

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

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

PSOB – Room 1B
800 NE Oregon St.
Portland, OR 97232

Agenda, materials, minutes, recordings, and transcriptions for meetings are available at:
<http://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Meetings.aspx>.

**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)

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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

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- 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

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- 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.

Item	Discussion	Action Item
Call to Order and Roll Call Genevieve Buser, Providence Portland (Chair)	50 percent of members present.	No action items
Introductions and Membership Updates Tara Buehring, Oregon Health Authority	<ul style="list-style-type: none"> • Two current vacancies: Consumer Representative and Health Insurer Representative • Audio issues <ul style="list-style-type: none"> ○ We will begin using microphones to help people hear across the room and on the phone 	No action items

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Approve June 2018 Minutes All Committee Members	June 2018 meeting minutes were approved.	No action items
Outbreaks update 2017 Alexia Zhang, Oregon Health Authority	<ul style="list-style-type: none"> • 61 outbreaks were reported since 06/01/2018 • Of the 61 outbreaks, 27 (44.2%) occurred in a healthcare facility <ul style="list-style-type: none"> ○ Outbreaks occurred most often in assisted living facilities (92.3%, n=24) ○ Most common etiology in healthcare facilities was norovirus (62.5%, n=16) • Question from Dr. Buser: Was measles outbreak healthcare-associated? <ul style="list-style-type: none"> ○ Alexia Zhang: No. 	No action items
Using NHSN for facility benchmarking Julie Koch, Salem Health; Molly Hale, OHSU; Jana Brott, Legacy Health	<ul style="list-style-type: none"> • Julie Koch presents: Use of Infection Data at Salem Health Hospitals and clinics <ul style="list-style-type: none"> ○ Fiscal year is July to July; halfway through the year, reflect on last 6 months of accomplishments and determine focus for next fiscal year. ○ Elevated infections identified during review of National Healthcare Safety Network (NHSN) data inform focus. ○ The organization decides to focus on a particular area of infection and starts at the approval of the board level. ○ Quality and Safety Baby A3: We see hospital-onset <i>Clostridioides difficile</i> in this graph in raw numbers. We 	No action items

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	<p>also depict days of therapy for specific antibiotics. This gave us the data to drive actions.</p> <ul style="list-style-type: none"> ○ We carefully plan how we use our NHSN data. ○ We also use NHSN data for payer scorecards. This data helps set targets that they'd like to see. <ul style="list-style-type: none"> ▪ 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. ○ We also use the infection metrics for leadership incentive payments. <ul style="list-style-type: none"> ▪ 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. ○ We do run everything off NHSN; we have baseline SIRs, different for all the metrics. <ul style="list-style-type: none"> ▪ We think of them as the ten-required metrics, including the catheter-associated urinary tract infection (CAUTI), central-line associated blood stream infection (CLABSI), SSI, <i>C. difficile</i>, 	
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	<p>methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), et cetera.</p> <ul style="list-style-type: none"> ▪ 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 <i>C. difficile</i>, MRSA, and SIRs. <ul style="list-style-type: none"> ○ I was asked to use NHSN data to predict what a 5 percent decrease would look like in CAUTI, CLABSI, <i>C. difficile</i>, 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: <ul style="list-style-type: none"> ▪ Data definitions are important, and should accompany all metrics ▪ Use appropriate calculations; when in doubt, ask for help ▪ Keep leadership informed <ul style="list-style-type: none"> ➤ Survey changes 	
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	<ul style="list-style-type: none"> ➤ Re-baselines ➤ NHSN adjustments <ul style="list-style-type: none"> ▪ Validate data ○ Question from Dr. Buser: Did you get an average of what all the payers were asking? <ul style="list-style-type: none"> ▪ Julie Koch: No, each payer asked for very different things. • Molly Hale presents: NHSN Analysis and Facility Benchmarking at Oregon Health & Science University (OHSU) <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ▪ 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 CLABSI and CAUTI in the adult population. <ul style="list-style-type: none"> ▪ Pediatrics do not factor into it, nor do our specialty units. 	
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	<ul style="list-style-type: none">▪ 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 <i>C. difficile</i> 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.<ul style="list-style-type: none">➤ 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.<ul style="list-style-type: none">▪ Within the safety domain, we have our healthcare-associated infections (HAIs), including CLABSIs and CAUTIs.▪ 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	
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	<p>scorecard once a year saying where we ranked relative to everyone else.</p> <ul style="list-style-type: none">▪ We do set internal performance improvement goals to make sure that we're meeting our internal targets. <ul style="list-style-type: none">○ We have our goals divided up among our patient population.<ul style="list-style-type: none">▪ We have adult inpatient, pediatrics and then our ambulatory access areas.▪ Within the adult inpatient for our HAIs, we're looking at <i>C. difficile</i>, 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.○ Fiscal Year (FY) 2018 HAI Goals<ul style="list-style-type: none">▪ Non-Mucosal Barrier Injury (MBI) CLABSI: 15% reduction from FY17 rate▪ CAUTI: 10% reduction from FY17 rate	
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	<ul style="list-style-type: none"> ▪ Hospital onset (HO)-CDI: 25% reduction from FY17 rate ▪ COLO: SIR Vizient top 10 ▪ HYST: SIR Vizient top 10 ▪ Cadence of reporting: <ul style="list-style-type: none"> ➤ CLABSI, CAUTI, CDI <ul style="list-style-type: none"> - Weekly: target # of cases per month - Monthly: target rate ➤ SSI <ul style="list-style-type: none"> - Quarterly: target SIR ➤ SIR reported quarterly on all HAIs ○ HO-MRSA Bacteremia LabID event <ul style="list-style-type: none"> ▪ 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 <ul style="list-style-type: none"> ▪ 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? <ul style="list-style-type: none"> ▪ Molly Hale: For OHSU, it's managers and above, including directors, senior directors, vice 	
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	<p>presidents, et cetera For physicians, they are employed through the school of medicine.</p> <ul style="list-style-type: none">• Jana Brott presents: Using NHSN for Facility Benchmarking at Legacy Health<ul style="list-style-type: none">○ Legacy Health has two big aims/goals for quality and patient safety:<ul style="list-style-type: none">▪ Eliminate needless deaths▪ Eliminate preventable harm○ Quality, Strategy & Leadership Committee sets specific, measurable goals to help ensure progress○ Goals are evaluated in a composite called the Harm Index which currently include the following HAIs:<ul style="list-style-type: none">➤ Catheter-Associated Urinary Tract Infection (CAUTI)➤ Central Line-Associated Blood Stream Infection (CLABSI)➤ Surgical Site Infection (SSI)➤ <i>Clostridium difficile</i> Infection (CDI)○ Performance assessment data sources<ul style="list-style-type: none">▪ Centers for Disease Control and Prevention (CDC) NHSN<ul style="list-style-type: none">➤ Standardized Infection Ratio (SIR) = Observed HAI / Predicted HAI▪ Centers for Medicare & Medicaid Services (CMS)<ul style="list-style-type: none">➤ FY20 Hospital Value-Based Purchasing Safety Domain▪ Department of Health & Human Services (HHS)	
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	<ul style="list-style-type: none"> ➤ 2020 National Acute Care Hospital HAI Targets ○ Question from Dr. Pierce: How much is benchmarking data shared with providers? <ul style="list-style-type: none"> ▪ 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. ▪ Julie Koch: At Salem, it depends on infection type, how it's communicated, and who it's communicated to. ▪ Molly Hale: At OHSU, we do a notification of every HAI. The unit leaders pull together a multidisciplinary debrief. 	
Legacy Health Ebola Assessment Center update Jana Brott, Legacy Health; Susan Diskin, Legacy Health	<ul style="list-style-type: none"> • Jana Brott and Susan Diskin present: Biological Isolation Care Unit (BICU) Update <ul style="list-style-type: none"> ○ 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 of 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

