QUALITY HEALTH STRATEGIES

Moderator: Sheena Siddiqui
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10:00 am CT

Operator: Ladies and gentleman, thank you for standing by.

Welcome to the Infection Prevention and Control, A New Era Conference Call. During the presentation all participants will be in a listen-only mode. Afterwards we will conduct a question-and-answer session. At that time if you have a question, please press the 1 followed by the 4 on your telephone.

If at any time during the conference you need to reach an operator, please press star 0.

As a reminder this conference is being recorded Tuesday, November 5, 2013.

I would now like to turn the conference over to Sheena Siddiqui. Please go ahead ma'am.

Sheena Siddiqui: Hi everyone. On behalf of the Delmarva Foundation for Medical Care and the Maryland Hospital Association, I want to thank you for joining today's webinar. We are excited to finish up the conversation we began at our October 2 workshop.

Today we will be discussing infection prevention and control in new era. As I said we are holding this webinar as a follow-up to our October 2 workshop for infection preventionists moving forward with a feature of infection prevention.

Before we begin today's program I'd like to recap briefly what we learned from our workshop and share where you can find the presentation slides and materials online. During the workshop we heard from Bill Ward of John Hopkins University who discussed how to make the business and financial case for infection prevention and control. And identified how to engage executive support for the IP program.

He highlighted the importance of understanding the business side of the case, how to speak to the CFO about revenue and expense behavior, and really more broadly how to present information to the CFO; switching our mindset from cost to revenue, meaning talk about the return in investment first with the CFO rather than just saying, "I need X amount of money."

Bill presented a HAI reduction model spreadsheet which helped IP's make the case for extra equipment or an additional staff member for example. And example cases worked out in the materials online. And the example case study we went over during the workshop is one where the infection preventionist wanted to purchase a new technology to reduce the incidence of hospital-acquired infections associated with room cleaning.

The goal of the HAI model spreadsheet and case study is to prepare yourself for a meeting with the chief financial officer. You must begin formulating the case you will make to the CFO, how you will convince them to - that it should be acquired, what arguments will you use to convince the CFO that they

should spend money on equipment. We must talk about the return investment rather than beginning the conversation with the cost upfront. These are the type of questions Bill Ward addressed during the workshop.

Next we heard from Theresa Lee and other staff members from the Maryland Health Care Commission. Theresa shared MHCC's plan for public reporting of infection measures and asked for feedback from the 2012 IP annual survey to better improve next year's survey. Additionally, they shared data on hospital vaccination rates and CLABSI rates.

Moving forward MHCC will align with CMS requirement in reporting and will support the Maryland Hospital rate-setting program. A list of new data beginning - being reported through NHSN was presented and can be found in the slides online.

During the workshop we did not get to Objective 1 listed on this slide, Slide 2, Identify Tasks Performed by the Infection Preventionists which can be Delegated. We have an exciting and excellent speaker with us here today to share this information.

Slide 3 is where you can find materials from the October 2 workshop and we will also be posting the recording of this webinar and presentation slides on this Web site as well. Please email me, Sheena Siddiqui, if you have any questions.

Now I am thrilled to turn the call over to Carolyn Jackson, Project Manager at the Delmarva Foundation for Medical Care. Carolyn is a registered nurse with over 35 years of experience in healthcare industry; healthcare including infection control, epidemiology and quality improvement and education. She

has recently served two elected terms on the national board of Association for Professionals in Infection Control and Epidemiology, APIC.

She is the recipient of several awards and also serves on a number of volunteer organizations in the Washington D.C. area. I'm sure many of you know her. Carolyn, thank you so much for agreeing to speak today.

Carolyn Jackson: Thank you Sheena. Let's see; it's always great to be talking to what I think is a number of my colleagues. And as Sheena said, we did not get to this portion during our meeting on October 2, so hopefully we'll be able to tie this up in terms of looking at "Infection Prevention and Control, A New Era."

