then the tables, um, the columns have just, you know, observed and predicted numbers. There's no SIR published, um, but then there's a check, you know, whether or not they meet the HHS target and then how the fared relative to baseline. I tried to put ****, because they're a little hard to see her, but, um, but you can kind of get a sense of the, the reduced tables. So it, so this report is, is much shorter, over half, uh, 50 percent shorter than the other one. Um, so again, this is how dialysis looks. These are all, so this represents how many, six different facilities, and it's just all BSI, or sorry –

Next Speaker: ****.

Next Speaker: Is it? Oh, I put the wrong, this is, this is the wrong chart. I, I apologize. Here we go. I'm sorry.

Next Speaker: Is there a link somewhere in the consumer report to the other report ****?

Next Speaker: Yeah, it's on the first page, I think ****. This is who it's for, and there's a link to that site. So, and, and then the big report, there's also a link to the consumer report ****.

Next Speaker: So, ****, in the consumer report as well, will that be released on ****?

Next Speaker: Yeah, the plan –

Next Speaker: Okay.

Next Speaker: – to release them on the both –

Next Speaker: Okay.

Next Speaker: – all on the same date. Mm hmm.

Next Speaker: And then what, what kind of marketing or publicity plans do you –

Next Speaker: That's a good –

Next Speaker: – do you –

Next Speaker: – question. When we worked with our, our communications staff here on some talking points, um, so, that's pretty much it, and we don't have, uh, the, we don't have, like, a huge plan for ****.

Next Speaker: We, I mean, I, I, we'd like your info on that.

Next Speaker: Yeah.

Next Speaker: What, what, what do you think ****?

Next Speaker: Well, let me, we first, I mean, you know, post it, but, you know, how many people go to your web site –

Next Speaker: Yeah.

Next Speaker: – looking for it? You know? So, I didn't know if –

Next Speaker: We'll know exactly, and so, we've thought about it a little bit and, and, um, should we, you know, try to do some kind of wider scale thing or ****.

Next Speaker: Do a press release?

Next Speaker: Diane –

Next Speaker: Press release.

Next Speaker: – you know, Diane emails that to –

Next Speaker: Okay. Yeah.

Next Speaker: – a lot of groups, right? I mean, you send it out to –

Next Speaker: Yeah.

Next Speaker: You sent it? Yeah.

Next Speaker: Yeah.

Next Speaker: All of it ****.

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

Next Speaker: Well, yeah, when ****, but –

Next Speaker: ****, but –

Next Speaker: We sent, yeah, we sent it to, I mean, you know, all the, all the medical facility types.

Next Speaker: They're all getting their own copy.

Next Speaker: Yeah, um –

Next Speaker: But do you normally do a press release?

Next Speaker: Right.

Next Speaker: We have done that, but –

Next Speaker: Yeah.

Next Speaker: I'll have to learn that ****. Yeah. Yeah.

Next Speaker: Um –

Next Speaker: We do it, we go through **** network **** press.

Next Speaker: Oh, okay.

Next Speaker: Do we do press releases? ****.

Next Speaker: But, you know, like, the, uh, so, hospitals –

Next Speaker: Mm hmm.

Next Speaker: – get calls from the –

Next Speaker: Mm hmm.

Next Speaker: – press, so –

Next Speaker: Yes, they do.

Next Speaker: – somehow the press gets alerted.

Next Speaker: Patient Safety Commission –

Next Speaker: Oh, we have –

Next Speaker: – ****.

Next Speaker: – we, so we alert, no we, we definitely, we definitely alert, uh, the press, but in terms of –

Next Speaker: Oh, okay.

Next Speaker: – that, we are going to be releasing it, but we don't –

Next Speaker: And we **** know.

Next Speaker: – do, like, a –

Next Speaker: Okay.

Next Speaker: – formal kind of a –

Next Speaker: Got it.

Next Speaker: Don't do a media blitz.

Next Speaker: We have done the, I mean, uh, actually **** used to do that, I think, if I remember. Is that right? Am I remembering correctly? I thought they did it the first couple of years. Um, I mean realistically, the first couple years of hav, having this, there's been so much transition, you know? Um, case position or where, and we've had two different people and that –

Next Speaker: Yeah.

Next Speaker: – position's underfunded in general. Like, **** had four staff –

Next Speaker: Mm hmm.

Next Speaker: – staff working on this, and here it's, like, Kay and other people trying to pinch it, help out a little bit and whatnot. So, that's part of why we didn't do it last year or the year before.

Next Speaker: Mm hmm.

Next Speaker: I think that's, I mean, that's getting in a place that I'd feel more comfortable with something in that direction.

Next Speaker: Mm hmm.

Next Speaker: Um –

Next Speaker: Well, it can feel like –

Next Speaker: So.

Next Speaker: – your process is working ****. I mean, I –

Next Speaker: Yeah.

Next Speaker: – I was just trying to understand what –

Next Speaker: Right.

Next Speaker: – what the process is.

Next Speaker: The ****. Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah, I, um, like, you're gonna follow that **** that you, that you have, say, over the past year to, for whatever reason, um, I think a lot of it does have to do with hospitals being contacted directly –

Next Speaker: Yeah.

Next Speaker: – and Patient **** Commission tends to get a lot of calls around this particular thing –

Next Speaker: Yes.

Next Speaker: – when you guys release the report, and so, I'm always, we are always searching for, um, a way to direct them to a point person at the Oregon Health Authority who will typically follow back on ****, because it's just –

Next Speaker: Yeah, just send them my way –

Next Speaker: You know, we'll just send them your way –

Next Speaker: – and I'll, uh, and then –

Next Speaker: – if that's okay.

Next Speaker: – I'll send the –

Next Speaker: Because I, I think the –

Next Speaker: **** or whatever. We'll ****.

Next Speaker: – likelihood of getting a call is pretty high, and –

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: – a minimum **** so we'll notice, and, so –

Next Speaker: Oh, yeah.

Next Speaker: ****.

Next Speaker: – ****.

Next Speaker: He calls in, he'll call –

Next Speaker: **** too.

Next Speaker: Yeah.

Next Speaker: Exactly, so.

Next Speaker: It's like, why are hospitals –

Next Speaker: Right.

Next Speaker: – why aren't they doing better?

Next Speaker: Right, right. Right.

Next Speaker: ****.

Next Speaker: Well, would it be helpful for us to share our talking points with you, so –

Next Speaker: Yeah, we should –

Next Speaker: – we kind of come up with collective –

Next Speaker: I think that –

Next Speaker: – rather than just, you can say, "Well, I don't know. Talk to them," like –

Next Speaker: No, no, no. That's fine, because we talk to –

Next Speaker: It, it doesn't matter.

Next Speaker: – ****. Yeah.

Next Speaker: I mean, it, yeah. Yeah, right.

Next Speaker: Well, we, but we also, we also send talking points to our hospitals to say –

Next Speaker: You, because you, yeah.

Next Speaker: – it's going to be released.

Next Speaker: Yeah.

Next Speaker: Uh, if you get contacted, here's what, you know, we recommend you say.

Next Speaker: Oh, that's great. Okay.

Next Speaker: And I think, do you guys kind of, in your executive summary, do you have some kind of key?

Next Speaker: With a take away.

Next Speaker: ****, some –

Next Speaker: Yeah.

Next Speaker: – take aways to better already, already –

Next Speaker: Well, yeah. I mean, that one's really –

Next Speaker: Graphics?

Next Speaker: – because it's like a piece, a tiny piece of a corner, but we also, yeah, we do have some bullets that we can share with you guys too as a starting point, I mean –

Next Speaker: Okay.

Next Speaker: – and –

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: As long as you guys are comfortable and, you know –

Next Speaker: Yeah.

Next Speaker: – I, I just felt –

Next Speaker: Yeah, this –

Next Speaker: – awkward about speaking on behalf of the Health Authority. I can only speak on behalf of the Commission, and –

Next Speaker: I think, I mean, I think –

Next Speaker: – you know?

Next Speaker: – you should feel **** and ****.

Next Speaker: Okay, well, there's **** and formal communication plans. There's the talking points, and then they can always call the patient, the patients ****?

