Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
June 22, 2016

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Speaker 1: Uh, the same exec, we're gonna have executive summary again and then we'll just really, um, emphasize, uh, leading people to data.oregon.gov and, and I'll show you what this web site looks like. But just to give you kind of an overview, uh, this is sort of an open data portal that a lot of different states are using. Data.gov is sort of a generic overall term and every state kind of has their own portal and, um, there's really, the Oregon Health Authority is encouraging various divisions, uh, to use this to publish data almost to kind of develop a, a standard way and to really get our, our readers and our, um, constituents, uh, used to kind of viewing data and, and it's really – and I've actually had it, uh, extremely easy to post and even make maps and things like, you know, I feel like we've spent months trying to figure out how to do and it's actually quite easy with this site so I'm excited.

Speaker 2: But, I'm very –

Next Speaker: When we go there –

Next Speaker: Yep.

Next Speaker: – can we see other state's data so we could –

Next Speaker: You can.

Next Speaker: – look and see what Mayo Clinic's doing and.

Next Speaker: Mm hmm. Yep, mm hmm. I mean, not through Oregon but you can, you can –

Next Speaker: Get on the data backup.

Next Speaker: – easily get to it from that portal. Mm hmm. Yes. So, um, so as I go through these I, actually, I would love feedback from you guys on, you know, if you're excited, that's great. Um, but also if you have concerns let me know. I'm completely biased because I love that we can get the data out fast and I'm really excited about it but don't let that sway you like because I, there're probably gonna be a lot of, uh, you know, there may be some kinks to work out in the beginning. Um, so we're gonna, like I mentioned, we're still gonna have the same, you

know, executive summary. Um, this is, people liked having all the data on one page but, um, some of the feedback from last year was that there, there's still too many words on this page, it's too busy and the table on the back was confusing. And so for 15 we're gonna, we're gonna actually split this graphic into two. Um, and on, on one page, we'll have, the front page we'll have the, the C. Diff and, uh, CAUTI on one side and then MRSA and CLABSI on the other, on the other side this person and then on the backside, we'll have all of the surgical site infections. So, I'm working with someone from publications right now who designed this and he has some ideas about making the backside of the person look like the back of the person but I, I don't really know how that's gonna, you know, I don't, yeah. We'll see how that goes. Um, and one of the reasons I wanted to split it in two is because, as you recall 2015 is the first year we had data we had from wards so we don't, uh, for the devices associated with infections CLABSI CAUTI, uh, prior to 2015, we were only looking at ICUs and 2015 now, we're looking at medical/surgical and med/surg wards. And so having this kind of little bit of extra space will allow us to summarize the data, uh, by location type which is think is, is interesting, uh, progress. So some of this, this data looks like it's slight updates from what I showed, uh, in March. You can these for CLABSI these are all the different types of locations that are reporting so we have, um, you know, we can, in the report, um, since we're not doing all the facility specific tables, we can take a little time to look at, cut our aggregate data, uh, in different ways. And, and I thought it was interesting that adult pediatric wards actually this kind of new, the newly on boarded locations actually have the majority of the CLABSIs with 2 percent.

Next Speaker: And the majority of the line days.

Next Speaker: And the majority of the line days. Yes. Yes. Um, so again, uh, since, since last March, we've really only added two additional hospitals so I think that that's, that sort of speaks to the fact that we could push this report publication date up even further especially if we, if we, uh, you know, get to use this data.gov, uh, and we, we could use the posted data there. So this is sort of the total, our total SIR and this is just, um, adult and pediatric ICUs and then the medical/surgical units so including NICUs and this is sort of how CDC looks at it, uh, you know, they look to look at ICU, other and then NICUs and need. Uh, the state met up the HHS target of 50 percent reduction so we, we would line up to see an SIR below point 5 or a point 43. Um, when you look at NICUs, our SIR is point 75, um, so we do not meet that 50 percent reduction target so, um, and I think everybody in the room is familiar with SIRs. Does anybody need a refresher? Okay good. This is the, the benchmark **** the national baseline. And then this, I, we, this has not changed from last time very much but just to kind of show that the SIR is up, you know, it's highest in the NICU, uh, next in the adult pediatric wards and then, uh, the ICU, adult pediatric ICUs and incidentally, if those adult pediatric ICUs that have been, um, have been the subject of a lot of national, uh, initiatives for reducing CLABSI - central line associated blood stream infections. So, this, this is an example of, um, this next slide, uh, and for those of you on the phone, this is Slide 9 in my data book This is, this is sort of what the data looks like on data.gov and, um, after I get through some of these slides, I'll kinda show you how we can interact with the data so its, if you kinda look at a report from last year, it's, it's similar. Um, the advantages you this, you can get to this table actually with a web link and you can actually sort, you can filter by location types so this really gives the user a lot of, uh, flexibility to view the data in the way that they want. And it also gives us a, a **** 'cause it's sort of, we're not restricted by the length of a page. We have some room to play with in terms of being a little bit

more descriptive about what the data means. Um, so here we go. Um, so this, here we go, this is just sort of another view of it and we put in, we have the HHS, um, reduction target there for each facility and within each facility the specific unit type. You can see which of your units met the target, uh, instead of just looking at an overall number which is what we call **** in last year's reports. Um, and this does get granular. We can look at, uh, adult pediatric units overall but you can look at your cardiothoracic versus your neurology unit, etc. Um, so this, and this is what the maps look like so basically it's just going from that data and projecting a map. Um, and so you can click on any of the, the data points that your little SIR indicator will come up with. It's gray if it's lower than would be expected but not specifically significant and green if it's lower than expected but specifically significant. And then when you click on an individual facility, this isn't published yet, but I figured facilities that are doing well wouldn't mind if I held them out so. Here's Providence Medford, you know, zero central, zero CLABSIs, um, about 5,000 central line days, um, and you know, you can see that it shows, a description of SIR interpretation statistically fewer than the national baseline and then the HHS benchmarks that and with the extra space, I kind of took the opportunity, I, to put in what that benchmark is. So, um, in this case, we consider, you know, meeting a benchmark if you have an SIR under point 5 or zero infections. 'Cause remember for some facilities, we can't calculate SIRs because their predicted value is less than 1 and so, uh, so that's what those little blue dots are, hospitals for which we couldn't calculate an SIR but we also, you can click on those and see all their, their information. Um, so there's a little, see there's a little blue link that says "view details for this row" and for people on the phone, we're on Slide 11. Um, if you click on that, that link, then at the bottom of the screen, all of the information from that row comes up and, and I'm kinda playing with this. We can make it look better. Um, but basically, you can kind of see just a more detailed summary. Um, like two checkmarks if they met, you know, they had for zero infections and had an SIR below the baseline. Um, we have received some feedback from some hospitals that they want, a, uh, they want us to know that it's been, how long it's been since they had an infection and we're looking for ways to highlight this so.

Next Speaker: Mm hmm.

Next Speaker: Um, so NICUs only, our NICUs are clustered in, in the, um, Portland area so I kind of used this opportunity to show on, on these maps, just like ones we've used with kind of other more complicated programs, it can still zoom in and so here you can zoom in, see, um, see what's going at, for example, Providence ****, where Genevieve is. Things are going well, or were going well. Um, for each, um, for each of the infections we're, um, we've sort of based on some feedback been trying to aggregate data in different ways so, uh, this isn't how it's gonna appear in the report but just to kinda let you know we're looking at, um, uh, you know, separating wards from ICUs. So, for example, for CLABSIs we can look at those and see how we're doing –

Next Speaker: Has anyone been here yet?

Next Speaker: – **** wards versus ICUs and then, uh, we have Jennifer here from the preparedness program sitting in for Akiko and, um, the preparedness program has, uh, they have meetings with different regions in Oregon and they've, they have been really interested in immunization data and in HAI data and so we've been starting to summarize data for them for

their meetings and so, um, we're gonna be working with them for **** to figure out, is this data useful? Is this useful to look at, you know, HAI data by region and how might it be most appropriate so that's, you know, we're gonna kinda make an effort in this year's report that it would be **** it would be worth it **** on that, so. Um, any comments or questions before we get started? Cheyenne, did you wanna, or, are you passing out? Do you wanna make any announcements or anything? You're good? Okay. Okay. Um, so CAUTI infections, this, this is, I think **** some of this data last time and see it hasn't changed very much at all. Um, but I, I really don't place much emphasis on SIR here because it's comparing to a 2009 baseline and in 2015, we had some definition changes so, um, I really think that 2015 for, almost for all of the infections, that's gonna be our new bench, baseline year. Uh, next January we'll be benchmarking, um, looking at 2020 HHS targets after this year so this is sort of the last year we're using these little targets and I think it's gonna be, the risk adjustment will be much better moving forward.

Next Speaker: Kate, what was, what was the baseline year for all of the other SIRs?

Next Speaker: Um, for CLABSI it was 2006 through 2008 combined. And for most of the SSIs it was 2006 through 2008.

Next Speaker: ****

Next Speaker: Um, That'll be nice.

Next Speaker: And then it was 2009 for CAUDI and, um, I think C. Diff and MRSA, it was like 2010 and 11 so.

Next Speaker: Yeah, I mean, I, yeah, two things. No. 1 is I think we wanta to indicate that prominently –

Next Speaker: Okay.

Next Speaker: – uh, in the report, uh, because I fear that people are gonna get the mistaken notion that we're better than everybody else when –

Next Speaker: Yeah.

Next Speaker: – you know, everybody has been goin' down since then. Uh, and secondly, um, you know, if it's at all possible to measure it against the more recent baseline –

Next Speaker: Yeah.

Next Speaker: – I think we wanta be trying to do that.

Next Speaker: Well, so that's one thing last year, I just haven't inserted this into the report but, I mean, last year we had as part of the row, okay so this is how you did based on base, this is how you compared the baseline with the arrows but then you had this percentile, where you fall on the

most recent national distribution. So we have that from CDC for 2014 so this would be including that –

Next Speaker: Mm hmm.

Next Speaker: – but, yeah, I do think that's important.

Next Speaker: Is that part of the data that got sent to you and I can see both of those.

Next Speaker: Yeah, we can put, we can, we can put that in for sure so. Uh, so again this is just kinda what, what data.gov looks like. I cut off the facility names but you can see kind of for, because this is CAUTI, there are a lot of different types of **** for each hospital, um, so it will be a little. You can see it like that. And so, here is like, for example, Med Columbia Medical Center they, we couldn't calculate an SIR for them but you could still see their **** days and number of infections. Uh, the other thing you can do from data.gov is export the data into an Excel sheet. You can, you know, do your own analysis or, um, have someone from your group, uh, look at it in whatever way you find you most useful. Um, here's some out-of-date tables. I don't, these, um, again, I don't really place much emphasis on SIRs for CAUTI so let's, we'll move past CAUTIs. We, we talked about these guys last time, too. They're still a majority of the sent, uh, CAUTI - catheter associated urinary tract infections occurred in ICUs so. Is that surprising? To you, do you know?

Next Speaker: That the majority occurred in ICUs?

Next Speaker: Yeah.

Next Speaker: That's where you would find most catheters.

Next Speaker: There'd be more central line ****

Next Speaker: Yeah, um.

Next Speaker: Of course, yeah.

Next Speaker: They're the higher risk population.

Next Speaker: Yeah.

Next Speaker: Yeah, that, yeah, I think that catheter days are becoming so short now that it, the, the line days are shrinking.

Next Speaker: Mm hmm.

Next Speaker: So our denominators are shrinking so our rates can **** also be –

Next Speaker: Yeah.

Next Speaker: – higher.

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: Uh, so, I don't know ****. So these are our, our SSI data not, have not change much since the, the other meeting and so, we're gonna **** time on that and go through these. Uh, so basically we looked at the, the six SSIs. We're looking at, uh, complex deep **** organ space infections and so we can, we can look at an overall SIR for all of those six reportables combined and so we had 196 so complex, um, uh, SRIs that were a deep incisional organ space that, you know, either required readmission or were detected, um, during that initial admission. And we had 40, 41 percent fewer than predicted based on these old baselines but, uh, HHS wanted us to be at 25 percent by 13. And, again, those HHS, uh, targets are gonna be reset for 2020 after this year. Um, and this sort of, this just shows you the numbers of procedures. I thought, um, on the, the procedure count are the blue bars. You can see we do, in **** Oregon the fewest cabbages of all in the report of old infections, um, and then the red dots are the number of infections observed so we have seen the most, um, colon infections, surgical site infections. Which I think is to be expected but, um, just in terms of ****. And then this, these are SIRs, um, and so I think it's, you know, we are, we are statistically significantly below one for every SSI which is the first time in the State of Oregon we've, we've achieved that so that's good. We're moving in the right direction. Um, but we'd like to be, uh, statistically like under that ****75.

Next Speaker: That's cool.

Next Speaker: That, that would be another thing where it would be, I think, good to, to get updated figures 'cause, you know, apparently, we've done great in cabbages but, but, uh, maybe not as, not as well in some of the other ones.

Next Speaker: ****

Next Speaker: And it would be interesting to see whether everybody else –

Next Speaker: Mm hmm.