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	<p>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.</p> <ul style="list-style-type: none">○ 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:<ul style="list-style-type: none">▪ Nurses from the intensive care unit (ICU), Med Surge, Women's health, emergency department and pediatrics.	
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	<ul style="list-style-type: none"> ➤ 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 <ul style="list-style-type: none"> ▪ Bi-annual learning and skills training <ul style="list-style-type: none"> ➤ Didactic from infectious disease physicians ➤ Simulation with clinical practice support specialists ➤ Coaching from Employee Health and Infection Prevention & Control ▪ Co-develop standard operating procedures <ul style="list-style-type: none"> ➤ 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 	
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	<ul style="list-style-type: none"> ○ Internal future plans <ul style="list-style-type: none"> ▪ Write a procedure for just in time recruitment and training ▪ Practice “no notice” drills and multidisciplinary handoffs, e.g. EMS to burn intensive care unit (BICU) ▪ Lead community-wide exercise for a novel respiratory infection ▪ Develop contingency plan for pediatric assessment and treatment ○ External future plans <ul style="list-style-type: none"> ▪ Evaluate ETC capability with NETEC & OHA) ▪ Strengthen partnerships with regional EACs and ETCs ▪ Continue to collaborate with preparedness experts • Question from Julie Koch: How long should a frontline facility be able to care for a patient? <ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> • Monika Samper presents: Healthcare Worker Influenza Vaccination Survey, 2016 – 2017 <ul style="list-style-type: none"> ○ The 7th annual vaccination survey of healthcare workers (HCW) includes: 	No action items

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<p>Monika Samper, OHA</p>	<ul style="list-style-type: none"> ▪ 64 hospitals ▪ 137 long-term care facilities (LTCFs) ▪ 86 ambulatory surgery centers (ASCs) ▪ 67 Dialysis facilities ○ Executive summary <ul style="list-style-type: none"> ▪ Influenza virus infections associated with 12,000 to 56,000 annual deaths in the U.S. ▪ During the 2016-2017 flu season, Portland area reported 1,466 flu-related hospitalizations ▪ Flu has been responsible for 5 Oregon pediatric deaths over the last five years ○ Influenza vaccination rates for all HCWs by health care facility type and season: <ul style="list-style-type: none"> ▪ 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. ▪ The trend here is one of increasing vaccination rates, but there are fluctuations from year to year. ○ Mean HCW influenza vaccination rates for all facility types: <ul style="list-style-type: none"> ▪ This shows that there is an overall increase in vaccination rates with all facility types over the years 	
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	<ul style="list-style-type: none">○ Aggregate HCW influenza vaccination rate data for the 2015-2016 influenza season by facility type and HCW classification:<ul style="list-style-type: none">▪ 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:<ul style="list-style-type: none">➤ 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.	
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	<ul style="list-style-type: none">○ Facility-specific data:<ul style="list-style-type: none">▪ 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.	
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	<ul style="list-style-type: none"> • 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? <ul style="list-style-type: none"> ○ 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. ○ Dr. Buser: There are alternatives ways to be vaccinated like pharmacies, etc. 	
Travel screening in Oregon healthcare facilities Rebecca Pierce	<ul style="list-style-type: none"> • Ebola situation report- Democratic Republic of the Congo (DRC) <ul style="list-style-type: none"> ○ New outbreak declared on August 1, 2018 ○ 7th largest Ebola outbreak 	Dr. Guzman-Cottrill will send the Personal Protective

