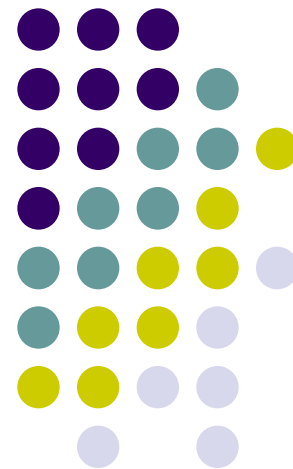


**Using the JIFSAN Pilot
Observational Study of Food
Safety Practices in Interagency
Listeria monocytogenes at Retail
Deli Risk Assessment**

JIFSAN Advisory Council
Spring Symposium
Sherri Dennis
March 24, 2010

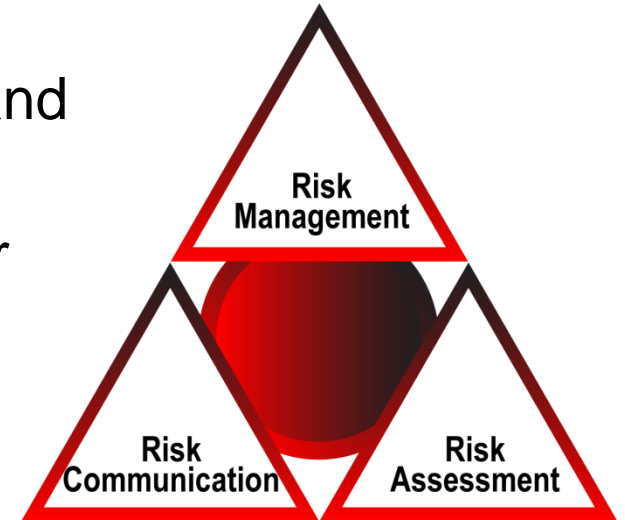


Role of Risk Analysis in Public Health Policy

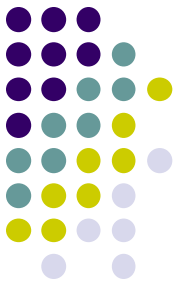


A Powerful Public Health Tool

- Scientific basis for food safety policies and allocation of resources
- Allows for transparency and stakeholder involvement to ensure credibility and scientific accountability
- Facilitates the application of science to policy – “informational bridge” between data and decisions



What's So Special About This Project?

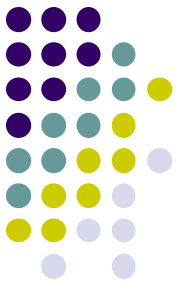


A new paradigm !

- Collaboration (FDA, FSIS, CDC, JIFSAN, UMD, and others)
- Develop data specifically for the risk assessment model
- First retail cross-contamination model
- Stakeholder participation early in the process

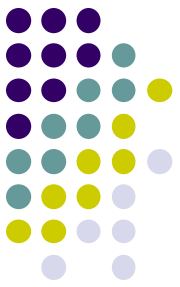


The Interagency Retail *Lm* Risk Assessment



- Objective: Ascertain the impact on public health of current practices and potential interventions that reduce or prevent *Listeria monocytogenes* contamination in ready-to-eat food sliced, prepared and/or packaged in retail facilities

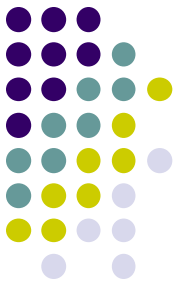
Background ... in 5 studies



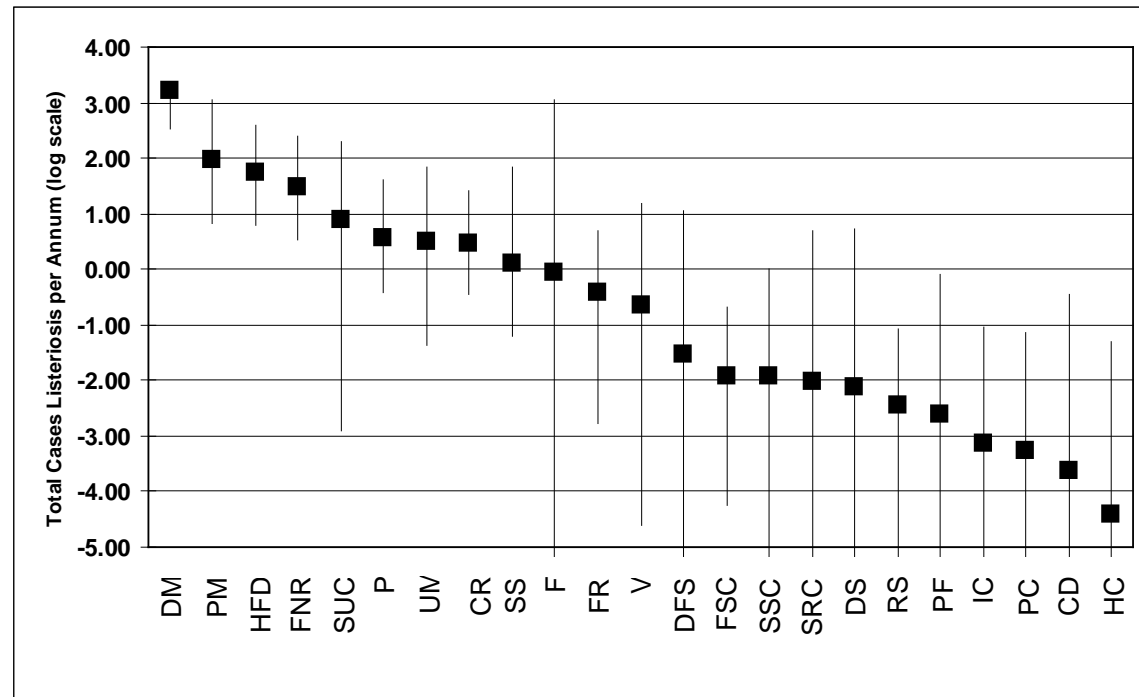
- *Listeria monocytogenes* (*Lm*): 2nd cause of foodborne-disease related death in the US
 - 500 deaths amongst 2,500 invasive cases (Mead et al., 1999)

