Oregon Health Authority

Healthcare-Associated Infections Advisory Committee
September 18, 2019

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

Speaker: Have to like get back to work again, but, uh, glad you're all here. Uh, so my name's Genevieve Buser. I'm, uh, at Stevenson's Providence. I do ****'s I.D., but, um, am currently the chair, and I'm going to begin with the call to order. So, I will start to my right here and we'll start the room, and then we'll go to the phone.

Next Speaker: This is Roza Tammer. I'm the healthcare associate at infections recording epidemiologist in the HAI program at Oregon Health Authority.

Next Speaker: I got ****.

Next Speaker: ****

Next Speaker: Oh.

Next Speaker: Oh, 'cause we don't have the, oh, it's over there. Right. Thank you.

Next Speaker: And we only have one.

Next Speaker: Yeah. **** broken ****.

Next Speaker: Oh sure.

Next Speaker: This is Roza Tammer. I'm the H and I recording epidemiologist in the HAI program at OHA.

Next Speaker: Hi, it's Jon Furuno, I'm, uh, associate professor, interim chair pharmacy practice at Oregon State University, College Pharmacy.

Next Speaker: I'm Nicole Reem, and I'm a patient advocate at the Iowa Speciality Hospital.

Next Speaker: I'm Dave Stevenson. I'm also a patient advocate at ****.

Next Speaker: Alyssa McLean, **** educator and **** Wisconsin ****.

Next Speaker: Lonna Costanvare, **** reporting coordinator at, uh, HA, I'm sorry HAI condition of ACDP.

Next Speaker: Uh, Judy ****, **** position at **** Hugh in, uh, **** Consulting for OJ****.

Next Speaker: Lisa Taheeji, epidemiologist with DHS ****.

Next Speaker: **** physician.

Next Speaker: Danielle Hubble, Public Health ****.

Next Speaker: Okay.

Next Speaker: Lonny Edwards, I'm a hospital surveyor for health facilities licensing and certification ****.

Next Speaker: Laurie Ogden, **** preventionist, Oregon Health and Science University.

Next Speaker: Hi, Dennis Drapiza, regional director of infection prevention. ****

Next Speaker: Julie Koch, infection prevention manager for Salem Health.

Next Speaker: ****, section manager **** acute communicable prevention center her at the Oregon Health ****.

Next Speaker: Hello, I am **** Lamon, and I am the new office specialist for the HAI program in ACDP.

Next Speaker: Uh, Diane Roarin, research analyst, um, OHA, the HA ****.

Next Speaker: Okay, I need –

Next Speaker: Hi, **** Shooty. I'm medical director of infection prevention of Asante.

Next Speaker: Thank you. Or, there's just a couple more folks in the room and then we'll, we'll get to the phone. Thank you.

Next Speaker: Hi, Melissa Parkerton, um, I used to work with HII, HAI when I was with **** safety commission a few year back and just here today as a teacher's assistant.

Next Speaker: And then, Mary can go next.

Next Speaker: Hi, my name is Morgan Onsley, and I'm just a vendor here.

Next Speaker: We have a full house here in the room, so just, I think one more person and then we'll go to the phone.

Next Speaker: I'm Mary Post from ****.

Next Speaker: Thank you. Now, uh, if the folks on the phone could introduce yourselves, uh, we had Sontel ready and then Les.

Next Speaker: Josh, Josh Bardfield, the **** manager for the Oregon Clinic.

Next Speaker: **** team and services.

Next Speaker: Could you repeat –

Next Speaker: **** Weber and **** Diskins from Legacy Emmanuel, and it was very hard to hear most of the people in the room.

Next Speaker: Thank you. Yeah, we'll try to circulate the microphone better.

Next Speaker: Thank you.

Next Speaker: ****

Next Speaker: Dennis, **** Children.

Next Speaker: Dennis, we have you? Who else was speaking?

Next Speaker: Uh, Pam Cortez, director of quality and safety Salem Health.

Next Speaker: This is Ryan Zen, director **** services for the Portland Clinic.

Next Speaker: Pat Preston representing long-term care calling in from Bend.

Next Speaker: Ordella ****

Next Speaker: **** Spokane.

Next Speaker: I think we might need both of you to repeat yourselves.

Next Speaker: Odelfric, uh, nurse analyst from Legacy Health.

Next Speaker: Joyce Carmella, **** Health ****.

Next Speaker: Tracy Warrick from Saint Anthony Hospital, Pendleton Infection Prevention.

Next Speaker: This is Heidi Steeves, the executive director at Oregon Patient Safety Commission.

Next Speaker: **** Practice Consulting for the Oregon Nurses Association.

Next Speaker: Well, could you repeat that one more time. The connection wasn't very good.

Next Speaker: Jessie Kennedy **** for **** Oregon Nurses Association.

Next Speaker: Excellent. Thank you. And there was someone who mentioned earlier they're from DHS, but we missed your name.

Next Speaker: Deb Cateora.

Next Speaker: Oh, Deb Cateora. Hello. Thanks.

Next Speaker: This is Melissa Sheck from Samaritan Hospital.

Next Speaker: Sharon Hunicky from Good Samaritan Hospital in Corvallis.

Next Speaker: Any last persons? Once, twice? 'kay. I think we're good.

Next Speaker: Good.

Next Speaker: Uh, so that ends roll call, and next we'll have a logistics update from Roza.

Next Speaker: 'kay. ****

Next Speaker: Hi, everyone. Thanks for joining us. Um, at our third meeting in 2019. So, um, a couple of logistics updates. Um, as you all probably know we added a webinar option, um, to our meeting invitations a few months ago, and we're gonna, going forward, starting with this upcoming meeting, request that everyone who's attending these meetings, whether you're, I mean in person is fine, but if you're planning on remotely attending these meetings, you will need to register for the webinar. Um, we're doing this so that we know who is attending these meetings more consistently. Uh, as you probably noticed, it's difficult for us to hear, um, everyone's information over the phone if we don't know who you are already. Um, so we will be sending out that webinar registration information going forward, and just so you know, you can still just call into a phone line. There's no need for you to be on a computer, but we ask that you register for the webinar, so we can track whose coming. Um, any questions or comments about that? Okay. Um, a few updates regarding, um, our membership. I just wanna welcome, um, our new labor representation. Um, Jason, do you wanna introduce yourself?

Next Speaker: Jessie.

Next Speaker: Jessie, I'm suh –

Next Speaker: ****

Next Speaker: – Jesus, I'm so sorry. I don't know what I'm saying. I'm sorry. Jessie, Jessie Kennedy.

Next Speaker: Yes, so, I am a nurse practice consultant with the Oregon Nurses Association. Um, fairly new to the position. I've only been here since June. Uh, previous to being a nurse practice consultant I worked for Pefelt at the Oregon Network Clinical Nurses Educator, and previous to that I was an ICU nurse for 3 years or so. Um, and in the **** pool prior to that. As far as board experience, I was the president of the National Student Nurses Association and then I was on the American New, American Nurses Association Board of Directors for two terms.

Next Speaker: Thank you so much, and we're really excited to have you joining us. Um, and just thank you to Jordan, uh, Barris, who served in this position for quite a while. Um, we also have a new member, um, from the Oregon Patient Safety Commission. Uh, Heidi, would you like to introduce yourself?

Next Speaker: Sure. So, I am decided to join the work, um, with this committee. I'm most recently with Kaiser Permanente. Hi Dennis. I hear you in the room.

Next Speaker: Hi.

Next Speaker: So, um –

Next Speaker: ****

Next Speaker: – I was, uh, ambulatory, uh, quality and patient safety new director. **** could be and have a lot of operations experience and, um, definitely, um, excited to, to work with y'all, uh, with all of you.

Next Speaker: Thank you so much for joining us. So, welcome to our two new members. Um, and then finally I just want to mention that, um, we have an, um, Genevieve, you serve a wonderful chair, um, and she has actually been in her position, as chair, for over 2 years now, and our sort of formal term limit for our positions on this committee is 2 years. So, I think at this point I will just say that if, um, anyone is interested in putting their name forth to be considered for being the chair of this committee, um, please email me directly. Um, we can talk about what that might involve, and this person would need to be already a formal member of the committee meeting that you occupy a formal position.

Next Speaker: Can members nominate someone?

Next Speaker: Um –

Next Speaker: Or is it simply –

Next Speaker: I don't see –

Next Speaker: – by –

Next Speaker: – why not. Yeah.

Next Speaker: ****

Next Speaker: Yeah, this, this September is 2 years right now. Or this meeting is 2 years. So.

Next Speaker: Yeah, ****

Next Speaker: So, thank you for you –

Next Speaker: And if anyone has questions about what it involves, um, please feel free to reach out.

Next Speaker: Thank you. Did someone else join us on the phone?

Next Speaker: Uh, yes I did. Uh, my name Graham. I'm in infection prevention at, with, uh, **** Newburg.

Next Speaker: Thanks Graham. Okay. Okay, so next, uh, on the agenda is to approve the June 2019 moo, minutes. So, if anyone would like to give a motion to approve, one of the members of the committee. And for those in the room, the minutes are in the packet.

Next Speaker: **** I should abstain.

Next Speaker: Do, it's usually members that approve and we need a first and a second if anyone moves to approve the minutes. And, apologize for the feedback. Don't know why that's happening. Um, it's, for those on the phone if you can mute if you're not speaking. In case it's that. We're not sure.

Next Speaker: Okay.

Next Speaker: Okay, we think it, okay, never mind.

Next Speaker: Microphone.

Next Speaker: Maybe it's in the microphone.

Next Speaker: **** Yeah. I can't tell.

Next Speaker: We'll see. Mm hmm.

Next Speaker: And it's off. I know it's not the ****.

Next Speaker: Again, would, uh, does anybody move to approve the June 2019 meetings?

Next Speaker: Sure.

Next Speaker: I have a first over here. Do I have a second?

Next Speaker: Mm hmm.

Next Speaker: Okay. Thank you very much. The minutes are so approved. And next we will move onto update on the OHA, NHSN reporting requirements.

Next Speaker: Thank you. Um, so I'm Roza. I'm gonna be presenting on this agenda item today. So, this is something we've been discussing at, um, all of our HAI advisory committee meetings. So far, um, this year, as well as hop, having brought it to a couple of our Oregon and southern Washington Apec chapter meetings. So, many of you are probably already familiar with this conversation, um, but the, uh, essentially our goals are two-fold here. We wanna be ensuring that our reporting requirements are addressing the priorities of Oregon's patients and infection control community, and also be responsive to feedback that we get from our infection prevention partners and stakeholders regarding what our recording requirements should look like here in Oregon. And **** a little further context we really haven't made, um, substantial changes to our reporting requirements since they were sort of originally, um, **** by this committee, which happened quite a while ago. So, we're having ongoing conversations about this. And we are gonna actually start out with a vote. So, we have brought forth a number of different potential changes, and we've been having, as we've been having these ongoing conversations, we've been refining, um, you know, what we want to be seeing in our rules, which establish what our reporting requirements look like here in Oregon. Um, so I think everyone should have, um, an impact statement in their materials. I believe that's on Page 22 of the printed, second to last page, and then folks who are joining us remotely, you will also have access to that impact statement in the materials that were posted.

