Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
June 19, 2019

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Speaker: Uh, so first of all, let's start with a call to order, uh, and I'll just begin to my right here in the room, and then we'll go to the phone.

Next Speaker: This is Rosa Kamer **** reporting epidemiologist at the, uh, HAI program.

Next Speaker: Uh, Dac Tran, HAS public health physician.

Next Speaker: Um, Atakia Waiviston with ATV.

Next Speaker: Allison McLean, uh, public educator with ACDP.

Next Speaker: Uh, this is Lisa **** epidemiologist, um, at the HAI program.

Next Speaker: Monika Samper, HAI program.

Next Speaker: Natalie Compos, ****.

Next Speaker: ****, infection productionist ****.

Next Speaker: **** interviewed the, uh, regional ****.

Next Speaker: **** Jones, also HAI epidemiologist, also with the HAI program.

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

Next Speaker: Julie Cox, Salem Health.

Next Speaker: **** communicable disease here at the Public Health Division.

Next Speaker: Diane Roy, research analyst, uh, OHA.

Next Speaker: Okay. Uh, is, uh, David Cruz ****?

Next Speaker: Yes.

Next Speaker: Okay. Uh, David ****, uh, **** chair, runs a practice at ****.

Next Speaker: Jeanette ****, **** student, um, ****.

Next Speaker: Great. Thank you. And then, uh, on the phone, if you guys could please introduce yourself and where you're from.

Next Speaker: Uh, Josh Barfield, supply chain manager for the Oregon Clinic.

Next Speaker: Jackson Bowers, Jackson County Public Health Division Manager.

Next Speaker: This is Kristin Choodi, Medical Director of Infection Prevention at Asante.

Next Speaker: Pam Cortez at Salem Health.

Next Speaker: Uh, Sydney Epland at the Oregon Patient Safety Commission.

Next Speaker: Diane Long, Female **** Medical Center, Baker City.

Next Speaker: ****, OHSU **** infection prevention.

Next Speaker: Mesa Greenfield from Lake District Hospital.

Next Speaker: This is Ryan Graham from the Portland Clinic.

Next Speaker: ****.

Next Speaker: Mary Pone, Shriners.

Next Speaker: **** County, uh, infection prevention nurse for pub, uh, for Crook, Jefferson and Chutes County Public Health.

Next Speaker: This ****, Nursing Professional Consultant Board **** Association.

Next Speaker: Can you repeat that again?

Next Speaker: Jesse Cantulo, nursing practice consultant for the Oregon Nursing Association.

Next Speaker: Thank you, Jesse. Anyone else? Great. Well thank you for your representation from around the state. So next we will go to our logistics update ****.

Next Speaker: So very briefly today, um, uh, just a reminder for the folks in the room to please use the mic. Thank you, uh, for doing that already. Um, at the back table, and we will email this around, is a little announcement about, um, our current vacancies, and, um, I should mention that, uh, we have two vacancies since Jordan Ferris at the Oregon Nursing Association is going to be, um, transitioning away from her role as labor representative on our HRI advisory

committee. So we will have a vacancy for a labor representative as well as our healthcare insurer representative position which has been vacant for quite a while now. So, just as always, please feel free to pass on this information, uh, to your networks and colleagues and we will send out, um, a one-pager with information on how to apply for one of these positions, um, and hopefully we'll get a good response. Um, with that being said, I just also wanna thank Jordan for being a valued member of our committee, and also that we have, um, one of our Americore Vistas with us in the room today who will be working, um, with me on a project aimed at doing some, um, patient and family engagement, so little teaser for that. Um, we will bring that up at the end of the meeting.

Next Speaker: Next.

Next Speaker: So at this point, uh, is the time to go ahead and review and approve the March 2019 minutes from our last meeting, and if anyone, um, would like to support approval please declare it so.

Next Speaker: I move that the minutes be approved.

Next Speaker: So we have one move to approve the minutes.

Next Speaker: I'll second.

Next Speaker: And we have a second to approve. Thank you very much. So with that business aside, next we have Rosa who will talk to us about the OHANA, NHSN reporting requirements. Uh, and if someone new just joined the, um, the line, would you mind introducing yourself and where you're from please when you get a chance?

Next Speaker: This is Jessica Symack from Washington State Hospital Association representing, uh, Oregon Association of Hospitals and Health System.

Next Speaker: Great.

Next Speaker: **** that.

Next Speaker: Thank, thanks for joining.

Next Speaker: ****.

Next Speaker: Okay. So, um, I'm gonna go ahead and get started, um, talking about our reporting requirements here in Oregon. Um, this was first brought up at our, um, previous HAI advisory committee meeting. Um, it was a very brief presentation. We did send out the materials afterward a couple of times to encourage some feedback. Uh, we also brought this to our local APIC chapter, um, and, you know, just for a little bit of a refresher, um, the sort of purpose of this advisory committee at its onset was to, you know, give our program advice regarding HAI reporting requirements here in our state. So, uh, our reporting requirements have stayed relatively stable for the last, you know, 4 or 5 years. We did make some updates mostly

based on changes to CMS' reporting requirements. Um, so having gotten some feedback and questions in the last year, um, about, you know, why are certain things reportable or certain other, uh, measures not reportable here in Oregon, we are starting to have this conversation. Um, so jumping in, just as a refresher, um, you know central line-associated bloodstream infections are reportable here in Oregon in adult pediatric and neonatal ICUs and adult and pediatric medical, medical-surgical and surgical wards. Generally the trend under the new baseline is that in acute care hospitals we're seeing decreases in CLABSIs and our SIRs are pretty much below one, and then in critical access hospital our, um, we are seeing an increasing, uh, trend in CLABSIs and SIRs above one. For catheter-associated urinary tract infections, those are reportable in Oregon in adult and pediatric ICUs and adult and pediatric medical, medical-surgical, surgical and inpatient rehab wards. The general trend under the new baseline is that we're seeing kind of steady numbers, um, in our acute care hospitals with SIRs around one, um, and in our critical access hospitals also see, seeing pretty steady numbers with an SIR, and I should say standardized infection ratio, of less than one.

Next Speaker: Can you, can you remind me what the baseline for the SIR is?

Next Speaker: I will, yes. So the, the baseline, um, is national data for 2015. So, um, when NHSN originally established the capacity to produce standardized infection ratios, which is the observed number of infections compared to the predicted number of infections bash, based on national data across all different measures for different facility types, those numbers were not consistent. So the baseline for some measures was from 2008, and for other measures it was like 2011 so we really weren't comparing our numbers to kind of a single point in time and they were also pretty old. So the 2015, um, NHSN took all of the national data and used it to calculate, um, or used it to create new models that would allow them to calculate the number of predicted infections based on something that was consistent across all measures and more updated in time. Thanks for the question. Um, in terms of our lab idea then, MRSA bloodstream infections are reportable in Oregon, and generally, the trend in acute care hospitals is that we're seeing increasing numbers, um, but still fewer than predicted, and in critical access hospitals seeing stable numbers and more than predicted, and in terms of our clostridium, or rather clostridioides to **** infections we're seeing decreases both in acute care and critical access hospitals with SIRs of less than one, again, meaning that we're seeing fewer than predicted which is great. And then finally, our surgical site infections, we require six procedures to be reportable to us through NHSN, CBGBs, knee and hip prosthesis, colon surgery, abdominal hysterectomy and laminectomies. In CBGBs we're seeing increasing numbers but fewer than predicted. In adults we're seeing stable numbers, I'm sorry, in knees we're seeing stable numbers more than predicted. In colons stable numbers but fewer than predicted. Hips, we're seeing a decreasing trend but more than predicted still. Um, hysterectomies, we're seeing increasing numbers more than predicted, and then in laminectomies we're seeing increasing numbers but fewer than predicted. As an example of what we see in other states, we've talked about this already, but just as a comparison, in New Hampshire, um, they require CLABSIs in all ICUs, clip or central line insertion practices in all ICUs to be reported, CAUTIs in all ICUs and SSIs following cavages, **** and kapros as well as flu vaccination and healthcare personnel, and then in AFCs, New Hampshire requires SSIs to be reported following breast, hernia and open reduction of fracture. Pennsylvania requires all HAIs associated with any inpatient location to be reportable so that is literally everything that, uh, an HSN has the capacity for, um, that facility type. And Alaska has

no reporting requirements, although I believe they access NHSN data with a data use agreement with PDC. So today we're gonna discuss changes to our reporting requirements proposed by Oregon infection prevention and our infection prevention and HAI community as a whole. So how do we wanna expand or reduce our existing reporting requirements to ensure that they best support, um, and align with our existing and future priorities, what timeline should these changes take place within, if any? And after today, I really encourage you to continue sending your thoughts and feedback to me directly, um, because our plan is to review proposals in September and vote. That doesn't mean that this would be, you know, instantly we would require reporting, which kind of circles back to the point I just made about within what timeline would we want to see these data. So, s, just going into changes to reporting requirements proposed by our IPs and, uh, they really were all IPs, I think, who gave me this feedback, but I just wanna say infection prevention in HAI communities since I, you know, it's not just IPs that have a state in this so really anyone is welcome to send me any feedback, and, and don't be shy about sharing this information or opportunity to give feedback with your networks and colleagues because, uh, as far as I'm concerned, you know, the more diverse feedback that we have the better, that we can create proposals better appropriate to bring to the table in September. So the first proposal was to remove laminectomy from hospital SSI reporting. The second proposal was to add non-ventilator associated pneumonia event to hospital reporting. And the third proposal was to add antibiotic use and antibiotic resistance to hospital reporting. And then outside of hospital reporting, the proposal was to add AST SSI reporting requirements for high volume or high-risk procedures, and the procedures that were mentioned included hernia, breast, colisisectomy, cataract and other eye procedures, joint procedures like hip and knee replacements, and laminectomy. So, um, what I will do, very briefly, just for a little bit of context for the latter part of this slide, is go through, um, some national acute care hospital SSI data for 2017. So, um, looking at SIRs of greater than one in adult SSI, I mean, sorry, SSIs with SIRs of greater than one in adult procedure in 2017, which is the most recent national data we have available to us, we saw that craniotomies, C-sections, FX or open reduction and fractures and kidney transplants both in adult and pediatric populations had, um, you know, numbers that looked greater than predicted. And then, um, there were additionally certain adult SSIs that had, uh, national data showing more infections than predicted, um, and then other procedures in pediatrics that showed that same, um, pattern. So previous slide, we're just looking at the ones that are similar both in adult and pediatric populations, these sort of surgical procedures with, uh, high SIRs or SIRs of greater than one, and on the next slide, these are just the ones that aren't shared in common by adult and pediatric populations. And I think I misspoke when I said that we were looking at AFC dates because we're not. We're looking at acute care hospital data which is published nationally by CDC. So I'm just gonna navigate us back here to the proposals on the table and just open up the conversation, um, to anyone who might wanna talk about these proposals, um, or additional proposals that haven't yet been made, and this is gonna be while you guys are think, but I'm wondering if you can provide any context about why those particular, um, pieces were recommended or suggested? I don't, you know, if that came up in the conversations, just to give those who weren't in the conversation a little bit more background if, **** on experience or numbers or anything like that?

