Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
December 14, 2016

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Speaker: This is Mary Post, the other Mary. Mary Shanks, uh, had a conflict um that came up and so she asked me to chair and facilitate the meeting today. But um she does hope to join us later um in the meeting. So with that I'd like to go ahead and have introductions starting with people who are in the room and then we'll go ahead and ask people to identify themselves who have called in.

Next Speaker: Hi, this is Lexie Jone, HAI epidemiologist with the life health condition.

Next Speaker: Mary Post.

Next Speaker: Hi, I'm Jennifer Graham. I'm with the Health Security Preparedness Interresponse Program.

Next Speaker: Uh Zints Beldavs, Section Manager for communicable disease.

Next Speaker: Tina Meyers, the Health Specialist.

Next Speaker: Megan Broy, Research Analyst.

Next Speaker: Monika Samper, HAI reporting coordinator for the CUB.

Next Speaker: I'm Rosa Tamera. I'm the healthcare associated infections reporting epidemiologist in the HAI program and I'm in Kate Ellingson's old position.

Next Speaker: And Rosa just started December 1st so she's bran new and we really welcome Rosa to the HAI team at the OHA.

Next Speaker: Hi, I'm Paul Cieslak, Medical Director for communicable disease.

Next Speaker: Alisa McLean, Award Coordinator and HAI public health educator.

Next Speaker: Okay, great. And um Dot Tron who is a new public health physician stepped out of the room but he is also joining us for the meeting today. Um, can we go ahead and have people on the phone introduce themselves.

Next Speaker: I'm Barbra Wade. I'm from the Hospital Association.

Next Speaker: I'm Kelly Qualo.

Next Speaker: Okay, Kelly can you for everybody just remind us who you are representing?

Next Speaker: Yes, I'm Kelly Qualo. I'm from Ambulatory Surgery Center representation. I work at Riverbend Ambulatory Surgery Center in Springfield.

Next Speaker: Okay, thank you.

Next Speaker: Dee Dee Vallier representing the consumer.

Next Speaker: Hi Dee Dee.

Next Speaker: Hi.

Next Speaker: **** Buser from Jacobs Providence.

Next Speaker: Okay, so um Jen I don't know if everybody could hear you but that was Jen Buser from um Providence.

Next Speaker: Jamie Grebosky. I'm a family doc and um Chief Quality and Safety Officer over at Asante in Southern Oregon.

Next Speaker: Okay. Anybody else on the line that hasn't introduced themselves.

Next Speaker: Uh, yes, Jedick Bruno, uh Associate Professor Oregon State ****.

Next Speaker: Okay. Anybody else? Okay. So um with that um I understand uh we don't have minutes to approve from September and will we be reviewing them at the next meeting then for both months? Okay. And so with that Alexia or Lexie Zing will go ahead and will present about outbreaks 2016.

Next Speaker: So this is just going to be outbreaks since out last meeting in September. Um, now that I think about it I probably should have done an outbreak 2016 but maybe that'll come next, next meeting. So I'm um an HAI or HAI epidemiologist here with the ACDP acute, acute and communicable disease prevention program with the public health division. So I'm going to talk really briefly about outbreaks that have been reported to us since September of this year. So since September 15th of 2016 we were -- uh 63 outbreaks had been reported to us. If you're following um with paper slides I'm on the second slide. Maybe, I don't know how your things are laid out but I'm on slide that says outbreaks since 9/15/2016. I'm on the first page. Um, so not surprisingly we have had a lot of norovirus outbreaks reported to us. Um, in long-term care facilities and 1 in hospitals um 3 in schools and 1 in other. We've also had a whole slew of other gastroenteritis outbreaks reported to us. Some, some outbreaks of **** was the **** outbreak in

a long-term care facility, acriptis veridiam outbreak in a pool, and we've seen some roto virus since some sample virus pop up lately around the state. We also have this large category of unknown gastroenteritis outbreaks. Uh 25 of them have been reported since September 15, 2016. Um the majority of which were in long-term care facilities. And so the next Section down is respiratory outbreaks. This is the **** season for respiratory outbreaks and we have had some reported to us so we have had 4 influenza A outbreaks reported to us, 3 in a long-term care facility and 1 in the community. Um, we've had a few pertussis outbreaks, a mumps outbreak which I will talk more about later and some other outbreaks as well. Um, we've also seen some rashes and some other outbreaks. So we dive on into healthcare associated outbreaks um between again 9/15 and last Friday when these slides were due. Um the healthcare associated infections outbreaks accounted for notes about 40 percent or 24 of all the outbreaks reported since September through December, and not surprisingly the most common etiology was norovirus or noro-like outbreaks. But this was the start I influenza season so again we saw 3 outbreaks of influenza A long-term care facility. Had I pulled the data for these outbreaks today we would have added 3 more influenza or influenza-like outbreaks to this list so they are rapidly coming in. We had 4 called in on Monday and Tuesday of this week. So if you look at facility type of long-term care facility and reported pathogen um again unknown GI norovirus has the majority of the outbreaks um but you can see you know it spreads through memory care assisted living facilities, field nursing facilities and um facilities that might have both assisted living residential care as well as skilled nursing facilities. So I have one more slide, and the outbreak of note that I'm going to talk about this month, yes in this meeting is community-wide mumps outbreak and so we've had an increased number of calls regarding mumps since October. Um, and so since September there's been 24 confirmed percent of cases of mumps in our, in our database so I figured I would just go through some case definitions of mumps with you guys since it is, uh it should be on our radar and of no -- uh other states have seen an increase of mumps cases. I think we just heard that Arkansas had like over a thousand cases mumps.

Next Speaker: There are over 2,100.

Next Speaker: Oh, over 2,100 cases of mumps now so um its spreading, and its uh -- in Arkansas it was -- there was a and Paul correct me if I'm wrong but uh it started predominantly in the Marshall Leeds community and now has since spread to other communities but uh for them they have really been trying to increase vaccination in the Marshall Leeds community. So case definitions: for us a confirmed mumps case is one that has a positive PCR or culture in a patient that has mumps-like symptoms like keratitis, um aseptic meningitis, encephalitis, hearing loss and the other ones that I'm not going to read because I probably will butcher them.

Next Speaker: Okay.

Next Speaker: A presumptive case definition is acute parotitis or other salivary gland swelling lasting at least 2 days or orchitis or oophoritis, um unexplained by other diagnoses, and this is in a person that has positive IGM serum or has or is epidemiologically linked to another case or outbreak. A suspect mumps case is one that has, uh, basically mumps-like symptoms like acute paro, paro, parotitis um but does or has a positive lab with no clinical symptoms. So if you guys see these cases coming into hospitals please report them to your local health departments. Um, that is all I have for today. Does anyone have any questions?

Next Speaker: I have a couple questions about mumps outbreaks. I haven't done a lot of reading on it at this point in time, but do we know, have any sense for what the overall state vaccination with MMI was for Arkansas?

Next Speaker: No, I don't know the answer to that question.

Next Speaker: Okay, I don't know how far they are in looking at this, and then what's the age group that we're seeing this in, the mumps in, is it

Next Speaker: In Oregon

Next Speaker: In Arkansas the big outbreak with the 20 some 2,000 some odd cases.

Next Speaker: I think it's right.

Next Speaker: Yeah, I don't know.

Next Speaker: Okay.

Next Speaker: As Lexie mentioned I mean a lot of it has been in um, in um Marshall Leeds community and uh I think it was kinda spanning the uh the uh age spectrum.

Next Speaker: Okay.

Next Speaker: Uh across the rest of the United States you know there have been all these university outbreaks and I think the reason is that although the vaccine is reported to be 88 percent effective um with 2 doses uh after you know a child has grown up – the, the, the 2 doses are recommended uh in 12 to 15 months of age and in preschool and so by the time you get to college it may have been 13, 14 15 year since you've had a dose and the immunity definitely wanes over time.

Next Speaker: Right.

Next Speaker: Still we still see some residual effectiveness and you're less likely to get mumps if you've had both those, the vaccines than if you haven't. In Oregon of the 24 that you mentioned 13 are confirmed or suspect so I'm sorry confirmed or presumptive so that's what our official case count is now, and I think six of them were in Marian County and six were in Washington County, and uh, uh and adolescence and younger children have been disproportionately affected, not many adults.

Next Speaker: Okay.

Lexie Zing and CDC has some pretty strict guidelines on when to give a third dose of mumps vaccine so.

Next Speaker: Yeah, we're not recommending a third dose for any group at this point. Although you know if we had like a massive university outbreak among people who had already had 2 doses we would probably consider it.

Next Speaker: Okay.

Next Speaker: Did Arizona do a third dose?

Next Speaker: I don't know.

Next Speaker: Arkansas?

Next Speaker: Oh, Arkansas.

Next Speaker: Yeah, Arkansas has been suggesting some folks to get a third dose. Um, the, they have also been trying to reach out to the Marshall Leeds community to just get -- uh I think it's pretty under vaccinated community so they're just trying to get them vaccinated.

Next Speaker: ****. Okay.

Next Speaker: Do you know anything about the one in Washington in the Marshall Leeds community there?

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

Next Speaker: No.

Next Speaker: Okay.

Next Speaker: Alright. Thanks Lexie. Um, Rosa.