Next Speaker: Listed online ****?

Next Speaker: Online.

Next Speaker: Online. Not in the email right?

Next Speaker: What?

Next Speaker: Online.

Next Speaker: The, the document requested online on the website or were they in the email to just the direct people?

Next Speaker: Yeah, they're online and also –

Next Speaker: I'll sort them out.

Next Speaker: Well they're in the, yeah the –

Next Speaker: **** packet.

Next Speaker: They're in the packet. Yeah.

Next Speaker: In the packet. So they would, so for those online that would be with the materials that came with the reminder for the meeting, and also online at the HAI website. If you're looking for them. So, we have discussed, um, removing laminectomy SSIs from reporting requirements. Um, right now we require our hospitals here in Oregon to report all laminectomy procedures to the National Healthcare Safety Network, and then perform surveillance for those, um, on those patients for surgical site infections. Um, so I would direct you to the impact statement, um, you know, we are discussing kind of the need to, for the rule here in this impact statement. Um, Oregon Hospitals have made pretty good progress towards preventing SSIs following laminectomy surgeries, especially over the last 3 years. Our data for that, um, procedure look better than they do for any other procedure other than coronary artery bypassed, hi, bypass graft surgery which we are not considering removing at this time. Um, we have received recommendations from our infection prevention partners and stakeholders that removing this recording requirement would not impact their access to, to useful data for HAI prevention, um, and that it would also free up some existing resources, potentially to perform sur****ance for higher priority procedures. Um, so we are proposing to remove laminectomy surgical site infections from hospital reporting requirements for Oregon Hospital. Um, the document also kind of shows what data we're using which are our own published data as well as data, um, published by CDC and, um, information, uh, regarding national targets for prevention published by the Department of Health and Human Services. Um, we believe that this role change will marginally reduce costs to us here at OHA, um, as well as the hospitals and health systems that have reported laminectomy in the past. Um, **** on facility staff time for treating, data collection and reporting will be reduced, um, by a small amount, I think, and then, uh, it will also reduce the burden on our staff time here at OHA for technical assistance, data validation, analysis and publication. Again, I would say it's a pretty marginal reduction. Um, we don't believe that small businesses will be impacted by this because we don't believe that the facilities who report them are small businesses. If you heard from us recently, and we asked in an email if you are a small business, please respond to us and let us know. Um –

Next Speaker: If, if you wanna show this on the ****, uh, after this –

Next Speaker: Oh. Oh. Thank you. Um, and we have included the proposed language here on this slide as well as in the impact statement itself. So, with that being said, I think we'll just, uh, have a discussion, and then after the discussion feels complete then we'll have a vote, and just to remind those of us who are nominated members of this committee can vote today. Um, if you are a voting member you will have a green sticker on your name tent. If you are not sure if you're a voting member because you don't have a name tent or because you're just not sure, just, um, I can come tell you. So, with that being said I think we'll just, um, open up the floor for conversation, and then those of us in the room, just a reminder to please use the microphone since I think it's difficult for folks to hear.

Next Speaker: **** question.

Next Speaker: Yes, Monica. Can you wait for the microphone?

Next Speaker: Yeah ****.

Next Speaker: I also wanna say, actually, I'm sorry, this, I'm like going on for a really long time. This is just the first kind of step in enacting this change. So, I don't want the, I guess, expectation to be that once we vote on this, this voting requirement is gonna just, um, disappear, uh, Steve, you wanna add something?

Next Speaker: Yes, cuh, I mean, what, I think what you're saying, uh, so –

Next Speaker: Yeah.

Next Speaker: – basically just as the advisors committee's recommendation relating to this. So that's, that's, it's, it's not whether or not it actually happens.

Next Speaker: Right. Right. So we're, we wanna have the recommendation firmly in place from our advisory committee, and then there's a number of internal steps that need to take place –

Next Speaker: Right.

Next Speaker: – here within our agency. So, just, just to make that expectation clear, and that is the case for all of the changes that we're gonna be voting on today and going forward.

Next Speaker: **** the process and ****.

Next Speaker: Um, my quick question is on the bottom of this impact statement it says some of these home businesses were involved in the development of this rule. It says you reached out to 21 facilities and then it says all 12 respondents. So, am I assuming 9 didn't respond?

Next Speaker: We have only received 12 – Yes.

Next Speaker: Okay.

Next Speaker: Exactly.

Next Speaker: Okay.

Next Speaker: So, there is nine of you out there who got an email from us asking if you were a small business so those nine straggles, please let me know whether you count. And, now worries, this is there draft impact statement. Right? So, it's fine if you haven't responded until now but we would like to make sure that we're covering all of our bases.

Next Speaker: Do we have a quorum of voting members that ****?

Next Speaker: Do we have, is there a quorum of voting members?

Next Speaker: I actually don't know if there's a quorum -

Next Speaker: Okay.

Next Speaker: - of voting members right now.

Next Speaker: So, we might need to defer the vote until we know that.

Next Speaker: Thank you. So, we might need to defer the vote until we know if we have a quorum -

Next Speaker: Based on who's on the phone –

Next Speaker: - but I think it will help –

Next Speaker: - as well.

Next Speaker: - us with the discussion.

Next Speaker: Oh, yeah. Absolutely.

Next Speaker: Yup.

Next Speaker: Absolutely.

Next Speaker: And if the Infectious Preventionists wanna comment on it since that's from the hospitals –

Next Speaker: We're –

Next Speaker: - uh, Mike, we just have the one ****?

Next Speaker: ****.

Next Speaker: Okay. ****.

Next Speaker: **** from OSU. **** that OSU is in full support of removing laminectomy surveillance.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: Uh, Julie, Salem Health, uh, we're also in full support of removal of the laminectomy requirements.

Next Speaker: I think there's a representative from Providence on the phone and, uh, maybe Asante I believe.

Next Speaker: ****. This is Kirsten Schutte from Asante. We're in support of removing the laminectomy.

Next Speaker: This is Dennis Drapiza. I'm from Kaiser Permanente. We are also in support of removing laminectomy.

Next Speaker: Mm hmm.

Next Speaker: Is there any, um, hesitations, or concerns about it, or otherwise? That part was pretty ****.

Next Speaker: Uh, this is, um, Judy from Legacy Emanuel and is this gonna be replaced by another procedure? I guess I'm trying to understand is this just to reduce surveillance volume? Is it intended to be replaced with another procedure? I think, there should be consideration for high-volume, high-risk procedures. You know, if the intent is, uh, surveillance for the procedures is to improve patient safety, um, we have seen laminectomy SSI events so I don't know that we necessarily are fully supportive of removing that.

Next Speaker: I think, um, Dat Tran, are interim program manager is going to, um, respond as soon as he gets a mic. Thank you for that though. I think that's an excellent comment and –

Next Speaker: I did ****.

Next Speaker: - point well taken. So, just one moment.

Next Speaker: **** some things that **** I think, um, we are being improved into a **** approach and I think you will see that as we present some of the data on this key reporting, um, -

Next Speaker: Whoever is speaking, we can't hear you.

Next Speaker: Do you, I don't think that the, I don't think the mic is being amped enough to get to the –

Next Speaker: Hello?

Next Speaker: 'Cause it, the amp is over there. You might have, Dat, you might have to come up here and talk into the –

Next Speaker: ****.

Next Speaker: Because it's not, it has to still be amped to get to this microphone so.

Next Speaker: Hi. This is, uh, Dat Tran. Is this better?

Next Speaker: Yes, -

Next Speaker: Yeah.

Next Speaker: - thank you.

Next Speaker: Thanks. So, I think we're in agreement with what you just you just c, commented. I mean, obv, obviously, we're looking at, um, a streamlining process and, um, in taking this away if this is the, um, the agreement, you know, amongst the panel and then us internally, uh, it's to then look at other opportunities to identify high-priority, um, targets. Um, related to, and, and we'll have a little bit of discussion about this as we present date on, um, ASC as well as, um, other relevant procedures for, uh, hospitals. I guess one of the things that I would, maybe, ask, um, what of our members to present- And, I don't know if we have that data readily available. Is to provide some context about SSI associated with laminectomy in comparison to the rate for SSI for other procedures that we are currently, uh, mandating reporting. So, I don't know, I know we have, general, um, national data. Right? And, Lisa can present that. But, I don't know if we, if we have Oregon's specific data on, on hand. And, Roza's smiling at me as I'm, I'm putting her on the spot. I don't know. Maybe Lisa can start with the nationals just to provide some context as a, as a general.

Next Speaker: ****. Oh, boy. Yeah. Oh, yeah. So, it looks like there is a data slide coming up for, um, known procedures that we currently have.

Next Speaker: This is just for Oregon.

Next Speaker: Just for Oregon. Um, but, nationally I did pull data for 2017, um, showing, you know, how laminectomies, um, compare to some of the other procedures that we don't currently have in our reporting requirements. Um, so, nationally, um, the SRI for laminectomies was 0.84, um, and then, uh, fusion, spinal fusion was another procedure that, um, was mentioned. Now, we currently don't have **** and that, um, had an SRI of 1.03. Um, essentially, like, 1,200 infections, um, reported across the U.S. versus with laminectomies around 350 infections. Um, there is also a fracture, open reduction of fracture procedures that had an SRI of 1.12 nationally, um, with around 420 infections reported in 2017. Um, so, that just gives you some context nationally about, um, I guess, how laminectomy, how we're doing with laminectomies compared to some of the other SSIs.

Next Speaker: Uh, Roza, is there anything else you wanted to share?

Next Speaker: ****.

Next Speaker: Did anyone have any questions around that data?

Next Speaker: Three people ****.

Next Speaker: Yeah. Wasn't there a re-baseline in 2015? And, I'm just wondering if we're really looking at, looking at apples to apples. Sorry, this is Judy from Legacy.

Next Speaker: Yeah. That was, that was 2017 data so that's all using the re-baseline.

Next Speaker: So, she's –

Next Speaker: I just don't –

Next Speaker: there's 20 –

Next Speaker: - see that on display. I see up to 2016 –

Next Speaker: Oh.

Next Speaker: - it was what's on the web. What we're seeing in the webinar.

Next Speaker: Yeah. Sorry. This is not, um, data that's on the webinar. I just had it pulled. Um, so, sorry, it's just something I can, I state it verbally but it's not, uh, in contents with the webinar slides.