Next Speaker: Why?

Next Speaker: So it's possible that someone in the room might be able to provide that context from a historical perspective. I'm not able to, and when I followed up with our staff who had been working in HAI here the longest but are currently available to me, they actually didn't have that information either. Julie?

Next Speaker: Um, **** but, uh, first –

Next Speaker: Uh, can we use the mic for the people on the phone please?

Next Speaker: Okay. Sorry.

Next Speaker: No problem.

Next Speaker: **** laminectomy. Um, they're low in volume on the inpatient side, and really, outpatient is one of the key pieces, and, um, our organization feels like we would have ****.

Next Speaker: Is that mic on?

Next Speaker: You think it's not on? Can you hear me? No?

Next Speaker: Answer.

Next Speaker: ****.

Next Speaker: You can hear it?

Next Speaker: Um, can, it just feels like it's not working.

Next Speaker: It doesn't feel like it's on.

Next Speaker: It's not on, doesn't feel like it's on ****.

Next Speaker: ****.

Next Speaker: Something.

Next Speaker: Okay.

Next Speaker: Can you hear me now?

Next Speaker: Yeah, that's better.

Next Speaker: ****.

Next Speaker: Okay. Thank you for, uh –

Next Speaker: ****.

Next Speaker: Do you mind repeating it.

Next Speaker: **** starting from the beginning for the phone folks. Thanks.

Next Speaker: **** laminectomies are, um, low volume on the inpatient side. Most of them are outpatient now as procedures. So, um, the rule requires inpatient reporting. And, um, also we're, um, our organization feels like it's not where **** is really in the fusion, where laminectomies are done, um, but it's the fusion is being implanted. It's really the ones that we feel like would be more value added. Uh, but I wanna add any, but, um, um, not do laminectomies and, um –

Next Speaker: So what don't the OHSU, um, it's also very confounded with the, there's most of the time they're doing a laminectomy and a fusion and so you end up attributing all of those to the fusion if you can't **** which one's the cause of the infection. So most of ours are just reported as fusions ****.

Next Speaker: In the recent consultation I had with NHSN said that we should also report 'em under lam, so there's real confusion on reporting, if they should go lami and fusion or –

Next Speaker: **** specifically says to report the higher level for the ****.

Next Speaker: And now what?

Next Speaker: ****.

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

Next Speaker: ****.

Next Speaker: It seems ****.

Next Speaker: ****.

Next Speaker: Is it on?

Next Speaker: Yeah.

Next Speaker: Yeah, it's on.

Next Speaker: It seems to me that it makes a lot of sense to do SSIs in ambulatory surgery centers just because the high, high volume and the more complex cases that they're taking on. It seems that, it's almost surprising to me that we're not doing that already.

Next Speaker: And, and this is kind of the reason why I pulled out these acute care hospital SSI data. So just looking at these ones that are kind of, we b, we see high numbers both in adults

and, and pediatrics. Uh, those are craniotomies, C-section, FX and kidney transplants, and then the ones that are in adults, they're listed on the side, and then peds are listed on the side too, and we can see that, you know, lam does not show up on any of these lists. Not that this is the only criteria that we should have. Um, you know, I think that folks brought up high risk and high volume, right, as a potentially interesting procedures to follow, but –

Next Speaker: Yeah. Uh, this is Paul. Um, the SIR is a, is a relative, uh, range, and it doesn't give you any idea of the absolute range. So I'm kinda less impressed by the notion that the SIR has increased since 2015 then I would be by what's the absolute rate of infection? My recollection when we first looked at this 10 years ago is that, uh, the, the risks from a laminectomy, at least without a fusion, is pretty darn low and, and, you know, you're following a lot of procedures in order to identify very, uh, low infection rate. So, uh, you know, I, I would favor, uh, discarding the laminectomies and focusing on, uh, infections that are both, um, more likely to happen and more morbid when they happen.

Next Speaker: Mm hmm.

Next Speaker: Similarly, I, I don't, I don't think the infection rates from things like, uh, breast surgery or routine hernia, or of these, uh, you know, are very, um, are very common, and, and are more, very morbid when they do occur. Um, with, uh, kidney transplants, I, I think it's possible that they are. Uh, I don't know, if I could see the data. Open, open reduction of fracture is, um, uh, would also be interesting because there's often internal fixators that get, uh, infected and, and that's pretty morbid, so –

Next Speaker: And Paul, would you, are, are you suggesting, um, in the, in the, uh, hospital setting kidney transplant and FXs, or outpatient, or both? Just off the top of your head since we're talking about, you know, proposals and ideas.

Next Speaker: Yeah. I, I, I would, I would just base it on, on what the infection rates are. Are, are they really doing kidney transplants at ASCs?

Next Speaker: I don't know, probably not.

Next Speaker: ****.

Next Speaker: But we don't actually have any nationally published data on these in ASCs which is why we're using the acute care hospital data by proxy.

Next Speaker: Right. So, so in either setting I, I would base it on, um, on, on mor, morbidity and, uh, frequency of infection.

Next Speaker: This is Kristin Choodi from Asante. I have a similar comment to Paul's in terms of focusing on the procedures that really end up having huge amounts of morbidity and poor outcomes, um, including fusion. I also, uh, think it would be helpful to look at that ambulatory surgery setting as well as the inpatient. I think there's a big push to try to create a structure to handle more and more complex patients in the outpatient setting as a cost-savings measure. And

while some of that structure and process is good, I think, uh, with our current practice that leaves us with potentially a gap where, you know, we're not catching all those infections and looking for opportunities where we should, and maybe some of those patients should even be, you know, in the hospital with a higher level of care, um, or closer follow up after their surgery is, though I would agree with maybe using fusions rather than laminectomies as kinda the key point where more risk exists, um, and with similar procedures. I think the ORIS would be interesting. It kinda depends on whether you have a traumatic open fracture and then they do an open reduction and fixation, or not. That might be a little complicated, um, in terms of determining how much of that is reducible risk, uh, through better infection prevention practices or antibiotic use. Um, we just reviewed kind of the east guidelines for open traumatic fractures and, um, I, I kinda got an opportunity to see the **** of data in terms of that antibiotic choice, and some of those situations are complicated that put patients at risk.

Next Speaker: This is, uh, Dac. Rosa, could you go back to that, um, suggestion slide and, and just focus on, oh, there, right there. Thank you, huh. Um, so, so the ASC, um, are those the ones that, um, we would be considering, I mean for those who are working in the hospital setting, the ones that's there? Are those the ones that are being pushed towards ASC or are there others?

Next Speaker: These are, these are the procedure types that were suggested by the folks who gave us feedback, just for context, um, that they might be interested in seeing ASC data here. We can certainly always add, you know, procedures to hospital reporting as well. So we're just really here to listen to the group. I guess, uh, and I guess maybe your follow up question is like for someone in ASC or ****, are these the high volume, high risk group –

Next Speaker: Right.

Next Speaker: – that actually do occur there –

Next Speaker: Yeah.

Next Speaker: – or are there others that –

Next Speaker: Yeah. Or, or, or is if there's a push, right, **** more complex, do we know what those are?

Next Speaker: Mm hmm.

Next Speaker: And the only people who would know are the, you know, the IPs that, you know, in, in the facility. So we're relying on you, I think.

Next Speaker: Well, uh –

Next Speaker: ****.

Next Speaker: Oh, go ahead.

Next Speaker: ****. So I know that our **** we have a laminectomy **** in-house, and there is a push to move those out. Uh, we just do high volume, uh, uh, cataract surgery as well. One of the recommendations I've had over at ASC that **** low and don't give them all **** at once, so ****.

Next Speaker: So perhaps starting with the maybe highest morbidity or frequency or some, maybe ones –

Next Speaker: ****.

Next Speaker: – like the joint procedures where there's a lot of, um, history of doing that on the inpatient side. So maybe it might be easier just start that on the –

Next Speaker: Yeah, just, uh –

Next Speaker: Or something like that. I'm just –

Next Speaker: – if, if we can find out any, if we had any idea of how many ASCs are doing and, uh, what procedures they're doing, 'cause it'd also be nice just to know across the board we're all doing hernias, how are we doing and how can we improve? ****, right? Yeah, ****.

Next Speaker: And –

Next Speaker: I think what, uh, this is Julie for Salem. Um, I know that, um, we're in the process of throwing two more ASCs and, uh, with the change in, um, 2-day stays in those ASCs, we're talking already about some joint procedures going there. We don't currently have that, um, but that would be my highest level of concern just because of what we're seeing inpatient.

Next Speaker: And this is Genevieve. Just as a follow up, is there anyone he, that's here today, and I apologize I don't know this, but who would be representing ambilatary, ambulatory surgical centers? And so Kaiser has, and then I guess, uh, my follow-up question is like which hospital systems also have those associated with them? So Kaiser, Salem. I wouldn't go, I actually don't even know for Providence like how many **** we have. I don't know. Anybody else, OHSU, do you guys have, uh, no, no outpatient, just the inpatient?

Next Speaker: We're not an ambulatory surgery center. We have outpatient surgery.

Next Speaker: Surgery, but it's not ambulatory surgery?

Next Speaker: No.

Next Speaker: Yeah. That's the same with, um, today, is that it's not an ambulatory surgery center.

Next Speaker: Mm hmm.

Next Speaker: And again, the two that were developing our joint agreement, so I'm not sure they'll even follow their, our, uh, reporting. Just don't know yet.

Next Speaker: So this is Genevieve to clear up my question.

Next Speaker: And will –

Next Speaker: Is, is the, if it's considered outpatient does that fall under your inpatient reporting? Or does it not reported, doesn't fall under any **** as of right now?

Next Speaker: Right, does not fall under any.

Next Speaker: So when we talk about ambulatory surgery center reporting, it would not include the outpatient surgery stuff at this point?

Next Speaker: ****, right.

Next Speaker: Okay. Just to clarify that, what we're talking about. Okay.

Next Speaker: Well if we made a reporting requirement in ASCs it would include outpatient procedures. It, uh, would include the outpatient surgery center –

Next Speaker: So are –

Next Speaker: – for that. That's what I'm wond, that was my **** –

Next Speaker: No, no, no, o –

Next Speaker: – does my question make sense? Sorry.

Next Speaker: Okay, yeah.

Next Speaker: It would be in facilities licensed as ASCs.

Next Speaker: Mm hmm.

Next Speaker: And it would be the procedures those facilities do, regardless of the length, duration of stay.

Next Speaker: Correct.

Next Speaker: So our current reporting requirements for hospitals are for procedures that are inpatient –

Next Speaker: Mm hmm.

Next Speaker: – meaning the patient is admitted and discharged on two different calendar days.

Next Speaker: Mm hmm.

Next Speaker: For ASTs there's a separate module for outpatient –

Next Speaker: Mm hmm.

Next Speaker: – reporting for SSIs, and that would cover, you know, all the procedures that they, they perform regardless of it, if it's one of those longer stays or if it's technically inpatient or outpatient according to NHSN. We'd wanna –

Next Speaker: ****.