Next Speaker: Hi everyone um I'm going to jump right into from an HSN subject matter today so this will be probably most relevant to those of you who work with an HSN or who have staff over, with an HSN but I could give also relevant to us all 'cause it have a lot to do with the way that we present and will be presenting data so um you all are probably aware that re-baselining is happening in happening in an HSN so this is just an introduction to that process. So as a refresher we use the standardized infection ratio or SIR which is um a measure comparing observed and predicted healthcare associated infection, and observed HAI is really simple, right? So that's the number of infections that we observe in our facility and report into an HSN during a certain time period. Predicted HAI is a little bit more abstract so that's the number that's calculated based on the national SIR baseline, and the national SIR baseline -- this is the NHSN languages an HAI incident rate for frank time period or in other words it just how many healthcare associated infections occurred and were reported into NHSN nationally during a certain time period. So in looking at the current national SIR baselines and just as a note these are not only the current baselines but they're the only baselines so they're the original baselines. Um, a couple of things that might notice. First they're different for each HAI measure and

they're even different for different facility types within the same measure. Um, that really makes our messaging kind of tricky and it makes it difficult to present a consistent snapshot in time because our reference periods are sort of all over the place, and the other thing you might notice is that most of these are pretty old so with the example of SSI data if we run an SIR and an HSN for our facility looking at 2015 or 2016 data what we're comparing ourselves to is what was predicted based on national data or what was happening nationally with SSI 10 years ago and a lot has really changed since then of at least we hope a lot has changed since then. Um, we really have made progress nationally so we want to be looking at how we're doing compared with more recent data. So why re-baseline? I'm not going to read all of this out loud but generally we want to account for changes that have taken place in an HSN since the original baselines were created. We have more data and we have different types of data available to us. However, we also have had very significant definition and protocol changes which makes a comparison of current data to old baseline data using the SIR and the current baselines not the most sort of robust statistical approach. So um again for example we're currently comparing our Cauti data um now that Cauti can't be caused by a **** organism with our Cauti numbers where a fumble infection could constitute a Cauti so that's not really comparing apples to apples anymore. Um, and this is just a list of some of the substantial changes that have been made to definitions and protocols you know over the years. I won't read them out loud. I think we're probably all familiar to some degree with some of these but they're here for our reference. So we talked about why we might want to re-baseline but what are the benefits of doing it. Well the new baselines will account for the really major changes that were made to 2015 protocols. Um, we will have a single reframe or time period that will result in more consistent methods for calculating predicted infections. We can use this 2015 data to create updated risk models. We can make our SIR analysis – um, we can have more SIR analysis available to us an HSN, and um, the last bullet is regarding changing the minimum precision criteria so that um -- actually I'm going to talk more about that on the next slide. But re-baselining really addresses all of these reasons. Um, so going through some of the activities that have been going on at CDC. Um, they've been updating the risk models, developing new risk adjustment methods for selected HAIs, introducing additional SIR output options that are stratified by facility category, um, assessing the potential of the new or the potential impact of the new baseline on trends in our data and adding new SIR output options into the application, and then the last one is what I was going to talk about on the previous slide so potentially lowering that minimum precision criteria it was that they were kind of tossing around the idea of making the SIR available for periods of time for which fewer than 1 predicted infection or fewer than 1 infection was predicted. So the SIR is only calculated if we have at least 1 predicted infection. They were kind of tossing around that thought that maybe they would make the SIR available for you know periods of time for which fewer than 1 was available, and they're actually not going to be doing that. Um, and I have a little bit more of their kind of justification for choosing not to do that at this time if anyone has questions about that. So of course re-baselining is going to have some real impacts on our data and know when we present it um data reported to an HSN front 2015 will be used as the new baseline for future SIRs. Risk adjustment methods and models might vary from those that were generated using during the original baseline period, and all of the new risk models are going to be implemented in the application as the new SIR output options. Um, and any user with data analysis rights will have access to SIR outputs using both the new and old baselines depending on the time period. So new SIR analysis options will only be compatible with data from 2015 and forward. 2014 data and older will be compared to the original baselines. 2015 and 2016 data will have both

baselines available. 2017 data and newer will be compared only to the new baseline. Um, and 2015 data, sorry, SIR that was produced under the new 2015 baseline will not be comparable to SIRs calculated under the original baselines, right. Because um the denominator will be different. So this slide is just a really broad overview, and again I have more information about this if that's of interest to the group. So pretty much what we're just waiting for all of these tabs completed in ongoing tasks are tasks that are going on at the CDC level, and we expect that most of these are basically done, and um what were waiting for is the release of the new version of the application which will include all of the new SIRs and all of the new baselines, and that was scheduled to take place on December 10th. It doesn't look like that's happened quite yet. Not a huge surprise. Um, so we'll be waiting eagerly to hear from them about when it is planned to come out. So I talked about new SIRs being available for us to use in our analysis output option in an HSN so these are some of the things that are going to be available in the system probably in some more detail well more detail is available about this as well, but I'll just talk briefly about the SUR um the Standard Utilization Ratio which is the last bullet point on this slide, and this is really relevant only to device associated data so here we're talking about um Class C Cauti and VID so the SUR is really just an SIR for device use instead of device utilization ratios. It provides a risk adjusted measure um that tells us whether the number of device days like central line days for example that were seeing is statistically similar, lower or higher than what we predict based on national data, and um, this is especially of great interest to us because our annual national device utilization ratios are no longer going to be available from an HSN. They are being replaced by the SIRs. So briefly talking about how re-baselining will impact reporting for STAMA first qualify reporting program. Q1 and Q2 of 2016 data were submitted using the new 2015 baseline. This is stuff that's all happening from an HSN to CMS by the way with the State of Oregon. States haven't really been involved here. Um and then CY2015 public reporting files were resent using the new 2015 baseline in August of 2016. And then for value based purchasing programs it looks a little bit different so fiscal year 2017 and 18 program years will use the original and HSN baseline and then fiscal year 2019 and later will use the new baselines. So considering the new SIR and its implications for what our data will look like which we will talk much more about. This is a very brief introduction to it, but we now have a new starting or reference point by which to measure our future progress. So all of our SIRs are going to shift closer to 1 particularly for the 2015 SIRs calculated using the 2015 baseline so we would expect those to be quite close to 1 and actually, um, so what will this look like? So here's an example of a chart using sample data, and its showing the SIRs from 2009 to 2014 for a measure. It really doesn't matter which one that happens to be declining over time. And we're seeing that SIR moving lower and lower, and all of our data points are actually falling below 1 meaning that each of the SIR represented on this chart are demonstrating that we're observing fewer infections than we're predicting based on national data and that's always what were hoping to see. And this line at 1 is calculated using the original or current baseline that are in HSN, and as a reminder the number of 1 for an SIR has a very specific meaning so it's not about the number of HAI that are observed alone. It's not about the number of HAI that are predicted alone. It's about the ratio of observed to predicted infections. So an SIR of 1 meaning you're dividing a number by itself or that you have seen exactly the same number of infections as predicted. So just to give another example if you observe 250 infections and you predict the same number the ratio is 1 meaning you have an SIR of 1 and just to give that little bit of context. So again to refresh the predicted number is calculated based on the national baseline and happily, generally what we're seeing is for many HAR measures, HAI measures that the um

SIR is getting lower and lower over time and that's the example that were looking at here and now that were re-baselining what that means is that were actually redefining what 1 means because we have a new predicted number unless the immediate falls lower than the original baseline because national numbers of this particular HAI have fallen a great deal since the original baseline period so we might have a new 1. So for a measure like we're using in our example what we're seeing is national numbers declining. Um, we might see the impact of this during re-baselining because the national baseline is now lower than what it was during the original baseline period, and that's a great thing so this is actually a cause for celebration because it where means, where it means were seeing their efforts for patient safety are really paying off. So if the new baseline is lower than the old baseline which again represents success in our facilities and at the national level, um, that means that new baseline is our new one. So whereas before we saw a nice sloping line of declining SIRs all going below 1 which is always what we want to see now we're seeing most of our SIRs falling above 1 because that new 1 is the new baseline even though we're still seeing the same declining trended. Um, and just to make a couple of points about this and let me just animate here. So this is our new 1, right? A couple of points here though. So we're not going to be using the new baselines to look at any data prior to 2015 as I mentioned earlier so data would never be presented in this way. Re-baselining is about accounting for the good progress that we've made and making a shift say you know okay you have success, um, now it makes sense to set a more ambitious goal for ourselves. Um, and we're going to be presenting these SIRs and this shift in a way that will account for re-baselining and that's something that we'll talk about at the next meeting, and secondly bear in mind that this shift is going to impact everyone so in this scenario where SIR has been declining for a particular measure everyone, all facilities, all states will see their low SIRs moving up closer to 1. And it can also work the other way, right. If everyone is seeing, uh, you know, uh oh, for nationally for a given measure numbers have gone up, then you will see, uh, our numbers going down instead of up. So our numbers will look comparatively better. Just an example, I have no idea if that will be happening, um, but it works statistically that way. So, and then these are just some further resources about re-baselining and highlighting the last link on the slide. I guess things got a little funky when formatting, sorry, um, but that's really the best place to go, the re-baselining web site if you want more information. So, I can just move on to the next presentation or we can talk a little bit about this.

Next Speaker: I think some questions would be good.

Next Speaker: Yeah.

Next Speaker: Great.

Next Speaker: Yeah, does, uh, anybody have any questions, anybody on the line?

Next Speaker: No.

Next Speaker: Anybody have questions in the room?

Next Speaker: I, uh, well I mean I guess, and you might've covered this, but just in terms of being able to compare data going forward to earlier data. I mean are, are we gonna be able to calculate using the **** baseline? Is that gonna be **** or not or what's the best method –

Next Speaker: So we will have, the original baseline will stay available to us in the system. Um, for years of data that would be appropriate to use it for.

Next Speaker: Oh but for not, for future years we will not be able to –

Next Speaker: Um, no, sorry, I'm just trying to find my slide, yes, so the original baseline will be available for data up to 2016 and the new baseline will be available for data starting with 2015.

Next Speaker: So what's the recommendation for like how to figure out exactly how we're doin' in next year compared to 2010?

Next Speaker: So **** so that's something that has come up on a lot of calls, and, um, I personally had a little hiatus while I was making the transition, um, from connected to here, but, uh, I think a lot of people want recommendations from CDC regarding how are we gonna, uh, present these data in a way that feels consistent and not overly complex.