Next Speaker: Is that for Oregon or -

Next Speaker: That's –

Next Speaker: - the U.S.?

Next Speaker: - for the United States.

Next Speaker: So, for the United States it was dated through 2017 but what's on the slides is only Oregon through 2016.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: So, we've either some, um, I don't know, I don't know if that data could be shared after the meeting? Just the, and circulate so folks can have that as well to, for that decision? Uh, the other question I had, if you could clarify, is even if we don't say for Oregon that it's reportable to NHSN, individual facilities or healthcare systems, 'cause it would kind of, of course, continue, decide to continue to monitor that if they feel like they have issues or concerns that they want to track forward so it has this doesn, of course, doesn't change any of that. but, I think you're, the, the comments are, are appropriate. If we stop looking at it, will something, you

know, will people stop paying attention to it. Uh, and I believe in our last, the last meeting there were conversations on -

Next Speaker: ****.

Next Speaker: - what types of infection that we might replace or do instead of –

Next Speaker: Yes.

Next Speaker: - and that, I don't know if that's part of the conversation today or future conversations about, um, what, what might we want, what would people, perhaps, want to add as far as, um, -

Next Speaker: ****.

Next Speaker: - high-impact HAIs to prevent?

Next Speaker: Yeah. We are gonna have more of that conversation later today if there's time during the agenda.

Next Speaker: Mm hmm.

Next Speaker: I think, um, -

Next Speaker: ****.

Next Speaker: - what we replace lam with, if, if anything, and –

Next Speaker: ****.

Next Speaker: - who will be reporting those data will be, just kinda, a separate conversation so that this is not a vote to remove lam and introduce something else. We'll be voting on additional procedures to add to either hospital inpatient, hospital outpatient and potentially ambulatory surgery center, outpatient procedures surveillance. Um, in, kind of like, future iterations of this conversation, this was the, um, proposal that felt most agreed upon and ready to come to the table for a vote. If we have a quorum, which is what we're trying to figure out right now. If that makes sense? So, so, we can certainly just flip forward. Are there any other comments regarding the removal of laminectomy though? Thanks, Judy. That was, that was very helpful. Yes. So, just that we have, you know, the select SSIs that we can potentially add to hospital reporting and potentially adding SSI reporting requirements for ASCs. So, those are on the table to discuss but were just going to be focusing on the vote to remove the lam at this point. So, sorry I interrupted.

Next Speaker: Okay.

Next Speaker: That's okay. This is Kirsten Schutte from Asante. I just pulled up the Oregon.gov website and the very helpful tables and maps that you have. And, so I'm looking at the 2017 surgical site infection data for laminectomies and it looks like the all-Oregon SIR was .396.

Next Speaker: Which is in the national e, what's the **** oh, that's SIR.

Next Speaker: And, so I don't have the national values so you'll –

Next Speaker: ****.

Next Speaker: - have to reiterate that but the, um, the 95 percent confidence intervals range then from, uh, -

Next Speaker: **** okay –

Next Speaker: .193 to .727.

Next Speaker: So, laminectomy saw a national SRI of .842 in 2017 which was about 15 percent fewer infections than predicted. So, we saw .3. So, it's, like, over 70 percent fewer infections than the predicted.

Next Speaker: And, that's the state level and, um, you c, you, that's. Sorry. Never mind. What I was gonna say.

Next Speaker: No. It's okay. What were you gonna say?

Next Speaker: Just that that's 1 year with the, with the baseline and versus, you know, a trend. But, it has been, it seems to have been a trend over the last couple prior years.

Next Speaker: Right. When we look at the six procedures that we follow here in Oregon at the state level, um, certainly lam is the one we're performing best on, again, other than CBGB which no one has, uh, recommended we remove surveillance for at this time. And, I'm seeing heads shaking around the room. Nodding. Shaking. Agreeing. So, thank you, Kirsten, for that data. Would anybody else like to have anything put on this and I don't, and I guess have we determined whether we can do a vote or just we'll end with the discussion today and, maybe, we can do a vote offline.

Next Speaker: I think we're still working on whether or not –

Next Speaker: Okay.

Next Speaker: I have the ****.

Next Speaker: - well, let's, let's go ahead and –

Next Speaker: - ****.

Next Speaker: - ****.

Next Speaker: You mean a show of hands?

Next Speaker: No. That's just our total. So, you –

Next Speaker: So, -

Next Speaker: - wanna ****?

Next Speaker: 'Cause we have to have a quorum. So, do we wanna go ahead and –

Next Speaker: ****.

Next Speaker: So, what we can do right now is as we, kind of, work on this, um, in the room, we can move forward with some of the other discussion on this agenda item. Where are we on time? We are ready to –

Next Speaker: We have 'til 1:45.

Next Speaker: 1:45.

Next Speaker: For this.

Next Speaker: Okay. Cool.

Next Speaker: So, we got ****.

Next Speaker: So, we have a few more minutes so as we work on this, what I'm going to do is just since it seems like a really seamless transition, we'll just, kind of, talk about the other proposals on the table as they relate to SSIs. It, does that sound okay to everyone? Okay. So, ongoing discussion. These are my, kind of, guiding questions for us. Right? So, is there support for these changes? You know, what are the major challenges and opportunities that you see, um, that are posed by the changes that we're discussing today? And, if a change were to be made, you know, what would the ideal proposal look like for you? Um, over what time period would we wanna implement any new requirements? And, what kinds of capacity-building activities would be most useful for facilities? So, um, we have discussed adding select SSIs to hospital reporting. We have talked about adding currently reportable inpatient procedures to outpatient procedure hospital reporting requirement. And, I have listed our currently reportable SSIs here and I've crossed out lam. I think we would not be discussing adding that requirement on if we're also discussing removing it. So, we can certainly revisit that if needed. And, then we have talked about adding new procedures to hospital reporting requirements as inpatient or outpatient, um, surveillance. And, these, which we just looked at, are our data trends in Oregon for our procedures. You should have in your packet. And, then we have some national acute care hospital SSI data from 2017 published by NHSN. And, what I, kind of, did is broke these down

into procedures and we've seen these slides before. Procedures that have, uh, standardized infection ratio of over 1 in both adult and pediatric populations. And, then on this second slide it's the procedures that had SRIs of greater than 1 in adult and then pediatric. Right? So, these are not the same procedures on this slide but on the previous slides. These are the ones that we're seeing that SRI of above 1 in both age groups. So, I think this is the most, kind of, relevant slide here. Um, -

Next Speaker: May I ask a stupid question?

Next Speaker: No stupid questions JJ.

Next Speaker: Is Cesarean section under peds?

Next Speaker: Is the what?

Next Speaker: It's –

Next Speaker: Cesarean.

Next Speaker: - Cesarean section under peds? Those are our infants that were born via Cesarean section that had an infection. Th, these are peds that actually had a Cesarean section?

Next Speaker: I would assume by requesting their **** -

Next Speaker: It's anyone under the age of 18.

Next Speaker: 18. Yeah.

Next Speaker: Oh.

Next Speaker: So, it would be, uh, yeah. A C-section –

Next Speaker: Oh.

Next Speaker: Well, **** -

Next Speaker: - in a patient under 18.

Next Speaker: Okay. I'm glad I asked that.

Next Speaker: Yeah.

Next Speaker: It's very –

Next Speaker: Can I ask a question?

Next Speaker: Yes.

Next Speaker: Should I just yell?

Next Speaker: Uh, -

Next Speaker: ****.

Next Speaker:

Next Speaker: No –

Next Speaker: Sorry.

Next Speaker: Okay.

Next Speaker: Uh, how many hospitals in Oregon perform kidney transplants?

Next Speaker: So, this is, this wouldn't be a question that I could answer –

Next Speaker: ****.

Next Speaker: - at this point. but, I think, let me just say if you have data in your facility or health system that can help us have these conversations, - You know, we're limited by what people are performing surveillance for. Right? So, we don't have Oregon data for these, you know, other infection types necessarily because we don't have a surveillance requirement. So, it's just like self-fulfilling prophecy a little bit. Um, so, folks in the room who have data and they wanna contribute to the cause, we can de-identify your facility and put it in a slide for the next time we revisit this conversation.

Next Speaker: I think I can have that information for you –

Next Speaker: Can you –

Next Speaker: - by the next – Yeah.

Next Speaker: - ****.

Next Speaker: ****.

Next Speaker: Can you repeat that with the mic?

Next Speaker: Yes. Um, I was just –

Next Speaker: Yeah.

Next Speaker: Is the mic working?

Next Speaker: - I, I think I can get the information about –

Next Speaker: ****.

Next Speaker: - the kidney transplants, uh, for you for the next meeting.

Next Speaker: So, those on the phone, Wendy Edwards gonna look into that. From -

Next Speaker: Oh, okay.

Next Speaker: From Compliance.

Next Speaker: Thank you.

Next Speaker: ****.

Next Speaker: Yeah. And, as we're talking, for the folks on the phone, let's introduce yourselves before we make a comment. Sorry if I did not remind. And, I haven't been doing it either. Okay. So, I think, it sounds like we have 12 of our –

Next Speaker: Yes.

Next Speaker: - 16, um, members here –

Next Speaker: Mm hmm.

Next Speaker: - in attendance at this meeting so, If I'm understanding correctly, that should constitute a, a quorum.

Next Speaker: Mm hmm. It does.

Next Speaker: So, with a few minutes left – Hmm?

Next Speaker: I don't know if everybody knows what they're voting on.

Next Speaker: ****.

Next Speaker: So, what we can do is read out names and how folks vote or –

Next Speaker: Yeah. We can do, I guess we can do that.

Next Speaker: I don't' know what the best way to do it is since we have a mixed group of phone and in-person attendees. Um, -

Next Speaker: **** go down the list.

Next Speaker: Down the, yeah, I was gonna say so the ones that have, the ones that are starred are the ones who are voting members. Correct? Okay. So, uh, just, starting, so, uh, so Joshua Bardfield. Who is also on the call. If you have a vote and you can vote yes or no –

Next Speaker: Or you can abstain.

Next Speaker: - or, or you can abstain as well.

Next Speaker: So, Josh Bardfield? Are you possibly muted? Josh?

Next Speaker: Yes. This is Josh. Sorry. I had to hop off.

Next Speaker: Are you, would you like to vote on the lam proposal here?

Next Speaker: On the current, so the current proposal is to at least submit, eh, basically it's to submit the, uh, impact statement saying that we're requesting changes, uh, to remove the laminectomy surgical site infections after procedure, uh, for post-discharge surveillance. It does not mean that this is nece –

Next Speaker: Uh, **** okay, we approve. Again, I apologize for hopping off.

Next Speaker: Oh, no problem. Uh, next is Deb Cateora.

Next Speaker: Uh, yes. Um, I think I'm gonna abstain since this is not part of our population at all.

Next Speaker: Okay.

