

# **E4: Infection Preventionists as Collaborative Partners: Lela Luper**—Transcript—

# **Sponsorship.**

[Intro music: “Skip to My Lou” by Neal Caine Trio]

**Bridget McDougall**

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[Music fades out.]

# **Intro**

**Bridget**

I’m a little bit giddy about the fact that ICRA [infection control risk assessment], talking about all things germ and yuck, has “ick” in it when you say it. So . . .

**John Williams**

Hehehehehe . . .

**Lela Luper**

It’s funny. I’ve never thought of that, but you’re right—“ick.” Some people call it an ICRA [“ick-rah”]. I generally call it the I-C-R-A.

**Bridget**

Oh! You’re missing a whole “ick” opportunity, Lela!

**Lela**

I am, but now that you’ve said it, I will use that from now on when I’m teaching novice IPs [and] see if I can get their attention with it, you know? So, thanks.

**Bridget**

Hey, now, OK! Whatever we can do [to help out].

**Intro.**

[Intro music: “Skip to My Lou” by Neal Caine Trio]

**Bridget**

Welcome to *Between the Lines with FGI*, a podcast brought to you by the Facility Guidelines Institute. In this podcast series, we invite you to listen in on casual conversations related to health and residential care design and construction. Coming to you from Washington State, the state that boasts the only green flag and the only state with a president’s face on it—

**John**

That’s Lincoln, right?

**Bridget**

No, that would be Washington, silly—is John Williams! FGI’s VP of content and outreach and chair of the 2026 Health Guidelines Revision Committee.

**John**

And coming to you live and in person from St. Louis, where in 1912 the very first successful parachute jump was performed, is Bridget McDougall, associate editor with FGI. And we’re here because we like to talk about health care and we like to talk about health care codes and standards and from what we’ve heard a lot of you do, too.

**Bridget**

There is a lot to talk about when we’re talking about health care design and construction. We’ve got those codes that tell you how to build the spaces, but there’s more there between the lines, so to speak. And that’s what we’re going to be exploring on this podcast with the help of invited guests and you along for the ride.

**John**

So, thanks for finding us or coming back to us, and let’s get ready to read between the lines with FGI.

[Music fades out.]

# **Who is Lela Luper?**

**Bridget**

Hey, John!

**John**

Hey, Bridget.

**Bridget**

We got a great guest today. Lela Luper, manager of infection prevention and control at the Chickasaw Nation Department of Health. You and I both know that not only is she a hoot, but she’s a vast wealth of knowledge, and I think we realized early on we could take this interview in several directions because really the topic of infection prevention (or IP as we’re going to refer to it several times here on) is so far-reaching.

**John**

Infection prevention is one of those touchstone issues in the *Guidelines*, and how do we take something like that and narrow it down to just 30 minutes? So, probably, my guess is that we’re going to be talking to Lela a lot over the next couple of months. But, what are we going to talk about today?

**Bridget**

Well, before we sanitize our hands and check our air exchanges and buckle our seatbelts for whichever IP-road we drive down with Lela Luper, it’s really helpful to understand a couple things about the *Guidelines* documents themselves. Let’s quickly do that through the lens of infection prevention. Sound good?

**John**

Sure, sure, let’s set the table.

**Where can infection prevention be found in the *Guidelines*?**

**Bridget**

OK, first thing, there are a lot of ways to keep health care environments safe. And it’s important to remember the *Guidelines* address the built environment, right? Not operational aspects. So, that means the *Guidelines* will tell you how many and what kind of sinks you should have. But the CDC will tell you *how* and *how* *often* to wash your hands.

**John**

Exactly, and that’s the classic balance between those things that are operational versus those things that are built. And many of the things that we intentionally design into those health care spaces are meant to do exactly that. Uh, and that’s create an environment that makes it easier to operationalize safety.

**Bridget**

Second thing to keep in mind is how the *Guidelines* are organized. Whether you’re looking in the hospital or outpatient or residential book, you’ll find part one in the beginning. And that has in it things that all facilities are required to do.

**John**

Like perform an infection control risk assessment or “ICRA.”

**Bridget**

Exactly. And then after that, skipping over the common elements for a second, you’ll find chapters that are specific to certain facility types. And I’m thumbing through the outpatient document right now, urgent care centers or infusion centers and endoscopy facilities, for example. And those chapters include infection prevention requirements that are specific to that type of facility.

