Healthcare-Associated Infections Advisory Committee Meeting Transcription
June 27, 2018

Speaker:And turn the – okay. I'm gonna get going. Uh, good afternoon, everyone, and welcome to the June 27th healthcare-associated infections advisory committee meeting. Uh, my name is Genevieve Busser and I will be your chair for today. Um, every – it's great, we have a lot of people who are meeting and, and talking here so thanks everyone who could be in person and thanks for those who are on the phone. Uh, there's a PAX scheduled today. So we will keep on moving through, and if we get to any topics that come up that look like they need a little bit more conversation, um, we'll make note of that and, either bring it up at the next meeting or contact you to work with you offline. Uh, and, likewise, if we don't get a chance to hear from you, if there's any concerns, um, please feel free to email, uh, Tara and we'll, we'll note that down and get back to it, either on the next meeting. So I will begin with call to order and roll call. So, again, my name is Genevieve Busser and I'm with Providence Saint Vincent's and I do pediatric infectious diseases, and I'll continue to my right with the people in the room and then we'll have the folks on the phone introduce themselves.

Next Speaker: Uh, this is Rosa Tammer. I'm an epidemiologist at the HAI Program here at the Oregon Health Authority.

Next Speaker: Um, **** I'm the HAI office specialist.

Next Speaker: Uh, **** Program.

Next Speaker: **** epidemiologist with the HAI Program ****.

Next Speaker: Judy Guzman, uh, **** and **** for ****.

Next Speaker: Uh, Lisa **** epidemiologist ACP at the Oregon Health Authority.

Next Speaker: Monica Santerre, uh, **** coordinator at the HAI Program.

Next Speaker: Debbie **** control ****.

Next Speaker: Um **** Shriners.

Next Speaker: ****.

Next Speaker: Diana **** HAI Program.

Next Speaker: Allison **** educator with the ACP.

Next Speaker: Julie Koch, I manage infection prevention at Salem ****.

Next Speaker: **** with the Oregon ****.

Next Speaker: Anne **** Oregon Safety ****.

Next Speaker: **** also with the Oregon Agency of Information.

Next Speaker: Rebecca Pierce, HAI Program Manager here at OHA.

Next Speaker: Uh, JJ ****, um, associate professor at Oregon State ****.

Next Speaker: Maureen Cassidy, epidemiologist with the HAI Program here at the State Health Department.

Next Speaker: **** Medical Director for Communicable Disease.

Next Speaker: Great, that's everyone in the room. Now to go to the phone if you could introduce your name and where you're from, please?

Next Speaker: Josh Barfield, Supply Chain Manager from the Oregon Clinic.

Next Speaker: Phoebe **** from Hood River.

Next Speaker: Deborah Cotura, um, DHS, Department of Human Services.

Next Speaker: Nicole –

Next Speaker: **** with Providence.

Next Speaker: Nicole West, epidemiologist with Multnomah County.

Next Speaker: Kelly Claylo, River Bend Ambulatory Surgery Center.

Next Speaker: Lori **** Health Insight.

Next Speaker: Amy Walters –

Next Speaker: Rachael Seal –

Next Speaker: – ****.

Next Speaker: Rachael Seal, I completed my master's practicum with the HAI program.

Next Speaker: Todd Nicks, OHSU.

Next Speaker: Great, okay.

Next Speaker: Christine Rabie, Quality Healthcare.

Next Speaker: Sorry, say that once more again?

Next Speaker: Christine Rabie, Quality Healthcare.

Next Speaker: Okay, sounds like everyone, thank you so much. Uh, if you're not talking on the phone, if you could mute your phone, uh, we appreciate that, uh, to prevent any feedback. So, next we'll get a logistics update from Tara ****.

Next Speaker: I just wanted to give a little update on the nomination process. So, anyone that sent nomination paperwork to me once that paperwork was sent to Pat Allen our Public Health Director, and everyone was approved and approval letters were sent out on Thursday, June 14th, so if you haven't received a letter yet, just let me know and we may have the wrong address on file. Um, but thank you so much for sending all the documentation. I know it's **** so thank you, and we do still have two vacancies, a consumer representative and a health **** representative, so we have flyers on the table if you know anyone that's interested or can maybe fill in those positions could relay them that flyer and that would be great. Okay.

Next Speaker: Uh, just one additional note on that, but I know that it's, um, some issues with folks on the phone being able to hear people and kind of the back of our room here, we have a large room, uh, we are working on that and we're gonna try and have microphones ready for our next meeting. Hopefully it'll only be an issue for this early part. All the speakers will be near the microphone.

Next Speaker: Great, thank you. So, next on the agenda is to approve the meeting, uh, the meeting minutes from the March 2018. So, do I have any, a motion to approve the minutes?

Next Speaker: So moved.

Next Speaker: I have one and I have two approval, so, so moved, the minutes from March 2018 are approved, thank you. So, next on our agenda will be an outbreaks update from Maureen Cassidy. And just as a reminder, a copy of the slides went out with the invitation for this meeting for those of you that are on the phone.

Next Speaker: Okay, so, uh, the outbreaks update since, um, March 22nd, 2018 when this data was last pulled and, uh, going to 6/18. So, there were 30, uh, gastroenteritis outbreaks and 14 occurred in long-term care facilities and one in a hospital. We had our first, uh, **** outbreak of the season and it was associated with a restaurant and oyster consumption. Oysters were from Washington State. There was an E-coli **** 01 11 outbreak in a daycare and this turned out to be a fairly-large outbreak with five culture-confirmed cases and about 10, uh, presumptive cases. There was one, uh, **** virus outbreak in a school, and then we had several where the etiology was unknown and one of those was in a long-term care facility. So, looking at the respiratory outbreaks, there were 8 influenza reported in this time period all in long-term care facilities, 3 were Influenza A5, Influenza B. There was a definite uptick in **** outbreaks before the end of the school year where 9 were reported in schools and one in a private home school environment. Other respiratory illnesses in long-term care facilities included three, um, RSV outbreaks, two rhinovirus, and one human **** virus. There are two rash illness outbreaks, and then there were some other interesting HAL, AI outbreaks reported in this time period. One, uh, **** producing ****-resistant **** or CRE and this was, um, one case, but we treat these as outbreak, as outbreaks with extensive follow up, so it's included in, um, these numbers here, and,

um, this person also had a **** producing ****-resistant **** and so I'll go over this case later. Um, we had a susceptible **** meningitis outbreak reported in a hospital ICU, four cases, and then in a long-term care facility we had two cases reported of invasive disease with strep **** one case in March and then another following about 2 ½ weeks later. Okay, so, um, looking at the HAI outbreaks, HAI outbreaks accounted for 54, uh, percent of the outbreaks in this quarter. The majority, 91 percent, were associated with one of three types of long-term care facility as listed on this table. The most-common etiology was neurovirus or neurovirus like and most of those occurred in assisted-living facility. Most of the influenza outbreaks that occurred in, uh, skilled nursing facilities. So, um, before I talk about, um, the ****-resistant **** or CRE case, I thought I'd do a, a quick refresher of CRE terminology. Uh, y'all know ****, they're the last line antibiotics and **** organisms of the GI tract, and we commonly refer to two types of CRE, and they're CP CRE which have the **** enzymes which are plasma mediated or encoded on mobile genetic units, um, the organisms can confer the resistance to other organisms and we're most concerned about these bugs because they directly inactivate the antibiotics and they've spread rapidly across the world and can be associated with increased, um, mobidity and mortality. The CRE that don't have a **** refer, we refer to CRE and the incidence of these has remained fairly stable. Usually there are multiple mechanisms of resistance that include **** and changes in cell walls such as **** loss. Okay, so the five most-common ****, um, usually found by PC are, and we refer to them by their initials, their acronyms, KPC, MDM, VIM, IMP and **** and each of these was originally identified in a certain area of the world but have spread far beyond their origins. Uh, KPC was originally found in the US. Okay, so in our state healthcare outside of Oregon is a risk factor for having a **** producing CRE and we're still low prevident, prevalence state and we want to keep it that way. So, of out of our 567 cases to day, three are **** producers and, um, 72 percent of these Oregon residents with the CP CRE had a history of healthcare out of state, either out of country or in a higher prevalence state, and as an example of, um, the experience of another state with higher prevalence, in 2015, 21 percent of Minnesota's CRE were KPC-producing CP CRE. Okay, so the blue shading shows the counties that have reported any CRE cases in our state and the yellow numbers show which counties and the number of cases of CP CRE that have been reported from those counties. So, there are 13 counties that have had CP CRE cases. Okay, and this slide shows the CP CRE cases over time reported by Oregon laboratories. Uh, they mention 18 of them are Oregon residents, the other 4 are from out-of-state residents who sought care in our state, um, so we've had 11 KPCs, 6 MDMs, **** 48, one VIM and we haven't seen any IMPs yet. So, this –

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: **** distribution of mechanisms compare with, I know it's small numbers, but **** how does that compare with what other states have seen?

Next Speaker: Well, um, KPC is the –

Next Speaker: ****.

Next Speaker: – most prominent or predominant ones. I think Washington State has had quite a few MDMs, and actually MDM is the second-most common that we've seen too.

Next Speaker: Are you talking about whether they're endemic or?

Next Speaker: No, I was just curious if the distribution of the mechanism –

Next Speaker: ****.

Next Speaker: – **** answered the question, I was just curious kind of what we look like, you know, I mean, you know –

Next Speaker: Right.

Next Speaker: – especially coming from the east coast and, and it's kind of hard to keep up.

Next Speaker: Yeah, well, um, there was just a webinar, um, from California yesterday, and, and there was somebody from Stanford that was talking about their experience, and they have seen very few, um, CP CRE and their, the distribution is pretty, you know, similar of, um, KPCs compared to MDMs and VIMs whereas it was very different in LA County –

Next Speaker: Mm hmm.

Next Speaker: – um ****. Okay, so, uh, the most-recent CP CRE case, um, this person had history of surgery in Egypt and retuned, returned to the US 2 weeks after surgery with a draining wound. The wound through a **** CP CRE but had an MDM or a **** and this was also our first case that had two ****-producing organisms in the same wound. Um, the wound also proved **** resistant as **** which also had an MDM ****. Um, the **** MDM was susceptible only to ****, um, the **** MDM was susceptible only to **** so they were both, um, extensively resistant organisms. So, uh, screening cultures were done in two facilities, both a hospital and a long-term care facility where this person had been, um, and we did the screening cultures to check for any spread of the organism. Of the 9 screening cultures all were negative. I think that's the end of my 10 minutes. Any other questions?

Next Speaker: Any questions about the outbreak update or about the outbreaks? I was curious about the, you mentioned that there were four **** meningitis, meningities, am I saying that right, in the hospital. Is there anything you can share about that? Is that thought to be a product contamination or equipment contamination which is very unusual.