Next Speaker: – was seeing the same pattern. It's maybe –

Next Speaker: Yeah.

Next Speaker: – more difficult to prevent an SSI in a knee prosthesis.

Next Speaker: Do you mean, uh, against other states? To compare Oregon against ****

Next Speaker: I mean a national baseline, yeah.

Next Speaker: National baseline. Mm hmm.

Next Speaker: Like a national, or not the national base, like a but, but the national like for 2014 or something.

Next Speaker: Right. Right.

Next Speaker: Okay. Yeah, we, we actually do, uh, and I will include that. So, similar to last year, we, uh, I, you probably can't see this but just like on the CLABSI we have this is, you know, one is the SIR but this, you can see the national rate is all the way down here so, yeah, it'll show, so yeah, we'd probably draw a line and edit all point 5 for uh. Uh, C. Diff we're actually doing, um, so C. Diff, I mean, we talked about this last time and, and the data haven't changed to change our interpretation since March that, uh, our SIR has gone up, um, significantly so with, uh, C. Diff in Oregon. So this is hospital onset.

Next Speaker: I can tell you why.

Next Speaker: Why do you think?

Next Speaker: Over testing.

Next Speaker: Over testing, yeah. Mmm, yeah.

Next Speaker: Over testing.

Next Speaker: You'll see a change in 2016 –

Next Speaker: ****

Next Speaker: – as people are sealing that –

Next Speaker: Interesting.

Next Speaker: – and being more selective on their testing.

Next Speaker: Hm. That's interesting.

Next Speaker: Yeah, because I mean SIR will adjust for type of testing but it can't adjust for the clinician practices, right? So, yeah.

Next Speaker: They're picking up a lot of colonized patients.

Next Speaker: Mm hmm.

Next Speaker: Hmm.

Next Speaker: And you get a laxative, gets diarrhea, sent to the lab.

Next Speaker: Got it.

Next Speaker: So that has been going on, I think, pretty widespread in hospitals.

Next Speaker: So how are they, uh, what's happened to this. You feel like it's ****

Next Speaker: Now, most places are coming up with identified criteria for testing after Hospital Day 3. So, the patient should have some symptoms.

Next Speaker: Mm hmm.

Next Speaker: Some risk factors and multiple episodes of watery diarrhea.

Next Speaker: Oh, wow. Okay.

Next Speaker: No laxatives in the last 24 hours.

Next Speaker: Mm hmm.

Next Speaker: But.

Next Speaker: Interesting.

Next Speaker: That's a, that would be an interesting thing for one of our surveys, you know, to find out.

Next Speaker: Mm hmm.

Next Speaker: What, what people are doing since I think that might vary from hospital to hospital. Yeah. Interesting.

Next Speaker: Now, I'm on an IHI, C. Diff call and that has, was brought up too. That a lot of tightening of testing requirements and criteria.

Next Speaker: Yeah. That's interesting.

Next Speaker: Mary, on the site ****, are you seeing sort of the, more urine testing sent as well just in the hope that they will not be identified as a CAUTI in the hospital.

Next Speaker: No, we have inappropriate urine culturing going on, um, not as much as we used to but no, no early testing. You know, if somebody comes in with a catheter.

Next Speaker: Yeah, but in the emergency department or health screening –

Next Speaker: No. No, we are not seeing –

Next Speaker: – you're just automatically testing –

Next Speaker: – unnecessary.

Next Speaker: – the event 3 days later they have to send when it's not. Does it take long?

Next Speaker: No, we don't do that. No. That's not the problem. C. Diff was a big problem.

Next Speaker: Are they treating those people that come back positive? What are they doing with those results –

Next Speaker: The, there is –

Next Speaker: – when they come back positive?

Next Speaker: Whether they are colonized or not.

Next Speaker: For a C. Diff?

Next Speaker: Yeah.

Next Speaker: Yeah, that's a good question. Sometimes they're treated and sometimes they aren't.

Next Speaker: So the whole issue is **** bacteria. Once you get that positive culture then you're now in the conundrum of do we do something about it and?

Next Speaker: Or do you document this is likely to be colonization. Will not treat.

Next Speaker: Mm hmm.

Next Speaker: Mm hmm.

Next Speaker: Right, but that's also gonna admit that they went, they inappropriately went ahead.

Next Speaker: That's okay because ****

Next Speaker: I, I agree that's better than treating someone –

Next Speaker: No, because, –

Next Speaker: – but I just wondered how that –

Next Speaker: – and like every, a lot of hospitals, because at every hospital there's standing orders now for C. Diff testing for diarrhea in order to catch it early. Okay, so, uh, we have C. Diff alerts so if documentation is made that the patient has, uh, loose stools, we get a HAPA, best practice alert in the medical record saying consider testing for C. Diff. So that was driving a lot of C. Diff testing.

Next Speaker: Mm hmm.

Next Speaker: So they kind of refined that tool.

Next Speaker: Be interesting to see that treated, uh, it'd be interesting to see that treated ****.

Next Speaker: So you said you're from OHSU?

Next Speaker: Well, not technically. My office is at OHSU but I'm **** I'm a state employee. But I could, I could, I could look at OHSU.

Next Speaker: I wonder what they've done.

Next Speaker: I mean, I could look at our data if, if we think this is a, uh, something that's happening, um, we could certainly look at increased, uh, test, uh, we have access to those data to look at testing that is getting, you know, **** C. Diff **** therapy. Sure. That's not a hard thing to do. And say, I, I, um, I'm not on the floor so I don't hear about this.

Next Speaker: Yeah, yeah, so.

Next Speaker: And, and you do adjust, uh, the data for PCR versus toxin testing?

Next Speaker: Yeah.

Next Speaker: Um, so again this is kind of what, what the data would look online. I cut off the hospital name but, um, for C. Diff ECU, most hospitals have an SIR calculated because they have, they'll have a, a predicted value more than one because, uh, the patient date **** is driving this rather than like a line date. Um, so this is kind of, you know, zeroing in on Portland's, um, you can maybe take a guess at who's who but. Um, and again, so for MRSA blood stream infections, um, just kind of, they're actually, far fewer SIRs than have been calculated. Um, but for this metric, we are sort of, we're below the HHS target for 13. Uh, a point 59 is our state SIR. Uh, and this is kind of like a, yeah, dated out **** so it's a little bit more sparse. Um, and you can see, so this is what it looks like, there are a lot of those blue dots where an SIR to be calculated but, again, you can look and see how many patient days and how many, uh, you know, **** there are so ****. And then, so, while we have you guys here, you guys, um, if you have any questions, I'm happy to take them and I'm gonna pull up the web site so we can. And once I make these public, anybody can just go to them like, uh, like, uh, like, we'll just post the link but for now ****.

Next Speaker: So when you say make public, just so who can access all of this data?

Next Speaker: Anybody. Yeah, anybody. So, basically, you'll, um, you, you can just go to, it, it's just like a link and so you'll click on it and it'll take you. Actually, **** here, um, I did make one secretly public just like, okay. ****But this is kind of what it would look like. So it's on, it's basically a web page and this is, and then you can kinda go through it. Click on what you want, um, smart screen, so this is good for me to ****. That's better. And then view more details for this row and we're sort of pull up more information. Um.

Next Speaker: So, it's got specific hospital information?

Next Speaker: Mm hmm. Yeah.

Next Speaker: That we can access.

Next Speaker: So, I'm gonna, I'll go back here and, and, and, again, you guys will get these but I just, **** that we'll definitely be able to map but so, uh, here's, this is the C. Diff DSF. So it all, you know, you can pull it up. Um, I think the way this is projected is a little funky but **** but you know, you can kinda like scroll, scroll down through all the hospitals. Um, so you can get to the raw data and then, you'll see this, too, when you're looking on line and you can, yourself, visualize the data. How do you want it? You can export it into an Excel spreadsheet. Um, so you know for example, and we have like county in here and HBT where you can, so, Jennifer, you could go ahead and, like, –

Next Speaker: Add ****

Next Speaker: – and do some application by your ****

Next Speaker: Are they gonna keep **** ?

Next Speaker: We used to –

Next Speaker: You can put whatever picture you want. If you, so, yeah, you can go to these links. And I think if you sign, anyone can sign up for data.gov and then you get like a little profile and you can start, uh, because you might take this kind of raw data and make a certain visualization. Say, you're just interested in data in, uh, the Medford area and so you create a map out of Medford. You can see that as your own map under your own profile. I mean, it can be, yeah.

Next Speaker: Hmm.

Next Speaker: If, you can put that picture of Lucy on your profile if you want.

Next Speaker: Are there safeguards for the accuracy in the data. Like there's only so much manipulation you can do –

Next Speaker: Outside of it, exporting into Excel though then data.gov.

Next Speaker: Oh, yeah.

Next Speaker: If you go to user **** just doesn't ****

Next Speaker: No one can change the data that's posted.

Next Speaker: So like if you could export something to Excel and change yourself but you can't go in and change what's in here.

Next Speaker: Right. Okay.

Next Speaker: Yeah, so that's, yeah, there's just some settings there. Uh, there's some settings for comments that I turned on. I think **** um, so we'll see how this goes and Diane Waldo, I, I'll be following up with you about sharing this with hospitals because I think we can share like a, you know, –

Next Speaker: Been –

Next Speaker: – **** distribution copy of the report.

Next Speaker: – right. Just what we've done in the past.

Next Speaker: Yeah.

Next Speaker: Kind of like an embargo copy.

Next Speaker: Yeah. And then, what I'm thinking of, we could do it even a little bit earlier this year and let them, like right online and see if they have any concerns with ****

Next Speaker: Sure.

Next Speaker: So. That's all I have for this.

Next Speaker: It's good. All right, well, next up.

Next Speaker: Anyone?

Next Speaker: Oh, sorry. Did you wanna talk about flu vacs and how –

Next Speaker: Oh, yes.

Next Speaker: – we're doing our reports separately this year?

Next Speaker: That would be great. Thank you for bringing that up. Flu vacs is not gonna be part of the big state report this year. Last year was the first year we had combined the two

reports. You know, flu vacs is the health care worker influenza vaccination survey which is what I'm responsible for collecting the data for. Um, the main reason we were able to do that last year was because the report had been pushed back so for that I had collected all the data by the time the HAI report was done and published. This year, um, the flu vacs data was due May 20th and on May 20th, I had only collected a very small percentage of the data. Um, where did I put that? Right now, I have approximately a little over 50 percent of the data. It's a month after the due date which was May 20th. I have 92 percent of the hospital data, uh, about 91 percent of the ASC's, 85 percent of the LTF's which is really good, or its sniffs and only 45 percent of the dialysis facilities but this is the first year they've had to report to us so we're having more NHSN issues than we are having compliancy issues so it's not really a reflection of dialysis as much as it is an HSN so and that's a whole separate topic. But, um, I'm assuming that the report will come out again in August or September when I used to republish it before. It's just not gonna be with her report this year.

Next Speaker: Okay.

Next Speaker: And actually last year we got some feedback that the, that people didn't like the combined reports because flu vacs was now on Page 83 or something instead of having its own kind of report so we ended up having to split it anyway so.

Next Speaker: Yeah. Yeah.

Next Speaker: Just to let you know **** counties have been using that data from last year to target the conversations with specific long term care facilities. **** facilities about influenza vaccination **** kind of have the toolkit.

Next Speaker: Oh, good.

Next Speaker: Good.

Next Speaker: **** toolkits are, that's, that's been very good **** information.

Next Speaker: Good. Okay.

Next Speaker: Everybody's to move on to our next agenda item which is sterilization disinfection. Teresa, thank you.

Next Speaker: Hi. Hi. Uh, I'm Teresa Shepherd. I work for the Portland VA and, uh, I'm here as the, I guess, sterilization and disinfection, uh, subject matter expert.

Next Speaker: Mm hmm.

Next Speaker: And I can honestly say that years and years ago, when I was in nursing school, this is something I never imagined in a million years I would know anything about. And it just one of those things like I guess most things, that kind of accidentally stumbles onto your plate. So, um, just a little history of, of, uh, how I know and I know is, is, um, working for the VA in

2009, uh, the, system wide the VA nationally went through a really significant system redesign with regard to, um, sterilization and reprocessing and cleaning of reusable medical equipment. Um, it, it came from a, an event at ADA where it had to do with, uh, colonoscopes not being cleaned according to manufacturers' instructions. So, um, um, all VAs nationwide through a, uh, system redesign, initially focused on, uh, endoscopy endoscopes, uh, and I was at the time a nurse manager of a, um, GI lab that had our own, uh, reprocessing room. So I was, uh, front and center of that. And, so, um, uh, you know, that evolved from, uh, scopes into just a complete redesign of sterile processing. So when I was, uh, wanting to move to Portland about 6 years ago, um, um, the VA at the time also moved sterile processing, uh, under the nurse executives and so the nurse executives then hired a bunch of nurses to be over sterile processing. So I was one of those nurses that was hired and brought up here to be the chief of sterile processing in the Portland VA. And so, it was really, really, uh, interesting times for sure.

Next Speaker: Mm hmm.