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	<ul style="list-style-type: none"> ○ As of September 24, 2018 <ul style="list-style-type: none"> ➤ Total cases: 151 <ul style="list-style-type: none"> - Confirmed cases: 120 - Probable cases: 31 ➤ Deaths: 101 <ul style="list-style-type: none"> - Confirmed: 70 - Probable: 31 ○ We are seeing a decrease in the rate of infection right now. ○ The World Health Organization (WHO) is now warning of a perfect storm of factors that may worsen spread. <ul style="list-style-type: none"> ▪ Misinformation ▪ Political violence ▪ Limited HCW access to hot zones ▪ Unable to perform contact tracing ▪ Unsafe burials ○ WHO discussing whether to declare Public Health Emergency of International Concern. ○ The area where there's conflict right now is Beni, where there's 29 cases. ○ 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. ○ We still see the Middle East Respiratory Syndrome (MERS) cases, particularly in Saudi Arabia. It's been 	<p>Equipment (PPE) calculator to Dr. Pierce for distribution.</p>
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	<p>less of a focus in the media, but the possibility of importation is always present.</p> <ul style="list-style-type: none">• Question from Dr. Pierce: Is there a need for continued travel screening?<ul style="list-style-type: none">○ Molly Hale: OHSU started screening after the 2014 Ebola crisis, and we screen when anyone presents for care.○ Julie Koch: For Salem, when the Ebola crisis died down we followed OHA guidance.○ 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.○ Dennis Drapiza: At Kaiser, we have a similar set up to Salem.○ Dr. Schutte: Asante has similar process to those being described.○ Dr. Guzman-Cottrill: Currently, there is no recommendation to do screening from DRC.• Question from Dr. Pierce: What information would be helpful to determine when/how travel screening is performed?<ul style="list-style-type: none">○ 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?	
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	<ul style="list-style-type: none"> ○ 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. 	
TAP assessments: Data report-out and future plans Dat Tran	<ul style="list-style-type: none"> ● <i>C. difficile</i> infection (CDI) & CLABSI TAP Assessments update <ul style="list-style-type: none"> ○ Facility recruitment <ul style="list-style-type: none"> ▪ CDI: All facilities with a cumulative attributable difference (CAD) > 0 ▪ CLABSI: All NICUs (VON) ○ TAP Assessment participation <ul style="list-style-type: none"> ▪ CLABSI: Total of 5 facilities ▪ CDI: Total of 16 facilities ○ Identification of leading and lagging areas <ul style="list-style-type: none"> ▪ Process for identifying leading areas <ul style="list-style-type: none"> ➤ % Yes: >75% ➤ Sum of often + always: >75% ▪ Process for identifying lagging areas <ul style="list-style-type: none"> ➤ % unknown: >75% ➤ Sum of no + unknown: >75% ➤ Sum of never + rarely + sometimes + unknown: >50% ○ Statewide CDI leading activities <ul style="list-style-type: none"> ▪ Leadership involvement in and promotion of CDI prevention activities ▪ Training for staff on hand hygiene and PPE upon hire ▪ Contact precautions signage 	No action items

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

	<ul style="list-style-type: none"> ▪ Cleaning of high-touch environmental surfaces upon patient discharge ○ Statewide CDI lagging activities <ul style="list-style-type: none"> ▪ Physician/nurse champion ▪ Staff awareness of antimicrobial stewardship practices ▪ Intra-/inter- facility transfer communication ▪ Adherence to use of gown/gloves/hand hygiene (staff and families/visitors) ▪ Cleaning of high-touch surfaces and shared medical equipment ○ Statewide CLABSI leading activities <ul style="list-style-type: none"> ▪ Leadership involvement in and promotion of prevention activities ▪ Daily assessment and removal of central lines no longer needed and audits of these assessments ▪ Feedback central line rates and/or SIRs ▪ Bundled approach to central line insertion ○ Statewide CLABSI lagging activities <ul style="list-style-type: none"> ▪ Physician/nurse champion ▪ Staff person with dedicated time to coordinate prevention activities ▪ Healthcare personnel empowered to stop non-emergent central line insertion if proper procedures are not followed ▪ Central line dressing change practices ○ Criteria for facility recruitment in 2019 	
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Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

	<ul style="list-style-type: none"> ▪ CAD ▪ Critical access hospitals ▪ SIR ▪ Facilities which have implemented quality improvement (QI) projects and wish to have repeat TAP Assessments <ul style="list-style-type: none"> • Question from Zints Beldavs: Is the leading and lagging a standard way this is analyzed? <ul style="list-style-type: none"> ○ Dr. Tran: We used CDC-defined analysis process • Question from Alexia Zhang: Any plans to move to other facility types? <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> • The next meeting will be a webinar for those calling in remotely. 	No action items

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

All members		
Public Comment	No public comment	No action items
Adjourn		

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

The logo for the Oregon Health Authority. It features the word "Oregon" in a small, white, serif font, positioned above the word "Health". The word "Health" is in a large, white, serif font. A horizontal line is drawn under the word "Health", and the word "Authority" is written in a smaller, white, serif font below the line.