Next Speaker: Although I don't see any objections.

Next Speaker: Okay.

Next Speaker: Thanks, Deb.

Next Speaker: Uh, next is Kelli Coelho.

Next Speaker: I approve.

Next Speaker: Okay. We have an approval. Uh, next is Pamela Cortez.

Next Speaker: I approve.

Next Speaker: Next is, uh, Dennis Drapiza.

Next Speaker: I approve.

Next Speaker: Next is Wendy Edwards.

Next Speaker: I approve.

Next Speaker: Next is Jon Furuno.

Next Speaker: Approve.

Next Speaker: Next is Jessie Kennedy.

Next Speaker: Approve.

Next Speaker: And, next is Pat Preston.

Next Speaker: ****.

Next Speaker: Uh, abstain.

Next Speaker: Okay. And, uh, next is Kirsten Schutte.

Next Speaker: Approve.

Next Speaker: And, next is, is Heidi Steeves.

Next Speaker: Approve.

Next Speaker: Okay. Great. Okay. Well, thank you very much for noting that and, uh, they will go ahead, I think that the comments and concerns that were raised are valid and, you know, that individual facilities, you know, even if this does go through, could still, of course, continue to monitor that if they like they have local issues that they're tracking.

Next Speaker: Yeah. Thank you for bringing that up. These are all things that can be monitored on a voluntary basis and NHSN. So, if you're facility chooses to continue monitoring lam and it should until we have a date –

Next Speaker: Mm hmm.

Next Speaker: - um, after which reporting isn't required anymore, um, please feel free to do so. Um, I also wanna mention, again, sorry for beating a dead horse here, but if you have not responded to the email stating if you're a small business, please do. And, finally, if you have any comments or addition to the impact statement that we shared, please let me know. We want to include your perspectives in that document. It will only make it stronger. So, please do go ahead and review that impact statement and let us know your thoughts on it.

Next Speaker: Okay.

Next Speaker: Sorry for a somewhat disorganized voting process here.

Next Speaker: We haven't done this in a, I don't think we've done this in a very long time.

Next Speaker: We don't do it very often.

Next Speaker: We'll, we'll, we'll try to do better next time.

Next Speaker: Yeah. But, I, I, I was just gonna say, you know, if, in the future what we could potentially do is try to just do, like, a mail one –

Next Speaker: Yeah. We know.

Next Speaker: Right.

Next Speaker: - if we have that kind of situation. 'Cause, and I was thinking about that because usually, in the past, most of the people were here but this time it looked most of the people were on the phone so that's, -

Next Speaker: Mm hmm. Mm hmm.

Next Speaker: - kind of, what I would recommend. Something in that direction.

Next Speaker: And, just, I think we just have to –

Next Speaker: Just do like email vote or something.

Next Speaker: Right. And, -

Next Speaker: And, we have done that –

Next Speaker: Yeah.

Next Speaker: - like years ago.

Next Speaker: Okay.

Next Speaker: But, there have been circumstances like that. But, yeah, we have –

Next Speaker: If the committee's –

Next Speaker: We used to –

Next Speaker: - okay with that,

Next Speaker: - do a lot of this.

Next Speaker: - we can do that.

Next Speaker: And, it's been a while. So.

Next Speaker: Okay. Thank you

Next Speaker: Thank you.

Next Speaker: Uh, -

Next Speaker: Okay.

Next Speaker: - and, then, yeah, and I think the other piece that, um, well, and we may not have time for it this time, but this did come up at the pri, previous meetings about, um, potentially, uh, you know, if there's nothing that's on that, sort of, national NHSN acute care hospital SSI date reporting that really appeals to the committee or to Oregon and the facilities, that one of the things we entertained we also what to do for the, um, uh, surgical centers and maybe choosing one I, you know, after speaking with that, the, those facilities, what would be one high-impact, um, SSI to follow and start, kind of, broadening the scope. So, -

Next Speaker: We think all of these conversations are on the table. I think what we don't wanna do is vote on something, um, kind of, contingent upon how another vote goes.

Next Speaker: Right. Oh, yeah. The laminectomy **** -

Next Speaker: So, -

Next Speaker: - separate from this. Yeah.

Next Speaker: - but, so I don't know if that will be able to be part of the future agendas or how that conversation will continue.

Next Speaker: I think we're gonna continue having those conversation –

Next Speaker: Correct.

Next Speaker: - in these meetings until we're done. So, watch this space.

Next Speaker: Okay.

Next Speaker: All right. Thank you so much.

Next Speaker: Okay. Uh, we, uh, at this point are gonna take a quick break now because the second half is gonna be very full. Uh, so, we'll be back in about 5 minutes. Stretch your legs and we'll continue with the second half.

Next Speaker: Okay.

Next Speaker: ****. Thank you.

Next Speaker: Um, we're really excited. We, uh, a interesting, we got some, uh, - What am I trying to say? Some visitors here to j, for a patient and family advocacy panel that we will get to. But, first we're gonna start with Dat Tran who's gonna, uh, discuss about furloughing of healthcare workers after vaccine preventable disease exposure. Let me get you to the right – Sorry.

Next Speaker: There are no slides. I don't think.

Next Speaker: Yeah. There are no slides.

Next Speaker: Mm.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: There, there are –

Next Speaker: No.

Next Speaker: - no slides.

Next Speaker: No slides. I know.

Next Speaker: Yeah. There's no, - Okay. So, first of all –

Next Speaker: We'll just stick it there but –

Next Speaker: Yeah. There are no slides. Um, first of all, -

Next Speaker: ****.

Next Speaker: uh, Paul Cieslak, uh, sends his regrets for not being h, being able to be here to present this to you. So, I'm presenting on his behalf. So, I think this, this, uh, rule, um, that

we're thinking about comes out of, you know, our recent responses to, um, measles cases and we've identified this SSI as a gap in, in our rules. So, we just want to bring it forth and, and see, uh, what you all think. So, we, so, uh, so this rule that we're talking about, currently there's a rule, uh, I'll state the number, 3330190010 and the, the title of that AOR is Disease Related School Childcare and Worksite Restrictions: Imposition of Restrictions. Okay? So, that's the rule we're talking about. So, this particular rule that's currently, as written, um, excludes unvaccinated, exposed school students. And we, it's clear that we have the authority, uh, to rule that unvaccinated, exposed healthcare workers be excluded but it's not explicitly stated, uh, in the rule in which, I guess, the way it want it to be written. So, we that to protect patients, uh, unvaccinated healthcare workers exposed to diseases that are contagious before definitive symptoms are recognized, such as measles, um, these, these, uh, healthcare workers should be furloughed for an inc, for, for one incubation period. So, in terms of the actual language, um, I'll just try to r, to, to, kind of, focus on the most important part, um, so, as currently, uh, that's written in, in the rule, uh, if you are to look right now, uh, there's a paragraph that currently states to protect the public health an individual who attends or works at a school or childcare facility or who works at a healthcare facility, or food service may not attend or work at a school or facility while in a communicable stage of a restrictable disease unless otherwise authorized to do so under these rules. That's a, that's a mouthful. Right? but, I think the key there is that, so, there's some, you can see there's some generalities about restriction. But, then under that currently, there are specific paragraphs addressing each of those groups of individuals. So, there's a g, a paragraph that talks about school or children's facility. There's a paragraph that, about a susceptible child. There's a b, a paragraph that talks about a susceptible employee of a school or children's facility, um, but, there's no specific paragraph that talks about an employee of a healthcare facility. And, I think, we felt that there should be a paragraph that explicitly calls that out. So, the proposed, um, I think, um, language currently that's, that, that I have here is that there's a n, a separate number, uh, called, and it's inserted into nothing in this rule prohibits and there is that language already in there. but, the addition to, under that, uh, under that particular item, "nothing in this rule prohibits" would read something like this. The authority or local health public authority from excluding an employee of a healthcare facility or a food service facility, I should say, who has a restrictable disease or who is susceptible. So, I'll read it again. The authority or local public health authority, uh, from, so, sorry, **** I'll read it from the beginning. Nothing in this rule prohibits the authority or local public health authority from excluding an employee of a healthcare facility or a food service facility who has a restrictable disease or who is susceptible. So, relevant to this group is the healthcare facility. I wanna point out that already in there, um, is this paragraph. The infection control committee at each healthcare facility shall adopt policies to restrict employees with restrictable diseases or who are susceptible to restrictable diseases from work in accordance with recognized principles of infection control. Right? So, that's already in there. You still have that, that, um, capability and that mandate but this allows us the authority to, to restrict.

Next Speaker: What's the number of that again?

Next Speaker: The number?

Next Speaker: The -

Next Speaker: The ****.

Next Speaker: ****.

Next Speaker: - AOR?

Next Speaker: The rule, the rule to the AOR –

Next Speaker: ****.

Next Speaker: - uh, 3330190010.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: So, I guess in, maybe we can just talk about the principle not so much the language. Um, what does everybody think about the principle of having, of us having the authority to restrict, we, healthcare workers?

Next Speaker: So, this is Genevieve. Uh, if I could ask a clarifying question. So, this would be in the situation where there's a healthcare employee who's in a county and they're talking to, and they're talking to the state and you would be able to supersede that? Or, in addition to what they can do at the county or the hospital? Or, in conjunction or like does this, um, like is the scenario that this would be something where the, the, they're seeking outside the county for input and guidance? So, that you would, as a s, when you say **** has the authority, you're really talking about the state like –

Next Speaker: The state.

Next Speaker: Oregon Health Authority –

Next Speaker: Oregon Hea, Authority –

Next Speaker: - not county –

Next Speaker: - or, no, or –

Next Speaker: ****.

Next Speaker: - local public county.

Next Speaker: Or local. Oh, okay. So, it would include the c, it includes the county.

Next Speaker: Includes the county. Yup.

Next Speaker: Okay. Okay. That's helpful 'cause I didn't know if this was –

Next Speaker: No.

Next Speaker: - state. Okay.

Next Speaker: No.

Next Speaker: This is talking about county and state?

Next Speaker: Yeah. Exactly.

Next Speaker: Okay. Thank you.

Next Speaker: Yeah. And, and, and it, it, really it may not, you know, in practicality, it may not have an impact because we would expect – Right? Healthcare facilities to act in a manner that protects their patients so it may not come to pass that it has an impact. but, I f, I think we feel that it's important that we have this authority to, um, order healthcare workers not to return to work.

Next Speaker: This is, uh, Deborah Cateora.

Next Speaker: Hi, -

Next Speaker: ****.

Next Speaker: - Deborah.

Next Speaker: *** hi.

Next Speaker: Could you speak up a little bit Deborah? A little bit more?

