Healthcare-Associated Infections Advisory Committee
March 20, 2019

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

Speaker: Good afternoon. Uh, apparently spring starts at, like, 2:39 p.m. today, officially, so –

Next Speaker: Hmm.

Next Speaker: – I'm gonna blame that on why we're, with good weather, and low attendance but that's okay, we're good.

Next Speaker: Okay.

Next Speaker: Um, so, thank you everyone for joining. I'm Genevieve Easter. I'm from Providence, and I'll do the leading, or kicking things off today, and first of all, let's go around and do a roll call.

Next Speaker: I'll start ****.

Next Speaker: Oh, the microphones. Okay. You should be over here, or, Rosa, do you want to start first then.

Next Speaker: Sure –

Next Speaker: ****.

Next Speaker: – yeah, all right. So, um, this is Rosa Tammer. I am an HAI epidemiologist in the HAI program.

Next Speaker: ****.

Next Speaker: Um, before getting all ****.

Next Speaker: I'm Chris Heifer. I'm part of the drop CRE team.

Next Speaker: Uh, Doug Tran, Public Health physician for the HAI program.

Next Speaker: ****.

Next Speaker: It's on.

Next Speaker: Lisa **** genealogist with the HAI program.

Next Speaker: Sorry, ****, Monika Samper at the HAI program.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: The ****. Uh huh.

Next Speaker: We'll just leave that one on this side.

Next Speaker: I'm Dennis Defugo, the regional director from Kaiser Permanente, **** prevention.

Next Speaker: Mm hmm.

Next Speaker: Julie Goth, **** infection prevention from Salem.

Next Speaker: Mm hmm.

Next Speaker: Does this thing work?

Next Speaker: Yes.

Next Speaker: Oh, **** say.

Next Speaker: Yes.

Next Speaker: Uh, this is J.J. Furuno. I am part of the drop CRE team and also at Oregon State University.

Next Speaker: You can just keep that microphone down there, down –

Next Speaker: Uh, this is Diane Roy from Oregon Health Authority, research analyst.

Next Speaker: Uh, **** you can just keep it down there for the ones that can't reach.

Next Speaker: Okay.

Next Speaker: Um, and then, uh, I think our, our audio little technicalities here. Is there anyone who's joining us from the phone if you could introduce your name and where you're from please?

Next Speaker: Hey this is Linda Gordon.

Next Speaker: This is Kristen **** Medical Director of Infection Prevention at Infante.

Next Speaker: This is Jordan Ferris, Oregon Nurses Association.

Next Speaker: Josh, Josh Bartfield, **** team manager from the Oregon Clinic.

Next Speaker: Vickie **** Company.

Next Speaker: **** from, uh, Good Sam Infection Prevention.

Next Speaker: Elli Quallow representing Ambulatory Surgery Centers. I'm from Bend River **** HAI Committee.

Next Speaker: This is Shannon **** from Infection Prevention at North Lincoln Hospital.

Next Speaker: Paul Cieslak, communicable disease, medical director for Oregon Health Authority.

Next Speaker: **** Britton, standing in for Michelle Shields whose our **** at Friendship Health Center.

Next Speaker: Could the last person just repeat that if you wouldn't mind. There's some audio issues.

Next Speaker: Sure, this is **** Britton, I'm standing in for Michelle Shields from Friendship Health Center.

Next Speaker: Thank you, **** and then just for those folks on the phone, if you have not registered for the webinar it would be great if you could go ahead and just sign up. It just helps us to track who's attending on the phone. And the link for the webinar registration should be in the e-mails that you received. And those have been sent out by Diane Roy.

Next Speaker: Right.

Next Speaker: Yeah.

Next Speaker: On Friday so if you're searching your Outlook like I do.

Next Speaker: Perfect, sorry. Just keep going. I just wanted to put a plug in for the webinar. Anyone else on the phone?

Next Speaker: Yeah, give me about five minutes and I'll be on the webinar.

Next Speaker: Who, who was that, that just spoke?

Next Speaker: Lisa Freeman.

Next Speaker: Thanks Lisa.

Next Speaker: You're welcome.

Next Speaker: And then there was some, uh, a couple, uh, folks who joined us in the room if you could just quickly, uh, give us your name and where you're from? Thanks.

Next Speaker: Uh, this is Sidney Edland from the Oregon Patient Safety Commission.

Next Speaker: Maureen Cassidy, um, OAJ.

Next Speaker: And did we get everybody on the phone? Excellent. Well great, thank you everyone for being here. So, uh, next on the, uh, agenda is our logistics up, update from Rosa Tammer.

Next Speaker: Hi everyone. I'm gonna give the logistics update today, um, because we are still in the process of bringing on our, our new office specialist so, um, as many of you may know, we've been working to make this meeting more accessible, um, especially as our attendance has grown, um, many folks join us remotely. We've been adding things like the webinar, like, microphones, um, just to make sure everyone can kinda access the materials as well as possible. Um, so just thanks for bearing with us through these changes. Um, we actually sent out a brief survey after the last meeting, um, to find out how we're doing with this. From the responses it sounds like we've made some improvements and people are able to hear and access the materials but if you have any suggestions about how we can make the meeting more accessible to you, or if you have any challenges that you encounter just please let us know so that we can try our best to make it, um, yeah, more accessible. Um, some of you may have noticed that we do not have an outbreaks update on our agenda today. We are developing some new guidelines around what kind of preliminary outbreak data we can share in a public meeting and we'll likely be able to resume presenting some form of outbreak data in the future so watch this space. Um, and finally, I wanna give a few updates about our HAI Advisory Committee itself. So, I believe that I introduced, um, Dennis Trapeza who is our RN with interest and involvement in infection control, that's his official position, um, at the last meeting and then we also have a new consumer representative, Lisa Freeman is the executive director of the Connecticut Center for Patient Safety and she has family and personal ties to Oregon, um, and she is replacing Dee Dee Vallier who served on this committee for many years. So I wanna just give a big thank you to both Dennis and Lisa as well as Dee Dee for her many years of service on this committee. Um, Lori Thompson, formerly Lori Murray-Snyder of Health Insight is retiring. Um, she could not attend today's meeting but I just wanted to say many of us on this call and in the room have worked with her, um, she's been an incredibly valuable partner to our program and we just wanna wish her a congratulations and that she'll really be missed. And lastly, I'm excited to say that we only have one vacancy at this time, um, which is our health insurer representative and that has historically been a really difficult vacancy to fill so if anyone has suggestions, folks they think might be interested, um, groups I could reach out to, um, please feel free to let me know or to

pass on that information to your colleagues. And I actually have kind of a nice one-pager that summarizes what, um, committee memberships sort of entails and I'd be happy to send that along to anyone who's interested.

Next Speaker: Okay, great, thank you. Um, one just quick thing that I noticed today and I'll just mention it here is that, um, the HAI program also puts on a lunch and learn webinar, uh, and these are around HAI topics and the next one will be tomorrow from noon to 1 and they'll be talking about injection safety, outpatient settings, policy options, four key policy elements for best practices so I just wanna make sure that folks on the phone calls if you are interested in HAI know about those. And they're about monthly and they've got some great topics, um, upcoming and also historical links if you're interested in that. And you can find that on the Oregon HAI web page. Look for the lunch and learn webinars.

Next Speaker: Thank you, Genevieve. We actually have another, um, webinar that we're presenting as part of the OPSC um, collaborative and that will be taking place on Friday so you can access the registration info for that on the OPSC web site. Is that right?

Next Speaker: Yeah, absolutely.

Next Speaker: Okay.

Next Speaker: Great. I know we've had, like, good conversations about safety injection, or injection safety so.

Next Speaker: Is there a lunch and learn, uh, email list or something?

Next Speaker: That's a great question.

Next Speaker: We don't have an email list. We kinda promote it along with our partners. We send it out, um, and then we have a website on our HAI program web page that, um, lists all of them.

Next Speaker: And that was, yeah, as a consumer **** on the other side. That was actually something back that was mentioned just like **** summary where you can sign up and then you get the auto emails, like, if there's a way as just a reminder and a trigger, um, you know, it could include **** others who are interested too.

Next Speaker: Okay.

Next Speaker: 'Cause, like, looking back over the topics there's some great topics there, so.

Next Speaker: Thank you.

Next Speaker: **** a lot of work into that so thank you.

Next Speaker: So, any other sort of updates or news around HAI stuff that people wanted to share with the group? Uh, next is on the list is to approve the December 2018 minutes. So if anyone who's had a chance to review that, um, would, um, make a motion for approval or any corrections, please.

Next Speaker: And as a reminder our, our committee members will be able to, um –

Next Speaker: Approve or disapprove.

Next Speaker: – make a motion too.

Next Speaker: Yeah.

Next Speaker: And it can be a member on the phone or in the room, either way if you've had a chance –

Next Speaker: Someone, please.

Next Speaker: Uh, Kelly Quallow, Rive Bend ASC, I move to approve the minutes.

Next Speaker: Thank you, Kelly.

Next Speaker: Second.

Next Speaker: **** seconds it, thank you. Okay, great. So next on our list is for general HAI updates from Lisa.

Next Speaker: Yes, so I mentioned a few moments ago that we are not presenting outbreaks at today's meeting so in lieu of that I have some exciting HAI program updates for you all. Um, firstly, the 2017-2018 influenza, uh, vaccination and healthcare personnel report is currently making its way through the publications process and approval process and we expect to have this released in April. We are also starting to get ready to delve into 2018 data, um, I sent out a reminder yesterday to our primary infection prevention contacts at all of our hospitals, um, that we will be initially freezing our data on April 1st, um, and then as in years past we will be sending out reports and guidance for each facility to internally validate its own NHSN data around April 8th. Um, of course, we will be available to provide technical assistance as you review. Um, we're also planning to provide two rounds of these reports, uh, which should be a positive thing since it will give everyone a chance to actually see their data initially, make changes, see it again, and then see it a third time when we send out all the data for preview. Um, please feel free to reach out if you have any questions or concerns about our timeline and we will send out a more detailed timeline when we send out the reports themselves. Our program just recently sent out our HAI surveys to all hospitals to complete as well so as a reminder those were sent only to the primary IV contact at each hospital. Uh, we are looking for one response per facility, um, and we are hoping to see data from all facilities by April 22nd. And speaking of surveys, we sent our sniff survey out awhile back and I wanted to present a few highlights from that survey, uh, specifically on the topic of injection safety which we've discussed a lot, um, over

the past year, uh, it will be very interesting to compare different, uh, data from the different facility types and we have our hospital data as well, um, and just please bear in mind that these are preliminary data which is why I am not presenting them on a slide. Um, so again we're talking about our skilled nursing facilities, um, 75 percent of these sniffs in Oregon provide IV transfusion using central lines and 96 percent have a written policy regarding injection safety including protocols for performing finger sticks as well as point of care testing. In terms of drug diversion 92 percent have a written policy regarding tracking personal access to controlled substances to prevent narcotic theft or drug diversion but only 41 percent have a drug diversion program that includes consultation with the person responsible for infection prevention when drug tampering is suspected or identified. Uh, 85 percent provides safe injections training to, upon hire to all responsible healthcare personnel, 77 percent provide safe injection training at least annually and 70 percent perform safe injection audits during resident care. 85 percent provides safe of point care testing training upon hire to all responsible healthcare personnel, 80 percent provide safe point of care testing training at least annually and 72 percent perform safe point of care testing audits during resident care. So some good successes here and some also places that we could see improvements. Um, we're looking ahead to try to engage more sniffs in the work that we do, u, both in this committee and in other ways, um, so just keep an eye out for that and if you have thoughts or suggestions about how we can kinda reach out to sniffs more again, feel free to send that my way. Um, and then finally since we're on the topic of injection safety as always I just wanna promote membership in our state one and only campaign. As a reminder that's an edu, educational campaign that is aimed at eliminating transmission of disease and outbreaks that's associated with unsafe injection practices. Um, membership is open to anyone. If you're interested just email me and I'll sign you up, um, and what you'll be getting are very brief quarterly newsletters from our program kinda covering important topics in injection safety, something from the news, a highlight of a free resource, what updates to our tool kits have been made recently and again we're really aiming for those to be very brief. They fit on one side of a printed page, I think. Um, and they include important updates about injection safety in Oregon and beyond. The only ask that we have for you to become a member of our state campaign is that you're willing to share resources as you see fit with your patients and your colleagues. Um, so that's also not only a great way to state up-to-date but a great way to demonstrate your commitment to injection safety and safe needle use. So those are my little program updates and just feel free to email me directly, um, if you have any questions and you should probably all have my email address, I'm guessing. But it's roza.p.tammer@state.or.us. Thanks.