Pathogen	Illnesses	Deaths	Case fatality rate
<i>Campylobacter</i>	2,453,926	124	0.1%
<i>Salmonella</i>	1,412,498	582	0.8%
<i>E. coli</i> O157:H7	73,480	61	0.8%
<i>Listeria monocytogenes</i>	2,518	504	20.0%

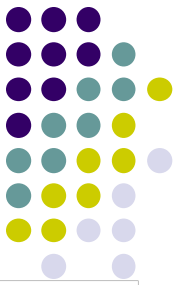
Background ... in 5 studies



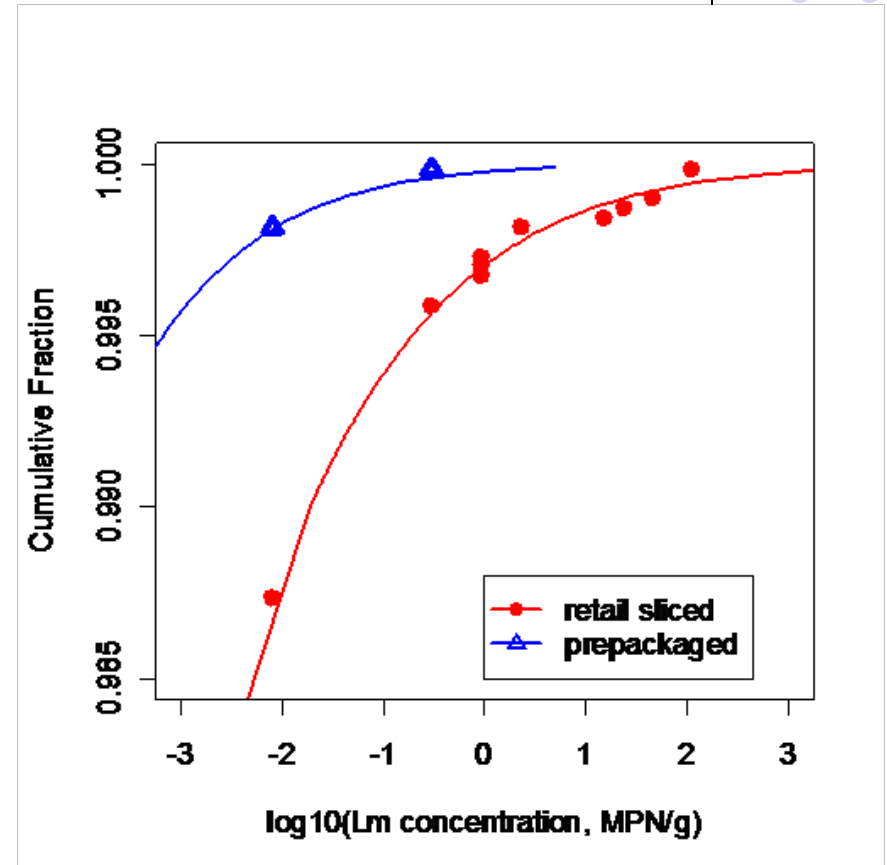
- Deli meat: 1st ready-to-eat (RTE) food vehicle of *Lm*.
 - ca. 1,600 cases per year (FDA/FSIS, 2003)



Background ... in 5 studies



- *Lm* prevalence and *Lm* levels are higher for in-store packaged than for manufacturer-packaged RTE food
 - Gombas et al., 2003
 - NAFSS, 2008 [unpublished results]



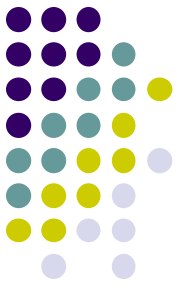
Background ... in 5 studies



- 83% of all listeriosis cases attributed to deli meat are from deli meat sliced and packaged at retail
 - FSIS, 2009 report using NAFSS contamination data

Category	Public Health Impact	Retail-sliced Deli Meat	Pre-packaged Deli Meat	Total Illnesses/Deaths
With Growth Inhibitor	Deaths	26.5	10.5	37.1
	Illnesses	146	58	205
Without Growth Inhibitor	Deaths	140.3	23.6	163.9
	Illnesses	773	130	904
Total	Deaths	166.9	34.1	201.0
	Illnesses	920	189	1108

Why would in-store-packaged products be more contaminated than manufacturer-packaged ones?

