Speaker: Okay, everyone. We'll get started. Sorry to break up any cool conversations ****. Uh, good afternoon. This is ****. Thank you for joining us today on September 25th for the healthcare-associated infections advisory committee and we will begin with a call to order. Um, which I, I have just done and I will start with introducing myself and then we'll go around in the room and then on the phone. Uh, so my name is Genevieve Peeper. I'm, uh, the pediatric infectious diseases at Providence Saint Vincent.

Next Speaker: **** section manager for the Communicable Disease Prevention Center.

Next Speaker: Uh, Dr. Pierce, healthcare associated **** program manager at Oregon ****.

Next Speaker: Uh, **** associate professor, Oregon State ****.

Next Speaker: Uh, Jenna Brotney, **** infection prevention for Legacy Health.

Next Speaker: Julie Cox, manager for infection prevention for Salem Hospital.

Next Speaker: Molly **** control at OHC.

Next Speaker: ****.

Next Speaker: Laura ****.

Next Speaker: Ryan ****.

Next Speaker: ****.

Next Speaker: Margie ****.

Next Speaker: **** educator ****.

Next Speaker: **** epidemiologist ****.

Next Speaker: Uh, Monika Samper, uh, **** coordinator, uh, ****.

Next Speaker: **** medical records for the Oregon Health Authority.

Next Speaker: Diane ****, Genentech.

Next Speaker: **** infection prevention for **** Hospital and **** PCH.

Next Speaker: **** epidemiologist ****.

Next Speaker: Uh, Jack Tran, HAI, public health physician with the, uh, Oregon Health ****.

Next Speaker: Tara Bering, office specialist for the HAI program.

Next Speaker: Uh, Rosa Cameron, the HAI surveillance epidemiologist. But that's not my title.

Next Speaker: I'm sorry. Uh, with the Oregon Health Authority and I coordinate the committee and if I haven't met you before, but I think I have met everyone. Please come and say "hi".

Next Speaker: Great. Thank you. That's everyone, I think, in the room. Uh, if we could go to the phone now and have folks introduce themselves, please.

Next Speaker: **** Department of Human Services.

Next Speaker: **** Oregon ****.

Next Speaker: **** medical director and infection prevention ****.

Next Speaker: **** Oregon Nurses Association.

Next Speaker: **** manager of the Oregon Clinic.

Next Speaker: Holly **** executive director at Riverbend Ambulatory Surgery Center.

Next Speaker: **** infection prevention specialist for the nursing home industry.

Next Speaker: **** Hospital.

Next Speaker: Okay. Maureen Cassidy, um, ECI program epidemiologist.

Next Speaker: Mary Powers, uh, infection control ****.

Next Speaker: Sara ****, infection prevention at Good Samaritan Hospital in Corvallis.

Next Speaker: **** infection prevention ****.

Next Speaker: Great. I think we've heard from everyone. Good to hear all the, uh, um, uh, representation from around the state, so thank you for joining.

Next Speaker: ****.

Next Speaker: Oh.

Next Speaker: Dennis Aviza, uh, director, Kaiser Permanente.

Next Speaker: ****. Thanks for joining. Uh, great. Thank you. I think – oh, and –

Next Speaker: **** latecomers. Uh, Judy Guzman, pediatric infectious diseases for OHSU and **** program.

Next Speaker: Great. Thank you for being here. Uh, despite the beautiful weather outside. Uh, so first let's start with logistics updates from Kara, please.

Next Speaker: Okay, there are no big updates. Um, we still have two vacancies which are, um, oops, ****. It's the consumer advocates and the, uh, healthcare insurer representative and we have microphones, as you can see so, um, especially for these on the other side of the room, if you could just, um, use them before you say anything so the people in the front can hear you a little better. That's it.

Next Speaker: Thanks. I think we filled several positions at last, so –

Next Speaker: Um, we, we, so, in the last meeting we, um, sent out, um, nomination paperwork and no new positions have been filled since then ****. Um, I think we already approved – yeah.

Next Speaker: **** remaining **** advocate and insurance.

Next Speaker: Yes.

Next Speaker: Okay. Um, yeah. If anybody has any connections or suggestions or things you'd like to put forward, that would be really, uh, appreciated. Uh, so next, uh, if you've had time to, uh, review the minutes from our last meeting in March, uh, right now I would like to move for a motion to approve the March 2018 minutes. Is there someone who would like to move to approve the minutes? Who's a voting member?

Next Speaker: ****.

Next Speaker: Thank you, David. Go ahead.

Next Speaker: This is Kelli Coelho, executive director **** Riverbend and I will move to approve the minutes.

Next Speaker: I need a second here in the room. Okay. Thank you. So, moving right along. Next, we have, uh, Lexi, one of our epidemiologists to present the outbreak update from last time.

Next Speaker: Good afternoon, um, can everyone hear me, that's both in the room and on the phone? Great. Okay. So, I'm gonna talk briefly about **** outbreaks, um, here in Oregon since this past June and, um, for people following along on the slides, they are numbered. I'm on Slide 2. I'll talk briefly about all outbreaks reported and talk about one outbreak in particular. So, since June of 2018, so June of this year, we've had 61 total outbreaks reported. Um, two also at the state Public Health Department. We've had 23 norovirus or noroviral-like outbreaks, 16 of which occurred in long-term care facilities. You'll notice that since the summer we've had a lot of gastroenteritis-type outbreaks that occurred not in long term care facilities but occurred in

other types of facilities such as ****, um, in three restaurants, salmonella outbreaks in four **** homes and one restaurant, um, along with **** virus in a restaurant, **** at a restaurant and other settings, um, and hepatitis in the other settings. Other settings for this outbreak, um, report would include fair festival mobile trucks, uh, reception facilities for placement in the community. We had seven GI outbreaks with unknown epidemiology; three of which occurred in long-term care facilities. **** respiratory infections. Since it's the summer, we really don't see that many, which is good. We did have one human **** virus outbreak in a long-term care facility; two pertussis outbreaks at schools, um, two measles outbreaks, which I'm sure people have heard of. One in a daycare center and one in general community setting, and two, uh, four unknown respiratory outbreaks, two of which occurred in long term care facilities. Okay. So, um, ****. We did not have 1,222 outbreaks in other settings. It should just be one. I'm **** that. But we also had a, a slew of other outbreaks, other epidemiologies that happened in healthcare associated settings, such as **** and long-term care facilities and **** in the hospital and **** in a hosp, hospital and **** in a long-term care facility. Moving on to Slide 3, if we're just looking at healthcare associated outbreaks, um, outbreaks in healthcare settings accounted for 44 percent of outbreaks from June to September and the majority of healthcare associated outbreaks occurred in long term care facilities. That accounted for 92 point, point 3 percent of all of the outbreaks occurring in healthcare facilities. And the most common epidemiology was norovirus. So, moving on to a specific outbreak. Um, this wasn't really, uh, this didn't occur in healthcare settings but it's interesting for public healthcare settings because we talk about, um, ESSENCE here, which is our **** surveillance system. So, um, we'll go back **** this outbreak. We received a report of salmonella in two unrelated patients, who had attended a birthday party back in July. The hosts of this party were Ethiopian and food served, um, during that birthday party included kitfo, which is a traditional raw beef dish, um, from Ethiopia. This family had purchased raw, raw beef, uh, wholesale beef from a wholesaler in Washington state. Um, along with our interviewing and, um, ESSENCE finding, we identified approximately 40 people that attended this party and then subsequently had GI illness. So, um, so, just a little bit about the results. So, 38 of 42 **** cases reported illness; 13 with confirmed salmonella Dublin. Um, salmonella Dublin is most commonly found in cows and beef, um, and all of these 13 cases matched by PFGE, which is pulsed-field gel electrophoresis. The two individuals that didn't eat anything didn't get ill. The majority of cases had diarrhea, um, diarrhea over three times in a 24-hour period, nausea, vomiting, uh, cramps and, uh, everything that you would expect for salmonella. What was really interesting was the, um, uh, onset for these cases. So, the meat was purchased, uh, a few days before the party. The host family had prepared it **** kitfo and ate it and subsequently two of the people that ate it got ill the next day, which is pretty fast for a salmonella. Um, the party occurred the whole day on 7/15, and the first onset was late on 7/15 but the majority of people that got sick on 7/16, um. And this was pretty fast, fast for salmonella, since we look at salmonella incubation being a couple of days but, um, we think that the viral, the bacterial load in the beef, though, was pretty high. Um, the community had also just come off of a vegan fast, to that, we also think that that contributed to the fast incubation period. But, um, talk about ESSENCE. So, we use ESSENCE for this outbreak. ESSENCE is our syndrome of surveillance here in Oregon. I don't know what the acronym stands for, but syndrome of surveillance is in it, and so we use, um, ESSENCE to try and find additional cases that have gone to either urgent care or hospitals. So all hospital **** report to ESSENCE as well as, um, a handful or maybe more than a handful of, um, urgent cares. So, we looked for, um, two queries. The first one with, um, key terms of birthday party or Ethiopian ****, um, and

