Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
December 11, 2019

Transcription provided by outside vendor
Full voice recording of meeting available through *Recording* link

Speaker: So I think what we will is start off with a roll call in the room, um, let's see, let's start to my right.

Next Speaker: Uh, Nicole Lest, ACDP OHA

Next Speaker: Uh, Liselle Luigi, um, HIS ****logist, ACDP.

Next Speaker: And well, good, great., microphones as a reminder.

Next Speaker: **** microphone.

Next Speaker: This is **** Jana, epidemiologist for the HAI program.

Next Speaker: Alisa McLean, uh, education and training coordinator for ACDP.

Next Speaker: Siantha Boskey, clinical specialist with Genentech.

Next Speaker: Morgan ****, ****.

Next Speaker: On page ****.

Next Speaker: Oh.

Next Speaker: Oh my goodness. Here, keep that ****.

Next Speaker: Oh, can you turn that one on. Oh, that one has to be spoken to in the middle.

Next Speaker: There we go.

Next Speaker: Maureen Cassidy ****.

Next Speaker: Monika Samper, GS program.

Next Speaker: Paul Cieslak, medical director communicable diseases.

Next Speaker: Thank you.

Next Speaker: ****. **** HAI program.

Next Speaker: Diane Roy, research analyst at OHA.

Next Speaker: Lynn Allon, office specialist for OHA with HAI team.

Next Speaker: Thanks everyone. Um, so, uh, let's see, can we unmute the folks on the phone so they can, we can do roll call with them, as well.

Next Speaker: Yeah, I have it.

Next Speaker: Oh, you got it, okay. I just did it.

Next Speaker: ****.

Next Speaker: Okay, we have Wendy Edwards, correct? And then, uh, let's let them introduce themselves and give them, give their position title. Are they are unmuted, Laura?

Next Speaker: Yeah, they should be.

Next Speaker: Folks on the phone, please go ahead and introduce yourselves.

Next Speaker: This is Ryan Graham with the Portland ****.

Next Speaker: Hi Ryan.

Next Speaker: Joyce is still muted, but she is here from Koanogin Health, just Carmella.

Next Speaker: The folks on the line, are you able to, to let us know your names and your positions and your organizations?

Next Speaker: I think she's ****.

Next Speaker: ****.

Next Speaker: Who is that tryin' to speak?

Next Speaker: I am getting it in the chat.

Next Speaker: This is Dennis with Kaiser Permanente.

Next Speaker: Hi Dennis. Is everyone unmuted?

Next Speaker: Yeah, ****.

Next Speaker: Michelle Shields did you say?

Next Speaker: Yes.

Next Speaker: Thanks Michelle, and where, tell me, remind us which organization you're with again.

Next Speaker: **** Health Center.

Next Speaker: **** Health Center.

Next Speaker: Thank you. Anyone else on the line?

Next Speaker: Okay. Um, those that can be unmuted are unmuted.

Next Speaker: They **** clear their phones ****.

Next Speaker: Okay, so some of you may have your lines on your phone muted, um, so just be aware of that if you're tryin' to speak today, that we'll be unmuting folks during Q&A and discussion time, and if your own phone line is unmuted, then just be aware that we won't be able to hear you. Okay, we're gonna move on, um, I think –

Next Speaker: Muted.

Next Speaker: Uh, I'm gonna give a very brief logistics update to get us started. Um, the first piece of information, um, that I want you to know is that we have a new one-pager for our HAI advisory committee. It would be the second, um, page in your printed packet, or your on line packet. Um, it starts with Bring Your Voice to the Table. I just wanna thank Alisa, um, McLean for working on this document and actually one of our vistas as well, um, so this is a new, um, research that we have that just explains what our HAI advisory committee is, um, why and when it was established, how you can be involved, and what are current vacancies are. So this is something that can be, you know, distributed around to your networks and colleagues, um, and it's also, um, serves as kind of our little promotional material to fill our current vacancies. Um, which brings me to my next, um, little logistics update, uh, which is, uh, we currently have four vacancies on this advisory committee. Um, one of them is our hospital administrator with expertise in infection control at a facility with fewer than 100 beds. We also are looking for a consumer and patient advocate, a health insurer representative, and although we have a wonderful chairperson, we, um, she has been in the role for over 2 years, so if any current advisory committee member is interested in the chairperson position, we encourage you to let us know of your interest. Um, a couple more quick logistics update. Um, we have added a question to our kind of check-in process for you to indicate whether you are a lobbyist, or a pharmaceutical representative, or the member of the public, etc., so just please remember to give us that information when you're signing in or checking in. Um, we are working on this webinar element of our meeting to make sure that we do know who's joining us and everyone has

opportunity to access the materials remotely, so, you know, we welcome feedback on that change as we iron it out. Um, and again, we will be muting on the line during Q&A period, unmuting, sorry, the line during Q&A periods, because in the past few meetings we've had some background noise issues, so we're just tryin' to make sure that everyone can hear. Okay, so what that being said, I'm gonna turn it over to our chair, Jen Busser, who's here with us, and, um, I think there are a couple of other people that may have joined us that didn't get an opportunity to introduce themselves.

Next Speaker: Vicki Nordby from Marquee Companies.

Next Speaker: Thank you Vicki. That's Vicki Nordby from Marquee, and I'm gonna pass the microphone back over to that side of the table, so you have one.

Next Speaker: Okay. Good afternoon. Apologies for being tardy here, uh, so we are onto approving the minutes, is this true? Do I hear a motion for approval of the September 2019 minutes?

Next Speaker: And those of you who are formally nominated members have a green dot on our name tent.

Next Speaker: And **** September.

Next Speaker: Thank you.

Next Speaker: Do we have a second, on the left.

Next Speaker: I second.

Next Speaker: Thank you.

Next Speaker: They've moved to approve the minutes from September. Uh, and next on our agenda is to hear from Lisa regarding the TAP strategy.

Next Speaker: So Lisa and I are gonna be kind of giving a joint presentation here.

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: Okay. How's this? Okay, so, um, our first topic here today is, um, kind of a summary of our statewide efforts around the TAP strategy or targeted assessment for prevention. A lot of you are probably familiar with this already, um, having heard about it from our program a couple of times at least within this meeting, or maybe we've reached out to your facility to see if you are interested in participating in some TAP strategy work with us in the past. Um, as a reminder, this is the, an approach developed by the Centers for Disease Control and Prevention, and it uses NHSN data for action to prevent healthcare-associated infections, and the TAP

strategy stands for Target Assess and Prevent. Um, targeting healthcare facilities and units within facilities with disproportionate burden of HAI, um, assessing infection prevention gaps using facility assessment survey tools and, finally, offering a section prevention strategies to reduce HAI incidents using implementing guides. In 2017, all state level HAI programs were funded for TAP strategy work by C, C is epidemiology and laboratory and capacity grant or the ELC grant, and in 2018 and '19, Oregon implemented a TAP approach, um, just with a slightly different process in 2019. We added to our process and refined our process a little bit, so the text in orange is actually kinda referring to what we did in 2019 above and beyond in 2018. But essentially it involved initial outreach and facility engagement, planning with facilities, providing CDC materials in 2018 and then CDC and HAI program development materials in 2019, which we actually built using feedback from the facilities that had participated in the work with us. And then providing technical assistance. Facilities deployed and returned completed surveys to us, um, we provided them progress reports. Our program also analyzed the data and provided it in feedback reports. In 2019, we added an additional survey completed by the infection preventionist, analyzed those data, and provided a cross, crosswalk report to tease out gaps that were due to process versus gaps due to, um, perception, and how several calls to talk about the data and reflect the topics on the TAP experience. So, let's get into what the TAP strategy actually is, um, in terms of targeting facilities and HSN data are used to identify those facilities and location with excess infections for CLABSI CAUTI CDI only available for three measures right now. The metric use for the TAP data is the cumulative attributable difference or CAD, which translates an SIR goal into a concrete and numeric HAI prevention goal, and CADs of greater than 1 indicate that more infections were, um, observed than were predicted. Facility engagement, or our process of engaging facilities in this work was based on many factors. We wanted to look at performance, as defined by both the CAD and the SIR, both high and low. Um, facility reverses an interest in participating and then, um, in 2018 we offered CLABSI TAP work only to those hospitals, um, participating in ****. In terms of assessment, uh, the tools allow us to kind of characterize the awareness and perceptions of prevention policies and practices, uh, for infection prevention at a facility. They're administered to facility healthcare personnel, including frontline providers, mid-level staff and senior leadership, and our recommendation was the collection of at least 30 assessments, um, per facility per measure for, um, generalized ability and interpretation. The tools are organized in, or the survey tools for assessment are organized in a similar way, um, there is a little bit of kind of difference between the sections of the survey for the different measures, just because, you know, for CAUTI, we're really interested in appropriate urine culture practices. Um, for CDI not so much. So this is just a little overview of those kind of main topic areas. Uh, we asked facilities, or those are completing these surveys to indicate what they knew, so it wasn't asking them to do any research. The survey questions were very simply sort of multiple choice, um, and it allowed us to kind of identify where different healthcare personnel diverged, uh, generate some conversation, cues to action, those aha moments to say, hey, you know, our facility staff are reporting that they don't actually maybe know what the practice is at our facility, or that there may be a gap in practice, as well. This is an example of a past feedback report, so this is how we get the data back, and I'm gonna kinda take us through the different elements of this report on the next few slides. Um, the first or the kind of major highlights of these reports are the leading and **** areas, so this is for clostridium difficile infection, um, and we provide kind of the areas where the facility performed the best according to the data that we were provided by them. And then the lagging areas, the areas that each facility has the most opportunity to improve. This is a,