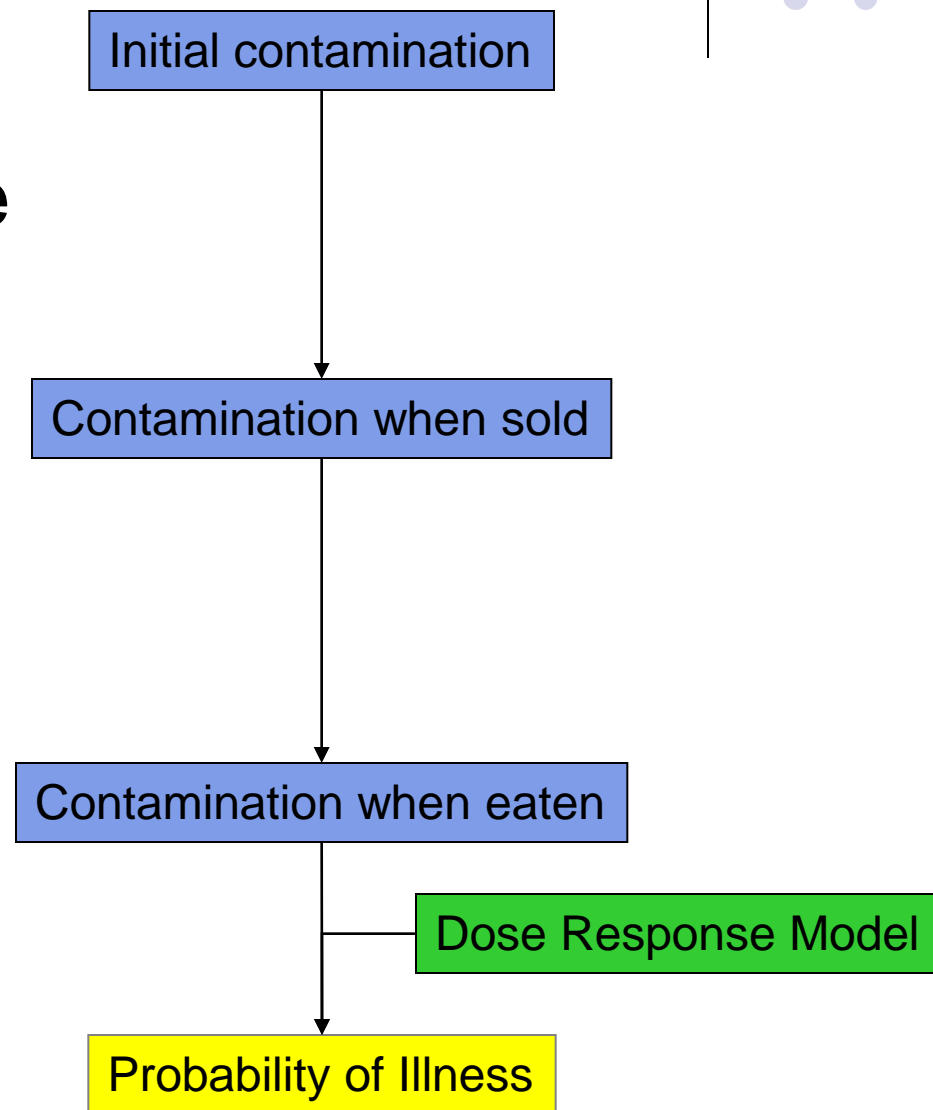


- Major hypothesis: additional cross-contamination
 - More than one kind of products manipulated at a given time / place
 - Meat, Poultry, Vegetables, Seafood, ...
 - More than one process at a given time / place:
 - Slicing, Cutting, Mixing, ...

Lm at Retail Risk Assessment Model

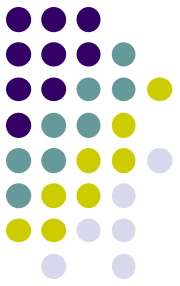


The mathematical model will simulate the retail environment and determine how practices at retail influence exposure.



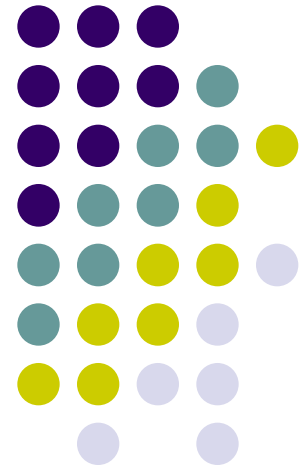
Data Needs

- Worker behavior
- Transfer coefficients
- Concentrations at retail
- Growth
- Product formulation
- Product sales
- Retail Operations
- Retail storage
- Retail sanitation
- Consumer handling
- Dose-response model
- Niches

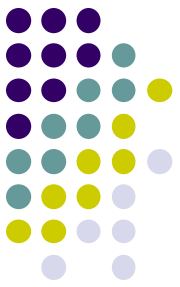


Pilot Retail Food Handler Observational Study

Meryl Lubran



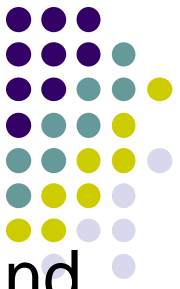
Available Data on Food Safety Practices of Food Handlers



- Several studies have assessed food employees' behavior in food service settings
- Methods used include:
 - Self-reports
 - Observational designs
- None provided data with the level of detail needed for the risk assessment model.

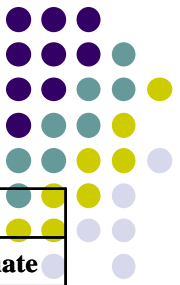


Methods



- Nine retail facilities which sell deli meat, cheese, and deli-type salads were selected for the study based on size, location, and other criteria.
 - Six chain stores ($n=25$)
 - Three independent stores ($n=8$)
- Procedure
 - Interview was conducted with store manager.
 - Employee was selected at random.
 - Researcher observed employee for 15 minutes during which time data collected was discarded.
 - Researcher continued to observe until at least 100 actions were performed/recorded (~15-45 min).