Next Speaker: – capture the population ****.

Next Speaker: So currently, um, if we have **** that stays over midnight –

Next Speaker: Mm hmm.

Next Speaker: – and it wasn't outpatient procedure, gets reported under the inpatient-reporting request.

Next Speaker: Because it meets the NHSN definition –

Next Speaker: Because it meets that definition.

Next Speaker: – of ****.

Next Speaker: But otherwise it would fall under outpatient procedure and there is no requirement for reporting.

Next Speaker: And, and I guess my follow up is even with this, we talk about it still would not fall under an ambulatory surgery center reporting either. So it'd be, and it's, it's still separate from that.

Next Speaker: Yeah.

Next Speaker: Okay. I wanted to clarify that that, so you're talking about reviewing those and reporting those, but that's not actually what would be covered by adding ASC reporting. Okay. That's a good, that makes –

Next Speaker: But –

Next Speaker: ****.

Next Speaker: Okay.

Next Speaker: Yes.

Next Speaker: Is that a yes?

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: Just to be –

Next Speaker: ****, yeah.

Next Speaker: – 'cause I think, 'cause I think the cons, what I'm hearing, the concern –

Next Speaker: Yeah.

Next Speaker: – from the, um, IPs is that while our systems are now doing more outpatient procedures, but we really have no way of being able to track and follow up their infection outcome, because they are, no long, they aren't under the inpatient and they aren't under the ASC. Am I –

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: And we could, and something that I mentioned, uh, is that we could, you know, expand our hospital reporting requirement to actually include outpatient procedures. You know, there's nothing to prevent us from, from doing that. Um, but, but no one, um, proposed that to me.

Next Speaker: And, and I'm not putting –

Next Speaker: And it, it may be that no one thought of that distinction, right? I mean it may –

Next Speaker: Right.

Next Speaker: – I'm not sure. I mean you can speak to that perhaps.

Next Speaker: Uh, I don't know if anybody thought of that or not. Um, you know, if, um, so one, one, um, thing to keep in mind is, um, IP resources –

Next Speaker: Mm hmm.

Next Speaker: – now today –

Next Speaker: That's right. ****.

Next Speaker: – of, at least at my facility, over 40 percent of the time within surveillance for reporting, um, which ****. So I would target things that we need to target, um, and take away things that we don't, because we have limited resource –

Next Speaker: Mm hmm.

Next Speaker: – to ****.

Next Speaker: Yeah, no, thank you, and, Ms. Genevieve, uh, for those on the phone. That was gonna be my next question is sort of the outpatient procedures would fall under the inpatient IP purview –

Next Speaker: Mm hmm.

Next Speaker: – but in ASC that's a fully different –

Next Speaker: Yeah, facility.

Next Speaker: That's a totally different facility, totally different IPs, who aren't currently maybe at the table or even exist or, yeah.

Next Speaker: It was some, it was someone, uh –

Next Speaker: Oh.

Next Speaker: – uh, who was, was –

Next Speaker: Oh, was it someone on the phone?

Next Speaker: – who just talked at some point, a point, yeah.

Next Speaker: Okay.

Next Speaker: Got interrupted, yeah.

Next Speaker: Sorry. If there's someone on the phone who wanted to make a point, apologies.

Next Speaker: Uh, no worries. This is Ryan Graham from the Portland Clinic. Uh, I represent two surgery centers that we have in town where multi specialties, um, and I, uh, I think, uh, one point that you just touched on, for sure, if we're gonna look at outpatient procedures I think we need to look at hospital outpatient departments as well as we start to look at the outpatient industry as a whole if you wanna understand what infection rates look like for that population, um, because they are all walking out, uh, the same day. But then secondly, um, staffing is, is a

big thing as well. You know, our IP department really consists of two of our staff nurses who, um, do that on the side as we use them in operations. So, um, you know, to some other, uh, comments from earlier, um, you know, looking at what we do as far as procedures and, you know, narrowing down, um, the data we already do gather, um, and we can certainly report that and we can start to see, you know, what trends are, that's why we do IPs. Um, so we're on board for that, but yeah, tailoring it to what, I think, would be most, um, effective, and certainly not all at once. I agree with that comment as well.

Next Speaker: Are there, this is Genevieve. Just as a follow up, are there, um, uh, you know, with your experience and knowledge of what's done in ASC are there certain procedures that rise to your con, level of, you know, concern, either it be morbidity or frequency, as far as the post-op infections?

Next Speaker: And I think frequency, uh, you know, looking at cataract is fair. It's a, it's a big number of, of what we do, um, other procedures where we really see, we're not doin' totals in our centers right now, um. But, you know, just tryin' to think back over the last few years of infections, our rates are actually really low and trying hard to think of if there's any service lines who ends up with more infections over others, um, oddly, it, it might be the ortho line, but again, that might just be volume dependent –

Next Speaker: Mm hmm.

Next Speaker: – um, because that's more of what we're doing. Uh, it's really hard to narrow it down to a certain area. I can tell you I don't remember ever having, uh, an infection on any of our breast procedures, which isn't a huge volume.

Next Speaker: Mm hmm.

Next Speaker: Um, I think maybe one hernia that I can think of in the last 4 years have had an infection in. Um, so, I mean that's just our, our experience at our center.

Next Speaker: Mm hmm.

Next Speaker: So this is **** as a follow up. Is there a significant difference between ASC and hospital outpatient surgeries in terms of the type procedures so that if we're gonna mandate is it gonna be the exact, the same across both settings, or gonna be potentially different?

Next Speaker: The –

Next Speaker: ****.

Next Speaker: – the protocol you mean?

Next Speaker: Uh, no, no, I'm just sayin' to understand, you know, is there a difference in, in the frequencies of the type of p, procedures that are performed in these two different types of, let, let's call them outpatient settings?

Next Speaker: I, from my standpoint, I think you've gotta ask someone who's operating a hospi, uh, a, uh, hospital outpatient department to understand that.

Next Speaker: I think we have to look at actual data to ****.

Next Speaker: So we don't know, like you, you don't know off the top of your head, right?

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: And it sounds like there's a lot of change in the last couple of years too.

Next Speaker: Yeah.

Next Speaker: Am I, am I correct in saying that? So it sounds like we need to, more information.

Next Speaker: Yeah. Uh –

Next Speaker: And I do think there's another question that I have. Um, you know, your ASCs, you're getting into a lot of joint ventures too, um, so I'm not sure who that reporting will stand on when you have, you know, like ***** too, I believe, will be opening a new center, uh, soon which is really on their campus, um, and I know Legacy is involved and a few others too. So which umbrella does that fall under?

Next Speaker: Great point.

Next Speaker: Uh, I, I just wanna say that of, of those you have listed as potential, potentially reportable by ambulatory surgery centers, the only one I'm really excited about is the joint procedures, uh, just given what I think I know about likely incidents of infection, uh, following ****.

Next Speaker: **** outpatient?

Next Speaker: ****.

Next Speaker: Yes. Um, my, my wife works at ambulatory surgery centers which probably constitutes all of my knowledge of –

Next Speaker: ****.

Next Speaker: But they do a lot of knees, and I have heard that occasionally they've done a hip, uh, and **** surgery.

Next Speaker: And this is Genevieve with a follow up. Um, Mr. Graham, thank you very much for your input on this. Do you as an ASC group, do you currently, I don't know, have any sort of, um, within that, uh, you know, nationally or in Oregon, amongst ASCs have any r, uh, reporting surveillance already in place for healthcare associated infections? And I'm sorry if that wasn't a very clear question. But I'm just curious if you guys already do some sort of, um, in your own profession, um, or is it just, uh, oops. **** on hold.

Next Speaker: Yeah.

Next Speaker: I don't know if Mr. Graham is still there.

Next Speaker: So, um –

Next Speaker: Oh, yeah, here, thank you.

Next Speaker: – tryin' to answer your question over the lovely music, uh, we, we, uh, really only benchmark through ASCA, um, which is a national organization where we do quarterly reporting, and infections are part of that, um, or un **** event reportings through that. Um, but we don't have anything like what is being proposed currently.

Next Speaker: Okay. And is that, is it, I'm just curious if it's reported the infections, is it at all like the CDC NHSN reporting, i.e., you know, infected observed SIR, or is it totally different? I'm just trying to understand what you, you know, what sort of change that would be from your current practice. And, uh, we'll have to go back and maybe we can, we're gonna type something to the chat box maybe about, tell people not to put their phone on hold.

Next Speaker: ****.

Next Speaker: So right, I'm sorry about that. Uh, do you, is your infection rate through that reported as an SAR, or is it just like a number, or do you happen to know?

Next Speaker: I really think it's just a number.

Next Speaker: Okay, great.

Next Speaker: So, so this'll be slightly different.

Next Speaker: Mm hmm.

Next Speaker: Um, but I don't think this'll be surprisingly different from what we're already gathering in our own practices.

Next Speaker: Okay, great.

Next Speaker: And I don't, I don't feel that, um, you know, when I look at the list of proposed, um, reportings, uh, it, it's not gonna be somethin' that's highly burdensome to at least our center, but I think it's fair to mention that we have a bigger network, the Portland Clinic, um, is a bigger structure than a lot of your independent ambulatory surgery centers that might exist throughout the state.

Next Speaker: Great, thank you. Yes? Oh, Julie?

Next Speaker: Um, I just wondered if, uh, nobody's addressed, uh, AURs, AU, um, antibiotics. ****?

Next Speaker: We have not yet, mm hmm.

Next Speaker: Um, and I don't be, I think there are only 13 hospitals so far reporting, but I'm not sure, in Oregon.

Next Speaker: There's, uh, so currently there's 21 hospitals –

Next Speaker: Twenty-one.

Next Speaker: – reporting about use, but not the hospital's ****, and, yeah.

Next Speaker: Um, 'cause I think there's real opportunity there, but we don't know what our opportunities are yet.

Next Speaker: Mm hmm.

Next Speaker: So –

Next Speaker: And, and I, and I think some of that goes back, this is Genevieve, to the resources around –

Next Speaker: Yes.

Next Speaker: – if you have a nice module it makes it easy versus, yeah, and so I don't know if, how that is rolling along and rolling out. I think Providence is going to be getting the Epic module to make it easier but I don't, yeah.

Next Speaker: ****.

Next Speaker: Yeah. But that's, I think, uh, and, and I think that's very progressive and forward-looking to do that. I mean it's just starting to happen around the country, so –

Next Speaker: Um, I can speak a little bit –

Next Speaker: Okay.

Next Speaker: – ****.

Next Speaker: Can we mute the, can we, we can't mute them, can we?

Next Speaker: Um, hi, this is Lisa. Um, but I can speak a little bit to what's going on with reporting **** across the United States.

Next Speaker: ****, mm hmm.

Next Speaker: ****.

Next Speaker: I don't think it's on. Oh, there you go.

Next Speaker: ****.

Next Speaker: Okay. Is this better?

Next Speaker: ****.