And one of the things we're going to do today is to try to make sure we're engaging you as we move through the presentation, so we have instituted some polling features which will be in the form of questions periodically throughout our discussion. And so when you see the question pop up on the screen, please take a moment to answer that question.

So our objective for the time that we have together is we're going to talk about the role of infection preventionists, how it's changed in healthcare setting, and then we're going to also identify some tasks which the infection preventionists may consider delegating. And then we'll finish up with talking about skills which the infection preventionist will need to acquire to continue to move our profession forward.

And so we're going to start out with our first polling question which will be appearing on the screen momentarily. So this question is, "How long have you been in the field of infection prevention and control?"

Just take a moment to answer that; we'll have the results of who's listening in the audience in just a few moments.

So we've ended the poll, and so our results will be available momentarily as I'm told.

So as we wait for those results it looks like about 24% of you have been in the field of IPC less than two years. So we have some novices on the phone. And then over 20 years we have about 21% of you, so that's very interesting. We have about 38 people on the line, and so it's fairly easily split. Interesting.

So that's who our audience is made up of today.

So as you know the role of infection preventionists has changed over the years, and this terminology may be familiar to some of you, especially those who have been around over 20 years in that we were once called nurse epidemiologists, infection control nurse, infection surveillance nurse, infection control coordinator. And if you'd like to put in the chat any additional titles that you may have been called over the years, that would be informative to the rest of us in the group.

Our IP practice then -- and when I say then I'm thinking about the 70s and 80s -- during the 70s and 80s our infection prevention and control practice, which was really called infection control at that time, on the lines primarily in hospitals. And that's where we set ourselves up to function in the area of infection surveillance and worked with our partners to look at infections that occurred within the hospital setting.

Our next question which you might answer at this time relates to, "How long have you been at your current job or facility?"

If you just take a moment to answer that, that will give us some additional insight into who we're talking to and the make-up of our audience today.

We need the Jeopardy music.

So just take a few moments to answer that question. If you've been in your current job or facility less than 2 years, 2 to 5 years, 5 to 10 years, 10 to 20 years, or over 20 years as your current job or facility?

As we wait for the answer to that question, we note now that infection prevention and control practices has extended from not just hospitals, but we're also involved in long-term care settings, ambulatory, surgical centers, correctional facilities and jails, quality improvement organizations; a number of us are involved in industry and a number of us are involved in home healthcare industry.

Research is also where we're found as well as educational institutions of higher learning. So it looks like we have been at your current job or facility for most of us less than 2 years. And then pretty evenly spread for 10 to 20 years and then over 20 years. Interesting information.

So as we move forward with our next slide, let's talk a little bit about the type of surveillance that we used to do in healthcare settings. Those of you who have been in the field for a long time, you'll note that we used to do what we called whole house surveillance in which we went from floor to floor looking for all types of nosocomial infections which they were called at that time. And then we began to understand that by targeting our efforts we could put our practice - change our practice and us and improve practices in the hospital, and so we came up with targeted surveillance.

Targeted surveillance allowed us the opportunity to look for infections and monitor infections in one or particular units within the hospital once we had established a baseline of infections in the hospital. And now we still use targeted infection - targeted surveillance, but it looks at primarily different types of healthcare associated infections.

So our next polling question is going to be before you, and that looks at "How many practitioners are currently working in your department?"

If you would take a moment to answer that question, we want to know if you're a solo practitioner for those of you on the line, are there are two to three of you in your department, are there three to five of you, or some of you may be fortunate enough to have more than five? And somehow I hear you chuckling when that last one goes up, more than five practitioners.

So just let us gain some insight in terms of how many practitioners are working in your department.

And we'll wait a moment for those results to appear.

So as we said our surveillance practices have changed over the years, and also our influences and our partners have changed over the years.

So it looks like in most departments there are two to three of you, and no one has more than five; that chuckle was right. And then also a number of you are still solo practitioners.

So as we gain some insight from our discussion with Bill Ward on the business case, maybe some of that will start to change.