Next Speaker: Yeah, it's gonna be hard for people to know what –

Next Speaker: It's gonna be hard no matter what. The SIR has never been a very accessible measure in general and we just struggle with how to do messaging around it. Uh, but what we will be doing is waiting, um, patiently for NHSN to come out with maybe some recommendations and in the absence of that, we will be coming up with our own recommendations and, you know, trying to, trying out a couple of different things, seeing, and bringing them to the advisory committee and seeing how people feel about that.

Next Speaker: So, and I'm guessing we'll discuss this in more depth at the next meeting. I don't know if anyone has any immediate thoughts though in terms of ****.

Next Speaker: Go ahead. Paul?

Next Speaker: Yeah, I just have another question. So the SIR is, is designed to do risk adjustment, right -

Next Speaker: Yes.

Next Speaker: - and adjust for various factors, so other than drawing a different baseline, will tho, is, is the risk adjustment itself being altered so that the curve would actually look different?

Next Speaker: We don't have access to the models. Um, none of this has been released to us, but my expectation is that it would be, yeah.

Next Speaker: So if I'm understanding this correctly, so there are some diseases like Clostridium difficile that we know has actually been creeping upwards instead of downwards. So I therefore would expect my SIR to rise, my baseline SIR to rise in this situation. So I guess what I'm saying is in this case, that's actually bad, right; we want to continue to be moving it down. So it's almost like a higher SIR. This situation may make people feel comfortable that they're doing the same thing as other facilities nationally, but again, we're movin' in the wrong direction, which may be not, which may not be the message we want to send.

Next Speaker: So I hate to say bad or good. I think what I would say is that we are com, we're comparing ourselves to a more accurate prediction. So if nationally we're seeing CDI creeping up then the baseline will go up and then our, and then our high SIRs will move closer to 1, meaning that they won't go down, yeah. So, um, this can work both directions and I think it's important to not let a high baseline lead us to complacency.

Next Speaker: That's what I'm saying.

Next Speaker: And this is what you're saying?

Next Speaker: Yeah, I mean –

Next Speaker: But it, it's **** –

Next Speaker: – but the opportunity to prevent actually if yours starts going up, you actually have a greater level of opportunity to, we hope, to prevent –

Next Speaker: Have they, have they said for sure that they would increase an SIR? So they might leave it the same potentially?

Next Speaker: No.

Next Speaker: It, okay, it'll definitely –

Next Speaker: They, they should not be leaving anything the same.

Next Speaker: The same, okay.

Next Speaker: All, I mean, I guess if, who knows, right?

Next Speaker: Well, it's gonna be based on what the actual data is.

Next Speaker: We hope, we hope that's true.

Next Speaker: ****, of that, yeah.

Next Speaker: Well –

Next Speaker: You get to see some of this conversation about what we should be achieving in our view HHS targets. So that is something else that, and I think these are important things that we can represent in our narrative when we're actually presenting and displaying data.

Next Speaker: I've heard some beeps on the phone, **** may well be people dropping off and maybe there are people joining, so has anyone joined the call? Okay.

Next Speaker: 'Kay.

Next Speaker: Okay. Any other questions or are you ready for more, more torture?

Next Speaker: I have one more question –

Next Speaker: Yes.

Next Speaker: – this is more for the, the group. You all expect healthcare facilities that get the new SIR data and see higher, you know, uh, whatever, they see their numbers go up, um, you cannot, I have to do plain language here. Um, do you expect to get a long of concern and questions that are, I'm assuming there's gonna be a huge communication campaign I guess around this or –

Next Speaker: So, and NHSN has been doing a lot of outreach already. Um, and that has been available to not just people like us who are group users, um, but also people at facilities, but we can definitely talk about doing some, like, targeted outreach to our facilities to discuss that. I mean, I don't know how much your facilities using it now.

Next Speaker: No, I, I would recommend some talking points, um, because it, it will be difficult, um, for some facilities I think to articulate because you know administrators are gonna be calling people up to their office suits to talk about the data and why it's gone up and why it doesn't look as good as it used to.

Next Speaker: And, and Mary, I suggest that that CBO **** presentations to the APIC **** committee –

Next Speaker: Yeah.

Next Speaker: – 'cause I think that's probably the organization's that gonna be the most interested, or does that seem like?

Next Speaker: I think, um, that would be –

Next Speaker: On this topic.

Next Speaker: Yeah, we might think through too if there's some other groups that we just –

Next Speaker: Yeah.

Next Speaker: – kinda wanna reach out to. And again, I would have you publish an annual report. You know you're gonna get calls from the media. So kinda getting some of those talking points together I think.

Next Speaker: Yeah, I'm, I'm happy to get this presentation wherever it feels most appropriate, so –

Next Speaker: Well, **** –

Next Speaker: And we can also adjust this to **** Vinnie and ****, as well.

Next Speaker: So I think you've been hitting a, a new group recently with all this healthcare coalition meetings too and they right now know about this data and who knows how interested or not they are but that's a totally different, to some extent you've got a lot of –

Next Speaker: Yeah.

Next Speaker: – people who wouldn't have been familiar with this before. So to see one or more change very drastically could be shocking and –

Next Speaker: Yep. And I think we can ask, like, Barbara Wade was on the line and some other people are members of this committee so we maybe can get some input from them, um, for, for what they maybe need to help communicate to their members.

Next Speaker: Great.

Next Speaker: Okay.

Next Speaker: Should I move on here?

Next Speaker: Sounds good.

Next Speaker: Okay. So, we just talked about re-baselining and an interest by which is part of the upcoming system update, date TBD, right?

Next Speaker: Yes.

Next Speaker: Um, but there's another piece of this system update that I wanna introduce today and that is the new user interface. So what does that mean? Just that NHSN is ruling out a new look and feel in its annual update. So before we start, just a disclaimer. This presentation isn't exhaustive. It's just something to give you a taste and help you expect what you're gonna be seeing and like I just said, NHSN will soon include new SIRs, new baselines, new variables, new reports but also will look visually different. Um, some parts of this application are in the same place but have a new look and some parts of the application have been moved or renamed and also have a new look. Um, and the goal of this is to create a more user-friendly intuitive

environment for creating reports and analyzing data and we do not know when these changes will be implemented but some of you may have noticed that Sam's already looks different and that kind of look and feel of Sam's is really similar to the new look and feel of what NHSN will be like. And I'm more or less just gonna start off by introducing kind of like, the updates that just impact the look of the surveillance system and then move on, run through some of the pieces that have had more substantive changes made or will have had more substantive changes made. Um, I know their disclaimer as I wanted to be very visual with this presentation because that's what it's all about, um, but some of the before screen shots may be really old or may not apply to you based on what you see of what type of facility, um, data I do work with. It may not be exactly what you're used to seeing, but it does just give a general sense. So, starting with alerts, alerts will still show up when log in and have the same names but they just have a different appearance so on the top, and this is how most of these lights will be structured as what the current system looks like when you're looking at your alerts and then they will move to this look on the bottom. Monthly reporting plans, again, they're in the same place, uh, when you're navigating to them but they just have a slightly look and feel. And just as a side note, all of these arrows and highlighting and things are just, they're not what the computer will look like when you're looking at it. It's just notes and I just pulled a lot of these off of other presentations.

Next Speaker: Oh are they, is, it's, is it, this is just mainly look appearance wise.

Next Speaker: Yep.

Next Speaker: Is, is there much difference in terms of anything else?

Next Speaker: Mm mm.

Next Speaker: Okay.

Next Speaker: No, this, the alerts and the reporting plan should be really really similar the way they function. It's just the way they appear on the screen.

Next Speaker: Is it easier to use?

Next Speaker: I haven't tried it out, you know? It hasn't been released, but that's the goal.

Next Speaker: That's, yeah, that's the main ****.

Next Speaker: Yeah, so, you know, sometimes NHSN does these changes, they can, make easier and more intuitive and user friendly and sometimes they don't. So we'll just have to see but I suspect that it will be better, yeah. Um, generating the **** again will look different but behaves exactly the same way. So above is what we see now, below is what we'll be seeing when the new interfaces rolls out so very, really very similar. And the same with the statistics calculator. And I'm not sure how many folks use the statistics calculator, um, but as a side note just to kinda plug the statistics calculator, this can be a really useful tool for analysis and for anyone who's interested in learning more about it, welcome, as with any of this to reach out to

me and they are adding, did add some more options in the statistics calculator as well which is nice.

Next Speaker: What are, what are the **** options?

Next Speaker: So the new options are compare a single proportion to a benchmark.

Next Speaker: Okay.

Next Speaker: And compare a single SIR to a nominal value. And I have yet to hear, um, anything in detail about the new statistics calculator.

Next Speaker: Yeah.

Next Speaker: Let's see, have you **** – so yeah, so I think we'll probably be expecting more communication from NHSN once they actually have this up and running.

Next Speaker: ****.

Next Speaker: But just, it's just nice to see what's coming down the line so it's not sort of shocking when you open it up for the first time and these things have rolled up. And just as a side note, I think we're also gonna expect that there are gonna be bugs in this because there are buts every time they do an update so, you know, if you see things that are not working the way they should be working, document them and write them down and send them to NHSH because they will not know if we don't tell them. And they are, they do take these things into account.

Next Speaker: Yes.