Next Speaker: Excellent. Well, great. Any questions about that from the phone or in the room? Okay. Next comes the much, much anticipated **** toolkit, toolkit for us ****.

Next Speaker: And I think **** enter. No.

Next Speaker: ****.

Next Speaker: There we go.

Next Speaker: All right.

Next Speaker: Okay, so, uh, hi everybody on the phone and for those in the room, I think most, I know most of the people, I think, by now. So, um, if, for those, a few that I don't, I'm a, n infectious disease physician primarily at the VA. I do hospital epidemiology. It's my primary job, uh, but I've been involved with our **** program at the state for, uh, a lot of years now, since 2012, um, and I'm reminded by this next slide is, uh, when this, where the network kinda got started so, um, today I'm gonna talk about the MDRO toolkit, um, that we, uh, will soon, I guess it's forthcoming in the next, hopefully, couple months. We've said that probably for several years now but we are actually quite, uh, we're quite close to getting it out, um, and so we wanted to present this, uh, at this meeting, um, to, yeah, I just kind of make sure the group was aware that this is coming out and, um, give you a flavor for what's inside of it. So, uh, the **** network, uh, to remind, um, yeah, I guess for, for folks that aren't familiar with it is our drug resistance organism prevention and coordinated regional, regional epidemiology network and, and this started in 2012 where, when this idea of a regional network of hospitals and, uh, public health, uh, institutions and kind of all stakeholders, private, public, academic, um, uh, really we got together to, you know, take a regional approach to prevent, um, MDROs and really our focus was CRE from the beginning and, uh, this, the goal was, you know, we didn't have much CRE in Oregon and we're trying to keep it that way essentially and, and try to figure out how to work together to keep it that way. Um, so over the last seven or eight years we've, we've done, uh, lots of surveys, um, as, uh, those of you who have been surveyed know. We appreciate your, uh, efforts and, in this and we've learned a lot about what's going on in the state with acute and long-term care and, uh, in the microbiology labs. Uh, we built, uh, lab capacity to track CRE, uh, uh, across the state and test for carbapenem production and, uh, good news is, is that we've really not seen many CP CREs so the carbapenem producers in the state to date, uh, less than 30. Maureen would probably be able to tell me the exact number. I didn't pull it from the, uh, web site. Uh, we've built HAI team response which is a collaborative response of, um, several of us in the room, um, uh, public and, uh, uh, academic, um, groups working together to, um, and then publish the CRE toolkit to serve as a guide for how that response would look. We, we, when we started this whole thing we, the, the, um, really noticed there was kind of a, uh, a lack of, uh, of kinda on the boots support for, for case response and filled the need there, we hope. And so, so over time really each CP CRE case, uh, receives a real time, um, essentially, uh, consultation with our group and we work with whatever facility is involved. And, and so far, um, and then we, we support kinda screening and anything that needs to be done for the outbreak so, uh, in, in really the good news so far is that there's really no known CP CRE transmission in the state, uh, to date. Um, and then we also have done a bunch of other things, one other highlight would be mandated, uh, mandated inner facility transfer **** of, uh, CRE and other relevant, um, bugs. Okay, so, so for, for quite a while we have, uh, had this idea that we wanted to put together an MDRO toolkit. This is kinda following the CRE toolkit, um, to, um, have a couple of goals and mainly to unify definitions of what an MDRO is for infection control and inner facility transfer purposes to facilitate communication between, um, yeah, uh, uh, healthcare systems and hospitals. And we also, um, uh, want to take advantage of what we had kinda started with CRE, um, regional approach is to bring basically hospital systems and, um, hospitals together to really understand kinda what individual needs hospitals have and, and what barriers there were to unify an approach to kind of, uh, MDROs in Oregon. Um, we also kinda took this patient perspective as, you know, why am I in isolation and, and in particular why am I isolation here when I'm not in isolation in that hospital? And so we thought that was a real jarring kind of experience that we've heard anecdotally at least from, I think all of us have probably heard, um, and so we

wanted to kind of, uh, think through that as a regional, as a region and how to, um, deal with that. So, so what we kinda did to, um, there's a lot of individual healthcare system and hospital policies, obviously and so what we kinda did was say, you know, we wanna come up with a regional approach that's, you know, reasonable cons, given whatever current science is available and, uh, has to be pretty simple to implement probably, um, so you know, no involvement of super complex testing, no electronic reminders that, you know, places may or may not be able to implement and it has to be kind of implementable ideally beyond the infection prevention office, um, so that, that was kind of our, some of our goals. So, um, this, we really kinda got the ball rolling, um, in 2017 and '18. We, uh, have done a lot of work and, and hopefully we'll, um, finish this, uh, in 2019. Uh, so, so over the last couple of years we, we con, we, um, held a hospital epidemiologists' task force, and we met by phone every couple of months to tackle various issues, like, you know, how are we gonna deal with MRSA, uh, when was, how are we gonna define a gram-negative rod, how are we gonna define gram-negative, uh, uh, well, resistant gram-negative rod, for purposes of, of the toolkit and how, and then we, you know, and our bacteria ACA, pseudomonas, ****, how are we gonna deal with all this stuff? Um, we presented this toolkit, the concepts kind of initially, and then, uh, more of a detailed look at it, uh, **** a couple of times and got feedback. Uh, we've prev, presented it to the **** advisory committee meeting, and now we're, uh, presenting it here, and it's in its final draft right now. Um, yeah. Okay, so here's the, uh, so I wanted to give you a flavor of what's in the toolkit. Here's the purpose statement, um, and that's mainly for reference. Really, the, um, it's to provide recommendations to Oregon healthcare facilities about strategies to present transmission of MDROs and newly-named cross ****, C. Difficile, during patient care, so I even have trouble saying that. It's too new. Okay, uh, once inside, there's a bunch of general info, kind of about, um, MDRO risk assessment and what factors we think are, or should be included for, for a facility. Um, differences in healthcare sittings and, settings, and how they impact approaches to MDROs, you know, sniffs to, uh, acute care to LTC. Um, general infection prevention control principles, um, with a clear emphasis on standard precautions and how critical that is, um, to, uh, infection prevention and, uh, the use of PPE, and some, some discussion of kind of the, the ideas of vertical and horizontal approaches to infection prevention. Um, and then we, we offer some guidance and, and really reference, uh, what are, um, uh, uh, uh, white papers, um, from, um, various groups. Uh, it published in ****, the infection control journal, uh, about visitor and animals, um, uh, to healthcare facilities, and, um, and then we kind of, you know, summarize what's in those, so, you know, one wouldn't actually have to go to those documents if one wanted to, you know, get a flavor of what is recommended there, so kind of practical things. And then, um, we have these different sections, uh, and these different pathogens listed here, uh, about what defines drug resistance, for the, for the gram negatives, 'cause that's the, been the sticky issue, and then, uh, how to think, uh, about, um, MRSA and CRE contact precautions. That's been the kind of other sticky issue, and then, uh, a few things about C. Diff. Uh, so each organism, it's got about a structure like this. There's a background in epidemiology, uh, section, um, some, some historical, uh, section for some of 'em. Uh, when it's appropriate, uh, we have a lab information and definitions, uh, section, kinda, uh, yeah, you know, what defines an MRSA for example. Uh, strategies that are, um, employed to prevent transmission, so, you know, we address kind of screening and/or decolonization and/or other, you know, things in there, um, for each organism. Um, we discuss cleaning and disinfection information. Um, you know, for example, for C. Diff, the, you know, bleach-based product is necessary and some, some things like that. Um, and, uh, regulated, so we have a section about related regulations and

requirements. We've kind of gathered together what is required around these organisms at least, uh, nationally, uh, for reporting and statewide reporting, and/or anything else. Um, and then we have kind of the summary table for that organism and the end of the, uh, section. Okay, so I wanted to, um, just basically walk through one example, uh, and then **** I'm sorry, ****.

Next Speaker: You have lots of time ****.

Next Speaker: Okay, good, okay, great.

Next Speaker: Take as much time as you ****.