Oregon
Health
Authority

Outbreaks: 9/1/18 – 12/6/18

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

Healthcare-associated outbreaks

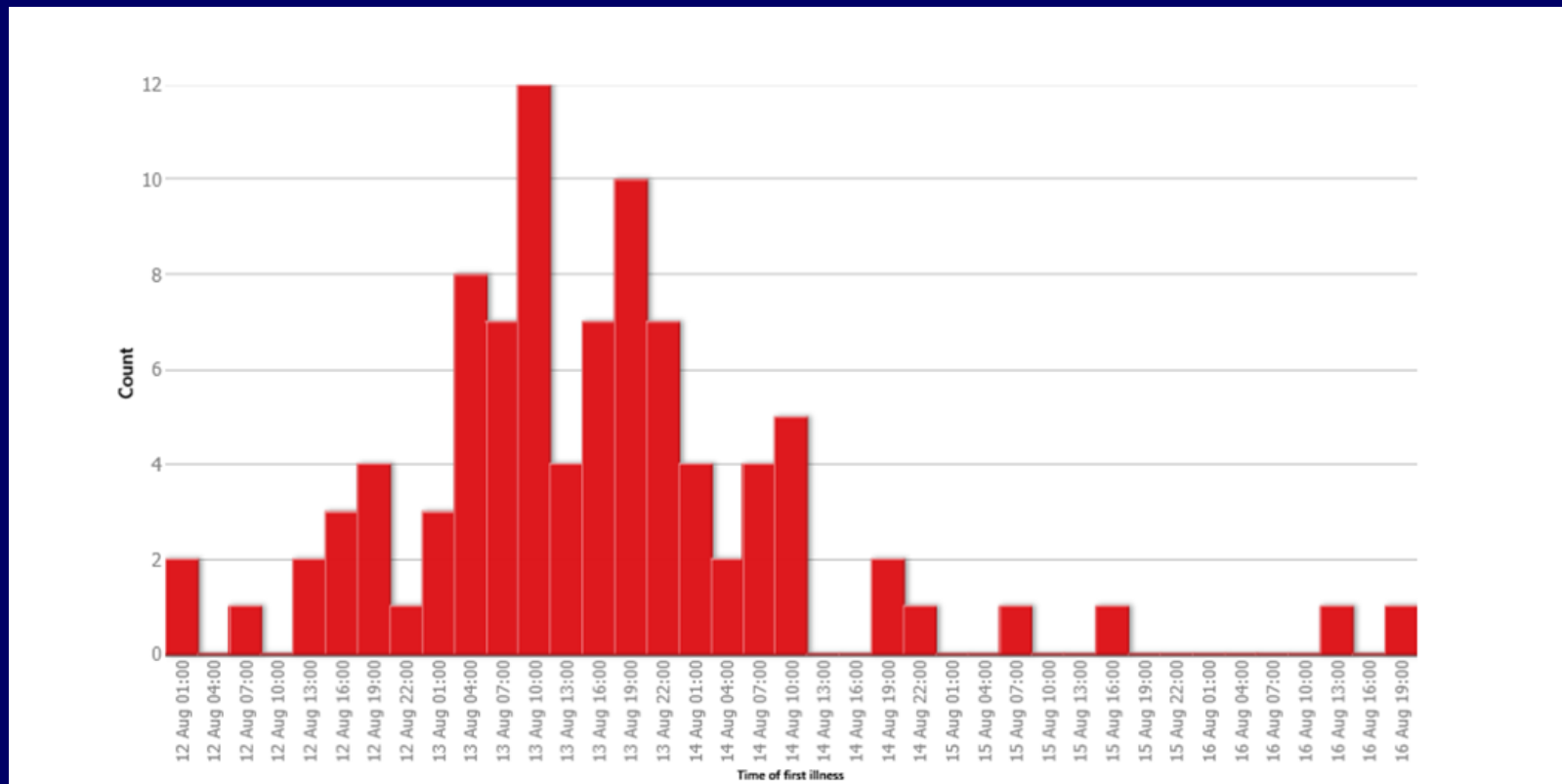
- Healthcare-associated infections account for 70% (49/70) of all outbreaks from Sep 1 through Dec 6
- Majority of healthcare-associated outbreaks occurred in LTCFs (n=45; 64%)
- Most common etiology was norovirus

Facility Type	Influenza	Other Respiratory	Unknown Respiratory	Norovirus	Other GI	Unknown GI	Other	Total
Skilled nursing facility	1	1	0	20	1	1	1	25
Assisted living facility	0	0	1	5	1	4	0	11
Residential care	0	0	2	5	0	2	0	9
Total	1	1	3	30	2	7	1	45

***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

Food	Odds ratio			Ill who ate	Attack rate
	OR	Lower	Upper		
Asparagus	12.44	4.14	37.36	96 (96.0%)	64.0%
Potatoes (au gratin)	4.23	1.59	11.22	93 (93.9%)	58.5%
Butter	2.90	1.54	5.49	77 (77.8%)	62.1%
Bread	3.18	1.49	6.79	88 (88.0%)	59.5%
Aioli	2.26	1.21	4.25	47 (51.7%)	65.3%
Mushrooms (chicken)	2.90	1.05	8.02	41 (83.7%)	64.1%

Food associated with ≥ 3 loose stools in any 24-hr period

Food	Odds ratio			Ill who ate	Attack rate
	OR	Lower	Upper		
Asparagus	16.70	4.86	57.37	95 (96.9%)	63.3%
Potatoes (au gratin)	4.01	1.51	10.65	91 (93.8%)	57.2%
Butter	2.71	1.44	5.12	75 (77.3%)	60.5%
Bread	3.01	1.41	6.41	86 (87.8%)	58.1%
Aioli	2.22	1.19	4.15	46 (51.7%)	63.9%
Salad	2.00	1.04	3.86	77 (78.6%)	58.3%

Questions?

Oregon
Health
Authority

NHSN Data: 2016-2017

Roza Tammer, MPH, CIC
Healthcare-Associated Infections Program
HAIAC
December 11, 2018



PUBLIC HEALTH DIVISION
Acute and Communicable Disease Prevention Section

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.

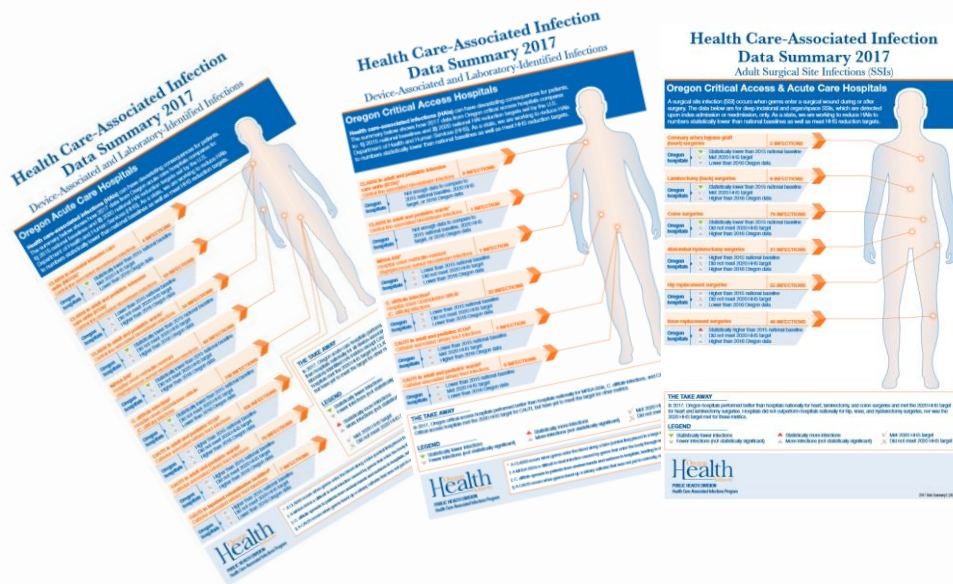
<https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/COMMUNICABLEDISEASE/HAI/Pages/Reports-and-Data.aspx>

