Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

September 26, 2018
1:00 - 3:00 pm

NOMINATED MEMBERS PRESENT:

- Joshua L. Bardfield, Supply Chain Services Manager, The Oregon Clinic
- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center
- Deborah Cateora, BSN, RN, Healthcare Educator Training Coordinator and RN Consultant, Safety, Oversight and Quality (SOQ) Unit, Oregon Department of Human Services (phone)
- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control (phone)
- Kristen Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante (phone)
- Amy Jo Walter, Infection Preventionist, Southern Coos Hospital (phone)

Agenda, materials, minutes, recordings, and transcriptions for meetings are available at:
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

NOMINATED MEMBERS

EXCUSED:

• Paul Cieslak, MD, Medical Director, Oregon Public Health Division, Oregon Health Authority
• Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center
• Pamela Cortez, MBA, BSN, RN, CNE, BC, Director of Patient Safety and Clinical Support, Salem Health
• Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon Health Authority
• Jordan Ferris, BSN, RN, CMSRN, Nursing Practice, Consultant, Oregon Nurses Association
• Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc
• Laurie Polneau, RN, MHA, CPHRM, Director, Quality/Risk Management/Infection Control, Vibra Specialty Hospital Portland
• Tom Stuebner, MSPH, Executive Director, Oregon Patient Safety Commission

OTHER PARTICIPANTS PRESENT:

• Jana Brott, MPH, CIC, Manager, Infection Prevention and Control, Legacy Health
• Joyce Caramella, RN, CPHQ, CHC, Project Manager, HealthInsight Oregon
• Dennis Drapiza, MPH, BSN, RN, CIC, Regional Director, Northwest Infection Prevention and Control, Kaiser Permanente Northwest
• Ryan Grimm, Director of Surgical Services, Ambulatory Surgical Centers, The Portland Clinic
• Molly Hale, MPH, CIC, FAPIC, Manager, Infection Prevention & Control, Oregon Health & Sciences University
• Julie Koch, RN, MSN, BSN, Manager Infection Prevention, Salem Health Hospitals and Clinics
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- Gretchen Koch, MSN, RN, Policy Analyst, Nursing Practice and Evaluation, Oregon State Board of Nursing
- Shanna Middaugh, MLS, BHA, CIC, Samaritan North Lincoln Hospital
- Laurie Murray-Snyder, Hospital Improvement Innovation Network Project Lead, HealthInsight Oregon (phone)
- Mary Post, RN, MS, CNS, CIC, Director, Infection Prevention/Employee Health Coordinator, Shriners Hospitals (phone)
- Diane Zhitlovsky, Clinical Specialist, Thrombolytics, Genentech

OHA STAFF PRESENT:
- Zintars Beldavs, MS, Acute and Communicable Disease Prevention (ACDP) Section Manager
- Tara Buehring, MPH, Healthcare-Associated Infections (HAI) Office Specialist
- Maureen Cassidy, MPH, Multidrug-resistant organisms (MDRO) Epidemiologist
- Judy Guzman-Cottrill, DO, Pediatric Infectious Disease Physician
- Alyssa McClean, AWARE Program Coordinator
- Rebecca Pierce, PhD, HAI & Emerging Infections Program (EIP) Program Manager
- Diane Roy, HAI Data and Logistics Coordinator
- Monika Samper, RN, HAI Reporting Coordinator
- Lisa Takeuchi, MPH, Emerging Disease Epidemiologist
- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist
- Dat Tran, MD, Public Health Physician
- Nicole West, MPH, OHA Epidemiologist
- Alexia Zhang, MPH, HAI Epidemiologist

ISSUES HEARD:
- Call to order and roll call
- Introductions and logistic updates
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- Approve June 2018 minutes
- Outbreaks update
- Using National Healthcare Safety Network (NHSN) for facility benchmarking
- Legacy Health Ebola Assessment Center update
- Healthcare worker influenza vaccination data, 2016-17 season
- Travel screening in Oregon healthcare facilities
- Targeted Assessment for Prevention (TAP) Assessment progress
- Discussion: themes and topics for future meetings and reports
- Public comment
- Adjourn

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker’s exact words. For complete contents, please refer to the recordings.

<table>
<thead>
<tr>
<th>Item</th>
<th>Discussion</th>
<th>Action Item</th>
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<tbody>
<tr>
<td><strong>Call to Order and Roll Call</strong></td>
<td>50 percent of members present.</td>
<td>No action items</td>
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<tr>
<td>Genevieve Buser,</td>
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<td>Providence Portland (Chair)</td>
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<td><strong>Introductions and Membership Updates</strong></td>
<td>Two current vacancies: Consumer Representative and Health Insurer Representative</td>
<td>No action items</td>
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<tr>
<td>Tara Buehring,</td>
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<tr>
<td>Oregon Health Authority</td>
<td>Audio issues</td>
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<td></td>
<td>We will begin using microphones to help people hear across the room and on the phone</td>
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# Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

| Approve June 2018 Minutes  
All Committee Members | June 2018 meeting minutes were approved. | No action items |
|--------------------------|------------------------------------------|----------------|
| **Outbreaks update 2017**  
Alexia Zhang, Oregon Health Authority | • 61 outbreaks were reported since 06/01/2018  
• Of the 61 outbreaks, 27 (44.2%) occurred in a healthcare facility  
  o Outbreaks occurred most often in assisted living facilities (92.3%, n=24)  
  o Most common etiology in healthcare facilities was norovirus (62.5%, n=16)  
• Question from Dr. Buser: Was measles outbreak healthcare-associated?  
  o Alexia Zhang: No. | No action items |
| **Using NHSN for facility benchmarking**  
Julie Koch, Salem Health; Molly Hale, OHSU; Jana Brott, Legacy Health | • Julie Koch presents: Use of Infection Data at Salem Health Hospitals and clinics  
  o Fiscal year is July to July; halfway through the year, reflect on last 6 months of accomplishments and determine focus for next fiscal year.  
  o Elevated infections identified during review of National Healthcare Safety Network (NHSN) data inform focus.  
  o The organization decides to focus on a particular area of infection and starts at the approval of the board level.  
  o Quality and Safety Baby A3: We see hospital-onset *Clostridioides difficile* in this graph in raw numbers. We | No action items |
also depict days of therapy for specific antibiotics. This gave us the data to drive actions.
  o We carefully plan how we use our NHSN data.
  o We also use NHSN data for payer scorecards. This data helps set targets that they'd like to see.
    ▪ We target three levels, usually 10% threshold, meaning a 5 percent change and a stretch target of 50 percent and each of those are tied to money.
    ▪ Then we calculate what is a 5 percent drop in the standardized infection ratio (SIR). Days of therapy is listed for that grouping of antibiotics based on historical data, and then some surgical site infections (SSI) data, where we look at raw numbers and SIRs.
  o We also use the infection metrics for leadership incentivative payments.
    ▪ It's weighted 20 percent of the incentive payment for leaders to achieve an infection metric of 5 percent each goal.
    ▪ This includes licensed providers, but it also goes to the manager level.
  o We do run everything off NHSN; we have baseline SIRs, different for all the metrics.
    ▪ We think of them as the ten-required metrics, including the catheter-associated urinary tract infection (CAUTI), central-line associated bloodstream infection (CLABSI), SSI, *C. difficile*,...
methicillin-resistant *Staphylococcus aureus* (MRSA), *et cetera*.

- Baseline data goes into NHSN and we are combining CAUTI, CLABSI, and SIRs into device-related infections.
- If I am combining SIRs of different types of infection, we don't think about improving them together necessarily.
- We look at improvement initiatives in each of those areas, but the board asked to see if we can combine our metrics. We combined *C. difficile*, MRSA, and SIRs.
  - I was asked to use NHSN data to predict what a 5 percent decrease would look like in CAUTI, CLABSI, *C. difficile*, and MRSA for each unit, which four or five units’ baseline data.
  - To produce an SIR for these units, we had to do a 12-month rolling, and then we established rules for what the threshold would be for units to start looking at their practices, and what would be their target be for the year.
- Lessons learned:
  - Data definitions are important, and should accompany all metrics
  - Use appropriate calculations; when in doubt, ask for help
  - Keep leadership informed
    - Survey changes
### Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- **Re-baselines**
- **NHSN adjustments**
  - Validate data
  - Question from Dr. Buser: Did you get an average of what all the payers were asking?
    - Julie Koch: No, each payer asked for very different things.