Next Speaker: Well, hopefully I won't. That'll give us a long break. So, uh, here, here's an example of what's in here, so it's, uh, drug-resistant enterobacteria CA. So, so we have a discussion around CRE, ESBLs, the type of resistance that occurs in, in our bacteria CA. Um, tried not to keep it too high level but, or, uh, but high-enough level so it's of interest to multiple different readers we hope. Um, and then we, we discuss lab information and definitions, and we, we, um, basically through discussions of the hospital epi task force, uh, decided that we wanted to kind of mirror our definition fairly closely to the CDC ECDC published, extensively drug-resistant definition. Um, that definition is super complex and can't be, you know, can't be directly translated to the clinical microbiology lab. So what we did was pull the, uh, the best way we could, pull the kind of, um, ethos of that definition and apply it to what is typically reported out of a clinical micro lab, and then divide, and we, so we, we're calling this the Oregon XDRE definition. So this is the definition. Oregon XDRE are organisms testing non-susceptible to at least one agent in at least four of the following six categories, and then you can kind of think about it in the reverse, and some people like to do that too, um, but that, we thought this is the easiest way for us to think about it. So, you know, essentially a non-susceptible organism to at least one agent in those categories that're basically, you know, always reported on a clinical lab report, and then that would flag, should flag it's an Oregon XDRE and flag as an M, you know, MDRO basically in Oregon, and that could be, you know, transferable across hospital, uh, systems and, uh, hospitals, and in long-term care as well. So you cross the, you know, continuum of healthcare in Oregon. Okay, and then we have a, uh, strategies to prevent transmission, uh, section, kind of discussing the role of standard plus contact precautions for enterobacteria ACA. The role of active surveillance testing and, um, you know, is, uh, and how, and what the limits of that are. Um, you, we, I think, I'm not sure if, yeah, we, we don't discuss decolonization, 'cause that's just not, uh, a thing right now. We, we talk about patient placement issues, you know, single-bed room if, if possible, uh, and that when the cohort patients, um, if they've got the same type of, uh, uh, XDRE. Uh, cleaning and disinfection information, essentially kinda for this section for, for XDRE, would be standard agents are acceptable. Um, and then, uh, regulated re, regulations and requirements, and, for example, for this, we, uh, have in there that there's an NHSN MDRO module that allows for reporting, this is mandated. Uh, and the, and then in Oregon, um, for XDRE, the inner-facility transfer notification is required. Uh, and then we, um, have a still subsection there about CRE. We obviously refer to the CRE toolkit for CRE-specific issues, uh, but then, um, mention that CRE and pan-resistant organisms are reportable, uh, to the health authority within a day. So then here's the table that we, uh, uh, have devised. So we have the table by, and this looks the same for each organism, by healthcare system, or sorry, healthcare setting, uh, and then we have suggested isolation precautions, and

then suggested when to discontinue isolation, and this is kind of a minimum, um, uh, recommendation. Okay, so, for acute care and, uh, long-term acute care, the select, uh, suggested isolation precautions, for example, carbapenemase-producing CRE, uh, would be, uh, see the Oregon CRE toolkit, uh, for recommendations. But, you know, clearly standard-plus-contact precautions. And for other Oregon XDRE, it's standard-plus-contact precautions as well. Uh, when to discontinue isolation, um, we have for CP CRE, um, indefinitely, and this is, um, you know, subject to change as we get more data, but for now, that's the recommendation. And for other Oregon XDRE, recommending at least 1 year after the last positive test, um, and then it's optional for facilities, of course, you know, to kind of do what they want beyond that and whether they want to screen or not, and we've got some, um, discussion around that. Uh, then we have some recommendations for the long-term care facilities, um, and then, uh, you can see down there adult foster, home hospice, homecare and ambulatory clinic. Uh, and, uh, for those other sites, I think it's a, a theme throughout the toolkit is that standard precautions really is, uh, recommended for, for all those other sites. Uh, but for long-term care facilities, um, you, it's written there as to what the recommendations are. CPCRE is different than XDRE, and I, uh, I guess I'll say that there's still a draft on that, so, you know, this is prob'ly not gonna change, but, uh, we are batting around some slightly different language that we might use. Um, and so for those of you reading this as a, this is an example of basically what is in for the rest of the sections, if you have strong comments, uh, or, or any comments, um, we'd totally appreciate, you know, some last-minute feedback, 'cause we are chain, we're here, you know, we're in kind of our last draft, uh, of this. Um, let's see, I think I'll move on there. Okay, so here's another example, uh, that I just kind of wanted to talk about for MRSA. Uh, what we have right now is, uh, CDC has recently come down, you know, again reaffirmed their commitment to using, uh, contact precautions for patients with MRSA colonization, and so what we have here, it, we, uh, so in the toolkit, we acknowledge the debate about the use of contact precautions in acute care for, uh, you know, and that there's, it's unclear as to, you know, they're, they're, and they acknowledge that certainly a lot of facilities and systems are moving away from contact precautions. And so kinda to acknowledge that, um, debate and uncertainty, we, uh, kinda have an asterisk here, which is, uh, we recommend standard contact precautions, but, um, had the asterisks is really if contact precautions are not used, the facility should demonstrate ongoing low infection risk and optimal adherence to standard precautions. But, –

Next Speaker: Can I ask a question, a –

Next Speaker: – yeah.

Next Speaker: clarifying question on that?

Next Speaker: Yeah.

Next Speaker: You mean that the asterisk is truly only for those colonized with MRSA? Because if they were actively with a draining wound but the wound and infected, is that, they would, would you guys still recommend standard plus contact?

Next Speaker: ****.

Next Speaker: Or is that even being called?

Next Speaker: Well, if you –

Next Speaker: It's a ****.

Next Speaker: – have a, –

Next Speaker: I think that is even being –

Next Speaker: – if you have an –

Next Speaker: – called –

Next Speaker: – open draining wound, –

Next Speaker: – in question.

Next Speaker: – that goes into contact.

Next Speaker: Yeah. In, in –

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: – theory, standard precautions should cover the open draining wound, 'cause people in, should use a gown and gloves for –

Next Speaker: Sure.

Next Speaker: – that.

Next Speaker: But they don't.

Next Speaker: But they don't, yeah.

Next Speaker: Okay, so I just, I was just curious, do you guys, –

Next Speaker: Yeah.

Next Speaker: – you are intending the asterisks to apply both for standard, for colonized or infected ****?

Next Speaker: I think to keep it simple, yes, yeah, yeah.

Next Speaker: So, –

Next Speaker: Yeah.

Next Speaker: – **** are you, –

Next Speaker: Mm hmm.

Next Speaker: – what are you recommending for outpatient departments?

Next Speaker: Standard precautions –

Next Speaker: 'Kay, –

Next Speaker: – for all patients.

Next Speaker: – for all of these?

Next Speaker: For all of these.

Next Speaker: 'Kay.

Next Speaker: Yeah, that's right. We, we've gone back and forth, so, so for CP CRE, we've really thought about augmenting the outpatient requirements, and I learned actually the other day, and, um, for MRSA even in, in Canada, they have outpatient isolation essentially, for, –

Next Speaker: We, we do too.

Next Speaker: – yeah.

Next Speaker: 'Cause, I mean, because it's, we're sending so much more to the –

Next Speaker: Yeah.

Next Speaker: – outpatient setting.

Next Speaker: Yeah, yeah, yeah. Yeah.

Next Speaker: I think radiation oncology, –

Next Speaker: Yep, yep.

Next Speaker: – for example, you know?

Next Speaker: And, and we do kinda certain, uh, I think special things in special clinics, like the CF clinic, there's certain things we do that're different, and for the bone marrow clinic, we do

slightly different things kinda practically speaking at OHSU. Um, but even for CP CRE, we've had trouble, and CDC, you know, CDC says standard precautions, and so we had trouble, you know, making a minimum requirement above that. That said, if, when folks ask us and we talk to the, you know, to whatever hospital system is dealing with the CP CRE patient, we recite critically important to maintain, to actually adhere to standard precautions in that a patient setting and clean the room, you know, ideally see the patient if it's a wound care patient. We had one, uh, see the patient at the end of the day and –

Next Speaker: 'Kay.

Next Speaker: – clean the room afterwards, kinda do –

Next Speaker: Get 'em in right away.

Next Speaker: – practical, smart things to, um, but still use standard precautions, yeah.

Next Speaker: Okay, thank you.

Next Speaker: Uh, okay, and then, uh, you know, again here, just kinda to simplify as much, but, but, uh, to simplify but be as kinda practical. And we just, we kinda talk a little bit about the duration of MRSA colonization and what the average duration is, etcetera. Ah, and what we kinda came up with, and, and I think what was, um, there's been a shaved duration of contact precautions kinda white paper that came out, uh, a year or 2 ago. And so, so we follow that to some degree, but they have a little, it's a little complicated in the way they interpret some of what they suggested, so even more simple is what we came up with, which is, um, really, uh, at least minimum is, um, 1 year after the last positive MRSA test and, uh, again, it's, um, uh, optional to perform screening to assess ongoing carriage, uh, for a facility. So if a facility does it, great, uh, but if a facility doesn't do it, um, that's okay too, 'cause we can't force facilities to be doing this. Uh, so, so this is kind of, you know, where we've come up with, um, uh, some of these, uh, recommendations and yeah, there's comments there. Uh, right, and this is just a, a slide essentially kind of, you know, the duration is kinda practi, for kinda practical purposes minimum, and I should add minimum here. Uh, 1 year for these, for most organisms, but indefinite for kind of hand-resistant novel organism, CP CRE and other CPOs, carbapenem-producing gram negatives. So we're starting to see, we've had, like, two or three now, uh, carbapenem-**** producing pseudomonas, uh, islets, and we're gonna kinda group those in the CRE, uh, CP CRE, uh, basket I think, as far as our team's approach to, um, being aggressive about those. Obviously we don't want **** spread. Um, CORS, we haven't, uh, you know, I guess we've, we have to think about. You know, we have a, uh, we haven't had one, so, –

Next Speaker: Candida auris?

Next Speaker: Yeah, candida auris, yeah. Yeah, so, but that would probably fit in this, at least for Oregon right now, and novel ****, you know, novel organism at least, so. Uh, let's see, C. Diff, so, so that section, you know, um, is, uh, a little-bit different but, in C. Diff, but I kinda will pull out some of the highlights is that, for that section, we really emphasize antibiotic

stewardship in addition to prompt detection and isolation. For the control, we suggest some sort of, um, a contact plus precautions or –

Next Speaker: ****.

Next Speaker: – **** precautions, whatever the facility is calling it, but something in addition to, um, you know, using bleach-based cleaners, um, in particular, for, for, uh, for, uh, the, the version of contact precautions that're being applied. Um, for cleaning, to use ****, uh, agent and, uh, national regulations. For example, we, you know, inform people that CR, CMS requires CDI as a lab I.D. Uh, here's the infection prevention recommendations for, uh, uh, C. Diff, and this really follows, um, for the most part, the Shea IDSA guidelines, there's not too much, um, too much controversial stuff here. Um, we acknowledge that for an endemic CDI, there's an unresolved issue as to, um, uh, oh, oh, so sorry, we acknowledge the hand hygiene unresolved issue, but not on this table. This table is acknowledging this unresolved issue about what we should do about CDI colonization. It's not currently recommended, but, you know, what is the best? I don't know, and I'm not sure anybody knows yet, so, um, yeah ****.

Next Speaker: And it vary **** very diff, but –

Next Speaker: Vary, and –

Next Speaker: – based on your patient ****.

Next Speaker: – it definitely would vary by setting and, yeah, –

Next Speaker: Yeah.

Next Speaker: – everything else, yeah. Um, yeah, so this is, so, so really the next steps on this toolkit, uh, are to publish it soon, um, evaluate the adoption of it, so we're kinda looking to see how implementable this is and what places, you know, how places are dealing with it and make sure people are aware of it. And then, you know, revise it as needed, so, you know, in a year or 2, reevaluate and see what's, if, what is any, what, if anything is new and, and, and certainly updated, so that's where we are. Uh, I will stop there, happy to answer questions.

Next Speaker: Well, we have, um, a little more than 10 minutes for Q and A.

Next Speaker: Chris, do you wanna talk about the dissemination plan and, uh, –

Next Speaker: The dissemination plan, the –

Next Speaker: – I know we've talked about it, –

Next Speaker: – dissemination plan, yeah, yeah, it's, –

Next Speaker: – but I **** I don't know what ****.

Next Speaker: – so, so I think, um, we are so focused on getting the thing finalized and to publishing that the dissemination plan would involve something similar probably to the CRE toolkit I'm thinking, as we, um, probably, you know, get some copies printed and send 'em to infection-prevention programs.