**John**

Right, and, we were just talking about one of those examples. In chapter 2.10 of the outpatient document that talks about renal dialysis centers or end-stage dialysis centers, there’s a requirement that says you have to have your fluid waste disposal sink located far enough—uh—away to prevent cross-contamination with your hand-washing station. So, you don’t want all of . . . those particles and droplets flying up and hitting those places where you have clean hands and you’re touching things.

**Bridget**

And that makes sense, that’s specific to dialysis. Finally, the chapter that I said skip over for a moment, the common elements chapter, or chapter 2.1. This is where the facility chapters will often tell you to go for things that apply to most facilities like that handwashing sinks have to be in each room where hands-on patient care is provided, or that ice-making equipment in public areas has to be the self-dispensing type, not the put your germy hands in there with the little nasty little scoop type.

**John**

And a usability reminder here might be helpful. Common elements in 2.1 is really kind of an à la carte menu of how to build a bunch of components, like a handwash sink or an exam room, inside of a health care facility. The facility chapters, those chapters that come after 2.1 tell you when they’re required. So, only go to common elements when you are told to do so by the facility chapter.

**Bridget**

Right, not the other way around. Start with the facility.

**John**

Right, start with the facility first. So, when it comes to infection prevention, there are so many different threads that we can pull on here, especially when we have somebody like Lela Luper, a black belt in infection prevention.

**Bridget**

Great description. For this episode, we decided to focus on where and how the *Guidelines* and infection prevention intersect and what that looks like in practice.

[Music fades in: “Skip to My Lou” by Neal Caine Trio]

**Bridget**

Let’s get ready to go between the lines with Lela Luper. Ready, John?

**John**

You bet, I’ve been looking forward to this for a while.

[Music plays then fades out.]

# **Welcome, Lela.**

**Bridget**

Welcome Lela Luper!

**John**

Welcome!

**Lela**

Hello everyone, how are you?

**Bridget**

Doing great.

**Lela**

Good, good.

***Aspergillus*, microbial growth, and mold.**

**Bridget**

Thanks for being here. John and I were talking about how tricky it is to narrow down a topic to discuss with you because infection prevention is mentioned so frequently in the *Guidelines* documents and rightly so, right? Cause these are spaces where people go to get well, not to find themselves going to the hospital for one thing and then suddenly facing a very serious life-threatening infection that could have been prevented.

**John**

And when we talked to Doug Erickson in episode one, he told us this story about *Aspergillus*. Apparently, there was a hospital in California, and they were doing some sort of agricultural work next door, and the tractors plowed up some dust that had *Aspergillus* in it that got into the facility through, you know, any number of different openings, and people ended up getting sick.

**Lela**

In most cases, we breathe it in every day. And if we’re healthy, we don’t have problems with it, but when we are immunosuppressed or have other comorbidities, that can be a real problem.

I was working recently on a design project and one of the architects wanted to add a wall hanging that was with this fancy, textured kind of thing, and I spoke up about it, and when I did they were like “What’s the big deal? This is not where inpatients are. We’re not doing acute care here.” I’m like, “You can still have collection of dust, and within dust you have *Aspergillus*. It may not be in acute care, but this is an area where we still need to be mindful of infection prevention and control concerns and take those mitigation efforts to avoid that. So, I’d like a smooth surface, smooth wall, please. Thank you.”

**Bridget**

I didn’t even know what *Aspergillus* was until that story that Doug shared. So, it makes me think, I’m not sure that designers and folks that are thinking about building spaces would necessarily have something like that on the top of their mind unless an IP [infection preventionist] was there to talk about it. You think that’s accurate?

**Lela**

Uh, somewhat. I mean, over the last 10 years, I would say, it’s become more, uh, prevalent. While they may not know what the word *Aspergillus* is, I do think they have at least an idea of what the risks are.

**John**

Yeah, a lot of times we don’t really even know it’s there until we start looking at outcomes inside of facilities. I was working at a[n] unnamed facility a couple of years ago and they started noticing different outcome rates in a particular set of operating rooms. Those operating rooms happened to be on the outside walls, and they had some non-permeable wall protection on them. We pulled that wall protection off, and there was some significant microbial growth underneath. So, um.

**Bridget**

Ugh.

**Lela**

Yeah, I’ve got another story if you have time for it.

**Bridget**

Yeah, we do. You know we do.

**John**

Absolutely.