Next Speaker: Yeah –

Next Speaker: ****.

Next Speaker: – it's an interesting one, so, um –

Next Speaker: So anything, anything we should learn from, or, you know, be aware of if it's –

Next Speaker: Yeah.

Next Speaker: – a product issue?

Next Speaker: So far it's been a confusing one really. It's, um, in a neurosurgical unit and, um, for patients that have ****.

Next Speaker: Mm hmm.

Next Speaker: So, um, I think the, you know, there's one case that happened, I believe, in May, and then the remaining three were clustered in June, but this was unusual and above baseline for them. So, um, they did quite a bit of legwork and actually sent the isolets out for POG testing and interestingly they were, none of them were related, not one. So, it kind of begs a couple questions about whether PFGE is the new appropriate discriminatory mechanism of the **** but also, you know, if it, if they truly aren't related, if this is confirmed by **** genome sequencing or something like that, how is the bug being introduced –

Next Speaker: Mm hmm.

Next Speaker: – **** really all different bugs. So, I think, um, more questions than answers at this point, but ****.

Next Speaker: Great. Let us know if there's anything that's learned from that.

Next Speaker: Mm hmm.

Next Speaker: It's something we all ****. So, uh, just as a quick, as we bring up our next speaker, Anne Eaves from the Oregon Patient Safety Commission, uh, to come up and give our next, uh, uh, piece, I just want to do a particular shout out to Josh Bardgild and Amy Walter who are two of our new members, um, filling both the healthcare purchasing and IPRN vacancies since the last meeting, so thank you very much for being new members. Um, and I don't know if Anne, if you want to come up here just to be close to a microphone. Would you be comfortable doing that?

Next Speaker: Sure.

Next Speaker: And you brought up all your slides up here as well.

Next Speaker: Okay.

Next Speaker: Thank you.

Next Speaker: Okay, uh, my name is Anne Eaves and, uh, I'm retired, uh, for about 3 years now. I was recently from, uh, Kaiser, but I had the opportunity to, uh, join the Oregon Patient Safety Commission as an independent contractor, and so I've done a lot of the visits to various facilities,

uh, within Oregon using a CDC assessment tool for the different kinds of facilities, uh, including long-term care, dialysis, ambulatory surgery, hospitals, and most recently, uh, some clinics. So, uh, what you have in front of you here –

Next Speaker: We can advance it for you –

Next Speaker: – okay, I've got –

Next Speaker: –****.

Next Speaker: – **** okay. So what you have in front of you are just, uh, some numbers, analysis looking at, uh, the results of the, uh, facilities, and I think what I would like to do is just kind of talk over the top of these and you can read the specifics if you like. Uh, generally what I see is a lack of training, uh, by staff whether it's, uh, the nursing staff in terms of competencies and, uh, audits and feedback and all that kind of thing. I think especially the environmental services folks need help. They work very hard. I've seen people down on their hands and knees scrubbing floors and yet still, uh, cross contaminating the room as they work. Uh, there are many people who are working in long-term care especially but others who, uh, English is not their, uh, primary language, so they have trouble understanding, uh, what is expected and all the specifics that go around the, the chemicals that are used for environmental services and that. Uh, for every one of these, I'm always encouraging them to use the Patient Safety Commission training, uh, videos. They're very good, they're very visual. I don't think you need to speak the language to understand it. So, I'm hoping that they have accessed those, and then the patient safety commission also has, has been doing a lot of, uh, training. The next slide, uh, so this is the competencies, and, and when we say competencies, I'm sure you probably know, but that means you train the person and then you have a return demonstration back. Almost nobody does that. Regardless of how, uh, important that task might be, including blood glucose monitoring, even, uh, the folks that are doing disinfection and sterilization have no one watching them, and I found a few places that, uh, that **** Dial soap might be okay for cleaning and disinfecting instruments, but the, uh, enzyme solution is a disinfectant sterilizer **** that the timing for other various disinfectants was off. They had the, the wrong, uh, disinfectant for the time that they were using. So, I think some of these are, are kinda serious and, uh, we're kind of working with those folks to, to get it straight. The last item on there is the drug diversion prevention program, and, um, most places have at least a safe that they lock things up with. However, they're wasting, uh, systems and monitoring are, uh, sometimes not as thorough as, as you would hope, uh, given the severity of problems when people, uh, are diverting drugs away from patients. Next one. Okay, uh, this is competencies again, and auditing. Uh, one little thing, uh, that I actually learned about in the process of, of doing these is there's these little brushes that they use to clean, uh, instruments that have lumens, and the CDC tool says that you either at the end of the day you either high-level disinfect those, uh, sterilize them or toss them, and some of 'em thought that their, their washer that runs instruments through was good enough, and I'm like, no. So, I kinda, as I've gone along and visited places like, I kind of make a point of looking for these little brushes and making sure that they are cleaned and high level or sterilized or tossed, and some of 'em are quite surprised about that. So, again, I think that's kind of a, uh, training issue. Next. So the next steps, um, are to continue to do, uh, these assessments. I use them as an opportunity to train. When I walk through the door I try to make sure they understand that I'm

not there to, uh, as a regulator or, uh, credentialing in any way, and I tell them, be deadly honest with me, um, if no's the answer then it's the right answer, and that we really want the data that we collect that goes to CDC to be accurate, so, hoping that CDC as they look at the data will say, okay, here's an area that really needs some help and focus and get some resources going, uh, that direction, and I feel that, um, sometimes they hang their heads but they tell me the truth, so, I feel pretty good about our relationship with them and, um, as time has gone forward since the last summer when I first started with this, we've had feedback, uh, positive feedback, I think, from, uh, the different facilities and, I feel like they're working hard to, to improve. Uh, so, some of the things that the Patient Safety Commission is offering are the training videos in several languages, and then, uh, seminars and little mini-conferences that are for infection control folks and also a, a really great EVS training program that Deb Hurst developed. I got to learn quite a bit just helping out and participating with that. So, I feel really good about the work and, uh, hope that as we go forward people will really benefit from it. Any questions, comments? Yes?

Next Speaker: So you did 45 of these and, um –

Next Speaker: I did.

Next Speaker: – is the intent to do them all or is this a random sample or, or what, or just, um, coalition of the willing?

Next Speaker: It's, it's, uh, Dr. ****'s asking, um, how people, how facilities are chosen, and they are contacted by the Patient Safety Commission and asked if they would like to have, uh, one of these assessments. So, basically yes, we get invited but we kind of twist their arm a little bit. What we find is once we get in the door one place, um, for example Marquis is a place that we visited a number of their facilities, and they go hey, you know, this would be helpful at another one of our facilities or the Oregon clinics, and now they're, it's been very positive, so, uh, we kind of have a reputation going and we do get visited. I can't, you know, as I drive around town I never realized how many ambulatory surgery places there are, how many long-term care places. They're in every neighborhood, and I have visited some that are really just in a neighborhood somewhere, small facility. So, I don't think that we have the resources to visit every one, no, but we can offer resources to all of them. Does that answer your?

Next Speaker: Yeah, thank you.

Next Speaker: It's been really fun. I'll just take a second to say it's really been a fun experience for me, uh, especially long-term care. The patients there are residents. They live there, you have to get their permission to come in their room, and they want to know who the heck you are and why you're there, and they have no boundaries. So, I've been asked to clip toenails and fingernails and take them to the cafeteria and all kinds of fun stuff, and it's really, it's, it's been fun, and there's some real characters out there, and even in some of the outpatient things. I was at an endoscopy unit and, uh, this lady wanted to know, you know, who I was and why I was there, and I tried to give 'em the short answer, and then she said, well, you know, come on in and watch my procedure if you want. I go well, you know, colonoscopy's not that interesting, and, uh, so every time I saw her she's like hey Anne, how's it goin' you know, yeah, it's goin' great. But it's really been an unexpectedly fun thing to do. Okay, all right, thank you very much.

Next Speaker: Thank you for, boy, all the work that went into that. That was a really neat project when that was starting out, so it's great to see it come to fruition and be able to learn from it and hopefully have some teach back later on down the road, so thank you all for doing that. Um, I think if, if we're gonna jump to one of our next, uh, presentation, it was actually supposed to be after the break, but since we're doing so well, uh, so this is Lexi and she's gonna be talking about the nursing home prevalence study.

Next Speaker: I am.

Next Speaker: Okay, so, actually, let me just take, pause really quickly. Any, any questions from the phone as a, make sure, first if there are any questions and then we think we heard somebody new beep and join on so if you wouldn't mind introducing yourself, that'd be great.

Next Speaker: Hi, this is Kirsten Schute, I was about 10 minutes late, I'm sorry.

Next Speaker: No worries, thank you for joining. Okay, if there are no further questions we'll go ahead with the –

Next Speaker: All right.

Next Speaker: – the next piece.

Next Speaker: Um, so, my name's Lexi. I'm an the epidemiologist here with the HAI program with the **** Communicable Disease Prevention Program. Over the past year and a little bit longer, my AP team, Emergent Infection Program team and I have been completing, um, a point prevalence survey in nursing homes, and so this is the first time that we've reported out data from this project since we've basically just finished collecting and cleaning and validating data. So, and last time if you joined us, I actually, um, presented on our hospital prevalence survey, so this is a very similar project to the hospital prevalence survey but it's done in nursing homes, and this is really the first, um, nursing home prevalence survey that's been done in the United States, in the US in such a large scale. So, it's really exciting. Um, we're excited to see the data that's coming out of this. Um, so, I'm on Page 31 for those that are following along on the phones. I'm just going to give a brief background about the EIP and the program and what we did. So, this program, or this project was done underneath Emerging Infections Program which is a, um, CDC grant activity basically and ten states, including, including Oregon, participate in EIP across the US. So, it's Oregon, Colorado, California, Minnesota, New York, Connecticut, New Mexico, Tennessee, Georgia, and –

Next Speaker: California?

Next Speaker: I think I said California.

Next Speaker: ****.

Next Speaker: I always forget one.

Next Speaker: Say them again.

Next Speaker: Okay, I'm gonna ****.

Next Speaker: ****.