Next Speaker: Well, I think we were mostly planning on posting it on the web site, um, and not printing it all, just because it would be, you know, and **** revisions ****.

Next Speaker: Yeah, either way, yeah, yeah.

Next Speaker: Yeah, so, –

Next Speaker: Sending it –

Next Speaker: – it would, –

Next Speaker: – to all our infection prevention –

Next Speaker: – yeah, we **** this, –

Next Speaker: – colleagues, –

Next Speaker: – right.

Next Speaker: – for, that we also send the surveys too, and long-term care facility colleagues that we, –

Next Speaker: And laboratories –

Next Speaker: – and labs.

Next Speaker: – ****. Um, ****.

Next Speaker: Um, we should hold a webinar too on it.

Next Speaker: Mm hmm.

Next Speaker: We could do a lunch and learn.

Next Speaker: We could do –

Next Speaker: Right, yeah, ****.

Next Speaker: – lunch and learn, exactly.

Next Speaker: I think that's **** on someone.

Next Speaker: Um, but yeah, I, –

Next Speaker: ****.

Next Speaker: – is there anything else that we should be doing? I'm sure there prob'ly is.

Next Speaker: Probab, well, I thought this would be a good forum –

Next Speaker: Yeah.

Next Speaker: – to solicit feedback from –

Next Speaker: Yeah.

Next Speaker: – the settings and see what, where it'd be most, you know, there'd be the most utility. 'Cause I, I think, you know, probably some, I think people'd prob'ly appreciate having printed copies or maybe printable copies that they can print themselves and have in certain places, but I agree that we might not wanna be the, uh, stewards of the actual printing, –

Next Speaker: Printing.

Next Speaker: – um, since it may require, yeah. As soon as we print, well, first 100, we'll find the first few.

Next Speaker: The first error.

Next Speaker: Yeah, exactly .

Next Speaker: Yeah .

Next Speaker: But, –

Next Speaker: Or, or if that was a consideration, not this version or ****.

Next Speaker: Right. Yeah, eventually maybe, once we, but, –

Next Speaker: ****.

Next Speaker: – yeah, I didn't know if other people had suggestions on, um, what, where they would want it in their facilities.

Next Speaker: In, infectious disease for sure, and then, of course, all the non-hospital.

Next Speaker: Yeah, right, I guess the other place we would, um, send an email or whatever to is the idea, so, um, –

Next Speaker: Yeah, ambulatory surgery centers, you know, **** contact ****.

Next Speaker: What about, I know DHS used to have that administrator alert, and apparently like a lot of, uh, long-term facilities, pay attention to what comes out on that, so I think just working with them, they could send an email out.

Next Speaker: **** Deb, –

Next Speaker: Deb Katora?

Next Speaker: – Deb Katora.

Next Speaker: What about all the people that respond to our, that we send our surveys to, so all of our, you know, seems like all of those people.

Next Speaker: Mm hmm.

Next Speaker: We already have their emails loaded, –

Next Speaker: Mm hmm.

Next Speaker: – so maybe we should, um, 'cause I think we want to show, like, we want to post it, right, so we'll know, um, **** number, you know, how many times it's accessed –

Next Speaker: Mm hmm.

Next Speaker: – and downloaded and.

Next Speaker: Mm hmm.

Next Speaker: Do we mention the HAN?

Next Speaker: Mm hmm.

Next Speaker: Home alert network?

Next Speaker: Mm hmm.

Next Speaker: Seems like that would make sense.

Next Speaker: Mm hmm.

Next Speaker: Yeah.

Next Speaker: Any, any suggestions from the phone, from folks on the phone? This is Genevieve, a couple more things come to mind, 'cause I think one of the, the nice pieces you call it here is the ambulatory clinic stuff, so I, I mean, how could you reach the ambulatory, 'cause I think folks are, you know, they've got these folks comin' in for whatever, checkups and MRSA colonization.

Next Speaker: Yeah.

Next Speaker: So I thinking of that way, with either the, the boards or, um, you know, Dr. Paul Lewis, they've got a really nice, uh, clinician alert, uh, email list that they use for clinician alerts and things like, you know, the, –

Next Speaker: Right, right, through the county.

Next Speaker: – yeah. Just thinking about more, if you want to push it to the outpatients who are, you know, um, taking care of these folks as well and might want to know what the state's doing, –

Next Speaker: The, –

Next Speaker: – or suggesting for ambulatory and other –

Next Speaker: – right.

Next Speaker: – things.

Next Speaker: Well, maybe just to OMA.

Next Speaker: Yeah.

Next Speaker: **** send notice to OMA to get it out to their members in, like, a newsletter or somethin'.

Next Speaker: Mm hmm.

Next Speaker: Jordan, what about ONA, or the Oregon, –

Next Speaker: ****.

Next Speaker: – the Oregon Nurses Association may also be interested, and then the other things that come to my mind are the boards of licensure. That's kind of opening a whole can of worms, but it's a lot of individually licensed healthcare providers, and if we can reach out to the boards, they may be willing to share.

Next Speaker: Yeah, the trade groups for different, you know, could push it out for us.

Next Speaker: Yeah.

Next Speaker: I mean, I wonder if we post it first and then, –

Next Speaker: Yeah.

Next Speaker: – you know, uh, –

Next Speaker: Get them, yeah, get them, –

Next Speaker: – and then prob'ly –

Next Speaker: – piloted, yeah.

Next Speaker: – have a few, um, –

Next Speaker: Changes.

Next Speaker: – conversations on how, 'cause I think we're gonna, if we really wanna study uptake, we've gotta have a very-strategic plan for how we disseminated it, and then, um, uh, –

Next Speaker: So what are you looking for for update, uptake?

Next Speaker: I mean, I think we wanna know, like, how many times people are accessing it, right, and then, um, and, you know, you know, so presumably people are accessing it –

Next Speaker: ****.

Next Speaker: – prob'ly initially just 'cause they're interested, but then they're prob'ly gonna go back to it, um, if they have a problem and, and want to see. And so I think there's ways of tracking, you know, clicks and, and, um, I think that's definitely something we should be doing. And then I think we should probably, maybe in our next round of surveys, ask people if they're using it and when are they using it.

Next Speaker: Or do they reference it, –

Next Speaker: Um, are they, –

Next Speaker: – **** policy changes.

Next Speaker: – yeah, right. Has this, has this changed policy.

Next Speaker: Yeah.

Next Speaker: So I think we need to, uh, you know, so Chris is right, we spent, like, like, you know, it's an effort of, uh, biblical proportions –

Next Speaker: Yeah.

Next Speaker: – **** get this thing written. Um, but I think now we're at, this, this is super critical. I don't wanna –

Next Speaker: Yeah.

Next Speaker: – kind of just **** say now we, let's kind of just have it sitting on top of the file cabinet in various places I think. We really want to know how people are using it, and then where we can improve the document, right? Like, this would've been really great but, you know, which I expect to hear, right?

Next Speaker: Yeah.

Next Speaker: Because, uh, we won't know until it's in the trenches ****.

Next Speaker: And so, yeah, and so there, there might be, like, you brought the **** point of doing the little piloting in the different, um, from representatives of each of the different, uh, audiences that you're trying to reach. I know you've done some of that already with the hospital-based Debbie, but, –

Next Speaker: Mm hmm.

Next Speaker: – **** about some of the other ones too.

Next Speaker: It would be really valuable if you, uh, **** asking to be surveyed, but how currently people are managing one another –

Next Speaker: **** Julie.

Next Speaker Yeah.

Next Speaker: **** survey.

Next Speaker: – and then distribute it and then measure it, um, –

Next Speaker: Yeah.

Next Speaker: – at a time period later and see what kind of impact you've had.

Next Speaker: Yeah, I would say, uh, –

Next Speaker: That was in the survey, wasn't it?

Next Speaker: – we, uh, –

Next Speaker: **** contact ****.

Next Speaker: – well we, we asked several years ago how people are, –

Next Speaker: Yeah.

Next Speaker: – what their definition of MDRO was, and it was, honestly, everyone had some different definition. It, we, it was all over the map.

Next Speaker: Right, we recommended **** that we're all, –

Next Speaker: Yeah.

Next Speaker: – we're all treating MDROs differently.

Next Speaker: And, um, so we haven't re-surveyed on that, because we figured it hadn't changed, and that was part of the reason for, for the, for us to do this. And, uh, and then anecdotally, I think when we got, when we talked to Oswe, you know, Oseep, **** say –

Next Speaker: Oswapic.

Next Speaker: Oswapic.

Next Speaker: Osweepi but, Oswapic, okay, but, so, so anecdotally, in talking to, to that group and then amongst our kinda hospital epi group, it, it still hasn't changed. I mean, it's still all over the map, so it'll be really, I mean, the hope is that we can standard, you know, get this adopted and standardized as close as we can. And, and with the definitions that we're proposing, I, it'll be, you know, each system has its different pushes and pulls, you know? Um, I, some are multi-state, some the, the definitions are controlled up somewhere else, where, you know, we really can't control them. So, it'll be interesting to kinda see what the, you know, we, we can, we have some ideas of what some barriers were to implementation, but, um, we, we won't know until it gets out there.

Next Speaker: The other partners that we work with to get things out and are certainly OPSDs, um, the Office of Rural Health, uh, Health Insight of course, we have our, um, patient, um, partnership for, oh my goodness, –

Next Speaker: Partnership for Patients?

Next Speaker: – it's not Partnership for Patients, but it's a partnership for pa, healthcare quality, it's a small group, and then, um, the Oregon Ambulatory Surgery Center Association, um, and then they also put on an annual conference, so we may have some opportunity there.

Next Speaker: ****.

Next Speaker: Any other questions?

Next Speaker: That, that's, like, about 50 groups that we can –

Next Speaker: Yeah, so I think initially post it, –

Next Speaker: – contact, so we should, –

Next Speaker: Start small.

Next Speaker: – we, we should think about, you know, how strategically to kind of, yeah, start and then, –

Next Speaker: We could put that as an agenda item on the ****.

Next Speaker: Yeah.

Next Speaker: ****.

Next Speaker: **** groups –

Next Speaker: Yeah, yeah.

Next Speaker: – are. Any questions ****? I had a question, well I guess we're ****, uh, you guys address what to do with ESBLs?

Next Speaker: Yes.

Next Speaker: Okay, great.

Next Speaker: ****

Next Speaker: And then, uh, my other one, my other question was around, uh, if you review or reinforce **** facility, transfer communication stuff, and is it only – 'cause the X, the EXDR, I mean, that's, those are rare and obviously ****, but are the other ones still on there? Like, MRSA –

Next Speaker: Yep.

Next Speaker: – and, uh –

Next Speaker: Everything is still on there.

Next Speaker: – CRE, and everything else –

Next Speaker: Yeah. Everything ****.

Next Speaker: – is still on there? Okay.

Next Speaker: Yeah. So every other, every organism –

Next Speaker: I wasn't sure ****.

Next Speaker: – discussed has, uh, kind of a plug for the interfacility transfer.