**** because a lot of our, uh, our cases actually didn't speak English. They spake, spake, uh, spoke Amharic, um, and then our second query had to do with, um, salmonella and also the phrases Black or African. And so what we found when, with our ESSENCE results was, um, ten people that were possibly linked to the outbreak and we had contacted the hospital **** to try to identify these individuals who are there because the hospital **** weren't a part of ESSENCE. We weren't actually allowed to share those cases with, with them and they weren't actually allowed to share the, um, identifying information with us, so we couldn't actually look at these cases, um, in the medical records. And so what we had to do, is we had to put together project proposals that went through the ESSENCE team here so that we could actually link cases that we found in ESSENCE with MRNs with people so that we can look at their charts. Um, it was really important for us to actually find these cases, uh, because, um, ****. It was really difficult because, uh, Ethiopian children take the same, their last name as the father's first name and so we had a lot of difficulty trying to figure out who was part of what family, um, and English was not this population's first language, so it's really hard when we're trying to find out to see if we could, um, if the cases were the same or different and how they were spelling their names and that sort of thing. And so these ESSENCE entries linked us to eight individuals. We had already identified seven of these cases as already **** cases, had made contact with them and were able to clarify patient information, identifying information from ESSENCE and we identified one new case in ESSENCE. So, um, just lastly, the meat consumption was associated with illness at this party with, um, both the raw kitfo and the cooked, uh, putting cooked in quotes here. Very lightly cooked kitfo, um, was significantly associated with illness as well as the other fully cooked roast beef dish. We also did send, um, we also did send samples, leftover meat samples up to a lab in Washington to get tested and those all matched by PFGE to **** as well. So, there were some, um, food safety concerns identified. Um, mostly that the beef was not refrigerated when it was purchased. There was about a 2-hour drive from the wholesaler back to the family's house and it was in the car and it was not refrigerated or frozen during the time. Um, the beef was served, uh, at around, like, the beef was made around 9, the kitfo, I should say, was made around 9:00 a.m. that day and was out the whole day, from 9:00 a.m. until about 10:00 p.m. and people were eating it throughout the whole day. So, um, likely, uh, beef was likely the source of this outbreak, um, but what I wanted to bring up today was that ESSENCE was useful in clarifying, uh, case ident, uh, case identifiers and contact information, but it was challenging for the investigators because we had to go through this whole, um, process of getting permission from the ESSENCE team to actually find the identifiers, **** all the **** and to sign up for ESSENCE because you, if the **** did have access to ESSENCE were actually active users they could have just shared information. So. Yeah. Any questions? I know that was really fast.

Next Speaker: ****. No?

Next Speaker: How many people had, how many people had **** do you know?

Next Speaker: I don't know.

Next Speaker: **** find out.

Next Speaker: I know I talked about ESSENCE a lot. Um, but we're working on presenting ESSENCE at the next ****, so. I know people have signed up, so there were users at the

hospital, uh, that were ESSENCE users but their, uh, their registration had lapsed or they weren't ****, so. Yes. If you wanted to join ESSENCE, then you can email the ESSENCE team at essence.oregon@state.oregon.gov. Um, if you also just Google ESSENCE Oregon there is a web site that has a fillable document that you can just sign up with, like, your name and email address, um, and then someone from the ESSENCE team will get back to you. There is a confidentiality form that you have to sign and agree to, but it's relatively simple. I think the hardest part is remembering to log in once in a while. Questions for the folks on the phone? I know there's a lot of you joining us remotely today.

Next Speaker: Well, thanks for letting us know how hospital's data is actually serving our communities here in Oregon. **** reported. Were there any healthcare-associated cases? **** mentioned that. Okay.

Next Speaker: No, there were not.

Next Speaker: Good.

Next Speaker: **** the phones?

Next Speaker: We could probably make time for you on the next ****.

Next Speaker: **** anyway, so.

Next Speaker: **** thank you. Okay. The next, uh, place we're gonna, or, next, uh, on the topic of the agenda is, uh, using, using **** for facility benchmarking. We're gonna from Jenna **** from Jenna Brott, Molly Hale from ****, and, uh, **** from ****. So, you guys wanna, um, rotate up here or should I just **** for you, what's, we can give you the microphone to talk.

Next Speaker: ****.

Next Speaker: Okay. **** with that or would you rather ****.

Next Speaker: Um, I can do it ****.

Next Speaker: Sure. Would you like a seat?

Next Speaker: Oh, I'm not first. Okay. You can advance that.

Next Speaker: I.

Next Speaker: Yeah.

Next Speaker: Um, I'm, well we're here to talk about how we use NHSN data and so I'm gonna review some of the **** and, um, in order to do that I, I need to tell you a little bit about, um, Sal, Salem's **** divisional management system because it really drives all of our data, and then lessons learned from using the NHSN data. Okay. Um, so we're a lean hospital and we have,

um, really, um, dug deep into being a lean management system, so you can see we decide our strategies, we start that work, um, mid-year. Our fiscal year is July to July, so halfway through the year, starting in January, we start reflecting on what we were able to accomplish in the last 6 months, and then we go through a very extensive deployment process for determining what we should focus on for the next fiscal year, which actually starts in July. So, um, we actually are looking at NHSN data through this process and, um, and then if our infections are elevated in any given area, that becomes a focus of our Mother A3s, which are the documents we use to, um, do our strategy planning, and from the mothers come Baby A3s, which are drilling those strategies now to a division level, and from those come, uh, Department A3s, so if the organization decides to focus on a particular area of infection and starts at the approval of the board level and that's the focus of the organization of that year. So next slide. Um, this is an example of a Baby A3 that focused on C. Diff, and so, um, just in the upper – I know you can't see a lot of the detail, but, um, in the upper left corner it tells the story of the previous year. Um, we see hospital-onset C. Diffs. It's actually in raw numbers, and then we also depict, um, days of therapy for specific antibiotics. Um, so that told us, gave us our data for driving, uh, actions, and then on the bottom left is just a reflection of how we did on previous strategic foc, low-side focus, uh, that year, uh, whether we were red or green. Green means we achieved our targets. Red means we didn't, and then the bottom left there is an analysis and it basically tells us our hypothesis that we're gonna test, so strategies we're gonna test and what our expected outcome is. So when you go on the right side, it's all the action planning for the year, and then it's showing you the months across, Janu, uh, July, August, September, October and grays out when we're going to implement a specific strategy. On the goal section, it actually, this one says, uh, decreased days of therapy for **** or **** and so on, and it gives our baseline data, days of therapy and our targets. Um, so some of the other things down there we, uh, implemented, uh, probiotics, um, algorithm and there are some other things, and what time of year we do those. So it's very planful how we use our NHSN data. Just letting you know that. Okay. Next slide. So we also use NHSN data for payer scorecards, so, um, different payers, um, su, help us, uh, set targets that they'd like to see. So this first one is showing some C. Diff targets and what we have been using in the last several years are SIRs, um, and we target three levels. Um, uh, a target, of te, usually 10 percent, threshold, meaning a 5 percent change and a stretch target of 50 percent and each of those are tied to money, so, um, and then we calculate out of what is a 5 percent drop in SIR for example. Um, and so days of therapy is listed there for that grouping of antibiotics based on all data, um, or historical data, um, and then some SSI data, where we actually look at raw numbers and SIRs, um, how we equate those together. Okay. Next slide. We also use the infection metrics for leadership invective payments. So, um, it's tied all the way through the organization, so this one is just showing, um, it's weighted 20 percent of the incentive payment for leaders to achieve an infection metric of 5 percent each goal.

Next Speaker: Ju, ju, Julie –

Next Speaker: Go ahead.

Next Speaker: – is this **** licensing dependent practitioners?

Next Speaker: Um, it's leadership incentive –

Next Speaker: Oh, okay.

Next Speaker: – payment.

Next Speaker: Oh, okay. Thank you.

Next Speaker: So it includes licensed –

Next Speaker: Yeah.

Next Speaker: – um, providers but it also includes, um, it actually goes to the manager level, so, um, next slide. Uh, so this is very complicated. I just wanna show you what we submit for data for all these measures to, uh, to our organization each month. Um, so there isn't any data on here, but I just wanted to show you that we do run everting off of NHSN. Um, we have baseline SIRs for, um, different for all the metrics. We think of 'em as the ten required metrics, um, including the CAUTI Class C SSI, C. Diff, MRSA, bacteremia and then the air, the SSIs that **** report. Um, and so baseline data goes in there and I am actually still in the process of calculating July based on the data 'cause we've had a few NHSN issues that, um, and so we found some coding issues that we had to readdress, so, um, and then, um, this year we did something different. We are actually combining CAUTI Class-C SIRs into device-related infections, and this is where I contacted Rose and said help me do the math here. If I am combining SIRs of different types of infection 'cause we don't think about, um, 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, so we combined C. Diff and MRSA **** D SIRs, and how to do that mathematically to actually ****. You can't just average SIRs. It's a ratio, right. So, um, looking at actual infections ****. Um, okay. Next slide. So this year, um, we are also have, we also have a new initiative, so, um, I was asked to actually use NHSN data and predict, um, what a 5 percent decrease would look like in CAUTI Class-C, C. Diff, MRSA for each unit, so I'm just showing the snapshot of, uh, four or five units there where we looked at their baseline. In order to produce an SIR for some of these units, we have to do a 12-month rolling, um, and even then, of course there are rules around SIR that you can't necessarily generate an SIR, so and then we established some rules for what would be a trigger that that unit would need to start looking at some of their practices, and what would their target be for the year if as an organization we targeted a 5 percent drop. Next slide. So what are some of the lessons learned? Um, using NHSN data, data definitions are really important, uh, because we have different people asking us for different metrics. Use for example the all SIR. No, use complex AR. Um, so or only the CMS-reported units for C. Diff. I don't wanna see all year Class **** units if they're not in that grouping. So clearly spelling out your data definitions, um, using appropriate calculations and when in doubt, ask for help. Um, keep leadership informed of changes. We had survey changes that changed all of our 2017 data, um, because it ended up being one of the variables that, that, um, is weighted in an SIR. Um, we know NHSN has rebaselined their data, and they have made several adjustments over this last year in their calculations that they discovered their own errors. I tell you as of yesterday we had, um, NHSNs in SIR calculations is instead of saying 100 procedures of hysterectomy, it's saying 100,000, so they have a problem right now. Um, so it's, uh, just this changing all the SIRs. Um, and then validate, validate, validate your data because so many changes in an organization even in

medical records, um, in the interfaces to all our surveillance system, changes our data and we don't even know it, so I constantly have to ask questions who is doing what with what. That's it for me.

Next Speaker: Thank you. And I, um, this is –

Next Speaker: ****

Next Speaker: – I should have given a little bit of context to this. I think this presentation it sounds like came out of questions that you had around presenting the data –

Next Speaker: Yes.

Next Speaker: – and you pulled this to, uh, put together to show us how you're usin' your data –

Next Speaker: Um, really the data. Yes –

Next Speaker: – and then ****. Yes.