Next Speaker: And so, um, I brought these, uh, uh, show and tells, I guess, because one of the first things we did was we wanted to, you know, we had to look at manufacturers' instructions to see what they said to make sure that we were doing things according to manufacturer's instructions. And these were FDA-approved manufacturer's instructions. And immediately we saw, you can't follow many of these manufacturers' instructions. They're either scientifically don't make sense. They're impossible to do, um, or, um, illegal to do in some cases. So, I have a few of those examples just to kinda show you, um, what it means. And this, this one is, um, just to show you how complex some of the manufacturers' instructions are and then, and thinking about it realistically when you have a large complex medical center with really busy ORs and everything goes to sterile processing, this is one tiny hand piece for, um, ENT, I guess. And so, these are the instructions to clean it and so the tests, you know, down in SPS, you know in processing, they get these trays full of stuff. And this is one tiny hand piece. And as you can see, it comes with parts into, um, many, many pieces with very detailed instructions on how to take it apart and then, um, scroll down. You can see where it says, "cleaning". Then, it's under demineralized water at a specific temperature. So those are things, uh, you know, we try to figure out how to meet. And then, you, you can see how many pieces are involved and this is just one tiny thing. So that just speaks to the complexity of something as simple as a hand piece for an ear surgery. Um, and that you've got, um, you know, techs down in, in sterile processing that are in charge of making sure this is done correctly. So that's one big risk factor right there. So, um, you can go to the next show and tell, I guess, if you will. These are just PDFs of manufacturers' instructions that's kinda what I said. So this one was really fun. This was a, um, Welsh admin, uh, Welsh Allen, ASL is really what it was and, um, these are some instructions that really you just can't follow. If you go down to I think page, maybe, seven, scroll until its, that's, that's what we're talking about. You guys have probably seen those. Just, uh, **** essentially. Uh, so go down to where it says cleaning. There, right there, uh, you can just see, you know, prepare your detergent and then, uh, uh, submerge and rinse with sterile water for 5 minutes, so that's 5 minutes. And, then, uh, I think this is a cord. Go up, please?

Next Speaker: Scrub the cord with the cleaning solution for 5 minutes.

Next Speaker: Yeah, that's the cord, yeah, we wanna go to the actual scope. Essentially, uh, –

Next Speaker: ***** anything?

Next Speaker: Up one more, up, there you go. Sorry, this is so funky but it, uh, essentially it wants you to, it had, it comes with a bulb piece on it that hooks to the scope and it wanted you to put, uh, uh, detergent in there and shake it for 5 minutes. And then it's, you know, it's, it's like a blood pressure cuff bulb.

Next Speaker: Mm.

Next Speaker: And then get all the liquid out. And then put water in it and, and shake it for 5 minutes and then rinse it. And that was with a detergent. Then they wanted you to do that with the, you know, disinfectant. Put that in there and then let it sit and then rinse it and then hang it for 24 hours. I mean it was essentially gonna take 3 days to clean one bulb. I mean it was really, it was just ridiculous. So, um, just another example of how, um, uh, manufacturers' instructions we're just not able to follow. Here, this is another picture that, um,

Next Speaker: I think I've seen this.

Next Speaker: Something that sterile processing folks deal with ev, you know, hopefully not every day but it's something that does happen and you, and you need to look at. These were, uh, orthopedic instruments so they showed up in sterile processing looking like this. So that stuff is gonna be, uh, **** bone and fat and gristle and it's all –

Next Speaker: Big.

Next Speaker: – you know, imbedded in there. And so.

Next Speaker: And that's where Hep ****

Next Speaker: This is why you find – not, not completely why – but a lot of times in orthopedic, you know, procedures that they go back from sterile and they'll have, you know, pieces of bone, you know, still in some of the reamers and in some of the cre, the crevices and stuff, um, uh, you know, this is one of the reasons why. Things are precleaned like they're supposed to be and rinsed off and so it sits there and makes it very, very, very difficult.

Next Speaker: So, technically, before it arrives **** should be totally.

Next Speaker: It, well, it should be a minimum, like they have, they have sprays and stuff that they can put on it that keeps it from drying.

Next Speaker: Yeah. Yeah.

Next Speaker: So it stays wet.

Next Speaker: Yeah. ****

Next Speaker: Um, I mean, they, you know, we don't want people up there **** surgeries.

Next Speaker: Yeah.

Next Speaker: But just to send it down like that, totally dry, no prepside spray or any sort of spray on it makes it so hard on sterile processing folks to get that clean timely and correctly. And this is just for a simple, uh, IV pump and this is, uh, again, you know, FDA-approved cleaning instructions. But if you look at the list of cleaners, it's just the most amazing list of, you know, there's a difference between a detergent and a disinfectant. You know, they do different things but they just kinda say, clean it with any of them. Um, from, uh, you know, bleach or alcohol, then they move into some detergents which aren't disinfectants. And then, uh, I, I think they had Hipaclens on there which is interesting.

Next Speaker: Yeah. Mm hmm.

Next Speaker: That's so ****.

Next Speaker: Um, warm water, **** not applicable. You need to see how it's just a mixture of not even disinfectants that they're saying is all you have to do to clean these IV.

Next Speaker: I've seen similar instructions with Sidex on there.

Next Speaker: So.

Next Speaker: Yeah. We –

Next Speaker: ****

Next Speaker: Yeah. Sidex is, you know, that, that, actually one of the stories I was gonna share was vendors are another big risk factors. Vendors are wonderful. I'm not dogging vendors. But, um, they'll oftentimes, they don't know what their manufacturers' instructions say. They will teach staff to do it just the way they think it should be done and a lot of times, it's not correct. So we had a, we got a call, we had a, um, it's called a, um, rectal, rectal thorough sensing unit. So it's a little thing that measure temperature when they're doing something to the prostate. I don't know. But, um, it's a kind of a reposable thing so you can use it like six or seven times and then get rid of it. Well, he, we didn't own them. We bought the system apparently but the vendor said I'll just bring in the probes.

Next Speaker: Um.

Next Speaker: These reposable probes. So he would bring them in. Staff, not knowing they would. He said, yeah, I take care of all the cleaning. And what he was doing was he was taking 'em to his van when he was done and –

Next Speaker: No.

Next Speaker: – uh, wiping them with Sidex.

Next Speaker: Oh, oh.

Next Speaker: And if you know anything about Sidex, that's not what you do with Sidex. Sidex is a high level disinfect. You have to soak in it for 20 minutes or.

Next Speaker: Oh, No.

Next Speaker: You know, so this is what he was doing. So, you know, and staff not gonna know this. Front line staff they, you know, and plus it has a cover on it, a sheath so people'll think that sheaths are, you know, eliminates risk. So, you know, that was just another risk factor with vendors is vendors will tell us that. Oh, it's fine, you know. We got it. This is the way we do it when it's, when it's not at all and it's actually a really big risk factor. Um, that might be all of the, uh, – we had, we did have a speaking of, uh, uh, instructions, we got a, uh, uh, neurosurgery, this, I don't really know what it did but it was very some sort of new neurosurgery instrumentation that we got. It was very intricate. Came from a company actually in, in Israel and, um, it's called a microguide neurosurgery something. So we got the instructions out and, um, it said that we needed to sterilize it in ETO, which we actually are one of the few facilities that still have ETO. Um, with an exposure time of 4 hours. A typical exposure time's, ETO is a very like toxic gas. Um, and it's actually really controlled by the EPA because it's very carcinogenic. You have to have these really elaborate systems to, to get the fumes out of the hospital. Um, and so it had a 4-hour exposure time. Well, everything that we do has 1-hour exposure time and then it has a 13-hour aeration time so it actually sits in the sterilizer for 14 hours. So when we saw this, we were like what, you know, nothing is 4 hours. And we actually looked into it further and it's illegal to ETO something for more than 3 hours in this country. And so, again, you know, these were FDA-approved instructions that go against EPA rules for what you can do. So we contacted – and we already bought this stuff, you know – and so, we contacted the company in Israel actually and, uh, they said, okay, we will revalidate it. So we waited a couple of months and got brand new manufacturer's instructions for this country that said 1 hour, you know, ETO disinfection time. But this is just an example of the, some of the things you really have to look out for that aren't, uh, obvious risk factors when you're talking about sterilization and disinfection. Just **** some of the outliers and then, um, uh, one other story that's not really about sterilizing, sterilization and disinfectant sterile processing that out about the things that people do that, um, you stumble across, which I'm sure Mary has seen a lot of in her travels.

Next Speaker: I have stories ****.

Next Speaker: All right. And we always, we always hear but this is the way they do it everywhere, you know? But, um, an example was, um, a, cath lab. And, uh, they were, we went into the supply room to just do general inspections and we saw this hotplate with a beaker on it with some water in it and it had been there for a while 'cause you could see kinda floaties in it. And thought, you know, what –

Next Speaker: Mm hmm.

Next Speaker: – is, what is this doing here?

Next Speaker: Sterilization.

Next Speaker: You know and seriously. Um, well **** we found what it was for was even like more scary and so, and this is something that they say is done in all hospitals. But, um, uh, they opened up something that they're going to use in the cath lab that's sterile that they need to somehow modify a little bit, bend it a little bit to make it easier to work with and so they ****, they turn on the hotplate and they start boiling the water and get the steam coming out and they hold it over that and that sterile prep resterilizes it. It makes it warm so they can bend it and then the steam actually resterilizes the sterile thing. So, um, and they argued with us. I mean, like, you wouldn't believe how incredulous they were that we didn't understand that steam sterilized things. You know, I mean really. Yeah. So they got, they got rid of this so they don't do that anymore. But, um, just another example of what you don't know is going on out there and you just find it walking around doing inspections and you're like, well, what's that? And it leads down, you know, roads you just can't imagine.

Next Speaker: And I think.

Next Speaker: So.

Next Speaker: More importantly it's a lesson on how things sort of become the community standard of practice if you will.

Next Speaker: Right.

Next Speaker: As in, you know, I know I have seen that practice as well so.

Next Speaker: Yeah. Yeah. And it, exactly. And once it starts and it's the way it's done, you know, nobody questions it.

Next Speaker: Mm hmm.

Next Speaker: It's just the way it's done. It's just, we, so, so, I don't know. It's just, uh, it's been a very interesting journey and, um, you just never know where your risks are. Um, they're everywhere, they're **** and, um, I know Joint Commission is hot on the prowl now with, this is a big topic with them, so.

Next Speaker: Well, I can appreciate what, you know, what you're talking about.

Next Speaker: Yes, yes.

Next Speaker: The hospital infection control thing because that is such a big, um, risk area for hospital acquired infections, especially of social type.

Next Speaker: Mm hmm.

Next Speaker: Um, is what's going on down there and not only that, but general cleaning and disinfections throughout the, the hospital because the buyers that purchase, uh, ers, don't look at how things are cleaned and disinfected and you will have, uh, you know, a 1000 pieces of equipment with maybe 500 different recommended products to use to clean and disinfect.

Next Speaker: Exactly.

Next Speaker: So what're you gonna do. You can't have those products but, because people will invariably use the wrong one, um, on the object and this is, this is a problem everywhere.

Next Speaker: Everywhere. And, you know, clinics, different procedural clinics, they'll order new, they'll buy new equipment, new, new things, and just without a real understanding of how things are reprocessed at all and, um, you know, one of the first things we did, uh, you know, in the VA was we went around and we found everything that was, uh, critical or semi critical RIB which is anything that's sterile or goes into a, uh, a mucous membrane and we centralized it. It all came to sterile processing. Nobody, nobody on any, no ENT clinic or radiology, nobody does any processing at all but, well, you know, we had no idea how much reprocessing was going on out there in these different specialty clinics and I think most facilities probably have no idea, um, what's going on out there in these clinics as exampled by the, you know.

Next Speaker: **** dental at all?

Next Speaker: Oh, yeah, dental's huge. Yes. Ye.

Next Speaker: No, I'm heartened by the fact that, that you were hired by the VA. I think it was, in the wake of a crisis –

Next Speaker: Mm hmm.

Next Speaker: – but, I mean, who, at, at any other hospital, who would fill that role?

Next Speaker: You know, it's, it real, I, you know, in, infection control I guess. You know, they're the ones. It's not, that has oversight but it's not realistic for them alone to do something like that. So you have to have somebody in sterile processing that gets it. Um, uh, it, and then, and then a facility, uh, you know, leadership that needs to, um, support this initiative because it can be really expensive too.

Next Speaker: Mm hmm.

Next Speaker: Because when you're talking about things correctly, a lot of times that means buying more scopes.

Next Speaker: Mm hmm.

Next Speaker: Because to do things right, you have to, it takes time. And so, um, it's a complete change of culture. It's very painful and we had a lot of clinicians that start at the VA that have come from other hospitals and they can't believe, what do you mean, I can't wipe off my uro, you know, my, my, cystoscope.. I have to send it down there and do all this stuff. Why can't we just do it in the office like everybody else does. You know. So. Um, it, it's. Yeah, I think.