Next Speaker: Okay, great.

Next Speaker: Yeah.

Next Speaker: How **** –

Next Speaker: **** person – oh.

Next Speaker: Please go ahead.

Next Speaker: Sorry, didn't mean to 'rupt.

Next Speaker: No, no, go 'head.

Next Speaker: Uh, this is Kristen **** with Infante. Uh, one other group that I'm not sure was mentioned, and I think their acronym may have changed. Um, we recently met with the Northwest Safety and Quality Partnership, which I understand used to be maybe WISHA, that it started in Washington and now has expanded to Oregon, um, so that might be another group that would be interested in, in this document.

Next Speaker: Mm, okay.

Next Speaker: ****

Next Speaker: Thanks.

Next Speaker: I was just tryin' to think, like, how, how you could encourage folks to **** take this document and look at what they currently have and at least do a reflection on –

Next Speaker: Gap analysis.

Next Speaker: – a gap analysis on that, and how could you incentivize folks to do that work once it comes out, uh –

Next Speaker: We can ask people to send us somethin'. I mean, we, they could do it, or they could send it somewhere.

Next Speaker: I was thinking more like a drawing for a 5-day vacation to Hawaii or something like that. Your guide analysis report.

Next Speaker: Honestly, if you included a GAF analysis template in, in the tool kit –

Next Speaker: I was just saying –

Next Speaker: – you, you could, we, you could really go somewhere with it across the state. 'Cause we all look at this different.

Next Speaker: Yeah. Mm hmm. Yeah.

Next Speaker: And especially, I don't know if you guys have any acre, accreditation or like, you know, they're always looking for oh these are, yes, we did a project, we did a GAF analysis whether, you know, something that could qualify to meet those things for your other regulatory boards that are checkin' on, or your administrators or whatever. That that might be something that could be for that purpose.

Next Speaker: We can spend the, the next year workin' on GAF analysis –

Next Speaker: That's true.

Next Speaker: – templates and –

Next Speaker: Don't ****.

Next Speaker: I'm kinda thinkin' most of the –

Next Speaker: I'm not kidding, that probably wouldn't be hard to do and it would be super –

Next Speaker: – documents would be **** --

Next Speaker: That, that's a good idea actually.

Next Speaker: What's that?

Next Speaker: I mean most of the document is pretty much just isolation recommendations per **** and then like cleaning ****.

Next Speaker: Yeah, ****.

Next Speaker: GAF analysis is really more total program.

Next Speaker: Maybe a, like a implementation, we, we could all it something.

Next Speaker: Even you, even just a statement in there that would say, um, encourage organizations to do their own GAF analysis. That would –

Next Speaker: Yeah.

Next Speaker: – get something probably.

Next Speaker: Okay. Yeah, I like the idea. Come up with some implementation guide or something.

Next Speaker: Providing it's more, I think, like you get –

Next Speaker: Yeah.

Next Speaker: – a little more traction.

Next Speaker: Yeah.

Next Speaker: Yeah, a worksheet.

Next Speaker: One **** paper. Okay.

Next Speaker: Yeah.

Next Speaker: Any other comments from the phone or the room around this? This is great. What's a, uh, what's your one-liner on the ESBLs? Is it, is it, are you treating it like –

Next Speaker: I **** like that. Uh, you do not, um, because labs are not reliably reporting ESBLs, we are, you are, uh, they're ignored essentially.

Next Speaker: Okay. So essentially –

Next Speaker: Going –

Next Speaker: – ****.

Next Speaker: Going on, but most of them would qualify as an organ, you know, XDRE anyway.

Next Speaker: Gotcha. Because of other –

Next Speaker: Because of –

Next Speaker: – **** --

Next Speaker: – resistance ****.

Next Speaker: Okay. Okay. Great. Awesome. Okay everyone, well that brings us to the end of our first hour. We're going to take a break here for about 5 minutes and we will see you back at 2:00 and we'll start up again. Folks on the phone, I'm going to mute our lines and we'll, and I'll unmute them after break.

Next Speaker: Thank you. Thanks for all the feedback.

Next Speaker: Good afternoon everyone, thanks for rejoining us. We're just gonna get started here with our next presentation, uh, from Pat Tustin. Thank you for much for joining in and giving a talk to our group. Uh, comes from the Center for Geriatric Infection Control and has, uh, worked with us and been a well-known partner here in the state for a long time, so we appreciate you coming in.

Next Speaker: You're welcome.

Next Speaker: And sharing your thoughts.

Next Speaker: I am, I presented to a group of dentists this morning in Salem, so they wore my voice out. They didn't provide a microphone, so if you hear me clear my throat way too much it's, that's the reason. It's a pleasure to be here. I lived in Bend, Oregon, I lived there now for about 6 years, and I cannot make it up here, it's a real honor and a pleasure to present before you all. I've been asked to present what I present nationally as a 1-hour lecture in 30 minutes. So what I've done is packaged for you all the core principles that were beholding to, relative to our certification and regular process. So as I through the slides I'll make a point and I'll move on quickly. Clearly I've divided the presentation into four core principles. I'm review the current CMS certification process, I'll introduce you to the responsibilities of our physicians and nurse practitioners, we refer to them as providers, I'll show you their part of antibiotic stewardship, then I will slip into the group that I think should be, shall be, will be the most effective leaders with our, um, antibiotic stewardship program; that will be nurses. And then I'll finish with a comment about the fourth group, pharmacists. So I'm going to clearly discuss four different princip, uh, responsibility groups in the half hour. So thanks for, uh, inviting me.

This looks like a really busy slide as I present nationally, and with different corporations. The audience looks at me and says all right, whom should we follow? Should it be CMS surveyors and what they're saying, and they have a book of guidance. Should it be Joint Commission. If you're a Lifecare Centers of America facility in our country they are, to my knowledge, the only long-term care group certified by Joint Commission. So either CMS Joint Commission, do we follow their guidelines? Or should we listen more to the CDC and their partner, we abbreviate with the acronym AHRQ and I'll you their resource tools. Or do we follow the physicians, by docs, for docs, CIDSA guidelines? And then here I sit with the state and I divided the state with three different categories. This committee is writing an update on our, uh, HAI toolkit and we decided to that, that that would be changed a little bit. And then we have occasionally some really nice CD summaries from this department within our state. Also we have rules and regulations, we call them Oregon Administrative Rules in this state. They have acronyms that are different in other states, but we have OARs that are relative to some aspects of antibiotic stewardship, and one of those is now the law to report our antibiotic resistant gram negative rods.

And then we have within our state, the Department of Human Resources, DHS, the Senior Citizens Adult Protective Services as a third entity.

A comment about our pharmacy service. We have about five different commercial pharmacy services within Oregon. Most of those are headquarters outside the state of Oregon. They have consulting pharmacists, and I can report to you that those consulting pharmacists are informed, advised, sometimes told by their parent company what role they will play, what guidelines they have, and they will do what they're going to do because they work for another company, not the long-term care facility. And then within our state we have what I refer to as intrastate resources. We have a very active, uh, professional group, uh, the, group that I'm going to say the best majority of our long-term care facilities do not participate in, even though I've been a member since the '70s, and they have tried, uh, their best, it's still not a, not a group that participates. They do a little but not as much as we want. Our local quality improvement organization called Help Insights which was previously referred to as Acumentra has their, uh, input, and by the way they're very actively involved in antibiotic stewardship activities within Oregon's long-term care facilities. And sitting right next to me is the former consultant head of our current Oregon Patient Safety Commission Group, Mary Post and I worked for years with this, and they definitely, Oregon Patient Safety Commission has, uh, antibiotic stewardship activities within long-term care.

So I'm often asked at the conferences at, to which I present, to whom are we supposed to listen primarily? Well, the answer is, who will give you a citation, close your doors to admissions and then make it very difficult for you to run a business. And so if you're the owner or the corporation your answer is very easily CMS and their process. So I'm gonna tell you that the current antibiotic stewardship program is very formally, very formally referred to in the citation process as CMS F Tag F881. What does that mean? November of 2017, all nursing, all skilled nursing homes in the United States were required, and the requirement is mandatory for participation under Medicare and Medicaid programs, we refer to the system and the requirement as ROPs, R-O-P-S, Requirements of Participation. Within the Requirements of Participation there are four distinct, just like Joint Commission, four distinct what we call F tags section. We have one general F880, we have one to train infection preventionists and the training was just announced this week, it's part of the slide that I'll show next. And then we have one for immunizations, right now only influenza and pneumococcal immunization. And my point is, F Tag 881 is the skilled nursing homes' formal antibiotic stewardship program.

So I'm asked by persons not in, within the long-term care, what does that look like? I copied and pasted twice within this presentation the surveyor's guideline. Now, they have a lot of subjective, uh, uh, leniency to interpret 1, 2, 3, 5 bullets that you see here. However, I do want you to notice the very bottom, No. 7, it's very simple if you're the surveyor. Did this facility, in my opinion, conduct on review, ongoing review for antibiotic stewardship? It's a yes, no, and I'm informing you that nationally in my 50 states, when that is checked off as no, there will be a citation given. So we do indeed feel we are beholdin' to the F Tag 881 CMS surveyor process before you.

Relative to the training for this F881, uh, requirement CDC is, as you all know, is now offering to nursing homes a free online 19-hour training program. Within that training program there is a

definite section on discussion of antibiotic resistance mechanisms, terminology and indeed I would like to point out to all of you when you go online, it's module, Training Module No. 15, specifically Infection Prevention and Antibiotic Stewardship. I'd like for those of you taking notes to realize there is a disjoint, CMS F Tag 881 is not a part of this training. These are two separate entities. Relative to F Tag 811 there is mention and on my original I had a, uh, arrow going to it, it's Bullet No. 2, there is mention that the facilities shall work with the second bullet, Protocols, shall work with the pharmacy, work with the medical director and consider especially two definitions of infections relative to when is it appropriate to use an antibiotic with a resident in a skilled nursing home. In 2001 it was published under the author's name Lobe, we all refer to it as the Lobe Minimal Criteria. And in 2012 Namali Stone and her colleagues published what we use as definitions, definitions for the surveillance. And it, and I want to point to you that these are specifically mentioned and the surveyors are specifically obligated to ask does the nursing home have an antibiotic stewardship program that incorporates the Lobe minimum criteria and the CDC/Shay/Magear type definitions from 2012.