Next Speaker: California, Maryland, thank you, Paul. So, we have a good mix of east coast, uh, central US, Midwest and, uh, west coast. So, and what this project is, it's going to be a multiphase project where we look at healthcare associated infections and, and through microbial use in nursing homes and we began our survey last summer, last spring really in 2017, and the goal for the nursing home prevalence survey is to estimate the HAI prevalence in, in the United States nursing home residents to determine the distribution of HAIs, the pathogens and infection sites, uh, estimate the prevalence and describe the rationale for anti-, antimicrobial use in the United States, determine the quality of antimicrobial drug prescribing and selected clinical circumstances and estimate the burden of HAIs and anti-, antimicrobial use in nursing home residents. So, what we actually did was we had a ten-county catchment area surrounding the Portland, Salem, and Eugene metro areas, and so this was like, uh, Multnomah County all the way down to Douglass County along the I5 corridor. We, um, had a list of all facilities that provide nursing, skilled nursing or post-acute rehab in this catchment area, and then my team and I, um, sent letters and then called each facility up to ten times to enroll them, which sounds like a lot, but usually the first five times was just us trying to find the correct person to talk to. Once we enrolled a facility, the nursing home team lead, which was usually the director of nursing services, build out a healthcare facility assessment and this is how we found out the facility demographics. Then, my team and I went, um, usually a week after their, um, survey day, which we named the assessment date because survey dates are not a good thing in the long-term care facility world and we completed case report forms on resident demographics, resident infection forms, and resident antimicrobial use forms for all residents that were in the facility on the assessment date. So, what did we find? So, um, we enrolled 21 facilities in the catchment area. We had a goal of either 1,500 residents or 20 facilities, and so we, we did better than that so that's great. Um, in total we, there is 1,267 eligible residents that were surveyed and arranged in 5 to 146 residents by the facilities, so residents were eligible to be surveyed if they were in the facility on the assessment day or the day before and this allows us to collect some information about the resident. There, um, MD21 facilities there was 1,654 total beds, 492 single resident rooms, and the average daily census was 63. Um, it seems a little low, but we had a couple facilities, uh, whose average daily census was really low because they were a five, or six-bed facility. So, if we're looking at the primary service, uh, services provided across the 21 facilities, uh, all of our facilities provided skilled nursing or sub acute rehab because that was the one requirement of participating in this project; 90 percent provides general nursing care, um, 48 percent provides dementia, 10 percent provides psychiatric or non-dementia related care, 5 percent provides some sort of ventilator re-insulated care, 43 percent provides bariatric care, and 81 percent provides hospice or palliative care. So, a good mix of facilities, and now we're looking at the demographics of the residents that were surveyed. So again, there's 1,267 total residents that were eligible. The average age was 77 years and the range was 23 to 107, so we had quite a large range of years. About 35 percent of the residents were considered short-stay residents. Um, 39 percent had diabetes, 51 percent were wheelchair bound or bedridden,

10 percent had pressure ulcers, and 20 percent were receiving some sort of wound care, and so, this whenever I, you know, do talk to the facility about their own data, I always tell them this is a snapshot of their day, it might not look this way if we're, like, looking at the average number of short-stay residents or average number of residents with diabetes across the year or quarter, this is just a snapshot of what we saw that day, so it's important to remember that. We also collected, uh, what residents had device-related care. So, 2.6 percent of the residents that we surveyed had a central line, 4 percent were on dialysis, and all of these 51 dialysis residents were sent out to outside, um, dialysis facilities. No, none of our facilities did dialysis in house. 6.2 percent had an ingoing urinary catheter, 2.2 percent had another urinary device, and we only saw, um, super-pubic catheters or other urinary devices. 2.3 percent had a feeding tube, and only 5, or 0.4 percent had a trach. All right ****. So, if we, um, for every resident that was on an antimicrobial on the assessment day or the day before, we did an in-depth chart review to see what kind of antimicrobials they were on, to see the rationale, and the treatment site. So, overall, 13 percent of the residents received one or more antimicrobial on the assessment day, a total of about 187 antimicrobials were administered among these 162 residents, and 36 for anti-, antibiotics and microbials were administered. So, this pie chart is showing the reason why antimicrobials were prescribed, and so for the vast majority, 71 percent, antimicrobials were being prescribed for active infection. 27.3 percent were being prescribed for medical prophy. We couldn't find any documentation of why antimicrobials were being prescribed in 1.6 percent of the residents, and 0.5 percent were noninfectious, and this was usually some sort of, um, like Acyclovir for herpes/HIV medication.

Next Speaker: So –

Next Speaker: Yes.

Next Speaker: – just a quick moment where I can get the medical prophylaxis, could you describe a little bit more about that category, what that –

Next Speaker: Yeah.

Next Speaker: – where the, an example or something.

Next Speaker: Yeah, um, for the most part our medical prophy was for a urinary tract infection prophy, prophylaxis. We saw some, uh, herpes, we saw some, uh, some people would have, like, abscesses where they needed medical prophy for it, but again, this is a chart review, so this is what we found in the charts, you know, in real life. They could be being treated for an active infection, but for our chart reviews we were finding that, finding these data, and it was mostly urinary tract infections.

Next Speaker: Mm hmm.

Next Speaker: Can I ask a real quick question?

Next Speaker: Yeah.

Next Speaker: Is this just inter-, like IV and oral antibiotics?

Next Speaker: Any systemic antibiotics.

Next Speaker: So, not topical?

Next Speaker: Not topical; however, so, for example, if someone was on **** swish and swallow, we would consider that an, a systemic antimicrobial because they're swallowing it, but if there's a swish and spit, it was not considered, so.

Next Speaker: And, and you're, you said herpes, you're counting anti-virals ****.

Next Speaker: Anti-mi-, yeah, and anti-fungals, anti-virals, antibiotics.

Next Speaker: And sorry, one last question.

Next Speaker: Mm hmm.

Next Speaker: Are these indications that were with the medication when it was ordered or was it elsewhere in the chart, 'cause I know that's been one, something that some places have made that you have to have indication to order it. I'm just curious what the –

Next Speaker: Yeah, we, this is mostly from the TARs the treatment assessment records, um, so with each administration they're supposed to put what the rationale and treatment site is.

Next Speaker: Okay.

Next Speaker: If we weren't able to find it there, we would look in the charts, um, so, but you know, for 1.6 percent we weren't able to find it anywhere in the charts, so, thanks. Any other questions? Okay. All right, I think this slide is really interesting. So, we're looking at, so again, for all antimicrobials we would lead with a chart review to try and see, um, what the treatment site was, uh, what, what the antimicrobial was being used for. So, if we're looking at this graph on Page 37, the majority of antimicrobials were being used for a urinary tract, um, treatment site. The next highest is skin or ulcer, like 28, and then 26 were for bone, we saw a lot of osteomyelitis, and then 18 for other, this is usually like your HIV, uh, herpes, and stuff like that, um, and then a smatting, smattering of other treatment sites. I thought what was really nice is that only 8 were not documented. So, for almost all of the antimicrobials, we could figure out why they were being used or at least what they're supposedly used for.

Next Speaker: Is, is this all, or is this active, or is this active, this is not just active treatment. This does include the prophy as well?

Next Speaker: Yes.

Next Speaker: Okay.

Next Speaker: Yep, yep.

Next Speaker: So you might wanna call it treatment sites –

Next Speaker: Yeah.

Next Speaker: – 'cause some of 'em are being actively treated.

Next Speaker: Yep.

Next Speaker: So, can you tell me again how you ascertained the reason that it is, is it associated with the antibiotic order when they have to go in and –

Next Speaker: Yeah, so most of the treatment, um, TARs, the treatment assessment records, has the antimicrobial and right below it is says for urinary tract infection, or for, you know, osteomyelitis. We saw some for infections, which is what the no documenteds are. It's just like, it just says for infections, but for the most part it says for, you know, oral thrush or something like that.

Next Speaker: Okay.

Next Speaker: It's pretty, it was pretty obvious.

Next Speaker: This is like a standardized thing that they always have.

Next Speaker: I, I'm wondering if it's a CMS requirement. I know hospitals it's pretty much required you have to have indications, but I don't know how in a nursing home. Maybe someone who's in a nursing home could answer –

Next Speaker: Maybe ****.

Next Speaker: – if it's like a, Vicki, maybe could you –

Next Speaker: It is a requirement when they have indication, um ****.

Next Speaker: Mm hmm, and a CMS requirement or –

Next Speaker: Yeah.

Next Speaker: – yeah, so, um, so Vicki was saying, sharing that it is a CMS requirement that even long-term nursing mark an indication when they start, uh, an antimicrobial.

Next Speaker: Because I know at the hospital when you go and you start someone you've gotta, you've gotta click on, like, what's the reason.

Next Speaker: Yeah.

Next Speaker: Or else the b-, the order won't go through.

Next Speaker: Yeah.

Next Speaker: I, I think, I don't think that's an actual requirement though **** CMS requirement ****.

Next Speaker: It's pretty easy to override in **** just –

Next Speaker: Yeah, click before the box pops up.

Next Speaker: **** oh yeah, I think for some, I mean, like for **** patients, uh, I know a lot of HIV providers physicians, or whoever's prescribing 'em, don't put an indication on there because they're afraid it's gonna be on the label, and **** you know, disclose the diagnosis, you know, like on the label, 'cause a lot of times when you pick it up from the pharmacy it will say the reason for, please take this for X number of days for whatever **** patient, and so, um, I don't know, at least in RPH I just click on the red X and then the indication disappears, so.

Next Speaker: We won't, we won't tell people about that, 'cause it makes these kinds of studies difficult.

Next Speaker: Oh yeah.

Next Speaker: Or they, but it sounds like very few, um, 8 out of 162 –

Next Speaker: Yeah.

Next Speaker: – didn't, so that's that's great.

Next Speaker: ****.

Next Speaker: And if we couldn't find it we would comb through the, the, the charts to see if we can find any reason. So, all right, um, this next slide, we're on Page 38 here looking at antimicrobials used, listed by, um, frequency. So, it's, No. 1 was Cefalaxin, followed by **** I'm just gonna trail off there, the third was **** followed by Amoxicillin **** and then **** Levofloxicin, so, this was the Top 15, um, really large mix of antimicrobials being used. We did see quite a bit of oral thrush going on, um, hence the **** and **** but what I wanted to show is the antimicrobials by hospitals and nursing homes because I think this is pretty interesting. So, on the left-hand side is the same Top 15, um, anti-, antibiotics seen in the hospital prevalence survey, and on the right-hand side is the Top 15 antimicrobials see in the nursing home side. So, um, right off the bat I can see there's a lot more, well, there's, No. 2 is **** so that's probably the most were used for some sort of UTI prophylaxis. Any comments, questions on this page?

Next Speaker: What was the Vancomycin used for ****.

Next Speaker: Long-term care? Oh, um, bone, osteomyelitis, I think. Yeah. So, you know, 2.6 percent of this po-, patient population, resident population had some sort of central line, and it was usually they were discharged with central line because they had sepsis, endocarditis, and they were being treated at the long-term care facility as a short-stay resident.

Next Speaker: Okay.