- Molly Hale presents: NHSN Analysis and Facility Benchmarking at Oregon Health & Science University (OHSU)
  - The attic of our plan is to provide the leading standard of care of patient-centered care to all of those we serve.
  - The rooms within our house are our goal, strategies, and metrics, and then our strategic house, or plan, is built on the larger OHSU vision.
    - This would include the research mission, the academic mission, and then our vision, mission and values.
    - Within the rooms of our strategic house we've got Metric No. 6, which is mortality readmissions and healthcare-associated infection. So, our data is right up there at the highest level of OHSU healthcare.
  - The HAIs that are included in this healthcare strategic plan are CLABSIs and CAUTIs in the adult population.
    - Pediatrics do not factor into it, nor do our specialty units.
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- We have a dedicated spine unit and we have a bone marrow transplant unit, so all those units that are excluded from Centers for Medicare and Medicaid Services (CMS) reported, do not go into the data that feeds into this larger strategic plan.
- Hospital-onset *C. difficile* is in there because that's a part of hospital reporting, except for the neonatal intensive care unit (NICU).
- Then for SSIs it's colons and abdominal hysterectomies that are shown in there, and our goal is to be in the top 10 of Vivient facilities.
  - This is a large collaborative group that we belong to that allows us to get best practices and to benchmark with other facilities.
    - There are six domains: mortality, effectiveness, safety and equity patient centeredness and, efficiency.
  - Within the safety domain, we have our healthcare-associated infections (HAIs), including CLABSI and CAUTI.
  - Last year, we did not crack the top 10 but we were number 12 of all university hospitals that are a part of the Vizient health system.
  - This report is pushed out annually, so our goal is to be in the top 10, but that's a moving target. We never know at any given time how these facilities are performing, we just get our
### Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

| Scorecard once a year saying where we ranked relative to everyone else. |
| ▪ We do set internal performance improvement goals to make sure that we're meeting our internal targets. |
| o We have our goals divided up among our patient population. |
| ▪ We have adult inpatient, pediatrics and then our ambulatory access areas. |
| ▪ Within the adult inpatient for our HAIs, we're looking at *C. difficile*, CLABSI, CAUTI and SSI. |
| ▪ Right now, the SSIs that we're most concerned about are those part of CMS reporting, so the colon surgeries (COLO) and abdominal hysterectomy surgeries (HYST). |
| ▪ Craniotomies we also do surveillance on and we have a dedicated performance improvement projects to reduce our crania infections. |
| ▪ Within our children's hospital, CLABSI is our big focus, and then SSIs. |
| ▪ We rate our peds SSIs against the Misquick database, and then the surgeries that funnel into that data source are our cardiac surgeries, fusions, etc. |
| o Fiscal Year (FY) 2018 HAI Goals |
| ▪ Non-Mucosal Barrier Injury (MBI) CLABSI: 15% reduction from FY17 rate |
| ▪ CAUTI: 10% reduction from FY17 rate |
### Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- **Hospital onset (HO)-CDI:** 25% reduction from FY17 rate
- **COLO:** SIR Vizient top 10
- **HYST:** SIR Vizient top 10
- **Cadence of reporting:**
  - CLABSI, CAUTI, CDI
    - Weekly: target # of cases per month
    - Monthly: target rate
  - SSI
    - Quarterly: target SIR
  - SIR reported quarterly on all HAIs
- **HO-MRSA Bacteremia LabID event**
  - All inpatient units
  - Poor quality of definition
  - Poor use of the metric by CMS
  - Contributes to significant financial penalties, multiple times
- **Incentive pay and payer contracts**
  - HAI data used in past years for leadership incentives; not included in FY18 or FY19
  - Small number of payers have built-in value-based measures
  - Some preferred contracts for specific procedures where additional data is required
- **Question from Dr. Buser:** Are the leadership incentives paid to the managers/leaders?
  - Molly Hale: For OHSU, it’s managers and above, including directors, senior directors, vice
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

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<td>presidents, et cetera For physicians, they are employed through the school of medicine.</td>
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<tr>
<td>• Jana Brott presents: Using NHSN for Facility Benchmarking at Legacy Health</td>
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<tr>
<td>o Legacy Health has two big aims/goals for quality and patient safety:</td>
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<td>▪ Eliminate needless deaths</td>
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<td>▪ Eliminate preventable harm</td>
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<td>o Quality, Strategy &amp; Leadership Committee sets specific, measurable goals to help ensure progress</td>
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<td>o Goals are evaluated in a composite called the Harm Index which currently include the following HAIs:</td>
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<tr>
<td>➢ Catheter-Associated Urinary Tract Infection (CAUTI)</td>
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<td>➢ Central Line-Associated Blood Stream Infection (CLABSI)</td>
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<td>➢ Surgical Site Infection (SSI)</td>
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<td>➢ Clostridium difficile Infection (CDI)</td>
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<tr>
<td>o Performance assessment data sources</td>
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<tr>
<td>▪ Centers for Disease Control and Prevention (CDC) NHSN</td>
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<td>➢ Standardized Infection Ratio (SIR) = Observed HAI / Predicted HAI</td>
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<tr>
<td>▪ Centers for Medicare &amp; Medicaid Services (CMS)</td>
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<td>➢ FY20 Hospital Value-Based Purchasing Safety Domain</td>
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<tr>
<td>▪ Department of Health &amp; Human Services (HHS)</td>
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## Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

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<thead>
<tr>
<th>Question from Dr. Pierce: How much is benchmarking data shared with providers?</th>
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<tr>
<td>Jana Brott: When an HAI is identified, as soon as possible the infection control practitioner team will have a huddle within 72 hours at the bedside.</td>
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<td>Julie Koch: At Salem, it depends on infection type, how it’s communicated, and who it’s communicated to.</td>
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<td>Molly Hale: At OHSU, we do a notification of every HAI. The unit leaders pull together a multidisciplinary brief.</td>
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### Legacy Health Ebola Assessment Center update

- Jana Brott and Susan Diskin present: Biological Isolation Care Unit (BICU) Update
  - Legacy Good Samaritan Medical Center set up an Ebola Assessment Center (EAC) during the outbreak in West Africa
  - Maintained this unit with help from a passionate team of providers, nursing staff, and leaders across the system committed to continuing this work long term
  - Brief background: In 2015, hosted a CDC and OHA team which evaluated the unit leading to formal EAC designation. In July 2018, National Ebola Training and Education Center (NETEC) team of clinical and operational leaders from Emory, University of Nebraska Medical Center (UNMC), and Bellevue

No action items
conducted 2-day evaluation of the unit. These three systems are the leading Ebola Treatment Centers (ETC) in the United States and are supported by CDC to visit and consult. Like the accreditation process, they have a large manual of capability standards that we need to meet to continue this work.

- Ebola assessment hospitals were asked to be able to safely hold a patient for up to 96 hours. When we had the NETEC team come, we invited others including emergency medical services (EMS), fire, hazardous materials (HAZMAT), OHA, and we learned a lot of valuable lessons around transport procedures.
- There are ten regional treatment centers across the United States, and our regional treatment center is in Spokane, Washington.
- Transferring a patient to Spokane, which is typically a 5½-hour drive, might take up to 10 hours, because every 2 hours along the route EMS would need to rotate team and their HAZMAT gear.
- There are 13 HAZMAT teams in Oregon and they all train to the same level and wear the same level of gear.
- Legacy's care team is made up of about 30 people:
  - Nurses from the intensive care unit (ICU), Med Surge, Women's health, emergency department and pediatrics.
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- There would be a minimum of three RNs per shift, and that could change depending on the acuity of the patient.
  - Physician team is made up of interventionist and hospitalists from across the system
  - Respiratory care
  - Laboratory technicians
  - Radiologic technicians
  - All other care is performed via remote consultation, and we have a telehealth robot for that.
  - We would adapt this as well for an airborne-type virus, which has a different intensity level for staffing.
  - Team commitments and training
    - Bi-annual learning and skills training
      - Didactic from infectious disease physicians
      - Simulation with clinical practice support specialists
      - Coaching from Employee Health and Infection Prevention & Control
    - Co-develop standard operating procedures
      - Test new ideas and procedure modifications
      - Debrief after every care simulation to share learning and facilitate improvement
      - Leadership team accountable for follow up
    - Engage in professional development and leadership opportunities
## Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

| Internal future plans | | External future plans |
|-----------------------|--------------------------|
| Write a procedure for just in time recruitment and training | Evaluate ETC capability with NETEC & OHA | Strengthen partnerships with regional EACs and ETCs |
| Practice “no notice” drills and multidisciplinary handoffs, e.g. EMS to burn intensive care unit (BICU) | Strengthen partnerships with regional EACs and ETCs | Continue to collaborate with preparedness experts |
| Lead community-wide exercise for a novel respiratory infection | | |
| Develop contingency plan for pediatric assessment and treatment | | |

- **Question from Julie Koch:** How long should a frontline facility be able to care for a patient?
  - **Dr. Guzman-Cottrill:** We currently have three EACs. All three still engage and have support. We would need to do an assessment of the patient and their risks, to see how sick they are at that time and then decide. If it was high-risk and they were mildly ill, we would transfer them to Spokane.