Now if you would look a little bit to your left it also says, SBAR. That is an abbreviation for a tool that nurses not only may use, I would recommend and suggest should use because it's mentioned, it is produced by CDC's partner, AHRQ. I'll show you this SBAR. I wanted to reference it when I do come to it. Relative to our total partnership with CDC and CMS I wanted to show you all that partnership on a slide. Our government, United States Department of Health and Human Services has a partnership with the agency for healthcare research quality, acronym AHRQ, take a look at the circled comment in the upper right hand corner. It says, CMS, and again this is F Tag 881 speak, CMS collaborated with the AHRQ to develop a listing of potentially preventative events. Now if you would, run your eyes over to the far right corner and they mention our cross-reference requirements. Respiratory infections in the skilled nursing home industry, many are viral, way too many viral infections are being treated with antibiotics. That's an F881 reference. Come down to urinary tract infections, please. Way too many bacteriuria, asymptomatic colonized resonance. And if you study humans 80 and over you'll learn quickly those with a catheter are all colonized 100 percent, and those without a catheter are primarily at least 40 to 50 percent colonized with these multiply drug-resistant organisms. There is an understanding that an antibiotic should not be used unless the resident has symptoms in the low criteria and symptoms in the, uh, CDC's 2012 definitions. Uh, down at the bottom there's reference to what we refer to in long-term care as a multiple drug resistant organism, Clostridioides, now called Clostridioides that many of us have been in the field for 46 years refuse to change. Clostridium Difficile, C Diff, and **** fortunate Clostridioides. And I remember **** sense of humor back in the '70s when we were all learning about anaerobes and we learned how to pronounce Bacteroides. It's a little bit easier for me to say Clostridioides, I can tell you, our long-term care nurses have not embraced that yet, 2 years later. So in other words AHRQ has, in partnership with CDC, an official toolkit for nursing homes. So now, uh, keep in mind what I've reviewed is the core group of CMS because we are inspected, certified, allowed to have a business under CMS and that's the partnership.

Physician, so the second grouping is relative to providers. In our industry physicians, DOs, MDs, we have nurse practitioners referred to as providers, provide the bulk of medical practice in skilled nursing homes. We asked the medical director, and actually there's an F Tag for this, we asked the medical director to follow all IDSA, Infectious Disease Society of America practice

guidelines. Well, at the, first of all they generally don't know what IDSA is, they're not IV docs, they're not specialists, most of them are generalists. So we try our best within the corporations, and it's our job to provide every IDSA guideline. As an infection preventionist, and those of you at the table and on the phone, you all recognize these. These IDSA guidelines are published and made available to my corporate ownership as part of my responsibility as they appear in the journals, Because I'm going to say 99 percent of my industry, uh, do not take all four of these journals, minimally they will take our APEC journal, the AJIC journal but that's in which these, uh, physician IDSA guidelines are presented. Well part of my job this morning was to bring forward what might be published that's not in a journal.

And I'd like to bring to your attention, and it's in your handout, that article published by Dr. Tama in JAMA at the end of last year, the moment it's referred to as, uh, four moments, and the moments are over to your left. The question is, is this an appropriate updated tool which will assist our providers in better antibiotic stewardship. And I would not have submitted it for your review if I thought it was not. And I think it is a very appropriate update. Let's look a little bit further into what's available. I'd like to draw your attention to the acronym. The acronym is the Journal of American Medical Directors Association and what's my point? My point is, every medical director in the United States is charged with being a member of our medical provider association, the American Medical Directors Association. Within JAMDA, is how we pronounce it, within JAMDA we publish medical director guidelines, and here's the one I submitted for your all, published March 18. It's the official guideline for the par, for the participation of physicians in the skilled long-term care setting antibiotic stewardship. Please understand it is disjointed from CMS F881, it is disjointed from CDC's guideline. These are ideas published by very active, very knowledgeable leadership within the American Medical Directors Association. In addition, there are other journals within American Medical Directors Association; the only other one of worthiness is referred to as the Annals of Long-Term Care. Predominantly the articles are written by either a physician or as you see here, Pharm.Ds, pharmacist assistants. That was the end of last year, this is a really very nice article, I would hope all of you all who are interested in long-term care get a copy of this. It's an updated version of our thoughts and leadership, uh, guidance. This one came out, um, December 2018, also from the annals and again remember, these are directives for physicians, the development of an antimicrobial stewardship program, resistance, uh, program within the skilled nursing home. Now that is the end of the second section within my half hour.

The third section I'm especially very, very strongly supportive of. I've been a consultant in the country for 46 years, I can report to you, whether you all agree with me or not, I can report to you that nurses in a skilled nursing home are the drivers of the majority of the usage of antibiotics. No qualitative subjective statement, they are the drivers. Now whether it's right or wrong, we'll learn that when we implement our programs. So I believe very strongly that if they're the drivers, by golly they are the primary leaders and the fixers and the implementers of F Tag 881, antibiotic stewardship programs within the facility. So I would like to offer for you, and please note, March 11, this is only about 2 weeks old, an article that I bring to your attention, and what it says is, we've now documented what those of us in long-term care know. Within the hospital patient population when patients come and go quicker than they've ever gone before, in every state in which I've practiced there is now a push to place, immediately place patients from a hospital into home care. We're, we're admitting, we're readmitting people way too quickly

from home care. This is a really nice article that shows, in my opinion, it's best to put them in a long-term care facility, stabilize them and so we have an advocation recently within this article for nursing home placement and again, where the nurses could be the leadership. If I were to recommend one article for you I would recommend this article. I said at the top, it's the best of the best. You all are used to seeing top 10 books or top 10 reads or whatever terminology you have. I want to tell you why I feel this way. First of all, it is brand new, it just came out. Secondly, that, actually up in the left hand, upper left hand corner it was just published electronically ahead of press in our hospital journal, Infection Control Hospital Epidemiology. And I want you all to take a look at the authors and follow with me the third sentence of the authors. This is directly from CDC's partner, The Center for Quality Improvement Patients' Safety, NAHRQ. In other words, this is an officially, full endorsed blueprint for a 2019 implementation of an antibiotic stewardship relative to F881 in today's skilled nursing homes in our country. And within that I abstracted five bullets. I won't read them because of time constraints, it's included in your package, you can all read that, and do note I'm smiling that I did say Clostridioides and didn't screw up and put Clostridium to make me look like I'm behind times. I want to point out that same article that I pointed out earlier within the physician's section. I do believe that we can incorporate this very same thought process, the so-called four moments. I think we can teach our nurses these same moments, the same principles. So I'm cross-referencing this article that came out very recently relative to nurses and their role in that.

Um, so the other one I'm proud and please take a look at the date, this is an article in press, hasn't been published yet, it's my job and I did pass this on to my corporate leaderships, antibiotic stewardships, and it discusses us in long-term care. We, we sort of, in long-term care want to listen to those of you hospital based, but we sort of would like to have language in our own terminology; in other words, ours are referred to as residents, not patients. And we would like to reference some of our, uh, CMS, um, F Tags and principles, and we find some of these in this article, and I'll let you all read that as you get it. Bottom line, upper right hand corner it says, bottom, at the very bottom of the article it says, education should start with a patient, we mean resident, regarding when an antibiotic is not needed. I'm informing you all that the nurses right there, we very unusually have a provider within the facility and the nurses I think can play a key role in taking their time to talk, for example, talk the family out of mandating an antibiotic for their loved one that has a cloudy or malodorous urine or for whatever reason, I think the nurses can play a real key role in driving non-usage as effectively as they drive usage in a, uh, in the follow, in the facility. Another article that came out in, up in the upper left-hand corner referenced ISICHE just came out 2019, and it's another really, really good article I have found, um, uh, relative to what we can do in our long-term care setting. Now, within this document that you just saw, there's a wonderful table. I think this is 100 percent nurse oriented. I think the nurse in 2019 can use this table and I think, more effectively, reduce the usage of antibiotics, especially with treatment of asymptomatic UTIs, that's the title of it, not minimizing but eliminating, in my opinion, misusage of antibiotics and treating our residents that our colonized and have no symptoms. I'd draw to your attention the bottom of the page, and it says, again, the Lobe criteria. So, I'd like to, again, point out quickly what that Lobe criteria looks like. This 2012 CDC stone definitions that we're to use as an indicator and it suggests, right there in the title, and I'm telling you the surveyors ask that we document why was that resident treated and we document by showing these signs and symptoms, documentation of signs and symptoms. That's a glimpse of what a nurse is supposed to look at as a dryer, a driver of usage or non-usage.

Now, most of you cannot see this in print. We can barely see it sitting here. This is a copy right out of and, uh, reference, we can get a copy of this for you. I can send it to Diane for present, to send off, uh, for this comes from our, uh, great state of Nebraska. Uh, April 27, I'm presenting to all the nurses in Nebraska, as soon they go, get out, if they get out from under their floods, I'll be presenting in the Omaha Lincoln area, and, and I can tell you that if you want the full Lobe criteria in a chart format like this, that's the URL, I would invite you to go to. The third, remember, was the AHRQ's S-Bar. So, what does that look like, how can we use this? What I would recommend to anyone that wants the recommendation is if you put square boxes next to those signs and symptoms, call the provider, mention these symptoms, and then listen carefully for the physician provider to say treat or not treat. We'll probably all be better off in antibiotic stewardship. In other words, it's a tool that standardizes the presentation of the symptoms and whether these should or should not be treated we, again, have to leave that up to the individual medical provider. We click our heels, salute, implement the order, but I think we can do better in presenting in a, a more standard way, and I can tell you that electronically, the, look, reading it, there are a lot of misspelled words. This is a conversion. It doesn't look, it's not spelled like this on the original. This is an electronic mis-conversion. Um, relative to Clostridium difficile, we're now proving that approximately, don't hold me to it but I believe, 20 to 30 percent, 20 to 30 percent of our residents in skilled nursing homes come in the door colonized with the toxigenic, right, OO27, toxigenic strain of Clostridioides difficile. Therefore, we, like with MRSA, understand the colonization is part and parcel of long-term care residency, and I want to begin my comments with you all appreciating that fact, that the data point at the top, 33 percent versus acute care hospitals. So, if you want, we may have twice as many colonized humans in our industry as does the acute care. I'm getting some affirmation nodes within the table, and we start there. Uh, this article came out late, I think, um, I'm looking for the date, but came out late in our American Journal of Infection Control. It talks about our real problem, and I would just wanna say what our real problem in long-term care is with C. diff, it's recurrence. It's not that we don't know how to treat. We understand the new idea, say guidelines recommend starting our residents on oral vancomycin and not the Flagyl that's been failing us, in my opinion, for at least 10 years, at least. So, we understand how to treat. We understand the principals of tapering and pulsing, but they keep recurring. Our recurrence rates in long-term care facilities are anywhere between 30 and 50 percent guaranteed residents get C. diff diarrhea and then go on, some, to get colitis and then some with toxic megacolon, and we don't see them return when we send them to your hospital. So, we have a problem and the problem is not so much, should we use an antibiotic, how to use it, and, I believe, those of you in hospitals have exactly the same problem. As you work hard to reduce your recurrent rates, I'm reporting to you our recurrent rates in long-term care are not going down, they're actually going up, and I think our initial cases and our recurrence is going to be a problem for a while in long-term care and I think all of you all would agree with that. This is an article, it's a late breaker article up at the very top, uh, uh, what we call late breaker. It just came out in, uh, on, uh, on press, ahead of press. Antibiotic exposure with C. diff infection, and it, and there, and there are some long-term care references within that. Now, now, relative to not UTIs and relative to not C. diff issues, but relative to treating or not treating viral respiratory illness in long-term care facilities, I want to refer the audience to this late breaking article. It came out in press. It came out just a couple of weeks ago in AJECK, and it speaks of, and I'll come down to the bottom line, it speaks of teaching nurses to better recognize viral syndrome versus, perhaps, 2 or 3 days after the viral syndrome, secondary bacterial pneumonia, of course, which may require an antibiotic intervention, but it teaches them