Next Speaker: But I can look into that further. Okay. So, the other thing that we looked at, um, was **** criteria for infections. So, all of the res-, so when we did chart reviews for, um, when we did chart reviews, we had a list of signs and symptoms that may indicate infections, and if there, if we found any of these indications then we would do an in-depth, in-depth chart review on, um, any type of infections. So, for example, if anyone had a white blood cell count on the assessment day, or the day before we would look and see if they had an infection. If someone had a fall or a change in mental status, we would also, um, look and see if they had any infections that met **** criteria. So, it was a pretty low bar for looking to see if there was any infections that met **** criteria, but even with this low bar, only 2 percent or 25 residents, um, had infections that met the revised **** criteria. So, the majority of the residents that met **** criteria, um, or infections that met **** criteria was skin or mucosal infections, followed by respiratory infections and then urinary tract infections. What was really interesting is if you remember back to the graph where I'm showing the rationale, um, or the treatment site for antibiotic, antimicrobials, the majority of antimicrobials were being, um, prescribed for urinary tract and there's only 5 infections here that met **** criteria. Um, so, I think, you know, **** criteria is kind of hard to meet, and for, especially for us that are doing chart reviews. So, one of the main criteria for ****, for meeting ****, for meeting **** criteria is, um, actual documentation of, uh, acute functional decline, and that's actually pretty hard to find in charts. I don't, I think, we don't, we didn't really find anyone that met the **** criteria for functional decline, uh, if I had it in front of you, I'd tell you what it is, but it's altered mental, I think it's altered mental status and disorganized thinking and two other things, and we didn't find anyone that met all three criteria to meet **** criteria. So, one of the things I would like to do is to go through our data and see what all these residents are missing in order to meet **** criteria. I think we'd find more residents that met, uh, had infections that met **** criteria if we were able to actually interview the frontline staff to see what was going on, but these are chart reviews, so, it's ****.

Next Speaker: Um, this is Kirsten Schute as well, just a comment. It sounds like you were only looking at a really short time period.

Next Speaker: Yes.

Next Speaker: I mean, it sounds like, um, urinary tract infections versus asymptomatic bacteria or prophylaxis would be a place to kinda dig down and see really what eventually what portion of those folks really required treatment or not, but to do that you may need to go back a little farther within the normal treatment window period to see if you could meet those criteria if folks, you know, they were on an antibiotic the day before, but they're on Day 5 or Day 7 or even longer of their antimicrobial course, you may not be flagging those folks.

Next Speaker: Yeah, um, but that's a really great point. Um, for those that were on to stomach antimicrobials we would go back for 7 days to see if they had any signs and symptoms, but what we found is that a lot of times a resident would develop signs and symptoms of say UTI, get sent to the hospital, be admitted to the hospital for a few days and then return back to a facility. The return back to the facility in this project was considered a readmission, and so we would actually not go back to see what symptoms were, what signs and symptoms the residents had before hospital admission.

Next Speaker: **** just **** like, um **** admitting from acute care **** antibiotic **** hospital records **** sometimes?

Next Speaker: We, no, short answer is no, yeah.

Next Speaker: Were those considered not meeting criteria ****?

Next Speaker: Yeah, exactly. So, so Vicki brings up a good point, so if someone was admitted from the hospital we were not going back to the hospital charts to look for signs and symptoms, so, you know, these residents may have met **** criteria at some point in time but in the charts that we were looking at they would not be meeting **** criteria, so, hence why it's kinda low. Okay, um, I'm almost done. The facilities also, uh, provided a healthcare facility assessment where they reported out what they are currently doing in terms of, um, core elements of antibiotic stewardship. This is kinda hard to read but this is the core elements of antibiotic stewardship, um, and I just want to point out that it ranged from 5 percent, which is our facility requires to write **** a follow-up assessment or **** timeout 2 to 3 days after a new antibiotic is started to determine whether it is still indicated and appropriate, that was 5 percent, all the way to 95 percent which is our facility requires providers to document the dose and route of the antibiotics. So, everyone completed this assessment before we did this project, and then when I went back to some of the facilities to talk to them about their data, um, it was nice to see that a lot of our facilities have actually implemented more requirements from a year ago, so. It'll be exciting to see where we go from here. All right, next steps, um, so I'm in the process of reviewing facility-specific data with each facility. Um, there is a really nice **** it's like a 14-page report that we've generated for each facility, um, so that they understand what data we've collected and where they, um, stand with all the other 21 facilities. Um, we're gonna use these data to determine what our facilities need in terms of education and resources. There's definitely gaps that we have seen and so we'll use these data to kind of guide our efforts there. I do want to do a deeper dive into, into the data, again, look and see what's missing in terms of meeting **** criteria and then obviously to compare Oregon data with all the other 9 EIP sites, and I think there's a plan for the next survey a few years down which will be exciting since this was pre-CMS requirements, and the next survey will be post, new CMS requirements.

Next Speaker: For steward –
Next Speaker: For stewardship and **** infection control and stuff like that, so. Any questions? I know that was a lot of information all thrown at you? Yes?

Next Speaker: Um, so, I think I'm having a timeframe issue to these assessments –

Next Speaker: Mm hmm.

Next Speaker: – and, um, where, were other sites doing these assessments at the same time from the same time period?

Next Speaker: Yeah. So, as we, all ten sites did the assessments between April 1, 2017 to October 31, 2017. So, we tried to stop before norvirus influenza season.

Next Speaker: Gotcha.

Next Speaker: Any other questions or comments, especially from our colleagues who are in nursing home settings maybe or does this seem to ring true or, I don't know, any thoughts?

Next Speaker: I have a question. Other states that have done this, are there differences that have been noted, like, any major differences noted between states?

Next Speaker: Other states, um, so we don't, uh, question, the answer I don't know yet, because other states are still cleaning their data, so, we're still waiting for finalized data from CDC, so, we'll see that. We did get some, um, preliminary data recently and Oregon ranks pretty low in terms of, um, HAI prevalence, so we were like third from last, third from the best, I should say, um, and it ranged from, like, 3.7 to like 0.54, so.

Next Speaker: Yeah, I mean, this is gonna be, this is a quick observation, I mean, the fact that Cefalaxin is the most-frequent is pretty nice, I mean, Cipro, **** is way down the list. It's sort of encouraging that, um, either people are narrowing or we, just not very resistant bugs, but.

Next Speaker: Any other comments?

Next Speaker: I'd **** like to hear whether people think 13 percent is a lot or ****.

Next Speaker: It's kind of low.

Next Speaker: I thought it was low too.

Next Speaker: And you're talking, just to clarify, you're talking about on this point –

Next Speaker: Yeah.

Next Speaker: – on this data only 13 percent of residents were on antibiotics or antimicrobials I should say of some sort?

Next Speaker: Well, in, in the places that I visited, I was kinda surprised how low the antibiotic usage was. Um, I thought it would be a lot more, and I only found a few places where the antibiotic they were using was kind of a big gun for what they were supposed to be treating. So, I, I think this is probably pretty close, at least from what I've seen.

Next Speaker: Just another comment, this is Kirsten, uh, Schute again, just another comment with the, uh, hospital antimicrobials and the **** would that include, um, at that point in time the pre-surgical doses of that antibiotic?

Next Speaker: Yes, yes, we –

Next Speaker: Okay.

Next Speaker: – we would have indicated it was for surgical prophylaxis, but we would have counted it.

Next Speaker: Okay. Yeah, I kinda wo-, I think it would be interesting to see that number without that in there –

Next Speaker: Mm hmm.

Next Speaker: – and see where the **** would fall on that list. Um, I agree, Genevieve, I, I would love to see it at the top of the list. I'd love to see it at the top of the list even with, excluding surgical prophylaxis fell.

Next Speaker: Right.

Next Speaker: And it would be valuable to dig into the symptoms with UTIs that **** see a lot of this even **** -

Next Speaker: Right.

Next Speaker: – **** area –

Next Speaker: Right.

Next Speaker: – who really don't have symptoms.

Next Speaker: Yeah.

Next Speaker: And that would be valuable information.

Next Speaker: Definitely, and for **** criteria, I think, um, well I know that systematic UTIs is the only, uh, infection type that where it requires a culture in order to meet the criteria, so.

Next Speaker: All right.

Next Speaker: And, that, just, uh, for those on the phone, the comment from the room is there, is that it would be nice to be able to look into the symptoms surrounding the diagnosis of the treatment of a UTI prior to that to see how, yeah.

Next Speaker: Yeah, that's.

Next Speaker: ****.

Next Speaker: **** to see what, um, **** you know, **** because I think that, um, really low meeting criteria is **** a reflection of **** prescribed **** care.

Next Speaker: Absolutely, yeah.

Next Speaker: ****.

Next Speaker: Yeah, the comment being that it would be important to know the origin of the order of the antibiotic, was this, you know, started in the hospital so they were just discharged to complete treatment and therefore, you know, aren't currently showing signs or it's not in the current records to, but it, it sounds like that was sort of a methodological issue that arose as, or, you know –

Next Speaker: Yeah.

Next Speaker: – as you did the study and maybe something that they change for the next, you know, so.

Next Speaker: Lexi, I have a quick question.

Next Speaker: Yes.

Next Speaker: This is April Gillette. Um, did you look at the standing orders that the nursing homes had in these situations because I also did some of the Oregon Patient Safety Commission's CDC list assessments and one of the things that I noticed in nursing homes was that, um, a lot of times I had standing orders that if a patient had **** fully that they could just, for whatever reason order a urine culture and then without the doctor actually having to see the patient or deal with it, and so a lot of those patients were getting started on antibiotics without actually having, you know, any specific symptoms. They could have just looked at 'em funny or they could have an off day and they could be starting on antibiotics because of that.

Next Speaker: I could make a comment to that. Um, we would see, we never saw the standing orders, but we did see a lot of, uh, urinalysis that we were wondering why they were ordered.

Next Speaker: Mm, mm hmm.

Next Speaker: So, a lot of those, um, without any comment in there as to why it was ordered all of a sudden.

Next Speaker: Did, were you able to hear that on the phone? The response was that although they didn't find standing orders, they did find urinalysis ordered but didn't seem to have a clear indication or clear clinical indication of why they were ordered.

Next Speaker: We didn't really –

Next Speaker: Yeah.

Next Speaker: – we didn't systematically collect standing orders, so. There's definitely a list of things that I'm gonna tell CDC for next time around.

Next Speaker: Right.

Next Speaker: Refining this process.

Next Speaker: Yeah, and the other piece too is sort of a question, uh, we're talking about antibiotics, this is Genevieve, um, about the appropriateness, you know, if there was a culture and determining –

Next Speaker: Mm.

Next Speaker: – you know, was Cipro appropriate in fact or not or, 'cause that's helpful too, especially with, you know, there's so many good guidelines around impaired UTI treatment, etc.

Next Speaker: We did collect pathogens, but we found very few results in the labs or in the, um, in the charts actually, so.

Next Speaker: As far **** culture results?

Next Speaker: Mm hmm.

Next Speaker: Okay.