**Lela**

There were two people that had gone into this interventional radiology department and had central line placement. And they discovered that the both of them ended up having an infection. Well, when they went into the IR lab, they actually looked and recognized that there was a restroom in there, and then they went to the opposite side of the wall, they pulled the wall back, and it was covered in mold. We use that example to talk about the unseen enemy. It’s not easy to assess, but the clinical background of an infection preventionist is often to try to work and figure out, OK, we’ve got a cluster, looks like an outbreak, what are the commonalities, identify what the organism is, and then go looking in the environment. Could it be environmentally related? And in this case, it was. There was a leaky toilet basically leaking into the wall.

**John**

Let’s talk about some of the things that we can do in design. There’s a couple of mechanisms in the FGI *Guidelines* that we can talk about of how to watch out for things during that design process.

**Lela**

Yeah.

**What is the infection preventionist’s role in the functional program?**

**Bridget**

Yeah, in the last episode, the last two actually, we focused on one of those mechanisms, the functional program, right? That mechanism for getting all the folks at the table for input during that really early process. What is the infection preventionist’s role during that process of the functional program?

**Lela**

So, if the infection preventionist is included at the beginning, as we need to be, truly that’s where IP needs to be brought to the table is during planning, during design, where that conversation’s going on: What are we gonna do in this space? How big is the space? What kind of patient population? What kind of services? All of that. That’s part of our role at the very beginning, and through the process of the functional program and the safety risk assessment, because as part of the safety risk assessment is that one piece, um, which is the infection control risk assessment that needs to be completed. And it clearly says in the *Guidelines* that infection prevention and control need to be present at the table to do that.

**John**

Right.

**Lela**

If we’re not there at the beginning and only brought in when it’s time for the risk assessment, we’ve missed all of this good, good healthy discussion that we really need.

**John**

Absolutely, and you mentioned that ICRA. So, the *Guidelines* point out that the ICRA is part of that safety risk assessment, like you said. Right, editor, you’ve got a section in chapter and verse here handy for us to look at?

**Bridget**

Oh, you know I do. I’m waiting for this. Section 1.2-4.2.1.1: “For a hospital facility project to support safe designs, HVAC, plumbing systems, and surface and furnishing material selections, an infection control risk assessment shall be part of integrated facility planning, design, construction, and commissioning activities, and shall be incorporated into the safety risk assessment.”

**How does the ICRA go beyond risk mitigation?**

**John**

There you go. And it talks about two different sections of the infection control risk assessment. And from my personal experience, many folks really seem to associate that ICRA with one of those parts—the infection control risk mitigation recommendations, those things that we do for construction. But they often forget to include the first part which is the design recommendations where you’re actually looking at the layout of the space, where the handwash sinks are, all of those things where, like you say, Lela, you need that infection preventionist presence there early on to be able to suss out those things. Can you speak to that?

**Lela**

Certainly, I’m over here rattling my head just like, “Yes, John. Yes, you got it right.” So, you know, again, when you’re talking about being at the table, that’s when you can pick up on those conversations. You know I think about If you’re going to have a pretty *furr down* it may look pretty when you first build it. However, after time, it’s going to collect dust. And if you don’t include your infection preventionist in those phases prior to the permit, then you’re still setting us up for failure; “us” meaning us as the organization, because it’s gonna be something that you’re gonna have to do after the fact or do during construction so that you have to then do a change order, and I don’t think anybody likes a change order.

**Bridget**

What’s a *furr down*?

**John**

It’s a drop where part of the ceiling plane lowers a little bit so that you’ve got a[n] extra design element in the room. Or a lot of times they do it over cabinets, so you don’t have that shelf on top of the cabinet; in the operating room, that just sits there and collects dust.

**Bridget**

Uh-huh. Is that an acronym or a truncated . . .? What’s happening there? How’s it spelled?

**John**

F-U-R-R-D-O-W-N

**Bridget**

OK, I just, you know, was picturing those 1970s vans with the wall-to-wall carpeting. I’m like—

**John**

Shag carpeting.

**Bridget**

—I do not want to go to a hospital that’s got a *fur* down, that’s covered in—

**John**

No. No, absolutely not.

**Bridget**

covered in, woo—shag carpeting.

**Lela**

I actually have a story related to that too, you know, involved in—[laughs]

**Bridget**

Oh God. I’m ready. Yeah, we’re ready.

**John**

Do tell.

**What are some hidden dangers behind decorative features?**

**Lela**

I know of a colleague that had been working with the designers and they wanted to actually put, live grass an—I know—there’s a term for that. It’s like a grass wall.

**Bridget**

Like a Chia-head wall.

**Lela**

There’s a term and I apologize for those that are listening—

**John**

Living wall?