Next Speaker: Uh, yeah.

Next Speaker: Yeah, he's the ****.

Next Speaker: Yeah.

Next Speaker: He's the main person, and so –

Next Speaker: He's the main one.

Next Speaker: – if you have reporters that call, just send them to him, and he'll direct it to ****.

Next Speaker: All right. I'll let my communications –

Next Speaker: ****.

Next Speaker: – person know that.

Next Speaker: But, yeah, we can share that ****.

Next Speaker: We should share, okay.

Next Speaker: I mean, I'm fine with you contacting me directly –

Next Speaker: ****.

Next Speaker: – and I know **** some –

Next Speaker: Oh, I know.

Next Speaker: – that's okay.

Next Speaker: Yeah, some of it is just, "Hey, we were asking these questions," but it wouldn't be –

Next Speaker: They're –

Next Speaker: – ****.

Next Speaker: – they're ****.

Next Speaker: So, maybe we should send that information out to the committee.

Next Speaker: I would like that.

Next Speaker: Since it's like, ****.

Next Speaker: That's right. Yeah.

Next Speaker: So, ****, are you aware of the ****.

Next Speaker: Right, give the talking points –

Next Speaker: Okay.

Next Speaker: – these are from the Health **** Network.

Next Speaker: Who had the –

Next Speaker: ****.

Next Speaker: – consumer representative? Is that Pat?

Next Speaker: It's Dee Dee.

Next Speaker: Only for –

Next Speaker: I mean the consumer representative –

Next Speaker: – long-term care.

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: Uh, Dee Dee is still the person there, right?

Next Speaker: Yeah, she's **** and she's not here today –

Next Speaker: Is she –

Next Speaker: – but I think, uh, you would follow that up with her and –

Next Speaker: Yeah.

Next Speaker: – ****.

Next Speaker: Because I, I think frequently –

Next Speaker: So she's –

Next Speaker: – the press will, right ****.

Next Speaker: We ****.

Next Speaker: **** for that role.

Next Speaker: Yeah.

Next Speaker: I think **** can draft a, a press release, just like a –

Next Speaker: Okay.

Next Speaker: – a ****, a brief paragraph ****. That's a good idea just to have it. You know? It's not a –

Next Speaker: Yeah.

Next Speaker: – I can't think of what ****, go down there with a microphone and, like, cameras. There won't be –

Next Speaker: No, no, no.

Next Speaker: – ****.

Next Speaker: But we, but, I mean, like –

Next Speaker: **** draft that, so.

Next Speaker: That, that, that does bring up this point though, in terms of consumers and whatnot. If anyone has, uh, other avenues that we can also, I, I, I just really would like to have more involvement from that end –

Next Speaker: Yeah.

Next Speaker: – if possible, and I don't feel like we do have enough.

Next Speaker: Yeah.

Next Speaker: I mean, it's great that we have a representative, but, I just –

Next Speaker: And you –

Next Speaker: – I don't know, maybe there's really –

Next Speaker: Yeah.

Next Speaker: – aren't those kind of groups in Oregon that much, but I, it's kind of ****. So.

Next Speaker: Well, the landscape of the, you know, sort of what I would call consumer, consumer advocacy groups in Oregon, it, there's, there's a very long list, and it's, it's a –

Next Speaker: Yeah.

Next Speaker: – difficult landscape to navigate in terms of –

Next Speaker: Yeah.

Next Speaker: – how do you reach them all? So.

Next Speaker: Yeah, I know, and you can, I can, yeah, ex, it can be pretty complicated. I, I –

Next Speaker: Yeah, that's ****.

Next Speaker: – I, we've, I've had, I have been approached a couple times by people that weren't directly consumers, but it didn't feel like –

Next Speaker: Mm hmm.

Next Speaker: – **** inside the white menu where they said that we should try to facilitate, try, I don't know, it was, it's –

Next Speaker: Yeah, yeah.

Next Speaker: – so, yeah.

Next Speaker: Right.

Next Speaker: But, I still would like to get that voice here, so that's –

Next Speaker: Oh, absolutely. Yeah.

Next Speaker: It might be a good opportunity to share since we have a separate consumer report to **** just do some reaching out. So, I'm going to actually kind of table this discussion for after, um, Vince and Mary get their ****, because I think a lot of what I wanted to talk about with you guys in wrapping up their data presentation was how to use this data to help target some of our prevention researchers, and what Vince and Mary are going to talk about it, like, in fact our prevention resources, so maybe just kind of keep in the back of your head, as you're hearing those conversations, you know, how can we kind of use this data. There's a lot of data out there, so maybe we need to be looking at the executive summary and deciding which ones we want to focus on, and then identifying facilities, or maybe we want to do some kind of composite across, but, um, those are really kind of my discussion points, which I think can easily follow after their presentations, so.

Next Speaker: Okay.

Next Speaker: We're going to take a break and just be back in, like, 5 minutes.

Next Speaker: And we'll get back to business.

Next Speaker: All right.

Next Speaker: Yeah.

Next Speaker: Thanks ****.

Next Speaker: All right.

Next Speaker: So, I will start. Uh, so yeah, I, I'm not, I'm, I'm basically just going to give a little bit of an overview of what we're doing right now and where we're going with the HAI program. Um, Kay mentioned that we've got some funding. Um, Mary's actually going to give a, give a more detailed, uh, exposition on some of the information, uh, but I typed, uh, this group of slides, Are We There Yet? This comes from when I, I was visiting my niece, my 5-year-old niece, um, about a week ago, and as any of you probably experienced, or maybe even have done this at some point, repeatedly, over and over, she kept saying, "Are we there yet?" And, um, actually, I had fun with it. So, I, I was like, "Well, are we?" and I asked her the question, and we made it, we had a "Are we there yet?" song. It was, it was, it was a fun experience, but anyways, that came to mind yesterday when I was, uh, putting these slides together, and where exactly are we trying to get? And I think that's extremely important. Keep, keep that in mind. What's the long-term goal? And, I would, myself, I tend to be a total optimist, so I would like to get to a point where we really don't have healthcare associated infections at all. Now, exact, so I look over at, at you and, and we were just talking about the cold wars and whatnot.

Next Speaker: I would like that too.

Next Speaker: Yeah, but it, and it –

Next Speaker: ****.

Next Speaker: And that might not be, it might not be totally realistic in all settings, but, um, that's kind of my reach for the stars goal, and, and then the other thing is the, the framework for how you actually get to that kind of point. So, uh, what we've been working on is this idea of detecting, protecting, evaluating, and then reinvigorating the effort, and one thing, I don't know if any of you saw CDC's recent vital signs, but I thought it was, uh, absolutely fantastic, right in the direction that I think things should be going, and the idea, if they didn't, I don't think they used this terminology, but no patient or facility is an island. Uh, people are interconnected. People move between these different medical settings. Uh, someone starts off typically in the community setting, and then they're going to, um, potentially go as an outpatient somewhere. Then they end up in the hospital, and then potentially in long-term care, and they had some great data also that showed that people really are moving between these settings, um, quite, quite a lot, and that's, that's a situation where you can transmit infections. So, our approach and where I want to get more and more is considering the fact that these are interconnected systems, and these kind of regional approaches. Uh, another thing is, how do we integrate, uh, these, our different efforts for maximal effectiveness? So, uh, so, for example, C. Difficile and MDROs are all related to appropriate use of antimicrobials, and those are also national priorities, and currently, we in Oregon, are thinking this is the direction that we should be going. So, okay, so, if you want to prevent HAIs, how do you actually, you have to first be able to find them, and so one of the main methods that we have is NHSN. Kate has put this great report together, um, that is on that, using that data, so that's one of the main methods, and then another thing is, uh, notifiable conditions, and in Oregon, for HAIs, that's pretty much CRE at this point, and a notifiable condition is where you have population-based surveillance. Typically it's with the laboratory, where you can identify, theoretically, all cases that are in, in the state. So, in the community, as well as in various medical settings. Uh, another thing that we have to do is, uh, enhance the, we have enhanced laboratory capacity, because a lot of the laboratories in the state

don't have the capacity to detect carbapedamase production. And so, we established that capacity at our state public health lab, and the reason for that is, so you get a lot of CRE, but you want to actually, the public health concern are the carbapedamase producers, so we need to be able to identify those, and we only have nine cases of these at this point, in Oregon, and, uh, so the part goal is to prevent the spread of those.