### Healthcare worker influenza vaccination data, 2016-17 season

- **Monika Samper presents:** Healthcare Worker Influenza Vaccination Survey, 2016 – 2017
  - The 7th annual vaccination survey of healthcare workers (HCW) includes:

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<th>No action items</th>
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16
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

<table>
<thead>
<tr>
<th>Monika Samper, OHA</th>
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<tbody>
<tr>
<td>▪ 64 hospitals</td>
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<tr>
<td>▪ 137 long-term care facilities (LTCFs)</td>
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<td>▪ 86 ambulatory surgery centers (ASCs)</td>
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<td>▪ 67 Dialysis facilities</td>
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<tr>
<td>o Executive summary</td>
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<tr>
<td>▪ Influenza virus infections associated with 12,000 to 56,000 annual deaths in the U.S.</td>
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<td>▪ During the 2016-2017 flu season, Portland area reported 1,466 flu-related hospitalizations</td>
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<td>▪ Flu has been responsible for 5 Oregon pediatric deaths over the last five years</td>
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<tr>
<td>o Influenza vaccination rates for all HCWs by health care facility type and season:</td>
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<tr>
<td>▪ Graph shows the fluctuation of the HCW vaccination rates based on facility type over the last 5 years from 2011/2012. I didn't include the 2009/2010 because it was mainly hospitals, ASCs and LTCFs.</td>
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<td>▪ The trend here is one of increasing vaccination rates, but there are fluctuations from year to year.</td>
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<td>o Mean HCW influenza vaccination rates for all facility types:</td>
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<td>▪ This shows that there is an overall increase in vaccination rates with all facility types over the years</td>
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### Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- Aggregate HCW influenza vaccination rate data for the 2015-2016 influenza season by facility type and HCW classification:
  - This shows us the aggregate data for the different facility types; hospitals at the top, ASCs, nursing facilities and then dialysis facilities.
  - It shows the number of people eligible for vaccination in the first column, the rate of vaccination in the second column, the rate of vaccination declination in the third column, the vaccination status unknown in the fourth column, and then the change in their rate from the previous season.
  - It should say 2016/17 in the title.
  - The rate of unknown vaccination status:
    - This could be 50 percent of independent practitioners, maybe 40 percent of them got the vaccine, and we just don't know it.
    - Better tracking would be important to be able to know the numbers better.
    - This shows a high unknown rate in several different facilities, and for some reason it tends to be the independent practitioners. Since they tend to move around from facility to facility, they’re harder to track.
    - It’s the same situation for the students and volunteers, especially in the skilled-nursing facilities.
Facility-specific data:
- We start with the number of people eligible for vaccine, the rate of vaccination, the rate of declination, the rate unknown, and then the change in rates in the next season.
- The Healthy People target produced by Health and Human Services (HHS), made goals for 2015. These goals included 75 percent of HCWs should be vaccinated for the flu, and by 2020, a 90 percent should be vaccinated.
- Green checkmarks mean they made 75 percent, and then the red “x” means they are not meeting that 2020 goal.
- I do have all the numbers for 2017/18 vaccination year, and it looks like every facility-type has an increase in the vaccination rate this year. I don’t think anybody’s reached that 90 percent mark yet, but it is still trending upwards, so our efforts are being recognized.

Comment from Roza Tammer: I wanted to mention when I analyzed the data in Alameda County as a fellow there, they implemented a masking order in patient care areas for those that were declining vaccination. We found that the percent in increase, which was around 14 percent pre and post season after the masking order, was almost the same as percent decrease in unknown status from the prior season. The unknown can make or break these targets often.
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

| Comment from Dr. Pierce: We will be focusing quite a bit on skilled nursing facilities (SNFs), due to their vaccination rate being around 60% overall. We will be doing direct outreach to ensure they have received CDC and OHA flu vaccination toolkits. We also have a LTCF survey going out in the next few weeks. This will ask about flu vaccination documentation procedures. |
| Comment from Dr. Buser: In the clinic, they’re supposed to be rolling out vaccines, but I know many don’t want to be vaccinated too early. All the messaging and outreach the HAI program can do would be beneficial. |
| Comment from Pat Preston: I had a major local client call today saying there’s a vaccine delay/shortage and may not be able to vaccinate by the end of October. Has anyone heard of a pipeline vaccine issue? |
| o Mary Post: I know Shriner’s was notified there would be a short delay. We only received about one third doses. Delay is not associated with quality issues but the approval process and the steps that need to be considered before it is released. Manufacturers have recommended that flu clinics should be scheduled at the end of October. |
| o Dr. Buser: There are alternatives ways to be vaccinated like pharmacies, etc. |

| Travel screening in Oregon healthcare facilities | Ebola situation report- Democratic Republic of the Congo (DRC) |
| Rebecca Pierce | o New outbreak declared on August 1, 2018 |
| | o 7th largest Ebola outbreak |

Dr. Guzman-Cottrill will send the Personal Protective
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

<table>
<thead>
<tr>
<th>o As of September 24, 2018</th>
<th>Equipment (PPE) calculator to Dr. Pierce for distribution.</th>
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<tbody>
<tr>
<td>➢ Total cases: 151</td>
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<td>- Confirmed cases: 120</td>
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<td>- Probable cases: 31</td>
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<td>➢ Deaths: 101</td>
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<td>- Confirmed: 70</td>
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<td>- Probable: 31</td>
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<td>o We are seeing a decrease in the rate of infection right now.</td>
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<td>o The World Health Organization (WHO) is now warning of a perfect storm of factors that may worsen spread.</td>
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<td>▪ Misinformation</td>
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<td>▪ Political violence</td>
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<td>▪ Limited HCW access to hot zones</td>
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<td>▪ Unable to perform contact tracing</td>
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<td>▪ Unsafe burials</td>
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<td>o WHO discussing whether to declare Public Health Emergency of International Concern.</td>
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<td>o The area where there's conflict right now is Beni, where there's 29 cases.</td>
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<td>o We saw some measles cases in Oregon over the summer, and we see measles endemic to many areas in Europe, Asia, Africa, and the Pacific. It's always something we need to be on the lookout for imported cases.</td>
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<td>o We still see the Middle East Respiratory Syndrome (MERS) cases, particularly in Saudi Arabia. It's been</td>
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Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

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<tr>
<th>Question from Dr. Pierce: Is there a need for continued travel screening?</th>
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<tr>
<td>Molly Hale: OHSU started screening after the 2014 Ebola crisis, and we screen when anyone presents for care.</td>
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<td>Julie Koch: For Salem, when the Ebola crisis died down we followed OHA guidance.</td>
</tr>
<tr>
<td>Jana Brott: Legacy considers it standard work. In all our clinics we ask the screening questions. After we ask about travel, then it cascades to the specific countries. Beginning next month, we built in the travel screenings into the registration process.</td>
</tr>
<tr>
<td>Dennis Drapiza: At Kaiser, we have a similar set up to Salem.</td>
</tr>
<tr>
<td>Dr. Schutte: Asante has similar process to those being described.</td>
</tr>
<tr>
<td>Dr. Guzman-Cottrill: Currently, there is no recommendation to do screening from DRC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question from Dr. Pierce: What information would be helpful to determine when/how travel screening is performed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Koch: As the outbreak started in DRC, the questions have come up like how many pappers should a frontline hospital have and other questions, so we could be ready. Could you put this question on your survey, so we can all learn from each other about the personal protective equipment (PPE) protocols?</td>
</tr>
</tbody>
</table>
### Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

<table>
<thead>
<tr>
<th>TAP assessments: Data report-out and future plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dat Tran</strong></td>
</tr>
<tr>
<td>• <strong>C. difficile</strong> infection (CDI) &amp; CLABSI TAP Assessments update**</td>
</tr>
<tr>
<td>o Facility recruitment</td>
</tr>
<tr>
<td>▪ CDI: All facilities with a cumulative attributable difference (CAD) &gt; 0</td>
</tr>
<tr>
<td>▪ CLABSI: All NICUs (VON)</td>
</tr>
<tr>
<td>o TAP Assessment participation</td>
</tr>
<tr>
<td>▪ CLABSI: Total of 5 facilities</td>
</tr>
<tr>
<td>▪ CDI: Total of 16 facilities</td>
</tr>
<tr>
<td>o Identification of leading and lagging areas</td>
</tr>
<tr>
<td>▪ Process for identifying leading areas</td>
</tr>
<tr>
<td>➢ % Yes: &gt;75%</td>
</tr>
<tr>
<td>➢ Sum of often + always: &gt;75%</td>
</tr>
<tr>
<td>▪ Process for identifying lagging areas</td>
</tr>
<tr>
<td>➢ % unknown: &gt;75%</td>
</tr>
<tr>
<td>➢ Sum of no + unknown: &gt;75%</td>
</tr>
<tr>
<td>➢ Sum of never + rarely + sometimes + unknown: &gt;50%</td>
</tr>
<tr>
<td>o Statewide CDI leading activities</td>
</tr>
<tr>
<td>▪ Leadership involvement in and promotion of CDI prevention activities</td>
</tr>
<tr>
<td>▪ Training for staff on hand hygiene and PPE upon hire</td>
</tr>
<tr>
<td>▪ Contact precautions signage</td>
</tr>
</tbody>
</table>

---

Dr. Guzman-Cottrill: I can send the PPE calculator to Becca and Becca can send it out.

- Dr. Pierce: If you know of any other questions to add to the hospital survey, please let me know.

