Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

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

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

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

NOMINATED MEMBERS PRESENT:

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

NOMINATED MEMBERS EXCUSED:

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

OTHER PARTICIPANTS PRESENT:

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

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

OHA STAFF PRESENT:

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

ISSUES HEARD:

- Call to order and roll call
- Introductions and logistic updates

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

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

Item	Discussion	Action Item
Call to Order and Roll Call Genevieve Buser, Providence Portland (Chair)	50 percent of members present.	No action items
Introductions and Membership Updates Tara Buehring, Oregon Health Authority	• Two current vacancies: Consumer Representative and Health Insurer Representative • Audio issues ○ We will begin using microphones to help people hear across the room and on the phone	No action items

Approve June 2018 Minutes All Committee Members	June 2018 meeting minutes were approved.	No action items

Outbreaks update 2017
Alexia Zhang, Oregon Health Authority
	• 61 outbreaks were reported since 06/01/2018
	• Of the 61 outbreaks, 27 (44.2%) occurred in a healthcare facility
	  ○ Outbreaks occurred most often in assisted living facilities (92.3%, n=24)
	  ○ Most common etiology in healthcare facilities was norovirus (62.5%, n=16)
	• Question from Dr. Buser: Was measles outbreak healthcare-associated?
	  ○ Alexia Zhang: No.
		No action items

Using NHSN for facility benchmarking
Julie Koch, Salem Health; Molly Hale, OHSU; Jana Brott, Legacy Health
	• Julie Koch presents: Use of Infection Data at Salem Health Hospitals and clinics
	  ○ Fiscal year is July to July; halfway through the year, reflect on last 6 months of accomplishments and determine focus for next fiscal year.
	  ○ Elevated infections identified during review of National Healthcare Safety Network (NHSN) data inform focus.
	  ○ The organization decides to focus on a particular area of infection and starts at the approval of the board level.
	  ○ Quality and Safety Baby A3: We see hospital-onset *Clostridioides difficile* in this graph in raw numbers. We
		No action items

	also depict days of therapy for specific antibiotics. This gave us the data to drive actions. ○ We carefully plan how we use our NHSN data. ○ We also use NHSN data for payer scorecards. This data helps set targets that they'd like to see. ▪ We target three levels, usually 10 % threshold, meaning a 5 percent change and a stretch target of 50 percent and each of those are tied to money. ▪ Then we calculate what is a 5 percent drop in the standardized infection ratio (SIR). Days of therapy is listed for that grouping of antibiotics based on historical data, and then some surgical site infections (SSI) data, where we look at raw numbers and SIRs. ○ We also use the infection metrics for leadership invective payments. ▪ It's weighted 20 percent of the incentive payment for leaders to achieve an infection metric of 5 percent each goal. ▪ This includes licensed providers, but it also goes to the manager level. ○ We do run everything off NHSN; we have baseline SIRs, different for all the metrics. ▪ We think of them as the ten-required metrics, including the catheter-associated urinary tract infection (CAUTI), central-line associated blood stream infection (CLABSI), SSI, *C. difficile*,	

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

	➢ Re-baselines ➢ NHSN adjustments ▪ Validate data ○ Question from Dr. Buser: Did you get an average of what all the payers were asking? ▪ Julie Koch: No, each payer asked for very different things. • Molly Hale presents: NHSN Analysis and Facility Benchmarking at Oregon Health & Science University (OHSU) ○ The attic of our plan is to provide the leading standard of care of patient-centered care to all of those we serve. ○ The rooms within our house are our goal, strategies, and metrics, and then our strategic house, or plan, is built on the larger OHSU vision. ▪ This would include the research mission, the academic mission, and then our vision, mission and values. ▪ Within the rooms of our strategic house we've got Metric No. 6, which is mortality readmissions and healthcare-associated infection. So, our data is right up there at the highest level of OHSU healthcare. ○ The HAIs that are included in this healthcare strategic plan are CLABSIs and CAUTIs in the adult population. ▪ Pediatrics do not factor into it, nor do our specialty units.	