how we may intervene earlier and the answer is, maybe some of, we don't know what we have available with our swabs like we do for flu, the PS, PCR testing that quick for norovirus. The PCR quick testing that you all do with multiplex in hospitals for all the viruses, but if we can figure out how to implement quick testing with nurses being the leaders in this, we can immediately separate out viral from bacterial and not treat so many viral respiratory illnesses. We have not incorporated biomarkers like procalcitonin in long-term care, like you have, uh, within the, uh, acute care of the hospital setting, but perhaps we will adopt that biomarker testing as this year goes on. Um, sepsis being the fourth category. Uh, urinary tract infection, C. diff, respiratory infections. There's a really nice review article that just came out, I thought I'd provide my colleagues, uh, with this presentation, and within it, it talks about, and here's my bottom line for you, it's the second bullet, of all the resident, of all the patient's that enter your hospitals, approximately 74 percent of them came in with the sepsis from a long-term care facility. So, I think we as a team and bridging the gap here, need to work together a little bit better in recognizing early-onset sepsis, starting antibiotics that third, I see the fourth bullet, suboptimal care, not only most often there's a delay, almost always there, there is not, uh, within 3 hours of recognition of sepsis, uh, a delay in, uh, administering antibiotics. We got a long ways to go relative to a sepsis management in skilled nursing homes. Um, I'll skip the MRSA and, uh, I'll go directly. My time is up, and the fourth component, just to help you track. First component was CMS regulations; second physician, nurse practitioner involvement; third, role of the nurse; and the fourth component is the role of the pharmacist. I wanna point out to those of you that care, we do have an F-tag for drug regimen review within a long-term care facility. It partners with our antibiotic stewardship program and it specifically, I've underlined, bolded it, specifically charges the consultant nurse with reviewing any pain medication, antipsychotic medication, antidepressant medication, and ta-da, antibiotic medication within what we call our quality assessment and, and performance improvement. We're now calling it QAA or QAPI, Q-A-P-I. Um, within Oregon, I want to point out to you all that we have four major and some of these, four major, and some of these do not reside –

Next Speaker: Amber alert.

Next Speaker: – in Oregon, and I want to point out to you Evergreen Omni Care is based in Vancouver, Consonus is based, based in Portlanery Wilsonville, PharMerica out of state, Pro Pike Payless is based in Vancouver. So, I want to point out to you all, when you think about, well what can our pharmacy services do, they don't reside in Oregon, except for Consonus, Consonus, and I want you all to realize that those pharmacists have directives from their corporate leadership. Uh, within that, that leadership, the pharmacists are directed the following: They sit down with the nurses under that F-tag 757 and F881 and they do what is before you, and I think all of you now know why this is a 1 hour lecture, I'm not reading, I'm not teaching, I'm bringing to your attention the highlights within our timeframe. I want to give total credit to Rosa Tamer for calling me and asking me to present. I feel honored to have presented to my group. I have a 4 hour drive back to Bin, and I shall turn it over to the next presenter.

Next Speaker: We can take a couple questions.

Next Speaker: Yeah, we'd, we'd love to take some questions.

Next Speaker: Yeah.

Next Speaker: If you have time.

Next Speaker: I would love – I have time, uh, I'm now in commute time in your lovely, uh, Portland traffic. I'm going nowhere. Uh, please, I'm available for any long-term care facility question. One of the, one of the experts, I gotta tell you, is sitting at the table. I followed him like a puppy dog for decades, Jay Jay and, and, his publications have been, uh, articles about antibiotic stewardship for nursing homes for years. So, we have a local, national expert within arm reach, almost. So, please address any questions you have. We have a national expert in the audience here. Thank you.

Next Speaker: All right.

Next Speaker: Um, this is Vicky**** with Mark. I just have a comment, um, one that I would encourage, um, ****.

Next Speaker: Vicky you're breaking up a little bit.

Next Speaker: Um, I'm in a terrible location. Is that any better?

Next Speaker: A little bit.

Next Speaker: Try again.

Next Speaker: Um, this is just a comment, um, that Pat might want to share with his customers, um, as far as with, um, for urinary is to, um, to take a look at the service algorithms. Um, I think this might help his customers in reducing their treatment of asymptomatic bacteriuria. Um, so, a couple other, um, resources for long-term care that I think are very valuable are those by, um, Dr. Robin Jump, Dr. David Nase, and, um, Dr. Chris Sternitch who, in addition to Jay Jay, whose a loved, um, those are an additional, um, resources that are practicing in our industry that, um, for antibiotic stewardship that may, um, have published some great materials.

Next Speaker: Yeah, I'll, I'll echo that. Uh, this is Jay Jay, and, um, one of the things, and I know Pat had to consolidate his talk, so the one other issue I think that, that's kind of, um, out there is that about, uh, based on our research, about 35 to, maybe up to 50 percent of antibiotics and in, in nursing homes are actually initiated in the hospital. Uh, and so, when we look at it, in the bladder it starts, but it actually started elsewhere. So, one of the major issues for, for nursing homes is that they have to deal with people showing up or receiving antibiotics, but often with poor information and, and having to make some determinations regarding whether or not they should be continued. From OHSU, which we think we do a pretty good job, um, so we published in OHSU earlier this year that about a quarter of, of patients, it's like 23 percent, uh, discharged to a long-term care facility, um, have at least one antibiotic prescription. Um, and, and, and, so, we're, uh, working with, uh, Vicky and Chris and Robin and others now, um, on a, on a pretty large project involving OHSU and, and Legacy and Wisconsin, um, to try to look at this issue, uh, uh, more closely, so.

Next Speaker: Just an additional footnote relative to antibiotic usage given to us in ada, in, um, from hospitals emergency department. Usage is, I think, and it's my personal opinion, a little appalling the number of antibiotics that are given to our residents because they do microscopic exam and see white blood cells, which are common when a resident's colonized. So, part of that 35, 40 percent antibiotic, I, we get in our country a lot of emergency department usage of antibiotic and they're back for the 7, 14 days, whatever, in our lap.

Next Speaker: Right. So I'll follow that and say so our 23 percent from OHSU does not include the ED. Those are actually inpatient, so if people are actually coming from the hospital and you include the ED, um, it's gonna be dramatically higher.

Next Speaker: Yes.

Next Speaker: Um –

Next Speaker: Yes ****.

Next Speaker: – and so, but when we look at the proportion among start, you know, among, you know, antibiotic use, you know, in, in the, in the facility, um, that does, you know, that 35 to 50 percent does include the ED so, um, you know, I mean other issues we certainly have on this transition are, you know, people get stu, you know, prescribed a week of antibiotics, uh, but will get 3 days in the hospital, then the clo, they restart the clock often when they get discharged, and so they're actually getting 10 days and not 7, you know, or whatever, you know. They, they don't account for the, those days. Um, we've done audits looking at pending tests indication, you know, like health ****. We have data on pending tests. How do we update our, do we have data on, um, what the indication is? Um, and, and it's really not very good, um, and so there's real opportunities for improvement there, but it's incredibly complicated, uh, issue, but it's, what, what ends up happening is like the onus falls on the n, on the nursing home to figure this all out. They're gonna be the ones that have to kind of re, you know, review these but, you know, with, with, um, I think very little help from our acute care hospital sometimes so.

Next Speaker: Now this is a, this is a fascinating subject and I feel like we've just scratched the surface of it, and I think it'd be lovely to kind of come back around maybe in, in one of our future meetings and kind of touch on what's being done in Oregon and how, again, through, you know, HAI, uh, is definitely linked with stewardship, uh, and how, you know, as an advisory committee if there are ways that we can help support our nursing homes here through resources or the local regions disseminating that. Any other comments from the phone?

Next Speaker: Well –

Next Speaker: Great. I just –

Next Speaker: – thank you so much to Pat and –

Next Speaker: – and then I think that, um –

Next Speaker: – we promise to bring more sniff content, uh, in the future to this meeting.

Next Speaker: Right.

Next Speaker: Thank you.

Next Speaker: Um, if there's any other questions you have for Mr. Preston, you can always send them to Rose and she can pass them on to him as well.

Next Speaker: Exactly.

Next Speaker: Call. So great, so thanks and the, the next part of our agenda, um, Rose is gonna, uh, talk to us about OHA NHSN reporting requirement reviews.

Next Speaker: Okay. So this will be a lightning fast, uh, presentation, but I just wanna first of all say, you know, the purpose of this advisory committee as it is written in our rule is that you folks are here to, you know, among other things, look, primarily advise us about our reporting requirements, and, um, we have had some intermittent changes over the years from when the requirements were initially established, but, um, it has been quite a while since any changes have been made to our reporting requirements, and in the past year I, personally, have gotten lots of questions. You know, why do we report this and not that? Can we add? Can we remove? And then recently, we have the ki, I know people have said add, so I'm getting incredulous looks, but it is actually true, um, and then we also have the most recent contacts of our CMS reporting requirement changes at the federal level for, uh, facilities that are participating in quality reporting programs. So we thought it was a good idea to revisit our reportables. Um, we will plan to discuss this again in June, and then we will plan to bring a proposal tentatively to this committee for a vote in September. Um, so this is really just to put the bug in your ear to get you thinking, and we have a limited time. I'm just gonna try to go through it quickly, um, but please do peruse the presentation and the handout, um, you know and, and email me your thoughts, and then if you have opinions on what our reporting requirements should be, please make sure to come, uh, remotely or in person, to our June and September meetings.

Next Speaker: When's your call out?

Next Speaker: What's, what date is the June meeting?

Next Speaker: I don't have the date –

Next Speaker: Okay.

Next Speaker: – memorized.

Next Speaker: I'll find it while she's **** –

Next Speaker: But –

Next Speaker: It's usually late in the month.

Next Speaker: It won't conflict with ****, right?