Next Speaker: You know, historically, I think '09 was a turning point and I wanna say the Joint Commission in like '09 came out with new standards saying, you know, sterile processing's important and you have to competency assessment, people have to be trained, blah, blah, blah. And, so that kinda started the refocus and it is a world where there hasn't been a lot of oversight for it as, as Teresa eloquently painted just the issues with the manufacturers and instructions but I know, nationally, in 2012 they had a huge conference with the FDA instrument manufacturers and **** vest partners really, and it was like a 2 or 3-day kind of session just delving into all these issues and the outcome was that, um, you know, the plan was to really make the manufacturers responsible for instructions and, um, you know, to hold them accountable for what is theirs. So I think we've seen a turn of tides. Um, it is a huge issue right now if you really think about what's been happening. We've moved to minimally invasive surgeries so more scopes, smaller instruments, more difficulty cleaning them at a time when facilities have moved to more automation such as tunnel washers. So if you look at those instruments on that picture Teresa had, very difficult to get those in a tunnel washer and get them really cleaned effectively. So, again, I think it's just a lot of circumstances that are all coming together right now but the bottom line is it is an area that really demands a lot of attention and focus and a whole messaging training and observational competencies and performance feedback, um, and audits is, is really critical and I think that's what we're starting to see facilities be held accountable for now.

Next Speaker: I don't think we have anyone from regulatory in here, but are there any kind of credentialing or people who work in, uh, ****

Next Speaker: Yeah.

Next Speaker: Certified.

Next Speaker: They have certifications.

Next Speaker: Certifications.

Next Speaker: There're certifications.

Next Speaker: They don't have to, no, they, a lot of places require them.

Next Speaker: Oregon. Oregon does not require it.

Next Speaker: Yeah.

Next Speaker: But –

Next Speaker: Yeah.

Next Speaker: – my understanding is it's being –

Next Speaker: It's on the table.

Next Speaker: – under discussion. And, uh, some states do require it. Um, Oregon, last year had a requirement that scrub techs had to be credentialed at least in the ambulatory surgery centers so I think we're starting to see regulations and licensuring potentially have more of a role, um, in terms of what's expected here in Oregon.

Next Speaker: Who, who's requirement is that? Is that, uh, the, uh, professional licensing people? Or is that the hospital –

Next Speaker: It's the hospital.

Next Speaker: – folks here. Okay then.

Next Speaker: Do they, do they come through OARs and, uh, –

Next Speaker: I, I think so.

Next Speaker: – facility licensing?

Next Speaker: I think so. I think so. But.

Next Speaker: So **** group, you know, would ****

Next Speaker: Yeah. I –

Next Speaker: I think that requirement for certification is on the employer and not all employers require it. I know we have some people that started in our department that are not yet certified. So, there, they, they will be but the, it's not a, a requirement.

Next Speaker: Well, it became a big, it's a big deal for a small rural hospitals, too. They're really worried about that, you know. It's hard enough for us to find staff and now you have all these other, you know, rules and regs around 'em.

Next Speaker: There's online testing.

Next Speaker: They're, uh, exactly. So.

Next Speaker: Yes.

Next Speaker: We're trying to, you know, cross that burden. But, um, also folks are being grandfathered into this process as well so.

Next Speaker: But it's, it's all about, you know, patient safety. Come on, now.

Next Speaker: That's right. And there's also a, a separate certification for scope, endoscopy processing which.

Next Speaker: ****

Next Speaker: Uh, uh, uh, a couple of thoughts on this, um, you know, I'm recalling that, um, maybe 15 years ago or so, uh, a recommendation came out that whenever there was a nosocomial case of Group A strep infection, invasive Group A strep infection, that it be considered a seminal event and it prompt an investigation and everything. You know, perhaps, thinking of, uh, well, postop infections but, you know, years ago, uh, puerperal sepsis. Um, and with 196 complex SSIs every year in the State of Oregon, I wonder whether it wouldn't be feasible and desirable to, to have that kind of thing happen, you know. Anytime you get, uh, a complex infection following one of these surgeries that involves instruments like this, uh, that it, you know, prompt, you know, a real thorough investigation into, uh, into –

Next Speaker: On the priority list.

Next Speaker: – ****

Next Speaker: I will, I will say this about that is that, um, you know, when a deep space infection happens, you know, everybody immediately does wanna blame SDS but there such group – when you're talking about – the, what about scopes which are high, high level disinfect versus instruments that are sterilized. There's a big difference. There's a big safety net, you know, in sterilization when something gets sterilized. Um, so, I would really caution when you have an issue with surgical site infections that you focus on sterile processes 'cause chances are for sterilized instruments, unless something's gone horribly wrong, it's not gonna be subtle, it's not gonna be them.

Next Speaker: So.

Next Speaker: It's gonna be something in the OR and if you start diverting it, well, it's just those people downstairs, I, I think you might miss what really the real problem is which **** tell ya.

Next Speaker: Well I, I mean, I think the assumption has always been that it's something that went wrong in the OR.

Next Speaker: Yeah.

Next Speaker: But it, but, uh, you know, you said –

Next Speaker: You never know.

Next Speaker: – the risks are events, you know.

Next Speaker: They are.

Next Speaker: They just kinda a ****

Next Speaker: And I, I, I, think the sickness, and I mean, again, tales from the trenches, but, you know, I, I've had phone calls where surgeons are holding instruments and, you know, says , Teresa there's still bone and tissue on them. So, I don't think we can say, no, that's not an issue.

Next Speaker: Right.

Next Speaker: I mean, I think, again when you have increases in rates or unusual infections, you know, you need to drill down and just it's your opportunity to evaluate that you have the basic ongoing infection practices in place. Um.

Next Speaker: And, and my other thought was, um, that, you know, given that so much of this is manufacturer dependent that maybe some systematically aggregated data on instruments and whatnot used in, in some of these, uh, surgeries, might not give clues. I mean, I gotta believe that some manufacturers and are better than others at making the instructions and the processes straightforward or making the instruments such that they can be cleaned in a pretty straightforward fashion.

Next Speaker: Again, what happened with the ERCP scopes and CRE outbreaks, I mean, that, that's, you know, that, the alarms were starting to ring in like, I think 2010 about that little tiny clusters and, you know, back in 2009, I said, why is nobody worried about these ERCP scopes? They're the most scary thing that we use, period. And, um, but they knew. I mean, Olympus knew there were issues back then and it just, you, you know, nothing ever ****.

Next Speaker: ****, you know, Paul, I know your thought in many ways it's just I wish we could do it because, you know, if there were some way that you could, you know, anytime you have a surgical site infection whatever it is, you know, report it and have somebody –

Next Speaker: Uh, it takes 30 to 90 –

Next Speaker: – ****.

Next Speaker: – to detect it so you're already out a week, 2 weeks, 3 weeks.

Next Speaker: Sure, sure.

Next Speaker: 90 days.

Next Speaker: But, I mean, it, I think what I heard Paul saying is wouldn't be interesting if we could sorta track infections on devices. You know, so we can see, is it this new device?

Next Speaker: Mm hmm.

Next Speaker: That maybe is a challenge in terms of the, and we actually are seeing a bounce. I mean, I love the concept but I just I just don't know how to.

Next Speaker: How to operationalize it?

Next Speaker: Yeah. So you know, I'm –

Next Speaker: Teresa, I'm really impressed with your presentation and I'm just trying to think of, um, what would you want the message to Oregon hospitals at large to be around this topic. Because I'm thinking, you know, it, this is great conversation. I would love to do something and have you like a webinar for Oregon hospitals, um, with, uh, with a message or, uh, you know, recommendations from a content expert. So, could you articulate something like what, what would you want to impart? What words of wisdom would you want them to know?

Next Speaker: Oh, gosh, the, the, its, I almost see it as two issues. We have the sterile processing issues and then we have the –

Next Speaker: All the scopes ****

Next Speaker: – the clinics and everything that goes on out there. So both, they're both really, really scary, uh, risky endeavors. But I would, I think that facilities, they need a subject matter expert on this. It's not just an added duty to infection control.

Next Speaker: Okay.

Next Speaker: Uh, because that's what's gonna happen, I guess, as more scrutiny comes on this. It's gonna probably fall into infection control's hands and they're already doing so much with Class D CAUTI and all this other stuff that, um, they, the facilities really needs a subject matter expert that can tie all of it together.

Next Speaker: And then I also heard you say about centralizing sterile processing making sure that you, you know, just get your arms around all of that.

Next Speaker: It's really difficult to do that, uh, it's very, very expensive to do that.

Next Speaker: Yep.

Next Speaker: Um, but I think at minimum, somebody needs to know what is going on everywhere. You know, what are they doing in the GYN clinic on the fifth floor in Tower B? How are they cleaning their probes?

Next Speaker: Right.

Next Speaker: Because I don't think anybody knows.

Next Speaker: Well, what happens when that person is on vacation?

Next Speaker: Exactly.

Next Speaker: Okay.

Next Speaker: Yeah. Are they, are they testing whatever it is under the sink in the bucket they're soaking the probe in when they're done.

Next Speaker: When –

Next Speaker: When was the last time they checked efficacy of it? When did they last mix it? what temperature is it? Is it, you know. Are they even doing it like they're supposed to? Is it Dawn dishwashing, I mean, people just, yeah, I think so. So.

Next Speaker: I'm also hearing you say that the leadership is key and oversight is, is key as well.

Next Speaker: Absolutely. Yes.

Next Speaker: So, I was gonna mention this during my presentation because obviously there's quite a few lapses that we're finding in this area out in the field and so, but improvement initiatives that, uh, Teresa has worked with us on trying to update. We have a toolkit on ambulatory surgery center on our web site that has competencies for instrument repackaging and also scope cleaning and reprocessing so I think we just need to get those out and, you know, again, encourage people to use them. Um, but we also, um, are entertaining the idea of having a hands-on training course.

Next Speaker: Mm hmm.

Next Speaker: And the issue with that has sort of been, how can we make it happen? You know, we, we have offers from ambulatory surgery centers to use their sterile processing departments because they often are closed on weekends so it's not like the hospital that's gonna be 24/7. Uh, just sort of the operational side of doing that. People would have to wear, we'd have to get scrubs and the department has to be cleaned on the weekend and then, the learning environment isn't great, because they don't really have conference areas but we're trying to work some of those bugs out. One of the thoughts we had and don't laugh but if we could, you know, potentially secure funding, um, and this could be a multistate collaborative effort but try and to basically get a simulation lab for sterile processing so –

Next Speaker: Love it. Love it.

Next Speaker: – people can get hands-on training, um, with, like a truck or something like that that can actually go state to state and drive up to facilities so you can have the combination of a classroom but then the facility as well.

Next Speaker: Do you know, scopes, they're like thirty to $60,000.00 so how are you going to get these?

Next Speaker: We, we have to probably get some donations.

Next Speaker: **** ones, though.

Next Speaker: And, and again it's not like, Teresa's message is to me you've got to know all your instruments and equipment 'cause they're all different. And this what I'm hoping to accomplish with this would not be something that would certify people because that takes a lot more time.

Next Speaker: Right.

Next Speaker: But I think it would be that exposure and experience

Next Speaker: Right.

Next Speaker: That I can say, this is what it feels like to clean and manually brush and when you're hooking up inside a scope washer, this is like connectors and what it feels like and what you have to think about and when you're, you know, placing, you know, indicators, chemical indicators in a sterilizer, these are the things, you know, you have to think about in places. So, again, I just sort of touched on those high-level critical elements of reprocessing.

Next Speaker: You know with the focus on education and competencies I think that's kind of a, a good way to go and I wonder if hospitals would contract, um, for some of this kind of education and competency testing ****.

Next Speaker: Mm hmm.

Next Speaker: It's important to remember it's not just sterile processing staff. I mean, it's X-ray techs. It's nurses. And this is an ancillary thing for them. This is noise for them. You know, cleaning, wiping this thing off after doing this procedure is just, it's not important in their mindset. The procedure is. And so, educating that group is, uh, also a big challenge.

Next Speaker: Yeah, outside of ultrasound, you know, I don't know there's too much other reprocessing going on in diagnostic imaging.

Next Speaker: Well, you've got, you know, uh, where they, anywhere they will do, you know, echos, um, or cystos. A lot of times those are done kind of in a quasi office setting. Cystoscopes and stuff like that. Stuff that's not coming –

Next Speaker: ****

Next Speaker: – rectal probes that's not coming to sterile processing. It's gonna be a tech or a nurse that's cleaning it. And –

Next Speaker: ****

Next Speaker: Yeah, so, there's a lot and that's just, there's a lot of stuff getting cleaned outside of sterile processing that's semi critical.

Next Speaker: Oh, yes, I know, ENT clinics are notorious.

Next Speaker: Yeah. ENT exactly.

Next Speaker: So, so in lieu of the, the van or the bus, or whatever –

Next Speaker: The truck and, I, I have visions of like, Bernie Sanders, in a 60s painted.

Next Speaker: I gotcha. I gotcha.

Next Speaker: My, my question is, I know, uh, let me ask, uh, before we just **** contact here. They, you know, they have simlaps for days.

Next Speaker: Right.

Next Speaker: I don't know if they if they have anything, you know, ****.

Next Speaker: I, I actually have spoken with them –

Next Speaker: Have you?