Next Speaker: Yeah, and that hasn't changed too much, has it?

Next Speaker: Nope.

Next Speaker: No. No.

Next Speaker: Uh, and, you know, and whether or not, with, with the recent being for that, and it's hard to say, it's probably partially ****, and hopefully that all the education and whatnot, so ****.

Next Speaker: Which is, just a quick comment to that, the cases that have been coming in have been brought in from California, from, uh, back east, from Europe, and they have been picked up, so that is a real **** where we would get it from ****.

Next Speaker: I'd blame California.

Next Speaker: **** we've been **** it's tough to meet that, and so.

Next Speaker: So, um, and then another, and so then the other thing is the emerging infection program. We've been, uh, an emerging infection site for a number of years, and so we have a lot of interesting projects. The idea, guys, is to be able to locate things that might be future concerns. We have **** surveillance in the tri-county area, C. Difficile surveillance in Klamath County, and we've got a pilot project for a carbapenem-resistant pseudomonas, and, uh, basically the idea of those is to determine whether or not we need to have more work going in that direction. We also do prevalent studies periodically, so that's, that's where you do, like a one day's, uh, go into a bunch of medical facilities and really look at everything. So, NHSN reporting that we have up above, and when we get to the state report, we have ten ****. Is that right? Kay? Yeah, so we have sub, it's a, it's a cer, certain number of infections that we determine are probably particularly important, but the prevalent studies help us identify which ones we really should be focusing on, so we look at any HAI. We look at any patient that's on, uh, using antimicrobials on that day and then determine of they have HA, any HAI at all, at all, and so we started off with 15 facilities in 2011. Now we've got, uh, 22 that are participating, and, and we also look at appropriateness of, you know, antimicrobial use in those settings, and then the last thing here is, uh, inner facility transfer notification. Uh, this again gets to this whole idea of, like, regional, um, approaches to infection control in a public health setting on the state level, and the, the idea here is that the reasons, I put it under detect, is that, that, that we may have a requirement where patients or facilities have to notify other facilities when they transfer patients if they have an MDRO or a C. Difficile or infectious disease. Protect. Okay, so, again, uh, just stressing the, the regional approach and the Patient Safety Commission has, uh, typically been the one that's headed up a lot of the work. We've contracted to them, and it's, uh, they've

done great a work, a great job with MDROs, dialysis, PSIs, um, stewardship efforts, and more recently what we're working on is, and this was kind of, kind of piloted on the MDRO effort is, again, this kind of idea where you have a hub of a hospital, and then associated long-term care facilities, and all of these places, uh, work together to prevent inter-facility transmission, and the most recent effort is one that Jen is working on with, uh, C. Diff. and, um, at a couple different facilities, and you, uh, Jen, I don't know if you want to say anything about that or, uh?

Next Speaker: Uh, I could. I mean, I think that, um, well, definitely what I, what I think in doing the collaborative is how much, uh, **** are the point, the poster child for doing all the right things in their facility transfer **** and antibiotic stewardship of good environmental hy, hygiene. So, although **** is the organism, I think **** looking at those fundamentals **** and environmental and facility transfer antibiotic stewardship.

Next Speaker: Yep.

Next Speaker: So.

Next Speaker: And, and I, like, I, I think CDC's kind of going in this direction in general, and so if, if this is successful, if we find these, these pilot projects work well, then we aim to potentially move this statewide, or at least to larger groups throughout the region, um, and, and see if that, how effective that might be. So, then, the next thing that's –

Next Speaker: Let me ask –

Next Speaker: – and this is –

Next Speaker: Can I ask –

Next Speaker: Yeah.

Next Speaker: – which communities are those, are you piloting this in?

Next Speaker: Uh, so, uh, Klamath County, so the ****, uh, and their skilled nursing facility, they, um, long-term acute care and, uh, important **** special areas, so HSU, and then we're, uh, **** working with, uh, **** and talking to the ****. So, **** right away **** with those cases, and ****.

Next Speaker: Are we looking at history of C. Diff. or just ****?

Next Speaker: Uh, both. I mean, for, for the, uh, for the communication?

Next Speaker: Mm hmm.

Next Speaker: It's, uh, for MDROs and C. Diff. it **** here.

Next Speaker: Okay.

Next Speaker: And so this is, is, I think, uh, you guys all know C. Diff. once a person gets it, they don't ****.

Next Speaker: That is, uh, tough. That's a tough one with industry.

Next Speaker: Yes, it is, but, um, but things where it's getting, it is getting into the top medical history of **** diagnoses, um, those are **** there. So.

Next Speaker: So, the, the next thing is educational efforts. So, with any, any of these things that we do, we typically try to reach out and provide education trying to meet the stakeholders that might, um, where it might benefit them. Uh, in general, if anyone ever has any needs in that direction, please let us know, and we are more than happy to do webinars, go to meetings, um, pretty much anything, create, create materials, and so, we're always looking for that, and I think we've been reasonably successful in that direction so far. And, so then the next thing would be outbreak response. So, what role does the state health department have in outbreak response? Because a lot of facilities have, um, or theoretically should have a really, uh, good capacity in that direction. So, in, in my, my perception, that would be more where you have public health concerns. So, we are trying to prevent the spread of **** producers in Oregon, so that's uh, a significant concern, and as a result, that's where we're working with outbreak response. Another thing would be multi-facility clusters. It's going to be hard for an N, a specific facility to be able to be able to identify that kind of a situation, and I think we're well, um, situated to be able to help with that kind of situation. So, that's, that's the direction we're heading. Uh, so, I, I think I alluded to this, uh, a little bit in one, when Kate was taking, but the, the quality of data is extremely important to be able to figure out how you should, how you make, um, actionable prevention efforts, and, and we've actually seen in the past that it, it's very important to do that, because it does change significantly the rates. So, we've had some efforts with that in the past. Uh, a couple of times with CLABSIs, also with C. Difficile and Cabitas. Ideally, I think you would do this ever single year with every, every HAI, but that's not realistic, because it takes a huge amount of work to do this. Um, so, I think what, what we're aiming for is getting enough funding and resources to be able to do two of these HAI types per year so that it would basically be repeated every 5 years or so.

Next Speaker: I had a question, sir.

Next Speaker: Yes.

Next Speaker: It's around this particular topic. Sometimes ****, I've been doing this for 15 years **** start, but, there are those cases that are extremely complex, whether they're colon infections, with, um, ****. Are they secondary? Are they reading the rules and stuff, and we're trying to figure it out.

Next Speaker: Yeah.

Next Speaker: These would be great to post and discuss, and I don't know, it might be something that we, if we collect a pile of them, uh, we could maybe have a –

Next Speaker: Yep.

Next Speaker: – a call-in with, um –

Next Speaker: Yeah.

Next Speaker: – state and talk about –

Next Speaker: That's a great idea.

Next Speaker: – this is the CLABSI. Is this an SSI?

Next Speaker: I know that, I mean, I know you guys have done a **** on these things **** –

Next Speaker: So, if we could formalize it –

Next Speaker: So you ****.

Next Speaker: – I think –

Next Speaker: Yeah.

Next Speaker: – and I think it'd be a great learning –

Next Speaker: Great.

Next Speaker: – opportunity for new IPs, and also a way to kind of validate, you know, our ****, you know, reliability –

Next Speaker: Yep.

Next Speaker: – integrated reliability time –

Next Speaker: Yes.

Next Speaker: – and things going on –

Next Speaker: And, like –

Next Speaker: – between hospitals.

Next Speaker: – an HAI support group. You could call it HAI grand rounds or something.

Next Speaker: Yeah.

Next Speaker: Mm hmm.

Next Speaker: Yeah, because they're interesting. I think people will call and –

Next Speaker: Yeah, I think that's a great idea.

Next Speaker: I agree.

Next Speaker: And, I think, again, it's, if our IPs can share some of their cases –

Next Speaker: Yes. ****.