Next Speaker: This is ****.

Next Speaker: There, yeah. You gotta go directly into their ****.

Next Speaker: Um, so, um, currently there's only two states that have reporting requirements, and it's specifically for the antibiotic use side, not for the **** reporting. The, um, the states are Missouri and Tennessee. Um, and Missouri has, um, already, uh, put in, put this, uh, requirement into place, at least ****, although, uh, the last numbers that we saw from **** not all the facilities have a report into the **** module. Um, Tennessee has, um, recently proposed and made it a, a requirement, and they are approaching it in a peer kind of approach. So they're targeting first, um, acute care hospitals, um, who are part of like large health systems, so they're basing it off that size. So **** if you have like more than 100 beds and you're an acute care hospital, then you're required to begin reporting antibiotic use at 2021. And they're set up for what, um, you, smaller acute care hospitals and then eventually **** hospitals. And it does have a starting year **** of that. Um, the challenge, I will say, um, with our hospitals or with our facility so far is that we're the facility that has that icon module ****, um, there is, uh, facilities that do that. However, that is an expensive add-on, um, and so, um, we're a licensed **** hospital, we're **** hospitals, you know, that is a challenge, and you do require some type of, um, software or your ****, it's up to you to make that reporting, uh, possible.

Next Speaker: And more ****, I would say that, um, we, we were one of the ones asking for the reporting requirement, and that will help us make the case to our hospitals to get software –

Next Speaker: Mm hmm.

Next Speaker: – uh, phar, and our pharmacy is in support of getting that.

Next Speaker: Yeah. That is ****. Um, I completely agree with that too. We've been, we'd actually like this module to support our **** program. 'Cause we actually started with three IP department system, we're down to one, and so we really would love the requirement because we love to see reporting ****.

Next Speaker: How do folks feel about rolling it out to, you know step-wise, and the way we said subscribing? So maybe just for acute care hospitals with beds over a certain number first, and then kind of expanding that periodically.

Next Speaker: I think that's a great idea.

Next Speaker: I, I do too. Um, it took us a year to get the module up and running, validated, and that's just the AU side. We're still working on the AR side so, so, um –

Next Speaker: Mm hmm.

Next Speaker: – AR is harder, uh, to validate.

Next Speaker: So, so this is –

Next Speaker: This is Kristin Choodi from, uh –

Next Speaker: Go ahead, ****.

Next Speaker: This is Kirs, thank you. Uh, this is Kristin from Asante. So I agree with those comments that, uh, have already been made that this would help us make the argument to administration that we need more investment in stewardship which we desperately do. Um, I guess one of the questions that I would have, 'cause I agree that we would need a tiered rollout to even attempt this, because we, we just don't have the structure in place to make that work as well as we need to currently, and so a push to develop that through a reporting requirement is great. Um, the one other thing I'd like to mention though, I mean I, I know I've been involved in some of the Oregon antibiotic stewardship network conversations that have been formed, um, and one of the things I think we also have some room to improve in is how we benchmark and then how we use that information. Um, it quickly gets complicated in terms of what antibiotics are you, being used for what purpose and whether they're truly appropriate or not, so I would just throw that out there as a comment that, you know, if we're gonna have a reporting requirement it would be nice to kinda have a, a thought of where we're headed with that, and how that would ultimately be utilized to improve outcomes and quality of care.

Next Speaker: Thanks, Kristin. Um –

Next Speaker: Welcome to the Chutes County Government. Thank you for ****.

Next Speaker: ****.

Next Speaker: We hope that all of you ****.

Next Speaker: Someone just added themselves.

Next Speaker: Um, so just a, a follow up in terms of tiered, uh, reporting.

Next Speaker: **** 386570. Again, that number is ****.

Next Speaker: Um, so with that tier reporting of five to eight U versus AR, do, do the facilities have an opinion about that?

Next Speaker: For additional information you need about the Chutes County Services.

Next Speaker: Does anybody ****?

Next Speaker: **** department staff working to operation ****.

Next Speaker: Just ****.

Next Speaker: Oh.

Next Speaker: ****.

Next Speaker: **** necessary services and programs to the public.

Next Speaker: ****.

Next Speaker: The Board of County ****.

Next Speaker: Do you have a preference?

Next Speaker: **** 6541 per the AA 6570.

Next Speaker: ****, um –

Next Speaker: The three-member board of commissions ****.

Next Speaker: – I would suggest just because AR is so much more complicated.

Next Speaker: **** the Chutes County Government, and is the governing body for all county service ****.

Next Speaker: Yeah. ****.

Next Speaker: You can find out more about the board by visiting ****.

Next Speaker: I think the value is the state could help us with, um, with **** information to compare each other to ****.

Next Speaker: **** County administrative services department ****.

Next Speaker: Yeah. Yeah. So we, we do have a collaborative, uh, called a resin.

Next Speaker: **** divisions in the **** department include ****.

Next Speaker: Um, and as you know, that collaborative, uh, currently involves all facilities that are reporting AU.

Next Speaker: **** county **** preparation and veteran services.

Next Speaker: So, um, and part of that collaborative is to develop benchmarking.

Next Speaker: Please call 541-388-6570 ****.

Next Speaker: So I think we will have something in place to help facilities, and, and the facilities that do report AU will have a voice in that as well. But I think that, that's our goal.

Next Speaker: **** for more information. The 911 service district can be reach at 541-388-****.

Next Speaker: Um, yeah. I, I think, um, from, from my perspective, this is all from, uh, ****. Uh, you know, we, we have to **** to feasibility ****.

Next Speaker: The district operates the county's 911 center.

Next Speaker: If it's simply infeasibly for the smaller institutions. But I, I wanna offer my opinion that, uh, I, I, I suspect that problems with, um, inappropriate use of antibiotics or least **** small facilities as they are in the larger facilities and so I think, I wouldn't want to ignore them entirely. It would be possible for us to, to, uh, write a rule that, um, you know, gives it, gives some lead time, uh, to implementation of all this, and, and perhaps it would be best even to, um, to delay implementation until after your committee has **** and come up with some, you know, what do we do with the data, uh, um, messages?

Next Speaker: And you, this is, and this is Genevieve. Just **** that, um, from other work that I've done is picking areas, like whether it be sepsis or community-acquired pneumonia that are well-defined, where there's, you know, national work on what's appropriate antibiotic would be much better to focus on those rather than like **** generally feel like –

Next Speaker: Yeah.

Next Speaker: – utilization would be hard to compare. Um, but again, we get in the, the question of numbers and validity when you get to really small places, but, yeah, yeah.

Next Speaker: Can I ask you a question about, uh, what's at the top of the slide there, um, non-ventilator-associated pneumonia? Uh, is, is that well defined, and, um, and does it happen often that patients in the hospital for other causes who aren't on a ventilator are developing **** pneumonia? Does anyone know?

Next Speaker: So I don't have national data on that, um, or Oregon data either. Um, but it is well defined. I mean there is a surveillance definition for it. Um, NHSN has a whole kind of chapter of site-specific infections, or site-specific criteria, so it would hopefully capture a healthcare associated pneumonia case that isn't associated with ****.

Next Speaker: Uh, this is Laura ****. I just kept reusing that, um, to rule out bloodstream infections fairly often. So if patient's got a positive blood culture if you can meet for pneumonia then **** two or three definitions then it's not considered a central line-associated bloodstream infection. So we are using this quite a bit. I still find it a little bit subjective in a lot of the imaging reads because if, if different radiologists reading the images then you get different results. Uh, and so I'm not sure why some is suggesting to report all of those ****.

Next Speaker: That's always been the prop –

Next Speaker: Yeah.

Next Speaker: – ****.

Next Speaker: Yes, exactly.

Next Speaker: Um, I think you make a good point though, which is that with any of these site-specific infections, you know, bloodstream infections, um, whether, huh, so if a patient has a central line in place and they develop a bloodstream infection, um, and that bloodstream infection is in fact secondary to a specific infection at a specific body site but there is no reporting requirement for that site-specific infection, the bloodstream infection will be considered primary and it will be mos, most likely considered, according to the criteria, related to the central line. If there is a reporting requirement for the site-specific infection then it will, it's –

Next Speaker: ****.

Next Speaker: – more likely to be considered secondary.

Next Speaker: No, we're calling those secondary too. That's fine.

Next Speaker: Your mic isn't on, I think ****.

Next Speaker: Which –

Next Speaker: Is she, she said the, the opposite of what you just said.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Is what's happening.

Next Speaker: Is what happening. So basically –

Next Speaker: So **** of the positive blood culture and they have central line and then they also need for **** two or three then it is not a central line-associated bloodstream infection.

Next Speaker: Right. I –

Next Speaker: ****.

Next Speaker: – sorry if I misspoke.

Next Speaker: Okay.

Next Speaker: It, it's the reporting requirement that kind of has, the reporting requirement influences whether a bloodstream infection will be c, categorized as secondary to another site.

Next Speaker: No, you don't have to.

Next Speaker: No?

Next Speaker: Mm mmm.

Next Speaker: Is it, uh –

Next Speaker: You, you don't have to report **** in your reporting plan a pneumonia, for example. You just have to make the surveillance call.

Next Speaker: If you're not assessing for it though, I should say, in practice.

Next Speaker: That's true.

Next Speaker: Right?

Next Speaker: You have to assess for it.

Next Speaker: So, right, so, so, okay. So if a facility, I think that probably facilities handle this in all different ways. I guess, uh, my mind goes to the worst-case scenario.

Next Speaker: ****.

Next Speaker: But if, if a facility isn't assessing the specific site infection and they're only assessing the bloodstream infections and the central line then they're gonna attribute that infection where it meets criteria to the central line rather than the site because there's, they're not necessarily performing the site-specific surveillance that would lead them to categorize it secondary to a site.

Next Speaker: That's true.

Next Speaker: Does that make more sense?

Next Speaker: But it sounds like –

Next Speaker: I don't know if that represents what's happening. I mean so, you know, even without reporting these every time we have a, a bloodstream infection or, uh, that looks like it's line-associated, you know, our IPs are looking is there another source of infection –

Next Speaker: Another source.

Next Speaker: – that explains this that would meet criteria even if we're not reporting them to the state? I'm not ****.

Next Speaker: That is reassuring to hear, and it's reassuring to hear the feedback in the room, 'cause that hasn't been the case for a, this, some of the settings that I've worked before, so good to know. Good to know. If –

Next Speaker: Yeah, we don't, we don't want **** fees. So if we know that they had another infection somewhere else that accounts for that we want to tell you about it.

Next Speaker: I, I sometimes talk to folks who use N, uh, sh, NHSN regularly who aren't familiar with the, these, uh, site-specific criteria and they don't regularly use them to evaluate, um, infections. So I think maybe the practices are, vary a little bit between facilities as do they all, but it, it is very reassuring to hear that, that the folks in the room at least are, are doing that. So thank you.

Next Speaker: So this is Dac, just as a follow up. Is there any concern of underreporting of CLABSI and using the site-specific options, um, given some of the subjectivity of –

Next Speaker: It would be over, concern of over-reporting, right?