Next Speaker: – and we've had a conversation and, um, we may continue to pursue it. Part of the issue is, again, how do you coordinate the delivery and get all the supplies and all the **** –

Next Speaker: Sure.

Next Speaker: – and then everything you need in a space that probably isn't gonna stay there for that long.

Next Speaker: Yeah.

Next Speaker: It's just a lot of time and effort that goes into the planning compared to being able to access and SPD that is as current.

Next Speaker: Sure. Sure.

Next Speaker: And do the training.

Next Speaker: Yes.

Next Speaker: So.

Next Speaker: I wanted to. I think this is actually **** good supply. ****

Next Speaker: Well, that's my but I actually, no, I had a conversation with somebody from the CDC and I have to work on the business plan but they do have a foundation. um.

Next Speaker: Sounds like a subcommittee needs to be born.

Next Speaker: They, they didn't laugh about. They didn't laugh me out of the room. They actually thought it was a good idea.

Next Speaker: It is a good idea. You know, it's, it's like, uh, it's a challenge.

Next Speaker: And, and, APIC, APIC 2017 is here in Portland so I can see how we can roll this thing out.

Next Speaker: Literally.

Next Speaker: All right. So let's just, uh, take a break and I can continue the conversation and start back at, uh, 2:15? Karen?

Next Speaker: 2:15, yeah.

Next Speaker: Okay, and hopefully, people are still online.

Next Speaker: Yes.

Next Speaker: Um, that can hear us. So, um, last meeting, 3 months ago, um, I provided an update, Part 1 essentially, which covered our findings for, um, acute care facilities and long term care facilities. So now we will be, um, talking about our ambulatory settings and then dialysis facilities today. So, um, not going into a lot of detail because we covered this last time but, um, again, this work is funded by a grant from the CDC. It's known as the Ebola grant. Um, it is involved with the Ebola consultations for our assessment hospitals but also is allowing us to work on building statewide infection prevention capacity. Um, we have adapted in our approach a regional approach but we're trying to build partnerships between facilities across the continuum up there. The first year we, uh, had 25 facilities that we were going to do. Subsequent years, we'll be doing 35. Our goal was to be working with local health departments and APIC members so that again, we can help be building the infection prevention infrastructure in this state. Um, we met a year ago with criteria that we looked at to try and, um, choose possible, uh, facilities for these assessments using multiple approaches looking at missing data, outbreak data, nursing home compare data, influenza rates, got recommendations from various agencies, um, and what has really turned out over this past year is probably one of the biggest drivers were those with unusual pathogens or, um, some kind of outbreaks. Um, for the future, though, one of the things we realized is we didn't really take a system, hospital system, or a chain approach with our facilities. So there were some, um, chains, if you will that had several consultations but others

that didn't have any. So, um, as we move to Year 2, we're gonna kinda try and spread that out a little bit more. Plus, I think one of the big needs we're finding, especially for acute care facilities are those that have newer, um, infection preventionists. They would really like some additional help and support. Um, you can again see, we try to, um, mirror a lot of our, uh, consults, um, region, but some of the regions are rather large and when you're talking about driving all the way to Union County and working with La Grande, you know, you really want, so, it's very far to be going to the other end of the state so, again, even though we're trying to map this out with EPREP regions, there's still a lot of, uh, clustering and partnerships that is gonna have to happen that's, that's more local. Um, CDC is using four different consult tools for these assessments based on each setting. Different domains and requirements. Um, we have gone ahead and created template agendas for each of the facility settings that we give to facilities. Um, instead of, um, sitting down in a conference room and asking questions and having the facilities respond and answer, most of the data is now being collected out in the units or wards, um, and, uh, are collected with audits, observations and staff interviews. Um, this, again, I covered last week, last visit, last presentation, so I won't go through in detail, but I just wanted those who weren't present to have an opportunity to review, um, how we actually go about conducting, um, the visits. Um, this is a sample of the different assessment domains that are on all of the tools but, again, each facility setting has different domains and questions that are being assessed. And then you can see from this, a lot of the observations and audits that I do, for instance, if I'm in a hospital or in an ASC, I do, um, do OR observations. Um, if I'm in a long term care facility, I observe wound care. Um, pretty much any facility I get a chance to, I observe blood glucose monitoring and, um, medication administration, etc. Um, so last year, we were able to complete 24 of the 25 assessments we indicated we would do. You can see the breakdown of facilities, settings ****. Um, we will be providing 35 consults this next year. Um, one of the things, again, we're learning, I mentioned that outbreaks tend to sort of drive some of the consults but, again, we don't wanna do this during the middle of a norovirus outbreak because they have other things to deal with. So, it's really once the dust has kind of simmered, it's a good time to go ahead and go on, uh, because you're able to, um, provide additional education and support for them. Um, and the other thing I wanted to mention is the tools are very heavily based on what we're talking about at the last hour which is really having competency based training, performance feedback, and routine auditing of infection prevention practices. As you were hearing, as we talked about sterile processing, this is something that's not in place in a lot of facilities but I think it's really based on going with what we've learned with contact **** and the need to provide feedback, uh, people donning and doffing their, uh, PPE. Um, it's really, I think, where the state of the art in best practices for infection prevention are moving.

Next Speaker: Mary, can I ask you a question?

Next Speaker: Mm hmm.

Next Speaker: Um, the 35 that you have in the queue –

Next Speaker: Mm hmm.

Next Speaker: – is that for 2016 or 2017 or what's the –

Next Speaker: That, it's –

Next Speaker: – the calendar year?

Next Speaker: – basically it goes from April 1 through, uh, March 31 ****

Next Speaker: So you have some of those already probably started for the ****

Next Speaker: We, we have some, mm hmm, mm hmm.

Next Speaker: And out of that 35, can I ask how many hospitals were included?

Next Speaker: Um, I think we indicated, I wanta say nine or ten. It was up a little bit but not –

Next Speaker: Great.

Next Speaker: – a lot.

Next Speaker: ****

Next Speaker: Uh, we bumped up mostly long term care. We went from 10 to 15. I think we bumped up a little bit on clinics but I can, I can send you the breakdown of, of what we, you know, our targeting for this next year.

Next Speaker: Okay.

Next Speaker: They gave us a target.

Next Speaker: Great.

Next Speaker: Everything is very pliable if you will. We can shift as we see the needs, uh, need to move. Uh, so I did wanna mention, I'm gonna be going through again, just like last time, um, the results and quite frankly because of the lack of competency observations facilities are not performing well. There's a lot of zeros that we get. And I don't want to infer that they, that means they're not quality organizations. Um, it's really again just measuring whether or not they have this new practice in place. Um, so, for ambulatory surgery centers and ambulatory clinics, um, one obviously performs surgical procedures and needs to be doing a lot of SSI, um, planning and training, but, um, it still is gonna combine tool and it's the same tool that is used for outpatient, um, ambulatory clinics. Um, in terms of overall infection control program infrastructure, only one in five facilities met all requirements. Three of the five, um, had annually updated, um, infection prevention policies and procedures. Two had designated and trained infection preventionists. This does not mean certified infection preventionists but they at least have designated somebody and have documentation of additional training like our infection prevention fundamentals training course. Um, 60 percent actually had a system for early detection and management of individuals at point of entry to the facility. Terms of competency based education again no facility, um, had this in place. Healthcare personnel safety demand.

Um, one facility met all requirements. 60 percent had exposure control plans for blood and bodily fluids. 80 percent actually met all of the training requirements. Um, all provided post exposure, uh, follow-up, following a blood and bodily fluid exposure. Only 40 percent actually tracked and trended and tried to improve or decrease their actual exposures. 40 percent had work exclusion policies, um, that were specific about when they should not be reporting to work when ill. 40 percent encouraged prompt illness reporting to the supervisor. And 60 percent had policies for not penalizing ill staff. Now, um, everybody hopefully, everybody is aware that Oregon now has new sick leave policies and individuals are able to have 5 days of sick leave so some of the penalizing, you know, 60 percent have policies that penalizing of staff, uh, is almost a value judgment. Because if you use sick time then sometimes that, if you have PTO, it comes out of PTO so people feel like that's penalizing them if you will. I think it's just one of the things that we need to clarify with the CDC tool. Um, 80 percent, um, conduct appropriate TB screening and offer hepatitis B and influenza vaccinations to their, um, employees. In terms of surveillance of disease reporting, everybody met all of the requirements for this domain. They had lists of reportable infections that they educated patients on signs and symptoms of infections that they need to report. For hand hygiene, unfortunately nobody met this domain. Uh, 60 percent had education on hire, 40 percent annually. Um, nobody did observational competencies and only one, um, per, provided, performed any type of periodic auditing for hand hygiene. Um, only one facility had a policy that, uh, promoted preferential use of, uh, alcohol-based hand rubs. 60 percent has supplies readily available and then in terms of actual auditing practices, they were running about 20 to 40 percent, um, compliant and most commonly, I observed it not being performed after patient contact, um, or after removing gloves.

Next Speaker: Okay, Mary, what are the things do you have a **** policy for preferential use **** what do you see in terms of practices? Like what did, at those places? You know, I guess if it's what you're **** that you think ****

Next Speaker: There were some myths.

Next Speaker: Yeah.

Next Speaker: There were some myths in terms of if they had available, uh, alcohol based hand rubs.

Next Speaker: Okay.

Next Speaker: So, um, you know, again, there's still some of, and I have to think back to the five. Um, you know, not all, two were AFCs and not all had, um, uh, hand rubs and OR suites so there's again, some opportunities, I think, there. Um, in terms of, um, personal protective equipment, again, nobody met all domains. Um, however, 80 percent do provide training. Um, everybody had supplies available. Um, you can see, again, that, um, one of the gaps that we had here was really just in not wearing gowns as required and not wearing facial protection as required. In terms of injection safety, um, 60 percent, um, provide training on hire, but, again, are not doing annual training or competencies and feedback. Um, only 20 percent had a policy and procedure that actually spells out how they are tracking controlled substances to prevent drug abuse, diversion here. And again, this is the lack of a policy and procedure. There were

systems in place and as you can see, all controlled, um, substances were locked and secured. Um, but I think as Kate in her injection safety work attests to, this is an area where I think we need to have further work and focus on. And one the things that the tool is not asking for ambulatory care but it does ask in other domains is, are they notifying infection prevention to help identify what's the real risk of blood born pathogen exposure and do they have, um, you know, a policy that actually indicates what will, they will do should they identify drug diversion and who are the state quarters that will be involved?

Next Speaker: So, so the, the drugs are locked but they can't, they have no way of going back to see who opened the lock and.

Next Speaker: Yeah. It depends a lot on, what, sometimes they had a process that was purely they're missing a policy for what they're doing, so some was a paperwork issue. But, um, I will tell you that especially once it hits the anesthesia cart, a lot of the documentation would, would fall to the wayside. And, um, unfortunately, again, I saw anesthesiologists having narcotics in their pockets and leaving them on anesthesia carts during room turnover and things like that so. Um, and then again, um, just looking at, um, there's a lot, um, issues still that's out there with the USP 797 requirements and drying up, um, medications which really are designated for immediate use and not labeling them appropriately and sometimes drawing them up and not using them within an hour's timeline. Um, respiratory cup etiquette, 60 percent, um, met requirements for this. All had, uh, signage posted at entrances. All had required supplies available. Um, all but one facility had designated space for sick individuals. All were educating families and visitors about appropriate precautions and all but one facility actually educated staff on respiratory precautions, which, of course, as you know is very important during influenza season. In **** supportive care testing, um, 80 percent trained on fire, but only 20 percent annually. 40 percent had competency based training. Um, no facility was, um, providing audits or feedback. All did use single-use lancets; however, um, six, 40 percent did not adequately disinfect shared point of care device, devices according to manufacturer's instructions. Um, I wanta say there was one facility that was using a device that was not approved by manufacturer to be shared and then the other, um, facility really wasn't using the appropriate disinfection for the appropriate contact time.

Next Speaker: So did you like glucometers?

Next Speaker: I'm sorry?

Next Speaker: Did you like glucometers?

Next Speaker: Glucometers.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: You know, a lot of people don't see them as being a source.

Next Speaker: Yeah.

Next Speaker: Mm hmm.

Next Speaker: Because the patient has the test strip and the test strip goes.

Next Speaker: Yeah. The other one, Paul, that you're seeing though is a lot of, um, the coagulation testing. I forget what they call the device. It, you're gonna, you're gonna drive for –

Next Speaker: On the **** stab?

Next Speaker: Well, they, they've got other devices. They now have actually disposable ones that draw, draw the, um, coagulation tests **** now.

Next Speaker: PT/PTT?

Next Speaker: I'm drawing a blank on the name of it.

Next Speaker: PT/PTT?

Next Speaker: Do, ****?

Next Speaker: But ****

Next Speaker: INR?

Next Speaker: Right, what's it called?

Next Speaker: I think it's **** but.

Next Speaker: INR.

Next Speaker: Yeah.

Next Speaker: INR?

Next Speaker: Yeah, but there's, I, they have a name for the machine.

Next Speaker: No, the, the test. No, the machine.