No action items
<table>
<thead>
<tr>
<th><strong>Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Cleaning of high-touch environmental surfaces upon patient discharge</td>
</tr>
<tr>
<td>o Statewide CDI lagging activities</td>
</tr>
<tr>
<td>▪ Physician/nurse champion</td>
</tr>
<tr>
<td>▪ Staff awareness of antimicrobial stewardship practices</td>
</tr>
<tr>
<td>▪ Intra-/inter-facility transfer communication</td>
</tr>
<tr>
<td>▪ Adherence to use of gown/gloves/hand hygiene (staff and families/visitors)</td>
</tr>
<tr>
<td>▪ Cleaning of high-touch surfaces and shared medical equipment</td>
</tr>
<tr>
<td>o Statewide CLABSI leading activities</td>
</tr>
<tr>
<td>▪ Leadership involvement in and promotion of prevention activities</td>
</tr>
<tr>
<td>▪ Daily assessment and removal of central lines no longer needed and audits of these assessments</td>
</tr>
<tr>
<td>▪ Feedback central line rates and/or SIRs</td>
</tr>
<tr>
<td>▪ Bundled approach to central line insertion</td>
</tr>
<tr>
<td>o Statewide CLABSI lagging activities</td>
</tr>
<tr>
<td>▪ Physician/nurse champion</td>
</tr>
<tr>
<td>▪ Staff person with dedicated time to coordinate prevention activities</td>
</tr>
<tr>
<td>▪ Healthcare personnel empowered to stop non-emergent central line insertion if proper procedures are not followed</td>
</tr>
<tr>
<td>▪ Central line dressing change practices</td>
</tr>
<tr>
<td>o Criteria for facility recruitment in 2019</td>
</tr>
</tbody>
</table>

24
Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

- CAD
- Critical access hospitals
- SIR
- Facilities which have implemented quality improvement (QI) projects and wish to have repeat TAP Assessments

- Question from Zints Beldavs: Is the leading and lagging a standard way this is analyzed?
  - Dr. Tran: We used CDC-defined analysis process

- Question from Alexia Zhang: Any plans to move to other facility types?
  - Dr. Tran: We are piloting LTCF Tap Assessments and will launch soon.

- Comment from Dr. Guzman-Cottrill: I’m not surprised by the lagging activities.
  - Dr. Pierce: There were no major shocks on leading/lagging data. We are encouraging all our facilities to look at the TAP website to identify quality improvement opportunities.
  - Roza Tammer: If you wanted to focus on a provider type or unit type these tools are available online. We use the CAD to identify facilities. We use CAD to identify who may need/want an assessment. We recognize CAD has limitations.

**Discussion: Themes and Topics for Future 2018 Meetings**

- The next meeting will be a webinar for those calling in remotely.

**No action items**
### Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

<table>
<thead>
<tr>
<th>All members</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Comment</strong></td>
<td>No public comment</td>
</tr>
<tr>
<td><strong>Adjourn</strong></td>
<td></td>
</tr>
</tbody>
</table>

Next meeting will be December 11, 2018 1:00 pm - 3:00 pm, at Portland State Office Building, Room 1B

Submitted by: Tara Buehring  
Reviewed by: Roza Tammer  
Rebecca Pierce
Public Health Update
Healthcare-Associated Infections Program

Dat Tran, MD, MS
HAIAC
December 11, 2018
### Outbreaks: 9/1/18 – 12/6/18

<table>
<thead>
<tr>
<th>Etiology</th>
<th>Count</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastroenteritis</strong></td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Norovirus</td>
<td>35</td>
<td>LTCF (30); DCC (3); School (1); Clinic (1)</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>1</td>
<td>LTCF (1)</td>
</tr>
<tr>
<td>Sapovirus</td>
<td>1</td>
<td>LTCF (1)</td>
</tr>
<tr>
<td><em>E. coli</em> (STEC) 0157</td>
<td>1</td>
<td>Other (1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
<td>LTCF (7); School (1); DCC (1); Other (1)</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Pertussis</td>
<td>6</td>
<td>School (6)</td>
</tr>
<tr>
<td>Influenza A</td>
<td>1</td>
<td>LTCF (1)</td>
</tr>
<tr>
<td>RSV</td>
<td>1</td>
<td>LTCF (1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>LTCF (3)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Coxsackievirus</td>
<td>4</td>
<td>School (3); DCC (1)</td>
</tr>
<tr>
<td>Rash</td>
<td>3</td>
<td>School (3)</td>
</tr>
<tr>
<td>CP-CRE (<em>P. aeruginosa</em>)</td>
<td>2</td>
<td>LTCF (1); Hospital (1)</td>
</tr>
<tr>
<td><em>M. abscessus</em></td>
<td>1</td>
<td>Clinic (1)</td>
</tr>
<tr>
<td><em>B. cepacia</em> complex</td>
<td>1</td>
<td>Clinic (1)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>
Healthcare-associated outbreaks

- Healthcare-associated infections account for 70% (49/70) of all outbreaks from Sep 1 through Dec 6
- Majority of healthcare-associated outbreaks occurred in LTCFs (n=45; 64%)
- Most common etiology was norovirus

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Influenza</th>
<th>Other Respiratory</th>
<th>Unknown Respiratory</th>
<th>Norovirus</th>
<th>Other GI</th>
<th>Unknown GI</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>20</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Assisted living facility</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Residential care</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>30</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>45</td>
</tr>
</tbody>
</table>
Shigella flexneri type 3a outbreak

- Wedding in Yamhill County OR 8/11/2018
- ~100/263 wedding attendees reported GI symptoms
- 3 attendees hospitalized with septic shock
Epi curve (all wedding attendees)

198 survey respondents
1st case: overnight after wedding; last case: 5 days later
84/93 (90%) cases: 12-72 hrs
Characteristics

- 107 (54%) of 198 respondents were cases
- Age: mean 37.6 yrs, range 2-93 yrs
- Female: n=60 (56%)
- Symptom profile
  - 91 (85%) fever
  - 51 (48%) vomiting
  - 49 (46%) bloody diarrhea
- Impact
  - 57 (54%) sought health care
  - 10 (9%) hospitalized
  - None died
### Food associated with diarrhea or loose stools

<table>
<thead>
<tr>
<th>Food</th>
<th>Odds ratio</th>
<th>Ill who ate</th>
<th>Attack rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Asparagus</td>
<td>12.44</td>
<td>4.14</td>
<td>37.36</td>
</tr>
<tr>
<td>Potatoes (au gratin)</td>
<td>4.23</td>
<td>1.59</td>
<td>11.22</td>
</tr>
<tr>
<td>Butter</td>
<td>2.90</td>
<td>1.54</td>
<td>5.49</td>
</tr>
<tr>
<td>Bread</td>
<td>3.18</td>
<td>1.49</td>
<td>6.79</td>
</tr>
<tr>
<td>Aioli</td>
<td>2.26</td>
<td>1.21</td>
<td>4.25</td>
</tr>
<tr>
<td>Mushrooms (chicken)</td>
<td>2.90</td>
<td>1.05</td>
<td>8.02</td>
</tr>
</tbody>
</table>
## Food associated with ≥ 3 loose stools in any 24-hr period

<table>
<thead>
<tr>
<th>Food</th>
<th>Odds ratio</th>
<th>Ill who ate</th>
<th>Attack rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Asparagus</td>
<td>16.70</td>
<td>4.86</td>
<td>57.37</td>
</tr>
<tr>
<td>Potatoes (au gratin)</td>
<td>4.01</td>
<td>1.51</td>
<td>10.65</td>
</tr>
<tr>
<td>Butter</td>
<td>2.71</td>
<td>1.44</td>
<td>5.12</td>
</tr>
<tr>
<td>Bread</td>
<td>3.01</td>
<td>1.41</td>
<td>6.41</td>
</tr>
<tr>
<td>Aioli</td>
<td>2.22</td>
<td>1.19</td>
<td>4.15</td>
</tr>
<tr>
<td>Salad</td>
<td>2.00</td>
<td>1.04</td>
<td>3.86</td>
</tr>
</tbody>
</table>
Questions?
NHSN Data: 2016-2017

Roza Tammer, MPH, CIC
Healthcare-Associated Infections Program
HAIAC
December 11, 2018
OHA’s 2017 HAI data

Reportable HAI Data in Oregon

2017 Oregon HAI Facility-Specific Maps and Tables

These online tables and maps show how specific facilities performed in 2017 compared to the U.S. as a whole and to national goals for HAI reduction.

Tips for viewing tables:
- After clicking on the table you would like to view, please select "View Data" in order for all visual elements of these tables to display correctly.
- data.oregon.gov is not supported by versions of Internet Explorer prior to IE11. Please try a different browser if you are unable to view the maps and tables.
- Data for these maps and tables were generated on September 4, 2018.

Supporting Documents:
- 2017 Oregon HAI Data Summary (pdf)
  This document summarizes Oregon's hospitals progress toward national goals for HAI reduction.
- About the Data (pdf)
  This document describes our data presentation and analysis methods for 2017 Oregon HAI data that are available in facility-specific maps and tables.