Next Speaker: So, now we're able to look at some other parts of the application that not only look different but have had other changes as well. So the analysis menu, which is located in that blue navigation bar on the left-hand side of the screen has changed, so instead of out-print options, users will choose reports under the navigation bar. However, it's still located under analysis. And this is just where custom reports are located. So for folks who are creating custom reports, now all of them are located in one folder whereas before they were kind of spread out throughout the **** and I think this is a great change 'cause I had the experience myself of creating custom reports and then forgetting which output I had used as kind of like the starting point, and then, like, clicking around all over the place trying to remember, where did I hide it. So for those of you with bad memories like me, now they're all grouped together in the same place. Selecting a baseline will be new because before there was only one baseline so you'll notice we don't have a before and after for this light but this is where you'll go to generate outfits using the original baselines. The default is the new baseline. So baselines at one refers to the original baselines. And for running and modifying output, um, the run and modified buttons that were found in earlier versions of NHSN have been replaced by a drop down menu. This allows NHSN to display the full report name. Um, sometimes it was doc report **** presented some difficulties and users can eith, either left or right click on a report name to display the available options, um, in a drop down. And for CDCs **** reports, those are the caned reports from

CDC. Um, the drop down menu just like before gives the option to run or modify and you can also export the data set which just means that the system will give you a line listing of all the data that contributed to the analysis that you've selected. Um, for custom reports, again, they're all located in the same place. The drop-down menu gives run, modify and then delete report which is only available for your custom reports. You can't delete CDC canned reports. Um, and users can also export the data set, publish the report and remain in the report and I'm really not familiar with what publish report will mean. Um, I don't know if anyone in the room can educate me about that but I did send the question to NHSN so we'll see what they have to say. So before all the possible modifying, or all the possible options for modifying, um, data sets were in the same page and that's that screen shot on the left. And whereas now the new modification screen actually has tabs for each of the kind of sections of this ****. Um, depending on the report being modified, the modified screen may include tabs for title format, time period, filters and display variables and I'm gonna go over each of those in a little bit more detail and how they correspond with the old modification screen. And a screen in addition to the tabs also includes the analysis data is that name, it includes the report type like whether it's an SIR or a line listing, it includes the date that the **** that was generated on and a checkbox that says show descriptive variable names which replaces the checkbox that said display variable labels, so that's just to see the more expanded or intuitive name for the variables in your output. So title format is the first tab, formerly known as output title. This allows you to change the name and title of your report. Will be most useful, um, when you're creating custom reports so you can distinguish them from one another. The second time is time period replacing selected time period or leave blank for cumulative time period. Um, you still have the same data variables available to you and the option to enter the data variable or time period at the time the report is run by checking the box next to that option as well. Filters will be the third tab. Um, this replaces, this'll, uh, specify other selection criteria and instead of that grid, now we can dictate how data are displayed by grouping them, um, via drop-down menus that assign rules in those drop-down menus, um, and hopefully this will be a really positive change because the grid could get a little tricky and, like, glitchy at times and depending on, yeah, your Internet browser I guess. This one is slightly different from the others because it's only available for line listings, um, and this has not changed but from line listings this will occupy the fourth tab and, uh, before it will allow you to add, delete and change the order of variables in a line listing. And this replaces the modified variables to display by clicking but it will work the same way. And then finally, the last tab'll always be display options which replaces other options as the header for the final section of the modification screen and this gives you the ability to group your data in your report by summarying your month half year and quarter or to create a report that displays all of your data in one cumulative table. So some more resources for other information. This last piece has not yet been posted on the re-baseline and web site but I expect that it will be, um, and that is all. So any questions regarding this?

Next Speaker: Does anybody have any questions for Rosa? N'kay. Um, I just was gonna comment, Rosa. I, I think what I may do is explore with the AIC chapter if they would like a separate webinar, um, a lot of the information you presented today, um, so we'll kinda find out how much, how many webinars they've been able to see but it might be something that we offer specifically for that group.

Next Speaker: Yep, I'm happy to do that.

Next Speaker: 'Kay. Any other comments?

Next Speaker: No one on the phone?

Next Speaker: Nope.

Next Speaker: N'kay. So, um, I believe we were scheduled to take a break but I know that we are looking at some beautiful snow falling outside and, um, I wonder, um, if, can I have everybody's permission to just continue on and skip the break?

Next Speaker: Yes.

Next Speaker: Is that okay? Okay. I'm seein' lots of nodding heads and hopefully those on the call agree.

Next Speaker: I have to pretend I'm not here though.

Next Speaker: So, um, Ann, are, are you comfortable presenting now or?

Next Speaker: Yeah, sure, it's just my stuff ended up on a –

Next Speaker: Yeah, it should be. Thanks. There you go.

Next Speaker: Okay.

Next Speaker: Okay.

Next Speaker: So, Ann Tonis, this, Ann Tonis joined us. Ann, I'll just let you officially –

Next Speaker: All right.

Next Speaker: – introduce yourself.

Next Speaker: Thank you for inviting me to talk. Today I'll be, uh, presenting some data from a vital Hepatitis profile that we published last year. Uh, we have a small grant from the, uh, uh, Association of State Territorial, um, epidemiologist, no, she was at –

Next Speaker: Health Officials.

Next Speaker: – Health Officials.

Next Speaker: Yeah.

Next Speaker: Thank you.

Next Speaker: Okay.

Next Speaker: From them, very kind of them, and so we were able to produce a, a profile. In March we covered data from 2009 to 2013 and I'll run through some of that for you. Uh, we cover acute and chronic viral Hepatitis and that most of what I'm showing you today is Hepatitis C. We, we did cover acute Hepatitis A, then chronic, um, acute and chronic, uh, Hepatitis B. But I'll be focusing mostly on Hepatitis C today. And we'll also show you some trends in liver cancer, has, hospitalizations, transplants and deaths. Oh, that color did not show up very well. Huh, I've done this, uh, presentation before. It didn't, uh, it was, it was beautiful before but, well, what I can tell you is that we average about 25 cases a year of acute Hepatitis C, which doesn't sound –

Next Speaker: **** with the hard copy to show **** –

Next Speaker: Yeah, look at your hard copy. It, it shows up well. Um, oh yeah, the dark is much better. Um, but in any case, uh, we, it doesn't sound so impressive, only 25 cases a year but reminding you that 70 to 5 to 80 percent of cases are asymptomatic and then not everyone, uh, presents for medical care when they have these symptoms. And CDC, uh, estimates that for every acute case that's reported, they have this multiplier of, like, 13.2. So our real number is probably about 300 new, uh, cases each year in Oregon and, um, our next slide here shows up a little bit better. We've got some contrast. Shows the age distribution, that the cases from 2009 to 2013 and you can see that this is generally, uh, uh, an infection that is acquired in the younger years, the bulk, uh, the highest number of cases were in our 20s. And basically about 50 percent, um, well actually this was nearly half the cases are under age 30 and, and really the majority are, um, under, uh, age 40. Uh, 56 percent were male but in some of the younger age groups of, of men and, distribution of men and women were even. And then the majority, it's in black here, huh, um, the majority, uh, reported injection drug use as, as their risk factor. And then this compares us to the national average, the Oregon, uh, rate is in green and the U.S. rate is in purple there and you can see that for, with the exception of every year but 2013, um, we were above the national average and since then I can say our numbers have dropped down slightly as, and the U.S. average has gone up because of, uh, largely due to this, these big outbreaks, um, of injection drug users in rural areas that have been detected. Uh, now this is, uh, this slide is showing you kinda the trends in our chronic Hep C cases. And we don't know that much about them because there were so many of them we don't require our county health departments to investigate them. We get the information that's on the lab slip so we know things, uh, like their age and sex and, uh, county of, of residence. I think the, the striking thing is to really impress you with the burden, um, 'cause if I just told you that, oh, we average 5,000 cases a year, it's like, oh, that's sort of a lot but what does that mean? Um, what I did is, here, on this slide, the bright, uh, green cases are the cases of Hep C. And the blue bar represents all of other, uh, reportable infectious diseases sums together, that's including HIV and the, um, the STDs except we've excluded chlamydia because that's another HCV magnitude like disease. And so you can see, uh, this is why for instance, we can't get county health departments to investigate these 'cause it would essentially double their, their workload. And then the other sort of thing to point out is that two thirds of these cases were 45 to 64 years of age and so-called, uh, kinda baby boomer age group and so that's, uh, contrast, uh, from the acute, um, cases. Uh, another thing that sort of strikes people is that, you know, usually, I think for years you would just, just, you would just do, uh,

frequencies of cases and so it always seemed like, oh, there's a lot of disease in Multnomah County because they're the biggest county and maybe 20, 25 percent of the cases in our state every year occur in Multnomah County and probably just under 50 percent are reported in the metro area. But if you look at rates and take into account the size of the respective county, uh, it turns out that the top five counties here, uh, and these are in order by their rank. The number next to them is the average counts of cases. Um, you know, the rates are really in several, uh, rural coun, you know, counties, and, you know, if you do it by incident rate, Multnomah is not even in the top five. They're, they're ninth. Uh, I think that's striking to people who kind of assume that this was sort of, uh, a big city injection drug user problem. It's really, as I point out, this touches every corner of our state. And then another thing we did is, I mean, we all know that Hepatitis B and C are, are risk factor for liver cancer but, uh, I think people are often surprised to find that, um, cancer registries in U.S. states don't actually collect this information among the data they collect about liver cancer patients. So we, uh, decided to take a look at this and we obtained, um, data from the Oregon Cancer Registry from 1996 to 2002 and we matched it up with our Hep B and Hep C registries. So as you can see, um, and this is by the year of the liver cancer diagnosis. It runs, for this, you can't see the numbers, it runs from 1996 up to 2012, um, and so the bright green bars are cases that are not associated with Hepatitis and in the first few years here you see some that are associated, uh, that kind of lighter color is cases were found in our registry to have Hepatitis B. Uh, now we did not make Hep C reportable in Oregon until 2005 which I think is one of these bars where you start seeing the purple bars which are the Hep C cases. Um, and it looks like, oh, it shot up rapidly. I mean, the fact is in 2005 you wouldn't be marked as a purple, uh, unless you are in our state registry. So unless you were diagnosed in the state of Oregon in 2005, you wouldn't have been found in the, you know, the cancer registry for that year. Um, so this kind of rapid increase is a bit of a surveillance artifact. But by the time you get to say 2010 here, what we see is well, how we've had the reporting, you know, if you, if you were diagnosed with Hepatitis C in the last 5 years in our state then you would have a chance of being found by this kind of detection system. And by 2012 here, um, we find that, uh, over half the cases in our state are associated with viral Hepatitis and 47 percent are, um, related to Hepatitis C. And if you look at little bit about their demographics, you can see that something that, uh, it doesn't sort of show up until years. I mean, most of these B cases were probably perinatal cases. They're, um, the majority of these patients are foreign born persons and you can start detecting liver cancer in that group around 40 to 49 years of age and it really takes off in the 50s and 60s. Uh, for Hepatitis C, probably most of these people acquired it in, uh, you know, in the U.S., uh, in their 20s and 30s and so you really see its effect in, uh, kinda the 50s and 60s. And again, it's, uh, a male preponderance here. Uh, we also took a look at our hospital, uh, discharge data for this state and we had a, a fairly tight case definition. 'Cause I think initially we just looked for, like, any Hep C diagnosis among our hospital discharge diagnoses and that gave us, like, thousands of why, that was maybe that was 15 or 16,000. It's, like, well, you know, they could also be having heart attacks or having their hips replaced or something. So we decided that we would include them only if they had Hep C as the reason for hospitalization or if they had a chronic liver disease diagnosis as their main, um, reason for hospitalization plus Hep C in one of the other fields. So even with that restrictive diagnosis or kind of case definition, we again find about 800 cases a year over this 5-year period. There wasn't really a trending up during that time period so we lumped everyone together. See that there're not very many young people here. Most of 'em are in the, again the, the baby boomer age group, two thirds are male and, uh, nearly two third were on some sort of, uh, public