Next Speaker: Well, you know –

Next Speaker: You, you did ****.

Next Speaker: Julie actually assembled this panel. We should have mentioned that at the beginning –

Next Speaker: Oh.

Next Speaker: – so I just wanna thank all three of you for agreeing to present. I think it's so important for facilities to hear from other facilities. It's much more powerful to hear about your shared experiences, um, and Julie especially a big thank you to you for –

Next Speaker: Well thank you –

Next Speaker: – organizing and for all of you.

Next Speaker: Um.

Next Speaker: I just wanted to give that context so we, to you what, how we're hearing this, and –

Next Speaker: ****

Next Speaker: – I, I have follow-up questions. So the, you, you mentioned about the payers giving setting, you know, the levels, and is that like the, do you take all the payers and kinda do an average of what they're asking? Are they ask for very different things or –

Next Speaker: No, each one asks very different things, so I am usually not part of that conversation, but, um, I am asked for information based on those conversations. Um, you know, we're negotiating with, um, I'm gonna pick say Kaiser. We're negotiating with Kaiser who are taking care of their patients, and Kaiser has some expectations of they look at our data and say ah, you know, you could show some improvement in this area, and they're partnering with us in a lot of respects. Um, and so their payments to us will be related to how ****.

Next Speaker: And do those, those questions that you like do all the yearly **** or you're sort of?

Next Speaker: Do what?

Next Speaker: Do the question usually come through quality or **** –

Next Speaker: Uh, well my department –

Next Speaker: – **** –

Next Speaker: – is in quality.

Next Speaker: Mm hmm.

Next Speaker: Um, the questions come mostly through the executive team I would say. Um, although they are, come from all over the place truly.

Next Speaker: Well thank you for sharing how you –

Next Speaker: Yeah.

Next Speaker: – how you show your data.

Next Speaker: **** next.

Next Speaker: Uh, we have Molly Hale from OHSU.

Next Speaker: Okay **** –

Next Speaker: If you would like. Sure. Yeah. And I think we have plenty of time so we can take questions all at the end, um, before we break.

Next Speaker: Okay. So I am Molly from OHSU, and we start at the very high level. This is our OHSU clinical enterprise strategic plan. Uh, 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, um, the, the larger OHSU vision, so this would include the research mission, uh, the academic mission, um,

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, um, healthcare strategic plan, we've got CLABSIs and CAUTIs, and these are only cases that are on CMS reporting units, so only in our adult population. Pediatrics do not factor into it, nor do our specialty units. We have got for example a dedicated spine unit and we have a bone marrow transplant unit, so all of those units that are excluded from CMS reported, um, do not go into the data that feeds into this larger strategic plan. Um, hospital-onset C. Diff is in there because that's a, a whole hospital reporting except for the NICU, and 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, and those that might not be familiar with Vivient, it's formerly known as UHC or the University Healthcare Consortium, and this is a large collaborative group that we belong to that allows us to get best practices and to benchmark with other facilities. Uh, UHC was bought over, or was taken over by Vivient a couple of years ago so now, um, our goal is to be in the Top 10 of Vivient, Vivient hospitals. So the things that go into our ranking, there are six domains, mortality, effectiveness, safety and equity patient centeredness and, um, efficiency, and within the safety domain, it's where we have our HAIs, so our CLABSIs and CAUTIs, and again, those are from our CMS reporting units. C. Difficile and then those two surgical site infections that go into our reporting. Last year, if anyone's interested, we did not crack the Top 10 but we were No. 12, um, of all of the university hospitals that are a part of the Vivient 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, uh, uh, relative to everyone else. Um, so we don't know any, uh, during the any given year how we're doing, so of course we set some internal performance improvement goals to make sure that we're, uh, meeting our internal targets. So we have our goals, um, divided up among our patient population, so we have adult inpatient, pediatrics and then our ambulatory access areas. So within the adult inpatient for our HAIs, we're looking at C. Diff, CLABSI, CAUTI and SSI. Right now the SSIs that we're most concerned about are, um, those are part of CMS reporting, so the colons and ABHIST, and then craniotomies we also do surveillance on and we have a dedicated performance improvement projects to reduce our crania infections, and then within our children's hospital, uh, 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 and ****. So our HAI goals for the last fiscal year was to have a non-MBI CLABSI rate, so these are not **** codes, so barrier injury CLABSIs we take those out of our performance improvement target, but to have a 15 percent reduction in our, um, what are largely considered to be preventable CLABSIs from the prior year. For CAUTI, our goal was a 10 percent reduction from the prior year. For C. Diff, it was a 25 percent reduction. We set a very aggressive goal because we were rolling out a big initiative that we knew would be successful, and then for colons and ABHISTs, um, our goal is to be in that Vivient Top 10, but again, that number is only produced once a year so we calculate out what the SIR is in order to have met the Top 10 for last year, hoping that it would be, um, similar to what it might be this year. The cadence of reporting of our internal performance improvement efforts for CLABSI, CAUTI and hospital-onset C. Diff, we report out monthly at our administrative huddle how many, uh, what our monthly target is and then where we're at in that month. So for example, if our target is to have four or fewer cases per month, uh, where we're at within that. We generate that monthly target based on the rate, and that rate

comes from that, that X percent reduction from the prior year. So we've got a lot of visibility around our HAIs, we publish our, our rates monthly and then for SSIs we publish that SIR quarterly when we have our infection prevention and control committee, um, and then SIRs for all the metrics get bundled into that quarterly, um, larger analysis. I did wanna mention the hospital-onset MRSA ****. Um, this is the, all inpatient units are included in this reporting. Very poor quality of definition. We found out that we're getting dinged. Um, we had 30 cases in 2017 when we did a, um, a clinical analysis of those cases. If we took away the duplicates, if we took away those that were present on admission and if we took away those that had an alternative primary site of infection, we would be less than, uh, what's expected from NHSN for, uh, for a facility of our size, and what's really unfortunate is that this contributes, um, to significant penalties for the hospital over multiple years. So right now hospitals are getting penalized for their 2016 and 2017 data. So right now we had this, this, um, increase in MRSA in 2017 so we're getting hit for it this year. We're gonna get hit for it again next year when, uh, uh, CMS is penalizing hospitals for their 2017/2018 data. So really this accounted, um, uh, for, you know, 1 bad year that really was 2 bad months, um, uh, but we're getting penalized for it in two consecutive CMS repayment years. So it's unfortunate that, um, very low quality of definition is being used for, for this purpose. Regarding incentive pay and payer contracts, uh, HAI data has been used in the past for leadership incentives but not recently. Um, and, and no HAI data was included in the FY '18, nor is it included in the current FY '19, uh, leadership incentive plan, um, and then for payers, a small number of payers have some built-in value-based measures. It's not all of them, and those do request additional data, um, usually just like Salem goes through our quality management department. Uh, and then there are some preferred contracts for, um, specific procedures where additional data is requested, but it's not all of them. Um, and we provide data, uh, ah, as one-off requests as it comes in. I'm happy to take questions either now or at the end.

Next Speaker: I think we'll definitely have time at the end, so.

Next Speaker: Good.

Next Speaker: Okay. ****. Okay ****.

Next Speaker: Okay. Great. Well thank you Molly. Um, I have one clarifying, and again, this is has come to the clinician that one's familiar, familiar with this but for the leadership incentives is that something that actually gets paid to the managers or the leaders or does it come back to the, 'cause, uh, that, I've heard that in a couple of the presentations ****.

Next Speaker: So, uh, so for OHSU it's managers and above, so –

Next Speaker: Mm hmm.

Next Speaker: – any managers, directors, senior directors, associate VPs and VPs.

Next Speaker: Mm hmm.

Next Speaker: Um, and I can't speak to the physician side of things. They are technically employed through the School of Medicine.

Next Speaker: Mm hmm.

Next Speaker: Um, and so I don't know what their, um, incentive payouts might be.

Next Speaker: Okay. **** thank you.

Next Speaker: Uh, I would say it's the same incentive.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Interesting you **** that data. Um –

Next Speaker: **** drive **** –

Next Speaker: Yeah.

Next Speaker: – incentive payment.

Next Speaker: Yeah.

Next Speaker: So.

Next Speaker: Yep. Great. Uh, is the one ****.

Next Speaker: Thank you.

Next Speaker: Yeah.

Next Speaker: Um, well I've really, um, limited this to how we use NHSN for, um, benchmarking or goal setting, and so, um, feel free to ask me questions because, um, I don't have in my slides, um, all the venues and places where we share data. Uh, but, uh, Legacy Health has, uh, two big aims for quality and patient safety, and these were set from our board of directors in 2008, um, and that is to eliminate needless deaths and preventable harm, and so, um, this is kind of our umbrella approach, uh, where each fiscal year then we set, uh, goals to help us achieve these big aims. We have, uh, a committee called quality **** and leadership committee that's, uh, made up of our hospital presidents, our chief nursing officers, um, several of our clinical vice presidents, um, and is chaired by our chief medical officer and then, uh, my manager, our vice president of quality and patient safety, and, uh, this group, um, around this time of year, um, is setting goals for our next fiscal year, which begins in April, and, um, the goals are included in this composite that we call the hard index, and so, um, HAIs always make up about half of that index, um, and there is usually, um, **** between seven and, and nine metrics, and so, um,