OHA’s 2017 HAI data – Data Summary

Expanded version of Executive Summary (2015 and 2016 data)
- Acute care hospitals (ACH): Device-Associated and Laboratory-Identified Infections
- Critical access hospitals (CAH): Device-Associated and Laboratory-Identified Infections
- ACH and CAH: Adult Surgical Site Infections

### Health Care-Associated Infection Data Summary 2017

#### Device-Associated and Laboratory-Identified Infections

**Oregon Acute Care Hospitals**

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Infections</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI in neonatal intensive care units (NICUs)</strong></td>
<td>4</td>
<td>Statistically lower than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Met 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower than 2016 Oregon data</td>
</tr>
<tr>
<td><strong>C. difficile infection</strong></td>
<td>748</td>
<td>Statistically lower than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not meet 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower than 2016 Oregon data</td>
</tr>
<tr>
<td><strong>CLABSI in adult and pediatric intensive care units (ICUs)</strong></td>
<td>59</td>
<td>Lower than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not meet 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher than 2016 Oregon data</td>
</tr>
<tr>
<td><strong>CAUTI in adult and pediatric ICUs</strong></td>
<td>108</td>
<td>Higher than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not meet 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher than 2016 Oregon data</td>
</tr>
<tr>
<td><strong>CLABSI in adult and pediatric wards</strong></td>
<td>34</td>
<td>Statistically lower than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not meet 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher than 2016 Oregon data</td>
</tr>
<tr>
<td><strong>CAUTI in adult and pediatric wards</strong></td>
<td>79</td>
<td>Higher than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not meet 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher than 2016 Oregon data</td>
</tr>
<tr>
<td><strong>MRSA BSI</strong></td>
<td>60</td>
<td>Statistically lower than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not meet 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher than 2016 Oregon data</td>
</tr>
<tr>
<td><strong>CAUTI in inpatient rehabilitation facilities</strong></td>
<td>7</td>
<td>Higher than 2015 national baseline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not meet 2020 HHS target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower than 2016 Oregon data</td>
</tr>
</tbody>
</table>

**LEGEND**

- ▼ Statistically fewer infections
- ◀ Fewer infections (not statistically significant)
- ▲ Statistically more infections
- ▶ More infections (not statistically significant)
- ✔ Met 2020 HHS target
- ✗ Did not meet 2020 HHS target
Health Care-Associated Infection Data Summary 2017
Device-Associated and Laboratory-Identified Infections

Oregon Critical Access Hospitals

CLABSI in adult and pediatric intensive care units (ICUs)*
Central line-associated bloodstream infections

0 INFECTIONS

Oregon hospitals
- Not enough data to compare to 2015 national baseline, 2020 HHS target, or 2016 Oregon data

C. difficile infection¹
Hospital-onset Clostridioides difficile (C. difficile) infections

22 INFECTIONS

Oregon hospitals
- Lower than 2015 national baseline
- Did not meet 2020 HHS target
- Lower than 2016 Oregon data

CLABSI in adult and pediatric wards*:
Central line-associated bloodstream infections

1 INFECTION

Oregon hospitals
- Not enough data to compare to 2015 national baseline, 2020 HHS target, or 2016 Oregon data

CAUTI in adult and pediatric ICUs⁶
Catheter-associated urinary tract infections

1 INFECTION

Oregon hospitals
- Lower than 2015 national baseline
- Met 2020 HHS target
- Higher than 2016 Oregon data

MRSA BSI³
Hospital-onset methicillin-resistant Staphylococcus aureus bloodstream infections

1 INFECTION

Oregon hospitals
- Lower than 2015 national baseline
- Did not meet 2020 HHS target
- Lower than 2016 Oregon data

CAUTI in adult and pediatric wards⁶
Catheter-associated urinary tract infections

6 INFECTIONS

Oregon hospitals
- Lower than 2015 national baseline
- Met 2020 HHS target
- Lower than 2016 Oregon data

LEGEND

▲ Statistical fewer infections
▼ Fewer infections (not statistically significant)
▲ Statistical more infections
▲ More infections (not statistically significant)
✔ Met 2020 HHS target
☒ Did not meet 2020 HHS target
# Health Care-Associated Infection Data Summary 2017

## Adult Surgical Site Infections (SSIs)

### Oregon Critical Access & Acute Care Hospitals

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Infections</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary artery bypass graft (heart) surgeries</td>
<td>5</td>
<td><strong>Statistically lower than 2015 national baseline</strong>&lt;br&gt;Met 2020 HHS target&lt;br&gt;Lower than 2016 Oregon data</td>
</tr>
<tr>
<td>Abdominal hysterectomy surgeries</td>
<td>21</td>
<td><strong>Higher than 2015 national baseline</strong>&lt;br&gt;Did not meet 2020 HHS target&lt;br&gt;Higher than 2016 Oregon data</td>
</tr>
<tr>
<td>Laminectomy (back) surgeries</td>
<td>9</td>
<td><strong>Statistically lower than 2015 national baseline</strong>&lt;br&gt;Met 2020 HHS target&lt;br&gt;Lower than 2016 Oregon data</td>
</tr>
<tr>
<td>Hip replacement surgeries</td>
<td>55</td>
<td><strong>Higher than 2015 national baseline</strong>&lt;br&gt;Did not meet 2020 HHS target&lt;br&gt;Lower than 2016 Oregon data</td>
</tr>
<tr>
<td>Colon surgeries</td>
<td>79</td>
<td><strong>Statistically lower than 2015 national baseline</strong>&lt;br&gt;Did not meet 2020 HHS target&lt;br&gt;Higher than 2016 Oregon data</td>
</tr>
<tr>
<td>Knee replacement surgeries</td>
<td>48</td>
<td><strong>Statistically higher than 2015 national baseline</strong>&lt;br&gt;Did not meet 2020 HHS target&lt;br&gt;Higher than 2016 Oregon data</td>
</tr>
</tbody>
</table>

### LEGEND

- ▼ Statistically fewer infections
- ▼ Fewer infections (not statistically significant)
- ▲ Statistically more infections
- ▲ More infections (not statistically significant)
- ✔ Met 2020 HHS target
- ✗ Did not meet 2020 HHS target

---

**Oregon Health Authority**
OHA’s 2017 HAI data – About the Data

• New document accompanying OHA’s 2017 facility-specific and statewide HAI data
  Includes:
  • Background
  • Methods
  • Data Presentation and Usage
  • Data Interpretation
    • Standardized infection ratio (SIR)
    • Benchmarks
    • Table elements
  • Prevention Activities
  • Acknowledgments
  • References

OHA’s 2017 HAI data – Tables and maps

• Similar to prior tables and maps (2015 and 2016 data)
  • Display overall statewide and facility-specific data for 2017
  • Interactive web-based tables and maps – can filter and sort
  • Stratified by facility type for CLABSIs, CAUTIs, MRSA BSIs and CDIs
  • Stratified by patient age (adult/pediatric) for SSIs


Tables, maps, executive summaries and reports for prior years are available online under “Archived Data”

## OHA’s 2017 HAI data – Tables

### 2017 Catheter-Associated Urinary Tract Infections (CAUTI) Table – Acute Care Hospitals

Oregon hospitals report CAUTIs from adult and pediatric intensive care units, and adult and pediatric medical, surgical, medical/surgical, and inpatient rehabilitation wards as part of Oregon’s mandatory healthcare-associated infections reporting program. For information regarding standardized infection

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Hospital Location</th>
<th>Catheter Days</th>
<th>Observed Infections</th>
<th>Predicted Infections</th>
<th>SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All Oregon</td>
<td>All Adult/Ped ICUs &amp; M/S/M/S Wards Combined*</td>
<td>171,204</td>
<td>187</td>
<td>173.8</td>
<td>1.076</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Cardiac ICUs</td>
<td>3,715</td>
<td>3</td>
<td>5.94</td>
<td>0.505</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Cardiothoracic ICUs</td>
<td>8,563</td>
<td>7</td>
<td>8.46</td>
<td>0.827</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Medical ICUs</td>
<td>5,040</td>
<td>2</td>
<td>5.6</td>
<td>0.357</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Medical/Surgical ICUs</td>
<td>53,093</td>
<td>63</td>
<td>51.08</td>
<td>1.233</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Pediatric Medical/Surgical ICUs</td>
<td>1,764</td>
<td>1</td>
<td>3.02</td>
<td>0.331</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Neurosurgical ICUs</td>
<td>3,665</td>
<td>19</td>
<td>12.07</td>
<td>1.574</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Surgical ICUs</td>
<td>9,103</td>
<td>13</td>
<td>13.71</td>
<td>0.949</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Medical Wards</td>
<td>25,187</td>
<td>20</td>
<td>25.18</td>
<td>0.794</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Medical/Surgical Wards</td>
<td>24,170</td>
<td>23</td>
<td>19.45</td>
<td>1.183</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Pediatric Medical/Surgical Wards</td>
<td>1,067</td>
<td>2</td>
<td>0.76</td>
<td>*</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Pediatric Medical Wards</td>
<td>760</td>
<td>0</td>
<td>0.61</td>
<td>*</td>
</tr>
<tr>
<td>1. All Oregon</td>
<td>Adult Surgical Wards</td>
<td>32,137</td>
<td>34</td>
<td>27.93</td>
<td>1.217</td>
</tr>
</tbody>
</table>
OHA’s 2017 HAI data – Maps