Next Speaker: No. But if you are, but if you're actually, if you have a secondary site infection you're not gonna report it to CLABSI, right? So my point is that if some of the secondary site infections are not hardly, you know, you, you, you have, you have an X-ray that's, you know, maybe normal but it's called abnormal, and then you say, okay, that's a pneumonia, but site's not a pneumonia. It's actually a **** infection but you didn't report it this way. So I guess that's my question. Is there a concern –

Next Speaker: I think it goes both ways on **** so it probably washes out ****.

Next Speaker: It, so it washes out. So you think it's, it's good?

Next Speaker: Yeah.

Next Speaker: Okay. Just wanna make sure.

Next Speaker: Yeah. And I would say when we have questions we pose them to NHSN.

Next Speaker: Okay.

Next Speaker: To ****.

Next Speaker: And, and what –

Next Speaker: **** all the answers. They're great.

Next Speaker: And, uh, ****.

Next Speaker: And I would mention, sorry, didn't mean to interrupt. I would mention that a lot of these include microbiologic data to be able to call them a different primary source. So it has to match. You know, we recently had a CLABSI that we had to report where it was a gentleman with a UTI, a **** that a had a lip, uh, lipotripsy, and because he didn't meet the microbiologo, uh, microbiologic criteria of having enough colony-forming units of the same organism in his urine we couldn't attribute it to a urine infection, but clinically we know that's what happened.

Next Speaker: Right, right. And that happens, I think, all the time in NHSN. And the, the reverse is true too, right, where it's very clear that something is probably HAI but doesn't quite meet the threshold for criteria and, you know, that's the, the, the nature of surveillance reporting, right. I, I think introducing one of these, um, site-specific infections of the reporting requirement might have interesting reverberation for some of our other reportables, particularly CLABSI, um, just as we saw removing Canada from, you know, CAUTI criteria changed the landscape of what our CAUTI looks like nationally as well. So, um, I think we're reaching the end of our allotted time for this agenda item, but it's really great to hear that everyone's kind of interested and engaged in this conversation. And we, uh, again, our sort of thought is to come back to the table with some proposals for voting in September which gives, you know, 3 months for us all to mull over, percolate, debate, views and dream about our reporting requirements in Oregon. So, um, feel free to email me or call me with any thoughts. You can send them directly to me. You can give me your opinions on the things that we've talked about today. Um, uh, this is by no means just the end of it, um, so if there's additional stuff you would like to see removed for our requirements, added to our requirements, or changed about our requirements, is all, um, you know, up for conversation. So please don't be shy and send it along. And it sounds like, especially, uh, regarding the SSI piece of the conversation which inspired a lot of discussion, you know, if you do happen to have, um, outpatient SSI data that, or outpatient even procedure data, um, either if it's outpatient in a hospital setting or, um, AST-based procedures, I think that it

would be wonderful to see some of that information, um, to just inform, you know, what we talk about in September.

Next Speaker: **** I have a request-related timeframe of data and then we can get that back to you like how many surgeries, what surgeries have been in, uh, about 3 months or something, that wouldn't be outpatient ****.

Next Speaker: Sure. Any final thoughts, uh, everyone?

Next Speaker: I am Julie. Um, just one final thought. Um, as we consider this, or as you consider this, think about, um, what we already have as federal requirements, 'cause it wouldn't pay to take those away, um, because we have to do it anyway.

Next Speaker: Mm hmm. Good point. Is lam, is laminectomy a separate requirement?

Next Speaker: No.

Next Speaker: Okay.

Next Speaker: Mm mmm.

Next Speaker: Just **** and ****.

Next Speaker: Okay.

Next Speaker: Was it, is there ****, do you ****?

Next Speaker: Oh, no. I thought you had. Anybody from the phone, any last comments? Otherwise, this is Genevieve. I think in summary, kind of what I was hearing folks say is that they're interested in, in SSIs that are morbid and frequent, uh, laminectomies, low volume and so, especially in the hos, in the inpatient, and wasn't as important as maybe prior, um, antibiotic use or some administrative benefits for making it mandated as far as funding, uh, and that there sh, you know, talking about parity between outpatient settings, where the outpatient settings and the ASC or an outpatient hospital that we can parity in reporting and that it be, um, again, focused on those that are really morbid and frequent and, and, uh, step-wise, um, and about the tier, tiering as well as for AU reporting perhaps. So just some, some summary thoughts. So lots of good conv, conversation there. So we're gonna go ahead and take a break now for about 5 minutes, so let's come back at –

Next Speaker: ****.

Next Speaker: – is this the real, is that the real time, do you know?

Next Speaker: ****.

Next Speaker: Two –

Next Speaker: ****.

Next Speaker: Two-ten too late?

Next Speaker: ****.

Next Speaker: Okay. We're gonna restart at 2:10 then. Thank you very much.

Next Speaker: ****.

Next Speaker: Thanks everyone. Just, uh, as a friendly reminder, please if you're calling in on the phone line not to mute it because it goes to your hold music. Um, if you have to make, if you have to do something maybe mute yourself and then call from a different phone ****.

Next Speaker: Or actually just jump off the conference line –

Next Speaker: Or just, or jump, uh, yeah, jump off of the call.

Next Speaker: – and you can always come back on –

Next Speaker: Yep.

Next Speaker: – if you, if you need to do something else, 'cause –

Next Speaker: Better.

Next Speaker: – the, the rest of us can all hear the music in the ****.

Next Speaker: Mm hmm.

Next Speaker: Okay, great. Well thanks for coming back. Uh, so next we have Lisa who's gonna be talking about our 2018 OHA NHSN reporting and giving us an update on that, so thank you.

Next Speaker: Um, so everyone, this is Lisa, um, **** with, um, discussion around HI reporting. I'm gonna go over, um, what we have currently reporting, um, data for. And so, um, first I wanted to review the national 2017 HI data with you, um, because CDC just released this earlier this year. Um, then I wanna take an opportunity to preview our Oregon 2018 HI data so we can see how we look as a state. And then, um, really what we want the focus of, um, this part of today's meeting to be on is around, um, getting feedback regarding format and considerations for our HI annual reports. Um, so I won't go over this because Rosa kindly already talked about the SAR, um, but this is just a refresher if people aren't familiar. Um, so this table is showing the data from CBC, and this is for 2017. Um, just a note, that we did publish our Oregon data, um, last year for 2017, um, but CDC also publishes, um, state and national level data, and, um, this is for acute care hospitals for the six HI types that are required by CMS. So the first column is

**** type, um, second column is number for your facilities that contribute to this data, and then you can see third and fourth column are, um, are Oregon SAR versus the national SAR, and the last column is, um, a quick comparison of how our SARs compare to the national, um, from last, from 2017. And so you can see, for the most part, that the SARs are less than one indicating that, um, on a national level we're seeing fewer infections than predicted, um, for Oregon. In 2017 it looks like, um, for CAUTIs and, um, surgical site infections following hysterectomies the SAR was greater than one, um, but the difference was, um, significantly higher for CAUTIs. The rest were, um, not significantly, um, you know, worse or better. Okay. So, um, I wanted to, um, preview our Oregon 2018 data, but preface it by saying that, um, for our 2018 data similar to what we do on an annual basis, we conducted internal validation, um, and so this is the procedure where, um, we send facility their data, um, so that they have the opportunity to review it and make corrections, um, and ensure that it is accurate. Um, so thank you, if, you know, I reached out and asked for your assistance with this process. Um, we conducted this in April and May, and we also did our own internal data quality check, um, to make sure that we were seeing, you know, all of the data that we, um, expect to see for the facilities. And then we froze the data on May 27, um, so that is just to say that this is the date that we consider the data final. Um, if facilities make any changes after this date then, um, we won't necessarily incorporate those changes into the, um, reports that we, um, have online and are publically available. And this is just a reminder of the matrix that we have which I will go over in the next live. Um, so for our acute care hospitals, again, this is, um, the data that we haven't published yet, but just to give you guys a preview, uh, for, um, acute care hospitals our ****, CAUTI SAR is MRSA and CBI. Um, you can see that I've listed the SAR value as well as, um, simple comparisons for how we're doing compared to the baseline as well as whether or not we met our HHS target, um, reduction goal. So for the most part, it looks like we're seeing SARs less than one with the exception of, um, CAUTIs in inpatient rehab units. Um, I'll go to our critical access hospital data. Um, similarly, um, we're seeing, for the most part, SARs less than one with the exception of the CAUTIs in adult and pediatric wards and for the MRSA bloodstream infections. And then, um, for surgical site infections, um, this is separate by adult and pediatrics, uh, procedures although there are a lot of data for the pediatric procedures, um, but, um, similarly, overall, I think most of the procedures we're seeing an SAR of less than one with the exception of the hip and knee prostheses. Okay, the next one is for dialysis. Um, this is our bloodstream infections for outpatient hemodialysis facilities. Um, so we saw an SAR of 0.55 in 2018. Um, CDC doesn't publish a national, um, SAR for this, um, for this metric, so I pulled the national SAR from dialysis to compare which had 2017 as the most recent, um, data available, and just had a comparison to see how we compared to that metric. Okay. So now I'm gonna go into, um, talking about how we're presenting our 2018 HI data. So that was a preview of the data itself. Well now working to compile, um, aggregate and facility-specific level data for our reports. Um, any questions about the data before I dive into this?

Next Speaker: ****?

Next Speaker: Yes.

Next Speaker: ****.

Next Speaker: Okay. Quick question about the validation part. Like when you ask facilities to **** discrepancies what, how often are you, I guess how frequently are those discrepancies ****? And, and then what if you have a d, uh, different **** for ****, I guess I'm trying to understand how that process ****, like the frequency?

Next Speaker: Yeah. So we send facilities a spreadsheet of their data. Um, we give them the opportunity to review it, but we don't necessarily require them to say like, yes, we've reviewed the data and it's correct. So we don't expect the office, we don't like believe that all facilities have really looked up their data and reviewed it. We can't say that for sure. Um, there are, that's, and that's kinda why we do our internal quality checks because we review, like if they're unresolved alerts that would, that would indicate like missing data for a facility. We review whether or not we actually see data for, um, the measures that facilities should be reporting for. Um, and that's the, kind of the extent of our validation checks ****. We're considering making it a requirement for facilities to at least just confirm that they received it. Um, most facilities look at their data at least somewhat, is my sense.

Next Speaker: Mm hmm.

Next Speaker: And then in term, uh, and then in terms of, um, disagreement, that was your question ****, there really aren't –

Next Speaker: If, even if, I mean how often is there a, a, um –

Next Speaker: External, external, ex –

Next Speaker: – it's more just a discrepancy –

Next Speaker: ****.

Next Speaker: Often, pretty often.

Next Speaker: Pretty often, okay.

Next Speaker: Yeah, yeah. There are often discrepancies between –

Next Speaker: Mm hmm.