Example Notational Analysis Chart



Action No.	Action Sequence	Notes	Specific Food Safety Action			
			Action	Required	Attempted	Adequate
1-TIME: <i>10AM</i>	<i>WS HDS</i>	<i>No soap</i>	<i>WS</i>	<i>X</i>	<i>X</i>	
2	<i>PON GLVS</i>					
3	<i>OPN CAS</i>					
4	<i>PUP SAL</i>					
5	<i>CLS CAS</i>					
6	<i>P SAL ON SLI #3</i>					
7	<i>SL SAL ONTO GLV</i>					
8						
9						
10						



Frequency of Events

- Wipe Slicer (8%)
- Change Gloves: Wash-N-Change (40%), Change Only (27%), None (33%)
- Touch NFCS(5%)
- Open Case (82%)
- Touch Refrigerator Handle (3%)
- Contact When Open Chub: None (35%), Sink (24%), FCS (35%), Slicer (6%)
- Touch Knob (22%)
- Slice On Gloves (99%)
- Touch Scale (100%)
- Put Chub On FCS (1%)
- Wipe Slicer (22%)

Approximately 3,300 data points !

The “Virtual” Deli is Open !



- Products in display case
- Food workers
- Sites/ equipment
- Products sold

Tracking changes
in contamination
levels



Example: Serve Customer Event



Wipe Slicer



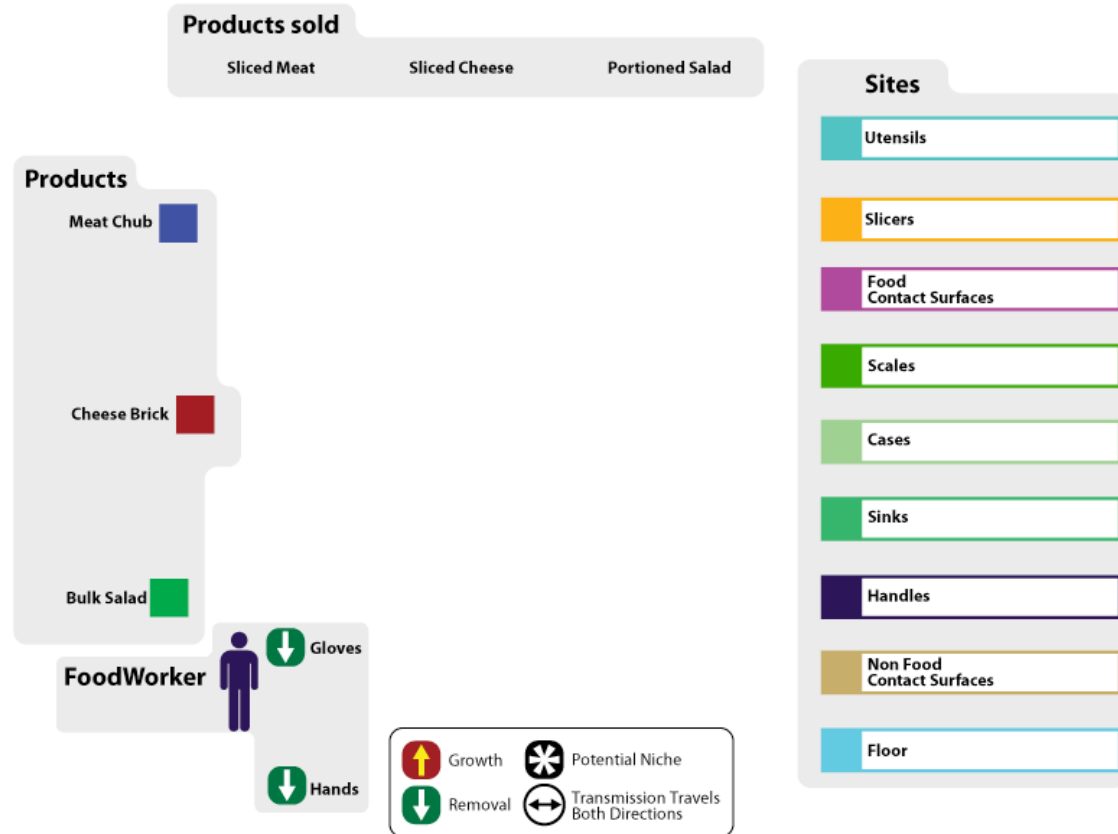
Removes some bacteria from the slicer

Example: Serve Customer Event



Wipe Slicer

Wash hands &
change gloves



Removes some
bacteria from hands

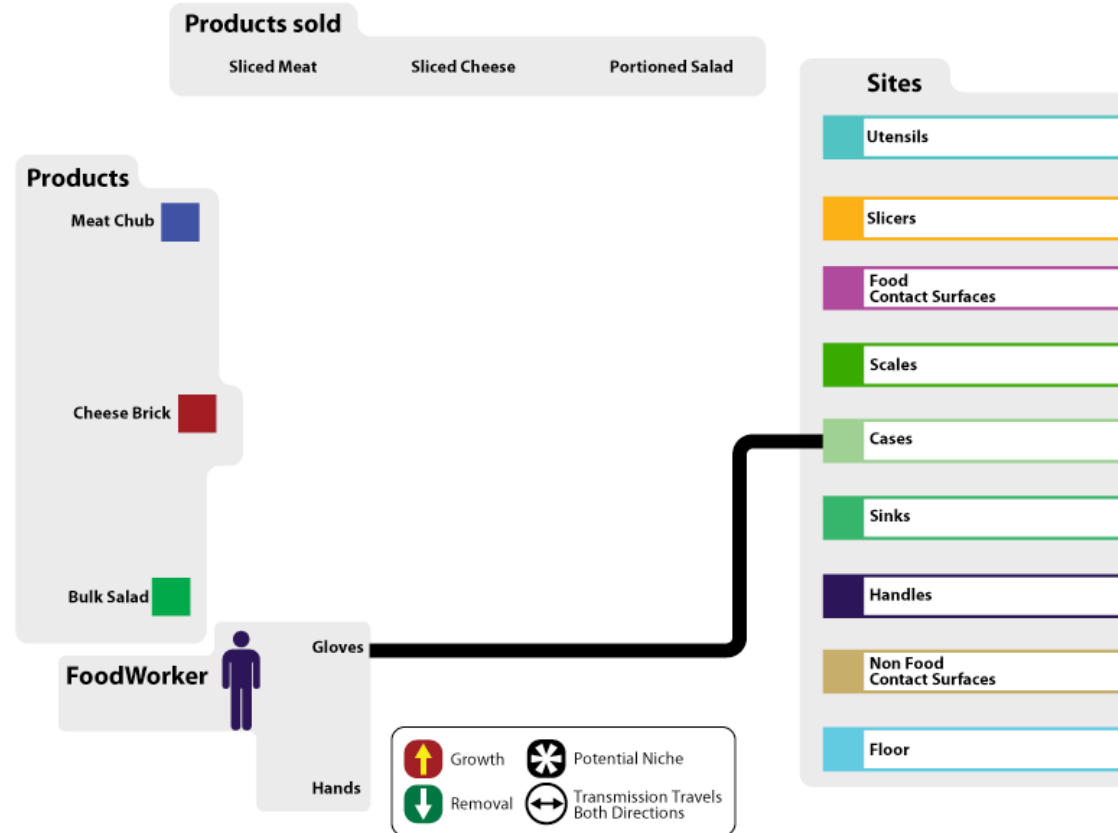
Example: Serve Customer Event



Wipe Slicer

Wash hands &
change gloves

Open case, remove chub,
close case



Cross contamination