Next Speaker: – and, again, um, it, it really ****. We've got a lot of retiring IPs –

Next Speaker: Yeah.

Next Speaker: – and new IPs, and a lot –

Next Speaker: Yes. ****.

Next Speaker: – want-to-be IPs.

Next Speaker: Yes.

Next Speaker: So, so again, I think we could, um, you know, potentially have a great educational forum that wouldn't require a lot of background prep for it.

Next Speaker: Yeah, and, I think that's a great idea. I, I've, I would, the people that have been involved with the prevalent study, we've actually benefitted from some of that kind of training with CDC where we've gone there –

Next Speaker: Yes.

Next Speaker: – and then we have calls where we discuss those kinds of cases. I think we might even be able to get some CDC people that want to call –

Next Speaker: Yeah, that's what I was –

Next Speaker: – which would be really –

Next Speaker: – I was thinking too.

Next Speaker: – helpful. So.

Next Speaker: Help with clarifications.

Next Speaker: Yeah, yeah. Be, we'll –

Next Speaker: That's a great idea.

Next Speaker: – try to do that.

Next Speaker: Yeah.

Next Speaker: Uh, so then, let's see, emerging infection program. So this is, again, we're just, uh, studies to try to understand the landscape of HAIs. Uh, Kate worked on a mortality study where we were looking at whether, uh, **** mortality, and I don't know if you have any ****, well, we're not ready to really present that information yet.

Next Speaker: Yeah, I think –

Next Speaker: If you have anything to say about it.

Next Speaker: Um, yeah, I, I don't have the numbers with me, but, it, but it was interesting, because it, typically in these studies, um, you know, we can meet, we typically know, like, from the literature, uh, the proportion of patients that die after HAI, but this was, uh, a study to really get at, um, at how many of them die once they're released from the hospital. So, we linked, um, these patients with vital statistics data, so it's an effort, uh, between, I think, nine states, um, and **** who die here in Oregon, and so we were able to actually identify **** patients with it ****. So.

Next Speaker: So, it's a –

Next Speaker: ****.

Next Speaker: – an association within that ****?

Next Speaker: Yes. It's, it's still, it's, it's more, like, enhanced case findings, like, but still, I think, um, I think we need, where we need to move forward is, like, really figuring out whether it's ****.

Next Speaker: So, we'll hear more about this in the future?

Next Speaker: Yeah.

Next Speaker: Yes.

Next Speaker: In the future.

Next Speaker: In the future. Yeah, because what, they're still putting all the data together and doing some analyses and ****.

Next Speaker: That's, I mean, that's one thing with the IP studies. We typically kind of have to wait for CDC and all the other states and whatnot. Um, and, and we have also done, as, as, uh, anyone that works in these settings knows that NHSN definitions can be, um, frustrating at times, and whatnot, so, we've worked on a couple projects to help improve those, and we will, um, definitely offer to participate in any future ones, because I hear loud and clear when there's frustration over that.

Next Speaker: **** coming up is, uh, the ****?

Next Speaker: Yeah.

Next Speaker: That is going to be huge, because a lot of **** upload our denominator surgical procedures –

Next Speaker: Mm hmm.

Next Speaker: – you know? And that's going to be ****.

Next Speaker: Yeah.

Next Speaker: Here in October.

Next Speaker: And there's –

Next Speaker: ****.

Next Speaker: – denominator simplification project –

Next Speaker: Right. ****.

Next Speaker: – related to that. We've had a couple things that are, uh, the idea is to, to decrease the workload for IPs, because we'd rather have people focused on preventing infections than entering data, and, and that kind of thing. And, then we've had, we've had numerous studies, um, focused on various things, the C. Difficile risk factors, colon infection with other, other infection types, etc. And then, then the last thing here is, is a, is an exciting, interesting project that we have going on right now where we are working as consultants with the Ebola assessment facilities to help make sure that they are where they need to be, and Jen's kind of taken the lead for us on that. I don't know if you, um, where, we've got, most of the facilities have been assessed at this point.

Next Speaker: Uh, four of the six have been assessed –

Next Speaker: Yep.

Next Speaker: – and then next two will be assessed in the next month ****, you know, for the first round.

Next Speaker: Okay.

Next Speaker: And, this is great.

Next Speaker: ****.

Next Speaker: That's right.

Next Speaker: Uh, where are we going? We invigorate. So, that's the idea is to go back to the beginning and, um, reinvigorate the effort and, and continue on, and so, again, I think, I see the, the future focusing on these, these regional prevention hubs, with, uh, multiple facilities working together. Uh, go ahead.

Next Speaker: I was just going to ask, is the, um, **** month's edition, there's a great article by the Iowa, um, modeling, the –

Next Speaker: Oh, yeah.

Next Speaker: – **** modeling, where they both at inter-facility transfers and delayed understanding that the facility's risk of HAIs is more related to the **** issue **** rather than their ****. I was kind of **** with that, but –

Next Speaker: That's –

Next Speaker: – you know, trigger a focus to look at that ****.

Next Speaker: It's, yeah, that's a place, so –

Next Speaker: ****.

Next Speaker: – I mean, I, I've, I've had the suspicion, so I'm pretty happy to say, I mean, I, I, I'm seeing that that, that seems to be the case, that they're, the data's bearing that out, and we actually, yeah, we have another project that, you know, working with that same group to, to look at our own pattern of **** –

Next Speaker: Our pattern.

Next Speaker: – yeah, so we can –

Next Speaker: Yep.

Next Speaker: Another thing, just, uh, another thing is that, like, with, um, the **** task **** in healthcare, we're seeing entirely new populations –

Next Speaker: Yes.

Next Speaker: – entering our healthcare systems –

Next Speaker: Sure.

Next Speaker: – with entirely different results.

Next Speaker: Yeah, that's ****.

Next Speaker: ****. Yeah. So, it would be interesting ****.

Next Speaker: And, **** multiplying that, or is it –

Next Speaker: I think ****, yes. So, I think we will.

Next Speaker: Mm hmm.

Next Speaker: And there's just a, I think a ****, uh, **** or treating **** in people who actually, in, in ****.

Next Speaker: Yeah, I, I –

Next Speaker: ****? Yeah. ****.

Next Speaker: So, so the next bullet point, I've, I'm not going to really talk about it, because Mary's going to talk about it, uh, in a lot of depth, but, again, really excited to be able to actually do some, uh, statewide help with infection control evaluation and support for, especially for settings where you really need more resources, long-term care facilities, etc. Uh, we got a little bit of funding to do injection safety. I'd love to do more work in that direction. Uh, there's a couple surrounding states that have had issues with that. We've had various other places around, over the country and some indications that this could be a concern in Oregon, so, uh, initially it's going to be kind of dovetailing onto some other efforts, but we also are going to be doing a couple of pilot projects that are, that are more highly focused, and we're still working out the details. We wrote the grand proposal, but we're still figuring out exactly how to make it actionable considering we've got, like, a third of the funding that we asked for. So, then, um, I, I think we're going to, this is what I'm really interested in, and I think the idea is to discuss this later on, but, um, **** we make an HSN ****, an HSN data actionable? Uh, there, we definitely have a pilot project that is going to be going on, focused on increasing healthcare worker influence and vaccination rates in long-term care facilities, but the other things are what can we do. I mean, can we use NHSN data, and this may or may not be workable, because it's, there's a time delay, but for an outbreak detection. We haven't really done that. We're, we are already working this, targeting facilities for prevention efforts, and, so, I'll leave that for later. And, let's see. What outbreak response capacity? We'd like to work in that direction. Uh, we have all kinds of studies. That's the thing. I, I, I was going to supply this list of all the stuff that we're working on, and it's this, there's too many items, but a couple of other interesting ones that are, uh, looking at for CREs. So, we, right now we're saying the CRE, at least carbapenem-****

producing CREs is not endemic in Oregon. Uh, that's, that's kind of where our surveillance data say, but, is that true? We don't really know for sure, and so, so we're going to do a study looking at hospital effluence. So, they're using a lot of antibiotics, and is that, is it possible that you, you could actually find CRE in the sewage that comes out of the hospital, and, and we've seen that in some other, other locations. So, I think it's kind of an interesting study, and I'm hoping we don't find it, but it, it would be interesting if –

Next Speaker: Mm hmm.