Next Speaker: – what a facility expects their data to appear like and what their data actually appear like. But it's not a true disagreement because we are pulling data that facilities themselves collect and enter. So the, the discrepancies come about when, um, the data are either analyzed in a way that excludes, for example, we don't include outpatient procedures, right, 'cause we don't have a reporting requirement. So a facility may say, you know, we performed ten of the procedure type, why is only nine on the report, and so that really is just like an analysis question. And then the other piece of that would be if the reporting hasn't actually been completed, uh, correctly, so there's maybe an administrative step that has been skipped, and that can cause the data also to appear different from expected. But again, it's not, you know, it's not

that our program has arrived in a different number. It's that the way the data have been collected and entered don't appear as the facility expect it to.

Next Speaker: Were you asking about external validation, or –

Next Speaker: No, I think we're good **** validation at a nursing home. But I was just more curious upon the process ****.

Next Speaker: Sorry. And then **** was, uh, kind of ****.

Next Speaker: Or like –

Next Speaker: ****.

Next Speaker: And we provide multiple rounds of data.

Next Speaker: Yeah.

Next Speaker: Multiple rounds well so facilities have an opportunity to check, correct, check again, sometimes more –

Next Speaker: Mm hmm.

Next Speaker: – more times than that, um, and we make every, you know, effort we can to address any corrections that are, that are made.

Next Speaker: Okay. ****.

Next Speaker: Yeah. And we, we do always give facilities a, another chance to look at their data before we make it public. We give them a week to review that data and letting them know hey, this is gonna go up, so, yeah. Okay. Um, so, now I'm gonna get into, um, basically, feedback we want to get from the group around how we present our, um, HI data in our reports, um, and as a reminder, um, we currently, we don't have that requirement anymore for us to produce a report on an annual basis. Um, the last time that we have published a more formal report was in 2016. Um, so, these 2016 HI reports, um, were provided just for you guys to have reference to help guide this, this discussion. Um, and so, given that, we think that this is an opportunity now, um, for us to review the reports that we have published in the past, um, see are they still useful? Should we continue it, should we continue, um, producing them in the same, in a similar format? Um, you know, what other information may be useful to include, um, and just get feedback from the group around how they're using this report. And so, I have bulleted four points on the slide. Um, first, I wanna talk about data censoring considerations, um, timing of reports, um, what information to include, and then lastly about the format and display of data. Um, I have a slide here. This is from a, a prior presentation just to remind us of the goals that we set for the annual report. Um, we wanna ensure that it is clear, brief, and useful, and the target audience for these annual reports were for, um, patients to use the data to make their own healthcare choices, and also for healthcare facilities and our partners to use the data to improve patient safety. Um, so,

the first question that we had for the group was around data censoring, and, um, I've just posed those two questions up on the board, but I'll preface, um, it by saying that we don't have any data censoring in our reports, and we have not done so in the past. Um, however, it is a question that has come up, so we wanted to just see what the group thought about whether or not we should put some type of data censoring in these reports, especially for those facilities that have, you know, small numbers of procedures done. Currently, if a facility only performs, like, one, um, hysterectomy, that, that number will be included, um, in our reports. Um, so, the questions I have were is there a concern for patient identification with small numbers and is it useful for us to present the small numbers for our, for our reports. And a, and a little bit of context, you know, when we talked and voted on removing these exemptions, um, in 2018, you know, part of the reason was to make our data more representative, right. And so, we wanted to remove these exemptions so that we would see data from facilities that do have, you know, lower volumes, um, so there's kind of this balancing act that we're considering now. Does anyone feel strongly about censoring the data? No.

Next Speaker: I hadn't really thought about it before –

Next Speaker: Okay.

Next Speaker: – but, um, I don't think it's an issue.

Next Speaker: Okay. And we haven't –

Next Speaker: **** and I –

Next Speaker: – uh –

Next Speaker: – think I have the smallest critical access hospital, five beds or something, so –

Next Speaker: Okay. That's good feedback for us. We haven't gotten any, like, concerns from hospitals saying that, you know, this is an issue, but we just wanted to bring it up.

Next Speaker: I think it would only be a concern if you've got a hospital like **** Central ****. They've got ten **** or something.

Next Speaker: Right.

Next Speaker: But if you scan the data, I didn't have any big issues then.

Next Speaker: ****.

Next Speaker: Okay. So it sounds like we will continue to not censor the data unless other people have thoughts.

Next Speaker: I'm mean, uh, I'm still, I'm thinking about it a little bit myself to in terms of, yeah, if you really have some situ, and I'm not sure, but if there's a situation where we, we're gonna

identify patients, then that, to me, would be of concern. So, I don't think there's, it sounds like no one's –

Next Speaker: Right.

Next Speaker: – no one's seeing it here, but I don't know if there's any **** –

Next Speaker: Yeah.

Next Speaker: – do to –

Next Speaker: And I will just also note that, um, on Hospital Compare, which, you know, our, Oregon's facility data is publicly available as well, they don't censor the data there, so.

Next Speaker: Right.

Next Speaker: Okay. Sounds good. So, I'm gonna move on. Oops. Um, so, um, the other question we had was around the timing of the report. So, um, annually, we do publish an executive, or, like, a data summary, which is kind of the two to three-pager that you see in the front of these, um, these PDF reports. Um, and we also publish, um, aggregate and facility specific data online, and we do that annually, um, we did that for 2017, and we'll continue to do that on an annual basis. This 2016, um, PDF report that we have, um, what it included that we don't have for 2017 is trend data. So, we have the trend graphs in our report as well as we have information around recommendations for providers, patients, and their families to minimize HI risk. And so, we were thinking that with 2018, um, we'll have, with the new baseline, 3 years of data, so we can have, you know, a trend, trend graphs that show, you know, the 3 years of data over time. Um, we think that would be useful for people to see. Um, so we're considering, you know, producing some type of formal report this year, but not necessarily having a formal report every year, maybe more around the lines of 3 to 5 years. How to people feel about the timing? Do we want it to be more often or any, any strong opinions?

Next Speaker: I think **** just needs to be representative of what we think it might be, you know, the trends dictate that we should be, like, you know –

Next Speaker: Mm hmm.

Next Speaker: – pushing this data out more frequently, then I think **** doing **** data reasonably consistent and is not, that doesn't seem to be indicated then, I, I know it's a lot of work to pull these things together, but I think that there may be occasions. Or, if there's changes, right, –

Next Speaker: Right.

Next Speaker: – um, and that conditions or, you know, um, new categories –

Next Speaker: Mm hmm.

Next Speaker: – or new types of facilities, then I think that we need to be puttin' those data out as well for the four regions.

Next Speaker: Mm hmm.

Next Speaker: Um, I, you know, I don't think needing time to come up with a general –

Next Speaker: Yeah.

Next Speaker: – decision on that is gonna be, because it seems like we're making less. Every year, we're, we're kind of resubmitting this, and, um, –

Next Speaker: Mm hmm.

Next Speaker: – whether or not, I think ****.

Next Speaker: Yeah, so then we can just have a note for that to revisit the question around reports on a yearly basis, but I think that for this here, we will, we'll plan to produce some type of, um, report, like, a formal report with the trends data, so that you guys can see how it's, how we're looking. Um, –

Next Speaker: Um, –

Next Speaker: – yes.

Next Speaker: – I mean, it's possible you could ki, kinda come up with some kinda, like, what you're kinda talkin' about, some kinda criteria for when you're gonna actually have somethin' that's, that's gonna dry our need for this kind of a formal, longer report or whatnot, you know? If there's, like, a situation where yeah, we're seeing new changes in infections or, you know, new reporting requirements or whatever, and, and otherwise not necessarily have the **** report, and just have it online, the data and whatnot. We're still gonna have that, right?

Next Speaker: Yes, yes.

Next Speaker: And still have a brief summary of what –

Next Speaker: Yes.

Next Speaker: ****.

Next Speaker: Yeah. Okay, um, and so the other question we have was around what information should the report include. Um, so, as I've, as I mentioned, the prior reporting included those recommendations. Um, some people find that information useful and something that we should continue to include in these reports. Um, other thoughts we had is, should we discuss other things, like, HAI program activities, information about how we as a program are using the data

to inform and prioritize our projects and activities. Um, do we think that is useful to have in these reports? Um, other things I thought about is, including other information that we can get from NHSN, like, information from the annual surveys, which are required. Um, so, like, CC publishes information about facility characteristics. Um, we could look at other things, like, stewardship metrics, to get a sense of how facilities are doing in other parts, um, of data that we have from NHSN. Any thoughts? Do people like having the recommendations? Yes?

Next Speaker: Yes.

Next Speaker: Okay.

Next Speaker: Mm hmm.

Next Speaker: Yeah, especially if this is meant to go to the public, –

Next Speaker: Mm hmm.

Next Speaker: – you know, and they see this, any way that we can get that information to them ****.

Next Speaker: I'm tryin' to figure out if there's some way that we can understand how and who in the public might be using it, if there's, like, lead, you know, statistics or whatnot that we could look at and try to figure out –

Next Speaker: Yeah.

Next Speaker: – what we could do in terms of understanding –

Next Speaker: Uh, –

Next Speaker: – what's goin' on now and how to better outreach to, to, you know, –

Next Speaker: – mm hmm.

Next Speaker: – whomever we might wanna be, I mean, I'm thinking yeah, probably, what, and what that, what does that mean even specifically to the public. Is it specifically, you know, certain groups, or, you know, people that have been impacted by HAIs, or is it, like, a larger group where we wanna prevent HAIs from ever even happening?

Next Speaker: Yeah.

Next Speaker: But I also think, you know, I do like the, even the, you talk about how they're usin' the data.

Next Speaker: Mm hmm.

Next Speaker: I mean, I think that that's pretty important to kind of, you know, people are gonna look at these data, some people are gonna, you know, maybe use this to inform kind of healthcare decisions, but I think a lot of people are curious about these things, curious about, like, how, how we're, you know, ****, and they wanna see what we're using **** and **** the main policy and things like that. So I think that that's very helpful, but, you know, I think when someone's gonna be **** you gotta **** here, like, why isn't this here. You know, I mean, I think they're, it's pretty intuitive what people, like, some of the information that I think should included, and then there's other kind, so **** besides it can be less than one-stop shopping for, –

Next Speaker: Mm hmm.

Next Speaker: – certain things, and the other thing that ****, you know, help **** all over the, the –

Next Speaker: Right.

Next Speaker: – you know, uh –

Next Speaker: Right. Yeah, come to that point how to use the data. That might be something that people would want to know all the time anyways.

Next Speaker: Right.

Next Speaker: And so does it necessarily have to be attached to this report, or should it be, you know, its own link on the HI web page or own, own little section –

Next Speaker: Right.

Next Speaker: – but with examples there so it could be updated in real time and not just, you know, every time there's a full report.

Next Speaker: Exactly, yeah, and so that's kinda of what we discussed at, I think before. Did someone on the phone have something to say? No? Okay. Okay, sorry, I think I might have heard something, but –

Next Speaker: And then your, your comment to the annual survey data from NHSN and stewardship metrics, um, again, that may be something that sort of independent of the report would be useful for us to know about kind of general trends in the health care facilities around the states –

Next Speaker: Mm hmm.