assistance. And this shows the distribution if diagnoses. We, this first one, it's hard to read, this is, um, cirrhosis, and the next one is decompensated cirrhosis. So these are patients that had hepatic encephalopathy or, uh, esophageal varices and, uh, we counted all of their diagnoses so they sum up to more than 100 'cause most people had a couple of liver-related diagnoses. And then 22 percent are other liver diseases, uh, like metabolic disease and fat, you know, fatty, um, fatty liver and then 15 percent, uh, were due to liver cancer or some complication of liver cancer and then, uh, a small percentage here, that's supposed to a 3 is, um, liver transplants. This shows, uh, the number of liver transplants performed at OHSU. The other liver transplant center in our state is the VA. And they have difficulty separating out Oregon residents from other people that come from all over the northwest, um, to get their liver transplant. So this is just what we have in OHSU. And they do an average of just over 30 transplants annually and the light blue bar are the, the non-hepatitis-related ones. And you can see there are on eor two, uh, cases done for Hep, in Hep B patients but that the, about half, eighteen a year on average are performed in patients with Hepatitis C. Then, uh, we'll talk about mortality next. Uh, a **** show the, **** time the bright green line are the age-adjusted rates, mortality rates in Oregon which you can see are, are climbling rapidly over the last several years. Um, the purple bar in the middle just below it is the, um, the national mortality rate. Again, that's age adjusted, and so you can see that over the last sort of 5 years our, uh, mortality rate is almost twice the national average. And then, uh, the good news is that, uh, the blue bar below that is, that's from HIV for which not only is, uh, are there good medicines but they tend to be more available to be people because of Ryan White funding. Uh, the other striking thing is a little factoid off to the right there, um, these are pretty premature, especially now that I'm in this age group, this is premature death. Um, 83 percent of these, uh, people were age 45 to 64 years of age. So, you know, uh, that's, you know, it's young. I mean, a, a small, only a small fraction of workers 65 vary.

Next Speaker: And is there any reason to believe that, uh, Oregon's high rate compared to that of the United States is, is artifact? Are we better at, at recording Hepatitis C on the death certificate?

Next Speaker: No, I think that's largely unknown. I haven't kept up with the literature but back in, like, 2000 we did a study where we went through, I think it was just in Multnomah County and we identified all deaths that had some chronic liver disease etiology and Hepatitis and then sent, uh, a questionnaire to the physician listed on the death certificate to see how many of them, um, had Hepatitis C. We found that Hepatitis C was grossly under reported. I don't remember the names, and I don't know if that's been repeated in other places. I mean, in general, it's probably safe to say that Hep C is under reported but I don't know if we know the magnitude of that nationally.

Next Speaker: Is, is your team taking steps to get Hep C listed on the death certificate if, if –

Next Speaker: No.

Next Speaker: – if you know that – it, okay, so you're not **** –

Next Speaker: Now I mean, we published a paper so I'm sure it was widely read by, um, primary care physicians filling out death certificates. Um, so no, I, I can't say that we've, we've done

anything. Yeah, so this is, I mean, it's probably real as well as, uh, I don't know if we, if there's anyone, if there are other, if each didn't know if there are other chronic diseases where people have done that kind of validation work and find that Oregon clinicians are different from anyone else. I don't, I don't know.

Next Speaker: We were twice the age-adjusted death rate?

Next Speaker: Yeah.

Next Speaker: Um, uh, that's **** –

Next Speaker: Yeah, and I mean, I guess what I'm gleaning from your presentation, too, is we still don't really have our hands on, on risk factors, right? I mean, some of the things we thought might be risk factors might not be, like when we're looking at the Royal County slides and things like that.

Next Speaker: Well, the hard thing that's, it was always sort of hard to get away from is like, oh, there's a lot of –

Next Speaker: IV drug use.

Next Speaker: – drug use or something out of –

Next Speaker: Yeah.

Next Speaker: – those counties. And, and one that's partly true. The other thing you have to think about, uh, which makes these data sort of hard to get a handle on, is that these are people who probably got the disease 20 or 30 years ago. So, you know, even if you add some risk factors and got a history of injection drug use from people, when you're asking them, um, for people who are largely in their 50s and 60s, um, it, I mean, it's not necessarily pertinent to what's going on with them now or is not –

Next Speaker: Mm hmm.

Next Speaker: – necessarily a reflection of where they live now. I mean, maybe they got it in Portland 30 years ago and now they're, they're living in, uh, assisted living down in, uh, down in the coast somewhere. Um, but it does show you that that's where people, no matter where they, how they acquired it, that's, they're everywhere. You know? I mean, I think it's some kind of thing we wanna impress state legislatures with. It's like there are people with Hep C in your, you know, in your district. Um, maybe they didn't acquire it there, uh, but then the second piece is, um, you know, injection drug use. I mean, we're, we're seeing the highest overdose death rates are in some of these rural –

Next Speaker: Mm hmm

Next Speaker: – areas. And then lastly, um, I wanna talk about some of the racial disparities we uncovered and the first row, let's see, so to set it up for you here in the dark, this, uh, the first set of columns are, uh, uh, among American Indians and Alaska Natives. The middle group are blacks and the third group are white. This top column are the race, uh, among chronic cases. Now the fact is, we don't have good race and ethnicity data for this group so we just have what's on the, um, the lab set for the most unless some counties do a little bit more investigation and, uh, find this out for us. So if I'd just seen these showing that, you know, that we had twice the chronic rates in these racial groups compared to whites, I probably would not, I would've been very reluctant to publish it, you know, or with huge huge caveats because there's so much missing data, but the middle bar here shows the liver cancer cases by race and the last one are the deaths. And for these, I mean, race although it, people may get misclassified, um, uh, you know, that those data are there for like, over, you know, 98 percent of the cases. And here, it's, it's a little bit more subtle but this is 5.1 and this is 4 something, and this is 3 for whites. We did see the highest liver cancer rates in blacks followed by American Indians followed by whites. Uh, and then with the deaths, we saw kind of the same trend we saw up here where the, the deaths in blacks and Alaska Natives are roughly twice what we see, um, in whites. So just as, uh, a summary, uh, at this point you will hopefully be impressed by there's a significant burden of disease, uh, from Hepatitis C resulting in these chronic sequela, hospitalizations, cancer and deaths. Um, most of them are occurring in a fairly young age group, the baby boomers. Um, but most of the kinda the current transmission is occurring in people under age 30 and we think that most of that is, is due to injection drug use. Uh, and then again as I've mentioned before it re, really it's kind of all over the state. No one's, uh, it's, you know, if you look for it you'll, you'll find it. And then kinda the high-risk groups in, in Oregon are the American Indians, Alaska Natives, blacks, persons who inject and then I, I had another, uh, on a, on my longer talk, I have a section on incarcerated persons but that's also as you can imagine a, a high-risk group. Um, so that's all I have. I'm happy to answer any questions you have.

Next Speaker: Did you pull the data from all stuff that you guys collect directly or what, what **** _

Next Speaker: Pretty much. So the data sources, uh, were our surveillance data and then, uh, the Oregon Cancer Registry, uh, we entered the data use be with them and then we also worked with, uh, vital records to get the death data, and then we also, um, you know, worked with health analytics to get hospitalization data.

Next Speaker: it would be interesting to see, um, incidents of liver cancer in chronic cases and case fatality rate by race and ethnicity.

Next Speaker: Oh, right, among the liver cancer, uh –

Next Speaker: Exactly.

Next Speaker: You probably have it. I think that those numbers are pretty small –

Next Speaker: Would **** –

Next Speaker: – once you get there 'cause I think there were, uh –

Next Speaker: – their disparities by –

Next Speaker: Yeah.

Next Speaker: – race and ethnicity though and outcomes.

Next Speaker: Yeah, 'cause once we got to –

Next Speaker: Yeah.

Next Speaker: – yeah, well, so there were 600, yeah, if you go through 2012 there were 600 c, liver cancer cases, so, I think once we broke it down by race the, the numbers get pretty small, but it would be interesting to see if there are, are, like, a delayed diagnosis for instance, late stage **** _

Next Speaker: Access to their –

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: For **** you got an enormous disparity by sex.

Next Speaker: Yeah.