So our influences and partners then were the CDC, the Joint Commission, incorrectly stated here as JCO, and then also APIC. And certainly as you remember back to the 80s the great influence that the HIV/AIDS epidemic had on our practice; it actually brought additional focus to the fact the practice of infection prevention and introduced concepts such as universal precautions now called standard precautions. So these were the influences and partners then.

As we look at the list now we have many, many more influences and partners that we work with to practice our craft of infection prevention and control. These include the Centers for Disease Control, the Joint Commission, certainly CMS, and the list as you see before you. Also we have ARC that is influencing our practice Infection Prevention and Control, as well as our hospital association such as the Maryland Hospital Association.

Healthcare as we know it is now offered on a continuum. We have acute care, we have rehab, we have long-term care, we have home healthcare and our patients go back and forth between these facilities as they try to restore their health. And so we communicate as IP's with practitioners in a number of these type settings as it relates to HAI.

Our practice has also evolved and now we're using more evidence-based practices as it relates to infection prevention and control. And several years ago we looked at "sacred cow" things that we were doing in infection prevention and control just because they sounded like they were good things to do. And so now we've started to put away those "sacred cows" and focus on the implementation of evidence-based science.

We also have expanded roles in our organization as it relates to anti-microbial stewardship and some other areas that we never focused on in our practice of infection prevention and control. There's a new language; nosocomial infections are now healthcare-associated infections. We have CLABSI, we have CAUTI terminology that has come about in the last several years to help us focus specific efforts at infection reduction.

We also now find that our HAI determinations are reviewed; there's a lot more scrutiny in terms of public reporting. I remember the old days if you called it a HAI, then, you know, it was a HAI; and now in talking with colleagues this is a practice that is frequently scrutinized in our facilities. To some degree our work is recognized by the C-Suite within the hospital, especially as it relates to public reporting and report cards, putting this information in the public domain definitely undergoes additional scrutiny by the C-Suite.

We've integrated our practice with quality and patient safety and that has brought about additional work in terms of keeping the patient at the core of what we do, and we also have multiple practice settings as previously stated. We've introduced terms such as ICRA, Infection Control Risk Assessment, and we also are involved in doing risk assessments within our facility so that we can target our efforts at infection reduction along lines in which we are - highly have - where we have increased risks to our patients.

We have developed and coined the phrase for, "Zero tolerance of infections in our hospitalized patients," recognizing that zero is a moving target may or may not be achievable considering the immunocompromised hosts that we serve. But we certainly all support the concept of zero tolerance for violation of infection - good infection control practices.

So our next question that you will see - and thank you for your participation because we are getting a great deal of insight from your participation. Our next question looks at our C-Suite involvement and your perception of how well you think that is going. So on a scale of 1 to 5, "How well do you think top management, i.e. the C-Suite, understands the role of infection prevention in your facility?" Number 1 is not engaged, and up to number 5 is very engaged.

If you would take a moment to identify what's your perception of the C-Suite involvement and understanding of infection prevention and control that would help us.

So in just a moment we'll have those results.

A number of you didn't answer, but it's good to see that very engaged, about 25% of you C-Suite is very engaged. So obviously we are making some progress in that regard. But this also indicates that there's also some work to be done and hopefully the information that we continue to provide is helping you to get from the not engaged to the very engaged piece of the work that you're doing.

And those who have a very engaged C-Suite it's good to know and we'll continue to work at - strive to get all of us to that level.

So as we look at our practice of infection prevention and control, I wanted to spend a few moments talking about the APIC competency model. And most of you have seen this; it has patient safety as a core of what we do, and then also supports the practice of certification in infection prevention and control.

I'm going to share my desktop at the present time so that we can look at a short video from Marilyn Hanchett.

Okay. Technology challenges are always things that come up, and so it looks like we're not going to be able to see that video.

Okay, so we'll just go on and talk about the APIC competency model, and this is something that you all can look up a little bit later on YouTube. But it talks about the four domains of infection prevention and control.

And prior to going with that we'll put up our next polling question which asks the question, "Are you certified in infection prevention and control?"