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

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

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

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

	➢ 2020 National Acute Care Hospital HAI Targets ○ Question from Dr. Pierce: How much is benchmarking data shared with providers? ▪ Jana Brott: When an HAI is identified, as soon as possible the infection control practitioner team will have a huddle within 72 hours at the bedside. ▪ Julie Koch: At Salem, it depends on infection type, how it's communicated, and who it's communicated to. ▪ Molly Hale: At OHSU, we do a notification of every HAI. The unit leaders pull together a multidisciplinary debrief.	
Legacy Health Ebola Assessment Center update Jana Brott, Legacy Health; Susan Diskin, Legacy Health	• Jana Brott and Susan Diskin present: Biological Isolation Care Unit (BICU) Update ○ Legacy Good Samaritan Medical Center set up an Ebola Assessment Center (EAC) during the outbreak in West Africa ○ Maintained this unit with help from a passionate team of providers, nursing staff, and leaders across the system committed to continuing this work long term ○ Brief background: In 2015, hosted a CDC and OHA team which evaluated of the unit leading to formal EAC designation. In July 2018, National Ebola Training and Education Center (NETEC) team of clinical and operational leaders from Emory, University of Nebraska Medical Center (UNMC), and Bellevue	No action items

	conducted 2-day evaluation of the unit. These three systems are the leading Ebola Treatment Centers (ETC) in the United States and are supported by CDC to visit and consult. Like the accreditation process, they have a large manual of capability standards that we need to meet to continue this work. ○ Ebola assessment hospitals were asked to be able to safely hold a patient for up to 96 hours. When we had the NETEC team come, we invited others including emergency medical services (EMS), fire, hazardous materials (HAZMAT), OHA, and we learned a lot of valuable lessons around transport procedures. ○ There are ten regional treatment centers across the United States, and our regional treatment center is in Spokane, Washington. ○ Transferring a patient to Spokane, which is typically a 5½-hour drive, might take up to 10 hours, because every 2 hours along the route EMS would need to rotate team and their HAZMAT gear. ○ There are 13 HAZMAT teams in Oregon and they all train to the same level and wear the same level of gear. ○ Legacy's care team is made up of about 30 people: ▪ Nurses from the intensive care unit (ICU), Med Surge, Women's health, emergency department and pediatrics.	

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

	○ Internal future plans ▪ Write a procedure for just in time recruitment and training ▪ Practice “no notice” drills and multidisciplinary handoffs, e.g. EMS to burn intensive care unit (BICU) ▪ Lead community-wide exercise for a novel respiratory infection ▪ Develop contingency plan for pediatric assessment and treatment ○ External future plans ▪ Evaluate ETC capability with NETEC & OHA) ▪ Strengthen partnerships with regional EACs and ETCs ▪ Continue to collaborate with preparedness experts • Question from Julie Koch: How long should a frontline facility be able to care for a patient? ○ Dr. Guzman-Cottrill: We currently have three EACs. All three still engage and have support. We would need to do an assessment of the patient and their risks, to see how sick they are at that time and then decide. If it was high-risk and they were mildly ill, we would transfer them to Spokane.	
Healthcare worker influenza vaccination data, 2016-17 season	• Monika Samper presents: Healthcare Worker Influenza Vaccination Survey, 2016 – 2017 ○ The 7th annual vaccination survey of healthcare workers (HCW) includes:	No action items

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

	○ Aggregate HCW influenza vaccination rate data for the 2015-2016 influenza season by facility type and HCW classification: ▪ This shows us the aggregate data for the different facility types; hospitals at the top, ASCs, nursing facilities and then dialysis facilities. ▪ It shows the number of people eligible for vaccination in the first column, the rate of vaccination in the second column, the rate of vaccination declination in the third column, the vaccination status unknown in the fourth column, and then the change in their rate from the previous season. ▪ It should say 2016/17 in the title. ▪ The rate of unknown vaccination status: ➢ This could be 50 percent of independent practitioners, maybe 40 percent of them got the vaccine, and we just don't know it. ➢ Better tracking would be important to be able to know the numbers better. ➢ This shows a high unknown rate in several different facilities, and for some reason it tends to be the independent practitioners. Since they tend to move around from facility to facility, they're harder to track. ➢ It's the same situation for the students and volunteers, especially in the skilled-nursing facilities.	