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

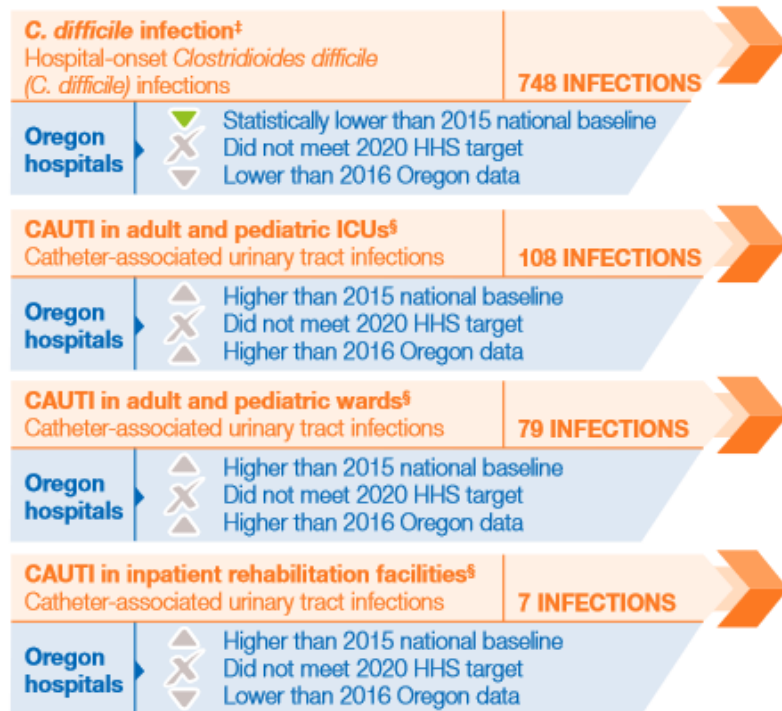
https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/COMMUNICABLEDISEASE/HAI/Documents/Reports/Data_Summary_2017.pdf



Health Care-Associated Infection Data Summary 2017

Device-Associated and Laboratory-Identified Infections

Oregon Acute Care Hospitals



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




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




MRSA BSI†
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



C. difficile infection‡
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







CAUTI in adult and pediatric ICUs§
Catheter-associated urinary tract infections **1 INFECTION**

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

CAUTI in adult and pediatric wards§
Catheter-associated urinary tract infections **6 INFECTIONS**

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

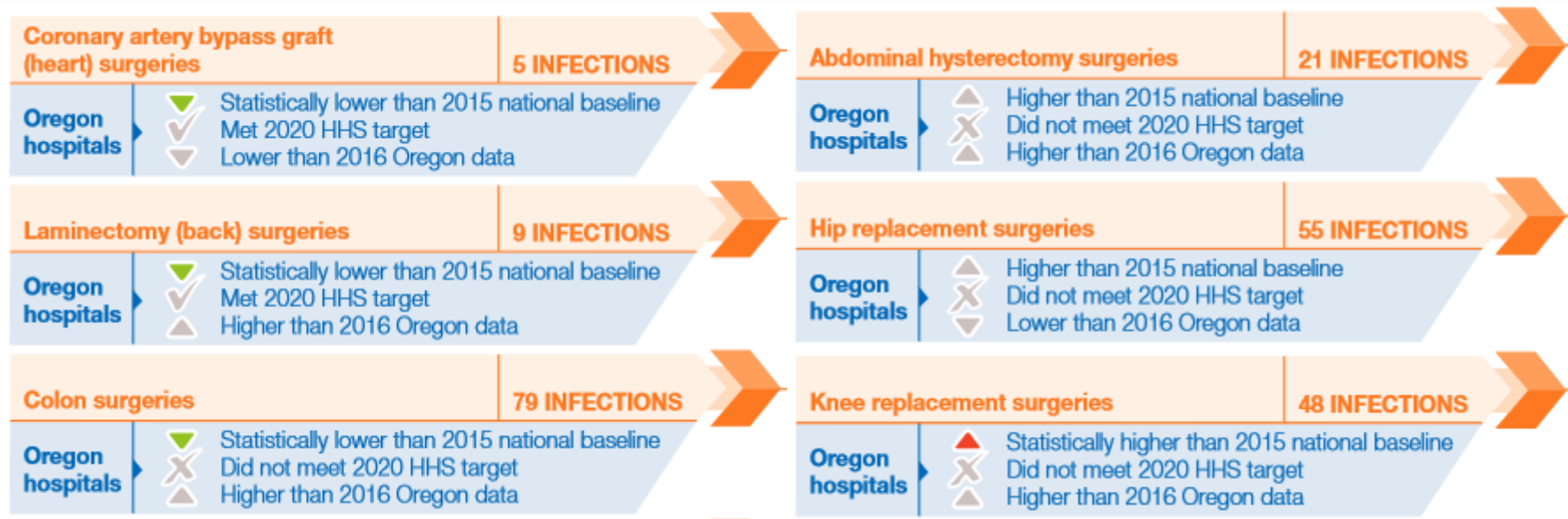
LEGEND

-  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

Adult Surgical Site Infections (SSIs)

Oregon Critical Access & Acute Care Hospitals



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

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

https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/HAI/Documents/Reports/OR_HAIs_2017_About_the_Data.pdf