Next Speaker: Yeah, as far a cul-, as far as culture results. It was, you know, a –

Next Speaker: And where did –

Next Speaker: – handful maybe that we actually found results, and this is including asking the DNS to like go look at the results for us –

Next Speaker: Mm hmm.

Next Speaker: – at outside hospitals, you know.

Next Speaker: Mm hmm, yeah. So the pathogen, it would just say E-coli but you wouldn't have the sensitivity?

Next Speaker: Right.

Next Speaker: Okay.

Next Speaker: You might not even see that it was E-coli, it might just say positive.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Well, great, well this sounds like a really fascinating first look and so, we'll look forward to see how it compares to the nation. Um, and if any other questions, if people have any questions or otherwise that come up, either during or after, uh, our meeting regarding the, that data, please feel free to reach out to the State, and Lexi would be happy to, and her, her, um, email address is included in the presentation if you have any questions or follow-up clarifications on that. Well, excellent. Well, I think at this point is a great time to take a break. Um, we're gonna adjourn here for about 5 minutes. We'll put the phone members on mute, and we'll be back, so stretch your legs, etc. We'll start back again at 2:05.

Next Speaker: And before we mute, did we have a couple new folks join the line?

Next Speaker: ****.

Next Speaker: They might have fallen **** lost the connection.

Next Speaker: Yes, ****.

Next Speaker: Uh, Gerald Martin with Silverton.

Next Speaker: Gerald Martin from Silverton, and then was that Paula?

Next Speaker: Yes ****.

Next Speaker: Thank you.

Next Speaker: Thank you.

Next Speaker: Thank you, folks.

Next Speaker: I'm sorry ****.

Next Speaker: **** um.

Next Speaker: ****.

Next Speaker: All right.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: How are you?

Next Speaker: ****.

Next Speaker: Okay, folks, I think we're gonna, I think we're gonna pull it back together here. We've got some good stuff. Okay, folks, thanks very much for that break, we're gonna bring it back here. Uh, Rachel Steele from OHSU is going to be presenting to us about injection practice and needle use project update. Uh, I'll be advancing the slides from here and she'll be, uh, presenting remotely. So, Rachel, just let me know when you're ready.

Next Speaker: Great, thank you, and do, would you like me to verbalize when to advance the slides?

Next Speaker: That would be perfect, thank you.

Next Speaker: And did we have –

Next Speaker: I will **** thank you.

Next Speaker: – anyone else join the call, sorry, during the break?

Next Speaker: Pat Pluston.

Next Speaker: Thanks, Pat.

Next Speaker: Okay, so, uh, my name is Rachel Steele, and I completed my field experience at the OHA with the HAI program, but I was finishing my MPH at OHSU. So, I'm gonna talk about the needle use and injection practices survey that we piloted in Jackson County, next slide. So, first, I'll talk about the relationship between needle use and injection safety and the impact that that has on healthcare associated infections, um, and then I'll talk about what we've been doing to understand these in Jackson County first with a pilot study of practitioners, and then how the pilot study shaped the final survey for the county. I'll discuss one way that we're addressing practice breaches with the development of a safe injections toolkit, and what the preliminary results of our survey look like, and then we'll wrap up with reflections on the project and future opportunities. Next slide. So, a safe injection process is defined by the World Health Organization as an action that poses no risk to the individual receiving the injection and no risk or harm to the healthcare worker administering the injection, or the community at large when the injection materials are disposed of. So, administering safe injections is a technical skill, as we know, within the larger context of infection prevention, um, and although we would like to assume that all of our healthcare providers know how to deliver an injection safely, we have data that indicate otherwise. Um, for example, there was a recent survey of nearly 700 nurses and

physicians in the US that showed about 12 percent of doctors and 3 percent of nurse witness syringe reuse on multiple patients in their facilities. Next slide. Um, we also see real-life examples that breaches occur and that they result in infections. So, this is an info graphic provided by the CDC's one and only campaign on the impact of unsafe injection practices in the US, um, and it shows that there have been over 50 injection-related outbreaks occurring between 1998 and 2014 and, um, one of these outbreaks, uh, resulted in approximately $18 million with of excess costs, which is really expensive and it's also expansive. Um, next slide. So, a little closer to home, Oregon became involved in a hepatitis C investigation in 2015 that was associated with a **** therapy clinic in Santa Barbara. **** therapy, just briefly, is a practice in which an irritant solution such as dextrose is injected into the joint or ligament area and thankfully, uh, no hep-C cases were linked to their sister clinic in Ashland, Oregon. Um, the investigation, did, however, highlight the importance of understanding how needles are being used in a wide variety of practice settings throughout Oregon. So, in response to this outbreak, um, and investigation, a project team led by Dr. Rebecca Pierce aimed to assess needle use and injection practices and ongoing education through a survey in Jackson County. So, we first distributed the questionnaire to a small pilot samper, sample, and then we made changes to this questionnaire according to the results that we found, and then we distributed the questionnaire to all facilities and some individuals in Jackson County who may use needles in their practice. Uh, responses have already been collected and we're now working on data cleaning and analysis, and then we also created an educational toolkit of injection safety resources for the OHA website. Next slide. So, first, um, the pilot survey we selected a convenience sample of 9 healthcare workers who spanned the spectrum of care. Um, our goal was to refine the questions for clarity, for comprehensiveness and accuracy, and we constructed a post-questionnaire interview so that we could document their feedback. So, uh, I briefly want to go over a few of the results that we found, uh, they showed some interesting things and specifically we learned that wording could be changed or specified throughout our questionnaire. Um, for example, one question we asked was what facility are you reporting on behalf of, which wasn't received well. It had sort of a regulatory tone, so we changed this to what facility do you work for. Another question invited people to become a safe injection champion, um, in their facility, and respondents felt that this was going to be a big-time commitment and they perceived that they, uh, were required to have a lot of knowledge beforehand, so instead we asked if we could occasionally send them materials to distribute. So, we were also interested in assessing the education that occurs in facilities if and how they receive outbreak reports, and their willingness to distribute injection safety educational materials at their facilities, and we found that buy in initially was a particular challenge with the injection-related outbreaks because many piloters, indicated they don't see this as an issue both within their facility and more broadly, and as a result, they felt that the survey and the educational toolkit wasn't very applicable to them. Next slide. So, once interviews were complete, um, we used the qualitative analysis tool called In Vivo to analyze the feedback and this is what the interface looks like. Um, the analysis helped us to decide which suggestions we incorporated into the questionnaire. Next slide. So, after making changes to the questionnaire we distributed the final version to all businesses and facilities who may use needles in Jackson County as well as individual practitioners. We mailed out a total of 3,474 letters with a link and QR code to the online questionnaire, and I just wanna point out that we chose to mail out physical letters, um, as opposed to an online, uh, link, because we didn't have an email address for all of those that we wanted to reach throughout the county, so instead we used addresses that came from the Oregon Business Registry, OHA mailing list, and then addresses found online.

So, the goal of this survey is to surmise the types of needle and injection-related services that are offered in Jackson County, and some of the ways that we plan to do this is to summarize type of services offered, the personnel handling injection-related equipment, and then what kind of education they receive in their facilities, um, as an ongoing activity. So, I mentioned earlier that we tried to recruit what we called safe injection champions, um, and the feedback that we received caused us to rework this request. So, at the end of the final questionnaire is now an invitation to distribute safe practice materials in the respondent's workplace, and currently 70 percent of respondents have provided their contact information to do this, and then once the questionnaire is completed, respondents are automatically redirected to the OHA toolkit, which helps to promote the resources provided there. Next slide. Um, so, as I mentioned, we created an Oregon-specific injection and needle safety toolkit to provide actionable resources like posters, checklists, and info graphics that practitioners can printout and display in their facilities. The OHA toolkit also provides formal guidelines, legal regulations, and training materials for practitioners as well as resources for the general public. Next slide, and basically this is what the top of the toolkit page looks like. Um, we posted a description of the CDC's one and only campaign, with a link to their website, and then we also provide a rationale for our toolkit and ways that people can get involved. Next slide. This is a table of contents, um, each subject heading contains a link that connects viewers to the specific content area that they're looking for, um, and I encourage you to peruse it in your off time if you'd like. Next slide. So, in Survey Monkey, we currently have 72 responses, 45 of which are complete questionnaires from respondents who currently use needles in Jackson County. Right now, we are working on data cleaning and analysis as I mentioned but I want to give you some of our preliminary findings. Um, so, this pie chart shows that we have respondents coming in from a wide variety of practices including inpatient and outpatient facilities, traditional and alternative practices, um, and then we also have more specialty and dental clinics than we anticipated. Next slide. So, this paragraph here shows the majority of our respondents are not part of the larger hospital or healthcare system. Um, and then below that we also learned that the average number of patients receiving an injection at respondents' facilities ranges somewhere between 0 and 200 patients per day. Next slide. So, perhaps unsurprisingly, we see here that those who use injectable medications in their facility, um, nurses actually draw up the most medications more than any other healthcare workers, um, but worth noting is that we identified many other provider types that are commonly involved in the preparation of medications, um, and this is really helpful to know as we structure targeted education. Next slide. Um, we see on this slide, however, that of those who actually administer the injections, um, nurses, uh, far more than, than those who draw up, they, they administer the most, um, and again, though, we still see representation from a variety of healthcare workers. Next slide, and in terms of education, respondents most often indicated that education is offered once per year in their facility or business. Um, worth noting, though, is that, uh, 12 percent and 16 percent, uh, respectively indicated education either never occurs or only occurs once upon hire, so that's a great opportunity for us. Um, next slide. After the data are cleaned, uh, one part of our analysis will look at needle practices and education by practice type, so, I just wanted to give an example of that. Um, of the 45 respondents in Jackson County, 3 of them are acupuncturists, and we found that all three reported not receiving regular notification of **** outbreaks or patient notifications at their facility. Next slide. Uh, we also found that all three, however, agreed to distribute educational mat-, materials, uh, safe practices in their facility, so that's great. Next slide. Uh, so I'm going to now shift gears and talk about what we're going to do in the future. Um, so, following this project, targeted education in the form of in-

person trainings will continue. Um, the toolkit will also be more widely distributed and promoted, um, with continual maintenance and updates. Um, and part of these updates are gonna come from a, an evaluation link that we invited in the toolkit itself, and so people can indicate what resources they would actually like to see, and then in the future we're also considering a more-formal definition possibly of a workplace injection safety champion, uh, with more information as to the time commitment and knowledge requirements, and then finally, we may also distribute the questionnaire widely in the State of Oregon. Um, we may also consider expanding the assessment to a broader variety of practices. Um, we've thought about tattoo and piercing businesses, correctional facilities, tribal communities, law enforcement, and then first responders. Next slide. Um, and so far we have learned a few lessons from this process, um, first we've had quite a few returned letters, um, mostly from individuals, practitioners, and then we did receive the fact that some people in our sample were either retired or have deceased. Um, so this may mean that for the statewide survey it would be better to find a more up-to-date database if possible, for facility and individual contact information, and then along the lines of sampling, the decision to include individual practitioners came later in the design process, um, and given challenges that we've encountered, um, sending letters to the subgroup we may, uh, we may decide that that's not worth the, the effort in the next phase, and then as I mentioned earlier, the piloting process highlighted the importance of wording, and specific to the champions we learned that justifying tasks relevant to removal improved buy in as did removing the title which may, made respondents feel unqualified initially to sign on. Uh, I'd like to point out though that in fact Nebraska has rolled out their own injection safety champion role successfully. So, we're continuing to explore the most-effective way to partner with our providers in order to promote, um, injection safety materials. So, overall, some preliminary results, uh, we do see the need for further and ongoing education in these facilities, um, and we're excited by the more-targeted directions that we've learned about, um, and we are hopeful about the toolkit and expanded survey will help make clinical needle use safer for Oregon, and next slide. Um, thank you for your attention. Um, and I do specifically want to thank the project team listed here, um, since they provided not only a lot of hard work on this project, but also, um, mentored me, uh, and provided a lot of work on my own development, so thank you so much. Um, and if there are questions, I'd like to open it up for that now.