a little sample of what the questions actually look like, um, and then we provide the summary data, we well, in this **** report. So, for example, um, Question 1 is does your facility senior leadership actively promote CDI prevention activities, that was one of the questions on the survey. And then we saw that, you know, in this example, 85 percent of staff who responded said that, yes, that did happen, 4 percent said no, it didn't, and 11 percent said they didn't know. And we can see that one is actually highlighted in green, it's one of the kind of leading areas for this example facility, uh, where it's highlighted in red, that's where we are seeing kind of things that might indicate a lagging area or an opportunity for improvement. Um, for example, on this slide, you'll see our facility had a staff person with dedicated time to coordinate CDI prevention activities. It also includes a breakdown of respondent types and their scores. And in 2018, just so we are all kind of the same page with this, what we've done over the past 2 years since the intention of this presentation is really kind of to summarize some the work that we've been doing over time. In 2018, we had 476, um, completed surveys returned to us for **** facilities who were doing TAP strategy work with us, um, 16 facilities participated in CDI TAP assessments in 2018, and five facilities participated CLABSI TAP assessments in that year. Last year, or I should say this year, in 2019, we have 553 individual surveys returned to us, three facilities participated in CDI TAP assessment work, three in CLABSI and one in CAUTI. So some of the kind of major findings we've seen over time, these are successes for CLABSI, are leadership involvement and promotion for CLABSI prevention activities. And as a reminder, these are things that our facilities in Oregon seem to be doing really well on for CLABSI, um, that, you know, central lines are often assessed daily and removed when they're no longer needed. The assessments themselves are audited, CLABSI and device utilization data are, um, sent back to healthcare personnel. Central line insertion practices are, um, implemented using a bundled approach, coverage of the insertion sites with sterile gauze or sterile, um, dressings, um, is another area, leading area is CLABSI, and then the routine monitoring of insertion sites, um, as well. So what are some of the challenges over time with CLABSI, um, well, one of the challenges we found very common was staff people with dedicated time to coordinate CLABSI prevention activities, physician and nurse champions for CLABSI prevention activities. These are really staffing kind of issues and leadership issues, so it's not surprising that we're seeing those two come up together. Um, we saw another area for improvement might be, um, the empowerment of healthcare personnel to stop non-emergent central line insertion, um, the proper procedures aren't being followed, central line dressing change practices, documentation of the indication by the ordering provider, replacement within 48 hours, um, when **** septic technique can't be ensured. That's kind of a little bit, uh, related to that empowerment of healthcare personnel to stop the non-emergent central line insertions. Um, replacement of tubing for propofol infusions, **** it was 12 hours when the vial is changed, and then competency assessment on proper central line insertion. There's a lot of checks on these sides, I apologize. So what discusses did we see statewide for clostridium difficile infection? We saw that for CDI our state is doing really well and involving leadership, um, in CDI prevention activities. We're doing well on contract precaution signage, adherence, um, to the use of, uh, appropriate TPE and hand hygiene for contact precautions, cleaning shared medical equipment during use, training on hand hygiene TPE, contact precaution and environmental cleaning, terminal cleaning of high touch surfaces, soap and water, hand washing, involvement of unit level leadership in CDI activities, and then rapidly implementing contact precautions as soon as C. Diff testing has been ordered. And challenges over time statewide for CDI, um, you know, there is some staff, uh, similar to CLABSI, right, so dedicating staff people and physician or nurse champions, um,

monitoring and reducing antibiotics that are high risk for CDI, providers of appropriate, uh, inappropriate testing patients with known causes of diarrhea, um, adherence of family and visitors to the use of gowns and gloves for patients on contact precautions and hand hygiene, staff awareness of anti-microbial stewardship practices, inter and intra facility transfer communication about, um, folks who have had these infections, and then cleaning of high touch surfaces and sharing medical equipment, uh, actually I think, um, both a leading and a lacking with CDI, which is very interesting. So we're not going over, um, CAUTI today, because we only have one facility who did CAUTI results, and I'm gonna turn it over to Lisa to talk more about some additional work that we did with TAP.

Next Speaker: Uh, thanks Rosa. Can you hear me? Okay, this is Lisa. Um, so I'll be talking more about the prevention piece of the TAP work, and what was mentioned that will be added this year in 2019, but as additional step for facilities. Um, and so, um, what Rosa just outlined were the common **** and challenges, um, over time based on that feedback report, which really looks more the survey responses for perceptions and awareness of these infection prevention processes. Um, so this year we had called the facilities to review that TAP **** report. And during discussions, um, it was clear to us that there were, you know, just kinda between what was identified as a gap in perception versus what was actually gapped in infection prevention practices, um, for example, staff may not be aware of **** cleaning or sterilization practices occurring in a facility because they aren't the ones involved in that. That doesn't necessarily mean that the facility is not doing those things, and so we wanted to get an understanding of what are the gaps actual practices, um, perception, and so Rosa mentioned this year we asked the infection preventionists to complete the TAP facility assessment tool that are **** the actual practices going on in their facilities. And what we did is we crosswalked those responses, um, with the survey responses that we received from those healthcare personnel, um, and we provided documents that identified those, um, lagging and **** practices and perceptions, ans well as what implementation resources were available, um, from the ECEC website. And this is just a screen shot of the ECEC website for TAP. You can see that there are implementation resources, um, for CAUTI, CDI and CLABSI as part of the prevention along with the TAP strategy. Um, and when we looked at these resources too, we saw that a lot of them addressed, um, how to improve, uh, practices rather than addressing how to increase awareness or education, so **** to really kind of identify those gaps in processes and provide resources for facilities and how they can improve those. Um, the **** is kinda small. This is a different screen shot of the, um, the, the additional guidance document that we provided to facilities, um, so on the left column we, um, highlighted the lagging items, um, that were, that were from the **** report. In the middle column is the **** response that represent the actual facility practices, and then the last column is, uh, links to different resources. Um, so first **** on the first row, um, one of the lagging items was that, um, **** they did not receive feedback on Facility 1, you get level CDI data, and the IT responded that they don't provide unit level CDI data to personnel, and so once of the resources that we have linked here is a CDI TAP report by, for a facility user, **** developed, um, facility level or unit level reports for that facility. Um, and then I also kinda wanted to highlight common themes that we saw among facilities, um, in, in order to gap these practices, and this I think is reflective of what, of what Rosa just went over, um, but to kind of pinpoint that, that we, um, for all the measures, um, regarding the facilities that they did not have a physician champion for **** activities, um, whereas you retain auditor competence, **** and some proper practices. I just pulled, um, one thing out for CLABSI,

CAUTI and CDI, as well. Um, then as part of our work, we really wanted to understand from the facilities what type of quality improvement activities were being done, um, if that was informed by our, by our TAP **** of this. And I think it falls into, you know, the, um, **** improving or increasing awareness and perception, um, and there is a lot of work that facilities have said they're already doing in regards to staff education. Um, for example, facilities had the, an FAQ, um, incorporated where infection prevention and education into their regularly scheduled training days, by providing additional **** resources at the bedside, and then addressing the actual practice gaps, um, facilities are working on establishing competency assessments and audit processes, incorporating new policies such as, um, testing, **** bundles and tools and some facilities are, um, implementing ways to teach, um, staff more about how to interpret data, looking at the SIRs for, um, for different infections. And I think one thing that, um, was also talked about in our calls with facilities was the need and, um, ways to engage with providers, and that's something that I think facilities are still, um, trying to work on. We also wanted to highlight, um, the patients' family perspective with, um, with this work, so each of the, um, TAP assessment, instead of asking questions that relate to patients' family and visitors, um, when we looked at this data, it looked like the main gaps, um, were in CDI prevention and, um, respondents said that they, there was a process in place to ensure that patients washed their hands before eating, and after using the bathroom, um, **** Rosa mentioned ensuring that the family and visitors do use gowns and gloves. Um, for patients on contact precaution, then to add hygiene. Um, CAUTI and CLABSI data, it seems like they're doing pretty well, um, there has been occasion **** care for urine and catheters among patients, I think and their families, and then CLABSI data showed that patients were encouraged to report new changes or discomfort with their central line. And just to summarize, um, the feedback that we received from facilities was that based on all these assessments to be helpful in identifying gaps and targeting their quality improvement efforts, um, we just had, you know, these calls where we provided these reports at facilities a couple of months ago. So many of them are still in pro, in the process of identifying what specific implementation strategies and resources they're going to be using. Um, and from our perspective, we think our facilities in Oregon have a great, great capacity for the TAP work, um, however, for us the specific **** funding, um, **** is discontinued, um, so we can still provide materials and technical assistance if facilities are interested in doing TAP strategy independently, um, and we're happy to support that, but the, the work that we spend in this kind of fashion that Rosa and I have presented, um, is not going to continue, um, for the next year. Um, and that's all we have, so any questions or impressions?