2017 Catheter-Associated Urinary Tract Infections (CAUTI) in Adult and Pediatric Intensive Care Units (ICU) and Mixed Units (M/SM) Wards

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Hospital Location</th>
<th>Catheter Days</th>
<th>Observed Infections</th>
<th>Predicted Infections</th>
<th>SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Oregon</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>171,034</td>
<td>187</td>
<td>173.8</td>
<td>1.076</td>
</tr>
<tr>
<td>Advocate Medical Center</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>4,394</td>
<td>1</td>
<td>3.11</td>
<td>0.322</td>
</tr>
<tr>
<td>Asante Rogue Regional Medical Center</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>7,201</td>
<td>9</td>
<td>7.14</td>
<td>1.250</td>
</tr>
<tr>
<td>Asante Three Rivers Medical Center</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>4,130</td>
<td>6</td>
<td>4.24</td>
<td>1.415</td>
</tr>
<tr>
<td>Ashland Community Hospital</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>729</td>
<td>1</td>
<td>0.37</td>
<td>0.46</td>
</tr>
<tr>
<td>Bay Area Hospital</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>3,470</td>
<td>2</td>
<td>2.46</td>
<td>0.814</td>
</tr>
<tr>
<td>Good Samaritan Regional Medical Center</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>4,250</td>
<td>5</td>
<td>4.27</td>
<td>1.170</td>
</tr>
<tr>
<td>Kaiser Permanente Sunnyside Medical C...</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>8,523</td>
<td>9</td>
<td>8.34</td>
<td>1.079</td>
</tr>
<tr>
<td>Kaiser Permanente Westside Medical C...</td>
<td>All Adult/Ped ICUs &amp; M/SM Wards Combined*</td>
<td>3,721</td>
<td>3</td>
<td>2.77</td>
<td>1.082</td>
</tr>
</tbody>
</table>
CDC’s 2016 National and State HAI Progress Report

https://www.cdc.gov/hai/data/portal/progress-report.html

<table>
<thead>
<tr>
<th>Acute Care Hospitals (ACHs)</th>
<th>Inpatient Rehabilitation Facilities (IRFs)</th>
<th>Long-Term Acute Care Hospitals (LTACHs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CLABSI</td>
<td>• CLABSI</td>
<td>• CLABSI</td>
</tr>
<tr>
<td>• CAUTI</td>
<td>• CAUTI</td>
<td>• CAUTI</td>
</tr>
<tr>
<td>• Total VAE, including VAC, IVAC, and pVAP (IVAC-plus)</td>
<td>• C. difficile</td>
<td>• Total VAE, including VAC, IVAC, and pVAP (IVAC-plus)</td>
</tr>
<tr>
<td>• SSI*</td>
<td>• MRSA bacteremia</td>
<td>• C. difficile</td>
</tr>
<tr>
<td>• C. difficile</td>
<td></td>
<td>• MRSA bacteremia</td>
</tr>
<tr>
<td>• MRSA bacteremia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*National SSI data includes 39 inpatient surgical procedure categories reported to NHSN.

Includes: Executive Summary, 2016 HAI Progress Report; Data Tables; Technical Appendix; References; Acknowledgments; Glossary
Nationally, among acute care hospitals, the highlights in this report include:

- About 11% decrease in CLABSI between 2015 and 2016
- About 7% decrease in CAUTI between 2015 and 2016
- About 2% decrease in VAE between 2015 and 2016
- About 6% decrease in SSI related to the 10 select procedures tracked in the report between 2015 and 2016
  - The 10 select procedures are Surgical Care Improvement Project (SCIP) procedures. For a list of the SCIP procedures, please see: https://health.gov/hcq/pdfs/ssi2012.pdf (PDF - 2 pages)
- About 13% decrease in abdominal hysterectomy SSIs
- About 7% decrease in colon surgery SSIs
- About 7% decrease in MRSA bacteremia between 2015 and 2016
- About 8% decrease in *C. difficile* infections between 2015 and 2016
CDC’s 2016 National and State HAI Progress Report

HAI data available in interactive report card format

https://gis.cdc.gov/grasp/PSA/HAIreport.html
CDC’s 2016 National and State HAI Progress Report

Select your healthcare-associated infection (HAI) data for various healthcare settings.

Oregon Data for Acute Care Hospitals, Year 2016

- **CLABSI**
  - Lower compared to Nat'l baseline
  - **-32%**
  - Oregon hospitals reported no significant change in CLABSI between 2015 and 2016
  - Among the 25 hospitals in Oregon with enough data to calculate an SIR, 0% had an SIR significantly higher (worse) than 0.89, the value of the national SIR.

- **CAUTI**
  - No change compared to Nat'l baseline
  - **11%**
  - Oregon hospitals reported no significant change in CAUTI between 2015 and 2016
  - Among the 28 hospitals in Oregon with enough data to calculate an SIR, 11% had an SIR significantly higher (worse) than 0.93, the value of the national SIR.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**
When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS**
When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.
• About 11% decrease in central line-associated bloodstream infections (CLABSIs) nationally
  Oregon: 32% decrease (statistically significant)

• About 7% decrease in catheter-associated urinary tract infections (CAUTIs) nationally
  Oregon: 11% increase (not statistically significant)

• About 2% decrease in ventilator-associated events (VAEs) nationally
  Oregon: 0% change (not statistically significant)

• About 13% decrease in abdominal hysterectomy surgical site infections (SSIs) nationally
  Oregon: 44% decrease (statistically significant)

• About 7% decrease in colon surgery SSIs nationally
  Oregon: 30% decrease (statistically significant)

• About 7% decrease in methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia nationally
  Oregon: 36% decrease (statistically significant)

• About 8% decrease in *Clostridioides difficile* (*C. difficile*) infections nationally
  Oregon: 6% increase (not statistically significant)
CDC’s 2016 National and State HAI Progress Report – Oregon IRF data

**CAUTI**
- 21%
- No change compared to nat'l baseline
- Oregon IRFs reported no significant change in CAUTIs between 2015 and 2016
- Not enough data to report how many IRF had an SIR significantly higher (worse) than 1.07, the value of the national SIR.

**C. difficile Events**
- -81%
- Lower compared to nat'l baseline
- Oregon IRFs reported no significant change in C. difficile between 2015 and 2016
- Not enough data to report how many IRF had an SIR significantly higher (worse) than 0.96, the value of the national SIR.

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS**
When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

**LABORATORY IDENTIFIED HOSPITAL-ONSET C. DIFFICILE EVENTS**
When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridioides difficile* (C. difficile), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**LTACH:** Not enough Oregon data to assess performance
**CAH:** Not published
Exemptions to OHA reporting

- Reminder: Exemptions to OHA reporting for CLABSI and SSI not available starting with data reported to NHSN for 2019
  - Oregon hospitals will be required to perform surveillance for and report CLABSI and SSI to OHA for applicable procedures (SSI) or locations (CLABSI) regardless of the number of procedures or central line days observed annually
  - Facilities without applicable location types for CLABSI or that do not perform relevant procedures will not be required to report these data

- The HAI Program has two recorded webinars and will offer technical assistance to any facilities needing help
  - CLABSI webinar: August 29, 2018
  - SSI webinar: September 25, 2018

Questions and discussion

Roza Tammer, MPH, CIC
Healthcare-Associated Infections (HAI) Reporting Epidemiologist
Public Health Division
Acute & Communicable Disease Prevention
Healthcare-Associated Infections Program
Direct phone: 971-673-1074
roza.p.tammer@state.or.us
Injection Safety and Needle Use in Jackson County, Oregon

Roza Tammer, MPH, CIC
Healthcare-Associated Infections Reporting Epidemiologist

Healthcare-Associated Infections Advisory Committee
December 11, 2018
Background

• 2015: Oregon Public Health Division (OPHD) investigated a prolotherapy clinic after a case of acute hepatitis C was linked to injections at an affiliated California clinic
• Though no cases identified in Oregon residents, investigation revealed incomplete understanding of injection and needle use practices in alternative care settings
• Funding from CDC’s One and Only Campaign
• Survey developed for providers, businesses, and facilities providing health-related services
• Project goals:
  1. Assess needle use and injection practices
  2. Develop resources for healthcare facilities
  3. Engage healthcare personnel in educational activities

Note that results are preliminary and subject to change
Background

- Perception
  - Injection safety is a fundamental skill that HCP should already be well-versed in
  - More education is unnecessary

- Reality
  - Delivery injectable treatments/medications involve complex competencies requiring multiple skills
  - Simple slip-ups or misunderstandings can cause serious harm
    - Patient morbidity and mortality
    - Repercussions for healthcare facilities, providers, systems
  - Survey data show HCP self-report observing unsafe injection practices in their own facilities
  - Outbreak investigations confirm these practices occur

Note that results are preliminary and subject to change
Project progress

- **Completed**
  - Survey developed, piloted, finalized
  - Toolkit developed
  - Distribution list prepared
  - Survey distribution
  - Data collection, analysis, and report preparation
  - Round 2 distribution list prepared
- **In progress**
  - Round 2 of survey distribution
- **Next steps**
  - Additional data collection, analysis, and report preparation
  - Data sharing

Note that results are preliminary and subject to change
Survey recruitment

The Oregon Health Authority is surveying all facilities and businesses in your area that provide health-related services.