Next Speaker: ****

Next Speaker: It's just, it's the same thing basically –

Next Speaker: It's a porting care test.

Next Speaker: – as the **** kilmoter and it is a porting care test that is done in a lot of ambulatory clinics so. Okay, um, environmental cleaning. Again, another hot issue here. Um, so we had, um, lapses. And, again, this is an area just like sterile processing. I think it's really hard to perform well and, um, there was a lack of policies clearly defining responsibilities for cleaning and disinfection. Um, not all, all personnel involved in cleaning and disinfection were training. That's just basically anybody who's doing which should include RNs. Um, and then, just in terms of observations, um, you know, staff was not able to, um, consistently articulate the glove times for the disinfections as well as really indicating that they were mixing it and more and more solutions are now requiring testing of the concentration level. It's one of those things you have to read on the manufacturer's instructions for use and so there were some, um, gaps in that as well where they weren't being tested after they were mixed.

Next Speaker: What do you you test the concentration with?

Next Speaker: Yeah.

Next Speaker: Dipping sticks?

Next Speaker: Sometimes they'd have dip strips and sometimes it's an issue that you have to get like a, a pH strip.

Next Speaker: Uh huh.

Next Speaker: Um, to do that. So. On surgical site infection prevention practices again that's only applied to two of the facilities that actually were doing surgical procedures, um, and the lapse here was mainly again not doing monitoring of adherence to preop scrub application, use of surgical attire, drapes, antiseptic techniques, ****, ventilation requirements or work traffic environmental cleaning during group turnover as well as terminal cleaning. So, I think again, this is an area, um, you know, I know Mary and Teresa commented on how great it would be to have an infection preventionist who could be assigned just to the OR –

Next Speaker: Okay.

Next Speaker: – as well as sterile processing. It's a dream for all of us but, um, it's just an area that I think again, –

Next Speaker: ****

Next Speaker: Who would monitor adherence as obviously these are all important practices.

Next Speaker: Mm hmm.

Next Speaker: But how would you expect a facility to monitor, um, adherence to, to this?

Next Speaker: Um, you're actually an OR procedure so, so.

Next Speaker: Procedures, yeah.

Next Speaker: You, you actually monitor –

Next Speaker: So, occasional, okay.

Next Speaker: –how they set up the field you actually monitor, you know, how they –

Next Speaker: It's not ****

Next Speaker: – how they move the instruments, how they place them on the sterile field so it really involves observing surgical procedures.

Next Speaker: But, but, uh.

Next Speaker: Being in the room.

Next Speaker: On a spot check basis and not.

Next Speaker: Right. You just would periodically audit. You don't have to do it all the time obviously. But again, it's, it's that snap, it's that periodic, you know, audit view and presence and I think that allows you, I think most of us have done an ****

Next Speaker: Oh, yeah.

Next Speaker: Been in the OR and it allows you to again, talk to the staff, ask them what they think may be contributing to infections. Um, ask them if there's any, you know, have questions or anything they're doing that they're, you know, may be wondering if it's correct and it's just presence is just really critical I think. Plus the other thing we're really learning in terms of surgical site infection is the role of ventilation systems and, are they functioning appropriately and how much room traffic do you have? How much, you know, door opening is going on? And, again, there's data that's coming about particle counts and how that potentially could be contributed to a lot of the infections we're seeing as well.

Next Speaker: So, Mary, if a facility, you know, wanted to meet this requirement or this, this competency domain, how would they? Is there a guidance for them on sort of, I mean, you can say spot check but is there a sort of guidance on, like ****.

Next Speaker: It, it just says periodic.

Next Speaker: Okay.

Next Speaker: The wording is periodic monitoring and documentation. It says that.

Next Speaker: So, they just sort of like they don't, it's however we define periodic. I mean, like.

Next Speaker: Well I would be happy if I –

Next Speaker: **** audits.

Next Speaker: – I would be happy if I see it once. But, you know, 'cause again it's, it's not defined for this tool.

Next Speaker: Yes.

Next Speaker: It's just, is it happening, so when I say, no it's not happening, that means it hasn't happened at all.

Next Speaker: You know, those aren't familiar, I mean, things to me because those are things you look at, you know, as far as you SSI workout, you know, it, you definitely do look at all those little elements because they're all risk factors.

Next Speaker: Yeah.

Next Speaker: Well, I'm **** I mean, it's wouldn't be hard to necessarily operationalize. I mean, you know, if you were to you know, checklist it.

Next Speaker: We've got audit tools.

Next Speaker: Right. Yeah.

Next Speaker: You know, that people can use. ****.

Next Speaker: But here's the thing as the draping for some of these, um, uh, surgical procedures is quite elaborate.

Next Speaker: Mm hmm.

Next Speaker: Yeah.

Next Speaker: And unless you're an expert in that domain, your, an IT is not gonna pick up on little misses.

Next Speaker: And this, there, there are things there again, maybe this is where we can do more training for ITs, but just general rules in terms of applying the drapes and, you know, not having contact.

Next Speaker: Mm hmm. I think that work.

Next Speaker: Whatever.

Next Speaker: Absentias, yeah. I know, again, I think there's some kinda high level thing.

Next Speaker: So, yeah.

Next Speaker: Yes.

Next Speaker: I mean, it's simple to put on but really, it's a complicated process.

Next Speaker: Sure.

Next Speaker: Yeah, and I've done **** updates as well, uh, for infection control and so, I mean, 'cause a lot, there's a lot, there's a tremendous variety –

Next Speaker: Mm hmm.

Next Speaker: – so there should be some expectation they'll miss it periodically because of the frequency even if they're not major procedures they're doing and types of procedures they're doing and then I think there should be minimal expectations for all procedures for what types of things just, you know, I, it'd be hard to apply those across the board for someone who's not trained to look at them but, because one of them of them, I think, um, it wouldn't take long to train somebody up to look for certain things like you know, that they're not, you know, oh, you know, breaking the sterile field.

Next Speaker: Yeah, you're not walking away from the sterile field. You're not turning your back.

Next Speaker: Or you're supposed to be looking at that in the room and, and stopping that.

Next Speaker: Yeah. Yeah.

Next Speaker: Alarm ****.

Next Speaker: And I think sometimes too, I mean, infection preventionists are not sterile scrub techs and they're not –

Next Speaker: Yeah, I almost walked right through.

Next Speaker: We're not certified in any but I think if you've watched enough procedures, sometimes you see something and it just doesn't feel right, you know, and then you can raise that question.

Next Speaker: Right.

Next Speaker: You know. I mean, and I can point to a time where I saw that this last year and it's like this, this is something I've never seen before and then you can ask your colleagues. You know, you can ask other hospitals, what are your people doing? So, again, part of it is just presence and I think, conversation that's critical. Um, so, device reprocessing. Um, again, you

can, this follows up very nicely to what, uh, Teresa was presenting and um, just again, um, you know, I think the, the whole centralization is really, um, happening. It, it is hard to get out of all areas but you wanna do it as much as you can because it's really hard to keep people trained and on top of it in all the areas. Um, so 40 percent, um, actually had policies and procedures for all the reprocessing that they did, um, and, again, those two were pretty much the ambulatory surgery centers. I think the lapses here were primarily clinics and that is where, you know, that's kinda the piece that's keeping me up at night right now, if you will, is all of the clinics and what is really happening out there. Um, Oregon, like many states, are moving to a lot of ambulatory care settings and, I don't know if it's happening before we actually have rules and regulations and requirements to really support that movement but I think it's something that we're gonna have to begin to talk about. Um, 60 percent received hands-on training. Only 20 percent annually, 20 percent had observational competencies and nobody was performing any type of audits or providing feedback. Um, one of the requirements is that you have to hand out policies and procedures and manufacturer's instructions available to staff, um, for reprocessing the instruments and only one of the facilities had that. Um, only one completed the whole process, um, completely correctly. Um, 20 percent, um, actually one facility, um, actually reused a single-use device which is not to happen. That was, uh, a common practice that they were doing so that was something that we had to correct and, and so.

Next Speaker: What was the device?

Next Speaker: What this was, was they were opening, um, sterile trays from the manufacturer and then there were sutures and some other items that were on the tray that were not used.

Next Speaker: ****

Next Speaker: So they would then go ahead and sterilize it again and so that again is one of those old practices that was out there that can, you know, is no longer acceptable by FDA regulations so one of those things we have to correct. Um, 40 percent had appropriate workflow being soiled and clean, um, work spaces. Terms of sterilization of reusable devices, um, 60 percent used the enzymatic cleaners correctly. Most of the gaps here were not measuring it appropriately. Um, 20 percent, uh, only one used brushes appropriately and here, it was really, you know, assuring they have the right sized brushes for the instruments, um, according to recommendations and then, that after use, um, disposable brushes are discarded or reusable brushes are either high-level disinfected or sterilized. Um, only one was following all the wrapping and packaging instructions correctly. Most of that was, um, some of that was associated with not having indicators and labeling appropriately on it. Uh, 40 percent, um, used biological indicators correctly and, um, you know, the gap here was some were really not keeping, uh, and this again was the clinics.

Next Speaker: Clinics.

Next Speaker: Not keeping logs of biological indicator used and some using them monthly instead of a minimum of weekly and some having even a longer gap than a month. Um, 40 percent, um, labeled packs and pouches appropriately and appropriately maintained logs for each load and this, again, was primarily documentation, um, issues and ensuring that each load is

identified and, you know, a good sample of the instruments that were included in the load. Um, terms of high level disinfection, only two of the facilities performed high level disinfection. Um, one facility did everything correct, um, but the other had some issues in not, um, using enzymatic cleaners appropriately, um, not handling the brush appropriately. Um, but the good news is both, um, measured, mixed and did QC checks appropriately on the high level disinfection which is one of the big areas we're really concerned about.

Next Speaker: I gotta display my ignorance here and ask what is high level disinfection.

Next Speaker: Thank you for asking that. I was afraid to ask.

Next Speaker: Um, so, high level disinfection is, um, it's used commonly on scopes and other types of equipment that come in contact with mucous membranes and nonattached skin, etc. They tend to be hazardous chemicals so, it's like your Sidex or Glucoraldehide, your OPA, etc. They can do cold sterilization if it soaks for long enough but, uh, typically the instruments need to soak for, depends on the chemical –

Next Speaker: Oh, 30 or 40 minutes at the temperature.

Next Speaker: –- **** be using. Yeah.

Next Speaker: But what does the high level mean?

Next Speaker: It means that it kills everything but spores.

Next Speaker: Ah, okay. ****

Next Speaker: Well, not all spores.

Next Speaker: Not all.

Next Speaker: It'll, it'll clear most spores.

Next Speaker: It'll kill some spores, yes.

Next Speaker: Not all. Not all.

Next Speaker: It'll kill C. Diff.

Next Speaker: Technical discussion here.

Next Speaker: As, as opposed to, uh, ****

Next Speaker: Sterilization which is the absence of all.

Next Speaker: It kills everything.

Next Speaker: Right.

Next Speaker: Yes.

Next Speaker: Okay, so this, this is a step below sterilization.

Next Speaker: A step below.

Next Speaker: Step below sterilization. And, and again, you can, you can have cold sterilization with these chemicals. Um, but high level disinfection, again, is gonna kill most everything other than some of the spores, so.

Next Speaker: So you can't throw it in the autoclave so you do this.

Next Speaker: Uh, if you throw it in the autoclave, it's gonna fall into sterilization.

Next Speaker: And you'll melt it.

Next Speaker: Right.

Next Speaker: If you follow parameters appropriately. But, you know, again, so, so most commonly it is scopes, but it's a lot of times its, um, instruments that have lumens that are really hard to clean. A lot of dental equipment. Really falls into high level disinfections.

Next Speaker: Anesthesia.

Next Speaker: Respiratory equipment. Yeah.

Next Speaker: And so, Mary, who, uh, at these, uh, these ambulatory clinics, do they all have sort of onsite high level, well, you said one didn't have it, so does that mean they're send –

Next Speaker: Two. Two.

Next Speaker: – the instruments elsewhere?

Next Speaker: All right.

Next Speaker: Two up to five had it.

Next Speaker: Two to five had it.

Next Speaker: They're just not doing procedures.

Next Speaker: Oh, they ****

Next Speaker: That require that equipment or instruments be high level disinfected.

Next Speaker: Does anybody send out their equipment to a **** disinfections/sterilizations or do they offer it?

Next Speaker: There, there were clinics, and it's not uncommon, but there are clinics that have centralized reprocessing so some of the clinics –

Next Speaker: ****

Next Speaker: – so some of the clinics I was in do send it out to one location.

Next Speaker: Um, do you, just sometime I'm wondering if we can do dialysis at the next meeting or is it do hepatitis if it's not.

Next Speaker: A Part 3?

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

Next Speaker: Oh, with hepatitis. Well that would be an interesting combination.

Next Speaker: Yeah. ****.

Next Speaker: Why not, I'd like that.

Next Speaker: So, um, 'cause I think I'm gonna get flex use outbreak update and then we have, I'm gonna do a little legislative update on, uh, healthcare workers **** think about that, so. So that, that okay?