Next Speaker: If you want disparities, there it is 78 to 22. I, I have a hard –

Next Speaker: Yeah.

Next Speaker: – I have a hard time understanding if, if most of the Hepatitis B was perinatally acquired, whey would there be such a male preponderance?

Next Speaker: Oh, that's true. Um, there is, again we don't have a lot of data. I mean, and I don't know enough about liver cancer and Hepatitis B to see if there, to know if there is some biologic reason for men to more likely to get it. Uh, one theory I had, and I don't know if, and I don't have any way to substantiate this and maybe more men are drinking and that accelerates their –

Next Speaker: Oh.

Next Speaker: – uh, that's –

Next Speaker: Their diagnosis?

Next Speaker: Yeah.

Next Speaker: Hi Ann, this is Genevieve. I'm from Providence. I just had a couple of questions.

Next Speaker: Sure.

Next Speaker: Um, one was I was wondering if you happen to have an idea if any or if any of these were healthcare associated, those, so, such around case injection practices and healthcare settings and then also which I think might affect us and the hospitals is, uh, what, uh, you know, what the rates are around, uh, women of childbearing age.

Next Speaker: Mm hmm.

Next Speaker: Uh, because I can say in pediatrics, I think this is something we don't look for enough.

Next Speaker: Right.

Next Speaker: Uh, and, um, there's also poor communication with OBs, the pediatrics about, about that and sort of follow up for, for kids and things like that –

Next Speaker: Mm hmm.

Next Speaker: – and if you had anything, comments on those things?

Next Speaker: Yeah, there's, um, you know, we have not had any big, or we've not been able to detect any big outbreaks or, or that much, we have not as, not really had many cases that we could attribute, uh, to healthcare settings. And No. 1, the reason is that most of these cases are asymptomatic, and for instance, you know, even though we get 5 or 6,000 cases of, you know, chronic cases a year reported to us, we don't so any investigation, so the times we hov, have done an investigation, um, is when we've had an acute case that really didn't have seem to have any of the typical risk factors but had, you know, had surgery or something or some healthcare, um, exposure in the previous 6 months. And we've tried to do investigations then but it is very difficult to do when you only have one case. I mean, typically what we would do is we find other cases, yeah, say someone who'd been, had been a case in the OR in the previous 2 days, you know, prior to our person being in the OR and we'd look at the staff and we'd take this list and we'd run it across our registry and maybe find that 2 or 3 percent of them did have Hepatitis C but that's what you find in the population, and it's always hard. Um, the next steps then would be, like, notifying patients and asking to get blood from all of these Hep C-positive people, uh, to see if it's, you know, to see if we, we can get it sequenced to CDC to see if it matches. Very difficult based on one case to get hospitals to agree to this or to agree to any kind of widespread patient notification. And if you think to any of the outbreak reports you've read, it's like they have it easy. Like, all of a sudden in, uh, was it Las Vegas, there's, like, six h, acute cases in a month and four of them had, you know, this, uh, you know, colonoscopies or something. And it's like, that almost never happens. There were all these sporadic cases and it's, it's hard to find. We did participate in a case control study with a couple other EIP sites, oh, it's probably been almost 10 years ago now where we, uh, did detailed, uh, questionnaires of cases

over, I think acute Hep B and C cases over the age of 50 and did identify some risk factors like having been hospitalized and so forth. So we know that these cases occur. I don't know that we really have a good sense of how many. Um, as to your second question, uh, I would agree that for Hep C, we just haven't paid attention to it. We assume that children who are born to infected mothers would get screened and we'd, they'd get reported to us. And if you look in our database, you know, we have maybe two or three cases a year but then I was at the Vermont Oxford collaborative meeting and talking to all these neonatologists who were talking about the number of neonatal abstinence syndrome cases they had and how many of their mothers were, um, were positive for Hep C and it make me think that we need to be looking at this, uh, more carefully and that's an area where I would like to do some, uh, more investigation.

Next Speaker: Yeah, I think that would be, um, that would be, you know, nice to whatever, you know, data you have to help inform that because there are some –

Next Speaker: Mm hmm.

Next Speaker: – general guidelines out there that, you know, people **** test to analyze in 18 months or can you do DNA testing in 2 to 3 months and then kids get lost in follow up. So I, I would say from personal experience there's, there's very poor follow through –

Next Speaker: Right.

Next Speaker: – on that.

Next Speaker: Right.

Next Speaker: Um, Hepatitis C status is, it's not, it's not one of the normal prenatal labs. It's not, you know –

Next Speaker: Right.

Next Speaker: – here in Oregon. I know other states have it as an opt out lab, um, for prenatal testing, which I think is great, but here it's not, so it doesn't sort of make in that, uh, standardized formation transferred ****.

Next Speaker: Right, exactly. And I think, um –

Next Speaker: So, so those would be, could be really interesting to kind of see how we could've improved that, but –

Next Speaker: Yeah, I was thinking we could do a study where we took, like, a year, if we took, like, just birth certificates from 2015 and matched against our registry, we could come up with a number of infants exposed to Hepatitis C in 1 year and if you would expect that, say, 5 percent of them would have infections and then see what was reported that year and show this, probably vast divide between expected number and observed number, that we might have a case to, to go for opt-out testing.

Next Speaker: Well –

Next Speaker: Yeah.

Next Speaker: ****.

Next Speaker: So get in touch and, and, uh, we'll, uh, we'll see if we can find someone to work on this.

Next Speaker: I'll look into ****, yeah.

Next Speaker: So in your mind, you have some planned next steps, where you want to go to next. I mean, I heard a couple ideas coming across but –

Next Speaker: Yeah, I think –

Next Speaker: – anything else –

Next Speaker: – the hard thing is that we, um, we don't even have a dedicated hepatitis epidemiologist right now with the state. Uh, so it's hard to sort of keep up with this stuff. I mean, last year I did, uh, another study looking at this kinda thing more carefully, and among Medicaid patients because they had a preventive medicine –

Next Speaker: Mm hmm.

Next Speaker: – resident working with me for 6 months. Um, but we're applying for some new grants. One, we're working with, um, Todd Korthuis at OHSU whose, um, done a lot of HIV work and he's a pain and addiction specialist, so he does, he's done a lot of work, like, training providers to do medication, assisted treatment so that one is actually, um, to, to start, uh, expanding HIV, hepatitis and STI screening in rural, to rural injection drug users and we're working on that grant. And then I just got an RFA from CDC for, um, to approve hepatitis surveillance and there are gonna be 14 Awards so I'm hoping that we can, um –

Next Speaker: Hmm.

Next Speaker: – get one of those. 'Cause 'specially if I had a full-time epidemiologist to do, like, some of this stuff, I think I would like, like to start looking at, um, 'specially we, like, we know that there's a lot of rural injection drug use and I'd be curious to know, like, from it, some of our Hep B cases is, uh, injection drug use popping up as a risk factor –

Next Speaker: Right.

Next Speaker: – more often in rural areas in contrast to, you know, for, foreign birth. Um, but I think we could do a lot more with the perinatal cases. I think the other thing is, is just, um, I mean, really thinking upstream, public health is, um, you know, preventing and treating, uh,

mental illness, addictions a lot better than we currently do. It's, out of **** of this group right now but –

Next Speaker: Mm hmm.

Next Speaker: – um, –

Next Speaker: Yeah, the, the sort of upstream I think is a really key point and –

Next Speaker: Yeah.

Next Speaker: – ****, thanks for bringing that up.

Next Speaker: Yeah.

Next Speaker: Especially with treatment available, um, you know, if you're identifying say women of childbearing age that have Hepatitis C, you know, or those folks that could be potentially fast tracked to treatment, um –

Next Speaker: Yeah, exactly. Um –

Next Speaker: Take away that even risk to, even passing it on. Even though it is a very low, low risk, but still.

Next Speaker: But just the, the vast, I mean, I, I would, I'd have to look this up. I think, um, just that we knew, like, in these younger age group there are, you know, almost equal numbers of men and women being diagnosed with Hepatitis C. Um, and just our numbers, al, although there's an intervention for HIV and the rate of transmission is much higher, there aren't that many women liv, of childbearing age with HIV in this state. I've, I'm guessing, compared to the numbers of Hep C. I mean, that would sort of make the risk of being born with Hep C probably higher in this state than being more with HIV. Um, that's why I need to get numbers to, to prove my hypothesis. But for right now, it's a good working hypothesis. But for right now, it's a good working hypothesis and –

Next Speaker: Thanks for your work on this.

Next Speaker: Oh sure, sure, well thank you all for inviting me taking you off topic a little bit, but –

Next Speaker: That's okay.

Next Speaker: Did we have, um, did anybody else join us on the phone line who have, haven't introduced themselves?

Next Speaker: Hi, this is Debbie Herst, I've been on here.

Next Speaker: Hey, Deb.

Next Speaker: Hey.

Next Speaker: Anybody else join us? Okay. All right. So, um, now, Alisa, Elisa.

Next Speaker: Yeah.

Next Speaker: We'll talk about drug diversion and injection safety. What a nice segue.

Next Speaker: Okay. So this is, uh, just some data that I pulled from the 2016 Oregon HAI survey. Um, and this is something that I think the HAI program do you guys do it every year or every other year?

Next Speaker: The **** Jackson hypothesis?

Next Speaker: No, the HAI –

Next Speaker: The, uh, the HAI survey.

Next Speaker: – **** the survey.

Next Speaker: Which one? We do all sorts **** –

Next Speaker: I know. I think we do it every year.

Next Speaker: It's a big survey. I believe they do it annually, um, for hospitals, um –

Next Speaker: So –

Next Speaker: – skilled nursing facilities and ambulance service ****.

Next Speaker: Yeah, we **** –

Next Speaker: Yeah, we typ, we typically have done one for each of these so –

Next Speaker: So, it's an –

Next Speaker: – almost like a big overall survey –

Next Speaker: Yeah, okay, so this is 2016 data and I just pulled out the question specifically talking about, um, safe injection practices and drug diversion.