Next Speaker: So – oh. I'll start by just talking about mandatory HAI reporting requirements here in Oregon, and I wanna mention that we are not discussing healthcare personnel influenza vaccination today. Um, all of our, uh, current requirements are outcome measures except for this one process measure, healthcare personnel vaccination for flu. So we require the reporting of CLABSIs in adult, pediatric and neonatal ICUs, adult and pediatric medical, medical surgical and surgical wards, and for QAPIs it's very similar, adult and pediatric ICUs, not neonates, and adult and pediatric medical, medical surgical, surgical and inpatient rehabilitation wards. We also require the reporting of two laboratory, um, identified events. MRSA bacteremia, um, and Clostridium difficile infections, or sorry, Clostridioides difficile infections. I still haven't made the transition either, and then surgical site infections resulting from six procedures, uh, which I will not read out, but we all are probably familiar with these. I just wanna go through some of the data trends first, because I think it's important for us to have this context when we're thinking about what our reporting requirements are for and what they should be in the future. So these are all on this side, 2016 to 2018, using the new – I'm sorry. These are all from the 2016 report using the old baseline, and we have not validated or published our 2018 data yet, but I'm gonna verbally give some trends over the past couple of years, according to the new baseline. Um, and I will not give LTC data here, uh, in this forum because we really only have one, um, so we'll really be talking about, um, CAUTI, I'm sorry, uh, CAUTI and CLABSI in acute care and critical access hospitals. So we can see that, um, the trend in CLABSIs in adult and pediatric ICUs kind of, uh, you see a little bit of a J-shaped curve, I guess. It's starting to kind of uptick there at the end. Um, CLABSI in NICU is a lot more, um, sort of all over the place, and that's to be expected considering the small amount of data, um, and then for CAUTI in adult and pediatric ICUs we're seeing, um, some stability over the past couple of years with a drop from the initial reporting. Um, in terms of what we've seen under the new baseline, um, across all locations, CLABSI in acute care hospitals, uh, did drop from 2016 to 2018, while CLABSIs in critical access hospitals rose quite a bit from 2016 to 2018, and just as note, in 2016 that SIR was above one and, um, in 2018 we're looking at a SIR that is substantially above one. Um, across all locations, our acute care hospitals saw CAUTI kinda going up and doing over the past 3 years of data, and then CAUTI in critical access hospitals was also kind of up and down, seeing numbers below sort of, below one, um, which is good but a little bit inconsistent. In terms of – and I'm sorry for being so really obscuring these numbers, but I just don't want to give any data that hasn't been validated because these SIRs do change quite dramatically after data validation and the CMS deadline occurs. Um, so in terms of MRSA and CDI, we see MRSA staying pretty stable. Um, looking at the new baseline data, our acute hospitals saw MRSA BSIs going up, and MRSA BSIs in critical access hospitals being pretty stable. Uh, in terms of CDI data, we're see, you know, we can see kind of a little bit of a rise there, um, from the original baseline, and then looking at new baseline data in acute care hospitals, it's, uh, it actually went down, um, and it also went down dramatically in critical access hospitals over the past 3 years, but we will see what the data show after validation occurs. Data trends regarding SSIs. So seeing a drop, uh, in SSIs following CBGB. Um, it actually did go up under the new baseline between 2016 and 2018. KPROs, um, kind of having a little bit more of a complex pattern up and down, um, but saying

pretty stable under new baseline data, and laminectomy, um, kind of falling over the past few years here under the old baseline, but under the new baseline up, going back up quite a bit again, and then our last three SSIs are looking at colos in adults, um, dropping over the past few years, and then staying stable more or less under the new baseline. HPRO staying stable and going down slightly over the past 3 years of new baseline data, and has kind of going up and down both under the old and the new baseline. So options for expanding existing hospital reporting are myriad. We could add new measures. We have many options in NHSN and for this I would sort of start to refer you to this handout which is this large table that you have in your packet. So we could add new measures. Some of our facilities are already reporting antibiotic use and, and antimicrobials, um, and antibiotic resistance data at UAR. There is lab-based surveillance available for other MDROs. There are prevention process measures for MDROs. Um, so, there's another process measure called central line insertion practices. Several opportunities to track and report ventilator-associated events and pneumonia, healthcare personnel exposure and blood safety surveillance. All of these terms are actually defined on your handout. I realize not everyone might be familiar with all of the different options in NHSN. I'm, you know, not super familiar with all of them myself. Um, we can also consider, aside from adding new measures, we can consider adding new locations so CLABSI and CAUTI are located based so we can consider expanding the locations that we require reporting in. We could consider expanding new procedure types for SSI or requiring outpatient procedures to be reported, which is not done at this time, and new variables, like race, ethnicity, date of birth etc., which we currently don't have access to in NHSN, but would certainly be useful and interesting for us to look at. Other than hospitals, we can consider expanding reporting to new facility types, and for this I would really refer you to the handout, because it goes through all of the various measures that are in NHSN, the capabilities for reporting by facility cavalry and the back part of that, um, page goes through all the abbreviations and explains what those measures actually are. So our current requirements apply to acute care, critical access and long-term acute care hospitals, but NHSN can support additional reporting for other facility types, uh, including ASCs, long-term care facilities, outpatient dialysis, inpatient rehab and inpatient psych facilities. I will quickly, quickly go over what CMS requires. Actually, I won't read it out loud. We're probably all somewhat familiar with this. Many state reporting requirements align pretty closely with these, and I have done a little strike through on those that were recently removed. Um, this doesn't cover facility types that only have to report healthcare personnel flu vaccination. Um, until recently, um, hospital outpatient departments, outpatient dialysis, AFCs and inpatient psych facilities were all required by CMS to report. That is parts, part of their quality reporting, and LTCs had to report MRSA bacteremia and BAE. ERFs had to report MRSA as well, so as of October 18th, these are all removed, and just for a point of comparison, um, NHSN requirements in other states. So I always like to pick on New Hampshire since I worked there. Um, hospitals require to report CLABSI in all of their ICUs. CLIP in all of their ICUs. CAUTI in all of their ICUs. SSIs following CABG, colo, hyst and KPRO, as well as healthcare personnel flu vaccination, and then AFCs in New Hampshire are required to report SSI following breast, hernia and open reduction of fracture procedures. Pennsylvania requires its hospitals to report all healthcare-associated infections associated with any inpatient location using the patient safety module, and Alaska is quite different, right? So the, the State of Alaska's program can view reports made by facilities bound by CMS rule concerning certain HAIs. So we could kind of broadly consider that aligning with the CMS requirements, although access is questionable, right. I, I couldn't speak on their behalf. So I know this is very fast. We're gonna wrap up in just a moment. Um, so

these are just questions for you to keep in mind for our next conversation. Again, please email me, please call me, tell me your opinions because we, otherwise we're gonna just come up with a proposal on our own, but we want the advice of this committee. This is what, one of the main jobs of this committee. So please tell us what you think. Should we consider expanding our requirements. Should we consider reducing our requirements, and how can these requirements best support and align with our existing and future priorities, both with the state and within our facilities and partner agencies? So, um, questions, comments should come to me directly and, sorry, we are almost at time.

Next Speaker: Okay. Don't worry.

Next Speaker: Great, and I think that's a great starting point. Thank you for doing that. So again, yeah, any questions or comments please send to Rosa. I'm gonna move on to our final two pieces here, uh, which are, first is discussion topics or future meetings. Uh, if there's any thoughts around that, and what people are thinking about. The first thing that comes obviously to my mind is the recent measles outbreak. I think if, um, someone from the hospital might be willing to share like what they did, how they did it, um, you know, once the dust settles. Certainly not, you know, beat you, but anyways. That was just a thought, and I think that was really, um, you know, affected this region quite a bit and led to a lot of, um, work **** that so that we learned those lessons it would be fabulous. Any other, um, suggestions from the room or the phone?

Next Speaker: I think that it would be good for this group to, or perhaps give g, guidance, um, on location mandate because I think we are all over the map. I know we talked about that before. Um, right, Mary?

Next Speaker: Mm hmm.

Next Speaker: I think we've had a conversation.

Next Speaker: Oh.

Next Speaker: I think there's a need, this is just my personal opinion, but I think there's a need to do some validation on facility location mapping, and, um, we're gonna see what capacity we have to potentially do that this coming grant cycle.

Next Speaker: There are some, um, there are some things that we have access to and some we don't, to follow the CMS guidance or NHSN guidance on it, so and of course the, this whole initiative, uh, in hospitals of care in place is going to complicate location mapping this year, and forward because we've got a step-down unit and a med-surg, or step-down patient and a med-surg all in the same bed.

Next Speaker: I, I was just gonna say that, just looking at your, the rates against, some might just be shift into inventory, and I know NHSN is now having their ambulatory modules for SSIs, so might be good to kind of talk about and look at how we can evaluate that, but, Rosa, the thing I always worry about too is you guys can require reporting, but do you guys have the bandwidth or

the resources to roll out the reports and manage all the follow up and everything that's required 'cause I think that, you know, whatever's required has to be doable.

Next Speaker: And that's the same on the –

Next Speaker: **** –

Next Speaker: – acute care. We'll do **** certain steps –

Next Speaker: Sure –

Next Speaker: – maybe the ****.

Next Speaker: – I mean there are –

Next Speaker: Yeah.

Next Speaker: – any, any changes we make, even if it is removing reporting requirements –

Next Speaker: Yeah.

Next Speaker: – it's gonna create work for our program, right? So we will need to make sure we have some capacity to assist facilities, get them signed on. They will need to be trained to do this reporting. Some of them may be doing it already though. So I think this is just kind of an initial conversation about what is our wish list, right, and then we can start thinking about our capacity. That's my thought, you know. If we want ASCs to be reporting SSIs, let's talk about which ones, um, and then we'll look and see, you know. What are the different proposals on the table and how can we **** them down to a manageable level, but I do think having more, more proposals is better because then at least we have ideas to play with, but, yeah, it is a lot of work I think. So thanks for recognizing that.

Next Speaker: But and, and, and this is Genevieve, for those on the phone, I think just echoing that that's the whole role of this committee is like what is best for the people and patients ****. If you were gonna be a patient tomorrow in a hospital, what would you want hospitals to be working on or ambulatory care surgeries to be working on and be accountable for and trying to **** excel, and, and like Rosa said, it's just a starting point in a conversation. Doesn't mean we do anything different ****.

Next Speaker: Yes, and I, I just wanna clarify too when I mentioned ambulatory, I know hospitals are shifting a lot of their inpatient population to their own ambulatory –

Next Speaker: Yeah.

Next Speaker: – so it's not necessarily ambulatory surgery centers. It's just, again, when you look at those rates –

Next Speaker: Yeah, we talked about that –

Next Speaker: – it's a, it's a higher –

Next Speaker: – **** –

Next Speaker: – it's a –

Next Speaker: – ****.

Next Speaker: – it's a higher risk population than it was a few years ago.

Next Speaker: Yeah, and of course we're constrained right, by the types of –

Next Speaker: Yeah.

Next Speaker: – we're not, uh, talking about creating kind of a new surveillance system here. So we're constrained by the capabilities within NHSN, right?

Next Speaker: Yeah.

Next Speaker: Yeah. We talked about like the inpatient because it's not an overnight **** –

Next Speaker: Yeah.

Next Speaker: – **** but yeah.

Next Speaker: No, I think those are great conversations to have and dealt with too so we understand the changing landscape so. Thanks for that input, and then the last little part if there's, are there any more comments from there, but this, it's all for the, the good of the order, as Dr. Cieslak likes to say. If there's any, um, general comments or clarifications or requests. Otherwise, apparently it's officially spring now, uh, and, uh, so lots of good things. Uh, so we send you on your way. Um, apologies to be a couple a minutes, uh, a few minutes late, but thank you for hanging in there, and we'll see you next time in June. Take care.

Next Speaker: Thank you.

Next Speaker: Thanks ****. Did anyone else join the call while we were, um, during the meeting that didn't get a chance to say their name at the beginning?

Next Speaker: Do you happen to have parking validation?

Next Speaker: Uh, yes I do –

Next Speaker: ****.

Next Speaker: – ****.

Next Speaker: And if you, if you, you can also just email Rosa so we can make sure you get on the list and get credit for showing up. Thank you. Thank you. Have a good day.