So if you can just take a moment to indicate if you're certified, that will give us some additional insight into the participants on the call today and most certainly the infection prevention and control competency model, does APIC competency model does stress the importance of being certified in infection control.

As we look at that model you would have heard Marilyn talk a little bit about the four domains on the infection control competency model and I'm just going to run through those domains ins somewhat of a brief fashion.

Domain 1 is a domain that deals with leadership and program management. And as we function in the world of infection prevention and control we note that our leadership is based on influence rather than authority. We note that we have to be good collaborators, and also leaders - as leaders we also are sometimes followers. We have to hone our program management skills as well as our critical thinking skills as well as communication.

And it does look like about 48% of those who are on the call are certified IP's and 40% of us are not certified. Several of you did not answer, so we do have about 40% of people on the call who are CIC certified in infection prevention and control.

And as we look at Domain 2 which is the infection prevention and control domain, it supports the practice of an epidemiology and surveillance as well as this assessment which we talked about a bit earlier, risk reduction and infection prevention. And it's important that we be able to use and interpret diagnostic tests in this area. Anti-microbial stewardship is an area that is focused on in this Domain #2 as well as education and research to promote evidence-based practices of infection prevention and control.

This model is based on the continuum of infection preventionists so that from the novice to the proficient IP there's a way that we can all fit into honing our practices and skills in these various domains.

As it relates to the area of technology, this is a technical domain which looks at information technology support, surveillance technology and electronic medical records. And this is becoming more and more important to our practice as we look at increasing our influence within the facility.

And then finally Domain 4 looked at performance improvement and implementation sciences. And within this domain we identified a need for performance improvement, we learned new skills and new tools as we looked at working with our quality improvement staff. We learned how to do team work as we assembled performance improvement teams and as we implement what we have - areas that we have identified where improvements need to be met.

And then we also note that we learn how to measure our success for infection prevention and control in our particular institution.

I've taken a snapshot and looked at select competencies across the career span such that the novice infection preventionist when it comes to case signing will be conducting case signing as the proficient IP would be applying the surveillance principles to diverse populations. And then the expert infection preventionist, those who have had more time in the field, would be identified as experts in especially areas such as public health or outpatient settings.

So as you can see the infection prevention and control practice occurs along a continuum as it relates to our practice of becoming more and more proficient from the novice to the proficient - professional to the expert who's practicing infection prevention and control within our institutions of choice.

Now when I approached my colleagues to talk about what are some of the things we can stop doing, what are some of the things that we as infection preventionists can put in the trash, that can free up our time to do things that we want to be doing more of; and some of the things that I heard from colleagues are hand hygiene observations. And I think I just heard through the telephone line a collective groan - or sigh maybe that was - go up.

We can stop taking minutes and is there opportunity for us to stop doing data entry, as well as I heard from colleagues that some of the cusp information is repetitive and that we have the same teams doing cusp work and then that work is repetitive.

So our next question looks at, "Do you have support for data entry for your department?"

And we'll take a moment to look at your results from that polling question.

"Do you have support for data entry for your department?" And that's a yes or no question.

So that poll has ended and as we look at again some of the things that we can stop doing, preparing and filing minutes are some of the issues that colleagues identified, and monitoring team's progress. Might we want to take an opportunity to develop teams that can also take on this task so that we as the IP are not strictly involved in monitoring their progress.

So it looks as if a number of you, about 35% of you responding said that you do have people who can enter the data for your department; however 50%, more than half of you, do not have support for data entry for your department. And so as we look at tweaking our roles and functions within the facility, and we looked at information from Bill Ward and others how we might be able to enhance the work that we do, this might be an area in which we can get some additional support so that we are not having to collect the data into the data.

And this is a task that could certainly be delegated to someone else within our organization.

So in addition to the types of things that we wanted to stop doing, there are also some things that IP's identified they want to start doing more of. And at that top of that list is education within the organization. IP's want to be able to get out and educate our colleagues about how to reduce the risk of infection for our hospitalized patient; however because we are doing things that we saw on the previous slide, it's been very difficult to be able to do that.