	○ Facility-specific data: ▪ We start with the number of people eligible for vaccine, the rate of vaccination, the rate of declination, the rate unknown, and then the change in rates in the next season. ▪ The Healthy People target produced by Health and Human Services (HHS), made goals for 2015. These goals included 75 percent of HCWs should be vaccinated for the flu, and by 2020, a 90 percent should be vaccinated. ▪ Green checkmarks mean they made 75 percent, and then the red "x" means they are not meeting that 2020 goal. ○ I do have all the numbers for 2017/18 vaccination year, and it looks like every facility-type has an increase in the vaccination rate this year. I don't think anybody's reached that 90 percent mark yet, but it is still trending upwards, so our efforts are being recognized. • Comment from Roza Tammer: I wanted to mention when I analyzed the data in Alameda County as a fellow there, they implemented a masking order in patient care areas for those that were declining vaccination. We found that the percent in increase, which was around 14 percent pre and post season after the masking order, was almost the same as percent decrease in unknown status from the prior season. The unknown can make or break these targets often.	

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

Travel screening in Oregon healthcare facilities
Rebecca Pierce
	• Ebola situation report- Democratic Republic of the Congo (DRC)
	  ○ New outbreak declared on August 1, 2018
	  ○ 7th largest Ebola outbreak
		Dr. Guzman-Cottrill will send the Personal Protective

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

	less of a focus in the media, but the possibility of importation is always present.
	• Question from Dr. Pierce: Is there a need for continued travel screening?
	  ○ Molly Hale: OHSU started screening after the 2014 Ebola crisis, and we screen when anyone presents for care.
	  ○ Julie Koch: For Salem, when the Ebola crisis died down we followed OHA guidance.
	  ○ Jana Brott: Legacy considers it standard work. In all our clinics we ask the screening questions. After we ask about travel, then it cascades to the specific countries. Beginning next month, we built in the travel screenings into the registration process.
	  ○ Dennis Drapiza: At Kaiser, we have a similar set up to Salem.
	  ○ Dr. Schutte: Asante has similar process to those being described.
	  ○ Dr. Guzman-Cottrill: Currently, there is no recommendation to do screening from DRC.
	• Question from Dr. Pierce: What information would be helpful to determine when/how travel screening is performed?
	  ○ Julie Koch: As the outbreak started in DRC, the questions have come up like how many pappers should a frontline hospital have and other questions, so we could be ready. Could you put this question on your survey, so we can all learn from each other about the personal protective equipment (PPE) protocols?	

	○ Dr. Guzman-Cottrill: I can send the PPE calculator to Becca and Becca can send it out. • Dr. Pierce: If you know of any other questions to add to the hospital survey, please let me know.	
TAP assessments: Data report-out and future plans Dat Tran	• *C. difficile* infection (CDI) & CLABSI TAP Assessments update ○ Facility recruitment ▪ CDI: All facilities with a cumulative attributable difference (CAD) > 0 ▪ CLABSI: All NICUs (VON) ○ TAP Assessment participation ▪ CLABSI: Total of 5 facilities ▪ CDI: Total of 16 facilities ○ Identification of leading and lagging areas ▪ Process for identifying leading areas ➢ % Yes: >75% ➢ Sum of often + always: >75% ▪ Process for identifying lagging areas ➢ % unknown: >75% ➢ Sum of no + unknown: >75% ➢ Sum of never + rarely + sometimes + unknown: >50% ○ Statewide CDI leading activities ▪ Leadership involvement in and promotion of CDI prevention activities ▪ Training for staff on hand hygiene and PPE upon hire ▪ Contact precautions signage	No action items

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

	▪ CAD ▪ Critical access hospitals ▪ SIR ▪ Facilities which have implemented quality improvement (QI) projects and wish to have repeat TAP Assessments • Question from Zints Beldavs: Is the leading and lagging a standard way this is analyzed? o Dr. Tran: We used CDC-defined analysis process • Question from Alexia Zhang: Any plans to move to other facility types? o Dr. Tran: We are piloting LTCF Tap Assessments and will launch soon. • Comment from Dr. Guzman-Cottrill: I'm not surprised by the lagging activities. o Dr. Pierce: There were no major shocks on leading/lagging data. We are encouraging all our facilities to look at the TAP website to identify quality improvement opportunities. o Roza Tammer: If you wanted to focus on a provider type or unit type these tools are available online. We use the CAD to identify facilities. We use CAD to identify who may need/want an assessment. We recognize CAD has limitations.	
Discussion: Themes and Topics for Future 2018 Meetings	• The next meeting will be a webinar for those calling in remotely.	No action items

All members		
Public Comment	No public comment	No action items
Adjourn		

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

Submitted by: Tara Buehring
Reviewed by: Roza Tammer
Rebecca Pierce