Next Speaker: And we'll just, unmute the line to the folks from the phone. Sorry, we'll unmute the lines for the folks on the phone, so you can ask, should be able to ask questions.

Next Speaker: They can also ask them to chat, and I'll monitor the, the questions.

Next Speaker: So you can be able to ask questions, um, either by phone or in the chat box. And if anyone on the line or in the room, um, has participated in TAP strategy work and you wanna reflect on your experience, we'd love to hear about it as well.

Next Speaker: Hi, uh –

Next Speaker: Canugo.

Next Speaker: Hi, uh, this, this is Paul Cieslak. I have a question about the survey. Uh, there must have been many responses per facility, so who are these people who are responding?

Next Speaker: Um –

Next Speaker: Turn yours off.

Next Speaker: Oh, turn this off.

Next Speaker: Can you hear me okay?

Next Speaker: Turn it off.

Next Speaker: Turn it off.

Next Speaker: Uh, I think it's varies, I think it varies by facility. I'm gonna try to ****. Um, I think we had **** respondents per any, um, one of the slides shows it, but, um, I would think for the most part there was direct, **** with direct patient care, so nurses, um, yeah. It's in that slide. I would like nurses **** and then we try, I think philosophy we tried to get physicians as well as ****, um, **** that.

Next Speaker: Um, the only thing I'll, the only thing I'll add is that for this CDI TAP assessment, um, in addition to kind of general staff, um, across the board, uh, there are two additional surveys, so unlike CLABSI and CAUTI, which have one survey each, CDI has three surveys, so there's one for general staff, one, um, for antimicrobial **** specifically for, um, I'm sorry, one specifically for, um, pharmacy, and one specifically for the lab, because the lab and pharmacy elements for CDI are so crucial.

Next Speaker: So when you say, when you say general staff, do you mean it was sent to like every nurse that works in the facility, they were invited to respond or, uh, every respiratory therapist that, uh, you know, all the ancillary staff, I, who, I'm just wondering how, I'm picturing this big universe of potential respondents and wondering who is, who is really being asked to respond.

Next Speaker: It's a great question. Um, so it really was up to the people at the facility who are implementing the TAP strategy to determine who would be, you know, of interest, so, uh, some of our facilities that participated are huge and they could really kind of drill down and say, hey, we only want to survey these individuals, because they're supposed to have some specific infection prevention knowledge, um, or some of our smaller facilities who really struggle to return 30 completed surveys at all, because they had very few, very low numbers of staff as critical access hospitals, for example. Um, so in the smaller facilities, I have the sense that the kind of distribution of respondents is a lot more diverse, and in the bigger facilities, they focused a little bit more on specific roles or particular units. Um, for example, I mentioned in CLABSI, in Year 1 that we did this work, that we only offered it to, uh, facilities, um, participating in the Burma Oxford Network, so that was facilities with NIC, NICU, like CLABSI work ongoing, and

so it was done within those specific personnel. Um, there is definitely question, there are questions that are, that are vague, I guess, by this, because the survey can be kind of long, and it, you know, it's kind of who needs to know, right? So is it important that the person who's turning over the room knows that there's a physician champion for a particular measure. And I think that's a totally legitimate question, um, and I think it also speaks to just like the more respondents that you can get, the more targeted that you can be with something like this, the more informative it's gonna be. But it's also still interesting to look at kind of broad responses.

Next Speaker: And this is Jesse, just a quick ****.

Next Speaker: This is Pam Cortez from Salem, uh, Hospital, and we did a large, um, survey group with the TAP surveys, um, we actually sent out hundreds of them, um, so we targeted the units where these, our general care units where the infections occur, and, uh, established a number for R.N.s and CNAs and asked them to, uh, get as many people fill them out as possible, and we had, um, over 300 come back to us at –

Next Speaker: ****.

Next Speaker: Thank you for sharing and how, and how did you find it useful, this is Genevieve. How was that useful, the data that you gleaned from the returned assessments? How did that help inform your strategy?

Next Speaker: Um, certainly we had, uh, some areas where we could see where the R.N.s understood a lot more than the CNAs did, so we might, might wanna target some of our, um, work with the CNAs a little bit more. We had been working with the, um, R.N.s as what we were calling infection liaisons, um, a group of them. We actually marked our surveys **** in paper and marked them where we could tell if our infection liaisons we'd been training had a higher level of understanding than the non-liaisons. Um, we did this survey very early on in their, uh, evolution, and so we were, uh, we saw a difference that may, in certain areas, but not as big a difference in some others, so where we could target our work with the, um, liaison group and, um, there were a couple of areas of the TAP survey that was around very specific, um, use of antibiotics and, and surrounding antimicrobial stewardship that, uh, really our general staff don't have an in depth knowledge of, or, um, broad awareness of some of the AMS work that's going on in the background, so that was possibly again a place to share, but was, um, an area of the survey that we felt was a little, um, difficult to give out to the general staff population.

Next Speaker: Great, thank you. And I just wanted to ask Lisa again where you guys can find these TAP assessments, 'cause I would imagine this is probably a, even though there's not gonna be funding going forward, these tools are available on line for facilities to take and maybe even modify them as a great way to get the lay of the land where their facility is and where they might go.

Next Speaker: Yeah. ****.

Next Speaker: It's on the ****, yeah.

Next Speaker: Okay, so just CPCHI and TAP, okay, excellent. Thanks so much.

Next Speaker: This is specific to the implementation resources that you can kinda see how to navigate towards the TAP website, and all **** are available, as well as the implementation guides, and likely ****, we're, you know, if your facility's interested in **** out independently, I mean, we're still available to talk to you about how it works and how you might leverage it, and where to find all the good stuff. I mean, we have resources that we're happy to share with you, like best practices and things that we've developed through a couple of years of experience working with facilities on this, so we're not completely um, hands off, we just don't have dedicated funding to do data collection and analysis for anyone anymore. Uh, no, I, I, not misrepresented at all ****. Um, but, we, we, you know, we still think that this might be a useful, um, thing for some facilities to pursue depending on how you're planning to use it, so if you're interested, don't be shy.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: Yeah, we're um, Lexi's gonna add a comment.

Next Speaker: I was wondering if this is for hospitals only, or if they **** their nursing homes with TAP.

Next Speaker: That's a good question.

Next Speaker: This is ****, um, unfortunately I haven't heard that to know what that long-term care facility TAP is, so they conducted this pilot, um, and Morgan contributed data to it, and we got their feedback with performance, but it's not in state as far as I know for widespread use. So I haven't seen TAP assessments for long-term care facilities on the CDC website yet. We could also, we can always just reach out and, and ask them and, uh, can report back the next time.

Next Speaker: So if any, if there's a nursing home that was interested, that'd be a great reason to Lisa or Rosa and they help you with that, so, um, it does give a really good framework for asking those, uh, good questions for assessments. So thank you, so we'll move on to the next topic on the agenda. **** Trans is gonna give us an update on our long-awaited **** copay. Yeah. There's like the ****.

Next Speaker: Enduro, so I think you've been hearing about this for, I don't know, 5, 5, 5 years something like that.

Next Speaker: **** or somethin'.

Next Speaker: You're good.

Next Speaker: And you're good.

Next Speaker: Interference or somethin'.

Next Speaker: What do, **** have to kiss the mike is that what?

Next Speaker: Do you wanna try the other mike?