currently in our harm index, um, we include, uh, CAUTI, CLABSI, and all procedures for SSI and, uh, C. Difficile. Uh, and then I just wanted to share how we assess our internal performance. Um, in, in some years we have set goals, reduction goals against our baseline, um, but, um, we, as we closer and closer to, um, uh, like the national thresholds, um, we are looking to our, our external, um, data sources to help us, um, with, uh, target setting, and so, um, with NHSN, um, we use a standardized infection ratio to report, um, infection data all the way up through the board of directors, and, um, uh, uh, this is different from in previous years NHSN, uh, when they were using rate data, of course we'd get to see like what is the 50th percentile or the Top 10 percent of, um, all acute care hospitals. Um, that's no longer reported as we are using the SIR, um, which is a, a great measure, um, but how we're able to use, uh, the SIR is, um, since our predicted performance will be at one. For us, we just see that as the, the minimum performance and we wanna be better than what's predicted. Um, so that's the left-hand column there. Um, and then the middle two columns, um, are the data we receive from, um, CMS. Uh, we look at our, uh, value-based purchasing program. Um, each fiscal year for CMS they report data, um, from all acute care hospitals, um, that are required to participate, and from that we can see wu, wu, how are other, um, how is the nation performing in terms of the, um, 50th percentile or the national average and then the Top 10th or the 90th percentile, and so, um, in its current fiscal year, um, we have, um, for our Calendar Year 2016 and CAU, looking at CAUTI as an example. Uh, the national average is, um, a .828 standardized infection ratio, and so, um, although the CDC would say based on your patient populations we, um, **** you if you had a 1.0. We can say that most hospitals in the country are performing about 20 percent better than that's predicted. Um, and so **** for our CLABSI, about 30 percent better than predicted, um, and, and C. Diff around the, around the same, um – I didn't include the SSI, um, metric in here because, um, for, uh, CMS they are looking at abdominal hysterectomy and colon procedures. Um, uh, we report our, our SIR for SSI as, as all procedures, um, using the same parameters that CMS uses for those two procedures of the same report. Uh, and so kind of the best external measure we have, or, um, external data source to help us figure out how to **** around all procedure SSI is, is Department of Health and Human Services. Um, we have our 2020 HAI targets for ****, so, um, they set these, um, targets as a percent reduction from what's, what's predicted using, uh, **** 20, um, 15 baseline, and so, um, if we looked at what's predicted as 1.0, um, they, uh, set a 30 percent reduction for SSI, um, which we would see as .7, um, in the form of a SIR, and so, um, that's what our, our aim is. Um, our, our top performance is zero because we aim to have no preventable harm, and if we could **** this all a part of our harm index, and so, um, that range there is from one to zero or from the, um, the 50th percentile to zero, and, um, when we look at the whole composite at the system because this also includes things like, uh, readmissions and other types of harm events, um, then the hospitals, um, internally we have this like scoring system where, um, all together you have a certain amount of, of points, um, toward, um, what's predicted based on patient populations and then, um, SIR and then, uh, zero for zero harm events, and so that's kind of how we, um, take a look at, um, our internal performance and assess how we are doing in comparison to the rest of the nation. So, um, that's, uh, that, uh, that's all of my slides, but I'm –

Next Speaker: ****

Next Speaker: – happy to answer questions about our process or other **** report data too because, um, SIR data is shared just up and down in the cost. The organization and, um, a lot of

our, um, as an example, a lot of our, uh, service lines, um, in surgery, they, um, our physicians will receive a SIR by physician that's not identified so that they can know what their performance should be. Um, and so a lot, we, uh, share a lot of, um, just data specific to, um, service line and, um, including count data, um, in all shapes ****. That's, that is it.

Next Speaker: Thank you. Well for three different examples, very different, on how it's used. Any questions from the audience in the room or on the phone?

Next Speaker: I have a questions, um, to all of you. Um, so how much of this, um, benchmarking data and progress towards those benchmarks is shared with frontline providers?

Next Speaker: **** I can start.

Next Speaker: Okay.

Next Speaker: Uh, uh, when, uh, HAI is identified, um, any one of these and including MRSA **** and some of the others that are on this slide, um, as soon as possible, um, our, my team members, I have nine **** practitioners, um, when an HAI **** will send the, um, case, uh, to the whole care team, um, including the bedside manager, um, and will include the providers, um, and then typically within 72 hours we do a huddle at the bedside, um, with as many people that can come just to see if there was any, um, process learning from the standpoint of the best practice module or otherwise, and a lot of times the physicians can't be there, particularly for like SSIs, um, and those are kind of handled differently, um, but the, um, surgeons and, or the hospitalist, will, um, sometimes comment and **** about what their perspective was to see if there was any, any learning, or if there is anything that we could have done better as a, as a leadership team or otherwise to help support the care of the patient in this, in the example.

Next Speaker: Um, at Salem, it depends on the infection type, um, how, how it's communicated, um, and who it's communicated to, so, um, for example hips and knees, um, which were an area of focus us, uh, were sent to the section chair, who then shared 'em with the provider involved in that procedure. Um, we're starting something this, uh, this year, um, just because we, um, moved to Icon surveillance system out of Epic, so we're gonna start using In Basket in Epic to notify providers, um, directly on the infections and, 'cause they ask to get it that way. So, um, 'cause they're in that all the time. Emailing providers is a challenge in the healthcare system because of none of 'em, at least in my system, use the Salem Health email, and of course this is protected health information, so we get into encryption and all the changes with encryption, so we're goin' In Basket this year.

Next Speaker: Uh.

Next Speaker: So at OHSU, we, uh, do a notification of every HAI. We let, um, if it was for example a CLABSI, CAUTI or C. Diff, it gets attributed to a unit using the NHSN criteria, so then the unit leaders pull together multidisciplinary **** rate, well and we ask that get pulled together within 7 days of the notification, and any that have not been completed, I include that in my weekly update to our, uh, administrative huddle which case reviews are past due, and then just like, um, at Salem, we're also a lead organization, so we have A3 performance improvement

teams around our four, um, that are in our Tier-1 priorities, so, um, monthly when those groups come together we share the most recent data, and so that would have it. If we're able to provide an SIR we will, um, but at least we can provide the rate and provide some risk adjustment.

Next Speaker: Any questions or clarifications from the phone audience? Well if you have any furthers, if there are questions that come up, what's the best way for folks to follow up?

Next Speaker: You're welcome to email me and I'll pass it along to our panelist.

Next Speaker: Okay.

Next Speaker: Yeah. ****

Next Speaker: Thank you. Uh, it's very –

Next Speaker: ****

Next Speaker: – it's a very complicated subject **** –

Next Speaker: Yes, it is. It is.

Next Speaker: To hear about how you **** so thank you. Uh, so at this point, um, we are due to take a break.

Next Speaker: Okay.

Next Speaker: Okay. Folks. Thanks for the great conversations. Um, we'll jump back in here. So, uh, next we're gonna hear from Jenna Bronze from Legacy Health and **** also from Legacy Health, on how they setup, uh, their **** center and how that went. Oh no. Excuse me. I have a different title here on the page than what's on the screen, so I will let her introduce herself.

Next Speaker: Sure.

Next Speaker: ****

Next Speaker: Oh good.

Next Speaker: **** thanks for giving us time to share, um, about our unit. Um, at Legacy Good Samaritan Medical Center, um, we have setup an Ebola assessment center in, uh, 2014/2015 during the time of the outbreak in West Africa, and, um, we continued to, um, keep up our unit, um, because we have a, just a really passionate team of providers and nursing staff and, um, leaders from across the system that, um, have, um, an interest in continuing this work and are committed to, um, doing this long term, and so, um, I'll share that. Um, a brief background is that in 2015 we had a team from the CDC, um, and, uh, uh, from the state come and do an evaluation of the unit and that, um, was when we were formally designated as Ebola assessment

center and then, um, just recently, um, this last July we had a team from the National Ebola Training and Education Center, or NETEC, come and conduct a 2-day evaluation of our unit, and this team is made up from, uh, made up of, um, clinical and operational leaders from Emily, UNMC and, and Bellevue, um, and these are three considered the leading treatment centers, um, in the United States that are now supported by, um, the, um, CDC to come and provide consulting services, and so, um, similar to the, the accreditation process, they have a, um, a large manual of, um, capability standards, um, that we need to meet to continue this work. Um, it's sort of this, about the same for assessment and treatment centers, um, but if you **** next slide.

Next Speaker: Mm hmm.

Next Speaker: Um, **** out of order.

Next Speaker: Sure.

Next Speaker: Um.

Next Speaker: Oh, you know what?

Next Speaker: Oh, there you go.

Next Speaker: This is why. Excuse me.

Next Speaker: That's okay. It's okay.

Next Speaker: There we go.

Next Speaker: Okay. Um, so –

Next Speaker: ****

Next Speaker: – **** during the outbreak you may remember that the CDC grouped US hospitals into categories of preparedness, um, that all, um, all facilities are considered, or hospitals are considered frontline, um, centers and, um, what's the requirement of being able to safely, uh, receive, um, and isolate a patient who may be at risk for a high risk, or infectious disease, and, um, Ebola assessment hospitals, um, uh, were asked to be able to, um, safely hold a patient for up to 96 hours as, um, treatment centers for the duration of the illness. Um, and when we had the NETEC, um, team come, we invited others, um, our partners from EMS, fire, hazmat, um, or health authority, and, um, we, uh, learned a lot of, um, we had a lot of valuable learning around, um, EMS, um, transport procedures. Um, so for an assessment hospital, um, after the 96 hours of providing care of the patient did the long-term care for, um, a disease like Ebola. Um, there are ten regional treatment centers across the United States, and our regional treatment center is, um, Provident Sacred Heart, um, in Spokane, Washington, and so, um, transferring a patient to Spokane, which is typically a 5½-hour drive, uh, might actually take up to 10 hours, um, and that is because every 2 hours along the route from Good Sam to, um, Provident Sacred Heart, EMS would need to rotate team because of the hazmat-like gear that they're waring. Um,

so there are, are 13 hazmat teams in the state of Oregon and they all train to the same level, um, and regardless of a dry or wet patient, um, they would still kind of, uh, wear the same level of, of gear. Um, so depending on the stage of disease and other factors, it, it may actually be safer to keep the patient at Legacy Good Sam, and so, um, inviting the NETEC team, um, was something we wanted to do to assess, um, how we were doing, um, and if we were ready to, um, consider being a treatment center for the state of Oregon, and so that's something that we wanted to explore internally, um, as we continue to want to get better and better at our preparedness operations. Um, so you could skip two slides and so then we'll share about our, our team.