Next Speaker: Oh. Sure. Yeah. Sure. Let me get the phone closer to my face ****. Um, it seems to me that this would help make it clear that there is already an expectation because, you know, they're already, um, um, various rules including in our programs, um, around, uh, the, uh, caregivers give need to, you know, they can't have communicable diseases. And, I think some of the problem I see is all the way **** and it's not a real straight path on who has the authority. Even though, I think, technically, we could get there. Um, -

Next Speaker: ****.,

Next Speaker: - with what, you know, if you look at all the, the rules. So, from my perspective, I think, that it's, potentially just make it clearer. And, I agree, it might not have any real impact, um, except in rare occasions.

Next Speaker: Any other comments for or against, or questions regarding, or clarifications?

Next Speaker: Yeah.

Next Speaker: ****. I agree with the last comment. I think this would be incredibly helpful for clarifying exactly what the expectations are. I feel like, um, oftentimes there is a, a general understanding of what should be done to some extent but very little, um understanding of what could be done be should, um, an employee choose not to, um, take the necessary precautions which is a real potential risk for patients so.

Next Speaker: So, would th, would this rule empower facilities, um, to implement your own infection prevention polices respective for all their employees?

Next Speaker: ****. Um, -

Next Speaker: This is Kirsten Schutte from Asante. I think that one of the groups that this might help us with, um, is for those of us who have credentialed but not directly employed, um, staff as well. I know that falls, probably, under the letter of the law, uh, but sometimes it can be harder to enforce so I think having a backup where our own, you know, policies and internal processes, you know, there's a little grey zone. When their not direct employees of our facility that would be helpful to have the backup from the state. Have that authority as well.

Next Speaker: The state and county. Yeah.

Next Speaker: You All right. ?

Next Speaker: Public Healthcare.

Next Speaker: ****.

Next Speaker: Thank you.

Next Speaker: So, I'm just not –

Next Speaker: This is –

Next Speaker: - clear –

Next Speaker: This is Deborah. This is, this is Deborah Cateora again. Oh. This is, this Deborah Cateora again. So, for DHS, we do look towards the healthcare **** local community Health Department to give us feedback because in our agency those are the things which determine when somebody, um, has met those, uh, prescriptions on, um, working and clinical behaviors.

Next Speaker: So, Deborah, we're, we're having, can we, can you say that again now that it, um, the buzzing's off?

Next Speaker: Oh, okay. Um, what I was gonna say is DHS –

Next Speaker: Oh. No.

Next Speaker: - um, as an agency actually was forced the health division or the local county health department to make that determination about whether or not somebody **** or they should not be in contact with residents. We, ourself, **** that authority even though we have **** rule we've adopted **** so that would be another way for it to be helpful.

Next Speaker: It's hard, but, I know, I think, we understood.

Next Speaker: Yeah. I think we, I think we, we –

Next Speaker: ****.

Next Speaker: - we, -

Next Speaker: You can go into summarize it.

Next Speaker: Yeah. So, so, I think, just, sorry, Deborah. So, I think, essentially, the, the short of it is that what Deborah Cateora is saying is that, um, this rule would also help DHS, um, in effectively, um, implementing, uh, their own rule for requiring, um, furloughing of, of employees. Is that, is that a fair s, quick summary?

Next Speaker: Um, yes that is. Especially, since we would already be looking for help with any, or the local, um, Health Authority ****.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: Right. So, what Deborah's saying is they're looking towards us, um, to, kind of, exercise our authority.

Next Speaker: It sounds like Deborah has, like, there's some specific issue with the phone. I'm just wondering if she could, possibly even, hang up and call back or something.

Next Speaker: Yeah.

Next Speaker: It just sounds like it's her –

Next Speaker: ****.

Next Speaker: - connection I think.

Next Speaker: Yeah. Deborah, do you mind, um, i, is it possible for you to hang up and then call back and see if the connection's a little bit better? 'Cause it's, I think it's, it appears as –

Next Speaker: Sure.

Next Speaker: - you're speaking, um, the static increases. Thank you.

Next Speaker: Okay. I'm, I will hang up. Bye.

Next Speaker: Okay. Thank you.

Next Speaker: Uh, this is Julie, um, would this, um, not having it in front of me, I'm sorry, I'm just trying to reflect on what you said –

Next Speaker: Right.

Next Speaker: - Dat, but, um, did it include individuals who have been exposed but not with disease?

Next Speaker: Right. So, it's, it's about individuals who are susceptible, exposed but before they develop disease.

Next Speaker: Okay. So, exposed, non-vaccinated –

Next Speaker: Right.

Next Speaker: - for example.

Next Speaker: There are specific – I mean I can read it to you. You know? "Evidence of immunity means that" and there's a whole bunch of things. Right?

Next Speaker: That's –

Next Speaker: Has received the vac, vaccinations recommended by the CDC, um, has up, has other evidence of immunity to **** disease as specified by the CDC. So, that's, like we have definitions about what susceptible means or what evidence of immunity means. And, then we also have about definitions for susceptibility for each –

Next Speaker: So, -

Next Speaker: specific criteria.

Next Speaker: - so, is the focus really on, um, susceptible for developing disease or would it also encover those that come to work with communicable disease?

Next Speaker: That's a different rule.

Next Speaker: That's a different –

Next Speaker: That's a different rule?

Next Speaker: Yeah.

Next Speaker: So, we're really focusing on exposure and –

Next Speaker: Exposure.

Next Speaker: - susceptible.

Next Speaker: Yup.

Next Speaker: Asymptomatic, exposed susceptible asymptomatic.

Next Speaker: ****.

Next Speaker: Uh, this is Laurie. I would just encourage you to keep it really broad and say infection control or employee health in case they're separate departments.

Next Speaker: The, the paragraph about infection control committee. Is that what you're talking about? That section?

Next Speaker: Uh, I can't remember.

Next Speaker: I think, yeah.

Next Speaker: ****.

Next Speaker: 'Cause I think –

Next Speaker: - we read **** -

Next Speaker: - - the, I think the infection control committee at each healthcare facility shall adopt policies to restrict employees so you, what you're saying is change that to what you just said. Correct?

Next Speaker: Oh. I thought you just referenced just the department of infection control. Sorry.

Next Speaker: It did.

Next Speaker: I didn't hear that right.

Next Speaker: No. It did. –

Next Speaker: ****.

Next Speaker: It does just say infection control committee so –

Next Speaker: Yeah.

Next Speaker: - you're saying to add employee health –

Next Speaker: Well, keep the picture to be broader.

Next Speaker: - ****.

Next Speaker: Employee health. Right. Okay.

Next Speaker: But, I think that most of the places an infection control committee oversees **** weighted policy –

Next Speaker: Well, -

Next Speaker: - and procedures ****.

Next Speaker: - how descriptive does it have to be? I mean, can it just say the facility has to do it? And, then they, I mean, I don't know.

Next Speaker: I mean, these, this, I think these are, we can take this back. I mean this is language that's actually currently in place –

Next Speaker: Uh huh.

Next Speaker: - so that terminology we're, actually, not changing. I'm just, I'm just providing context for you. Right? So, this part is not, we're, we're not looking to change the terminology but if you think that this is important we can certainly bring it back, um, to our legal counsel to, to, t, and Paul to think about does it need to be that specific? Right? Or, or should it be more general?

Next Speaker: Well, for, like, long-term care, a number of facilities won't have an infection control department or they'll have a person maybe?

Next Speaker: Right.

Next Speaker: Um, part of a person?

Next Speaker: Right.

Next Speaker: So, I think, again, how, it depends how descriptive you want it to be –

Next Speaker: Right.

Next Speaker: - and, um, -

Next Speaker: I think it's a good point. I think it's a committee issue.

Next Speaker: Patient safety or –

Next Speaker: Force.

Next Speaker: Yeah. Forces us to look at a broader healthcare facility definition than hospitals' settings so –

Next Speaker: It also –

Next Speaker: - make sure it applies -

Next Speaker: ****.

Next Speaker: - at the system level.

Next Speaker: Yeah.

Next Speaker: Any other –

Next Speaker: Comments?

Next Speaker: - comments? Questions?

Next Speaker: Should we s, have a have a quick vote? An aye or a nay? So, -

Next Speaker: Oh. We're not asking for a vote?

Next Speaker: Oh. Well, if you just wanna say, I should say –

Next Speaker: No. I just, I just –

Next Speaker: - **** sounds most people are -

Next Speaker: -Yeah. I just wanna make sure, like, are there any concerns? Right?

Next Speaker: You want, like, a thumbs up?

Next Speaker: Thumbs down? We think this good? take it forward –

Next Speaker: I think, we just wanna get a sense of feedback. You know? Um, are there any particular concerns and, um, You know? and, and there'll be a different, kind of a, time for voting. It sounds like, overall, from what I can gather, they're, they're not, um, those overall, overall support for this.

Next Speaker: And for differ, and for different settings too.

Next Speaker: And, from different settings. And, then there are not any particular, certain concerns other than s, uh, maybe the language. Some of the language. Okay. All right. Well, thank you for your time.

Next Speaker: I just wanted to be able to say, the ayes have it. I just wanted to.

Next Speaker: You ****.

Next Speaker: Okay, great, thank you, so, next on our agenda is, uh, patient and family advocacy panel, and Rosa is going to introduce our guest.

Next Speaker: Yes.

Next Speaker: **** away.

Next Speaker: Thank you. So, um, I wanna just preface this by saying, um, you know, in our HIA program, we do not regularly interact with patients and families and healthcare consumers here in Oregon. And we talk a lot to the folks in this room and the kinds of folks on the call today, you know, our infection preventionists and our I.D. documents and our patient safety professionals across the state, um, but we really don't hear the voice of people who are impacted by healthcare on a personal level. Um, we do have a wonderful consumer advocate on our HIA advisory committee, Lisa Freeman, and we had, um, really great consumer advocates in the past; Dee Dee Vallier, and we want to build our ability to incorporate this voice into the work that we do. So, I have been working with Tom Healy, who's here in the room, and he's with AmeriCorps Vista. Um, and we have been reaching out to all of our hospitals across Oregon, to find out, as a starting point, if they have a patient and family advisory committee and who convenes that advisory cumulative trauma, and trying to kind of create with the, I think with ultimate goal of creating, um, a relationship between our program and consumer and patient advocates here in Oregon. We have relationships with our infection preventionists. You folks know who to contact if you wanna talk about HAIs, um, but it's not totally clear that HAIs are even on the radar of patient and family and consumer advocate groups or that folks who are working with those people know that we are here as a resource as well. Um, so with that kind of being said, our first step was to convene a few people to come here and talk about what their experience has been at one of our healthcare facilities in Oregon, um, working as patient advocates and doing patient and consumer advocacy and how that has or hasn't, or may in the future, intersect with work on healthcare-associated infections, and I wanna give Tom an opportunity. Uh, Tom, do you wanna talk a little bit about the outreach that you did?

Next Speaker: Actually, ****.