Next Speaker: I think it has something to do with –

Next Speaker: By the way, although I sound sick, I'm not infectious any longer.

Next Speaker: Yeah, that's what they all say.

Next Speaker: Um, so just as, as an update, um, the **** tool kit was posted at the end of October and I'm gonna, uh, slide that ****, you, you –

Next Speaker: Talk into that, people aren't gonna be able to hear ya. As long as we can hear you and that ****.

Next Speaker: ****.

Next Speaker: Yeah, so, so you can see on this, uh, slide just, uh, where you can find the Enduro tool kid, and we tried to place it in several places, so this is on the HAI, uh, site, um, and then there's another place here on the drop CRD network, as well, um, and then I think we've posted at, uh, another place, Alisa, I can't exactly remember where, uh, and I couldn't find it, but I know we've added it, so the bottom line is that it's been posted in several places. If you can't find it and you feel like it's better placed in yet another place, just let us know and we'll add it, because I know, you know, sometimes you, you know, the more places it's placed, it's better, easier for people to, to find it. I, I don't wanna go through what's in the tool kit, just let people know that it's been posted on the website. Any questions on that? So, if not, I just wanna maybe talk a little bit about the CRE tool kit. So, as you know, it's been a while, uh –

Next Speaker: You did.

Next Speaker: – since we updated the CRE tool kit, and we're looking to provide, uh, kind of a one-page update, and I just wanna point out two things that we'll be updating, uh, so that you're aware of. We're still tryin' to figure out how best disseminate this update and how we're gonna post it, but the first one is, um, is incorporation of this interim guidance for public health response to containment, uh, of novel and targeted, mul, uh, MDROs, uh, that was provided by the CDC, and I think this was a January 2019 document, um, and in there, um, I've just highlighted a specific number of things who, you know, for us, so they have now Tier 1, Tier 2, Tier 3 active organism. For, for CPCRE we, uh, fall into the Tier 2 organism and, and that's the definition that they provide for Tier 2 organism, as you can see, so organisms primarily associated with healthcare settings, and are not commonly identified in the region. And this organisms may be found more commonly in other areas of the U.S., right, so this is true for CPCRE, and information is available about how transmission of these organisms occurs and the groups primarily at risk, so that's their definition of Tier 2. So for us, CPCRE fits into this

Tier 2. And then within CDC document, I've **** here, you know, Pages 8 and 9 and Tables 1 and 313 talk about what, what you need to do in terms of whom, whom to screen. It's all in there, and, um, and so this gives you a status of, you know, one of the things they, they provide, you know, Tier 1, Tier 2 or Tier 3, and what we need to do from an investigational perspective. But this is just a table and there's more detail in the text. I really don't wanna go into this, uh, into the details here, but just so that you know that this document is out there, and we'll be referring to this document when we, when we provide that one, uh, page update about CRE tool kit. And, um, as we work with facilities, we'll still continue to work with facilities on a one-on-one basis with each case with phone calls and conference calls, and then we'll point out, uh, the specific pages of this particular document, uh, as necessary. And then the, uh, other things we wanna highlight, uh, and this is probably for us a change, uh, significantly, and some of the tables will need to be changed in our CRE tool kit in terms of, uh, precautions for long-term care facilities, so we just wanna say that, uh, some of you are probably already aware that CDC put out this, uh, implementation of, um, um, you know, personal protective equipment, but using enhanced variable precautions, so that this new category that enhanced variable precaution, and, and this is what we're gonna be using instead of strict contact precautions, uh, for patients who are, uh, colonized with, uh, CT ****, um, so this is just to give you a sense of the table. Again, I want, I don't wanna go into details, but the bottom line is its overall it's actually less strict than what we would have asked facilities to do in long-term care for patients who have CPCRE, um, who are longer gonna be asking them to either to contact across, across the board, but only implemented when there are things like draining wounds and so forth. Otherwise, we're asking to, –

Next Speaker: I knew that –

Next Speaker: – **** precautions. Um, and that, and that's part of the enhanced variable precaution, they don't need to be, to be stuck within a room, 'cause I think that one, that was one of the biggest challenges for, um, uh, residents of facilities like this. Um, so I think that is where I'm gonna end. I don't think I had anything else with respect to, to this. So just be on the lookout for this, um, this one-page update, uh, and with references to these, uh, two documents from the CDC.

Next Speaker: Do you want me, will you be updating the rest of the tool kit or just this one page of it, like, like ****.

Next Speaker: Just one, no, I, I don't think we're, I don't think we're gonna redo the whole ****.

Next Speaker: I mean like everything else.

Next Speaker: Yeah, 'cause I think it's, it's gonna take a long time, as you can imagine. I think we're just, we'll have to figure out how best to –

Next Speaker: But everything else pretty much stands, like ****.

Next Speaker: Stands, right. So I think, I think it was just hard to say in a one-page update, you know, what changed within the document –

Next Speaker: Mm hmm.

Next Speaker: – and what new, um, you know, references we want people to look at, um –

Next Speaker: Great.

Next Speaker: – and we still need to see, how, how it looks, but I think that's what we're intending, we're not intending to redo the whole CRE tool kit at this point in time. But we always have ****.

Next Speaker: And it, it might end up being too –

Next Speaker: Microphone.

Next Speaker: – to included being stable.

Next Speaker: Right.

Next Speaker: You know, uh, mentioning of, uh –

Next Speaker: Turn it on.

Next Speaker: – ****, uh, we would mention what had changed, and then we would also include a table of the, um, changes for the precautions.

Next Speaker: In case that wasn't clear, um, Maureen was just testifying that there might be two pages that'll be a table that will, that will be added and available, so.

Next Speaker: It was a long journey here where you're, um, going to insert the enhanced barrier precautions. Are you thinking the same timeframes, so most of those were at least a year from the last positive culture, um, so, that's always a question for us. How long are these precautions going to last, um, and so, –

Next Speaker: You're not going to like to hear this answer. Um –

Next Speaker: Forever?

Next Speaker: – yeah, 'cause that's the CDC recommendation –

Next Speaker: Right.

Next Speaker: – is for the duration of the resident's stay, so on the one hand it's less stringent, right, when you think about it, but on the other hand the duration of its effect is gonna be longer.

Next Speaker: A couple, oh, and this is Jennie, just a follow-up question that about how this will all be **** to the nursing home.

Next Speaker: That's a very good question. I think that's, that's part of the discussion, as well, in terms of how we're gonna communicate this. Um, I don't know that we've landed on the communication process, uh, of this as yet, um.

Next Speaker: But any feedback from, you know, members on the HAI committee have that, it will be a useful way to communicate that out to you guys.

Next Speaker: And let them use the folks on the line, so if anyone has any thoughts on how best to communicate this or any other questions or thoughts, now's the time, I think, or now's a time, there will be other times.

Next Speaker: **** healthcare association.

Next Speaker: Mm hmm.

Next Speaker: I mean, we know that there are some infection control consultants out there who can, who can, uh, get the information through to a lotta facilities –

Next Speaker: Yeah.

Next Speaker: – potentially.

Next Speaker: Go ahead, is there someone on the phone? Any other questions about the MDRO, MDRO tool kit or the CRE tool kit? And just, just of clarify, MDRO tool kit includes, it's MRSA, but there's also acenovator or several other types of Enduros as well, not just MRSA.

Next Speaker: Correct.

Next Speaker: If people were curious.

Next Speaker: Thank you.

Next Speaker: And it, and like the CRE tool kit it does have division based upon facilities, hospitals, long-term care facilities, etc., so tried to approach it from the viewpoint of those different settings. Great, okay. Well, we are at the end of essentially our first hour –

Next Speaker: ****.

Next Speaker: – oh, go ahead.

Next Speaker: I knew that –

Next Speaker: Oh, that's okay. Uh, we're at the end of our first hour, so let's take a quick break and reconvene back at 2:00 for the second half of the meeting. Thank you very much.

Next Speaker: Thank you.

Next Speaker: Okay, thanks everyone. Okay, this is Genevieve, we are back for the second half of our December meeting, and now Dat Tran and Richard Lehman are gonna talk to us more along, continuing along the select organisms, things to watch out for.