Next Speaker: Hi. So, um, our care team is, about, uh, made up of about 30 people, so we have a mix of nurses that are from the ICU, uh, we have Med Surge, Women's, we have pediatrics, and we have some ED nurses as well, and then our physician team is made up of just, um, intensivists and hospitalists from across the system. And then we've included respiratory care and lab technicians on our team as well, so everyone on the team is responsible for all aspects of care whether it's the patient to, um, waste management, daily cleaning, um, and then we just bring other specialists if we need, so like imaging staff has, um, come up to help us do portable X-ray, um, and then most other stuff would be done via remote consultation, and we have a telehealth robot for that. So, at this time our staffing levels should be adequate for a couple weeks of people with **** illness, um, but that's just with a minimum of three RNs per shift, and that can change depending on the acuity of the patient. Um, and then we would adapt this as well for an airborne-type virus, which has a different intensity level for staffing. Um, we are required to do, um, training throughout the year, so we currently have two trainings; one, um, at the beginning of the year, which we do, um, a simulation with our training as well as the usual, uh, donning and doffing. Um, with that we do include an education from our infectious disease experts, um, who come in and just do a didactic about what kind of, um, infectious diseases are going on in the world and, um, what are the things we need to prepare for. And then in our simulation, we practice, um, a range of skills from basic things to, um, things that are outside of their normal workflow, um, but everything is done while they're in their PPE, which is just a very different experience when you have on three layers of gloves and **** suit and PAPR um, and then oftentimes multiple steps for most of these things as well, just baseline requirement for Ebola. Um, and we, we trained at this level because it kinda gets it in the highest level as well. Um, and then we try to integrate a lot of tools and techniques into the **** setting because when you have a PAPR on, you can't use a stethoscope, so we have Bluetooth, um, capable stethoscopes. Um, you can't open the door and walk out and get in supply, so, um, having conversations, um, has to be done, you know, in a different manner, so we did add an intercom system into our, um, isolation unit as well so that people can talk with the door staying closed. Um, so, and then we just develop our SOPs around that, so all of our standard operation procedures were essentially based on what Emery and UNMC shared, but we have adapted them for our legacy workflow and, you know, what, what, um, is going on in the BIC-U as well. Um, and so every time we do a simulation, we talk to our care providers, and we debrief afterwards, um, talking about what types of things we need to adapt or change, so everyone has a, um, input into what they're doing.

Next Speaker: Um, just looking to the future, um, we have a, a long list of things that we wanna do and, um, internally, um, I think we need a system for, um, developing a, um, **** program. During the time of the Ebola outbreak, um, we had, um, maybe about 70 people that were really

interested in being on the team and that trained initially, um, but of course as things are, um, less exciting and not in the news, um, I think people have forgotten, and we have a big system, and so, um, uh, part of it is advertising ourselves. I think more people would be willing to be on the team if they knew we still existed, and so **** is always challenging, but in the event of an outbreak or otherwise, I think there are new people that would step, step up and say I, I'm willing to be a part of the team if, if, um, someone can train me. Um, and then practicing **** drills, um, that was, um, a great, um, piece of advice we received from NETEC, and, um, and that was thinking about it in terms of like the entire, um, uh, start-to-finish setup, but you could take, um, just sections of your standard operating procedures, like just the handoff from E and S to the BIC-U and, and practice that, and so, um, how do we need to get off hairnets and **** and **** and it doesn't have to be the, uh, you know, a 5-day exercise. Um, we would love to be a part of the **** exercise for an upper-respiratory infection, but part of our standard operation procedures, um, is care of a patient with MERS, and so we've taken all of our procedures for, um, a bio-hemorrhagic virus and translated them to an upper-respiratory infection, and what would that look like in the BIC-U. It's gonna be just an entirely different setup, um, and probably a lot less complicated. And, uh, I won't go through all of these, but, um, we're looking forward to hearing back from NETEC, um, to help us assess our **** rates as an assessment hospital and look to the future potentially as, uh, a treatment center, um, and so they'll arrange a phone call with us hopefully in the coming months, and, um, share kind of a written report of things that we need to be working on to, um, improve our, our, um, performance. So, and I just wanna, um, thank Judy for being such an important liaison of, of this work. Um, I think that I – with, without your leadership on the community and in our hospitals and stuff, we probably wouldn't have been able to continue in the way that we have, so, um, Judy has helped us, um, form good partnerships with all of these organizations, um, and our teams have visited treatment centers and gone to training thanks to **** OHA, and so, um, we've been to UNMC and, um, the NETEC simulation training. We've sent, um, our, some of our pediatric nurses and, and other leaders, so it's been a really important part of like, um, keep maintaining momentum and just, um, overall education. So, any questions?

Next Speaker: Um, how, how long should a frontline facility be able, be able to care for a patient, and would it be related to time to get to your facility? Um, I'm, since you said the 10-hour ride, that's, you know, to Spokane takes how many **** changes, right?

Next Speaker: So, I can speak to that.

Next Speaker: Yeah, hopefully.

Next Speaker: So, um, so there's, there's currently, currently still have three assessment hospitals.

Next Speaker: Okay.

Next Speaker: Um, so we have **** here in the Portland area. We have, um, ****, um, uh, Samaritan. Uh, Samaritan, though would have **** nationals. That's, are all three very, still, very much engaged, still doing simulation exercises, still have excellent support from their hospital leadership. So, I think if there was a situation where we would have somebody, who potentially **** a sick person, or Ebola was on the ****, we would, you know, we would have

to then do an assessment of that specific person, looking at their risk. You know, were they actually in the DRC 2 weeks ago working with people with Ebola, or, you know, do they have some travel in that area, but really weren't doing any, you know, they weren't a healthcare provider or whatever. So, we have to look at their risk; how sick they are, um, at that time and then make a decision that – because if, you know, and we kind of talked about all of the protentional situations and think, well if it's somebody who actually is very high risk, say, you know a physician or a nurse who was there on a medical mission, um, and at the moment that they develop a fever and diarrhea, they're actually mildly ill, we actually – at least if this happened today, we would probably just send that person straight to Spokane because the risk would be lowest to transfer that patient before they're having bloody diarrhea and vomiting and **** or the EMS and everyone else who had to be in, in charge of that transportation, but if it was somebody who even was very, very ill, but their risk was actually quite low in terms of their activities and ****, then we would probably try to keep that person near the **** and decide which of those three hospitals from a transportation and readiness perspective would be ready to accept the patient. Um, you know, and then, of course Legacy's, you know, kind of looking at well what if we have an Oregonian, who can't be transported because it's what of those weird snow days or something.

Next Speaker: Yeah.

Next Speaker: Then, you know, so that's why we're trying to, you know, we're so grateful that Legacy is looking at their capacity to be able to **** the treatment center. But, you know, it was sobering when NETEC came. You know, when the, you know, when the physician was life-flighted to ****, he was there for 40 days, so you have – if you say you're a treatment center, you have to be a treatment center, so, um, so NETEC said it was in 3 months to have their completed report come back to, um, to Jenna's team, and they came in July, so it should be coming by the end of next month, and then I think, you know, we'll come together and decide if, you know, Legacy has that capability to do an effective ****. So, um, but, you know, I – so, thank you Jenna for your team, uh, and to the other two hospitals, um, to, for their continued, uh, support. I mean, you know, OHA has been really great with, um, providing some financial support to all of the teams to get them to training, um, sessions and, um, conferences all over the county just to continue the, the readiness, and I, you know, I mean, as CEO of Ashland Community Hospital, I wanted to, um, ****. I mean that just shows you the level of support at the administrative level for ****.

Next Speaker: Thank you, and I think also, you know, back to your original question to Ublie about if you're a frontline healthcare facility, the expectation is that you'd be able to ****. They say help in 24 hours on it.

Next Speaker: Yeah.

Next Speaker: Dr. Gubman, if you wanna clarify that, but I think you should be able to say ****, you know –

Next Speaker: Right, yeah. I mean it's at least **** 24 **** be able to sort it out ****.

Next Speaker: Right, but if, but the expectations are recognition, so –

Next Speaker: Yeah.

Next Speaker: – incorporate triage, travel, symptoms, isolation –

Next Speaker: Yeah.

Next Speaker: Let's say, like you, like for, um, a, yeah they're ****

Next Speaker: Identify, isolate and ****

Next Speaker: Identify, isolate – so those are the ****, but the, I, I **** if folks on the phone or in the room have more questions about those kind of things, I, I CDC, at least last time I checked, had a great website, and they've got all of that **** these things.

Next Speaker: Yeah, I think it's still up.

Next Speaker: Um, but that, that is sort of the expectation and part of – while, while we did some of the, I think the state is doing the ICAR, and Dr. **** that to also make sure all our hospitals have gotten some, um, good, um, fundamentals, and so like if anybody could do the initial steps, and then, um, so –

Next Speaker: Give us 3 hours.

Next Speaker: Give us 3 hours. Thank you. Well, I think it's very timely too because at the end, I knew they could, you know, there, it is resurged in different parts of DRC and Congo because of the local conflict, um, you know, these are, these are realities, so thank you. Um, great. Well, on to our next, um, more local and probably more prescient upcoming infectious disease, influenza. Uh, Monica Sample will talk to us about the healthcare worker and influenza vaccination data.

Next Speaker: Thank you. Thank you.

Next Speaker: Uh, and she's got a microphone ****. Perfect. Or if you, if you wanna come up here, you're welcome to come here.

Next Speaker: How do I know this is working or not? Red light mean it's working?

Next Speaker: I think so.

Next Speaker: Okay.

Next Speaker: And if, if folks on the phone can't hear her, please let us know, and we'll, we'll make adjustments.

Next Speaker: So, I am embarrassed to say that this is the data from 2016/2017. It took me, it took, for a variety of reasons, it took us a while to get that report done. Um, this is what the report looks like currently. Oh, there.

Next Speaker: Yay!