Next Speaker: And a big huge thank you to Tom for all of his work on this.

Next Speaker: All right, um, yeah, so just kind of what Rosa said. Like, even though these meetings are open for the public, um, a lot of people might find them inaccessible, um, both 'cause not everyone is very close to Portland, but also, people who might be interested in HAIs might be a little intimidated by, you know, the content and language, um, you know, of the meetings that most people don't really understand that well. So, I feel like this is a really great opportunity to give all the people at the HAIs, you know, an opportunity to have their voice heard. Um, yeah, and I was speaking with a lot of infection preventionists throughout the state and patient and family advisory committees. Um, not, a lot of, or, there are a lot of, um, people that didn't know about HAIAC, so, you know, I feel like this could be a good first step in kind of getting the ball rolling as Rosa says a lot, and I like. Um, yeah, and to try and, to get a better relationship with these different groups and just try to, um yeah, hear the voices, um, of people throughout Oregon, um, and their concerns about HAIs and how we can all, you know, try to help each other. And I'm really grateful that Nicole and Dane are here, and I'm excited to hear what they have to say. Yeah, thank you.

Next Speaker: Thanks Tom.

Next Speaker: **** to use the microphone ****?

Next Speaker: Yeah, why don't you folks both come up here, –

Next Speaker: ****.

Next Speaker: – and **** mic we have right now. So, I'm gonna ask you both to introduce yourselves, and –

Next Speaker: Of course.

Next Speaker: – these folks are from our, uh, one long-term acute-care hospital here in Oregon, which is Vibra.

Next Speaker: Hello, I'm Nicole, and I am a patient advocate at Vibra, like Rosa said, and I was invited today to speak about the intersection of patient advocacy and infection prevention and to just represent the perspective of patients and families that are impacted by HAIs. And I am very excited, we are very excited to be here, so thank you for having us and Tom for reaching out. Um, so, if you don't know about Vibra, we, like Rosa said, we're the only long-term acute-care hospital in the entire State of Oregon, which makes us very unique. Our average length of stay is 3 to 6 weeks, and we specialize in wound care and respiratory care, and all of our patients are referred from other hospitals, so often our patients have been through, um, something very medically traumatic, and frequently, they come to us due to HAIs. And then our roles, as the patient advocates, um, are to check in with the patients about how their care is going during their stay and to do our best to guarantee patient satisfaction. Um, we provide a listening ear to both patient and family concerns and issues, and we do our best to investigate and resolve those

issues, and we also provide a lot of emotional support for patients and families when needed. Um, one way we can prevent infections is through education, and that often becomes the role of the patient advocates. Um, as the patient advocate, I am als, um, I am often called when patients or families are upset or distressed. And a great example of this is that, many of our patients and family members are unhappy with our policy at Vibra not allowing children under the age of 12 on the patient floors. And this is, of course, because children are at a higher risk of contracting infections, patients are at a higher risk of acquiring infec, infections, 'cause they are all so sick, and, of course, children are just famous, famously carriers of all the most-recent strains of bacteria and viruses. And usually, after I educate the patient and the families about this, they usually understand, because people wanna keep other people safe. No one wants to get someone else sick, and we also, um, have a policy. Uh, we have a room, a special room that we allow patients who are able to sit in a wheelchair to sit with their families and with children under 12. Um, another example of this is following isolation precautions so, because our patient population is very unique and our patients have all been hospitalized for very-long durations of time, they are very susceptible to HAIs. Uh, many of our patients come to us with infectious agents that require isolation, um, and family members often feel that they are exempt from this, um, in following isolation precautions. Though it is not my job at all to enforce this policy, as the patient advocate, I am responsible for the wellbeing of all of the patients in the hospital. And safety is always the first concern, so I take time to educate the family members about the importance of following the isolation precautions and the risks, um, associated with not following the isolation precautions, so that they're not only putting themselves at risk, but they're also putting every patient in the entire hospital at risk. And this doesn't always go so well. Um, we once had the wife of a patient who was staying in the patient's room every-single day all day, and she refused to comply with this policy. The patient had an active-and-communicable HAI. Um, when the staff attempted to educate the family member, she got very angry, very upset, and she actually filed a complaint with the hospital and still refused to comply. Uh, this put many of our immunocompromised patients at risk, and unfortunately, I don't have a pretty ending to this story. HAIs harm patients, their families, and, in situations like this, risk the lives and the health of dozens of other patients in our hospital and in all hospitals. Um, I wish I had an answer, but, just as it's not my job to enforce this policy, my job today is to help you know the challenges and costs of HAIs on the wellbeing of Oregon's patients. Also, her, her main argument was, I should be able to hold my husband's hand without having a glove. This skin-to-skin contact was very important to her. Um, I also, uh, have patients open up to me a lot about the emotional impact of being in isolation. Patients describe it as dehumanizing, it makes them feel diseased, uh, gross, like a monster. Those are words they use, um, and they often do struggle with the skin de, the lack of skin-to-skin contact, especially from visitors and family members. Um, and it's just a constant reminder of how sick they are and their, their current situation. Um, and, uh, as the patient advocates, we also facilitate a weekly family support group, and we hear a lot of fears from family members, and we also, uh, get to hear about a lot of the challenges that they face. Um, we're, like, since we're the only long-term acute-care hospital in the entire State of Oregon, we get patients from all over, even other states sometimes. And family members have to travel from far and wide to visit their, their loved ones in the hospital, and I'm gonna let Dane talk more about some of the fears that they face and the challenges that they face. And also, he's gonna tell a story about the emotional and financial costs of hospital-acquired infection, so, thank you.

Next Speaker: So, my name's Dane Stevenson, and, uh, I've been a patient advocate at Vibra for about a year. And, uh, while it is, while it is, as Nicole said, it's our job to, to listen and, and hear the concerns of our patients, um, we, we hear a lot of stories, a lot of really heartbreaking stories. And, uh, because, uh, Vibra Specialty Hospital is a, an unusual kind of hospital, we end up with a lot of very, uh, very-severe patients, patients who have experienced, um, really traumatic things, and their healing is, uh, significantly slower than the average patient. And so, uh, that frequently comes with a history of hospital-acquired infections. Um, uh, our family support group is, uh, is a place where we, we meet with the families of, of these patients, and we talk with them on a weekly basis, uh, and we hear a lot from them, the, the fears that their pa, their family member will get another infection. Uh, they'll be, like, we've been doin' this for six, we've been doin' this for 6 weeks, we've been doin' this for 3 months, and they're on their path to recovery and then something will hit them. Uh, they'll get a flu, and that flu will send them back to the emergency room, and we'll be here for another 3 months. They're sleeping in their cars, um, and there are some real, uh, yeah, they're sleeping in their cars, they're, they're tryin' to juggle a life and a job and kids and also be the emotional support that their family member needs, and it, it's, it's truly tragic. So, I have a story to share with you. Um, afterward, if you have any questions, Nicole and I are happy to help you. So, a while back, we had a patient come to us who had, um, who had been in a motorcycle accident. He had several, um, lots of broken bones and, uh, some brain injury. And while he was in the, the short-term acute hospital, he developed a, uh, uh, multi-drug-resistant infection that went systemic, and, uh, he ended up I the short-term hospital for about, uh, 2 months before he was stable enough to come to Vibra. Once he's stabilized, he was still in antibiotic treatment. He came to Vibra, and we began to care for him. At this point, the wife had already been through hell. Um, she had, she'd already, um, realized at this point that her husband had a very-difficult time emotionally handling care, uh, especially when she wasn't present. So, during the 3 months where he was res, receiving care, or the 2 months he was receiving care at the other hospital, she had come to the realization that, whenever she left his side, he began refusing care, so she determined that, in order for her husband to get better, she needed to be by his side. And so, by the time they came to us, she was a constant presence in, in his room. Uh, this was, of course, very challenging. She had to ask for an extension at work, a long, a long absence, uh, and it wasn't easy. She ended up in my office frequently, uh, with tears. Um, the, the combination of, of depression and anxiety that comes from months and months in a hospital, combined with, uh, his brain, his brain injuries caused him to occasionally, uh, become vitriolic and angry, uh, and he, he would pour that out on her. And, but then, when she would leave, he would just start tanking. His health would start tanking, and she'd get a call, he, he fell out of bed or he, you know, he, we had, we had to call a rapid response, and she would rush back. So, it's just, it was a truly terrible, um, story. She, she stayed with us for months. Um, this, this patient would get better and better, and then, uh, a UTI would happen, or a, uh, they would go to the, they would go to the hospital to get a, the other hospital to get a CT, and something would happen in transit. Um, and the person, this, this individual's, um, uh, immune system was so compromised that any exposure, uh, caused him to, to get, uh, some new infection. Um, eventually they were with us long enough that she lost her house, uh, they lost her car, um, so she was living in the hospital. It got to the point where she was, she was, uh, struggling to find food, and she was living in the hospital with us. At one point, uh, his condition, his condition worsened. He almost had a fall, and so they moved him to the high-observation unit. Um, and when he was in the high-observation unit, tho those rooms are smaller in our hospital than the, the other rooms, and so there wasn't room for her to sleep.

And she came to me crying, saying, where, where am I gonna sleep, um, so we ended up putting her up in one of our, our doctors' overnight, um, rooms for a while, until he stabilized and was able to go back to a larger room. Um, eventually he had a, he had an incident, um, I can't remember what it was, and he was, he was discharged to the emergency department and he, he passed away. Um, and to, uh, as of a couple months ago anyway, uh, she was homeless and jobless, and everything, her life had been ruined by this event. Um, she had poured out everything, she'd given everything she could for her husband, as any of us would for our spouses. And, uh, there's no insurance that covers homelessness, there's no, there's no healthcare plan that's going to prevent this sort of thing from happening. And I wish I could say this is the only time I've known patients to lose their homes while they were, uh, while their family members were at Vibra, but I've known at least three other family members who have lost homes because, uh, they are, they're giving their best for their family, and, uh, sometimes that means losing everything. Um, hospital-acquired infections cost, cost lives, as we know, but they don't just cost the lives of the patients. They often cost, uh, are, are incredibly detrimental to the lives, lives of family members. And so, we need to be very careful, um, and we need to do the best we can to prevent infections from happening, and then also, provide, in whatever capacity we can. I know as a patient advocate, there's very few things that I can do. Um, I, you know, I can make a, I can put around a collection to try and, try and get some materials, some, some basic living materials, but there's only so much that we can do. We need, we need some sort of, um, we need to understand that the cost of hospital-acquired infections is not just numbers, that it is people's lives and livelihoods and, uh, it's hurting, hurting a lot of people.

Next Speaker: Thank you Dane.

Next Speaker: So, um, if you have any questions about our work, uh, and the families that we interact with, or, um, how, or anything really, uh, Nicole and I –

Next Speaker: ****.