Next Speaker: – and then, um, CRE prevalent studies, for C. Difficile, uh, stool specimens. So, that's, again, we're just looking at more, getting a sense of, in general, if there's some, something we might be missing with the CRE. Uh, then getting back to this, the whole thing with inter-facility transfer notification requirement, I'm, I'm happy to say that they went from about 22 to 25 percent of facilities complying with the requirement to close to 50 percent, uh, more recently, which I think actually is very positive, considering there was really, the infrastructure was not then in place, and I'd like to see it go to 100 percent, but it's an indication that this, um, requirement is important.

Next Speaker: So, you know, I have ****, my question is, do we think that, are we pretty sure that people really know about this and know that No. 1, it's, a, a rule, a law?

Next Speaker: Yeah.

Next Speaker: You know? So, and then, and then start from there, because I, I think there's probably, um, this group was like, "What? What do you mean?"

Next Speaker: So, that's one of the questions –

Next Speaker: Yeah.

Next Speaker: – on here, and most of them do say they know about it, but they, a lot of them still are trying to figure out how to implement it. So, but yeah, we need to, um, exactly. We need more education.

Next Speaker: Yes.

Next Speaker: I think we need, that, that's the thing. We, it's not really a funded thing right now. We think it's very –

Next Speaker: Mm hmm.

Next Speaker: – important, but we need to find better ways to –

Next Speaker: Okay.

Next Speaker: – evaluate it and help facilities to get them –

Next Speaker: So, your data, that 50 percent compliance now, how, was that **** –

Next Speaker: That's, it's self-report.

Next Speaker: Self-report.

Next Speaker: That's the thing. So, Jen's doing a bit of work in that direction, uh, with this project, but, yeah, we really need a larger scale effort to, and some dedicated staff to, to ensure that is enforced and whatnot, but we didn't even want to start off in that direction. It didn't seem appropriate, because their infrastructure was not in place, so –

Next Speaker: Yeah.

Next Speaker: – it's, um, it started off kind of as a somewhat soft requirement, I guess.

Next Speaker: ****, um, looking at this, it looks like maybe 9 percent or so weren't aware of the rule.

Next Speaker: Yeah.

Next Speaker: And then it looks like there's only 5.4 percent that haven't really, you know, they've **** up, but they haven't really put it into practice.

Next Speaker: Well, true, but also if you look at the, how many responded, there wasn't a great –

Next Speaker: Yeah.

Next Speaker: – response there.

Next Speaker: Well, actually, the **** –

Next Speaker: So –

Next Speaker: – the **** hospitals, so –

Next Speaker: Yeah. That's the most –

Next Speaker: – we have 56 reporting hospitals, right? And, and so they ****, but these, like, for instance an update, um –

Next Speaker: That's, well, the, the top one is long-term care.

Next Speaker: But then what is the –

Next Speaker: It's most –

Next Speaker: – ****.

Next Speaker: This is most facilities in ****.

Next Speaker: Yeah.

Next Speaker: **** like in our, ****.

Next Speaker: Oh, okay.

Next Speaker: ****.

Next Speaker: Yep.

Next Speaker: Um, **** hospitals ****.

Next Speaker: Was this sent, this was sent to the ICP?

Next Speaker: Yeah.

Next Speaker: Got it.

Next Speaker: Okay. Um, and then this is, I think, it might be the last slide. It's basically trying to facilitate some questions, um, you know, what, what is the appropriate goal whether or not CRO is, uh, is an appropriate goal, or where we want to get with that, and then how do we maximize existing resources? How can we all best work together or bring other stakeholders into, to meet the goals of, of decreasing HAIs, and then I, I kind of talked about this a bit before, but how can we make sure that those people that are really impacted by this are going to be part of the decision making process? So, the patients, family members impacted, how can we help healthcare workers in all these different settings to do their work, and, and everyone else, and, I mean, anyone in this, this, this room and everyone outside of this room is going to, uh, go to a medical setting at some point most likely, unfortunately. And, so, everyone is at potential risk for getting an HAI, and so how can we make sure that the future, all these people in Oregon, um, is going to be included in that? I think that's it. Oh, wait, I can –

Next Speaker: ****.

Next Speaker: – leave that open. Okay.

Next Speaker: It's not, not the first time for a **** discussion, but I, kind of, I mean, Diane, I know that there's a lot of effort going on right now in terms of hospitals. There is some structure around, like, advisory councils and things like that that have the patient voices and ****, so, how this happened may be some of that structure.

Next Speaker: Yeah.

Next Speaker: In the other healthcare settings, there isn't as many ****, or as much structure, I guess, but I think that it is becoming more and more, um, structured, so –

Next Speaker: More ****.

Next Speaker: Well, we're actually running a –

Next Speaker: Yeah.

Next Speaker: – big patient –

Next Speaker: Right.

Next Speaker: – family engagement collaborative right now.

Next Speaker: Right.

Next Speaker: They're **** –

Next Speaker: Right.

Next Speaker: – and so –

Next Speaker: Yes.

Next Speaker: – um, we haven't specifically touched on HAIs –

Next Speaker: Mm hmm.

Next Speaker: – but, um –

Next Speaker: Right.

Next Speaker: – now it, it's more about identifying patients to be advisors, and –

Next Speaker: Yes.

Next Speaker: – how you have to onboard them and how do you run a, an advisory committee meeting –

Next Speaker: Mm hmm.

Next Speaker: – so it's more about –

Next Speaker: That's great.

Next Speaker: – **** structure ****.

Next Speaker: Right.

Next Speaker: Let's put a timeline for that. When will they pretty much be, so, it's been going on, it's a 15-month –

Next Speaker: Mm hmm.

Next Speaker: – collaborative.

Next Speaker: Mm hmm.

Next Speaker: It started in March, so they're about a third of the way through, and they'll go to meet in May of next year.

Next Speaker: Okay.

Next Speaker: ****.

Next Speaker: So, I'm just wondering, again, hopefully they've watched, and then maybe they're ready for –

Next Speaker: Yeah.

Next Speaker: – you know, ****.

Next Speaker: For, for Part 2.

Next Speaker: So, the specific agendas.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Part 2. Yeah.

Next Speaker: So.

Next Speaker: ****.

Next Speaker: And, uh, I just got a **** comment also about, um, implementation ****, you know, how people **** the fact that **** actually going in to evaluate. Whenever we are, uh, dealing with a CRE or, you know, we're dealing with anything, do you always **** talk about and actually be how they're going to communicate, make sure it's **** and things like that, but,

um, but that's ****, like, do ****, how to actually get them to show up, and that is, I think, where there's still **** in that ****.

Next Speaker: Yeah.