And there's an understanding on my part certainly and I think as we influence others it's understanding on their part as well that there are some things that we consider much more important such as education within the organization, engaging leadership in our prevention efforts. Some of us have done that quite successfully, but as we saw from the previous slide, the poll, there's a lot more work to be done here in terms of engaging leadership.

It is not - in the old days the thought process was, "Well you're the infection control nurse; you control the infection." That certainly is not true, and so we need to be able to engage everyone within the healthcare institution and infection and prevention efforts.

A number of us want to focus more on environment of care, and certainly as we see this - the importance of the issue as it relates to Clostridium difficile and some other of our MDRO's, this is an area that we continue to need to focus on because it's very important. We need to be able to be there to look at, assess and provide recommendations in terms of focusing on that vehicle for infection transmission in our institution.

We also - colleagues also identified the need to start getting leadership support and commitment for new technologies; this relates to EMR and other technologies, perhaps room cleaning technologies, perhaps hand hygiene monitoring technologies. How do we get support and commitment from some of these new technologies which would help us in terms of infection prevention.

And so along those same lines is how do we get the organization to purchase and install more sophisticated surveillance resources.

We should have program goals and objectives within our department that are aligned with our organizational strategic priorities and our annual operating plan. This is - these are some of the things that we need to also start doing more of.

So we'll finish up by talking about some of the skill building that we need to do to move our practices along the continuum within our facilities. And there are some leadership skills that we as IP's need to hone; we need to know our leadership style and recognize that a good leader is the life blood of any organization. We also need team building skills. IP's are seen as a champion - should be seen as the champion of HAI prevention.

It doesn't mean that we are only - the only people within the organization who are doing HAI preventive work, but we're certainly the champion of this effort within our organization. We function sometimes the team leader, we function sometimes the team member and we also function as a facilitator within our institution. And so coming together at the beginning, keeping together is progress, but working together is success. This quote I think by Henry Ford says it all.

And in order to hone our team-building skills we need to also have good communication skills, good verbal communication skills and good written communication skills as we build our credibility for our championship of infection prevention within our institution.

We also need to be good negotiators and this I think as you can see is much more important as we move through our institutions trying to build the case for infection prevention, trying to build into our program the resources that we need, trying to help people understand that there is a return on investment by investing in infection control resources. We need good negotiating skills to

build resources within our department so we can move our practice forward, so that we can move our institution forward.

And so that we can promote to the public that we are the institution that keeps our infections at a minimum and that we are an institution that focuses on infection prevention. So we need to be able to build in negotiating skills as well.

So how do we develop some of these skills within our institution? Well, you know, there's - it's a challenge. And some of the things that you might think about doing are shadowing. You know, perhaps, you know, we built into some of our teamwork shadowing, but we as IP's could also build into our professional development shadowing. Perhaps we can shadow our CEO's for a day. Perhaps you can shadow other people within your organization for a day just so they can see - and then also have that coin flipped in which they can shadow you and your work during the day.

Another skill that we need as we move our profession forward are budgetary planning skills; we need to understand the economic environment that we live in and as it relates to pay-for-performance in the light of the fact that CMS is one of our partners and that "never events" impact our hospital's bottom line. And so we need to be in the framework of making sure that these "never events" such as HAI do not occur.

And as most of you can recall that this has expanded; it originally started out with CLABSI; now there's CAUTI and eventually there may be other types of infections that are appearing on that list. And so we need to be in the business of continually scanning the environment and recognizing the economic environment that we work in. There are changing payment trends in our influence of quality-based incentives that our facilities, particularly if we're

working in acute care, are confounded with in that these HAI's do erode the financial health of our organization.

And our financial stability will in large part depend upon our ability to reduce and eliminate healthcare-associated infections.