Next Speaker: – separate from **** –

Next Speaker: Mm hmm.

Next Speaker: – and yeah, something that can be ****.

Next Speaker: So maybe those of you who do enter data on behalf of your facility into NHSN or use NHSN, you know, if there's data that you enter into NHSN or that you're interacting with in NHSN that you think it would be useful to see, you know, what the state looks like as a whole, that's something that we can consider presenting in aggregate, um, so if you wanted to know, I don't know, the average bed size in Oregon or, you know, how many major teaching hospitals we had or stuff like that –

Next Speaker: Yeah.

Next Speaker: – so those are things that you can pull out from the, the survey, um, so just, just a thought.

Next Speaker: I'm wondering, I mean, it's starting **** HAI program activities, but I'm also wondering about other activities and a lot of activities at different hospitals or different, you know, groups that might be workin' on HA prevention or what else we might be able to include in that direction.

Next Speaker: Which I think you, you have the **** page –

Next Speaker: Right.

Next Speaker: – **** there.

Next Speaker: Right.

Next Speaker: Mm hmm.

Next Speaker: There are definitely things ****.

Next Speaker: There's some of that.

Next Speaker: Yeah.

Next Speaker: But it could be expanded.

Next Speaker: Yeah.

Next Speaker: And is the plan to still continue to have a hard copy, or is this just gonna be PDF?

Next Speaker: That is my next question.

Next Speaker: Okay.

Next Speaker: Um, so thank you. Um, so my next question, and this kind of leads, I think, well into things that **** brought up as well around, you know, seeing who's using our reports and such is, um, thoughts people have around having a hard copy or paper-based report, um, versus kind of translating this data into a web-based report. Um, we feel like it would be, um, more of an advantageous for us to have it be, have a web-based report. Um, we could track, we could track, you know, who's actually using and clicking on the links. Um, we could actually put the links for you on to, you know, onto the other web sites as mentioned that talk about our program activities. We'd have links directly on the web sites to those data, um, tables and maps, um, and the, I guess, disadvantage would be that it wouldn't be a printer-friendly report, um, so we're wondering do people feel strongly about having it be in a kind of PDF format, or are people okay with exploring the idea of a web-based report?

Next Speaker: Um, we use both.

Next Speaker: Okay.

Next Speaker: Um, because there are so many reports coming out in health care now, um, we actually have a monthly, um, public reporting meeting, and so my, my chief officers walk away with paper copy 'cause we can't do all of it in one session.

Next Speaker: Mm.

Next Speaker: Um, but, you know, other settings, I mean, I use it at my desk. I use a web-based.

Next Speaker: Okay.

Next Speaker: But, um –

Next Speaker: And when you provide that report, is it the full report or the executive summary?

Next Speaker: Um, I provide the whole report.

Next Speaker: Okay.

Next Speaker: Because the biggest concern at the executive level is that they know what the public is seeing –

Next Speaker: Yeah.

Next Speaker: – so they can be ready to respond, so, um, it's important –

Next Speaker: Okay.

Next Speaker: – to, to the, up, to the C suite.

Next Speaker: Okay. Thanks for that feedback.

Next Speaker: Uh, for me I think online is fine. Is that better?

Next Speaker: It's okay.

Next Speaker: We'll just talk about ****.

Next Speaker: Okay.

Next Speaker: Um, I do think you have a lot of really important recommendations in here, and we get a ton of calls from the public just not that, **** not getting ****. They're just calling us asking for general information, and just maybe sending out reminders to the hospital saying we have all of these resources. Link to them on your web site, 'cause I, honestly I have seen this before, but it's been a long time, so I'm just reminding if we're updating these materials, we have all this for potential patients no matter what hospitals they're going to to refer to this, uh, 'cause I think it, it's great information, uh, just to have so.

Next Speaker: So by, and by that you're saying web-based but also having a PDF that you could just, like, download and forward and print.

Next Speaker: Or that we could somehow just send people to – I mean, we could send people to your web site or at least putting links on our internal web site that we **** people to look at would be helpful. Uh, we just have a lack of patient education **** so just any way **** –

Next Speaker: Mm hmm.

Next Speaker: – would be good, yeah.

Next Speaker: Any other thoughts? That was the last thing that I wanted to talk about, and if you guys do come up with other thoughts or suggestions, my contact information is, um, on the slide, so please reach out as well.

Next Speaker: Great. Thank you. Okay, next we have Rosa, who's gonna talk about injection, give us an update on the injection practices needle use in Jackson County.

Next Speaker: Thank you. Uh, so this will be, um, a final summary of some data that we revisited in a project that we revisited a couple of times over the years in this meeting. Um, this is a full slide set. I'll be kind of cruising through the data, um, but these slides are available to you, so feel free to come back and take a more detailed look if you're interested. So, um, after cases of Hepatitis C were identified as being transmitted in a California prolo therapy clinic in 2015, Oregon investigated an affiliated clinic located in Jackson County, which is a sort of rur, largely rural area in southern Oregon, and as a remind, prolo therapy is, um, an alternative modality that involves injecting, um, plasma, uh, blood, sugar solution, fat, or basically anything else into the body to stimulate a healing response. Although happily no cases were identified as having been trans, or having been, um, developed, I guess, in the Oregon clinic, there were infection control breaches related to injection practice noted there, and we began to wonder

whether the understanding of what constitutes a safe injection practice was strong enough, especially in an outpatient or alternative care setting. Um, funding was received from CDC to develop a survey for all licensed health care personnel, businesses, and facilities in Jackson County with the goal of assessing needle use and injection practices and engaging health care personnel around this topic. By way of a bit more background, the perception among I think our HAI and infection prevention community is often that injection safety is a really fundamental skill that health care providers should already be well versed in and that additional education about safe injection practices is not necessary, um, but the reality is that delivering injectable treatments and medications involves complex competencies and multiple skills and that simple slip-ups and misunderstandings can cause serious harm, including patient morbidity and mortality and can also have serious repercussions for health care facility systems as well as health care providers themselves. We also have survey data showing that health care personnel observe unsafe injection practices in their own facilities, and we have outbreaks, uh, to confirm that this does unfortunately happen. Our methods including survey development, a pilot of our survey, and three rounds of survey distribution via email and mail. We also developed a tool kit on safe injection practice and needle use and posted it to our web site. Um, is anyone in the room familiar with the tool kit? Great. Okay, so some folks are. Um, you know, this is something that I just wanna sort of promote as much as possible. It is part of our permanent web site. It collects resources for patients and health care personnel both and is organized by specific setting, like dialysis, but also according to specific practice duties, like medication compounding. When we distributed the survey, we shared our goal of understanding needle use and injection practices to inform educational activities, and that survey was non-regulatory, and we asked 48 questions on facility demographics, types of services delivered and providers employed, procedures and practices around injection and needle-based care, education, and communications, and it was really, um, an interesting process to determine what types of questions to ask that would be relevant both to traditional and alternative settings, so I'm just curious. Has anyone else assessed infection prevention practices in alternative care settings as part of their job? Yeah, so that, that is just, I think – it, it just speaks to maybe our, our own lack of, um, clarity round what's going on in, in outpatient settings and alternative settings, and this is a screenshot of the tool kit that I mentioned. It has a link to the tool kit as well as to a built-in evaluation of the tool kit, if anyone wants to take a look, and the survey was set up so that everyone who completed it was automatically redirected to this part of our web site. As I mentioned, the survey has 48 questions, so we won't be reviewing all of the data today but just some selected results. Of about 3,000 potential respondents to whom we distributed the survey, we had a response rate about 9 percent. That's not totally unexpected for essentially a kind of a cold call, um, but still lower than we had liked, would have liked to see, so we really consider this a hypothesis-generating survey that points us in the direction of where to invest our resources going forward. Our respond, respondents were about half inpatient and half outpatient, um, and then we also had several outpatient acupuncture settings that responded. Just to note, this is probably an under-representation of outpatient settings in Jackson County since we have just one hospital located there. Um, we sent this to all licensed health care, uh, providers as well as businesses and facilities that provided health-related services, so people could have responded multiple times on behalf of one facility, which was the intent. Bless you. So a bit more detail on our respondings and what settings they represent, um, and notably about 71 percent of our inpatient settings reported that they were affiliated with a larger hospital or health system versus just about 22 percent of our outpatient settings and just 17 percent of our acupuncture settings.

Facilities reported procedures and licensed providers, um, and this is just some of the most common, uh, providers and service types that they mentioned on the slide. Nearly all of our inpatient settings reported administering injectable medications or treatments and about ¾ of our outpatient settings reported doing so. We also found that the mean number of patients or clients who received at least one injection per day was lowest in the outpatient setting and highest in the inpatient setting. And in analyzing the data, we did find that there were some differences in practice duty among different types of healthcare personnel by setting. The statistically significant results here are, uh, in light blue so for example in the inpatient setting, a nurse, physician or mid-level practitioner is more likely to insert peripheral intravenous catheters than in the outpatient setting. We also see some interesting patterns where physicians or mid-level practitioners were more likely to administer the majority of infec, injections in outpatient settings than in inpatient settings, and some of these results are likely driven by relatively large numbers and diverse types of healthcare personnel that are employed in inpatient settings versus outpatient settings where the number of staff are fewer and the diversity of licensed provider types is also probably less. We also found some differences between practices by setting. For example, inpatient facilities were more likely to use safety syringes than outpatient settings were. Inpatient settings were also more likely to mix or reconstitute or draw up medications less than an hour prior to administration so that is the recommended timeframe, right, is to mix, reconstitute or draw up those medications, uh, within an hour prior to, um, administration, so inpatient settings were more likely to comply with that recommendation than outpatient settings were. We also asked whether facilities ever used a vial of medication for more than one patient, um, so this practice is allowed if a vial is labeled as the multi-dose vial, but the best practice is to dedicate even those medication vials labeled as multi-dose to just a single patient, and we found that most facilities reported that they never did this. However, outpatient facilities were more likely to ever report doing this than inpatient facilities were. Because the initial impetus of the project, uh, was related to alternative care, we wanted to make sure we were capturing all of those types of procedures, as well, so we asked whether they provided care using needles that did not, uh, involve injections and most did not. Uh, however, I think this data point is interesting since just 50 percent of acupuncture settings reported doing this. We would expect 100 percent of acupuncture settings to report doing this, since acupuncture does involve needles, and it does not involve injectable medications or treatment, so I think this really just speaks to the length of the survey itself, um, and the drop-off that experienced or that respondents experienced or maybe we experienced the drop-off. I'm not sure, but the data, um, are less complete at the end of the survey than they are at the beginning. Because the CDC's one and only campaign, which is that, um, national campaign aimed at eliminating transmission of disease in healthcare settings due to, um, unsafe injections, uh, is primarily educational and our funding came from CDC, we asked several questions about education, training and communications, situational awareness. One interesting finding was that inpatient settings were statistically significantly more likely than outpatient settings to provide training and education about drug diversion, and they were also, um, more likely to offer assistance to staff with substance use issues. Finally, we asked what educational topics would be useful, and we can see that not only were inpatient settings more interested in each individual topic than outpatient settings, um, but were more interested in education generally than outpatient settings were. Um, recalling that about 75 percent of our outpatient settings versus about 97 percent of our inpatient settings reported providing injectable medications or treatments, uh, we would expect to see some of these numbers lower in outpatient settings because some of them are just not, you know, applying to what's going on in their