Next Speaker: And this is Rosa Tamara, I just wanted to say, you know, Rachel was with us for 6 months, she really kind of went above and beyond, um, the typical MPH practicum experience. She really contributed a tremendous amount, so, thanks to her and she's moving onto a permanent position at a County Health Department in Florida.

Next Speaker: Congratulations.

Next Speaker: Thank you, thanks.

Next Speaker: I have a, um, this is Genevieve, just a question to kind of get things started. Um, I was wondering if you a-, asked in your survey about diversion practices or monitoring for that or anything, if they were using, um, controlled substances.

Next Speaker: Yeah, so we asked –

Next Speaker: Yeah, we did –

Next Speaker: – I'm sorry, go ahead, Rachel.

Next Speaker: – oh sorry

Next Speaker: Go ahead. Go ahead.

Next Speaker: Go ahead.

Next Speaker: Rachel, go ahead, go ahead.

Next Speaker: It's hard without being able to read body language and make eye contact. Uh, okay, uh, yeah, we did ask, we asked, um, if there is education provided on an ongoing basis in facilities about drug diversion, um, and then we also asked if the facilities provide assistance, um, for drug diverting activities, so that was addressed.

Next Speaker: Yeah.

Next Speaker: This is Anne, um, when I've been visiting facilities, I, I ask about, I have some questions about safe injection practices and everything, but also I, I've kinda been surprised at the management of medications. I find medications that are unlabelled, outdated, uh, you know, just all kinds of things going on with that. It might be nice to, since you're already looking in that arena, to maybe look at those as well, um, 'cause I think there's -

Next Speaker: Mm hmm.

Next Speaker: – a real safety issues with those.

Next Speaker: Mm hmm.

Next Speaker: And there are this, I mean –

Next Speaker: Yeah, I –

Next Speaker: – **** standardized questions around that, so, you know, that might be you could compare, um, across different, different surveys by using those standard questions around injections, if they're not already included.

Next Speaker: We were trying to kind of find, uh, a way to ask questions that would not directly elicit the need to take regulatory action against our survey respondents, so it was hard. You know, we did look, we did look at all of the various kind of injection safety assessment tools that are around, and then built them out and kind of removed things. Uh, we still actually had people reporting things that were, would warrant a regulatory response, so we had to do a little bit of follow up on that, but you know, what, what we included was trying to sort of get that.

Next Speaker: Yeah, I mean, I think that's well said. I think some of, um, our preparation around getting the survey out was just seeing whether we could administer a survey about injection practices that people would actually respond to that wasn't regulatory, and we really went back and forth on these questions many times to try and do that, and I think from my perspective the lesson learned from this pilot was, you know, we can do this, but, you know, we can get information, like, who is drawing up meds, and we can get a sense of who we need to target education to, but I think what we realized just in Rachel's pilot of our pilot is that, you know, these kind of small groups and, um, interview processes and even, um, you know, collecting more qualitative data around this tends to be much more informative sometimes than what people put on paper. So, I think that's something we're considering going forward that if we could somehow kind of anonymize the process a bit and get healthcare providers to talk to us more about what they're seeing, we might get some better targeted information. So –

Next Speaker: Mm hmm.

Next Speaker: – but it was a, it was a good lesson learned, I think.

Next Speaker: And I was gonna say, the, the, the sort of focus group or the individual interviews were done with the original nine, right?

Next Speaker: Yes.

Next Speaker: Okay.

Next Speaker: Yes.

Next Speaker: They were individual qualitative interview.

Next Speaker: Yeah, those are, I mean, they get so much, very rich in data.

Next Speaker: Yeah, and I, Rachel found that I think people would say oh, it's, you know, you asked about drawing up meds, I have this funny story that happened, you know, and they would like go into this whole thing, and she was like wow, this is more **** conversation, but, um, but it was really informative and really helpful and I think that might be a good forum to get some of these questions answered.

Next Speaker: And this is Genevieve again. Do you have, um, a sense of the type of injection, so were these vaccine injections, or were these, uh, you know, **** therapy injections or, you know, joint injections or, I mean, do you have a sense of the type?

Next Speaker: Yeah, we tried to make a list of all the different types of injections we could think of, so we have kind of a long list. We, we **** what kind of providers these are, so, is this a pain management clinic –

Next Speaker: Mm hmm.

Next Speaker: – or is this a dental clinic, things like that to help narrow that down a bit, and then we also asked about, you know, whether they do joint injections –

Next Speaker: Mm hmm.

Next Speaker: – and vaccines. So, ****.

Next Speaker: And then also the level of –

Next Speaker: Right.

Next Speaker: – intramuscular, subcuta-, like **** kind of **** in a number of different ways.

Next Speaker: Mm, this is Paul. I still don't understand, um, where your, uh, target, you know, how you got your list of emails. I mean, 3,474 in, in little Jackson County with its population of about 200,000. I mean, there certainly aren't that many doctors and clinics there. What, what were you lookin' for in terms of who's, you know, giving injections, I mean, what?

Next Speaker: Right, so Lexi can probably speak to this a little bit more about the process, but our goal was to get as many clinics as we could, and I think we could very easily have identified, you know, ambulatory surgery centers, and dental clinics, and hospitals that are kind of within our **** regulatory systems and things like that. Where we struggled were these kind of, um, wellness clinics and the type of clinic that offer **** therapy and things that actually prompted **** survey to begin with. So, we not only, um, you know, cast a wide net for facilities that may or may not use needles like **** clinics, naturopathy places, things like that, um, we also sent them directly to providers as well, um, any licensed provider on **** list, and it's a very long list as you can imagine –

Next Speaker: And –

Next Speaker: – just trying to capture those ****.

Next Speaker: – and businesses in addition to facilities as well, uh, if you want –

Next Speaker: That were health related or something, okay.

Next Speaker: Yeah, so we, **** the Oregon businesses, business registry, and then –

Next Speaker: So, any, any business ****?

Next Speaker: No, so we gathered all of the **** and then **** business **** definitely couldn't do injections, so for example like **** or like whatever, like Toyota or car dealerships **** and then we ran an inclusion list for any business that may provide injections. So, this included like **** this is **** if any of the names were included **** or people that might do pain therapy or, like, um, plastic surgery or dermatology, and so we tried to come up with a list of, um, provider types that would ****.

Next Speaker: I'm still kind of blown away with the –

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: – ****.

Next Speaker: We also did get, um, the providers' list from the **** acupuncture, nursing, and –

Next Speaker: Medical.

Next Speaker: – medical boards, and then searched for all **** of those things ****.

Next Speaker: Yeah, if you're, if you're, if every nurse is gonna get a letter **** -

Next Speaker: Every nurse **** yeah.

Next Speaker: – that'll get you closer to that **** number, but **** –

Next Speaker: And just that, just –

Next Speaker: **** 30 percent.

Next Speaker: – so you know, the, the businesses, uh, it was only about 605 businesses and facilities and then the individuals are about 2,800 at those.

Next Speaker: ****.

Next Speaker: Did they count, uh, like CMAs, sort of like medical assistants, they do a lot of injections.

Next Speaker: Well, they should ****.

Next Speaker: Like, they are on our list. They're on ****.

Next Speaker: They are on the list?

Next Speaker: Yeah.

Next Speaker: **** scope of ****.

Next Speaker: **** we didn't send them the survey directly I don't think but.

Next Speaker: Is it out of scope of practice?

Next Speaker: It is.

Next Speaker: Are you **** like **** office **** there ****.

Next Speaker: Giving vaccines? Yeah.

Next Speaker: Medically speaking.

Next Speaker: And they're not supposed to be? I didn't know that.

Next Speaker: But **** –

Next Speaker: Unless they're exemptions.

Next Speaker: – do another survey whether you can –

Next Speaker: I think it's, it's –

Next Speaker: – because **** the survey.

Next Speaker: – their **** practicing –

Next Speaker: I think we will –

Next Speaker: ****.

Next Speaker: – pick a smaller group in the future.

Next Speaker: And they, they practice on **** physicians **** injections being administered by medical assistants.

Next Speaker: ****.

Next Speaker: And any, any thought to where, 'cause you said like a huge number were the nurses. Any thought to working with the nursing board specifically for them, I don't know, if they do any sort of routine surveys to increase your response rate from nursing –

Next Speaker: We –

Next Speaker: – at all or?

Next Speaker: – we have plans to reach out directly regarding safe injection practices for two boards –

Next Speaker: Mm hmm.

Next Speaker: – for this upcoming grant cycle.

Next Speaker: Nice.

Next Speaker: Um, as well as our local public health departments and our hospitals, so, some of you may be hearing from us directly in the coming months.

Next Speaker: Well, this is, I sort of, if there's more questions it's great, I just want to say this is really neat, I mean, having worked on some of that follow up from the outbreak with the **** therapy it's really nice to see something, you know, public health action like that turn into something, a project like this where we try to understand and intervene for the future, so, kudos on that work. Yeah?

Next Speaker: I just had a comment.

Next Speaker: Uh huh.

Next Speaker: This is Debbie Hurst. As a consultant, we get to go to lots of places in the country and I've been to more than one practice around, um, where they talk about their office nurse and the nurse, the nurse **** and by the end of the day when I'm there onsite I realize that the person is not a registered nurse or a licensed practical nurse, they're a medical helper or assistant that has been trained, so maybe just clarifying who you survey is a registered nurse –

Next Speaker: Mm hmm.