Next Speaker: Okay. So, um, um, last meeting, Judy, uh, Guzman-Catrell, um, gave an update to the committee about, um, the first piece of the CDC Ebola grant, and, um, she is the, uh, lead, the medical director lead, um, for, uh, the grant work that's being done. So, now you get Part 2, or Part B of the grant, um, which is, um, really going to be, uh, describing what this assessment or consultation component evolves, and again, this is funding that we've received from, um, the CDC, and the ELC grant. Um, so, again, the, the whole focus on the grant is to build statewide infection prevention infrastructure capacity and education. Um, the first piece, again, was to really focus on Ebola, um, readiness with our consultation for the, uh, Tier 2 assessment hospitals, um, with the whole thrust that we're really trying to overall build and spread infection prevention capacity, um, to prevent HAIs in this state, so that in a sense was alluding to we have early identification, intervention, um, and strong partnerships, and there's a proponent of the grant, I won't spend a lot of time talking about, which is really the biosafety capacity, trying to, um, build that at the public health lab as well. Um, it's really an exciting grant, and again, echoing, uh, Vince's words, um, because we have an opportunity to really work with a lot of different partners here in the state, not only our healthcare facilities, but our public health, loc, state as well, as county health departments, our labs, um, different committees, different professional organizations, like, APIC, um, federally with the Centers for Disease Control, and then, you know, we, we have a lot of emergency preparedness partners as well, and a lot of times we tend to work in silos and not really com, have them join us at the table. So, that again, is one of the efforts of the grant is that we really build partnerships there, as well as, as with our emergency, um, preparedness, our, our EMS services. And then, again, we really want to build relationships and ensure we are all aligned with our regulatory requirements in our professional organizations, such as the Hospital Association, the Ambulatory Survey Center, or Long-term Care Facility Associations as well. So, it's a great opportunity for us to all come together at the table and, um, really try and ensure that we're talking, com, um, coming together to sort of, um, establish some goals and ensure that everything is aligned and moving in the same direction, um, to really, uh, promote infection prevention practices in the state. So, um, again, there's different elements for this grant, um, and Kate will be involving you over the next, uh, few meetings about really the role of the HIAC Committee and how it really needs to be kind of the center wheel, uh, taking a lot of data from all the different groups and really helping to, to look at the data, analyze it, and make recommendations for next steps and actions. Um, it's really meant to improve coordination between our state health department, as well as, uh, all the facilities in the, um, healthcare settings. Um, one of the things that is so true that has really been happening over the next, uh, the last 5 years, is what I really perceive as the evolution of public health. You know? It's always been kind of, you know, maybe TPE or HIV-related, and it's never really, I think they've never really been involved with HAI prevention, but that's really a world they're moving into now, and I am always impressed, because I've worked with them on outbreaks and other things about the expertise that they could bring to the table, and so often, I think our facilities, you know, tend to want to kind of keep the issues or outbreaks or problems internal, but there's a whole bunch of resources in connection with the CDC and others and epidemiologists that could really partner with them in their, in their investigations, as well as give them additional person

hours of help. So, that is, again, one of the things that I think we'll be strengthening over the next couple of years. Um, again, a key component is assessing, uh, readiness of Ebola facilities, and then, um, looking again, as I mentioned, at their outbreak reporting and response. So, uh, the main focus of much of the grant work that I'll be doing over the next 2½ years or so now, is, um, really providing expanded infection prevention consultations, so, a lot of onsite work, a lot of onsite assessment and partnering. Um, we will be, um, going onsite and working with long-term care facilities, ambulatory surgery centers, and other ambulatory settings, including clinics, and, uh, our freestanding dialysis facilities. Um, additionally, if we become aware of an outbreak or unusual pathogens that turn out in this list, we may choose to respond to them as well. Podiatry clinics is one example. They're natural pathic clinics. Um, we're going to go ahead and incorporate, uh, um, they'll have an initial assessment. We'll go ahead and provide them with feedback. We'll try and hook them up with as many resources as we can, and then we'll follow up with, um, visits, um, 3 to 6 months after the fact, just to assure that they're doing well. Um, so, is that cut the time or a question?

Next Speaker: Oh, no, uh –

Next Speaker: I saw this **** time. Has there ever been any consideration given to dental clinics?

Next Speaker: Um, yes.

Next Speaker: ****.

Next Speaker: So, um, the tools that we've received from the CDC right now really are not geared towards the dental clinics. If we hear right now of any concerns or, um, you know, we can pool, you know, perhaps if we have complaints to, you know, the Oregon Dental Association or something, and they'd like us to go and look at a clinic, we're happy to do that. So, um, again, as much as possible, we're really trying to make this, um, uh, confidential, uh, to really make it, um, an improvement opportunity.

Next Speaker: Okay.

Next Speaker: Um, there will be some data if we're going in and, and working with the CDC, we are required to complete, um, some forms and assessments, but the data we submit to them will not even list facility names. You know? And it's, and they purely will be aggregating data.

Next Speaker: Oh, yeah, we've talked **** for injections and ****.

Next Speaker: Yeah.

Next Speaker: **** sterilizations.

Next Speaker: Sterilizations, yeah.

Next Speaker: Yeah, uh, so let me see where I was. So, um, we have a side, decided here in Oregon, because of the whole need to really try and regionalize and build partnerships in the region that, um, and work with our emergency preparedness and county health departments as well, we've tried to map out kind of a regional approach, and as we've selected potential facilities for this first round of assessments, we really tried to regionalize our approach so that, again, we're hoping we can, um, have some meetings with the second round of assessments where we actually pool people together and, um, begin to have some networking discussion and educational opportunities as well. Um, I'm hoping to, uh, partner with some of my APIC colleagues and have them come onsite, especially, um, to go with me into, um, areas that they may not be familiar with. So, maybe they haven't been to a pre-study dialysis facility, or maybe they haven't been to an ambulatory surgery center or a long-term care facility, so I'm hoping to have them come with me so they can really see the tool, and have some exposure and experience in some of those alternative care settings. Um, again, we're hoping long-term to build up a network that's regionalized, so that we actually have infection prevention consultives, um, and re, and people who can respond to problems in the different regions, and, um, it also will be involving, uh, opportunities for resource and tool development. You can see here from the map, um, we have identified basically six different regions similar to the, uh, hospital emergency, uh, preparedness liaison regions, and those are identified by the black line. So, if you look at HPP Region 7, you can see there are parts of that combine Region 6, 7, and 9 in terms of color coding. Um, but we will be working again just within those black lines. So, uh, the consultations, the goal is, again, to, um, identify common gaps and trends, so that state and national agencies can assess that and know where they can be targeting improvement strategies. Uh, the criteria that we're utilizing, um, we've pooled data from multiple sources. We've looked at outbreak reports, um, of unusual pathogens. Uh, we looked at what NHSN data we had. Uh, we have connected with regulatory surveyors for some of their recommendations. Um, we also looked at some of the CMS star rating data. Um, we looked at, uh, healthcare worker, uh, influenza data, and then we also just plain said, which, you know, if we had a targeted facility, who else is around them? So, that was kind of how we went around selecting our first 25 facilities. Uh, we're looking at, I, we have had one consultation, um, already, but the rest we're looking at, we're only now, um, this month and November, we have, uh, 25, uh, facilities that we're targeting, so, uh, we told the CDC we're shooting for seven hospitals, five ambulatory surgery centers, ten long-term care facilities, and three, uh, dialysis facilities. Um, again, the purpose, uh, we'll have an initial scheduling call with them, um, just really emphasizing that it's a consult. It's collaborative. It's not regulatory. The focus is on quality improvement. Um, they will receive the assessment forms that we'll be utilizing pre-visit. Um, we will go ahead and ask if there are any areas that they would really like us to focus on or work with them on while we're there, um, and then we'll review what they can expect during the visit and how the findings will be used, and then what will happen if there are gaps or lapses in infection control, and the one thing I want to tell, um, this committee that, uh, we have instruction that if we observe egregious practices, such as, um, safe injection practices where needles are being used on more than one patient, then we are obligated, um, you know, to inform them so that we know appropriate notification of involved patients and others, um, occur, and that's really the, the one thing we have to tell them upfront, um, will need to occur. Um, during the visit, um, there'll be an opening conference. We'll, um, depending on the facility, hospitals, as you know, can be really large, but if it's a nursing home or ambulatory surgery center, we'll probably start with a brief tour of the facility. Uh, we'll be meeting with the individuals responsible for the IP program. Um, we have assessment tools that