facility, but we still see lower numbers here than we might expect, even accounting for that difference. For example, 42 percent of inpatient settings h, were interested in education about needle-stick injury versus just 8 percent of outpatient settings. So, briefly, conclusions and limitations - survey provided tangible benefits for fostering safe injection practices and needle use in Oregon. Our small sample size and large volume of questions allow for hypothesis generation, and we feel that outpatient settings are less likely to adhere to best practices. Results confirm that there's an ongoing need for education, although the folks who we surveyed may not always recognize that need for education. Um, we feel that outpatient settings were likely underrepresented and methods that were established when the project was initially funded included mail surveys, which we did use, along with emails, but mailed surveys are likely to result in lower response rates and incomplete responses than our surveys kind of promoted in other ways. Our most immediate next step will be to look at our data in a slightly different way, so I mentioned at the very beginning that we asked each respondent to report if their facility was associated with a hospital or health system, which may be a more useful way to stratify the data than just inpatient or outpatient, since we know that, you know, facilities are businesses that operate under the license of an individual healthcare personnel versus being a licensed facility. They're much less likely to have the benefit of state surveyors, certification or accreditation or even the attention of an IP, however occasional, than those settings that are actually licensed facilities or at least affiliated with a licensed facility. Um, the tool kit I mentioned at the start of the presentation is part of our permanent web site. We've had about 1,200 **** kits in the last year. We continue to add resources. For example, we added those new CMS infection control trainings aimed for long-term care that are relevant to safe injection and needle use, and, uh, we haven't gotten much actionable feedback from our evaluation, which is built into our took kit, so if you would care to peruse the tool kit and let us know how we can improve, we would love that. We're also continuing to provide training on safe injection practice and needle use to healthcare personnel, state survey staff, professional audiences and developing new ways of framing, um, this information and counter some of the resistance that we mentioned at the beginning of the presentation. We plan to analyze data by healthcare system affiliation, um, and we think that it would be a good idea to target educational efforts to where it's individual licensed providers. We've started reaching out to boards of licensure and, um, you know, we hope that this will sort of lend some legitimacy and impetus to these licensed providers coming from that source. Um, some of the larger boards are open to this idea, but smaller boards aren't, don't really have a lot of capacity to do, you know, education or communications on our behalf, um, so they have reached out, they've encouraged us to reach out to providers directly, so, um, we're, we'll still be working on those relationships and seeing, you know, how we can partner with our boards to get, um, education out there.

Next Speaker: Are you guys gonna be sending the results back to the people who responded? 'Cause I think there's a lotta power in sorta peer, like, what's standard peer practice. Like, what are other people doing? So, does the respondent get a summary of the report? We can see what they should be doing compared to the first ****. Just a recommendation.

Next Speaker: Thank you. We don't have, um, a report quite yet –

Next Speaker: But just list –

Next Speaker: – but –

Next Speaker: – you know, kinda, like –

Next Speaker: – or we do –

Next Speaker: – the results –

Next Speaker: – have a draft report, I –

Next Speaker: Yeah.

Next Speaker: – should say, a very long one that I –

Next Speaker: Doesn't have to be fancy –

Next Speaker: – **** working –

Next Speaker: – but, like, executive summary –

Next Speaker: Yes. I think that's a great idea. Thank you. Um, finally, we've developed a network of nearly 200 members statewide in our one and only campaign that is state based here in Oregon. Um, this number's a little old on this slide. We have, yeah, almost 200 and, um, these are folks that are specifically interested in safe injection practice and needle use so if anyone has thoughts on, you know, content that would be interesting for them to receive, we do a quarterly newsletter. It's a very brief, uh, one page, front and back. There's no homework. We just wanna share educational information and resources, um, so if you're interested and aren't signed up for that, please just let us know and we'll get you signed up. And then I just want to acknowledge all the folks at the Oregon Health Authority that have worked on this, um, our wonderful, um, student who is now in Florida who worked on this, as well and to thank CDC for its financial support.

Next Speaker: Great, thank you. Any questions or clarifications or? How you might like to use this data or?

Next Speaker: Just a comment on getting the word out. Um, **** reminds me that, like, you know, kind of talking to some of the departments of the organizations, they're, they ****, um, I think quite **** the, uh, tool kit, um, network to go a lot more **** than **** and that's the use **** happening, um, ****, you know, obviously **** so if **** I can help with that.

Next Speaker: Thanks, JJ.

Next Speaker: ****.

Next Speaker: And pharmacy students are awesome.

Next Speaker: And pharmacy students are awesome.

Next Speaker: So –

Next Speaker: ****, uh, except ****.

Next Speaker: Great. Very cool. No, I think this is interesting insight and **** up to that outbreak, um, to take that information forward. Thank you. Uh, so n, we're onto, um, the last bit, wrap-up and so wondering if anyone from either in the room or on the phone has any recommendations for topics for future meetings and reports that we could cover here in the HAI advisory committee. I had one question about if, uh, 'cause I know our health sys, system is closely following the Ebola outbreak and sort of determining about when they might do more stuff but is that sort of on your guys' back burner if anything's were to change you'd give updates to the healthcare systems about different surveillance? I know. You don't have to answer that right now but that was something to maybe come back in the future.

Next Speaker: Yeah, um –

Next Speaker: There's some, some **** –

Next Speaker: – I mean, we take a lot of, we take our guidance from CDC on this, and they h, have not been makin' a very big deal out of it although they recently activated their, um, emergency operation center to, be, because, um, I think they saw a case or two in Uganda and, um, so we're, we're, we're just, uh, payin' attention to them and waiting for, uh, a signal that says, um, you know, they're gonna start telling us about travelers to those areas who are returning to Oregon or something like that.

Next Speaker: Great. And I think our healthcare system is looking to you guys ****.

Next Speaker: So, we just **** –

Next Speaker: This is, um, Judy from Asante. One other thing that I don't know if it's been brought up that I think would be helpful, um, you know, we are certainly keeping the **** Ebola situation but, you know, maybe more pertinently and especially for our area are always concerned about measles, um, and I know it, it seems like some of the other folks in the state have been able to make some headway with, uh, symptoms-related screening, not just travel based and then symptoms-related screening. Um, I don't know if there's any thought from the state or, you know, any, uh, ideas about bringing some presentation to this group about how we can better, uh, be identifying patients that have a concerning constellation of symptoms and moving that forward or maybe even having some statewide, statewide guidelines, um, as, you know, we're looking at an increasing number of cases of measles in the country. Fingers crossed, we don't lose our measles elimination status by the end of the, the fall. Um, I think that would be really helpful and timely.

Next Speaker: Yep, and ex, and this Jenny. We need to follow up on that 'cause there were some workaround, like, tiers and survey what to do, different surveillance but how well that was disseminated so yeah.

Next Speaker: Yeah, I'm sure we could bring a presentation here and, um, sort of offer our recommendations about when screen, when, uh, testing is appropriate.

Next Speaker: Yeah, and I think, you know, so understanding, like, with the different systems are. Are we all using the same? Do we all have different screening questions? It may be nice to be somewhat on the same page so we're all speakin' the same ****. So understand –

Next Speaker: I think that would be –

Next Speaker: – land to land would be helpful.

Next Speaker: – yeah, I think that. Yeah, I think that would be really helpful and, again, you know, sometimes it's hard to get that message across to our busy ED providers about, you know, when, when the, their thought is well, if we see a case, we may miss it at the first glance because everybody comes in with similar symptoms which is kind of not acceptable and so when we're only triggering, you know, more thought when people have traveled outside the U.S. and we don't have a good, um, way to create easily, um, releasable epic alerts when cases are within the U.S. or, you know, heaven forbid, we're the first one to see a case in **** epicenter of a, an outbreak. Um, I think having some guidance from the state, that would be something potentially very helpful to have at this meeting.

Next Speaker: Thank you. Julie?

Next Speaker: Um, I was just gonna say we just got some new interim guidance on pandemic, interim guidelines for pandemic planning that might be useful to, um, take a look at how people are managing that. We just started to look at it.

Next Speaker: Is that through Dr. Lehman or –

Next Speaker: Through, um, uh –

Next Speaker: – **** –

Next Speaker: – PAHPA, PAHPA, P-A-H-P-A. It's a legislation.

Next Speaker: Is that Richard's –

Next Speaker: Think, I think that's –

Next Speaker: Okay.

Next Speaker: – **** –

Next Speaker: So no. I'll look –

Next Speaker: Send it –

Next Speaker: – into it.

Next Speaker: – our way.

Next Speaker: Yeah. Send it our way then we'll look into it.

Next Speaker: ****.

Next Speaker: **** this is ****.

Next Speaker: Oh, yeah, maybe from, well, yeah, it may be from the emergency preparedness folks, yeah.

Next Speaker: Mm hmm.

Next Speaker: I'll follow up on that then, great, and it kinda goes into the measles thing, too, so all that together, yeah, and being s, in sync with that. I, I mean just the, like, being in sync for the flu surveillance has been amazing so yeah, extending that to other. Great. Any other comments from the phone before we - oh, go ahead.

Next Speaker: So, I just wanted to give a little teaser. I mentioned at the beginning that we had, uh, Vista with us here today, Tom, um, was, here at the beginning of the meeting in the room so for everyone here who's representing a hospital, um, if we haven't already talked about your patient and family advisory council, um, you should just be aware that we may be reaching out to you, uh, myself or Tom Healy, to find out, you know, do you have a patient and family advisory council at your facility. If so, you know, how, have they worked with infection prevention and if you can share their contact information with us because we feel that it's important to expand our network of folks who can really provide the perspective of healthcare consumers, advocate for healthcare consumers and provide the patient and family sort of picture. Um, so just a little head's up on that and we are planning to do a, at least an agenda item if not sort of a themed HAI advisory committee meeting focused on patient and family, uh, perspective and experience and how we can bring them to the table, um, to talk about healthcare-associated infections and how we can serve them statewide so feel free to send me any thoughts you have, um, or chat after the meeting.

Next Speaker: Ted, do you wanna mention the flu report and, uh, it's goin' out?

Next Speaker: Oh –

Next Speaker: Flu ****.

Next Speaker: Yeah, I don't know, uh, so the flu, the flu vax report will be posted tomorrow. Um, I don't know that we have much time to really say anything more than that, yeah, so you can keep an eye out.

Next Speaker: Okay. Uh, one last call for any, uh, folks who didn't, uh, tell us that they were on the call from the beginning? Or their, email Rose or just tell us right now. We don't, we'll, um, document you for today. Any closing comments? Questions, complaints? Kudos?

Next Speaker: Good job.

Next Speaker: Okay. Thank you, everyone. We will see you in September.