- Goal: to understand needle use and injection practices performed in your area to inform educational activities.
- Those completing the survey should be familiar with needle use and injection practices (such as a nurse manager or primary administrator). You may not personally be involved in these tasks, but your responses should reflect the overall practices of the business/facility.
- This survey is non-regulatory.

48 questions on facility demographics, types of services/providers; procedures/practices regarding injection and needle-based care, education, and communications

Note that results are preliminary and subject to change
Toolkit Contents

For the Public
- What to know about receiving healthcare involving needles
- At-home injections and needle use

For Health Professionals
- Guidelines and Recommendations
- Aseptic Technique
- Needle Safety
- Medication and Treatment Management
- Diabetes Care
- Reports of Disease Transmission
- Specialty Specific Resources
- Additional Resources
- References

Feedback
- We want to hear from you! Let us know what you think about this toolkit by completing this quick feedback form.
Data analysis

- N=73 responses; 70 included enough data to include in the analysis
  - All excluded facilities reported not providing services involving needles or injections
- Analysis was performed using Fisher’s Exact Test in SAS Version 9.4
- Missing responses were not included in analysis
- Due to small quantity of acupuncture data, only inpatient versus outpatient practices were statistically assessed

<table>
<thead>
<tr>
<th>Business/facility type (non-acupuncture)</th>
<th>Acupuncture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Outpatient</td>
</tr>
<tr>
<td>21.4% (n=15)</td>
<td>70% (n=49)</td>
</tr>
<tr>
<td>8.6% (n=6)</td>
<td></td>
</tr>
</tbody>
</table>

Note that results are preliminary and subject to change.
Facility/business type

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental clinic</td>
<td>16.3% (n=8)</td>
</tr>
<tr>
<td>Hospital</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Long-term care (such as nursing home, assisted living facility, or skilled nursing facility)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Primary care clinic</td>
<td>36.7% (n=12)</td>
</tr>
<tr>
<td>Specialty clinic</td>
<td>20.4% (n=10)</td>
</tr>
<tr>
<td>Urgent care clinic</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Wellness center</td>
<td>2.0% (n=1)</td>
</tr>
<tr>
<td>Other</td>
<td>36.7% (n=18)</td>
</tr>
<tr>
<td>Missing</td>
<td>0% (n=0)</td>
</tr>
</tbody>
</table>

- Nearly all inpatient settings part of larger hospital/health system, versus 1/4 outpatient and 1/6 acupuncture
- Inpatient facilities were largely hospitals (n=13)

Note that results are preliminary and subject to change
Provider and service types

- Licensed provider types and types of needle-based or injection services provided were diverse.
- Common provider types included CNA, DO, LPN, MD, NP, PA, RN, and LaC.
- Common service types included biopsy, blood draw/phlebotomy, chemotherapy, CT and MRI scans, dialysis, endoscopy, injection, intravenous infusion, pain management, point-of-care testing involving fingerstick, specimen collection from sterile body site, surgery, transfusion, and acupuncture.

Note that results are preliminary and subject to change.
Injectable medications/treatments

- Majority of respondents reported administering injectable medications/treatments, including all inpatient settings. ~10% of outpatient settings and >50% of acupuncture settings did not
- Mean number of patients/clients who receive at least one injection of any type per day
  - Outpatient: 14.7; acupuncture 52.0; inpatient: 72.0
- Medications/treatments commonly administered by injection or infusion included antibiotics, fluids, anesthesia, pain medications, sedatives, insulin, anticoagulants, vaccines, antipsychotics, opiate antagonists, steroids, birth control, TB serum, sedatives, vitamins, and hormones

Note that results are preliminary and subject to change
### Practice duties by HCP type: Inpatient versus outpatient

<table>
<thead>
<tr>
<th>Duty</th>
<th>Nurse</th>
<th>Physician, PA, NP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mix/reconstitute medications/treatments for injection</td>
<td>Inpatient facilities more likely*</td>
<td>Inpatient facilities more likely</td>
<td>Inpatient facilities more likely*</td>
</tr>
<tr>
<td>Draws up injectable medications/treatments into syringes or adds medications to infusion bags</td>
<td>Inpatient facilities more likely*</td>
<td>Inpatient facilities more likely</td>
<td>Inpatient facilities more likely*</td>
</tr>
<tr>
<td>Administers injections</td>
<td>Inpatient facilities more likely*</td>
<td>Inpatient facilities more likely</td>
<td>Outpatient more likely*</td>
</tr>
<tr>
<td>Administers the majority of injections</td>
<td>Inpatient facilities more likely*</td>
<td>Inpatient and outpatient similar</td>
<td>Inpatient and outpatient similar</td>
</tr>
<tr>
<td>Inserts peripheral intravenous catheters</td>
<td>Inpatient facilities more likely*</td>
<td>Inpatient facilities more likely</td>
<td>Inpatient and outpatient similar</td>
</tr>
</tbody>
</table>

Other: Dental hygienists, dentists, medical assistants, pharmacists, and others

*Statistically significant result

Note that results are preliminary and subject to change
Other procedures and practices

<table>
<thead>
<tr>
<th></th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety syringe use*</td>
<td>80%</td>
<td>45%</td>
</tr>
<tr>
<td>Injections involving blood/body fluids</td>
<td>53%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Most commonly, facilities reported injecting medications/treatments intramuscularly, intravenously, and subcutaneously

*Statistically significant result

Note that results are preliminary and subject to change
Compounded medications

- Administer compounded medications
  - Inpatient: 33%; Outpatient: 22%; Acupuncture: 17%
  - Facilities both compound their own medications and obtain them from an outside source

Note that results are preliminary and subject to change
Medication administration

• Injectable medications/treatments mixed/reconstituted less than an hour before administration
  – Inpatient: 75%; Outpatient 60%; Acupuncture: 17%
  – Not statistically significant

• Injectable medications/treatments drawn up or added to bags less than an hour before administration
  – Inpatient 75%; Outpatient 90%; Acupuncture 17%
  – Not statistically significant

• 2-step process for checking injectable medications/treatments
  – Inpatient 67%; Outpatient 37%; Acupuncture 0%
  – Not statistically significant

Note that results are preliminary and subject to change
Medication administration

- Facilities received medications packaged in a variety of ways, including infusion bags, manufactured prefilled syringes, multi-dose vials, and single-dose vials.
- Both inpatient and outpatient facilities most commonly reported “never” using vials of medication on more than one patient.
  - Outpatient facilities were statistically significantly more likely to “ever” do so than inpatient facilities.
  - Examples of this practice were drawing doses of medication/treatment (e.g. local anesthetic, vaccine) from a multi-dose vial.
- Most inpatient facilities administer anesthesia; most outpatient facilities do not.
  - Inpatient facilities administer anesthesia at a variety of levels; outpatient facilities reported only local or combined local/general.

Note that results are preliminary and subject to change.
Needle-based services

• Provide care using needle that does not involve injection
  – Inpatient 7%; Outpatient 2%; Acupuncture 50%
• Alcohol most common form of skin prep; chlorhexidine and betadine also popular options
• Descriptions of sharps disposal and environmental cleaning did not differ by setting type

Note that results are preliminary and subject to change
Education

• Most inpatient and outpatient facilities reported their business/facility providing education on needle use/injection practices once per year; most acupuncture settings reported this never occurred

• Facilities mentioned a wide variety of topics and types of educational materials would be useful

• Facility/business provides training/education about drug diversion
  – Inpatient 47%; Outpatient 22%; Acupuncture 0%
  – Not statistically significant

• Facility/business offers assistance to staff with substance use issues
  – Inpatient 67%; Outpatient 29%; Acupuncture 0%
  – Inpatient statistically significantly higher

Note that results are preliminary and subject to change
## Education: Useful topics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Acupuncture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aseptic technique</td>
<td>33%</td>
<td>27%</td>
<td>17%</td>
</tr>
<tr>
<td>Blood glucose monitoring and insulin administration</td>
<td>33%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Injection and needle safety and disease transmission, including outbreaks</td>
<td>47%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Medication/treatment management and storage</td>
<td>47%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Medication/treatment administration</td>
<td>47%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Medication/treatment preparation</td>
<td>47%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Medication vial use</td>
<td>33%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Medication compounding</td>
<td>20%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Needlestick injury</td>
<td>47%</td>
<td>41%</td>
<td>33%</td>
</tr>
<tr>
<td>Waste disposal</td>
<td>40%</td>
<td>14%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Note that results are preliminary and subject to change
Situational awareness