So acquiring those skills you can look at some of our APIC webinars and resources; we just did the workshop with Bill Ward and that information is available online. You can listen to that and also check out some of those resources that would help guide your practice in terms of building your skills in that area because we as IP's our work has changed over the years. And so we must change to be able to accommodate that.

We must also develop our critical thinking skills and this allows us to focus on goals, outcomes and the impact of prevention initiative. We have to understand the problems at hand while challenging the assumptions and considering the alternative. And we as IP's who - but IP's are better positioned to do that within our organization.

And so now I have our final polling question of the day which you'll see appearing on your screen momentarily. And it talks about the preferred method for you to learn new information. So, "Of the following which is the preferred method for you to learn new information?" If you could take a moment to indicate whether that's through competence, small group discussion, reading or webinars, that will give us some additional insight as we move forward planning to help you to acquire the types of skills that you need to move this profession forward.

And certainly as to move it forward within the state of Maryland because we are challenged with getting to zero in many, many of our areas.

So our results will appear on the screen momentarily.

And so as we look at the types of skills that I just went over; leadership skills, negotiating skills, critical thinking skills, et cetera, this will allow us the opportunity to now think outside of the box. And it looks as if a number of you do learn quite well from webinars, and that's encouraging to see. As well as conferences, some of you - a very small percentage of you learn from reading. So it's good to see that we are on track in terms of providing some of the educational priorities where you think you can learn from. And we'll certainly take that into account with future planning.

So for our practice we have to start thinking outside of the box. And in terms of doing some of the things that we like to do or think are necessary to do, and some of the things that we are charged with doing and how much time we now spend as IP's in front of the computer and not be able to do the type of things that we want to do.

So how can we free up some of our time? A couple of recommendations are we can consider light duty staff for projects, we can consider retirees for projects. And I heard from an IP in Connecticut who's actually implemented this practice in that they hire retired infection prevention managers as a per diem staff so that they can have coverage as needed. And this IP who is Renee Savage indicated that they started this practice in 2009 when we had the pandemic influenza reporting.

Not only do they use retired IP's, but they also use volunteers. And they use the volunteers to gather data, do filing, copying and so forth. So this might be one of the out-of-the-box things that you want to think about in terms of your facility.

I also heard from a colleague, (Roberta Vanderburg), in Sulphur Springs, Tennessee who uses light duty staff for their infection prevention and control efforts. And some of the light duty staff when they're able to get a RN who may have been injured at work, they use them to review cultures and help them with their infection prevention and control work.

So in terms of thinking outside of the box how can we continue to do our work and in light of the fact that we may or may not have additional resources, perhaps these are some approaches that you might want to think about taking within your organization.

In addition to that there are student internships, this area is right with college students and nursing schools and MPH students, medical schools. And so some of those students might enjoy an internship and learn - certainly they can learn a great deal from an internship in infection prevention and control. It does require some background leg work, but it can be done. And not only will you have a valuable asset at your department, but you'll also provide an opportunity for others to learn.

And then many of us have implemented the unit liaison framework in which you will have an infection preventionist who are trained, who are actually working in the units who you will have a unit liaison who works with the infection prevention and control team to promote a high level of infection control practice within the organization.

So hopefully we've given you some insight into how you might want to restructure, continue to restructure your program because as we move forward we're all concerned with reaching and obtaining zero HAI infection within the organization. And our practice has continued to move along the continuum

and then that's going to continue to happen as we look at the influence of other partners in our work.

So operator, we'll have an opportunity - we do have an opportunity for some questions; if you can open up the lines for that.

Operator: Thank you. Ladies and gentleman, if you would like to register a question, please press the 1 followed by the 4 on your telephone. You will hear a three-tone prompt to acknowledge your request.

If your question has been answered and you would like to withdraw you registration, please press the 1 followed by the 3. If you are using a speaker phone, please lift your handset before entering your request.

One moment please for the first question.

And our first question comes from the line of (Daphne Morgan). Please proceed with your question.

(Daphne Morgan): Hi, I was wondering if we would be able to get a copy of your presentation Carolyn?