Next Speaker: – are happy to answer questions or, or talk with you after the meeting today. Um.

Next Speaker: Just thank you so much for, that's an emotional thing to hear, and I imagine it's emotional to tell the story as well, um, and it's quite a shift from the first part of our meeting today, and it's a, pretty much a departure from most of our meetings. But I think it's really good for us to remember, even if it's kind of painful to dwell on these stories, that, um, we are –

Next Speaker: ****.

Next Speaker: – very much wrapped up in numbers and statistics and reporting requirements and things of that nature, but that, behind every number is a lot of other, there's, uh, many stories. So, I just, we have, um, like, 15 more minutes here. I think that, if there are questions, comments, there are many of you who are coming from health facilities and the clinical setting here in, in the room and on the phone. Um, so, hopefully we can just have a conversation about, you know, you know, how can we do better at representing this voice in our work and our program and that, how can we kind of develop these relationships for the long term, right? We have, again, **** networks of people who do infection prevention here in Oregon, and those of

you who are IPs or who have served in that role, you know, again, we're here as a resource for you. You can ask us questions, you can ask us for stuff, data, help, whatever it may be, and we go to you and ask you for those things too. And, what I would like to see, I don't know if other folks in the room have any reflections on this, but to have that same kind of relationship with our patients and family and consumer advocate groups, so they can represent their perspective to us, and we can be a resource to them as well. So, with that being said, I'll just, we'll just have a discussion and share any thoughts and feelings we might have for the next 15 minutes.

Next Speaker: I mean, I just wanted to say, I, I'm, I'm actually really happy to hear that we're kinda thinking about this stuff more in this direction. I think it's, it's on some level a long time coming. I think we have had some level of interaction, but, as someone who's, I mean, my own mother died from, uh, HAI. That's why I got involved in this work, and I'm pretty happy that we're actually starting to, you know, think more about that kind of engagement. I found, your presentation is very interesting, 'cause I don't think people talk enough about those kind of other effects on **** and other, otherwise. So I don't quite know exactly, I've experienced some of that myself, but I don't know exactly, yeah, what we could do about it, but I like, it, it's interesting to me, so yeah, thank you.

Next Speaker: Do you, um, get your families involved in, um, any of the work on HAIs in your organization, um, or do you get involved at all in, uh, prevention work or having people right at the table?

Next Speaker: Not really, no. The most I do is just taking upon, it upon myself to educate people to, I mean, really, the main thing is just properly gowning and gloving before going in rooms, but ****, oh, um, but not really. We don't have any programs that involve family. We don't really have any, –

Next Speaker: ****.

Next Speaker: – we don't really have any current programs that involve families being, um, working with this.

Next Speaker: We do have the family support group, and then, from our meetings with the family support group, we report to, uh, the leadership team the sort of things that're coming up. And occasionally we'll have something that his HAI related come up during our meeting, and it will get reported to the, to our infection prevention team, but we just act as a mediary between the families –

Next Speaker: Yeah.

Next Speaker: – and patients and the, the team. There's no, there's certainly no official position, uh, that has us at the table.

Next Speaker: Um, the reason I suggest it, we have, um, on several occasions, pulled in, um, volunteers, who have been patients in our facility, to sit on HAI prevention, um, teams, to really

be there for the patients' perspective. It's a, a slightly different turn on what, your roles, but, um, it's, um, it, it makes professionals sitting at the table be human.

Next Speaker: Mm hmm.

Next Speaker: Um, where they could say no, we could never do that, um, and all of a sudden, they've got a patient there who may have experienced the **** or something, um, and they've gotta explain themselves. It changes the tenor of the conversation.

Next Speaker: That's brilliant.

Next Speaker: That is a great recommendation. I will, um, talk about that with, our current infection prevention is Tara, who I'm, I think some of you have worked with?

Next Speaker: Yes.

Next Speaker: Mm hmm.

Next Speaker: Yeah, and she's the reason we're here, so, yeah.

Next Speaker: Hi, this is, uh, Dat Tran. Just a quick question, not nes, not just for you, but I think for all of the other, um, facility, facility representatives in the room. Um, you know, do you have an approach, right, to engage, um, patients and families within your facilities that could be shared, uh, amongst the group, um, to have a best practice, right? So, for example, are there facilities, um, advocating for families, to empower them to, for example, remind healthcare workers to wash their hands when they're, you know, going to, you know, see a patient? I mean, that, you know, that kind of work, where there's education, but there's also, um, a system in place? I'm just wondering whether there's an opportunity to do that, uh, broadly.

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

Next Speaker: You don't wanna do **** talking Julie?

Next Speaker: No, no ****.

Next Speaker: I would just say we're getting better and better at this, at trying to include. Um, we have a patient family that is **** committee now, um, and we're trying to at least have our patient family education looked at by someone who's in the committee, just to get feedback on, on those, um, education pieces that are there, um, leaflets or, um, through the verbal education that we're giving to people. But I do think there's still opportunities to improve with, with bringing in patient and family advocates.

Next Speaker: Mary posted, I'm trying to, um, we do have a, a patient-family advocacy committee and take a lot of recommendations, and, um, we have, um, implemented a lot of family educational material around HAIs as well and prevention and, you know, curricular, really trying to work with just nursing staff alone, at reinforcing the types of things we'd be need

to be teaching and talking to families about. You know, because they, too, can, you know, help maintain a lot of those bundled elements, like keeping Foley bags below the level of the bladder and things like that. You know, those are the types of things we want them to know, um, that they can be involved in **** they need to care for. But I agree 100 percent, the infectious, I mean, I just, we, sadly in healthcare, there's some very, very devastating, um, HAI infections **** very long term, and, um, you know, especially for adolescents and younger children, there's just the emotional impact of isolation I think is, has been long researched, and, and there's a lot of psycho, psychological detriment, um, to isolation. So, we do what we can, um, to individualize care as much as possible, um, for the child, so they can leave the room, they can go to school. You know, under certain conditions, they can be in a playroom and things like that.

Next Speaker: I said that, um, this is Jen. I was wondering, Mary, if there are other thing, other things besides, like, the bladder bag or sort of things that you have found that are amenable to having the patient and –

Next Speaker: ****.

Next Speaker: – the family, be, is it hand hygiene or just a couple of the other things, like, curious.

Next Speaker: I mean, I mean, we talk hand hygiene, you know, and we have some families that're diligent about that –

Next Speaker: Mm hmm.

Next Speaker: – and some families that even disinfect things, –

Next Speaker: Mm hmm.

Next Speaker: – disinfecting surfaces and things. Um, we also, uh, teach a little bit about central lines and ensuring the central lines stay, uh, dry, um, –

Next Speaker: Mm hmm.

Next Speaker: – you know, that they're not getting wet, um, with bathing or showering and that type of thing. Um, so, you know, we certainly do what we can to ensure they're not removing their dressings and things like that as well.

Next Speaker: Thank, thank you Mary providing me, um, the Class C bundle piece. We are actually giving this, um, an **** card to the patient or to the family member who's in the room and having them, uh, go through all the, uh, maintenance bundle with the nurse as they go through each step of it. And then, uh, that's actually helped coordinate care between the **** infusion clinics and then also their inpatient chemo, so it's actually standardizing things.

Next Speaker: Thank you Lauren. I wanna just give folks on the phone an opportunity, um, if anyone wants to speak who's on the line.

Next Speaker: Okay.

Next Speaker: And this is, oh, this is, this is Genevieve again. I just have a question for our panel. Um, you mentioned, uh, like the visitor policy **** thing. Are there a couple, are there just some, to give us an idea of the context of what are the things that you hear, as far as frequently, that are coming from your families? Uh, just curious about what, –

Next Speaker: Like, –

Next Speaker: – where, what, what they, what things they struggle with as far as the hospital and HAI infection? You mentioned the risitor, the visitor restrictions.

Next Speaker: The, the, the children.

Next Speaker: Children.

Next Speaker: Yeah.

Next Speaker: Are there other ones like that that you hear a lot, just to –

Next Speaker: Um, not allowing patients to go outside the building.

Next Speaker: Mm hmm.

Next Speaker: Um, we have a courtyard, um, where patients who are able to be in a wheelchair can go down there, um, but it's small. It's very pretty. We keep it, Dane helps keep it beautiful with the flowers and, but they wished they could be outside more.

Next Speaker: Mm hmm.

Next Speaker: Um, other than that.

Next Speaker: We do have, uh, some restrictions on what kind of decorations you can have in the room and then what happens with those decorations once they leave the, their hospital room. Uh, there are some challenges, especially when you're moving patients between rooms –

Next Speaker: Mm hmm.

Next Speaker: – during some sort of transfer, we have, um, there are, uh, there are some significant challenges that come up during that, especially when a patient has, has a communicable disease –

Next Speaker: Mm hmm.

Next Speaker: – um, and that, that can cause friction and, um, unhappiness among family members when photos – if photos get fecal matter on them, we have to throw them away, and, um, things like that. Um, no that photos get fecal matter on them all that often, but you know what I mean.

Next Speaker: ****

Next Speaker: We need to be extra careful, uh, especially with patients with communicable diseases, and sometimes that means that, uh, that we need to be careful about what gets put into the rooms so that people aren't upset when we have to throw it away.

Next Speaker: And then another big one is, uh, we have a policy that we allow one, um, adult family member to spend the night overnight if they're able to be approved and on the approved visitor log. Um, however, some family members want more than one family member to spend the night, especially if they're a new admit and they're really nervous about being in a new facility –

Next Speaker: Mm hmm.

Next Speaker: – and they're scared. So that has come up a few times. And then, as Dane mentioned in his story, some of our rooms are too small –

Next Speaker: Mm hmm.

Next Speaker: – to have visitors spend the night, um, especially if we have vented patients, and the recliner would get in the way of patient care, and nurses are worried about the recliner being up and there being some sort of emergency. So, yeah. So even though we do allow one, one family member to spend the night only with certain rooms, so that has definitely been, um, people are unhappy about that. Yeah.

Next Speaker: A lot of it's, like, having, yeah, being able to connect with their family members while ****

Next Speaker: Yeah. Yeah.

Next Speaker: Thank you.

Next Speaker: Thank you for asking.

Next Speaker: Thank you so much. I don't, I feel like we could continue having this discussion for, you know, the rest of our time today, and so I think what, just to move us along to our next agenda item, perhaps if there's further discussion and conversation during our kind of open forum and discussion time at the end of the meeting, we can revisit this. I just wanna say, I think there's a – if you can stay, and if not –

Next Speaker: Yeah.