**Lela**

—because I don’t, ye-ye-similar, yeah. And it was meant to be, you know, soothing. The problem is it was gonna be right next to the oncology unit. And you’re like, where’s the disconnect here?

**Bridget**

And for those that don’t have infection prevention on the top of their thoughts, what is the threat there?

**Lela**

Well, I’m thinking about the soil.

**Bridget**

Mm-hmm.

**Lela**

You’ve got soil and water and what’s the drainage? Same way we allow fish tanks, right? Closed fish tanks. But how many times have you gone back [and] lifted the back where the fish are fed? And look[ed]? Pull[ed] up the back where you’re actually feeding the fish. Look[ed] at that and see what’s growing or not clean. You know, so again, it’s just kind of grody kind of stuff.

**Bridget**

Mm-hmm.

**John**

And to your point about a planter wall or a living wall or something like that, how do you disinfect a flower?

**Lela**

Yeah, so from an IP perspective, we’re looking for solid, cleanable, non-porous surface that needs to be able to handle the EPA-registered disinfectants that we have to use within a hospital or in a healthcare organization. You still have to clean the walls in the OR, you know, the ceilings, you know, you gotta think about the, the floors in some spaces. So, while it may be pretty, it may not last long-term.

**John**

Really good point. There’s all sorts of those smooth and shiny surfaces that look cleanable and you can verify that they are cleaned. But if they don’t hold up to an ammonia compound and the scrubbing that happens and that wears down to a wood surface, then you got an issue.

**Lela**

Yeah, big problem.

***Guidelines* Table 1.2-2 (Infection Control Risk Assessment Design Considerations)**

**Bridget**

I wonder if you can take a journey with us to a table in the *Guidelines*. Lela Luper,

**Lela**

Yeah.

**Bridget**

Let’s get in our cars and drive on over to Table 1.2-2. It’s the Infection Control Risk Assessment Design Considerations table. You know, John and I were talking about that table. And I was saying that I think of these tables like a bus schedule, and the *Guidelines* are the roads and the neighborhoods that the bus drives through. And the table tells you where in the *Guidelines* the bus is going to be making infection prevention stops. Right? So, you kind of know stops, just stops to consider, stops to identify requirements, stops to point out where the ICRA is making determinations. What’s your engagement with this table? Does it help you as your role as an IP?

**Lela**

So, the table talks about HVAC. It talks about airborne infection isolation rooms. It also talks about water and water stagnation, right? But the main thing is with this table; it’s meant to be a guide. You know, it may say, OK, for a potable water supply system, see *Guideline[s]* section reference, but that’s not the end all. You really do have to think about what’s going on in your organization. How does it fit as part of your functional program? You still need to have the guidelines and understand what they say and how they impact you.

**John**

When you describe that this is not all-inclusive, I think that’s a real easy trap that a lot of people get into. Like, “Quality is really just a checklist that I go through and I check off.” Checklists are incredibly valuable—

**Lela**

Mm-hmm.

**John**

—but when you get to that culture of quality and watching and understanding the intent and purpose behind why we say surfaces need to be cleanable, air needs to move from clean areas into less clean areas. Once you get the concept and the intent, you’re approaching the environment with all sorts of questions. And you’re constantly vigilant and aware of the things that could be creating problems for patients.

**All eyes on the infection preventionist? The role of collaboration.**

**Lela**

One of the projects was funny because at one point, they were all looking at me like, is this OK for this plan or for the mitigation, you know, And I had to say, stop looking at me. You know, it’s not just me in this room. We all are sharing together, you know, coming up with a plan. But, what I appreciated about it is the fact that they were thinking, It was a situation where we had to think out of the box. And we were really working hard together as a group to figure out the contractor, the organization, we were really collaborating well.

**Bridget**

Yesterday I was using the table like the bus schedule, and I was taking myself on a bus ride all throughout all the infection prevention type things in the document. And in the flooring and wall bases section, it actually speaks to an allowance of when you *can* do something when it’s approved as part of the ICRA process.

And this specifically was about the use of carpeting and patient care areas, which kind of gave me the heebie-jeebies, but it says that you can have carpet in patient care areas, you can have it in clinical support areas like labs and pharmacies, that that’s permitted when approved as part of the ICRA process. So, I think we do kind of point out sometimes in the *Guidelines,* “Hey, this is OK, or should be considered not [to do] doing it if . . .,” and then all eyes on Lela Luper.