Next Speaker: This is, this is what the, my goodness. This is, oh, there we go. And I brought a bunch, and they're on the back table if anybody's interested, but they are available online as well. Um, go ahead and skip to the next slide. Oh, sorry Jen. Okay. Uh, this is the seventh annual vaccination survey, and it does include, um, data from 64 hospitals, 137 long-term care facilities, 86 ambulatory surgery centers and 67 dialysis facilities. Now, I do include that information because those numbers do fluctuate from year to year. Um, actually, there are four new dialysis facilities just this year alone. Go ahead to the next slide, Jen. Thanks. Um, influenza, we all know how important it is for everybody to get vaccinated, and this report focuses on the healthcare workers' vaccinations, not the residents at long-term care facilities or the patients in hospitals or ambulatory surgical centers. Um, the flu is associated with 12,000 to 15 – 5,600 deaths annually in the United States, and during this year that this report was developed, there were, um, the Portland area alone reported 1,466 hospitalizations related to the flu, and there have been five Oregon pediatric deaths over the last 5 years. Now, that was up to 2017. It's been more since then. Go ahead and next slide. This is a nice slide that shows, um, the fluctuation of the healthcare 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, um, and ambulatory surgical centers and long-term care facilities, and it wasn't as robust as this is. The, um, the trend here obviously is one of increasing vaccination rates, but I like it 'cause you can see, um, that there are fluctuations from year to year and that some of them are greater than others. And the next slide. This is nice 'cause it shows that, yes, there is an overall increase in vaccination rates with the at, the cumulative facility types over the years. And again. This slide, um, shows us the aggregate data for the different facility types; hospitals at the top, ambulatory surgical centers, nursing facilities and then dialysis facilities, and what it shows is 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. Now, I apologize. The numbers on here are incorrect. It should say 2016/17 in the title, and then the **** should be 2015 in the last column. Sorry about that. Um, the column I'd like to focus on is the rate of unknown vaccination status, especially like in the skilled-nursing facilities. You know, if we just knew – who knows. Maybe those unknown 50 percent of independent practitioners, maybe 40 percent of them actually got the vaccine, and we just don't know it. Um, so better tracking, I guess, would be important to be able to know the numbers a little bit better because this shows a really high unknown rate in several different facilities, and for some reason it tends to be the independent practitioners, and I think because they tend to move around from facility to facility, they're harder to track. They come and go. And you'll see the same thing for the students and volunteers, again especially in the skilled-nursing facilities. We don't always ask them the minute they walk in the door, and if they're only there to volunteer for a week, you know, hey did you get vaccinated this year, by the way, for the flu? So, that's why I think it's harder for them to keep track of those numbers. And the next slide. So, this is facility-specific data. I have pages and pages of it in the report itself. Um, I go by facility type with hospitals first, and then,

um, going on from there. I blacked out specific facility names, so we wouldn't pick on this group of ten right here, but again we start with the number of people eligible for vaccine, the number who – I'm sorry, the rate of vaccination, the rate of declination, the rate unknown, and then the change in rates in the next season. Then, the next two columns, I think are very interesting. We follow the, um, healthy-people target produced by the, um, Health and Human Services that requested or made goals that in 2015, 75 percent of these healthcare workers should be vaccinated for the flu, and by 2020, a 90 percent goal was, was the goal. So, you can see that the green, the checkmarks are the good, you know, the yay! They made 75 percent, and then the, the red X is not so great, not meeting that 2020 goal, but we're not there yet. We've got 2 more years, but still I'd like to see a lot more green even in the left, or the left side of those two columns. And then I like the last column because it shows facilities, I think – like, look at that facility, you know, fourth up from the bottom. They only needed 5 more people to vaccinate in order to meet the 2020, um, goal. Um, whereas some, you know, you can see the obviously bigger facilities, it may be 200 or 788 facilities, or individuals still needed to be vaccinated. I know that's kind of a busy slide. Any questions on that? No? Okay, and I think – is that it. No, yeah, that's it. I wanted to let you know that I do have all the numbers for the, um, 2017/18 vaccination year, and it looks like, for surprise, every facility-type has an increase in the vaccination rate this year, which is very exciting, yes. We'd like to see it higher, obviously. I don't think anybody's reached that 90 percent mark yet, but, um, it is still trending upwards, so our efforts are being recognized. Thank you.

Next Speaker: Uh, this is Rosa. Monica, I wanted to mention when I analyzed these data in Alameda County as a fellow there, um, they implemented a masking, a, you know, a, a masking order, um, in patient care areas for those that were declining vaccination. Um, this was a while ago. Um, but we found that, um, you know, the percent in increase, which was around 14 percent pre and post season after the masking order was almost exactly the same as percent decrease in unknown status from the prior season.

Next Speaker: Really?

Next Speaker: So, I do think that you're right that like, the unknown is, can make or break these targets often.

Next Speaker: Yeah.

Next Speaker: Yeah, and a lot of those folks are getting vaccinated. They're just not providing documentation.

Next Speaker: Yeah.

Next Speaker: Can I, Can I just make two comments.

Next Speaker: Yeah.

Next Speaker: Sorry, I just, um, want to plug a couple HAI program activities that are gonna come out in response to some of these datas. So, um, we're gonna be focusing quite a bit on

SNIFS. Um, our vaccination rates are around 60 percent overall, so I think that's where we're gonna see some big increases. Um, so a couple things we're doing. We're gonna be doing direct outreach, all 137 SNIFS to make sure they have received both the OHA flu vacc tool kit as well as the CDC flu vacc tool kit, um, and we want it to be a venue for them to ask questions and serve as a sounding board if they have strategy ideas and things like that. Um, and then we also have a long-term care facility survey that's going out in the next several weeks. Um, so that'll include questions specifically related to how they're documenting vaccination and also their strategies for vaccination in their facility, so hopefully, we'll have some more information to see if we can share ****.

Next Speaker: Great. Yeah, good effort. Actually, I was just – this is Genevieve. In the clinic, they're supposed to be rolling out vaccines, and I guess there's a lot of folks, who already don't – they wanna get vaccine, not vaccinated too early or their hesitant about it, so all the messaging we can do to, to change that – 'cause I feel like every year it's a new battle, but, um, thank you for all your efforts. Uh –

Next Speaker: Jen?

Next Speaker: Yeah.

Next Speaker: This is Pat Preston.

Next Speaker: Oh, yeah.

Next Speaker: May I ask a pertinent question?

Next Speaker: Absolutely.

Next Speaker: Good. Um, I had a major local client call today, who stated there is a vaccine, vaccine delay/shortage, and they may not be able to complete vaccination by October 30 or so. Have any of you all heard of a pipeline vaccine issue?

Next Speaker: I have not, but that would probably be a question for our immunization group. We ca pass that on and feed back any information.

Next Speaker: Um, this is Mary Post. Um –

Next Speaker: Hi Mary.

Next Speaker: – I know Trainer's, um, received information, and a lot of vaccine distributers, um, notified facilities that there would be, um, uh, a short delay, and, um, I know we received about a third of our doses that we ordered. Um, the delay – um, from my understanding, it's not associated with quality issues. It was, in fact, associated with changes to, uh, the approval process and the steps that need to be taken into account before it is released. Um, and, um, they were encouraging, uh, that flu clinics not be scheduled until the end of October.

Next Speaker: Mm.

Next Speaker: But we've already initiated our vaccination campaign, uh, but we're just focusing on, um, clinical employees and employees with high-risk, uh, medical conditions.

Next Speaker: Okay, thanks Mary. That validates her concern. Thank you.

Next Speaker: And I, you know Nick, and my messaging to everybody has, you know, at our facility has been very clear that there will be an adequate supply, but that shipment will be delayed.

Next Speaker: And then of course, there's always, and there are alternative ways to be vaccinated – through pharmacies, etc. that, you know, process normal insurance, so if anyone's concerned, there's many ways that they can go get the vaccine and have it covered, so encouraging that as well. Great. Any other comments, clarifications, concerns? Cool. Okay, next we're gonna hear travel update/travel screening.

Next Speaker: Yeah, so my, my charge today was to talk a little bit and facilitate some discussion about travel screening. Um, I wasn't planning on presenting any slides for this, but there was a little bit of late-breaking Ebola information. So, just to motivate the discussion, um, I just wanna also call out, um, Judy Guzman, who is our medical director for Ebola and special pathogen preparedness, so she's gonna interrupt me if I, um, say anything incorrectly or if she has any additional information. Um, so I just wanted to, um, communicate what the WHO has put out about the Ebola situation in DRC. Um, so as you all probably know, a new outbreak was declared on August 1st, 2018. Um, this is the seventh largest Ebola outbreak, and as of 20, of September 24th, there's 151 cases, including 120 of them that are confirmed, and, um, 101 deaths so far, so high case-fatality rate like we've seen with other outbreaks. Um, the epi curve is shown there. Um, we are seeing a decrease in the rate of infection right now, so it went from about 40 cases a week to now about 10. Um, next slide. But the concern that got quite a bit of media attention over the last 24 to 48 hours, um, this was a story that stood out coming to ****. So, the WHO is now warning of a perfect storm of factors that may worsen spread, so, um, a big piece of that is misinformation. Some of the political upheaval there is causing quite a bit of mistrust with community outreach and the government there. There's also been a lot of political violence in the hot zones, which has therefore limited healthcare worker access, so they've been unable to perform contact tracing in up to 80 percent of estimated contacts, um, and they are not able to maintain un, uh, save burials at this point, which as we know, is a major, um, factor for transmission in these areas. Um, so WHO is currently discussing whether to declare it a public-health emergency of international concern. And just to point out on the map here that, um, the area where there's particular conflict right now is Benese, and it's right about the center, uh, and there's at least 29 cases there right now, so pretty concerning. So, I just also wanna put a plug in while we're talking about this for some other high-impact pathogens. Uh, as we know, we all saw some measles cases here over the summer, and, um, just a, a plug that we, you know, see measles endemic to many areas in Europe, Asia, Africa, the Pacific. So, it's always something we need to be on the lookout for imported cases. Next slide. And same for MERS. Um, it's still, we still seeing cases, particularly in Saudi Arabia. So, though it's been less of a focus in the media, it's still there, and the possibility of importation is always present. So, onto discussion.