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 CLABSI, CAUTI, MRSA BSI and CDI
 - Stratified by patient age (adult/pediatric) for SSI

<https://data.oregon.gov/browse?provenance=official&q=2017+hai+report&sortBy=alpha>

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

<https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/COMMUNICABLEDISEASE/HAI/Pages/Reports-and-Data.aspx>

OHA's 2017 HAI data – Tables

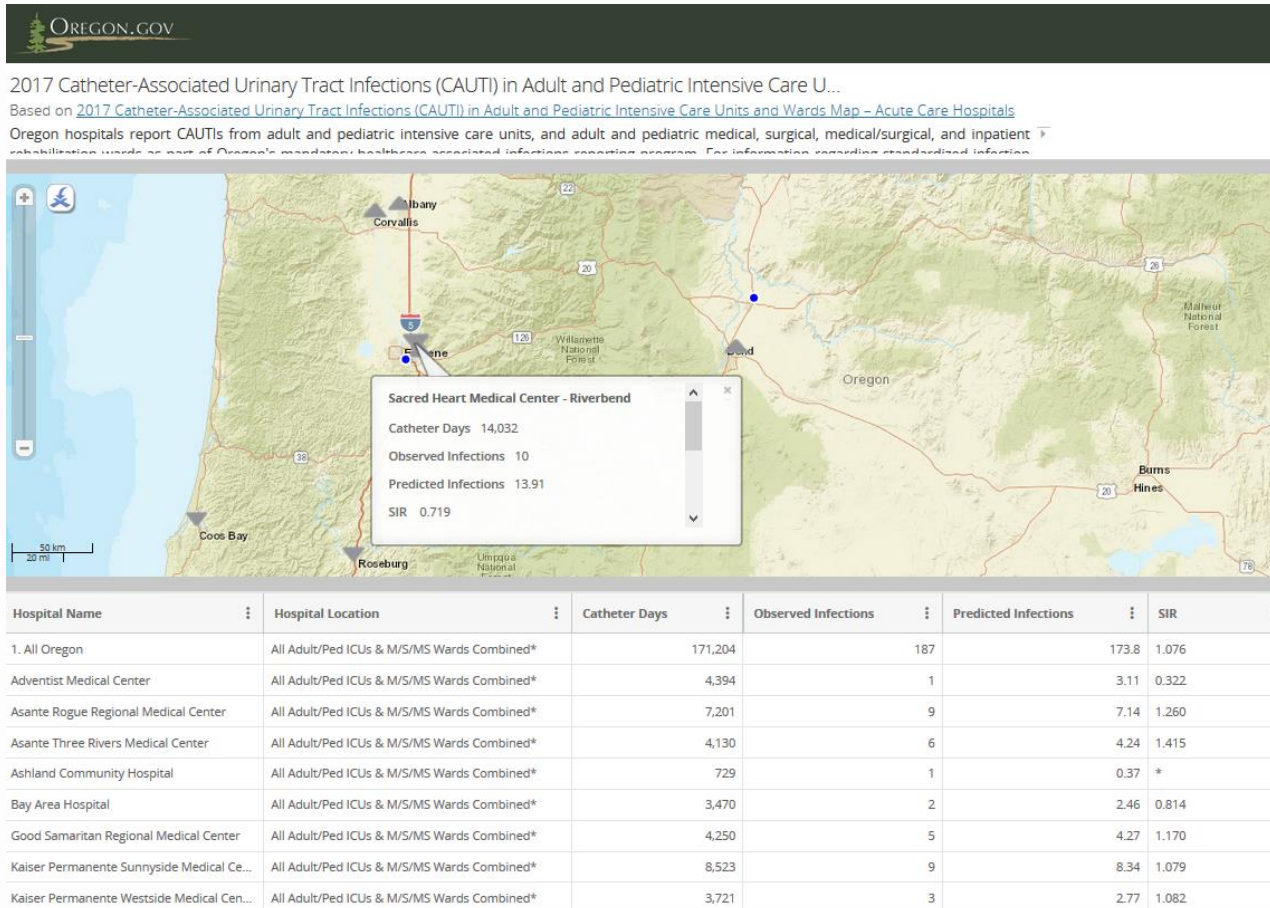


2017 Catheter-Associated Urinary Tract Infections (CAUTI) Table – Acute Care Hospitals

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

Hospital Name	Hospital Location	Catheter Days	Observed Infections	Predicted Infections	SIR
1. All Oregon	All Adult/Ped ICUs & M/S/MS Wards Combined*	171,204	187	173.8	1.076
1. All Oregon	Adult Cardiac ICUs	3,715	3	5.94	0.505
1. All Oregon	Adult Cardiothoracic ICUs	8,563	7	8.46	0.827
1. All Oregon	Adult Medical ICUs	5,040	2	5.6	0.357
1. All Oregon	Adult Medical/Surgical ICUs	53,093	63	51.08	1.233
1. All Oregon	Pediatric Medical/Surgical ICUs	1,764	1	3.02	0.331
1. All Oregon	Adult Neurosurgical ICUs	3,665	19	12.07	1.574
1. All Oregon	Adult Surgical ICUs	9,103	13	13.71	0.949
1. All Oregon	Adult Medical Wards	26,187	20	25.18	0.794
1. All Oregon	Adult Medical/Surgical Wards	26,170	23	19.45	1.183
1. All Oregon	Pediatric Medical/Surgical Wards	1,007	2	0.76	*
1. All Oregon	Pediatric Medical Wards	760	0	0.61	*
1. All Oregon	Adult Surgical Wards	32,137	34	27.93	1.217

OHA's 2017 HAI data – Maps



CDC's 2016 National and State HAI Progress Report

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

Acute Care Hospitals (ACHs)

- CLABSI
- CAUTI
- Total VAE, including VAC, IVAC, and pVAP (IVAC-plus)
- SSI*
- *C. difficile*
- MRSA bacteremia