• Facilities receive general information about clusters of disease, outbreaks, or injection/needle related patient/client notifications
  – Inpatient 67%; Outpatient 41%; Acupuncture 0%
  – Not statistically significant

• Information about needle use and injection practices also came from a variety of sources at work (e.g., training and messaging) and external sources (e.g., manufacturer instructions, local/state/federal agencies, drug and equipment manufacturers, journals and textbooks, and professional societies)

Note that results are preliminary and subject to change
Next steps

- **Injection Safety and Needle Use Toolkit**
  - 586 total views and 444 unique views since May 2018
  - Continuing to expand to include new information and resources
  - Plan to review and update on a recurring basis
  - No feedback from evaluation so far

- **Training**
  - New materials
  - New approaches
  - Continue to provide in-person and remote education/training

- **Second round of letters for additional data collection in progress**

Note that results are preliminary and subject to change
Partner with the HAI Program to promote safe injections and needle use in Oregon

• Sign up to join Oregon’s One & Only Campaign
  – Get periodic updates, news, and helpful resources from OHA regarding safe injection practice and needle use
  – Help get the word out by distributing educational materials to your colleagues and staff
  – 31 members and counting – all are welcome to join

• Use and evaluate the toolkit
  – Evaluation: https://www.surveymonkey.com/r/QLPN728

Note that results are preliminary and subject to change
Questions & discussion

- Priorities for education, outreach, and engagement
- How to ensure toolkit makes it into the right hands
- Other thoughts on using these data?

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Healthcare-Associated Infections (HAI) Reporting Epidemiologist
Direct phone: 971-673-1074
roza.p.tammer@state.or.us
Marquis Silver Gardens
FLU VACCINATION PROGRAM
Introduction

Kirstin King, RN and Director of Nursing Services at Marquis Silver Gardens in Silverton, OR
Employee FLU Vaccination Statistics at Marquis Silver Gardens

- 2016 staff FLU vaccine 67%
- 2017 staff FLU vaccine 98%
- 2018 staff FLU vaccine 100%
Masking Policy

This facility is dedicated to the protection of influenza for our residents, staff, volunteers, and visitors. Influenza vaccination is the most important measure to prevent seasonal influenza infection per the CDC. **It is the policy of this facility that any employee who declines Influenza vaccination will be required to wear a surgical mask during the Influenza season November 1st- April 30th.**
All staff required masking
Flu Vaccine Myths vs Facts

• Myth: “The flu shot doesn’t work”

• Myth: “The flu shot will make me sick”

• Myth: “Getting the vaccine is all you need to protect yourself”

Influenza Vaccine Myth vs Fact

- Vaccines do not cause the flu; it is inactivated. The vaccine viruses that have been "inactivated" and are therefore not infectious, or with no flu vaccine virus at all (which is the case for recombinant vaccines). The most common side effects from the influenza shot are pain, redness, tenderness or swelling where the shot was given, and fever, headache and muscle aches also may occur.
- Influenza vaccine takes 14 days to build the immune response. While developing the immune response you may generally not feel good, this is not the flu.
- Did you get sick from the flu? NO, you probably were exposed before you had immunity.
- Myth: You can’t spread the flu if you aren't sick – truth is you are contagious 1-4 days before having the symptoms, then up to 7 days after becoming sick.
- Myth: You don’t need a flu shot every year – truth is it is the flu virus that changes each year, the vaccine gives immunity for that year’s most likely strains.
- Myth: You can catch the flu from being in the cold and wet – truth is influenza occurs during cold weather season, but you only get it if being exposed to the virus.
- I can take antibiotics to get better if I get the flu – Truth is antibiotics are for bacteria, not viruses.
- Vaccines cause autism – study in 1998 by Dr. Andrew Wakefield in Lancet. No statistical basis, no control group, relied on memories of patients.
- Follow up studies:
  - 1999: 530 children – no link!
  - 2001: 18,000 children – no link!
  - 2002: 46,000 children – no link!
  - 2004: Lancet retracts Dr. Wakefield’s findings “Falsified Facts”
  - 2005: 10 million children in 22 studies – no link!
  - 2012: 14 million children, 27 cohort, 50 self-controlled, 3 time series trials, 1 case cross over study – no link!
  - Dr. Andrew Wakefield had his license to practice medicine revoked due to falsifying facts of his own study.
- Getting the vaccine is all you need to protect yourself - Truth is hand hygiene often, respiratory etiquette, avoid touching eyes/mouth, stay away from sick people (except at work or school), and getting vaccinated.
- I am allergic to eggs; I can’t get the flu vaccine.” Speak with your medical provider; unless you have severe reaction to egg, you are eligible to get the flu vaccine. History of severe reaction; vaccine administered in medical setting, parent or outpatient.
- Fact: Vaccinated healthcare workers reduce risk of transmitting influenza to their patients. It is estimated that between 75 percent and 90 percent of seasonal flu-related deaths have occurred in people 65 years and older. It is estimated that between 50 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people 65 years and older.
- Fact: CDC (Center for Disease Control) recommends influenza vaccination for all health care personnel to reduce the spread of influenza, especially to vulnerable populations.
- Myth: “The flu shot doesn’t work.” Fact: In scientific studies, the effectiveness of the vaccine ranges from 30 to 60 percent, depending on how well the circulating strains matched those in the vaccine. In populations in which the vaccine is less effective in preventing influenza, such as the elderly, the vaccine reduces the severity of the disease and the incidence of complications by 50 to 60 percent and the incidence of death by approximately 60 percent. Being vaccinated is the most effective way to protect against influenza and its serious outcomes.
- Fact: You can take influenza home to your family and friends.
Flu Information and Staff Prevention

Flu & Cold Prevention

Cover your mouth
Get a Flu Shot
If you aren't feeling well, stay at home.
Wash Your Hands

If you have Flu Symptoms:
Rest and Drink fluids

If You: Are unable to drink enough fluids. Or Feel better, then get a fever again. Then Call the Student Health Center or a Health Care Provider.

If You: Are short of breath or wheezing. Cough up blood. Have pain in the chest when breathing. Have heart disease and have chest pain. Or Are unable to walk or sit up, or function normally. Then CALL 911 Or Go RIGHT AWAY for Medical Care!
Quantity and Location of Hand Sanitizers

- Soap dispenser and sanitizer in each patient room
- 19 throughout hallways
- 2 in each dining room
- 1 in every staff office
- 1 of each dining cart
- 1 sanitizer outside main entrance of building
- Visitor station
House MD incentives for staff participation

FLU VACCINE

October 10th 2018
(Following all staff meeting)

When you receive the FLU vaccine you will place a sticker on your badge

We have incentives! House MD is contributing $$$$$$$$$$$$$$$

Benefits to Employees:

❖ 80% staff participation - $100 Visa
❖ 90% staff participation – (2) $100 Visa
gift card raffle
Promoting FLU Vaccine

Kirstin King, RN
Director of Nursing Services

Got my Flu shot for US!
Questions?

Additional resources:
CDC Vaccines
http://www.cdc.gov/vaccinesafety/Vaccines/Index1.html
CDC—Vaccine safety: addressing common concerns
http://www.cdc.gov/vaccinesafety/Concerns/Index.html
NFID—Adolescent vaccination
http://www.adolescentvaccination.org/
NFID—Adult vaccination http://www.adultvaccination.org/
National Public Health Information Coalition—National Immunization Awareness Month http://www.nphic.org/niam
Immunization Action Coalition—http://www.immunize.org/
Holgate Community
2018-2019 Influenza Vaccination & Masking Program
DeAnza & Michele
2018-2019 Flu Season Task

1. Masking Policy
2. Declination Form - Employees
3. Order Vaccine - placed order 8/21 (OE)
4. Syringes & needles ordered - 9/18
5. Stickers? QAPI
6. VIS Alternate Language (Staff)
7. Flu Clinics: Oct 9, 22, Nov 12
8. Resident Vaccine: Oct 22
9. OFH Pas Vaccine: 10/24 & Jessica
10. Lea from OFH incoming to 9/21 000
11. KPP - 10/5 - DeAnza
12. Special individual re: screening for < Vacc rate for specific department>
WE NEVER STOP TALKING ABOUT FLU VACCINATION RATES AND THAT THE VACCINE IS STILL AVAILABLE!!
Lessons Learned

- Next year we will not wait 2 weeks after vaccinating staff to vaccinate our residents. It will all be done at the same time.
- Don’t waste your money on fancy “FLU STICKERS” for badges buy smiley faces or gold stars.....
- Our Masking Policy WORKS! When we had a flu outbreak and initiated our “mask on” policy... our rates of vaccination increased by about 22%
- Stay in close contact with your flu vaccine vendor! We faxed our order and followed up with multiple phone calls to make sure that they received our order.
- Unrelated fact....... We found out how many employees had either lost their badge or just weren't wearing their employee badge.
**Masking Policy**

- IF you did not get the vaccine you must wear a mask. No exceptions!
- This includes contracted staff, students, instructors and volunteers.
- Time lapse from vaccine to masking
- Spot checks