between gloves and case

Example: Serve Customer Event

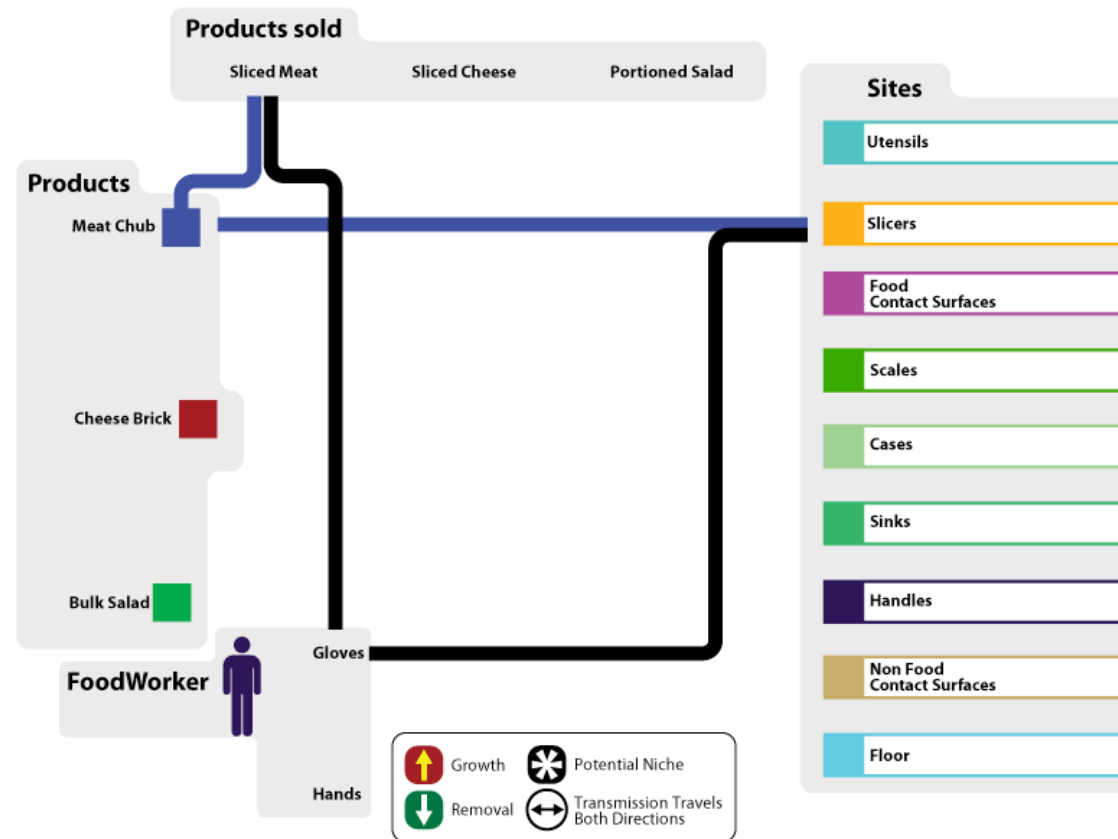


Wipe Slicer

Wash hands &
change gloves

Open case, remove chub,
close case

Slice on gloves

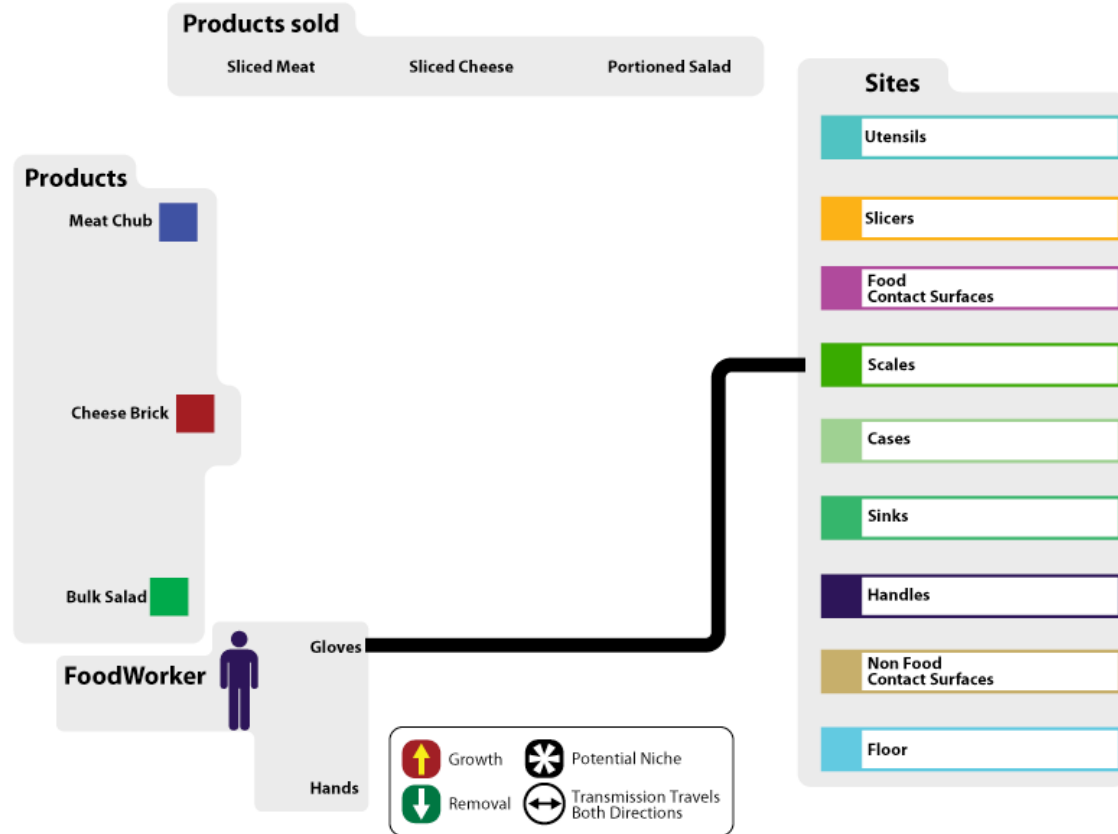


Cross contamination among
gloves, slicer, chub

Example: Serve Customer Event



- Wipe Slicer
- Wash hands & change gloves
- Open case, remove chub, close case
- Slice on gloves
- Touch scale

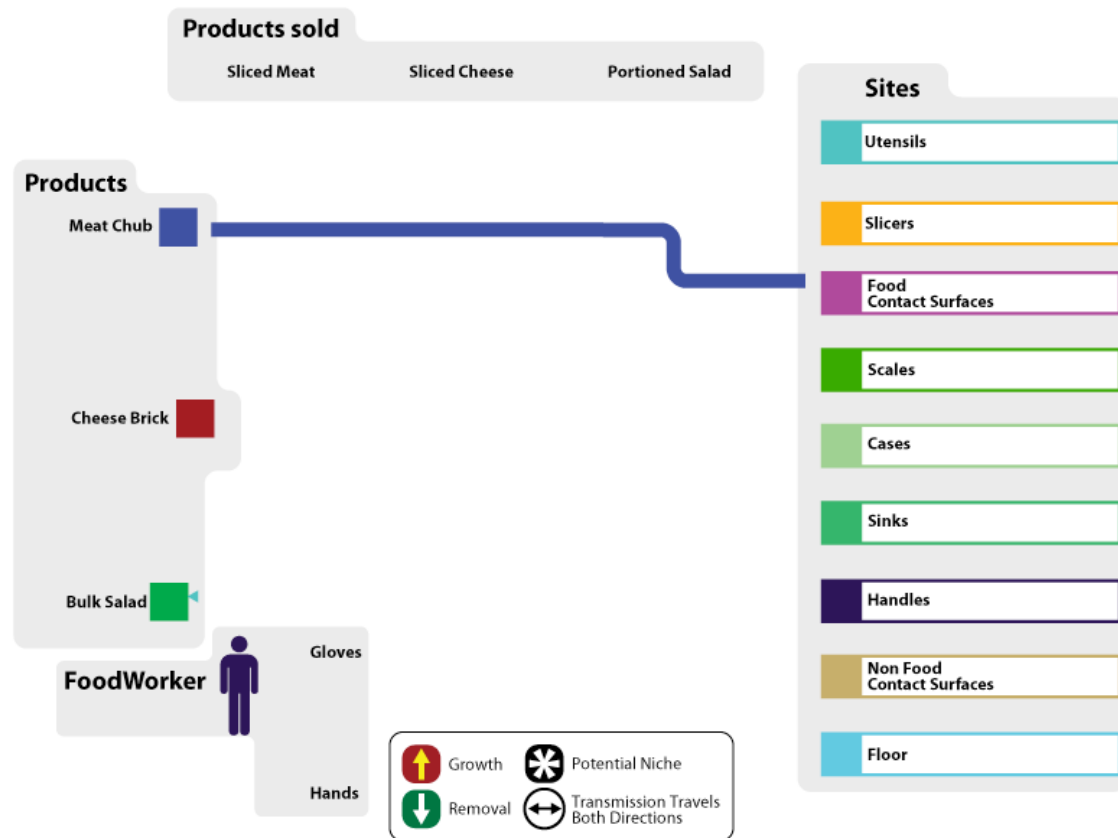


Cross contamination
between gloves and scale

Example: Serve Customer Event



- Wipe Slicer
- Wash hands & change gloves
- Open case, remove chub, close case
- Slice on gloves
- Touch scale
- Rewrap chub