**Lela**

[Laughs]

**Bridget**

It will happen, right? Like sometimes there *are* all eyes on the IP during the process.

**Lela**

Yeah, right. Yeah. Well, it is funny because I do. You’re right. Carpet gives me the heebie-jeebies, especially when you’re thinking about putting it down. And we had another area. We had a space that we put down. It was an exam area. They were doing feet. And they put, they put carpet down.

**Bridget**

Uh-uh.

**Lela**

[Laughs] Uh-huh.

**Bridget**

No, ma’am.

**Lela**

I was like, uh.

**Bridget**

Sorry, I just pictured an airplane with everybody’s bare feet up on the headrest. That’s what I saw when you said that, but now I’m in a hospital picturing it, OK?

**John**

Ugh.

**Form follows the *function* of the space.**

**Lela**

Exactly. I was like, let’s get the carpet off the floor, and they just they you know, of course they were like Lela and I’m like, mmm. No, no, we want that clean floor! But truly, you’re right. I mean, like, if you’re talking about a space where you’re not gonna have any blood or body fluid, it’s really that part because you can’t, they, look, carpet looks great. You know, and if you do it in tiles, some people would argue with me, “Lela, you can put it in tiles, and it’s easily picked up, and you can replace,” which is fine and all that, but then you also have to think about shampooing that carpet. And then when the water stays within the equipment that you’re doing, you’ve got another stagnant water. I mean, there’s a lot more to [it] than just the pretty looks of carpet. You have to think about where you’re actually using it and for what reasons. And what is the *function* of that space? If the *function* of the space doesn’t lend itself to carpet, then why are we putting carpet in it to begin with? But anyway, that’s just the world according to Lela.

**John**

So, another point about this table is not only does it give you sort of a tour of all of the different sections in the *Guidelines*, it drops you off at those bus stops, sometimes at a place where you’ll need to go to make an infection control decision.

For example, it may take you to the section on airborne isolation rooms. And in that section, it will talk about an anteroom, but it’s going to prompt you to have some kind of conversation with your infection preventionist to determine if one is needed or not.

**Why is it important to include the infection preventionist in early conversations?**

**Lela**

If you don’t include your infection preventionist as part of that conversation, as the *Guidelines* instruct you to do, then again, you’re gonna miss an opportunity to really be sure that you’re capturing what the patient population is, what you need for that space. Is this a space that is supposed to be an airborne infection isolation room where the exhaust goes completely out of the building, or should this just be a protective environment? Or are we trying to build a space that is both the combined airborne infection isolation room and a protective environment at the same time? The infection control risk assessment, looking at the *Guidelines*, helps drive what, what’s really needed, what kind of requirements are necessary to have, such as an anteroom.

**John**

And really that also helps you understand how you plan to operationalize the facility. Like if you’ve got a plan and you’re used to doffing and donning protective gear outside in the corridor and you’ve got good experience doing that, then that’s your plan. If you’ve had problems with it, that might be a point where your infection preventionist comes in and says, “Well, you might want to consider an alcove or a special anteroom to be able to make all of those things happen.”

And we have so many competing needs and competing interests inside of health care. We have the need for spaces to be quiet. We have the need for spaces to be cleanable. We have the need for them to be firesafe. All sorts of different risks inside of the environment that we need to mitigate.

**Lela**

You know, you’re right. John, there’s a lot more to it. From an IP perspective, you know, you want lighting. You think about the lighting. If you have a lot of hanging-down light fixtures, what are those? Those are great dust collectors. They can’t be cleaned, and how often is someone going to actually get up there and clean [them]? There’s just a lot of different things to be thinking about. And if you don’t include someone, your infection prevention and control representative, your, you know, whomever at the table, then in my opinion, it’s an error.

**Why is it that infection preventionists are not always included in early design conversations?**

**John**

So, I’m getting the message loud and clear that infection preventionists are not always included during those early design conversations. Why do you think that is?

**Lela**

in my mind, it’s really just about building a relationship. And I think if you don’t have a relationship with your plan ops or your maintenance team, whatever your department or organization calls them, that’s gonna hinder the infection preventionist’s ability to be at the table early. If you’re seen as a foe instead of a friend or a partner wanting to work together, then you’re not helping yourself either, you know. You got to earn their respect.

**Bridget**

So, Lela, whose responsibility would it be to foster that relationship then?