Next Speaker: – who is a licensed nurse **** because I think it almost becomes a catchphrase and that's the person in the scrubs that does all of your nursing activities.

Next Speaker: Mm hmm.

Next Speaker: And that was kind of, I –

Next Speaker: And for those on the phone, I think there was a request that it be important to clarify instead of just a nurse, actually clarifying what the, the real title of that person is. Are they are medical assistant, or a licensed vocational or –

Next Speaker: We did have a list –

Next Speaker: – etc., you know/

Next Speaker: – of all licensed healthcare provider types, so they were listed by their, the real –

Next Speaker: ****.

Next Speaker: – title and the, the abbreviation, so.

Next Speaker: Whether, yeah, whether in the clinic they're just known as nurse versus the **** yeah.

Next Speaker: Yeah.

Next Speaker: Yeah, I think one of the things that **** about I think there are, one thing that we kind of realized doing this and talking to different facilities, there are a lot of different models being used to deliver this kind of care, so, um, you know, we've seen a couple of clinics in the Portland Metro area kind of taking on this new, at least for me, new, um, approach where, um, they really want doctors and staff, medical assistants and no nurses, so the physicians are **** all of the meds and it's just interesting 'cause I, you know, I think most physicians get, you know, a good amount of injection safety training, but maybe not the same way we tend to give it to nurses. We expect them, and we've certainly targeted them the most in the past, but it is kind of interesting we're thinking about these kind of medical assistant and physician-driven outpatient centers where we're gonna need to target that going forward.

Next Speaker: And I would not assume that physicians have good injection safety because in training, I mean, you make the order but you're not the one that's giving –

Next Speaker: Right.

Next Speaker: – the medication, the injection and anything like, I don't know, just speaking for myself, ****.

Next Speaker: ****.

Next Speaker: Well, great, this is a fabulous topic and look forward to hearing more, um, on this project. And any further questions, feel free to reach out to anyone whose name is on that list who worked with the project, and we'll have some time at the end –

Next Speaker: ****.

Next Speaker: – **** for other questions too. So, next up, we have Dr. Dat Tran who's gonna talk to us, or give us an update on TAP assessment progress and remind us what TAP means.

Next Speaker: Uh, TAP, uh, Targeted Assessment Prevention. So, as you recall, the TAP assessment, um, uh, process is the second stage or the second, you know, letter in that TAP, uh, acronym, and this is, these are surveys, um, as you may recall, uh, aimed at identifying perceptions of healthcare facility employees, uh, about the infection prevention practices that are going on in that facility, so not necessarily what actually is happening, what, but what they perceive to be happening so that, uh, facilities can identify opportunities for targeted education, uh, and improving awareness of the, um, initiatives within their facilities. So, in terms of our approach, we focus on CDI and, uh, Class C because those were the two, um, issues that we felt most important for the state, um, and for CDI we focused on all facilities with a CAD greater than 0 and if you recall that the CAD stands for Cumulative Attributable Difference, which is the

number of infections that would have needed to, uh, prevent, to be prevented to meet the reduction goal, and we used the 2016 NHSN data to identify these facilities, and in the end, this was a really wide net because, um, I think it was half of our facilities, roughly, right?

Next Speaker: More.

Next Speaker: More than half, yeah. Um, so, that's that was, um, a daunting task, and when we set that target. Uh, for the CLABSI, we wanted to focus on the NICUs because that was, uh, a clearly identified issue for the state and we collaborated with, uh, Vermont Oxford Network to try to recruit these facilities. So, um, for the CDI, we sent them a letter to these facilities and then follow up with phone calls and then ultimately held conference calls with those who were interested to ident-, to explain more about the process, uh, and that's, that's what's the, uh, uh, process for recruitment of facilities, and that lasted over a period of several months, uh, actually. So, in terms of the participation, so this is the table. This has, summarizes, and you can see the CLABSI we didn't do too well, um, you know, we had five facilities that, uh, participated but in terms of the number of respondents per, per facility, uh, that was quite low for the CLABSI, and the reason I gave you those, uh, cut points, you know, 30, 20, 29, 10 to 19, just to give you a sense of, you know, what, what's of value and the CDC recommends that for these, uh, surveys, they would recommend at least 30 respondents per facility to be able to provide representative perceptions, right, of the facility. Um, so for CLABSI, you can see, uh, we did not have any facilities that met that 30 cutoff mark, and we'll still provide these responses to the facilities, but we'll just, um, tell them that, you know, this is not representative and that you can interpret it as such. Um, so the CDI, we had a little bit more success. You can see there we had 6 facilities that had at least 30 respondents, um, and then in brackets, you can see I indicate 5, and that means that of 4 of those 6 facilities who returned both a lab survey and a stewardship survey. So, the CDI, uh, TAP assessment consists of just general survey, that goes out to everybody, or whoever you want to, to target, but predominantly, you know, leadership, frontline workers, environmental services, uh, and so forth, and then there are two specific surveys, one to a lab and one to a stewardship, and only one of those surveys is supposed to be, uh, completed. An unlikely, um, the general survey that goes out to, um, the, the group, the lab and the stewardship surveys should really reflect what's happening, not, not a perception, uh, question, or survey. So, you can see the, the distribution there. So, overall, I mean, there were what, like, 9 facilities that had, uh, 20 or more respondents per facility.

Next Speaker: What was the, what was your target number of facilities for CDI?

Next Speaker: We really didn't have a target.

Next Speaker: Okay.

Next Speaker: I think –

Next Speaker: ****.

Next Speaker: – from our perspective we just want to get as –

Next Speaker: Yeah.

Next Speaker: – many as possible to participate.

Next Speaker: We, we sent it out to 40.

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: Mm hmm. So, um, I'm just gonna summarize by describing the mean score by assessment domain. So, I just wanna maybe put a caveat here is that this score was developed by CDC and from, from what I can tell you is that to a certain extent it reflects really, um, points given to, uh, answers, you know, uh, based on the number of questions per domain, so you see five domains there, general infrastructure, antibiotic stewardship, early detection, isolation, testing, contact precautions, cleaning, and environmental cleaning, so there's a maximum points that you can get for each domain, and depending on the responses you get a percentage score, right, out of that domain, and not, each domain has different maximum number of points, so the total overall score is not a simple addition and division of, of the domains, and some are weighted more than others. So, generally if the general, general infrastructure, uh, has a higher weight, and then the other one has contact precautions as a higher weight. Okay? So, just to give you a sense, for example, the total possible points for general infrastructure is 28, antibody stewardship is 7, early detection, isolation, and testing is 10, contact precautions is 27, and environmental cleaning is 8 with a total overall score of 80, so that's the maximum points you can get on this survey. So, if you look at the facilities there, I cut in two parts, right, there are facilities, um, so I put all 9 facilities that completed, had at least 20 surveys, and I also broke it down into 6 facilities that had at least 30 surveys to give you a sense, 'cause that's really what CDC uses the marker point, but really, there's really no difference 'cause most of the data are driven by the, the facilities with, uh, more than 30, but even the other ones have very similar scores.

Next Speaker: Mm.

Next Speaker: So, you can see there when you look at it, um, the major issue you can see there is antibody stewardship, right –

Next Speaker: Mm hmm.

Next Speaker: – where the score really as, at 24 percent. So there's clearly a gap there or a perception at least to what's going on in these facilities.

Next Speaker: And if I recall, the antibiotic stewardship is the core elements, right, having all of the core elements?

Next Speaker: Yeah, I mean –

Next Speaker: They're pretty in –

Next Speaker: Well, I mean, I can list you, I mean, I **** put up here, but I can, I can kind of read through the, these are the questions that they ask for the core, the antibody stewardship for CDI prevention. So, does your facilities review appropriateness of antibiotics prescribed for the treatment of other conditions such as UTI **** with new or recent CDI diagnosis? So, actually these questions are specific to CDI.

Next Speaker: Mm.

Next Speaker: Mm.

Next Speaker: So, second question is, does your facility educate providers of the risk of CDI antibiotics? Does your facility educate patients or family members about the risk of CDI with antibiotics? Does your facility monitor the use of the following antibiotics that are high-risk of CDI, and they list you, you know, for example fluoroquinolones specifically. Does your facility monitor use of the following antibiotics that are high risk for CDI third or fourth-generation ****? That's the second question tick box that you can get. Does your facility use strategies to reduce the use of the following antibiotics that are **** CDI? Again, fluoroquinolones they point out, and then the same question repeated for the third or fourth-generation ****. So they're very specific questions, not that **** general, you know, seven core elements.

Next Speaker: Mm hmm.

Next Speaker: So that's probably why perception is lower and I haven't had a chance to look at the actual, um, stewardship survey to see how that compares to the perceptions and it may align or may not align, all right, so I think that, that'll be important to look at as well. So, in terms of looking at, you know, areas for, um, improvement and opportunities, obviously antibiotic stewardship is, um, is an obvious area, but if, if you look at the scores previously, you know, I mean, the other areas, um, you know, the scores are not that great either, right? Ranging anywhere from the, uh, you know, 50s to the 60s in terms of percentage scores. So, in trying to identify specific areas, this is how CDC, um, bins responses into leading versus lagging. All right? So, to, to be lagging, if a percentage of unknown for a particular question is greater than 75 percent it would be tagged as lagging. If it's, if the sum of nos or unknown is greater than 75 percent, it's also tagged as lagging. If the sum of never, rarely, sometimes, or unknown, right, that's all, that's greater than 50 percent, that's all tagged as lagging. So, in terms of you look at the lagging areas within the other four domains, these are the, these are the one, and these, the specific questions were identified as lagging for all 9 participating facilities. I mean, there are others where, you know, let's say 8 or 9, right, showed as lagging, you know, or 7 or 9, but I just ha-, I just want to point out the, the ones who were all 9 who were identified as lagging. So, the first one is general infrastructure capacity and process and it's the Question No. 6. Does your facility have a physician champion for CDI prevention activity? Um, the third domain, early detection and isolation appropriate testing. Is CDI status that is suspected confirmed, recent history, communicated from other facilities upon transfer to your facility? So, this is consistent with our annual survey of hospitals about inter-facility communication. Right? Obviously. Um, the fourth domain, contact precautions of **** gene, there were three questions that stood out.

Uh, first one, uh, Question 11, is there a system in place to ensure that patients perform hand washing after using the bathroom and before eating? Uh, second question, uh, do families, visitors adhere to use of gown, gloves for patients on contact precautions? And the third question, do families, visitors adhere to hand hygiene policies? So, I think these are areas that facilities can, can, uh, look at. I mean, obviously each facility will have other areas, uh, opportunities and will provide, uh, in-, individualized feedback report highlighting top opportunities for improvement for each facility. So, that's gonna be really our next step to complete and distribute the TAP assessment feedback forms, uh, for the partci-, participating facility, and then we'll also complete the analysis of aggregated TAP assessment data, um, and then I'll think we'll have to refine our TAP assess-, assessment process for next year to see how we can be more efficient and, uh, try to improve, um, collection of, uh, um, surveys. Um you know, for the most part, um, you can see there number of facilities did quite well, but there's certainly challenges to get the required number or the recommended number of 30 surveys per facility. So, I mean, you know, at this point, I just want to open up for questions, even suggestions as how we can approach this, especially in terms of getting facilities to provide, um, an appropriate number of surveys.