We only have a few minutes for this, but, um, I just wanted to pose – oh great – I just wanted to pose to the group, um, about the need for continued travel screening. So, you know, I think our understanding from the HAI program is there was a large, um, scaling up of travel screening around 2014/2015.

Next Speaker: Thank you. ****

Next Speaker: Okay.

Next Speaker: Um, but since then, I, I think the term the CDC is using is the kind of fizz is out of the bottle. Um, not a lot of places, particularly outpatient centers are, are screening in anymore. So, I guess first I would just like to hear, um, if any facilities represented here today are screening or are considering screening and what their experience has been like.

Next Speaker: I can start with OHSU. We started screening, uh, with the 2014 Ebola, and, uh, we never stopped it. Uh, we have the ability in our electronic health records to quickly change out the countries of interest, so right now, when anybody presents for care at OHSU, whether it's for surgery at a clinic, visit at labor and delivery, all of our portals of entry into the institution, they're asked, "Have you had cough, fever or sore throat in the last 24 hours?" If they answer yes, they're handed a mask, and they're asked about travel. Right now, the travel questions are related to the, uh, the MERS activity, so the six countries that are on the CDC website pop up in our EHR, um, and so they're asked specifically about travel to those countries. If they say yes, um, we ask that they get roomed right away and that they page infection control, and then we take it from there. Um, if they have not traveled, then they're sent to the waiting room with their mask on. Um, so we have the ability if we decided the Ebola is a real threat again, we can swap out those countries, but when, um, the Ebola activity was at its highest a few weeks ago, um, we decided not to, to swap out those countries and still kept the MERS countries in there.

Next Speaker: I can, um, tell you for Salem, when the Ebola crisis died down, we followed OHA guidance and moved to, "Have you traveled out of country in the last 30 days, and if so, which country," and Epic has a nice little module that way. So, and then if they, um, it then puts a link to the CDC travel site because we realized emerging organisms are changing every day it seems like, so that gives the provider, be it a nurse or a physician in the setting to just go right to that link and look at that country and see what's in that country at that time, and that's how we're managing it today.

Next Speaker: And, um, Molly, you guys are Epic?

Next Speaker: Yep, mm hmm.

Next Speaker: I can speak for Legacy Health. Uh, we're also on Epic and have a similar process, and, um, it's now considered standard work, and so our staff know that this will never, ever, ever go away, and it's asked in, um, in all of our, uh, clinics, um, whether a patient is calling by phone or coming in person and then also in all of our EDs and triage and all of our admitting areas across Women's and **** admitting. Uh, after the question is asked about travel in the last 30 days out of country, um, then it cascades to the specific questions that, um, are managing

MERS and then the Democratic of Congo, and then we have three links; one is the, uh, travel notices link, um, that Salem uses, and then the other is, um, the other two – sorry – our, um, case definitions; either, um, Ebola or MERS, um, and then a link to our, um, our algorithm, which is an internally-built algorithm around our process where, um, what do you do in terms of assessing, assessing the level or risk, um, precautions, um, and then, uh, notifying **** health and others that might be involved in assessing the level of risk. Um, so it's sort of like an, uh, escalation tier.

Next Speaker: And that's directed towards the triage nurses?

Next Speaker: Um, all staff, who would ask the question about travel screen. And then, uh, we've had, uh, one kind of complication around, um, patients waiting in the, in the waiting area of our ED before being asked the question, and so, um, beginning next month, we've built in the travel-screening questions into the quick, the required, uh, quick registration process for all of our patient access departments. And so it'll be asked twice because Epic gives you access because it's linked to the ED, um, triage question, but it's, we just see it as a necessary redundancy.

Next Speaker: All right. Thank you. Um, any other comments? Any other facilities on the phones who might help us out –

Next Speaker: Oh, uh –

Next Speaker: Or in the room. In the room.

Next Speaker: At, at Kaiser, we, Brenda and I have the same, uh, set of **** so we're not doing **** specific questions. Uh, but we are asking, uh, **** for any questions. We actually have a interregional group at Kaiser that we have a phone call like every Monday to discuss, like do we need to change the question, do we need to an another ****. So we're, we've continued to meet **** since the first one. Every Monday.

Next Speaker: This is ****. I'm sorry, didn't mean to cut you off. This is Kirsten Shudy of Pompei. We have a similar process to those that have already been described, um, and we past the travel screening **** as well in terms of specific symptoms, and then **** is one of our infection preventionist, uh, is updating that information.

Next Speaker: Great.

Next Speaker: Just so we have so many facilities here, um, in terms of people out on break, um, so, **** keeps in touch with the manager of, um, the biocontainment and **** and they have, um, conference calls **** and so, um, their last conference phone call was probably about 3 weeks ago **** and, um, and that's when the first case was identified in **** 'cause that a really huge **** city so the risk of rapid transmission really went up ****. So, at the time, at this time right now, today, um, there's no recommendation from the CDC or WHO to do specific screening for **** or ****. If that would change, then you would hear from us because it would

kinda trickle down from the CDC to the region and then to me and that region would come up with **** so all of the healthcare ****. So for now, it's just on certain ****.

Next Speaker: **** I think that, that **** in our next question. Is there any information that our **** preparedness team **** OHA could provide to assist with these decisions other than, you know, kind of large-scale **** or CDC and WHO? It's okay.

Next Speaker: I **** is that it's sort of the standard, or **** back **** process but have some idea that everyone else is **** one level I think. Um, so that, whoever, whichever, wherever in Oregon one **** similar information ****.

Next Speaker: Right. ****.

Next Speaker: Um, so, in relation to that, um, we are, um, developing our hospital survey as well right now and we've added some, uh, general preparedness questions this year. Um, a few things related to **** negative pressure, facilities had to get a sense of readiness for a number of **** but, um, we are asking **** questions about, um, screening of ill patients for travel outside the U.S. as well as screening of well patients for travel outside the U.S. So, um, again, we'll be able to provide some baseline information back to everyone, hopefully, um, in a few months. Um, so we can now **** put this on our web site and have it be a little more accessible, so while making these decisions you can say, well, you know, 60 percent of our peers are already travel screening, so, um, ****.

Next Speaker: Um, as that outbreak started in the Congo back in August, we started, um, having conversations again about dusting off the **** because it kind of slipped. Um, and the questions have come up, uh, like, how many Pampers should a frontline hospital have given that kind of scenario, 'cause we wanna be ready. And when we started querying hospitals, it was all over the map. So, I'm wondering if you might help with that on your survey. Um –

Next Speaker: Yeah.

Next Speaker: And I will –

Next Speaker: What do you, what do you have, or –

Next Speaker: Pampers was really the big, biggest issue. Um, even if we could all learn from each other about our PPE in those scenarios, what do you, what should we be stocking?

Next Speaker: I think there's actually, I can't remember where, **** that there's actually a calculator you can use to –

Next Speaker: Does Debbie **** that?

Next Speaker: Debbie Drake.

Next Speaker: I can send that.

Next Speaker: Yeah. I can't remember the **** but there is one.

Next Speaker: Jane, you send it –

Next Speaker: I'll send it to you.

Next Speaker: Well, you, maybe you better just send it to, to Becca actually.

Next Speaker: Okay.

Next Speaker: Um, get Becca's name.

Next Speaker: Yeah.

Next Speaker: Yeah, well, uh, and I, I think in general, as for developing these surveys for long-term care hospitals **** and the laboratories, um, we'll be getting them out soon, but if there are questions that you would like to know what your peers are doing or have thoughts about, **** questions, we're happy to add them. We're open. So.

Next Speaker: Great. Thank you. Uh, and your many questions just, uh, send them **** Becca and move onto our last presenter for today, ****.

Next Speaker: I won't keep you too long. So I'll just present, um, the data that we've accumulated through the past **** for CDI and CLABSI. So just to review, if you recall from the last time I presented this ****. Sure, um, well, Becca just **** to my people at ****, uh, Targeted Assessment Prevention. Um, but really this assessment's looking at, um, employees, um, at various levels, perceptions, um, of infection prevention practices that's targeting, um, C. Diff and CLABSI. So in terms of invitation to facilities, we invited, uh, all facilities with, uh, CAD score of, uh, **** for CDI and CAD is the, yeah. ****.

Next Speaker: ****.

Next Speaker: A cubital difference, right? Which is the number of infections that the facility would have needed, or the unit would've needed to prevent to reach the, uh, SIR –

Next Speaker: Target.

Next Speaker: Targeted SIR. I don't need to define SIR, now do I? Um, and then for the CLABSI, we, uh, reached out, uh, with the help of Judy, uh, Devon, uh, in addressing, uh, all the ****. So, uh, this is a reminder again of the facility participation, um, uh, and for the CLABSI there were five, uh, who responded to, uh, our request and CI there were 16 and you can see the breakdown that I provided last time in terms of the number of responses for **** facility and just a reminder that **** asks us that, or tells us that if you, you, you might be starting to, uh, get a sense of representativeness of, uh, perception. So you can see that for, uh, CLABSI, uh, we can do to ****. Nonetheless, I will give you a sense of what the results are for, uh, our state. So