Inpatient Rehabilitation Facilities (IRFs)

- CLABSI
- CAUTI
- *C. difficile*
- MRSA bacteremia

Long-Term Acute Care Hospitals (LTACHs)



- CLABSI
- CAUTI
- Total VAE, including VAC, IVAC, and pVAP (IVAC-plus)
- *C. difficile*
- MRSA bacteremia

*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

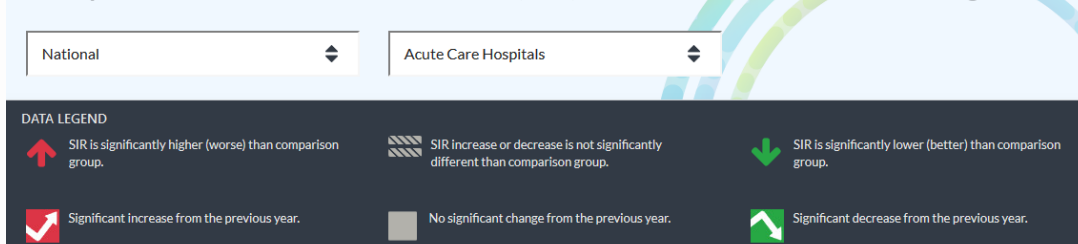
CDC's 2016 National and State HAI Progress Report

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

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



National Data for Acute Care Hospitals, Year 2016

Card View

Table

CLABSI

↓ -11%

LOWER COMPARED TO NAT'L BASELINE



U.S. hospitals reported a significant decrease in CLABSIs between 2015 and 2016

10%

Among the 2,345 hospitals in U.S. with enough data to calculate an SIR, 10% had an SIR significantly higher (worse) than 0.89, 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.

CAUTI

↓ -7%

LOWER COMPARED TO NAT'L BASELINE



U.S. hospitals reported a significant decrease in CAUTIs between 2015 and 2016

10%

Among the 2,591 hospitals in U.S. with enough data to calculate an SIR, 10% had an SIR significantly higher (worse) than 0.93, 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.

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

Acute Care Hospitals

DATA LEGEND



SIR is significantly higher (worse) than comparison group.



SIR increase or decrease is not significantly different than comparison group.



SIR is significantly lower (better) than comparison group.



Significant increase from the previous year.



No significant change from the previous year.



Significant decrease from the previous year.

Oregon Data for Acute Care Hospitals, Year 2016

Card View

Table

CLABSI

↓ -32%

LOWER COMPARED TO NAT'L BASELINE



Oregon hospitals reported no significant change in CLABSIs between 2015 and 2016

0%

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.

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.

CAUTI

11%

NO CHANGE COMPARED TO NAT'L BASELINE



Oregon hospitals reported no significant change in CAUTIs between 2015 and 2016

11%

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.

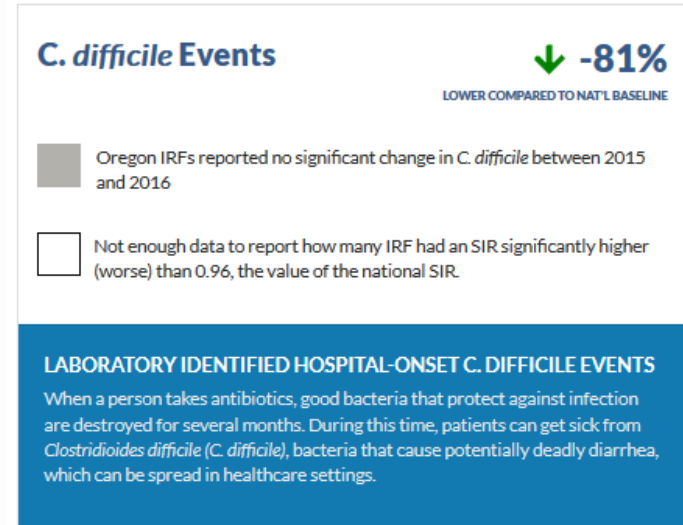
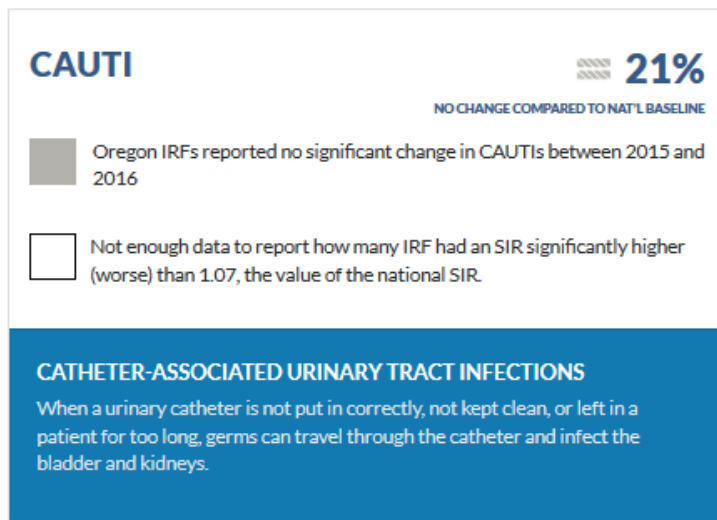
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

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.