Next Speaker: Thank you. Um, so Rich and I just wanted to provide, I guess, two, um, initiatives that we're thinking about, um, related in a way, 'cause they're about screening for select organism, um, the first one I wanna talk about, um, is, um, travel-based screening for, um, multi-drug resistant organisms. And I put this light up here so you can see in terms of what's been quoted by the CDC and recommended by the CDC. So the first one's about CPCRE, and you can see their, their focus on, um, screening people who've had, international healthcare exposure defined as having an overnight stay within a healthcare facility, uh, in the prior 6 months. And that's for CPCRE, and then for C. auris, which is a more recent recommendation, their website there, essentially the same definition except it's in the previous 1 year instead of the previous, um, 6 months, and then they say especially if in a country with documented C. auris transmission. They do put a note in there, though, for C. auris that colonization for longer than a year has been identified, uh, so that hospitals may consider, um, you know, determining the species we can isolate patients with more remote exposure to healthcare abroad. And in that example of CPCRE, I put up there for how you might want to implement that within your BMR, that's just an example question that you could pose, you know, has the patient had an overnight stay in a hospital outside the U.S. in the past 6 months? You know, you can frame that however, how you want, and at this point I just wanna maybe advertise a webinar that's gonna be happening, um, January the 21st, uh, and that's gonna be posted, um, I think by Washington State, with um, a whole bunch of, uh, um, speakers, including, um, one from a facility, uh, that has had experience, uh, implementing, MDRO screening, uh, implementing specific question looking for that, and, and really, you know, what their experience has been like and what the volume has been like, and what challenges they, they face. Um, Maureen, did you wanna say something else?

Next Speaker: Um, only ****. Okay, um, my plan to, uh, ****, to stand out, uh, the notice for this and the length on the infection preventionist, in the state, uh, Diane ran a list for me. If you think it should go to anyone else, um, I'd appreciate knowing so I can send that message to those folks too.

Next Speaker: Thanks Maureen. So, um, before I hand over to Richard to talk about the other select screenings, I just want you to think about, you know, what your plans are with respect to screening for travel-based screening for MDROs, and then, um, how that would align with screening that Richard's gonna be talking about, um, to identify, uh, very quickly, uh, patients who present **** we should be concerned about for high consequence ****. Richard?

Next Speaker: Thanks Dat. So, –

Next Speaker: Just scroll ****, just scroll for now.

Next Speaker: Oh, look at that, it works. Thank you, madam chairman. So, uh, great, and so hi, I'm Richard Lehman. I'm, uh, chief medical officer for Health Security Preparedness and Response, and I also work in acute and communicable disease prevention here at the Public Health Division. I'm very, uh, glad and thank you for allowing me to come and, and talk with you, uh, about this topic, uh, rapid recognition, and isolation of pathogens with high impact, high consequence infectious disease, and since this is the healthcare associated infections advisory committee, I'm lookin' for a little advice. So I guess my first question is, do we think that there is room for improvement in, uh, in Oregon's healthcare system in terms of the ability to promote, uh, rapid recognition and isolation of patients with high impact, uh, infectious diseases? So do we have, is the battle won and we just don't have any issues, or is this, uh, a place where we would potentially –

Next Speaker: Unmuted.

Next Speaker: – we could potentially, uh, make further headway? Any thoughts on that?

Next Speaker: Did everyone hear all of that? Did everyone hear all of that, so from the, on the line?

Next Speaker: You just repeat it one more time.

Next Speaker: Yeah, we are having issues at the moment.

Next Speaker: Oh, I see, okay, so, yeah, so my, my first question is do we think that there is, uh, there is work to be done, uh, potentially useful work to be done in order to promote rapid recognition and isolation of patients with measles, or Lassa fever, or anything else that might come down the road and potentially lead to infection of members of the public or, uh, staff in hospitals?

Next Speaker: We have from the chat, um, ****, says yes, room for improvement, Deborah Katora says I think we should but would have to think on how to effectively promote it.

Next Speaker: Sure. And I guess that's sort of the next question, uh, are there effective, simple ways to, uh, to promote this from, uh, healthcare facilities, and I, I have a modest example that I have brought with me that I'd like to share with you. And I guess the other question is, um, is, do we think that there is sufficient benefit to make this worth pursuing, that is, is this something that the Public Health Division, you think the Public Health Division should be involved in pursuing, either in, potentially in part through, uh, HAI program, in part, uh, through preparedness where I'm funded. We certainly see potential in this and are just interested in your thoughts on whether we think that there is enough chance to move the needle here, that this is worth pursuing?

Next Speaker: Dennis says yes,

Next Speaker: Oh, we've got a yes.

Next Speaker: Yes, we've got a yes.

Next Speaker: Okay. Any thoughts, any thoughts on this?

Next Speaker: This is Pam Cortez, uh, yeah, this is Pam Cortez from Salem Health again, and I would say yes, that the early recognition and, um, isolation is incredibly important and we've been working here tryin' to figure out how to do that will on an ongoing basis.

Next Speaker: Okay, thank you Pam.

Next Speaker: We have another question from Sandra, um, what about the rhino data, or what about the use of rhino data, which is the rapid health information network. Why don't you read, why don't you read the full ****, yeah, go ahead.

Next Speaker: Okay. The rhino program is responsible for syndromic surveillance data collection, analysis and distribution of the department. Syndromic surveillance data is collected in near real time from hospitals and clinics from across the state. Key data elements reported include patient demographic information, chief complaint and coded diagnoses.

Next Speaker: So I guess, uh, we could certainly look at how that might contribute, but I'm also thinking that not just in near real time, but real time. Somebody has to make a decision about how to manage a particular patient and how to recognize whether or not precautions need to be taken right up front. And so let's, let's move on and, uh, and take a look at that a little further. So many of you may be familiar with the infection control assessment and response, uh, or ICAR program, uh, Dr. Busser was involved in this, uh, in its inception, and basically, uh, we were able to get funding to, uh, some hospitals here in Oregon to improve, uh, their ability in infection control, uh, both in the emergency room and in the care of patients, and the two ICAR centers for excellence are Legacy Good Samaritan and Asante Ashland. So these folks had, had, uh, worked, uh, they received funding –

Next Speaker: ****.

Next Speaker: – and training in order to be able to implement, uh, identify isolation and informed programs in their facilities.

Next Speaker: Unmuted.

Next Speaker: Oh, there we go.

Next Speaker: But it, it says it's unmuted again.

Next Speaker: So do I need to repeat that?

Next Speaker: Perhaps, Richard.

Next Speaker: Okay, so, uh, so Legacy Good Samaritan and Asante Ashland are, are two infection control assessment and response hospitals in the state, and each of those facilities received funding and training in order to be able to implement and identify, isolate and inform program, identify whether a pathogen is present, isolate promptly and inform appropriate staff, uh, that there is a suspect, uh, high consequence pathogen. They also received funding to design staff and maintain, uh, treatment facilities, uh, so that they could care for these high impact patients. And it's pretty impressive what they've been able to, uh, what they've been able to accomplish. The question is, it's wonderful that these two facilities have accomplished so much, but can we find ways to share what they have learned, uh, so that other Oregon hospitals can benefit from that, and I just have a modest example of what we might consider doing, so without further ado, I'm just gonna launch into it. Uh, so this would basically be a presentation that we could potentially take on the road, uh, we could take this to, to healthcare, oh, coalitions around the state. There are seven of those, and we could potentially share this at, in those settings. We could also potentially take this to individual hospitals and we would talk about why, why this is a good idea, and I don't think, I, I think I'm probably preaching to the choir, here, it certainly sounds like it from your responses, but, uh, certainly nasty bugs are, can get here very quickly on a plane, and we need to take care of ourselves, we need to take care of our patients, we need to take care of the general public, and the quicker we can recognize when, uh, these walk in the door of the emergency room, and take steps to protect that patient and protect others, the better off we're gonna be. So just to illustrate the importance of this, uh, we need go no further than an outbreak of measles that occurred in Arizona back in 2008. Uh, I'm sorry that the, I hope, uh, folks can see this a little bit better on your screens. It's kind of small here. It's smaller than I thought it would be, but in any case, just to walk you through this, there was an unvaccinated, uh, index case who came in from Europe, who walked in the door of the emergency room, she had fever, conjunctivitis, uh, she had a morbilliform rash, and it was not recognized as measles, so she went home. She came back. It was again, not recognized as measles. So she had no, no special efforts at isolation, she was not offered a mask, and as a consequence of this, there were four people in the emergency room who became ill with measles. They came back to the emergency room and interestingly enough, they were not recognized to have measles. They were not put in any isolation at the time, and that resulted in several other cases, six cases which can be linked to that particular emergency room and encounters there. I think we'd agree that's not the ideal. So let's fast forward to Ashland, Oregon, March of 2019, and at Asante Ashland there was a no notice drill where a mystery patient, who I will refer to as Patient G, although her name is actually Judy Guzman, and she works at – no, just kidding. But anyway, so, uh, so this is a person who presented with symptoms of Ebola, consistent with Ebola. Showed up, no notice at the emergency room for intake. Uh, this is a person who in this scenario had worked in an Ebola treatment center in North Kivu Province in the Democratic Republic of Congo. However, she was not gonna tell anybody that unless they asked her about travel. Aren't you wondering what happened?