Cross contamination between the chub and the food contact surface

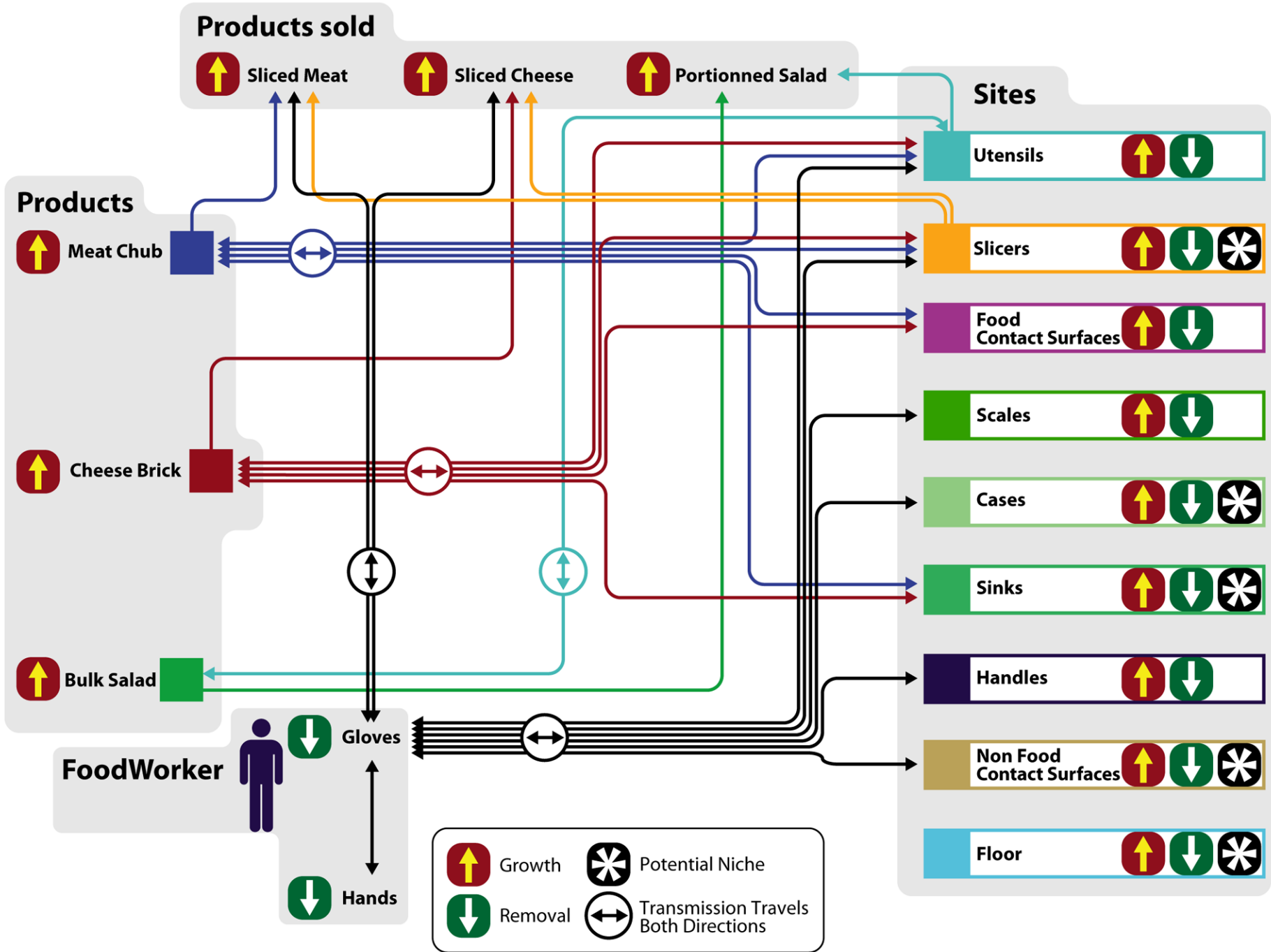
Example: Serve Customer Event



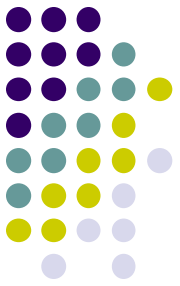
- Wipe Slicer
- Wash hands & change gloves
- Open case, remove chub, close case
- Slice on gloves
- Touch scale
- Rewrap chub
- Open case, remove chub, close case



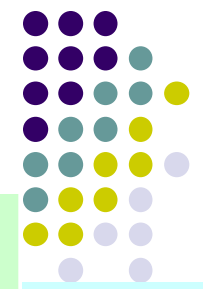
Cross contamination between the gloves and the case