we'll be using from the CDC, but we have some additions that we may opt to do. Um, mostly because a lot of the work we've done has involved rounds or observations, which have provided us with very meaningful, um, findings. Um, and, uh, much of the tools, again, uh, the state of the art and, uh, best practices for infection prevention are really ensure that facilities are, are doing audits, that they have observations that they're collecting data on, and that they really have solid, um, performance improvement, um, programs in place using that data and findings. Unfortunately, you know, our hospitals, I think, for the most part have most of those in place, but when we move to other care settings, it doesn't exist. So, again, I think the CDC's hoping to use this data and will plan future programs on interventions based on, uh, what they find. Um, we'll be performing, um, you know, again, the type of observations will depend on facility sites. We'll have an exit conference, and we are being told by the CDC to expect the first set of visits to take anywhere from 4 to 8 hours, probably depending on the facilities. Uh, assessments domains are going to vary based on, uh, the facility setting, but basically we'll be assessing the infection prevention program and infrastructure, and then we'll look at training competency and implementation of policies and procedures for all of those practices you see on the slide, and then we're looking at systems to detect, prevent, and respond to HAIs and MDROs. Um, another component of the grant that we're working on is increasing infection control competency and practice. Um, this, again, is very exciting, because we have opportunities and funding, um, for training. Um, as we identify common gaps or trends, we may want to really look at what our OARs and, uh, licensing board requirements are for those positions. We may want to have some discussions that maybe we need to make changes here in this state, and one example I can give you is, um, you know, uh, we don't have a requirement that people, uh, who do, um, instrument reprocessing and work in sterile processing have had any training, and, um, certainly as you move out to, uh, clinics, um, you'll find that a lot, and so maybe we need to ensure that somehow they have documentation of an actually training program. Um, we are looking at, again, establishing, uh, training with multiple partners. Um, we are going to be offering training workshops, um, around the assessments and tools. We've had, um, ambulatory surgery center courses and long-term care facility courses offered in the past, so, um, we have an opportunity now to, uh, roll them out again, and then, uh, we'll be offering, um, five different infection prevention fundamental training courses over the next 3 years. It will be to, again, work with our surveyors as well as our, um, public health partners, and then the, uh, other component, the grant, which I won't spend a lot of time talking about, is really enhancing surveillance analytic and reporting capacity. Uh, so in terms of our fundamentals training course, we've got our faculty meeting now. Uh, most likely our next, uh, fundamentals training course will be the last week in February. We likely will have the second one sometime in the fall. Um, we're looking at some hands-on training courses. Um, I'm working, um, likely will work with, uh, the Ambulatory Surgery Association here in Oregon to actually roll out a hands-on instrument reprocessing course, um, so that again, that's some training, if we find problems, we can refer somebody to. Um, and then, uh, let me see. And then, I think, again, you've heard a lot of talk about webinars. Mary had a great idea about NHSN case studies, and I think we'll really be looking for those opportunities to roll out, to try and increase the overall knowledge and standardized practice. So, again, I'm really excited. I think we have an absolutely fantastic opportunity here, um, to build our practices and infrastructure, and partnerships here in the state. Um, when we do that, we know it's going to overall enhance our early identification of organisms and outbreaks, um, and again, hopefully we can close some gaps that we have in licensing and credentialing, um, and

again, great opportunity for us to, um, provide some onsite assessments and free educational opportunities.

Next Speaker: That's great, Mary.

Next Speaker: And here is our grant steering team, because, again, there are multiple components of the grant and what we're all responsible for. Any questions that I can address?

Next Speaker: Uh, I think that is excellent, and really, and what an, uh, you know, and visions. It's ****, but from what I hear from what CMS is doing, in terms of their, um, survey techniques –

Next Speaker: Mm hmm.

Next Speaker: – and that that they will be employing and –

Next Speaker: And **** anywhere here in –

Next Speaker: Yes.

Next Speaker: – **** doing it.

Next Speaker: And we'll find, I think, hospitals will be, especially the hospitals **** will be more receptive to collaborative and, um, non-regulatory assistance.

Next Speaker: Sure.

Next Speaker: You know, we, we've talked a lot about, um, making this a somewhat practical ****, that they have a very strong consultative branch ****, regulatory branch that are separate, consultative works that they're focusing –

Next Speaker: And they do grant –

Next Speaker: – to educate the ****. We like that.

Next Speaker: We like that model. And again –

Next Speaker: Mm hmm.

Next Speaker: – we're hoping –

Next Speaker: Yeah.

Next Speaker: – like, um, you know, if anybody's tried to pool, you know, facility, uh, survey data, it's, it's kind of hard to get meaningful, useful, actionable data is what I have found. No

offense to them. It's just associated I think with, with the, the computer system. Um, but, we're hoping to, when they find concerns –

Next Speaker: Mm hmm.

Next Speaker: – you know, let the facilities know that we're available, and then, you know, as a consultant to these facilities, and then the facilities can contact us so that we can be part of their action plan that they're submitting. So, again, we're hoping to get out in front of this and be, um, you know, a little bit more proactive and, and truly be a, a useful, um, resource for them.

Next Speaker: And so just a follow up on your ****, I think that the, we'll talk about this more at the December meeting, kind of how the, the role of this team or, uh, this committee is going to, um, you know, work just slightly, still focused on the data, but we'll be hearing reports. Um, Judy, uh, Guzman is going to report next time on aggregate level findings from the Ebola assessment hospital work, um, and then, you know, Mary, with the first round of assessments done here will present some aggregate findings, and so we're considering this data we can use in conjunction with our NHSN data as we, kind of, **** kind of facilities based on NHSN data, or maybe these, these would **** will make us think about what kind of data we want to be collecting **** or if we don't need to collect it.

Next Speaker: I would also like to consider facility collaboratives. Uh, for example, if you're having issues with **** or **** here, it's not where you want to be, but somebody else is and has, um, a, you know, an appropriate number of procedures done that kind of looks like yours, I think it would be to collaborate and to **** –

Next Speaker: Yeah.

Next Speaker: – with other facilities.

Next Speaker: Like ****, maybe, like mentor hospitals or something.

Next Speaker: Mm hmm.

Next Speaker: I just wanted to see, recheck to, to, just to make sure anyone on the phone has had any comments or whatnot. Sometimes it's hard for people to speak up then.

Next Speaker: Is there anybody left on the phone.

Next Speaker: No? Okay.

Next Speaker: Is there anybody left there?

Next Speaker: Okay. Does anybody else have any questions?

Next Speaker: Oh, I **** our ****.

Next Speaker: Yeah. The –

Next Speaker: I had questions about –

Next Speaker: – **** to define ****, yeah, so there's actually –

Next Speaker: Mm hmm.

Next Speaker: – a, a subcommittee of this, uh, AGI Advisory Committee, um, sort of dedicated to, um, to helping, um, and sort of, uh, evaluate this data and ****, they **** the, the data that comes back from the ****, and so, um, there's some people who are already noticing on the committee, um, seeing here sort of defined, uh, you know, a basic **** versus **** regulatory. So, you know, ****, um, and then we'll have representatives from, um, a couple of different communities, and certainly, if anybody on this committee, after seeing the data, you know, presented would like to be part of that subcommittee –

Next Speaker: Mm hmm.

Next Speaker: – it would just be a little more of an active committee. We'll have some, um, you know, interactions outside of this quarterly meeting to really make decisions about the data and **** together and **** recommendations ****. We'll definitely, uh, talk a, a little bit more about that at the, the next meeting. We're actually going to invite people who are aren't on the committee already to the, that meeting, so.

Next Speaker: Okay. If there's no other, uh –

Next Speaker: You know, we have a lot of great –

Next Speaker: – ****.

Next Speaker: – questions about how to really leverage our partnerships, just based on everything you've heard today in terms of looking forward, and I know we're at the end of time, but, I think everybody who presented and is involved with the work here would love your feedback and ideas. So –

Next Speaker: Yeah.

Next Speaker: – how did, how did **** facilities ****, um, ****. Like, I think, you know, really get the **** consultative and you want to partner with ****, you know, ****, but, yeah, I think they, I think ****.

Next Speaker: Yeah, just contact us if –

Next Speaker: ****.

Next Speaker: – if, if, if, you know –

Next Speaker: Yeah.

Next Speaker: – and ****.

Next Speaker: Incentives or, you know, maybe the, this is a question ****, but also **** and things like that. Right?

Next Speaker: See, probably ****.

Next Speaker: But ****.

Next Speaker: Where you had, like, you adjourn the meeting.

Next Speaker: Yeah, that's what I was going to do.

Next Speaker: Before you start to ****.

Next Speaker: Okay. Thank you, everybody.

Next Speaker: Thank you.

Next Speaker: ****.

Next Speaker: I appreciate all the comments. Do you have one, Stephanie?

Next Speaker: Oh, I was just going to comment and say it was more of a question, really, an open-ended question. Mary, I haven't prepped you for this question, but I'm going to ask it anyway. In general, how would you categorize the receptivity in terms of those selected for assessments, uh, in, in terms of hands-on assessments, considering the data that was evaluated to make those decisions and do they ask –

Next Speaker: Yes.