Next Speaker: Yes.

Next Speaker: Yes.

Next Speaker: On the edge of my seat.

Next Speaker: So as it turned out, from initial intake to this person actually getting an isolation in the negative pressure room, it took 4 minutes. So –

Next Speaker: How did she get there? Is he gonna tell us how that happened?

Next Speaker: How, the –

Next Speaker: I'm –

Next Speaker: – sorry, that's classified.

Next Speaker: How, how did you, you know, –

Next Speaker: No, yeah, and, well actually I wish, I wish that Judy were here, because I think Judy would have more details than I do, and actually I had sent her, uh, an email. She's, you know, she's busy, she's on call, poor lady.

Next Speaker: Oh, God has a inside, inside information.

Next Speaker: I think ****, okay.

Next Speaker: I **** 'cause I was her neighbor who drove her to the –

Next Speaker: What a guy. What a guy.

Next Speaker: But basically, um, all of the intake questions were, uh, done by the, um, registration clerk.

Next Speaker: Mm hmm.

Next Speaker: So the first question was, you know, what's the reason you came in, right?

Next Speaker: Mm hmm.

Next Speaker: And she said, oh, I have a fever, and the, the second question was, you know, well, you know, have you been outside of the country? And yeah, so that was part of the screen question, and I think that prompted, well, she said, well I've been here, so what were you doing there? Well, I worked there, and then immediately called the nurse and then the triage nurse came and asked exact same questions again to ensure that the history was correct, and then placed her in, um, negative pressure room.

Next Speaker: Do we know when she was given a mask?

Next Speaker: Oh, the mask was given, uh, by the triage nurse. No, not by the triage nurse, by the, the registration person.

Next Speaker: Excellent.

Next Speaker: When she mentioned –

Next Speaker: Yeah.

Next Speaker: – when she mentioned she had fever.

Next Speaker: Yeah, yeah. Okay, so.

Next Speaker: Did they, did they, so they didn't even have to get to like, are you vomiting, diarrhea, it was just they –

Next Speaker: Yeah.

Next Speaker: – they were right at that travel disclosure.

Next Speaker: Yeah, yeah.

Next Speaker: Okay.

Next Speaker: Now since this is one of our ICAR hospitals, had we primed them beforehand to take a travel history on anybody who comes in with a fever?

Next Speaker: Well, they have, I mean, they, that's part of, that's part of their protocol, right, to ensure that they can, they have an appropriate screening mechanism to identify such patients, so I mean, they're in a different group, obviously.

Next Speaker: Mm hmm. And what we would like to do potentially, is to share what they were able to accomplish so that other facilities in Oregon might be able to accomplish something similar. And just so you know, we have done similar mystery patient, uh, evaluations in other facilities that are not ICAR facilities, and, uh, there was one example where someone presented with cough to a, uh, an Oregon facility, and there the person had been in the Arabian, on or near the Arabian Peninsula, and uh –

Next Speaker: **** something.

Next Speaker: – so, but anyway, so there was a potential concern about MRSA, and uh, in this case the person at the front desk said, so are you here for that cough, but did not offer a, uh, did not offer a mask, and, uh, so the, uh, mystery patient sat in the emergency room, waiting room about 15 minutes before seen by an R.N. who brought the person back, and then, um, to his credit, asked appropriate questions, determine, oh , this is a problem, and got the person in a, uh, mask and instituted isolation; however, uh, this person was sitting in the emergency room for 15 minutes on a mask, and I don't know that that's the best example of a systematic approach to this. I think in this case there was one person who thought of the right questions to ask and did the right thing, but it was dependent on that one person doing it as opposed to being part of the

system. So what made the difference between these two situations? And I think a number of the things that we might consider presenting to, to facilities, uh, are the fact that if you have policies in place where people who have febrile illness, uh, get masks very quickly and if those folks who are symptomatic with certain conditions, then get asked about travel, uh, that you can uncover very useful information which may help you in guiding the management of that patient. Also training, so that folks know that at intake you regularly ask certain patients about their travel, and you do ask them about their symptoms, and if they have certain symptoms you provide them with a mask in order to limit the exposure to other healthcare workers and other folks in the facility. And then also, the use of prompts, uh, where there is a flag in the electronic health record, which helps that person remember at intake to ask that question. So these are things that I think we might consider putting together in a presentation somewhat like this, to take on the road and see if this is, uh, if this is something that, uh, that folks would be interested in. So again, just in summary, if we, if we offer these things and we can offer fairly simple approaches that allow people to do this, it may help us move the needle on this, uh, on this particular topic, and so just wanted to, to see what people's thoughts were and getting input that folks might have, uh, Deborah, uh, if you had any thoughts, Deborah Katora, if you had any thoughts about how we might do this and put this together in, in a way that it is acceptable to people and motivating to people, uh, just be interested in your thought. I will mention that Judy Guzman does have a nice presentation that she had put together which is available on our State of Oregon training website, and that people could access, but I'm wondering if that's as little passive, uh, people have to come to us in order to see that, and so I'm wondering if maybe it does make sense for, uh, me, for Judy, Dat if we can talk him into it, uh, to, uh, potentially go out and, and talk with people about this and see if we can, see if we can move the needle on this. So thank you very much. Glad to have had the chance to talk with you, and be glad to take any questions or comments.

Next Speaker: Okay, Deb Katora actually says I like the simplicity of –

Next Speaker: Unmuted.

Next Speaker: – okay, Deb Katora says, I like the simplicity of what are the triggers, as almost any type of staff could use appropriately.

Next Speaker: This is great.

Next Speaker: Got any comments from the phone or in the room?

Next Speaker: Couple thoughts that, I'd love to hear somebody else, I had a couple thoughts, but I was looking for ****.

Next Speaker: This is Rosa. Uh, this is Rosa, and I think that was, I think the, um, developing scenarios that are participatory to allow people to kind of **** how it would happen, um, was kind of the specific, right, like context, I think would be an awesome way to incorporate some, uh, you know, –

Next Speaker: Mm hmm.

Next Speaker: – uh, just that like nice **** report between a training that can fire some of the questions.

Next Speaker: So I'm gonna go get my paper to write this down.

Next Speaker: I can also send you this afterwards, Richard.

Next Speaker: Okay.

Next Speaker: This is Genevieve. I'm just curious to hear from some of the healthcare systems that come from Providence, and I know that this is something that we've been working at, and working on, and with, uh, prompts with their EMR when patients present to the ED. I think we reached out to the, the health department a little bit ago because we were trying to come up with phrasing, uh, to identify high, you know, infectious pathogens of high consequence, so just wondering if any of the other health systems are doing something, if they wanna comment on, um, because I think with, especially if you're like EMR, I think approaching the hospital with a system might be more efficient, and also help you to reach out, 'cause they are putting things in place and making sure that, that the bases are covered or, rather than maybe doing it more piecemeal.

Next Speaker: Right.

Next Speaker: That's my thought. Oh, lemme get ****.

Next Speaker: Hey, this Dennis ****. So, um, yeah, no, I think it's a great idea. So at Kaiser we do utilize some of those prompts in the medical records, so the travel questions are definitely there, and we actually have a simulation team that I have been trying for maybe 3 years to do these types of scenarios, so doing something coming from the state where you're actively coming in and not that kind of approach, um, I think it's a great idea, because, you know, our little tiny infection control department is trying to move the big, so it can sometimes be difficult, so, and that's, that's my –

Next Speaker: Okay. And I, I guess that's one question, uh, clearly we would want to engage preventionists, but who else, who are decision makers who we would need to, to see if we can involve in to be present at presentations in order to, uh, decide whether people wanna move forward with this?

Next Speaker: And so I **** for my own organization, this is Dennis again. Um, our emergency department, definitely our emergency management group and our simulation group too, 'cause we did that **** partners, of and as well, and infectious disease ****.

Next Speaker: And would your information system people need to be involved in that initial presentation as well?

Next Speaker: Oh yes. Uh, that would be a great addition, as well, I think dramatic.

Next Speaker: And then can you give us some kind of contact for, you know, the type of questions that we should talk about for screening of high consequence versus travel screening for MDROs. Where do they sit within your algorithm, right, because they may be separated in space or time in terms of are they all in the same, like I'm just tryin' to remember how each facility implements those questions. They may be the same questions, they may be separate questions, they may be separated, you know, in, in the algorithm, do you recall?

Next Speaker: I, I **** together.

Next Speaker: It's all together?

Next Speaker: Yeah.