Carolyn Jackson: Yes that will be available on the MHA's Web site. And so you can have it from that point (Daphne).

Thank you.

(Daphne Morgan): Thank you.

Operator: Again ladies and gentleman, as a reminder, to register for a question, please press the 1 followed by the 4 on your telephone.

And our next question comes from the line of (Olivia Hesona). Please proceed with your question.

(Olivia): Carolyn, being involved in APIC as a leader, do you see any opportunities for mentorship for persons who - there were a number of persons who are solo enterprises and a number of people also; I'm not sure if that was from that group that were in solo practice in their respective facilities. But do you see an opportunity for mentorship through APIC if you don't have that in your facility?

Carolyn Jackson: Very good question. And what you should know is that if you are a member of APIC they do have a mentoring program. And not only do they look for people who want to be mentored, and they also look at people who want to mentor. So if you go on apic.org Web site and join the mentoring group, there's numerous opportunities for people to serve to mentor you and that's one way that we can fulfill the ongoing development of those professionals who work in the field.

So yes, there's opportunity for that. And if you want to obtain a mentor you can log-on to the Web site and I’m sure that they can hook you up with someone.

Operator: Again, ladies and gentleman, as a reminder to register for a question, press the 14; that's the 1 followed by the 4 on your telephone.

And our next question comes from the line of (Brenda Gross). Please proceed with your question.

(Brenda Gross): I don't have a question so much as I have just something to say regarding maybe the mentorship. The Greater Baltimore Chapter just to encourage those new folks with zero to two years experience to come to the meetings and meet some of the gals with more experience that know some faces, know some people to contact when they have issues that they just want to talk over.

Carolyn Jackson: That's great (Brenda). I think the next meeting, can you let the audience know when your next meeting is going to be?

(Brenda Gross): Actually our November meeting is actually going to be a vendor fair. Probably won't have another regular meeting until January.

Carolyn Jackson: Great.

(Brenda Gross): When they come to visit the fair there'll be people there to meet and greet and talk to.

Carolyn Jackson: And I think that's particularly important for a solo practitioner because I can remember when I first started we didn't have the Internet, and that gives you some clue as to how long ago it was. But you just called up someone the next hospital over and asked them how do you do, you know, X, Y, Z and that person became your life-long partner for sharing.

So that mentorship piece is very important because, you know, in this field of infection prevention and control Friday afternoon at 3 o'clock is when most problems occur. So it's always good to have someone who shares that insight and certainly can identify what you're doing. So I think it's very important that we continue to support those who are novice people because they are going to

be the infection preventionists of the future and they are the ones who are going to have to deal with, you know, up and coming emerging pathogens.

(Brenda Gross): Absolutely.

Operator: Ma'am, we have no further questions at this time. I'll turn the call back over to you.

Carolyn Jackson: Great, well I want to thank you all for your participation. And I'm going to punt back to Sheena who's going to finalize our call. And look forward to continuing to work with you as we expand our roles in infection prevention and control and certainly expand our influences and get the recognition for the work that we do.

Hopefully all of you had the opportunity to celebrate a little bit doing IIPW week a couple weeks ago and take some time out for yourself.

We do have an evaluation poll up on the screen, so if you take a moment to answer those questions. We will use that information as we move forward for future planning.

And I'm going to turn it back to Sheena.

Sheena Siddiqui: Thank you Carolyn for the informative and excellent presentation. Thanks for getting us started to think about tasks that we can delegate and skills we should acquire to move the profession forward. And of course getting us to start thinking about - thinking outside of the box.

As a reminder, we will be posting the slides and recordings on the Web site listed on Slide 3. I encourage you all to visit this site and download the material and I will also email it to you guys after this call.

We hope that you've learned something from today's call.

And again, as Carolyn said, please do answer the evaluation questions listed - they should be on the screen right now. So please do go ahead and answer those questions for us.

And thank you everyone for joining the call - the webinar today. We hope that you have a great rest of the day.

Bye.

Operator: Ladies and gentleman, that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.

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