Next Speaker: ****.

Next Speaker: Um –

Next Speaker: How do you get that, okay.

Next Speaker: So there's just a couple, there's just, like a couple slides for each one. So I'll start with hospitals.

Next Speaker: Mm hmm.

Next Speaker: Um, and so this is, the question was, um, there's a, a variety of questions here and you can see –

Next Speaker: Make sure we got the right **** –

Next Speaker: – the light blue, um, teal color there is, yes.

Next Speaker: Um, how –

Next Speaker: Yes.

Next Speaker: Can we have ****, please?

Next Speaker: – just hit X. Um, the, you're gonna be on this call here for about another hour.

Next Speaker: Forty five minutes.

Next Speaker: Okay.

Next Speaker: Can we mute –

Next Speaker: Those on the phone, could you go ahead and mute your phones?

Next Speaker: Yeah, we can hear somebody talking in the background.

Next Speaker: Thank you.

Next Speaker: Great. So the teal is yes. The purple is no. And the gray is unsure. Um, so the first one there is does your facility provide inject, safe injection practices training on hire? Um, the next one is do they provide that training annually? Are personnel required to demonstrate competency with safe injection practices following each training? The fourth one is does your felicity maintain current documentation of safe injection practice competency for personnel. And the final one, does your facility perform safe injection practice audits during patient care?

Next Speaker: So the yeses are on the bottom?

Next Speaker: Yes.

Next Speaker: And the nos are in the middle and the unsures are on top?

Next Speaker: Yes, that's right.

Next Speaker: Yes.

Next Speaker: So this is one, there's a couple questions that are, that were asked of each different type of facility, um, so you'll see some repeats and at the end I have a slide that kind of compares them all so we can see that version as well. Um, this question, does your hospital have a drug diversion prevention program that includes consultation with an infection preventionist when drug tampering is suspected or identified? Um, so on this one the teal is yes, purple is no, gray is unsure.

Next Speaker: The teal?

Next Speaker: Yes. Teal, the first one. Is it white? Is it clear on –

Next Speaker: Yeah.

Next Speaker: – the handout?

Next Speaker: But that's not the problem. They're not gonna see any colors **** –

Next Speaker: Oh, okay. So people don't have the handouts on the phone?

Next Speaker: No, they have the handout. It's just not in color.

Next Speaker: Oh, okay. Sorry about that.

Next Speaker: So the first one is –

Next Speaker: Yeah, is a **** –

Next Speaker: Well, it's just on the screen, yeah.

Next Speaker: Just, just tell them the percentage so –

Next Speaker: Okay.

Next Speaker: – that, 19 percent are yes and –

Next Speaker: Yes, 19 percent is yes, 47 percent is no, 26 unsure and 7.5 is other. And 53 people answered this question so 53 different participants in this study. Um, so that's, those are the two questions for hospitals. Um, ambulatory surgery centers, so this is that same one as the first one we looked at, again, the, the teal, the bottom number is yes. The purple in the middle is no and then the gray on top is unsure. So again, for that first one if they provide this

safe injection practice training on hire, next one do they provide it annually, uh, and then the middle, do you require a demonstration of competency after each training, um, do you maintain documentation and do you perform safe injection audits during patient care? N'kay? And this is another repeat question, uh, for ambulatory surgery centers. Um, asking whether they have a drug diversion prevention program that includes consultation with the infection preventionist when drug tampering is suspected or identified. So 30 percent yes, 34 percent no, 24 percent unsure and 11 percent other. Um, and this is a, a question that was different for the ASCs. Um, it was just asking, this was a, a long list of if they have a written policy about all these different, different elements and these were just the ones that apply to safe injection practices or drug diversion. So 89 percent, um, said that they do have a written policy around injection safety which includes protocols for performing finger sticks at point of care testing, 90, almost 93 percent said that they use, um, they have a policy around the use of new needle and new syringe each time a medical bottle is entered, almost 83 percent have a written policy requiring staff to draw up individual dose for multi-dose viles only outside of patient care areas, almost 88 percent have a policy about tracking personnel access to controlled substance to prevent narcotics theft or drug diversion and almost 77 percent, um, identify, have a policy about identification reporting and investigation of suspected drug diversion. Okay. So then last section is skilled nursing facilities. Um, again, this is that, that same question set about safe injection practices. Um, so we're fairly familiar with those now. And that same questions again if they have a program for drug diversion, if it's, um, suspected or identified. 51 percent do, 31 percent do not and 17 are unsure.

Next Speaker: I mean, let's, uh, ****, by how many facilities are applied to these? This ****?

Next Speaker: I'm sorry I didn't mention that. Um –

Next Speaker: It's all right.

Next Speaker: – skilled nursing facilities, so the ASCs, I think it was 100 and how many have answered the KSC questions? 77 percent answered, 77 people answered the ASC's questions and skilled nursing facilities, 109 –

Next Speaker: Oh.

Next Speaker: – answered these ones. Yeah, and I think for hospitals it was –

Next Speaker: Think you said 53.

Next Speaker: – 53, yeah. Okay, and this one, this, it was worded a little bit differently, um, about if they have a, a written policy about these two different topics, injection safety which includes protocols for performing finger sticks at point of care testing, so for skilled nursing facilities 110 replied yes, 3 replied no and 6 were unsure. So that's just total numbers. Um, and then for whether they have a written policy around tracking personnel access to controlled substances to prevent narcotics, um, theft or drug diversion, 101 reported that they do, 5 reported that they not and 13 were unsure. So, um the coloring got a little off on that but this compares those, this first slides with all three. See the differences? And then this is whether they have,

um, a drug diversion prevention program that includes consultation with infection prevention when drug tampering is suspected or identified. So that first column is stacked hospital, second is ambulatory surgery centers and the third is skilled nursing facilities and again, there was an other option for skilled nursing facilities so that's why nobody selected it. And that's all I have. Is there anything –

Next Speaker: Uh, I just was gonna make a comment.

Next Speaker: Mm hmm.

Next Speaker: Okay. And, um, you know, I think overall, um, hospitals are not performing as well and I think some of that may be, it, um, and with all due respect, probably a little bit more honest reflection of actual practice. Um, sometimes, like, I don't, you know, again, there's a big difference between you have a policy and maybe you educate on orientation but then it's a huge leap in terms of are you actually auditing and observing practice and what you see. And that's where I find the greatest gaps, especially when it comes to safe injection practices and I can tell you from being in all all of the facility types, um, it is not uncommon that, um, disinfection of the glucose monitor is not appropriate for the type of device they have and they're not using the disinfectant for, like, the contact time appropriately, so some of this I think is how knowledgeable people are in terms of what the practice should actually be and then are they actually, you know, assessing for that practice. Um, and again, I, I know that, um, you know, in OR settings, um, especially, um, sharing of multi-dose viles in the OR and from the anesthesia cart and/or in the recovery room where they have a cart sitting in the middle of the unit for meds still is a common occurrence. Um, I think for the most part, Sniffs don't give a lot of injections, uh, um, you know, insulin probably foremost, um, and I think, you know, they do pretty good about scrubbing the hub, but again, you'll see practice gaps in other settings for that. So I guess I just wanna emphasize, um, the importance of ensuring that there are observational audits that are happening periodically for these practices.

Next Speaker: Where I think is so shocking the different comment is how few hospitals offer the diversion program for, uh, or diversion prevention program, I should say or don't suspect it, of diverting drug tampering.

Next Speaker: Yeah, yeah. And I think these questions –

Next Speaker: ****.

Next Speaker: – these questions came off the new CDC ICAR tools. And so for a lot of facilities, the concept of involving the infection prevention program and notifying them is different. Most of the time diversion has been handed by, like, you know, handled by nursing supervisors. Maybe employee health departments and has because of the sensitivity of the issue has been kept pretty hush hush.

Next Speaker: Yeah.

Next Speaker: So I think the request involved infection prevention in this is relatively new and a different concept.

Next Speaker: Yeah, yeah.

Next Speaker: All right. I think that's the end of the topics. Does anybody have any comments they wanna make about safe injection practices or drug diversion? Okay.

Next Speaker: Oh, I just have a quick question, Mary. This is Genevieve from Providence. Uh, Are you goin' to, uh, I'm just wondering if there, um, if there is a suspected case, like what's the best, is there a state resource to help go through that, 'cause, uh, you were saying there was sorta, there's maybe different approaches to **** each but some would be whether it's through quality or risk or legal or which kind of thing is –

Next Speaker: Well, I think, you know –

Next Speaker: **** –

Next Speaker: You know, there's a couple resources for stuff, in, in terms of facilities, they really do need a policy and the CDC has, um, a nice tool kit that's over all they're recommending for use any time there's a breach in infection prevention practices whether it be associated with sterilization or disinfection or diversion. And part of that is you have a policy and pull a stakeholders group together. Um, I certainly know HAI program, uh, is available, um, to assist with consultation and resources can be provided and then, um, there are some regulatory requirements, um, about notification of licensing boards, especially if, um, diversion is, uh, suspected. And sometimes, um, and I know this has come up a lot and it's very hard if you have individuals who you do want to test and getting consent for testing in this situation when it's suspected can be challenging but facilities have involved, um, security and law enforcement departments. Um, so I think you have to have to just have a policy in place with a group of stakeholders to be involved and then know that there are resources from, um, the community available to assist.

Next Speaker: Thanks.

Next Speaker: I don't know if anybody else has anything else they wanted to add to that? 'Kay. All right, Monika, influenza.

Next Speaker: Yes, so at the end of your packet, everybody should have a copy of our newest greatest –

Next Speaker: Is it **** –

Next Speaker: Okay. Healthcare worker influenza vaccination survey, uh, annual report. This report has actually not been released to the public yet so while you all, you have a copy of it please fill the form out and share it with the world. It's still in the processes of being approved here, which is **** –

Next Speaker: This ****.