Next Speaker: Okay. So that one travel question should, could get at both, uh, something like that as well as the MDRO?

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: And I, this is Jennie, just a follow-up. I think sometimes it's a time difference around all the work with ICAR and Ebola that Dr. Guzman work, we think we're really focusing on, you know, 21 days to a month.

Next Speaker: Yeah.

Next Speaker: Versus the longer 6 months to a year.

Next Speaker: Yeah, exactly.

Next Speaker: And so some of that because you might be more of an inpatient, inpatient, okay, everything's good, here, patient question, but um, apologies for that. Spilled coffee here, it's all good folks on the phone. Uh, so anyways there might be a little difference on the time.

Next Speaker: Yeah, I think that's what I was tryin' to get at.

Next Speaker: Yeah, yeah, okay.

Next Speaker: In terms of when it's actually being asked, right?

Next Speaker: Mm hmm.

Next Speaker: And, and, and how we implement, uh –

Next Speaker: Most the –

Next Speaker: – these types of incorporate fees, you know, questions when they're, in my mind, may be relevant to different groups.

Next Speaker: Smells really good.

Next Speaker: **** coffee, yeah. Uh, and this **** I say, yeah, I think that working with EMR or the EDs, the other piece I wanted to bring in is I know be, uh, kinda because the Ebola stuff, the hospital EDs have a done a lotta work with, with it, that won't be the first time they've heard this. Uh, the other part would be urgent cares, more an outpatient setting. They typically haven't had as much historical infection control oversight and support as I think the main hospitals and EDs have, so that is another big patient focus, uh, or patient looking, uh, entrance, or entrance that patients would enter the system and, and might benefit, again, from going back to the very basics about, you don't need to have, oh, go ahead.

Next Speaker: You know, also, um, I just thought of it though, uh –

Next Speaker: Use your, do you have your thing, oh.

Next Speaker: ****.

Next Speaker: Like our, like our on line, uh, and telephone advice line.

Next Speaker: Hmm, mm hmm.

Next Speaker: That would be wonderful to involve too, as well, 'cause I know when, when measles was going on, we targeted them first **** the patient's gonna call **** first, so we were able to stop it on infectious patients coming in ****.

Next Speaker: And, and **** just to follow up on that. I know that's a, a big good for pediatric patients, which a lot of times they are call, and those are the kids are gonna have the chickenpox and the measles and things like that, so involving that.

Next Speaker: Right, and I, I guess this brings up another question I'd be interested in your input on. What are the pathogens we outta be talkin' about, 'cause you know, uh, we, we certainly ran into this back in the day. There was a certain level of Ebola fatigue, uh, maybe there is less Ebola fatigue now that we have another outbreak going on, although I half some fingers crossed, like it may be, it may be, uh, settling down a little bit, but are we gonna, are we gonna be able to get the same level of interest with, uh, measles? Are we gonna be able to get the same level of interest with, uh, varicella? Are we gonna be able to get the same level of interest with meningococcus? I, I don't know. I mean, should we be talkin' really exotic things or, uh, do we need to, you know, what should we be focusing on that will catch people's attention?

Next Speaker: ****. I would say, this is Genevieve, and, and, and so someone from the phone, go ahead, please.

Next Speaker: Oh sorry, this is Pam Cortez from Salem again. Um, we actually, the travel question is at every access point where we are asking if they traveled outside the U.S. in the last 30 days, but with the measles we overlaid another question in our AHR that all of that all of the access persons asked that have said, uh, have you been exposed to anyone with the measles or have you had symptoms of measles and, you know, and had asked that question. We, we ended it as soon as the outbreak was kinda called off, but it's been off and on with these measles cases coming into the area. So we did use it for that.

Next Speaker: Okay.

Next Speaker: Yeah, Pam brings up a great, this is Genevieve, brings up a great point, is I think guidance when there are creating these EMRs to have flexibility where you can turn on and off questions. I know that was important with Providence when they were trying to figure out the, the order in which they would ask the questions, is having that flexibility later on, you can turn on and off without completely messing up your algorithm is, I think, helpful foresight to have for the IT people.

Next Speaker: Uh, this is Paul, and you know, I think, I think you need to sorta decide whether we're gonna go for asking these questions on every patient who is encountered, or whether there's gonna be some sorta clinical trigger for them.

Next Speaker: Mm hmm.

Next Speaker: And, you know, if the latter, which I suspect are the lines along which we're thinking, um, you know, uh, measles and chickenpox, you don't need to go overseas to get necessarily.

Next Speaker: Sure.

Next Speaker: And so, um, you, you know, you probably wanna put in isolation maybe anybody with a fever and a, and a unexplained rash, uh, and then, then otherwise I think it's fever is about the only thing you gotta go, go on for the overseas, nasty, potentially nasty bugs, but realize that, you know, there's gonna be a lot of people isolated and are you really gonna put 'em all into airborne precautions, um, for all of your cases of dengue and malaria which are, be far more common than Ebola and Lassa fever.

Next Speaker: Sure.

Next Speaker: Sure, and I, I agree. I mean, uh, just to follow up on that, this is Genevieve, is that I think some of what the other piece that you emphasize well is that if you don't, it's also about just using the mask right away, you know, then deciding if you need airborne, just even putting the mask on someone is a great step in the right direction, even if you're not going to airborne. And I just wanted to follow up real quick. You were saying about common things, answer that question. Having had to work through several of these clinic and ED ex, exposures there in an incredible amount of time, even if it's just "chickenpox or measles", the amount of, you know, human resources, and it's usually on a Friday afternoon, um, before a holiday weekend or

something like this, so I think, and so when we are doing that and we find out, oh, the kid was put right into a mask, like, you know, our concern level go, can start to go down or they brought in at the end of the day or these kind of things. Those simple steps can make a big difference regarding exposure risk.

Next Speaker: Right.

Next Speaker: And I guess I, I was asking that question in terms of motivation to a, uh, a facility that hasn't adopted this, or a health system that hasn't adopted this. What would make them say, oh, I care, I do wanna adopt this, uh, and is it more likely that they're gonna do that if we're talkin' about Ebola and Lassa fever or is it more likely that they're gonna do that if we're talkin' about measles, or is it more likely that they're gonna do that if we talk all of 'em? Just, just in terms of what, what's potentially motivating to, to, uh, chief executive officers and infection preventionists and anybody who needs to make a decision about this?

Next Speaker: I'm, this is Dat. I would venture to guess that probably what matters to them is hopefully seeing data that the amount of prevention put into this and the costs associated with that is, you know, more **** is paid off by, um, the amount of work that's required when such an outbreak occurs, right? So, I'm sure there's data out there, um, that helps that argument. Beyond that I'm not sure what would motivate the, um, leadership.

Next Speaker: You know, well, call me a cynic.

Next Speaker: I think also, um, how you perceived in the commun, I mean, like is this a, is it a responsible that, I think saying out, being in the media in only in a positive way and not a negative way.

Next Speaker: Mm hmm, right.

Next Speaker: Is also really important to them. So, um, I'm not sure if get anybody else from the different system would like to add something. But yeah, I, I don't know that you'll have a lot of trouble, actually, getting leadership. And do you need a microphone?

Next Speaker: All right.

Next Speaker: No, you're, but, uh, yeah. I, I think ****, I think it's on Providence's radar, for example, and it sounds like on ****, like I think it's on these big system radars, so I think you won't, my personal opinion wouldn't be that it'd be difficult to receive the, for them to get interested in it.

Next Speaker: Mm hmm. So are you saying that even the big systems would benefit from such intervention, that on their own they're not gonna progress and implement a system that's effective? Is that what you're saying?

Next Speaker: ****

Next Speaker: More quickly than it might otherwise, maybe that's a good thing too.

Next Speaker: I'm just trying to understand where to target resources, right?

Next Speaker: Right.

Next Speaker: Are we, are we come after big systems, or we, are we gonna support the smaller independent facilities in tryin' to get this up and running?

Next Speaker: Yeah I think it ****.

Next Speaker: It's like a great, it sounds like a great place for a survey. We, we could make it, no I'm kidding.

Next Speaker: No, no surveys.

Next Speaker: You know what, I, I think Jen, I think Jen's point, uh, Dr. Busser's point earlier is a good one, uh, if you have a health system that involves four, five, eight, whatever, uh, facilities, then you approach them at the health system level and if they say, you know what, we're already doin' this, then that's wonderful.

Next Speaker: But they might, ****, hey, but we could use some help with our outpatient –

Next Speaker: Yeah.

Next Speaker: – or our urgent care, or **** like that.

Next Speaker: Maybe scenario-based exercises as, as Rosa was saying, and that's potentially, I love writin' stuff like that, so anyway.