before I go through the leading and lagging, um, areas for, on these TAP assessments, I'll define what leading and lagging are based on CDC calculations. So, as you recall from last time, there're different types of questions. There are essentially yes/no questions and unknown and then there are ****, uh, scale questions. For, um, yes/no, if you have greater than 75 percent of respondents saying yes, that puts you in a leading category. Um, if it's greater than 75 percent unknown, that's in the lagging category. And then for leading, you can see some of often and plus always need to be greater than 5 percent or if you have some of no plus unknown greater than 75 percent, that's, counts as lagging. Or we have sum of never plus rarely, plus sometimes, plus unknown greater than 50 percent that's lagging. So all that is to say, this is the result for CDI test, that's meant for the State of Oregon. So you can see there from beading, and respective beading activities for Oregon, um, many of the facilities that participated in had **** involvement in and promotion of CDI prevention activities, training for staff on head hygiene and PPE upon hire, contact precautions, signage and cleaning of high touch environmental surfaces upon patient discharge. But if you look at the lagging activities, at the bottom, see cleaning of high touch surfaces and shared medical equipment. So that was a lagging activity on a daily basis. So on discharge it was very good, but daily, um, that didn't occur as I, as often. And you can see kind of more subgroups had involvement, um, uh, not the performance is not as good or perception of that is not as good so the physician or nurse **** in for CI prevention, staff awareness of, uh, antimicrobial storageship practices and then I think we all know from our previous work on intra, interfacility transfer communications for CI prevention is not ideal. And adherence to use of Galvan gloves or hand hygiene by, not just staff, um, but also family visitors. And I think the family visitors is really quite a prominent issue for many of the facilities. Well CLABSI so take the CLABSI **** that's in it with a grain of salt. It's, as you recall, um, not many, uh, respondents of those CLABSI but this is what we found in terms of eating and **** what stage for leading, uh, again, the **** involvement in promotion of CLABSI prevention activities, uh, daily subsequent removal of central lines that are no longer needed and then audits of these assessments, feedback of central line lates and/or SIRs and then the bundled approach to central line solutions. So I think this is pretty expected. In terms of line activities for Oregon, um, uh, we've noted that there was no staff person who dedicated time to coordinate loss prevention activities is not always there. Physician or nurse champion for **** prevention activities so they're similar to the, the CDI as well. Um, interesting this part of healthcare personnel entitled to stop and non-emergency central line insertion if proper procedures are not followed. All right, so they didn't feel it pop, uh, and then central line dressing chain **** that refers to temporary lines of dressing changes so your gauze, you really should change it every 2 days. Um, and then for 70, um, permeable and, uh, that cycled every 7 days. Um, obviously, including those young pediatric patients with a risk, uh, for dislodging, uh, with half way, uh, that regular ****. And then, uh, thinking forward for, uh, 2019, we're gonna take a different tact I think. And these are the, uh, some of the criteria that we're considering, um, in, um, choosing or inviting our facilities. We're gonna look at their tag obviously. Uh, I think we're gonna look at, uh, critical access hospitals, 'cause I think that, um, you know, those are probably some of the hospitals that need, uh, uh, our help in identifying, uh, the issues and then addressing them. And obviously what the PSIR, uh, and then I, obviously, any facilities, uh, which have implemented PI projects and wish to have the weekly TAP assessments. But I don't think we would be offering weekly testing assessments for those facilities that haven't done anything based on the last time assessments. Oh, and Codie, yeah, we have to do that, these are gonna be cauterized. Um, so I think that's all that I've, um, I want to present your TAP assessments and these are the,

the members of the TAP team and, uh, **** if you have any questions or you have any interest in participating in, uh, for 2019.

Next Speaker: Is this, is, uh, leading, lagging, is that kind of a standard way these are analyzed, up, so, yeah, okay.

Next Speaker: That is, well that is a way CDC has asked this channel obviously. It's, it's all by their template -

Next Speaker: Oh yeah.

Next Speaker: - ****

Next Speaker: Hey Dat, are there any, um, plans to move this into other facility types?

Next Speaker: Oh the, **** that question. I just have a check box on my **** to do. Um, so CDC asked us, um, and this we can thank Pat Crescent for this because Pat asked us, well, you know, can we look and, look at these for long-term facilities? So I reached out to CDC and CDC said, oh, actually, we are piloting a, a long-term care facility form. So we're gonna pilot for them and we're gonna be gauging over long-term care facilities and, and really at this point it's just how to do the forms to make sure it works in the same way. Uh, so we hope to launch that, um, before I leave. That's my goal anyway. I think there've been a number of facilities jobs already, uh, interested and with the help of Help in Sight, uh, we'll be able to reach ****. They're not asking for that many at this point but -

Next Speaker: **** refer a hospital of excellence **** -

Next Speaker: Sure.

Next Speaker: Yeah.

Next Speaker: All right. That's it. Any questions?

Next Speaker: ****

Next Speaker: I have a question.

Next Speaker: We're just getting this -

Next Speaker: I'm not surprised by the lag **** areas for a program it was all **** -

Next Speaker: So one thing I'll add about that, I think that's already mentioned as well that there were no major shocks really for leading or lagging activities. Um, CDC does have a consolation of, um, QI work that can respond to each of these lagging areas. Um, so it's fairly nice. So we're encouraging all our facilities to take a look at the, um, TAP web site. 'Cause whether you do these or not, they have some really nice QI sources.

Next Speaker: And, and they're listed under a top implementation guides so the, this is the A of the TAP, the assessment. And those are the P of the -

Next Speaker: Acronym?

Next Speaker: Prevention.

Next Speaker: The prevention. P for prevention and that's where the implementation guides live and there's an implementation guide for each measure for which TAP assessments are available, uh, so they're the guide for CDI for **** and for **** as well.

Next Speaker: Has, has, um, have the TAP assessments adjusted for floor changes yet?

Next Speaker: There's no, uh, adjustment, uh, process here, so the TAP assessments can be kind of tailored to what the facility would like to assess. Right? So if you want to focus on a particular provider type or a particular service type or a particular unit, or a particular facility within a system, you're, you know, you're welcome to do so. And these assessments, uh, these tools are available on line, um, they're available really to anyone that wants to use them. We just get funding to support, you know, to provide technical assistance in data analysis and producing the reports and kind of helping, hopefully helping facilities through this process. So, um, but anyone can do them on their own. Right? So you can really do the same kind of process that we did, at the state, to, to produce the same analyses and if you, uh, have sufficient numbers, you know, to feel confident that you, you're able to come up with a reliable number that kind of represents, let's say, physicians as a whole, or respiratory care therapy as a whole, or whatever, you know, you wanna focus on. Then you can certainly stratify by that way but it really would just be stratifying is the only way to kind of adjust unless you wanted to kind of leverage the data in some other way to perform your own statistical analysis. That -

Next Speaker: So what, I, I know how that works, but that, historically APs couldn't take into consideration if my surgical unit moved from the fourth floor to the fifth floor -

Next Speaker: Ah, okay, so to -

Next Speaker: - no -

Next Speaker: - clarify. Thank you for asking.

Next Speaker: 'Kay.

Next Speaker: So the T, which is the target, um, is ba - is, that's the part of the strategy where we're using the CAD to identify facilities that, um, might benefit from receiving the A or assessment, which is what we're presenting on today. So the actual CAD numbers really aren't, you know, we're just using them to identify facilities who might be engaged in the assessment piece. So these numbers aren't, um, analyzed in context of that CAD, we're just using the CAD to identify who might want an assessment or need an assessment. Right? Um, if that makes

sense. And, and we recognize that the CAD number itself, um, has its own limitations. Right? So we feel that, you know, it, um, prioritizes large facilities. We are seeing larger CADs and larger facilities. Um, so that's one of the reasons why, you know, DAT, uh, kind of went back to, sorry, um, to this slide here where we're talking about how are we prioritizing recruitment going forward? Well we're not just going to use the CAD. Right? We think the SIR is also meaningful. Again, that actually prioritizes large hospitals as well. But, which is why we're kind of looking at critical access hospitals as a group that might really benefit from a little bit of extra outreach and engagement as well as facilities that have already done some QI work with previous TAP assessment. So hopefully that answers the question.

Next Speaker: The - in, in your question, is it, it is location transferable? Like -

Next Speaker: Yeah.

Next Speaker: - could you -

Next Speaker: Uh, yeah.

Next Speaker: And, and -

Next Speaker: I mean -

Next Speaker: At least the last time I went to CDC on something **** pretty that wasn't, it didn't have the capability and then it just **** to adjust for floor changes. And there's a lot of floor changes at least in my hospital. People moving around for reconstruction.

Next Speaker: Mm hmm.

Next Speaker: So it, it makes it challenging for us to use TAP as a measure because of that.

Next Speaker: Because it's using the TAP more of, um, rather than being quantitative its more qualitative. 'Cause you really trying to get a sense of who's on board, where are people perceived **** our -

Next Speaker: Right but if your floor moves -

Next Speaker: - jobs.

Next Speaker: - three times in a year, you really - it limits your data analysis.

Next Speaker: It - that's really just about the targeting -

Next Speaker: Yeah.

Next Speaker: - that's just the **** so we're hoping that, uh -

Next Speaker: Yeah, not the assessment.

Next Speaker: Oh.

Next Speaker: Yeah so we're hoping to approach it a little bit more broadly by not just considering the CAD and not just considering the SIR when we offer these assessments to facilities so -

Next Speaker: All right. Yeah.

Next Speaker: Well, okay. Um, any other questions about that? **** and the last piece we will be wrapping it up here. Our next, um, before, the ****, the next Tuesday on the agenda is to talk about topics of the future but while you're thinking about that, um, I've been asked to let you know that in order - in keeping with the times, uh, the advisory committee will be adding a go-to feed, a webinar option. Um, so for folks who are joining from afar, or online, you will also be able to see in real time, I think the, the slides etcetera. So that will be, uh, **** so you can long onto that. It's actually really quite simple, um, to download and, and be able to join that. So hopefully that should work but any **** addressed.

Next Speaker: And we really -

Next Speaker: **** oh, sorry.

Next Speaker: That's okay.

Next Speaker: - I think it will just help us to track, you know, as more and more people are joining us remotely and in person, which is fantastic. It's hard for us to capture everyone who's on the line so, um, I think it will just allow us to track kind of who's registering and joining us on the call. I don't think anything will really substantively change about these meetings. We'll still have in person and we want you to come in person if you can. We think it's nice to see all your faces, but we'll just add that element to ease our admin processes.

Next Speaker: And there's also **** to the chat boxes **** so.

Next Speaker: Okay. And then so any, um, were any input or topics for future meetings at all that you come across? Is there -

Next Speaker: No.

Next Speaker: - on the phone? Any public comments? Airing of grievances? Okay. I think we're good. Okay ****. Okay so I will call, adjourn this meeting at **** 8:00 p.m. today. Thank you everyone for joining.

Next Speaker: Yes.

Next Speaker: And we will see you in 3 months.

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