CDC's 2016 National and State HAI Progress Report – Oregon ACH data

- 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



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

<https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/HAI/PREVENTION/Pages/lunch-and-learn.aspx>

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

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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

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

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

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

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

Business/facility type (non-acupuncture)		Acupuncture
Inpatient	Outpatient	
21.4% (n=15)	70% (n=49)	8.6% (n=6)

Facility/business type

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

- 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)

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

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

Practice duties by HCP type: Inpatient versus outpatient

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

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

*Statistically significant result

Other procedures and practices

	Inpatient	Outpatient
Safety syringe use*	80%	45%
Injections involving blood/body fluids	53%	6%

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

*Statistically significant result

Compounded medications

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

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

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

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

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

Education: Useful topics

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

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)

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

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
 - Toolkit:
<https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/HAI/PREVENTION/Pages/one-and-only.aspx>
 - Evaluation: <https://www.surveymonkey.com/r/QLPN728>

Questions & discussion

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

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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. Flu vaccine viruses that have been ‘inactivated’ and are therefore not infectious, or with no flu vaccine viruses at all (which is the case for recombinant influenza vaccine). The most common side effects from the influenza shot are soreness, redness, tenderness or swelling where the shot was given. Low-grade 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 the virus mutates 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 comes during cold weather season, but you only get it by 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 – 1 study in 1998 – Dr. Andrew Wakefield in Lancet. No statistical basis, no control group, relied on memories of patients.
Follow up studies:
 - ✦ 1999: 500 children – no link!
 - ✦ 2001: 10,000 children – no link!
 - ✦ 2002: 540,000 children – no link!
 - ✦ 2004: Lancet refutes Dr. Wakefield’s findings “Falsified Facts”
 - ✦ 2005: 10 million children in 31 studies – no link!
 - ✦ 2012: 14 million children, 27 cohort, 17 case-control, 6 self-controlled, 3 time series trials, 1 case cross over study – no link!
- ✦ Mr. Andrew Wakefield had his license to practice medicine revoked due to falsifying facts of his 1998 study.
- ✦ Getting the vaccine is all you need to protect yourself - Truth is hand hygiene often, respiratory etiquette, avoid touching eyes/nose/mouth, stay away from sick people (except at work use PPE), 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 eggs you are eligible to get the flu vaccine. History of severe reaction; vaccine administered in medical setting, inpatient or outpatient.
- ✦ Fact: vaccinated healthcare workers reduce risk of transmitting influenza to their patients. It’s estimated that between 71 percent and 85 percent of seasonal flu related deaths have occurred in people 65 years and older. It’s 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 70 to 90 percent, depending on how well the circulating viruses match 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 80 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.

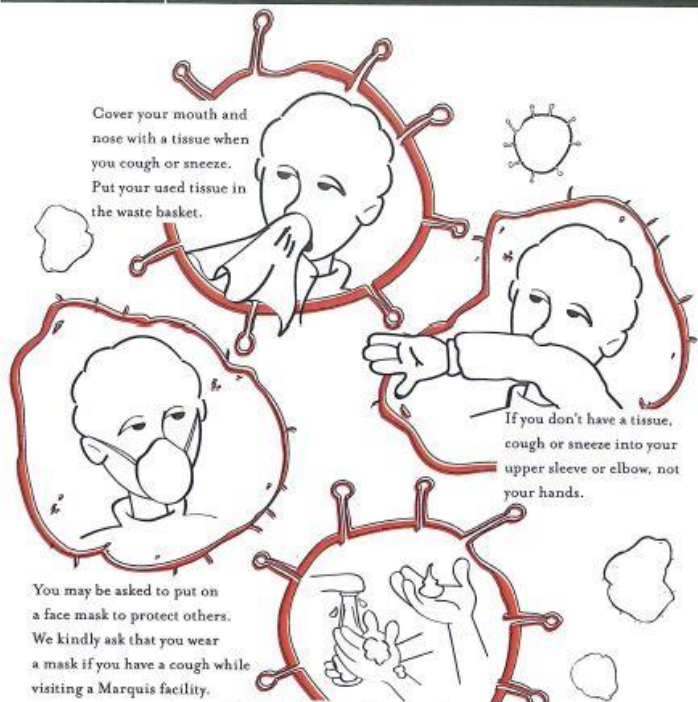




Flu Information and Staff Prevention



A COMMITMENT TO OUR PATIENTS
COVER YOUR COUGH
STOP THE SPREAD OF GERMS THAT CAN MAKE YOU AND OTHERS SICK!




Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.


If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.


You may be asked to put on a face mask to protect others. We kindly ask that you wear a mask if you have a cough while visiting a Marquis facility.

Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.

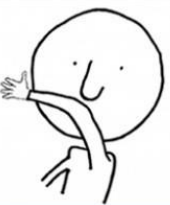
Flu & Cold Prevention


Cover your mouth


Get a Flu Shot


Wash Your Hands


If you aren't feeling well, stay at home.

If you have Flu Symptoms: Rest and Drink fluids


The Center for Health Education and Wellness & Student Health Center

You

If You:
Are unable to drink enough fluids.
Or
Have a fever for more than 3 to 5 days.

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 **Medial 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



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/>

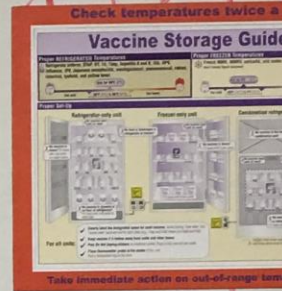
The background features abstract, overlapping geometric shapes in various shades of blue, ranging from light sky blue to deep navy blue. These shapes are primarily located on the left and right sides of the frame, creating a modern, dynamic border around the central text.

Holgate Community 2018-2019 Influenza Vaccination & Masking Program

DeAnza & Michele

2018-2019 Flu Season Task

- ① masking Policy ^{+ vaccine policy} → read & sign - QA @ staff meetings.
- ② Declination Form - Employees
- ③ Order vaccine - placed order 8-2-18 (DeAnza)
- ④ Syringes + needles ordered - 8/8/18
- ⑤ Stickers? QAPI
- ⑥ RIS Alternate language ^{Spanish tagging}
- ⑦ Flu Clinics - ~~Oct 9~~; ~~22nd~~; ~~Oct 12~~ ^{all staff}
- ⑧ Resident Vaccine: Oct 22nd
- ⑨ OFH Res vaccine: ✓ 10-24 + Jessica
- ⑩ Lex from OHA is coming to 9/21/2018 ^{Staff meeting}
- ⑪ KPP - 10/25 DeAnza -
- ⑫ Special individual m-services for ↓ vac. rates for specific Departments.



Influenza Vaccination Program

**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