Next Speaker: Just, um, a question. What, what roles were surveyed? You had mentioned ****.

Next Speaker: So, you mean like the, the roles, so, I mean, we encouraged to, um, I actually haven't had a chance to look at that data to actually what came in, but we certainly encouraged the full spectrum, and I know certain facilities for sure, um, sent it out to environmental services, for example, to be completed as well, but really it's the full spectrum, it's intended to be leadership, physicians, nurses, um, environmental services, you know.

Next Speaker: And the reason I ask is I'm not sure that all roles would be able to answer those questions since it is ****.

Next Speaker: Right.

Next Speaker: Mm.

Next Speaker: And I would wonder what the value is to have an EVS person comment on stewardship, for example.

Next Speaker: Right.

Next Speaker: You see what, um ****.

Next Speaker: Yeah, I understand, I think I understand where you're coming from. I think when this tool was developed by CDC, I think their perspective is that, you know, this is a team effort, and part of the team effort is encouraging understanding the importance of CDI, and even if that's not your role, right, I think it's important for you to understand why it's important so that can improve your own role in preventing CDI. I think that's how they took the approach. Um, I know that, uh, I'm not gonna, you know, I'm putting you on the spot Genevieve, but you were

involved in, in part of developing this, this assessment, can you comment on that context of why this question was applied to all, um, roles?

Next Speaker: Well, I think it had to do, well, I think when it was originally conceived that you would, that assessment that the facility would reach out to different people, the right people for the right part of the assessment –

Next Speaker: Profession?

Next Speaker: – assessment, and I think it sort of evolved into this and being sent out, but yes, part of that was that they wanted to see hospitals have a group of core people that involved people from all of the different environmental lab, etcetera, so that at least the leaders could be on the same page about what was being done in each area. Um, but you're right, that is, that is one of the, um, the challenges with it and some facilities in answering it have just sort of divvied it up or onto the people who know more about it, but the idea is that by doing it, everyone understands a little bit better the total facility's efforts.

Next Speaker: And, and also hopefully, I guess in the future I know our **** TAP team as well, so hopefully we would see, um, maybe a greater number of responses and actually be able to stratify by role if we had sufficient numbers, um, to say, you know, EVS has this perspective, but this is the perspective from a different role, but I think that the numbers that we got maybe not this time, but you know, but your comment is the kind of feedback that we gave in the development process back to CDC is that some people just won't be able to answer.

Next Speaker: Yeah, I, one thing **** be added **** potentially, I do think the one thing the CDC did and did well is add some language in the instructions about, um, and I think some of the initial people that got the survey felt like they had to chase down –

Next Speaker: Mm hmm.

Next Speaker: – the answers to questions, you know, it's a, are you aware of the stewardship program in your facility and they'd go as their **** you know, and that really wasn't the intention. It was really, you know, if you're an EVS staff and you're not aware that, what stewardship is or why it's done then put unsure and that's a totally reasonable and acceptable answer, and it still kind of informative to our process, but, you know, then the disinfection section becomes highly relevant for that. So, I think there was that push and pull and I do think that it comes down to in the future being able to stratify, look at the **** in a little bit more detail, that, um, you know, the surveys do give you the options to not know, which I think in some ways is more informative, sometimes ****.

Next Speaker: How long ****?

Next Speaker: It's pretty long, it's pretty long.

Next Speaker: It's, it's long, uh, but it can be done –

Next Speaker: ****.

Next Speaker: – fairly quickly because you don't have to, you don't, it's not, you don't have to find a right answer, right.

Next Speaker: Yeah, you just say I know this I don't know –

Next Speaker: Nope, don't know, don't know, don't know, and that's fine, right, and that's appropriate. If you know, then you click, um, you do know. Um, I think specific to EVS, I think I notice on the CDC side that they also have now Spanish translations of some of these surveys, so I think that would probably be important for these, you know, some of the EVS staff at some of the, some of the facilities probably.

Next Speaker: Is that 30, maybe you already said this, is that 30 respondent threshold, like, regardless of the size of the facility?

Next Speaker: Yeah.

Next Speaker: **** random threshold.

Next Speaker: At the –

Next Speaker: ****.

Next Speaker: – yeah, I mean, it's not based on, I mean, I asked CDC this question, how you arrived at this number of 30, right, it's not, um, yeah.

Next Speaker: Well, just 'cause how it's being defined as a, I mean, you know, it's not generalizable to the facility. You would think they would just have it be the, a portion of the employees at the facility or something like that.

Next Speaker: Yeah, I, I, I think the way CDC looks at it, this is a starting point. Like, this is not meant to be used in any kind of, um, way to meet direct, you know, intervention. This is, most of it is about education –

Next Speaker: Mm hmm.

Next Speaker: – and recognizing, you know, where you can help staff within your facilities and understand what initiatives are going on, and, um, and I think that's their focus. So, I think, I think they understand and recognize the limitations, right, and I think they set at 30 because they probably know that, you probably need more than 30, like, depending on what you're trying to get at, and you probably want to say, well, it's not just 30, right? It's like X number of this type, X number of this type, X number of this type, but you can imagine if they specify that out, there's no way we're gonna get, we can't even get like the 30 sometimes, right, so to, to be, be very prescriptive **** it's gonna be very challenging, so I think it's, um, it's a low bar to, to get things started, I think.

Next Speaker: Okay, and just for the NICU piece –

Next Speaker: Yeah.

Next Speaker: – you know, you've got some pediatric folks here in the room that we might ****
to help, at least I can ****.

Next Speaker: Sure.

Next Speaker: **** more than 50 percent facilities represented.

Next Speaker: Right, 'cause there's only –

Next Speaker: There are only 9 units.

Next Speaker: Yeah, there's only 9 ****.

Next Speaker: No, no, but I think –

Next Speaker: **** you know.

Next Speaker: – but it's just that, it's –

Next Speaker: **** number.

Next Speaker: – getting, it's getting the surveys back, right?

Next Speaker: Yeah ****.

Next Speaker: **** for whatever reason.

Next Speaker: Are you supposed **** –

Next Speaker: **** quite a bit of, our NICUs did a lot of work in actually getting these out there.
I think some of the perception was NICUs in particular seem to be just like a bed, a hotbed of
research right now, so there's a lot of competing surveys and research **** and they just, they
really felt like at a certain point they can only send it out and bring it to staff meetings so many
times, and, um, I think that was a big limitation. That being said, we'll analyze any data that
people send us, so hopefully –

Next Speaker: ****–

Next Speaker: – ****.

Next Speaker: – responses?

Next Speaker: Well, and we've applied to continue to do this in the next grant cycle.

Next Speaker: Yeah.

Next Speaker: So, hopefully it'll be ****.

Next Speaker: But, but, but this –

Next Speaker: ****.

Next Speaker: – for this cycle, probably not. I mean, I think, I'm interested in actually chasing up, even though we set the deadline for June 15, and that's when we got the data, but, um, but I think I'd be interested in following with some of the facilities that provided us at least with quite a number of general surveys, but didn't provide us with like a lab survey or, you know, antimicrobial stewardship. I think we're about to chase down some of those facilities just to complete, have some complete data for more facilities.

Next Speaker: Yeah, I mean, 'cause you have, you know, four NICU centers represented on this committee.

Next Speaker: Mm hmm.

Next Speaker: Okay.

Next Speaker: So, or actually five, I mean, if you count Jen for both of the Providence hospitals, and so if you wanted more we can probably **** you know, NICU Salem, Providence, Providence, and ****.

Next Speaker: And one thing that might be helpful I think is like in aggregate there's a fair amount of CLABSI surveys, so maybe doing a bit of a preview of the aggregate **** so facilities can see like all, this is what I get to take away from this and this is how this information will help. On a survey it's a little bit hard to tell what kind of take away you're gonna get from that, so, um, maybe that, that would help to show a better end of it.

Next Speaker: Good.

Next Speaker: Okay.

Next Speaker: It sounds like a good next step. Uh, I think with that, we'll seg-, without any more questions regarding this, we will segue into sort of, um, ideas for the next, uh, next meeting, burning issues. I was just on a big call with my healthcare system how we're going back to adding EIA testing in for C-Diff again or something crazy, so, that'll be changing. Anyways, so just **** and again that might be affecting surveillance and sensitivity and specificity or, **** um, but I don't know if there's any other topics or concerns or, um, follow ups from this meeting.

Anybody rein-, reinstituting, um, you know, epidemic screening for Ebola travel? That came up recently in the news. Anyways, 'cause it's still out there.

Next Speaker: Um, we are, um, just revisiting readiness –

Next Speaker: Readiness?

Next Speaker: – kind of revisiting **** um, as it just kinda went by the wayside.

Next Speaker: Mm hmm, yep.

Next Speaker: **** supplies **** expired and that kind of thing.

Next Speaker: Mm hmm.

Next Speaker: ****.

Next Speaker: Yep, well.

Next Speaker: That's it.

Next Speaker: Great. Well, thank you everyone for joining, thanks for those on the phone. Good to see everybody's faces here, have a safe summer and –

Next Speaker: **** public comment.

Next Speaker: Oh, public comment, sorry.

Next Speaker: And did anyone else join the call, I heard a few more beeps.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: And the airing of grievances, the public comment and airing of grievances, if anybody is a Seinfeld watcher. Anyways ****. World Cup? No? Anybody? Okay, great to see you all, take care, thank you everyone.

Next Speaker: ****.

Next Speaker: Two minutes to spare.

Next Speaker: I forgot ****.

Next Speaker: I know **** 3:00.

Next Speaker: **** tickets for ****.

Next Speaker: **** over by 10 minutes.

Next Speaker: ****.

Next Speaker: I completely drifted my ****.

Next Speaker: No, great ****.

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: He's like ****. He's like that guy ****.

Next Speaker: ****.

Next Speaker: CHF and all the things, I know, so. Hey, if you want to go after work, we could always go after work sometime.

Next Speaker: **** I, I sit all day and like ****.

Next Speaker: I'm just trying to think about where you can get some motivation. ****.

Next Speaker: There's something to **** part **** have **** someone actually ****.

Next Speaker: I need to go around and find ****. I mean, I don't mind **** but this would just add to the –

Next Speaker: Yeah, ****.

Next Speaker: But, I mean, I can ****.

Next Speaker: Okay.

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