**Lela**

I think that’s hard. That’s gonna be dependent on the individual that’s in the infection preventionist role. At the same time, it’s really important in my mind that if the architect and designer is working with construction that they involve the IP—ask to speak to the infection preventionist and find out whether they’re going to be at the table; include them in those virtual meeting invitations, you know. Half the time we may not care about what’s going on, but we can at least be listening for those times when we do need to speak up,

**What can help an infection preventionist insert him/herself into these conversations?**

**Bridget**

I can imagine for some IPs, especially new ones, it could be pretty daunting to figure out how to go about inserting yourself into these conversations. What helps?

**Lela**

So, I think it’s about how you present yourself, you know? You need to go into it humble. Humble yourself and understand you don’t know everything about construction. I learned those terms, base cove, you know, what’s a monolithic floor? You’ve got to spend some time learning from those people that do this work day in and day out so that you can speak the same language. Sometimes you could just say, “This may sound like a really dumb question—

**Bridget**

But what is a fur wall or whatever you called it? A furr down. Yeah.

**Lela**

—I don’t know what this is.” Yeah, “What is a furr down?” You know, “What’s a furr down?” Maybe it’s reading the *Guidelines* and you don’t understand what a word means and say, “Hey, could you tell me what this means? I don’t really understand what this means.” I’m also a visual learner. My team has learned it’s not uncommon [to hear me say] let’s go take a walk. We spend some time walking, and we look at where we’re gonna put the barriers. We look at what we’re planning on doing. And doing that together, again, builds that opportunity for us to just have conversation. We can talk about what’s going on at home, you know, what’s, you know, what the dogs are doing. You end up learning about their life. And again, build a friendship over time.

**Walk the space to gain understanding.**

**John**

When you do those walks, whether it be with an architect or an interior designer or somebody on your construction team, that gives them also the opportunity to try to understand what you’re looking for. What do you see in the environment?

**Lela Luper**

Exactly.

**John**

And when you’re there in real time, you can look at actual situations and conditions and layouts, you know, the three dimensions of the space, and really try to understand what’s going on and where those risks are. So, it’s really kind of a 360-degree opportunity there.

**Lela**

Exactly, John. I would say 10 years ago, a designer would have not asked for infection prevention, would have not even known who we were, or maybe if they did, it would have been awkward to try to have a conversation because they’re used to talking construction language, right? And now, the ability to be in, you know, planning and design meetings and seeing a designer’s eyes just light up whenever we’re talking about IP stuff, that didn’t happen 10 years ago, you know?

**John**

Yeah. We’re cross-training.

**The payoff of working as a collaborative team.**

**Lela**

Exactly, exactly. And, and to the point of, I’ve got a third-party contractor that’s already thinking ahead, you know, gonna tape up a barrier and realizes, um, that’s not gonna hold well [so] we’re gonna tack it instead. Infection prevention never had to say a thing. They were already ahead. Again, I think that’s a change that’s happened over the course of time. But I also believe it’s because of building relationships and all parties being comfortable and [being able to] have an understanding, a better understanding, of what infection prevention and control is. We are really, uh, work as a collaborative team. We are not there to, say thou shalt do so and so.

**Advice for new infection preventionists.**

**Bridget**

Lela, we like to end each show by speaking directly to people new in their fields. What advice do you have for new infection preventionists when it comes to the *Guidelines*?

**Lela**

Teams are more willing to have conversation with you and respect you if you’re seen as an advocate for them and as a partner to them rather than seen as someone that is rigid and not willing to have some conversation. There’s a time and a place for which we need to be strict about what our mitigation activities are. Knowing when that time and place is. . . is crucial. And for everybody, that’s going to be different depending on the scenario in the world in which they live.

# **Wrap up/goodbye.**

**[Music fades in: “Skip to My Lou” by Neal Caine Trio]**

**Bridget**

Well, furr downs, fish tanks, and everything in between. I think we’ve covered a lot of ground on today’s show. Thank you, Lela Luper.

**John**

Thank you so much, Lela.

**Lela**

It’s been fun. Thank you so much.

# **Outro.**

**John**

Thanks for joining us for another episode of Between the Lines with FGI. Do you have an idea for an episode? Please get in touch with us by writing to podcast@fgiguidelines.org.

**Bridget**

And if you’re interested in becoming a sponsor for one of our episodes or a series of episodes, you can also reach out to us at podcast@fgiguidelines.org.

**Bridget**

Thanks to Neal Caine and the Neal Caine Trio for the use of his song “Skip to My Lou” from the album of the same name.

**John**

Join us next time as we go between the lines with FGI. Bye, everybody.

**Bridget**

See you next time.

**[Music fades out.]**