Next Speaker: – how receptive were people –

Next Speaker: Oh, ****.

Next Speaker: I'll you know next time.

Next Speaker: – to that idea? Okay.

Next Speaker: Because we, we haven't –

Next Speaker: Uh, okay.

Next Speaker: We're still –

Next Speaker: – we have just reached the point where we selected them –

Next Speaker: Okay.

Next Speaker: – and, um –

Next Speaker: And so we don't know that answer yet.

Next Speaker: Of course, yes.

Next Speaker: Okay.

Next Speaker: Mm hmm. Yeah.

Next Speaker: All right.

Next Speaker: It's too early yet.

Next Speaker: Yeah.

Next Speaker: So –

Next Speaker: So, is that going to be a bit of a, are you anticipating a bit of a back and forth there? Like, what if someone says, "We just can't take that on right now"?

Next Speaker: I can –

Next Speaker: What's –

Next Speaker: – I can appreciate you, you hearing that.

Next Speaker: Yeah.

Next Speaker: I mean –

Next Speaker: This is –

Next Speaker: Yeah. Yeah.

Next Speaker: – ****, just because of the –

Next Speaker: I think –

Next Speaker: I think we have ****.

Next Speaker: – we can bring this to our **** meeting.

Next Speaker: Meeting?

Next Speaker: Sure.

Next Speaker: As an agenda item?

Next Speaker: Yeah. Yeah, I think we're trying to, and then for **** actually trying to focus on ****.

Next Speaker: You think you're ****.

Next Speaker: Sure. Yeah.

Next Speaker: ****.

Next Speaker: I was figuring –

Next Speaker: But we're ****.

Next Speaker: – that's good to know.

Next Speaker: Yeah, yeah, we're trying to get **** –

Next Speaker: Yeah.

Next Speaker: – and there's also so many efforts in the Portland Metro area –

Next Speaker: Right.

Next Speaker: – we really have tried to make a point to get out to the other regions and get them connected –

Next Speaker: Okay. That's helpful.

Next Speaker: – so, just you guys, know that it, this is a 3-year project, so it's not the **** happen, it, like, ****.

Next Speaker: Yeah. So, in theory, if someone is saying, "We're truly overwhelmed at this moment. We'd rather bump it off a year," or something, uh, that's a conversation that's going to be –

Next Speaker: If this, this is a voluntary –

Next Speaker: Right.

Next Speaker: – assessment.

Next Speaker: I mean –

Next Speaker: Right. Right.

Next Speaker: – yeah. Yeah.

Next Speaker: And, and if we –

Next Speaker: Yeah.

Next Speaker: – can't get through the door at, you know, the first –

Next Speaker: Yep.

Next Speaker: – hospital on our list, then we'll move to the next.

Next Speaker: So, you know, and –

Next Speaker: I would be happy to help with, around communication or –

Next Speaker: Right.

Next Speaker: – engagement of the hospitals –

Next Speaker: Sure.

Next Speaker: – so, I don't know, uh, you know, are you targeting the CEO? Is that your first line of defense to say, yeah, hey –

Next Speaker: No.

Next Speaker: – so, you know, **** we got **** to do.

Next Speaker: A lot, a lot depends on the facility setting, and I am going to try to leverage partnerships as much as possible, so when it comes to hospitals, quite frankly, I was going to leverage my relationship with the IP and kind of, again, a conversation there where this is what we're doing. Give them background, kind of let them know what the opportunity is, but then we'll probably have a call, because we need their help identifying who should be a part of the call where we're going to, you know, sit together and if the hospital CEO wants to know, um, what's involved, we'll, um, you know, it, it, we'll have sort of a, a little FAQ. So, you know, some of those, uh, questions are going to be addressed.

Next Speaker: Right. Right. I mean, I would say that the CEO needs to know.

Next Speaker: Yeah.

Next Speaker: Right.

Next Speaker: Rather than –

Next Speaker: Yeah.

Next Speaker: – give him a choice, so, it's like –

Next Speaker: So –

Next Speaker: – get your hospital, I mean, he needs to understand, he or she –

Next Speaker: Mm hmm.

Next Speaker: – why were we in –

Next Speaker: Well, right, yeah.

Next Speaker: – ****, you know, the context here, and what an opportunity this is.

Next Speaker: Yes.

Next Speaker: So, I, you know, I –

Next Speaker: I think that's where we could do ****.

Next Speaker: Yeah.

Next Speaker: Um, you know, long-term care, we've worked with some of these facilities. We have relationships with them –

Next Speaker: Sure.

Next Speaker: – the same with dialysis.

Next Speaker: Sure. Yeah.

Next Speaker: Um, you know, we will reach out. We're hoping we'll, you know, my first contact there is probably going to be the DNS, and –

Next Speaker: Right. Okay.

Next Speaker: – you know, try and get the medical director involved, but –

Next Speaker: Mm hmm.

Next Speaker: – again, there's so much variation –

Next Speaker: Sure.

Next Speaker: – in terms of culture at different facility types, um, that I think we'll just respect that, and, you know –

Next Speaker: Okay, sure.

Next Speaker: – as a **** partner, we'll try and –

Next Speaker: And, yeah.

Next Speaker: – you know, **** –

Next Speaker: Just let them –

Next Speaker: – capitalize on our, our partnerships. Um, we have a presentation on Friday, and, you know, with multiple groups of long-term care, and I'm hoping we can have, ask their help in communicating the great opportunity that –

Next Speaker: Mm hmm.

Next Speaker: – this is.

Next Speaker: Yeah, we'd love for –

Next Speaker: Yeah.

Next Speaker: – yeah, medical directors and CEOs to be **** –

Next Speaker: Mm hmm.

Next Speaker: – and part of, you know, that ongoing **** radar ****.

Next Speaker: Mm hmm.

Next Speaker: That was just so much ****.

Next Speaker: Right. People are so –

Next Speaker: Yeah.

Next Speaker: – fatigued by the idea that we're going to be surveyed –

Next Speaker: Mm hmm.

Next Speaker: – or they have this tone to it, etc., and I just think there's some balance that could occur in terms of leveraging some of the partners to help pave the way to say, so they –

Next Speaker: Yes.

Next Speaker: – so they hear that it's an opportunity –

Next Speaker: Right.

Next Speaker: – and not that, so that there's –

Next Speaker: Yes.

Next Speaker: – a, or you could spend the next 3 to 6 months just trying to get people to believe that you really do want to –

Next Speaker: Yes.

Next Speaker: – help them, and get them to do it.

Next Speaker: Yes. Yeah, and you got to ****.

Next Speaker: So, we have to figure that out, yeah.

Next Speaker: We're going to that, really trying to think of the consultation –

Next Speaker: Right.

Next Speaker: – not use the word assessment.

Next Speaker: Right. No. Jen, you're right.

Next Speaker: **** not the word –

Next Speaker: I mean, but, yeah, absolutely.

Next Speaker: Yes.

Next Speaker: And, and I just wonder, because of the fatigue –

Next Speaker: Yeah.

Next Speaker: – and feeling like, you know, ****.

Next Speaker: And I think, again, you know, our, our, you know, Mary and I were having our little dialogue here, and –

Next Speaker: Mm hmm.

Next Speaker: – you know, if, if I can share, you know, the first thought was, "Aaaah!" I mean, you know?

Next Speaker: Yeah. And, and that's –

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

Next Speaker: – **** it's going to be that way.

Next Speaker: No, just through the **** study, because they did the Ebola assessment –

Next Speaker: Exactly.

Next Speaker: – and ****.

Next Speaker: Like, I –

Next Speaker: But, when I, then when I went through it, it was sort of, like, oh, another set of eyes might be –

Next Speaker: Mm hmm.

Next Speaker: – nice, you know? So, I think, again, it'll just be some processing and, you know, the bottom line is, again, if it's not this year, um, you know, we have outbreak data that's coming in, with some facilities that were not on our list, and, maybe we don't do seven hospitals. We do three, but it's gonna allow us an opportunity to respond in other areas.

Next Speaker: Okay. All right.

Next Speaker: Thank you.

Next Speaker: Thank you.

Next Speaker: Thanks, everybody.

Next Speaker: Thank you.