Next Speaker: Yes. So, um, if you folks wanna look at Page 5, let me get my glasses on here –

Next Speaker: Do you have an anticipated official chair date?

Next Speaker: I'm hoping, like, in a week or two.

Next Speaker: Oh, okay.

Next Speaker: Yeah. Um, yeah, hopefully. At Page 5 of the, um, annual report shows the vaccination rates by facility type over time. Um, you can see that the hospitals have done a great job of increasing their, um, influenza vaccination rates with their employees. Ambulatory surgical centers also have increased but dropped slightly this year. Skilled nursing facilities had a nice little jump this year and then dialysis facilities again reported for the first time this year and have a phenomenal rate. Um, I need to get this fixed because these rates should be written on top of here, so that's one thing I see already that needs to be fixed. Um, and then again, um, on that next figure too, this is the mean for all the facility types. So looking at all the facility types for the mind excluding dialysis since they weren't reporting until just this last year, you can see that we've had a nice steady increase in vaccination, uh, rates across the years for all facility types combined. Then if you turn the page to Page 7, here's aggregate numbers. I'm not gonna go through this. You all can look at it, um, in your spare time, but, um, in your free time when you really wanna look at this report, uh, it shows, uh, which I think is really kind of interesting, the total number of healthcare workers eligible to receive the vaccine you'll see in the first column for the different facility types, um, and basically what that means is it's all of their employees minus those that have a medical contraindication. Otherwise, you're counted in as an employee eligible to receive the vaccine. The next column is the rate of actual vaccination. The third one the rate of declination by employees and then the final, the third, fourth column, sorry, is the, um, unknown rate which I'm gonna come back to. And then the last column is the rate of change from last year to this year whether they went up or down in their total vaccination. Now what I think is interesting is a couple of points on this graph. If you look at hospitals and independent practitioners, students and volunteers, that unknown numbers are really high. They're in the 30s. Now you just were able to even get, at these facilities the hospitals are even to just be able to get half of these numbers, their total vaccination rate could probably go up, you know, for at that least that personnel type, or even their total vaccination could go up or down, I guess accordingly. But, um, that is a really high unknown rate, I think for those, um, employee types. And then if you turn the page and we look at skilled nursing, again, the same group, independent practitioners, students and volunteers, again, have a really high unknown rate. And then, um, it follows suit again for dialysis facilities, 24 percent and 13 percent. So, um, I think, you know, if we could get better reporting, that would really help, maybe their, these, these facilities with their own numbers might look better, you never know, if might look worse, who knows. But at least, I just think that the rate of unknown is, is exceptionally high, um, in these facilities, in these two categories and if we nailed 'em down it might make a big difference in the **** history. So, then you keep going through the report, Page 10, um, is starting with the hospitals. This is just an alphabetical listing of every hospital, again, the same four columns in

the beginning, the number of healthcare workers eligible to receive the vaccine, the rate of vaccination, the rate of declination, the rate of unknown and the change in the rate from the previous years. And then the next two columns are whether they met the, uh, healthy people 2015 and 2020 goals and then the last column was basically the number of healthcare workers that they needed to get vaccinated to improve their rates to meet the 2020 goal which is the 90 percent vaccination rate, which is interesting. And this gra, this chart was pulled, um, from last year's report. I just copied the same format 'cause I thought it was really helpful and we got good feedback on it last year. And then if you continue on to the end on Page 13, again, it's a chart of each hospital's vaccination rate. Instead of alphabetically this time it's by category, by percentage from high to low. And then we have the same things following for surgical centers, for, uh, skilled nursing facilities and then at the very end it's for dialysis and there's, I'm not gonna through every single section and, and hand hold you guys to read through these 'cause you can peruse it. But if you have any questions, again, you know, please don't share these numbers. They're final but they're not –

Next Speaker: I think you have –

Next Speaker: – it's a draft.

Next Speaker: I think we should talk about it again at the next meeting.

Next Speaker: Again?

Next Speaker: More of this, yeah. Well, we talk more about it once we have a final report.

Next Speaker: Oh, once we have a final, okay. Any questions?

Next Speaker: No, just a comment. Um, do we do any type of recognitions –

Next Speaker: Yes, that's a very good question.

Next Speaker: – for those groups that really are doing an exceptional job and maybe share stories about what they're doing –

Next Speaker: Oh, that's a good thing –

Next Speaker: – with others?

Next Speaker: – to do. We could ask them, that would be a good thing maybe is to have like, a SurveyMonkey even with those groups of people. But what we do is the greater than 90 percent, um, vaccination rates, those facilities receive a certificate and a letter from us congratulating them for their work and, um, documenting their exact rate. We've done that for a couple of years now. But that would be interesting to maybe poll those people to see what it is that they do that makes them stand out.

Next Speaker: I'm just thinking like, maybe a press briefing and pr, press release or communication or something to again highlight some of the facilities that are really doing a nice job and give them some, you know, promotion –

Next Speaker: Yeah.

Next Speaker: – of some type.

Next Speaker: The dialysis facilities have phenomenal vaccination rates. I'd really like to pick their brains.

Next Speaker: They're very coordinated on it, yeah.

Next Speaker: Yeah.

Next Speaker: And the patients are, have high rates of immunization as well.

Next Speaker: Right.

Next Speaker: And I think some of that is regulatory driven.

Next Speaker: Is it?

Next Speaker: Quite honestly, yeah.

Next Speaker: Wonder how much, yeah, it comes from the corporate too.

Next Speaker: Just in terms of really promoting it.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Is that easily, I guess I could probably pull it. But out of here, the, the ones that are over 90.

Next Speaker: Yeah. If you look at, like, Page –

Next Speaker: Just the top.

Next Speaker: – 10, or 15, I'm sorry.

Next Speaker: The bars.

Next Speaker: Yeah. It's the dark green bars are the over 90 percent.

Next Speaker: Okay.

Next Speaker: Yeah. 'Cause we, since we have those regional healthcare coalitions within, uh, that our liaisons kind of run, I think this, that would be another really great place to kind of highlight the hospitals in the region that have done well.

Next Speaker: ****.

Next Speaker: 'Cause this ties directly into preparedness and the –

Next Speaker: Oh yeah, yeah, yeah.

Next Speaker: – drug ****.

Next Speaker: That's a good thought.

Next Speaker: Definitely.

Next Speaker: Any other comments? Okay. Um, HAI report distribution.

Next Speaker: Uh, I think everyone in the room who wants any paper copy of the most recent HAI report has one, right? So we have paper copies. We'll be bringing them to the next meeting as well and, um, what we would like to do during our next advisory committee meeting is to look at, um, I understand the data from the most recent report has already been presented to this group, so our next step is to think about, um, you know, what we like about this new report and what are our opportunities for some improvements for our upcoming report which will cover 2016 HAI data. So maybe a little bit of homework would be if you have some time to take a look at the report, um, which is available on our web site.

Next Speaker: Yeah, yes it, yes it is.

Next Speaker: ****.

Next Speaker: It's very available. Go to, yeah –

Next Speaker: And, um, so that's available to everyone. And we will send out a little reminder, friendly reminder, um, to go ahead and take a look at it and come with some thoughts about, you know, what kinda data we're presenting and how we're presenting it and then we will go through that and try to incorporate some feedback into our next report as well as talk about that rebase lining and how we're going to think about addressing that, so.

Next Speaker: Oh, okay. Public comment? Any public comment at all? Okay.

Next Speaker: Nope.

Next Speaker: Um, so discussion, themes and topics for future 2017 meetings. Who, uh, anybody in particular wanna lead that?

Next Speaker: I'll lead it.

Next Speaker: Well?

Next Speaker: Anybody have any ideas?

Next Speaker: Yeah.

Next Speaker: We're open to that, let's just say and if you think of something later, please feel free to email anyone of us, um, myself and Rosa – this is Monika talking, sorry – Diane or Tina, and just let us know what you'd like to hear about, what sorts of things you'd like us to make some decisions on or actions on.

Next Speaker: Yeah, I mean, that's, I'm, that's my thinking in general so if there's some, and I don't know, but, you know, usually I think that ideally this meeting would be where we can kind of work on decision making for things that we're gonna be doing statewide and working on, so, um, I'm not sure exactly, I think it, this meeting's always been kinda interesting 'cause it's, kinda goes back and forth between that kinda meeting and then we more recently we've been doing a bit more of this kinda presentation. But I suspect that people are wanting kinda more the discussion and this isn't making a bogus meeting so, I'm not sure exactly how to, to best organize that but ID isn't that going to be helpful too?

Next Speaker: I mean, uh, you know, the reason the committee was established was to decide what should be reported, so –

Next Speaker: ****.

Next Speaker: – certainly if you have any ideas about, uh, additional, you know, things, things that we should add to the reporting requirements, or alternatively, things that we can subtract because, you know, uh, they're not as important as we thought. Uh, that, that should be a main focus.

Next Speaker: I guess a part of me would like to see us move into more, we have the data, now what are we gonna do with it.

Next Speaker: Mm hmm.

Next Speaker: You know, how are we, if we're asking people to submit the data, what do we with it, can we use it to actually drive improvement programs and/or priorities for us.

Next Speaker: And, and so –

Next Speaker: As a state.

Next Speaker: – so yeah, if we're doin' that then I think then we wanna make sure that we have a significant time allotted to kinda decision making and that direction.

Next Speaker: Right.

Next Speaker: I think that that's –

Next Speaker: Yeah.

Next Speaker: – probably the most useful thing.

Next Speaker: Yeah. Okay. All right. Well, with that, I would say we are adjourned for the meeting and thank you everybody.

Next Speaker: Thank you, Mary. ****.

Next Speaker: Enjoy the snow.

Next Speaker: Well run.