Next Speaker: So and, and if I may, I don't mean to monopolize this and if there's anyone on the phone, but I think the other piece where it still might be helpful to reach to the health system also, not only to see where they are and, you know, if they need more ****, but is for, um, standardization of the communication, so that when we're talking to the state or between the facilities, kinda like what we tried to do with Ebola, like, so when we talk about con, you know, infec, infections of high consequence we're using the same terminology, so we all know what we're talking about. That communication and **** can be very helpful, transferring patients, you know, taking the next level, that kinda thing, so.

Next Speaker: Mm hmm, yeah. And getting back to your question Dr. Tran, I think, uh, if, uh, if we can approach health systems, that's wonderful. Uh, if there are individual facilities, you know, that, that aren't part of a larger network, why not? And, and in many cases they might be folks who would really benefit from the level of support in terms of making, making adoption easy.

Next Speaker: Sure.

Next Speaker: Any comments from the participants on the phone? Okay.

Next Speaker: Well, thank you very much and it's wonderful having an advisory group like this to be able to ask about this, so thank you.

Next Speaker: Great. Well, thanks for coming, that sounds like a great project that ****.

Next Speaker: I'll have this done next week.

Next Speaker: Thank you.

Next Speaker: No.

Next Speaker: So, excellent, so we'll move on to our next topic, uh, which is HAI program updates from Rosa.

Next Speaker: Hi folks. I don't have any slides for this, so I'll leave, uh, Richard's contact information up for a little while longer. So really just two kind of HAI program announcements. Thank you. The first one is, uh, we have a new, newsletter, and so this is a quarterly newsletter. It will be 1 page, front and back. We are aiming to keep it short and sweet. Um, and we'll be, uh, putting things in that newsletter, um, like upcoming trainings that we're gonna be offering, new resources, other news from our program. Um, so if you are listening to this and you have not already gotten an email from me asking if you want to receive the newsletter, um, just email me, this is Rosa again, and let me know or anyone, really, that you want to get the newsletter, and we will sign you up. And, um, if you have gotten the newsletter, we're just trying to make sure as many people know about it as possible, so feel free to just pass on the announcements to your colleagues and networks and let them know that this is a resource for them, um, we've gotten some good feedback on it so far, so hopefully folks will find this to be not an added burden to their inbox or workload, but rather, just a really, kind of brief digest of what they might, what you all might find useful and actionable. Um, any questions or comments about the newsletter? Perfect. Okay. And then the second HAI program update I have, I actually already gave it, but I'm going to say it again, 'cause it's extra important. That we do have several vacancies on this advisory committee, so we really want to be aiming to have a fully staffed, filled up, um, committee, so that 1 page or that you should have in your email inboxes, as well as, um, on paper for those of us in the room, you know, please do take a look at those vacancies. Again, we have a, um, hospital administrator vacancy, we have a health insurer vacancy, patient and family, um, or consumer advocate vacancy and then, again, um, not quite exactly a vacancy, but an opportunity, uh, for someone who is currently on the advisory committee who would like to serve in the position of chair. Um, so again, please get the word out to your networks, um, we will be relying on you all to help us fill these vacancies, um, and you can get in touch with me directly if you have any questions or comments about that.

Next Speaker: Okay, awesome. Any questions, uh, on the phone regarding that at all?

Next Speaker: No.

Next Speaker: Nothing ****.

Next Speaker: So, this is, uh, Genevieve for those on the phone again, so I'm bringing us into the next kind of wrapping this up here, but I, we've got some time on the clock which I'm excited about, 'cause we're at the end of the year and sort of, we wanted to use this time to open up for any ideas for topics around future meetings, reports, data that might be helpful for your facilities or for yourself, uh, that, that the state, um, may have, uh, data around, etc. So I would love to hear from the phone or in the room. Just to get you guys thinking, um, I just wanna bring everyone's attention, the, unfortunate recent news report, uh, from Seattle Children's where they, um, uh, investigated and found retrospectively that there were several cases of mold infections associated to surgeries that were done in their operating room, and they investigated and found the mold, indeed, in the air ducts and stuff. Uh, and then went on to mitigate that, so I just, I wanted to bring this up as a reminder around, uh, all the technologies and machines, etc. that we use and monitoring and those can be sources of infection, uh, and just making sure that, um, you know, and, uh, that, uh, that's on your radar with infection controls. I'm sure it is, uh, for, for those kind of, um, situations. Uh, similarly, there's a lot of construction that's being done as facilities grow, and how important that is to have infection control as part of that process, so that these, uh, you know, any sort of potential exposures can be mitigated as well as possible, so just why don't, you guys, somebody needed a project for next year, maybe, you know, making sure your air ventilation system in your surgical suite has been recently maintenanced. Might be a place to start. So, any, any comments or thoughts, um, from the phone or in the room?
Dr. Cieslak?

Next Speaker: Yeah, this, uh, this is Paul, um, Oregon Health Authority. Uh, I wanted to ask folks about, um, about policies regarding furloughing, uh, susceptible workers and see whether anybody has any policies like this. Uh, I guess I'm thinkin' mostly about measles. We've seen 28 cases of measles in the state this year, that's our biggest tally since 1982. Um, and mostly being represents importations, well, they all represent importations, but then with one or two or three cases occurring in the wake of an importation and then the, um, then it dies out for lack of susceptibles, uh, and because we're able in general to keep people at home. Um, you may be aware that measles vaccination is required for school entry, and also for college entry. Um, and for kid, kids who, who decline the required immunization who get an exemption from the immunization, if they're exposed then, uh, we have a rule that excludes them from school for an incubation period following exposure. But we have no similar thing for, uh, healthcare workers who are exposed and susceptible to the disease, and I'm wondering whether your institutions have policies regarding excluding exposed, susceptible workers.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: ****. Uh, yeah, we, we definitely do and we actually, uh, not this most recent measles, but the one before the one before, I think we ****, uh, **** official, so we actually have impressed upon that policy with the pertinent facts for our limited resources **** labor

organization, so my advice to you is look at your policies **** also, and, um, **** out today that improved. So, yeah, we definitely have that in place.

Next Speaker: Thanks. Any, any others wanna comment on that? Do, do you know whether you have a policy or not?

Next Speaker: This is Genevieve. I don't know if Providence does, I assume we must, but again, I should ask and see if that's been reviewed recently, 'cause I guess, uh, pertussis would be another, right? Chickenpox ****.

Next Speaker: Conceivably, although the vaccine isn't as good for pertussis as it is for measles.

Next Speaker: Mm hmm.

Next Speaker: So, it's possible to be susceptible to even despite vaccination, but –

Next Speaker: Sure.

Next Speaker: – I guess I'm thinkin' mostly about measles and chickenpox, but potentially a few other diseases, as well.

Next Speaker: Yeah, this is Pam from Salem Health, and we do have, um, an exclusion policy that was different types of either symptoms or actual, um, like active measles or postexposure exclusion criteria for staff.

Next Speaker: This is Karen from Good Sam in Corvallis. We also have policies that will exclude employees who may have been exposed to Dalcasim a good venous status.

Next Speaker: Great, thanks very much.

Next Speaker: Any other thoughts on topics. I also wanna make sure, extend that, too, for next year for HAI committee meetings. Uh, you know, common questions that come up, I know a while ago we had something around pet therapy, animals and, you know, infection control stuff. Are there, if there's other thing like that that you come across commonly and would be interested in understanding if the more, you know, if there are statewide policies or what other facilities are doing, anything along those lines? And if you're too shy to share your great idea, uh, please forward any, uh, thoughts and comments to Rosa Tamara through email. Any other public comments, uh, from, especially from any of our public pa, partners, before we wrap up this year and this meeting?

Next Speaker: Um, Karen also has a policy, exclusion policy.

Next Speaker: Great. Kar, and it's Karen Schweute?

Next Speaker: Karen Knucke.

Next Speaker: Knucke.

Next Speaker: From Woodshaft ****, for which system?

Next Speaker: Hmm.

Next Speaker: It's **** Hospital in Corvallis.

Next Speaker: Thanks.

Next Speaker: Thank you Karen.

Next Speaker: Thank you.

Next Speaker: **** might be here.

Next Speaker: Great, well, uh, thank you everyone for coming to participate into the final meeting of this year, 2019, and we look forward to seeing you in 2020.

Next Speaker: ****.

Next Speaker: So from vaccines, wash your hands.

Next Speaker: Check your air.

Next Speaker: Yeah. Thank you very much everyone for your participation and again, any questions or comments, please feel free to forward the **** of the meeting to, to Rosa Tamera's email. Take care. Thank you.