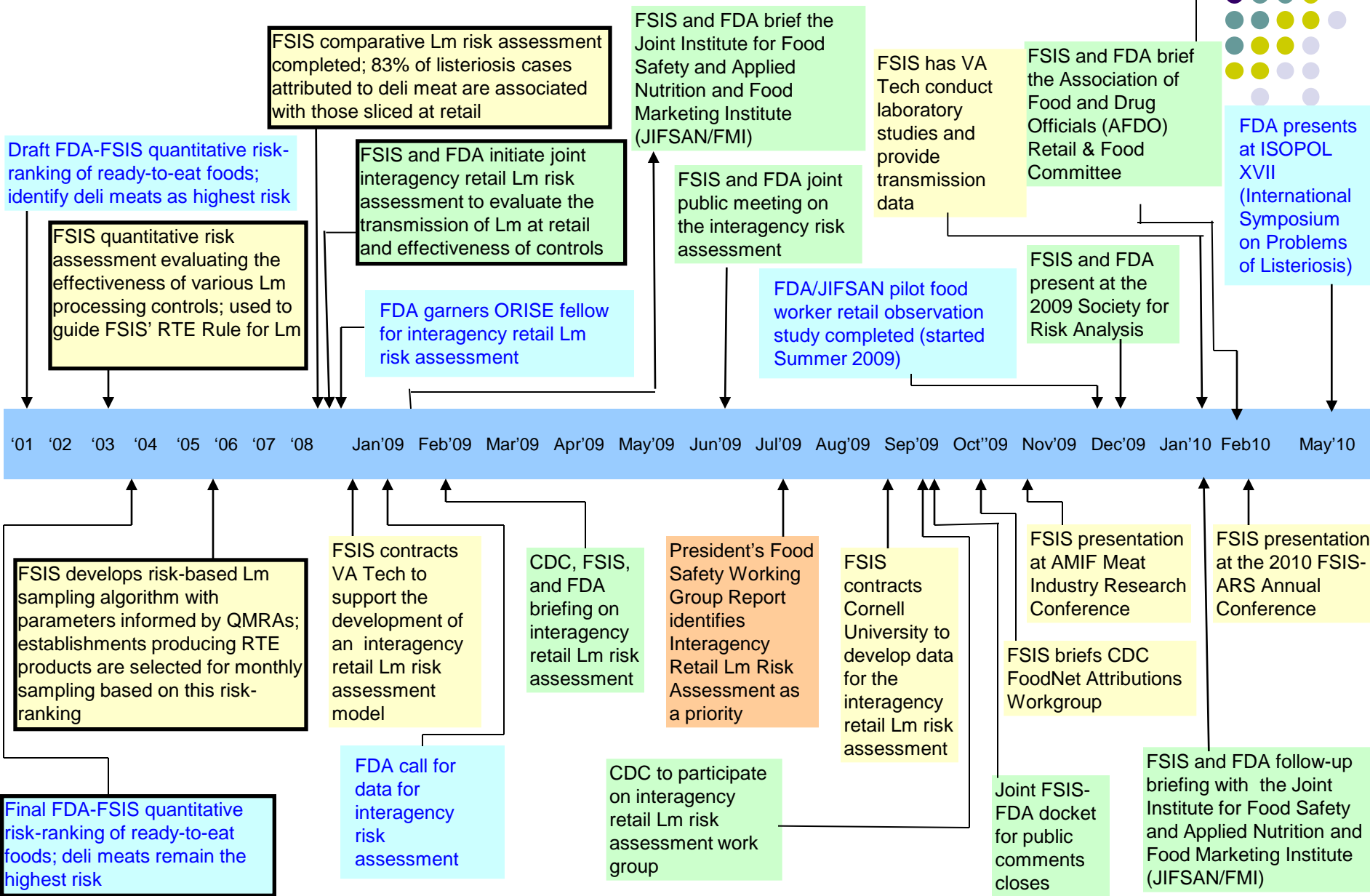
Timeline



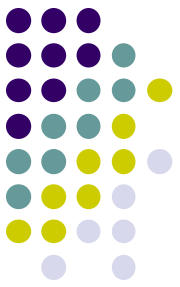
- Commission RA (Charge from risk managers)
- FR notice; June 2009 public meeting
- Collect data and information (an ongoing process)
 - Literature search
 - Expert opinion
 - Input from stakeholders
 - Pilot observational retail study
- Develop conceptual model
- **Develop and test Beta model**
- Prepare draft RA report
- External peer review
- Issue draft RA report for public comment
- Revise RA model and report, as appropriate



Timeline of Events



Acknowledgements



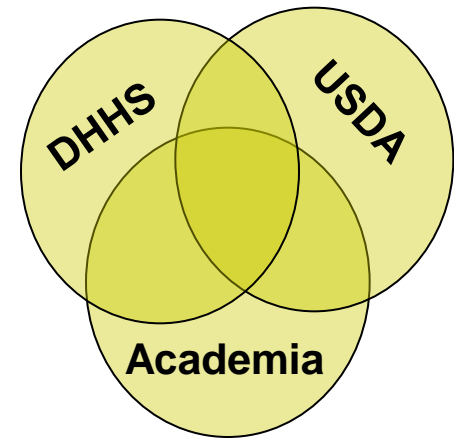
Interagency Retail Lm Risk Assessment Workgroup

• Federal Partners

- USDA, Food Safety and Inspection Service
- FDA, Center for Food Safety and Applied Nutrition
- CDC

• Academia

- VA Tech
- Cornell University
- University of Maryland/Joint Institute for Food Safety and Applied Nutrition



Food Marketing Institute (FMI)