Next Speaker: Oh, yeah.

Next Speaker: I'm fine with that.

Next Speaker: All right.

Next Speaker: ****

Next Speaker: All right, so, Lexi Zang is our, uh, HAI in the office and she **** report, uh, just an outbreak update, that we usually get at the beginning of meeting, uh, but I swapped out with Teresa so, I'm just ****

Next Speaker: You and I are gonna swap seats again.

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: Sorry. Let's see.

Next Speaker: Right.

Next Speaker: It's been, it's been an effort to kinda maintain our standardized, just sort of quarterly update, a quick update here. Lexi, uh, took a last-minute ****, so.

Next Speaker: Oh, last minute.

Next Speaker: Nice. Huh, **** one of these, yeah. It's a millennial **** yeah, freedom.

Next Speaker: Yes.

Next Speaker: ****

Next Speaker: Um, so she **** so basically we, uh, she looked at sort of the quarterly outbreak update so between March 1 and June 14, um, and so the, the vast majority, well, 36 of our 101 outbreaks, actually, I guess, were, um, gastroenteritis. Um, I think you kinda see, the, the back, the breakdown here, we, as usual, long term care facilities **** our, um, most frequent, uh, group to report, uh, outbreaks. We have asserted as ongoing shigella outbreak in the MSN homes population. And you can see there's sort of a various, uh, GI, outbreaks in long term care facilities and hospitals, and also respiratory as well. We had, you know, 15 influenza outbreaks. Um, and the majority of those were long term care or hospitals.

Next Speaker: Hm.

Next Speaker: Um, that other outbreak that's on there for the hospital. There'd be a cluster of surgical site infections in one hospital that, um, **** the hospital on.

Next Speaker: Did seem like a lot of influenza outbreaks that also went kinda late into the season. Uh.

Next Speaker: Mm hmm.

Next Speaker: I don't know if this is a new normal because there's more testing going on or whether it, it felt like a very heavy year.

Next Speaker: It wasn't that sort, it was sort of a delay in the start.

Next Speaker: It's a late season.

Next Speaker: ****.

Next Speaker: Yeah, um, and so, uh, I guess healthcare-associated infections, um, accounted for over half of all the outbreaks reported during this time period and here's sort of a breakdown of

the, the types. We were sort of expecting to see this bolus of the G24 Sidney, um, that seemed to, to be emerging, but, um.

Next Speaker: I don't know what the deal is with the untypeable. Paul, do you have, uh, any perspective on that?

Next Speaker: New strain probably.

Next Speaker: New strain?

Next Speaker: And so here's our healthcare-associated outbreaks just sort of, uh, broken down by, by pathogens so.

Next Speaker: Hm. ****

Next Speaker: And then this is, this is sort of a highlight. Um, I, we had one case of exotheologermititis, um, that we discovered in a, an outpatient, um, clinic, where a, a man had the proceeding corticosteroid injections in his knee so we just we thought we'd highlight how that, uh, investigation played out.

Next Speaker: What is that?

Next Speaker: Um, it's actually, it's a black fungus so this, um, it's just like a very rare fungal infection. Um, that's, we see it very rarely. It kind of isolates but it likes to live in hot places.

Next Speaker: Was it a contaminate in the ster?

Next Speaker: Well, this, that was what we were trying to figure out. Actually it looks like, uh, so, this patient was receiving several different types of injections and steroid like, as we called hilogen, which I guess is like a lubricant that they often give in these cases that kind of extend the life of the corticosteroid. Um, and so we actually contacted CDC 'cause it's a rare bug and they hooked us up with their mycotics divisions and said they hadn't seen this. You know, they didn't suspect that this was like intrinsic contamination of the product. Uh, they had seen this in one other clinic in another state but they said it was very, obviously, due to clinic practices. Like, there was black mold growing in the fridge and they –

Next Speaker: Oh.

Next Speaker: Oh.

Next Speaker: – **** grouping. It was like they were storing things in the fridge and, so, um, so they said, you know, it doesn't look like it's intrinsic but, um, you know, we've had, it sort of led us down this road asking about their multidose vial practices and, um, you know, we got Mary on the line to help consult based on her experience on the, um, field, and, and so there was some practices that I'll mention on the next slide if I can ****. Um, so here it is, yeah, black mold, rare clinical isolate. Um, it was associated in 2002 with, um, actually contamination of products

on intricate, intrinsic examination, um, due to a compounding pharmacy. And so that was sort of like the fungal meningitis was also due to a compounding pharmacy. And so we looked into that with these products and none of them had been compounded so, um, we sort of, like you know, ruled that as very unlikely that it would be.

Next Speaker: This was the ****. This was a joint infection or was it, it wasn't like ****

Next Speaker: Pleural fluid, yeah.

Next Speaker: Oh, okay.

Next Speaker: Oh, not pleural fluid, what is the fluid?

Next Speaker: Mm hmm. Yes.

Next Speaker: The aspirate?

Next Speaker: He had the **** originally.

Next Speaker: Okay.

Next Speaker: And they actually cultured several times from several different injections so.

Next Speaker: Yeah, the first time the I.D., the first time they thought it must be just a contaminant.

Next Speaker: Right.

Next Speaker: They just, like they can't. They **** doing it. It's in their, um, and so this is, we kind of asked them about their practices and this is how the medical assistant basically carries around the multi, multidose vials that at the beginning of the day, the assistant puts in her cart and then she takes it from room to room with the physician who then draws up the medicine at the patient's bedside, or not the bedside but just kind of in the clinic room. Um, and so, this is kind of a no-no based on, this is actually from the One and Only Campaign web site. Uh, there's a big emphasis on drawing up all medications in a clean, medication prep area that's away from, uh, the patient care area and, um, you know, this step is actually most of the One and Only Campaign, uh, guidance comes from this minimum expectations for standard care which actually is, ties in with some of our earlier conversations. Uh, the CDC has really just seen this as a need to just kind of impose the basic standards for all settings and so in their injection safety, uh, they really emphasize that multidose dials should be dedicated to a single pay, patient whenever possible. Um, but, you know, when they're not, so in this kind of scenario where they're actually, they're doing, many, many injections every day and going from patient to patient to patient but, they, the file should not be traveling around to these different rooms. So, um, so again the, the county, the way this rolled out is the county, uh, communicable disease nurses went out and did an inspection of the facility. They sent us like very detailed pictures, um, contacted CDC and so we're working with them on a remediation plan to try to get them to change their practices and

there were a couple of other little things like storing the multi, the cart's kind of, you know, above the refrigerator that has some mold in it. Stuff like that, but.

Next Speaker: And was this treatable for the patient? Did he have a good result, or do you know?

Next Speaker: I don't know actually what's going.

Next Speaker: I think they're still on antifungal agents.

Next Speaker: ****.

Next Speaker: **** he'd be on it for a long, long time.

Next Speaker: Long time.

Next Speaker: Oh, you know what, he was on, I think Fluconazole first. Yeah, but then that actually doesn't treat this bug

Next Speaker: Yes.

Next Speaker: So he was switched to **** just, just this month as soon as they discovered it but I don't know. Should that be known if that treats this bug?

Next Speaker: I don't know. You probably, uh –

Next Speaker: Yeah, he, he has an ID consultant who's following the case that I think actually notified you, right?

Next Speaker: Yeah. Exactly, yeah, he calls me so. Um, anyway that's sort of the outbreaks update.

Next Speaker: I, I just was gonna say one thing, um, just associated with this case 'cause again, I think it's a practice that's very common out there.

Next Speaker: It's very common.

Next Speaker: Yes.

Next Speaker: Um, you know, technically when you are injecting into a joint, you do that with very strict accepted techniques.

Next Speaker: Oh.

Next Speaker: And it's not uncommon that, um, individuals use large bottles of either Hibaclens or, uh, **** solution and they'll share those big bottles between individuals and if you really go

to manufacturer's directions, they want you to move to the single use, individual patient-steriled packaged products so, that, again, is just if you think about what people need to keep their eyes out for, that's I think again, a common recommendation that we can make.

Next Speaker: I know it's difficult.

Next Speaker: ****

Next Speaker: In, in clinic settings to, um, to get to the procedure, the, uh, medication procedure area and get it out of the rooms where the physician is because it's a workflow issue. So, because a person can't draw it up for the physician, the physician needs to draw it up. So the physician would have to go to the med prep area.

Next Speaker: Mm hmm.

Next Speaker: And, and there's a push back.

Next Speaker: Oh.

Next Speaker: But.

Next Speaker: Then, you know, in this particular –

Next Speaker: Have to keep on.

Next Speaker: – particular case, um, they could've ordered smaller vials than they did so you could either have more vials that are used for the procedure or discard less after the procedure so it, it is a challenge.

Next Speaker: Yes.

Next Speaker: It's not an uncommon challenge but, again –

Next Speaker: Oh, in the real world, you see this germ with Botox. I mean, things that are very expensive that you don't wanna waste and it's multidose so it is going on.

Next Speaker: The other thing that, um, I, and I'm still processing because I don't know if I agree with all things that was presented but, um, one of the topics that National APIC, um, was really stressing out if you are doing any type of work with an ultrasound probe which sometimes happens with injections that, you know, No. 1, you need to have sterile gel as part of your field, but they actually were saying, too, in this case, you're, you know, not only should you have a sheet over the probe but the probe should be high-level disinfected afterwards which is a huge leap, so just know that more may be coming with that practice as well.

Next Speaker: Mm hmm. Tuesday.

Next Speaker: Well, thanks.

Next Speaker: Thank you for the update. All right. What's next on the agenda. Me.

Next Speaker: Mm hmm.

Next Speaker: So, this is just a little legislative update regarding um, a proposal to amend the OARs in regards to, uh, mandatory vaccination for healthcare workers.

Next Speaker: Mm hmm.

Next Speaker: And, uh, you know by extension, could an employee mandate an, um, vaccination. We're looking specifically for influenza but it might apply to any other vaccine, uh, that the employer would be able to mandate that an employee be immune to all the communicable diseases by vaccine. So, um, we did get support from the APIC chapter. Pretty much everybody inside the, uh, APIC membership was supportive of this. Um, our current, uh present president, Janet Sullivan, and I did meet with, uh, a legislative rep, uh, his name was, uh, Rob Nossi's assistant, um, we met with him to talk about what were the processes and what we'd have to go through. And primarily, what you'd have to do is find a supporter, find a champion, in either the House of Representatives or the Senate and it would be, uh, for the session, uh, in 2017. Um, one of the barriers or, there is a strong anti-vaccine, um, coalition in the state, uh, that would really be, uh, uh, I think put up a lot of barriers to this. I know that the ONA has had some reservations as well regarding uh, mandatory vaccine for, um, nursing employees. Uh, so it would be, uh, a challenge to get, uh, No. 1 to identify a legislative champion and No. 2, to get the, the legislation, uh, passed. So, we, uh, did send out, or Janet did, send out, uh, emails to every senator and representative in the state asking for support and she really heard crickets so it's going to be something that, um, we might wanna start talking more about as a group. Uh, I don't know if ONA has any further discussion on the topic. Uh, if they've ever discussed this, if, in any of their meetings. But if you look at the OARs, that, that whole, um, paragraph really is in reference to, uh, post exposure prophylaxis and that the employer offers but cannot demand that the employee receive any medication or vaccine. So, I, I think we could take another look at that and see if that is the interpretation. If that would preclude, uh, an employer from mandating vaccine.

Next Speaker: Well, it means, and we've gone round and round with this for many years, an employer cannot use, use, or require vaccination as a condition of employment. So that means, you know, you can't say.

Next Speaker: It doesn't say that verbatim in, in the OAR.

Next Speaker: Mm mm.

Next Speaker: It's the interpretation so that you, to work here, you must have a flu vaccine. You can't do that so that's why everything is voluntary in this state and that's why the big push to, you know, up your flu vacs rates but there's only a certain, I mean, there's only a certain place you can get with voluntary.

Next Speaker: Yeah, and yeah, and pretty much hospitals are there.

Next Speaker: Right.

Next Speaker: Because many hospitals have gone to mandatory masking during influenza season.

Next Speaker: So, so the, we've had conversations with the ONA and the ONA's platform on this is that you can't require this because it's a violation of someone's civil rights. So that's where they come down to with. So we're trying, we tried to steer the, that conversation to well, what about patient safety. It's all about caring for the patient and making sure you as the care provider are not giving that patient something that could be untoward. So.

Next Speaker: right. That's the whole point. Mm hmm.

Next Speaker: Exactly. So, we're at the point of where do we go from here. Um. I don't know.

Next Speaker: ****.

Next Speaker: Yes.

Next Speaker: I was at, um, where did I go in my **** sorry. I went to, what'd you say it was?

Next Speaker: IDSA.

Next Speaker: I, uh.

Next Speaker: I.D. week?

Next Speaker: I.D. week, sorry. Yeah, I went to I.D. week in October of last year and presented my influenza data which was, you know, the, um, promotion strategies that were most effective, etc. We kinda looked at those and, um, it was interesting. I was surrounded by both New York and California who don't have it in law but their public health departments

Next Speaker: ****

Next Speaker: Mandated, uh, healthcare work, and they're, you know, influenza rates obviously skyrocketed and they had the same issue with masking as opposed to not being. And then their unions got all upset saying, well, masking is an announcement that I refuse to get my –

Next Speaker: Mm hmm.

Next Speaker: – and so, yeah, it goes, you can go round and round and round.

Next Speaker: There's a lot of legislative activity around this, uh, across the country, both to get it off of the, the law and to act, so there's a lot of churn –

Next Speaker: Mm hmm.

Next Speaker: – across the country on this.

Next Speaker: Frustrating.

Next Speaker: But, I mean, our, you know, the last survey suggests that we are doing actually better than I ever thought we would do. ****

Next Speaker: This is probably as good as we'll get.

Next Speaker: Over 75 percent in hospitals. Uh.

Next Speaker: Yeah.

Next Speaker: 67.

Next Speaker: So, so is it good enough as far as you know, what herd immunity.

Next Speaker: Herd immunity, yeah.

Next Speaker: ****

Next Speaker: Well.

Next Speaker: It's pretty close but you know, the problem with herd immunity is that –

Next Speaker: It's not –

Next Speaker: – it presumes uniform vaccination and, uh, you know, you're never gonna have that, right? You're always gonna have pockets where transmission can go on because the vaccination rates are a little bit low. So.

Next Speaker: We certainly have pockets geographically in the state so even though overall our hospitals are high, our southern Oregon, like across the, across the board, across the **** types is.

Next Speaker: But I'm talking about even, even in a, a region that's doing well –

Next Speaker: Even within its –

Next Speaker: – you're gonna have units of ****

Next Speaker: Oh, yeah, you know, a maternal child that doesn't do so well and oncology ****.

Next Speaker: Mm hmm.

Next Speaker: Yeah ****

Next Speaker: 'Cause uh, you know, all these healthcare workers are eventually gonna get exposed. It's not like measles in Southern Oregon where than can hope that nobody pops into the area with measles. Every one of these hospitals and probably just about every healthcare worker is gonna come in close contact with somebody with influenza sometime during the season so.

Next Speaker: so what's the rate of healthcare facilities offering free vaccine to the staff?

Next Speaker: They all do.

Next Speaker: Everybody.

Next Speaker: They all do it.

Next Speaker: Almost all everybody. Not everybody.

Next Speaker: Not all healthcare facilities so even like these ambulatory care centers we're talking about, long term care facilities are just ****

Next Speaker: You know, I don't know, I can't state for all ****

Next Speaker: I, I collect the data and some facilities do not offer it for free at all. But that's very, very few, I'm talking less than 5 percent probably.

Next Speaker: Okay. So it probably wouldn't be worth exploring maybe trying to figure out if –

Next Speaker: Right.

Next Speaker: – fixing a cost issue to ****.

Next Speaker: I mean, I think hospitals, it, my, my overall take on looking at a few years of this promotional data is that, is that hospitals are kind of maxing out. We may only go up a percentage point each year but many of them have implemented multiple strategies. They have mass vaccination fairs, free vaccines, peer programs, sometimes masking and long term care and ambulatory surgery have implemented fewer so it seems like, you know, they potentially could implement some of these programs –

Next Speaker: Mm hmm.

Next Speaker: – that might get their rates up a little bit but then at a certain point, you know, it's, it, I guess, yeah, do we want to put our eggs towards, **** work on this, you know, getting a legislative mandate or, you know, like ****

Next Speaker: I think it would be a long, uphill fight and –

Next Speaker: Yeah.

Next Speaker: Is it worth all that effort and time.

Next Speaker: Right. And it's for one pathogen. Like, cause you and I were talking oh, what about this whole presentism issue, like if someone shows up sick they could have –

Next Speaker: Norovirus.

Next Speaker: – any number of pathogens.

Next Speaker: Mm hmm.

Next Speaker: So if, you know, maybe we should be focusing more on the, you know, sick worker policy that's sort of more of a horizontal approach instead this, like, you know, one specific pathogen that we ****

Next Speaker: Let me tell you as somebody who used to work in a hospital, that sick worker policy thing should really be looked at because they really don't like you to call in sick at all but they also don't really want you to be there sick so it's a real trade off. I mean I literally was fired after having worked at Saint Pete's for 13 years for being sick too many times.

Next Speaker: You're allowed so many episodes of illness.

Next Speaker: Yep.

Next Speaker: Unless it's **** or something like that.

Next Speaker: Only a certain amount, yeah, four I think. So.

Next Speaker: That's a good place to start.

Next Speaker: Mm hmm.

Next Speaker: I'm not bitter about it though.

Next Speaker: I think that would.

Next Speaker: I think ****

Next Speaker: I agree, I think we should have a look at that. Yeah.

Next Speaker: Well and defining what sick **** is too 'cause, sometimes people might have some sort of like site infection so determine whether or not, you know, a staph infection on your skin ****

Next Speaker: Well, that's a work exclusion policy that most places have, um, that would define what you should not come into work with or to contact employee health. You know?

Next Speaker: They have an OAR like down to the manager level that's deciding –

Next Speaker: Yeah.

Next Speaker: – that's deciding whether or not you should come in helping **** with that policy.

Next Speaker: They don't care.

Next Speaker: Right. Oh, you're fine. Yeah.

Next Speaker: No, you hit a certain number and you're gone –

Next Speaker: It's, it's covered up.

Next Speaker: – whether it's.

Next Speaker: You're good, oh, I mean. You know.

Next Speaker: Well, physicians, too, come to work sick

Next Speaker: Mm hmm.

Next Speaker: **** be sick.

Next Speaker: Because they don't have anybody to cover their clinic or whatever so, a lot of physicians will come to work sick.

Next Speaker: Bentley. Interesting talk.

Next Speaker: Mary, sorry, one, one more question, sorry. Um, do any of the hospitals offer free vaccine to, like, the patient population at the time of the fair, or, or, uh, at, you know, employee families coming **** day. Or anything, do they kind of break out further than just the staff population at all ever?

Next Speaker: I think some do. I don't know how many offhand but, yeah, it depends on.

Next Speaker: It's not a very common practice.

Next Speaker: Well.

Next Speaker: Well, Trip Care pretty much does offer it to residents as part of their, you know plan for the year.

Next Speaker: Okay. Yeah.

Next Speaker: So I think it. And dialysis offers it to their patients.

Next Speaker: But I don't think it's free.

Next Speaker: So, a lot of it depends I think on the facility site.

Next Speaker: I think many if not most hospitals will have standing orders for flu vaccination if their patient stream includes ****.

Next Speaker: It is. But it's, uh, actually a measure.

Next Speaker: But it's not free. But it's not free.

Next Speaker: Oh, they're probably billing insurance.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Well, it's a inpatient measure that you, you vaccinate anybody from the start of flu season, um, until, um, March 31st. So, it October 1 to March 31st. You are measured on that.

Next Speaker: Can I see it?

Next Speaker: That's your hospital, you know, your patient, uh, vaccination rate and 100 percent is what's expected.

Next Speaker: Wow.

Next Speaker: So that's for inpatients.

Next Speaker: And I have heard of some facilities offering family members as well, but I think that's probably –

Next Speaker: Yes.

Next Speaker: – a small chunk. Um, I think usually, um, facilities feel that since they typically provide insurance for the families that they can work through their own providers for their vaccinations.

Next Speaker: Mm hmm.

Next Speaker: But you know there's one area where this, this committee might have some influence, uh, and that, and that **** last time with a letter from somebody who lived in independent living is, you know, to the, to the extent that we're requiring facilities to report to the state healthcare worker influenza vaccination rates, to the extent that actually possibly improves rates, because we're looking at as being published, you know, we, we are, you know, limited currently to, uh, long term care, dialysis, ASCs –

Next Speaker: And **** hospital.

Next Speaker: Which I say limited but it's a huge amount of work for you.

Next Speaker: No, but it is limited. It's only sniffs.

Next Speaker: **** possibly.

Next Speaker: Right. ****

Next Speaker: Yeah, it's not assisted living or independent.

Next Speaker: **** So there are people in independent living and that's the letter we got at the last session was from an individual –

Next Speaker: Yeah.

Next Speaker: – in independent living who said these, the staff weren't vaccinated –

Next Speaker: Mm hmm.

Next Speaker: – and they're sick and like we're a vulnerable population due to our age and so, that's, I mean something we may bang our heads against the wall in terms of getting a mandate passed but that's something this committee could actually choose to do in the future. Not, is to kind of broaden our recording mandate –

Next Speaker: Mm hmm.

Next Speaker: – to these other facilities. How we, I see Diane like, how are we gonna track these facilities and figure out who they are but that's something to consider.

Next Speaker: Yeah.

Next Speaker: So.

Next Speaker: I've always wondered why we only do sniffs.

Next Speaker: Yeah.

Next Speaker: The assisted living is –

Next Speaker: Well some of our, yeah, residential care facilities, you know, foster homes, sniffs are very, you know, fragile patients.

Next Speaker: Yeah. We have some foster homes with ventilated patients.

Next Speaker: Oh, yeah.

Next Speaker: **** requiring several, um, ****.

Next Speaker: I'm sorry, this is Deborah. I couldn't hear the comments about foster homes. Could people speak up please?

Next Speaker: Oh, she was saying we have some foster homes with very fragile patients and some that are even ventilated.

Next Speaker: So the conversation was around, um, reporting uh, employee vaccination rates.

Next Speaker: Yeah, okay, well, I just wanted to make sure I didn't miss something but yes, we do have a few ventilator homes –

Next Speaker: Yes.

Next Speaker: – and we do have outside of those, oh, uh, a number of homes that care for pretty compromised people.

Next Speaker: Yep.

Next Speaker: But do you, can you, um, I mean, do you consider independent living facilities to be healthcare facilities?

Next Speaker: Um, are you talking to me or to, to Deborah or to –

Next Speaker: Yes. Yes, over ****.

Next Speaker: Uh, well, actually I do. Um, it's not used that way by a lot of people, um, but all of the facilities that we license or certify is a form of long term care.

Next Speaker: Mm hmm.

Next Speaker: So I use it more globally. A lot of people when they hear that term, they only think of nursing home.

Next Speaker: Mm hmm.

Next Speaker: Hm.

Next Speaker: And, Deb, let's say we were to consider some kind of mandatory reporting policy for something like adult foster homes. How would, who would we even contact that, that is sort of charged with, uh, you know, maintaining records of, you know, the employee's vaccination status.

Next Speaker: Yeah, I, you know, I, I think that's like a much bigger discussion to have. I think the, if you're looking at the things that we should be doing with foster homes, that should be on the bottom of the list because a lot of the interventions that get discussed a lot kind of start at the nursing home facilities, maybe trickle down to the assisted living and the foster homes are not touched at all. Um, so, you know, I mean I'm looking at already making, I'm in the process of making some rule recommendations for both assisted living and foster homes to strengthen a number of things around infection, infection control, um, but there's really a big need to just push the understanding of the need and I'm not quite sure. You'd have to depend on each local county health department to follow up on that documentation and I don't think that's on their, um, you know, big list, right now. I'm not saying it should never happen, I'm just thinking right now may not be the ideal; time because there's other things we haven't done yet to kinda get them brought up to speed.

Next Speaker: Yeah, thank you for that comment. And I think that's something to keep, keep in mind and I'm gonna put on my list of, um, future topics for everybody to review because I think, um, it would be great, Deb, uh, if we could have you present to the committee on, uh, you know, infection control priorities in that setting and I know Pat Preston, I don't know if he's on the line anymore, has been –

Next Speaker: Yes, I am on the line.

Next Speaker: Dedicating that **** to, uh, to long term care so, um.

Next Speaker: Yeah. No, I'd be happy to do that. Um, the, you know, the nursing homes, you know, there, there is a lot of, you know, focus on them and ironically, there is a lot of pretty heavy, um, heavily specific rules and regulations even around survey that include infection control. Um, but there is no standardization within foster homes on what the local offices look at when they go into the home so that's all up to each and every individual **** county.

Next Speaker: Okay, thanks, Deb. Well, I think we're about to ready to wrap up the meeting, um, and, um, I just wanted, I think everybody that this will be my last, uh, meeting here. I'm not sure.

Next Speaker: Oh that's ****.

Next Speaker: We're hiring for my position so there will a new person, um, kind of overseeing the reporting and helping coordinate this meeting but it's been a pleasure to work with all of you and, um, –

Next Speaker: You will be missed.

Next Speaker: Yes. You have done such a fabulous job.

Next Speaker: For sure. For sure. Good luck.

Next Speaker: ****

Next Speaker: Thank you. Um, so, we'll be working ahead of **** for some ideas, uh, for the next meeting before I go so that there's, you know, the agenda doesn't kinda get lost in the shuffle so if people have thoughts, email me after this meeting and we'll try to get something together. **** Thanks everybody.

Next Speaker: Thank you.

Next Speaker: Thank you.

Next Speaker: Thank you.

Next Speaker: Good luck.

Next Speaker: All right. Thanks.

Next Speaker: Bye. All right.