Next Speaker: – that's okay. And I just think there's a tremendous overlap between, you know, what's going on in patient advocacy, what's going on in healthcare facilities regarding infection prevention, and then the kind of third step is what's going on here in our program. So I guess I'm kinda wondering, uh, in the group as a whole, does this feel like we should kind of revisit this at an upcoming meeting to talk more about, you know, what would we maybe wanna see? Like Dat mentioned, like, are there some best practices for working, you know, for facilities working with HAIs and patient advocacy. Are, is there, what are the, kind of, next steps for us to take here in our program? Would folks be interested in having more discussion about that?

Next Speaker: Well, I know that I've already taken notes about what was already men – this is Dane Stevenson again – about what was already mentioned from other hospitals about what you're doing to help engage families in, in HAI prevention, and, uh, I know that as, as, you know, a patient advocate, I would love to get a list of a, this is what this hospital's doing, this is what this hospital's doing, uh, so that we don't have to make everything up again. Uh, that would be fabulous. So.

Next Speaker: Thanks for bringing that up. And, you know, just for a little parallel, right, we have message boards and discussion groups that allow our infection preventionists to share that kind of information among themselves. Right? So I, if we can be a forum to have these conversations about HAIs and patient advocacy, I think that is a good role for us to take, so.

Next Speaker: Thank you.

Next Speaker: Thank you so much for your time.

Next Speaker: Thank you. And next up, we have Monika talking about healthcare worker influenza vaccination for the 2017–2018 season.

Next Speaker: So I have, um, ****, um, Lora is helping me. We have the actual report here. If you're interested in looking at it, you can take one. If you're not, don't worry about it, I won't be offended. It's long and dry. But this is the 2017–2018 report. It's not the one for the season that just happened. That one I'm still working on. Um, and it includes, um – well, let me sit down. Again, I'm Monika Samper. I am the, uh, the, uh, healthcare worker influenza vaccination survey coordinator as well as a, um – what else do I do. I also do, uh, a lot of, uh, chart reviews, so, for different programs within our program. So this report includes almost 316, 360 facilities across the state of Oregon. It includes all hospitals, all ambulatory surgery centers, all skilled nursing facilities, as well as our dialysis facilities. And within those facilities, we like to capture all the healthcare workers that we can, which are –

[Welcome to Deschutes County Government. Thank you for calling.]

Next Speaker: Oh, no.

[And we'll be right with you. We hope the following information is useful –

Next Speaker: Somebody put us on hold.

[– to you. Please feel free to call 541 –

Next Speaker: Oh, no.

[– 388-6570.]

Next Speaker: How do you do that?

[Again, that number is 541-388-6570. For additional information you need about Deschutes County ** –]**

Next Speaker: Anybody knows who's on Deschutes ****?]

[– department staff work in cooperation with many valued community partners –]

Next Speaker: What do we do?

[– to provide a variety of necessary services –]

Next Speaker: You might have to **** –

[– and programs to the public.]

Next Speaker: – unless you have another ****.

Next Speaker: Can everybody hang up and –

[** can be –]**

Next Speaker: – call back in, or –

[– reached at 541-388-]

Next Speaker: I'm gonna try to email her.

[6570.]

Next Speaker: Okay. We're gonna try to email this person and –

[** policymaking body of Deschutes County Government –]**

Next Speaker: – have her take us off of hold.

[– and it's the governing body for all county services.]

Next Speaker: I'm sorry, everybody.

[You can find out more about the board by visiting www.deschutes.org/**]**

Next Speaker: You'll have to hang, you're gonna have to hang it up.

Next Speaker: There. How's that?

Next Speaker: The people on the phone are still –

Next Speaker: I think you have to hang it up and then call back in yourself.

Next Speaker: I can turn the volume down for them.

Next Speaker: But you're still gonna have to hang up 'cause that person's on, ****

Next Speaker: I know.

Next Speaker: Okay, so I can't hear anybody if you're talking to me.

Next Speaker: Yeah, you have to ****

Next Speaker: **** so they drop off ****.

Next Speaker: But I can hear, I can't hear anybody who talks to me 'cause I turned the volume down.

Next Speaker: Let's turn it up again and just see what happens. Maybe ****

Next Speaker: And once that hold is hung up, I can hear you. I'll turn the volume back up. I apologize for this.

[–.org/**]**

Next Speaker: I'm just gonna continue.

Next Speaker: Can they hear you?

Next Speaker: Yeah, they can hear me.

Next Speaker: ****

Next Speaker: I just turned them down. What?

Next Speaker: I'm wondering if they're hearing it on the phone.

Next Speaker: Yeah, ****.

Next Speaker: I think they're hearing the same message.

Next Speaker: So I think you're gonna have to hang up.

Next Speaker: **** volume ****.

Next Speaker: And then re-call in yourself.

Next Speaker: **** still there. **** her.

Next Speaker: All right, everybody. They can't hear me, can they?

Next Speaker: ****

Next Speaker: I've already **** her, but I –

Next Speaker: Go ahead and –

Next Speaker: All right, I'm gonna hang up.

Next Speaker: We can't hear you in the background over the hold.

Next Speaker: I know, I'm sorry. I'm gonna –

Next Speaker: Wait a minute. I think I can ****.

[– ** taxes, assessment records and official **** –]**

Next Speaker: I'm sorry everybody. I think –

Next Speaker: Are they –

Next Speaker: **** not gonna do any ****

Next Speaker: **** Monika.

[– 388-**]**

Next Speaker: So I'm gonna hang up and call back in. Yeah, so we tried to, to contact the person, but they're not responding, so we'll have to have you guys hang up and call back – oh, wait. Did it stop? Oh, she's off. Okay. She must've gotten the message. Okay, don't hang up. Don't hang up.

Next Speaker: I think a lot of people already hung up.

Next Speaker: Tell people to make sure they don't ****

Next Speaker: Yeah, be sure not to put us on hold everybody. All right, I'm sorry. Okay, where was I.

Next Speaker: And the information is also in the packet, too, so.

Next Speaker: The information is also in the packet, so if you had to hang up or if you couldn't hear me, it's in the packet. Um, all right, where was I. So we try to include all the healthcare workers in this publication, and that includes employees, independent practitioners, students and volunteers, and other contractors. Other contractors, though, is an optional item that they include in the report, so you may not see them with all facilities. Uh, the definitions for the healthcare workers are eligible healthcare workers are those who are without a documented medical contraindication, and the rate of vaccination are healthcare workers vaccinated at the facility plus healthcare workers vaccinated elsewhere divided by eligible healthcare workers. And again, the eligible healthcare workers are those without a documented medical contraindication. Thank you. Next slide. So for the 2017–2018, um – I'm sorry, I'm so distracted from that – um, vaccination year and the years preceding, this is the mean healthcare worker influenza vaccination rates for the combined facility types. And I like this slide because you can see that there has been an overall increase in the rates. And the healthy people goal for the year 2020, which was, um, 90 percent, you can see we're quite a bit aways from there, but the 2015 goal which I took off of there because we passed it was 75 percent, and we have met that goal. So that's good to see. Next slide. The influenza vaccination rates for all healthcare workers by facility type and season you can see here, um, back in, um, for hospitals, they met the 2015 goal, uh, I'm sorry, back in, uh, 2015, which was nice. Actually, they met it back in 2014, and the, uh, ambulatory surgery centers have yet to meet it as well as the nursing, skilled nursing facilities, but dialysis facilities have met the 2015 goal, um, ever since they started reporting to us in 2015 as well as they met the 2020 goal for us in the 2017–2018 reporting year, which is quite impressive. I like that slide. It's pretty. Uh, the takeaways from that report, the overall influenza vaccination rate and facility-specific vaccination rates increased in 2017 and 2018. And like I said, the dialysis facilities have met the 2020 goal, 90 percent versus 90 percent. Hospital facilities have met the 2015 healthy people goal, like I said, 82 percent versus the 75 percent which was the goal, but remained short of the 2020 goal of 90 percent. Further improvement is needed in healthcare worker influenza vaccination in skilled nursing facilities and ambulatory surgery centers that remain short of the 2015 goal, which is 75 percent, and the 2020 90 percent goals. So what are we doing to help promote this campaign of healthcare worker influenza vaccination? We have ongoing dissemination of the CDC and the OHA toolkits to healthcare facilities, and those are available on our web sites. We have monthly convening of the flu group work, the flu work group to address vaccination challenges. We do take a break over the summer, but we have restarted those meetings now in the fall. We have presentations and educational webinars routinely provided to healthcare facilities. We collaborate with the Office of Rural Health to support vaccination promotion campaigns. And prior to the 2018–2019 flu season, we had outreach conducted to all 136 skilled nursing facilities to share our toolkits for healthcare worker vaccination, provided data to motivate action. We offer technical support and

troubleshoot ongoing challenges. Now, I wanna pause here. Our HAI group, we actually divided all 136 skilled nursing facilities among about, I think there were eight of us, and we all called 136 facilities, reached out to them. Prior to the phone calls, we sent out an email with an introductory letter with the toolkit, a couple of other items, and said did you get our information, did you have a chance to read it, do you have any questions, is there anything we can do to help you and to support you. And it was, we found that it was really, um, helpful. People were, some people were appreciative. Obviously, you didn't always get that response, but, um, a lot of people found it interesting and, um informative, which was really, it was really encouraging. And then here at the December 11, 2018, HAI Advisory Committee meeting, we convened a panel of skilled nursing facility administrators to share their H, healthcare worker vaccination success stories, and I personally, because this I what I do, um, thought that was a fabulous meeting. It was really interesting. We got some great, um, information from those people, and, um, I just thought it was a really great meeting, and I hope we can do something similar to that again in the future. And any questions? Pretty straightforward. Yes, Dat?

Next Speaker: I just thought it easier to walk up here.

Next Speaker: Yes.

Next Speaker: This is Dat Tran. So I was involved, um, with the team in calling those facilities. One of the things I noticed, that by the time we called, a lot of the facilities had already had their plans in place. So this is for those who are from skilled nursing facilities. When do you usually, uh, develop your influenza campaign? Like, when do you actually start thinking about it, at which point we can actually have input? We can provide input. Can you give us some context?

Next Speaker: I don't know ****

Next Speaker: ****

Next Speaker: Thanks, Pat.

Next Speaker: Yeah, I'm –

Next Speaker: That was meant for you really.

Next Speaker: – **** many of us I think **** uh, in the, on the call. Um, si, it recently started to change. Like, ordering vaccine. First stage is get the vaccine ordered. Our regional pharmacy service asks that to be done June–July for a September–October delivery. And then ****, CMS says follow the current CDC guideline, it comes out in August. This most recent one came out August of this year. And in it, there's the tiny little sentence that says it's recommended that you begin around the first of October but most importantly finish by the end of October. So the first campaign is an October campaign, as directed by the seasonal, um, recommendations from CDC. Thank you.

Next Speaker: But, but when do you actually start thinking about developing your campaign? Do you start thinking about it in June? Or do you start thinking about it right after the end of the, the influenza season? I'm, I just wanna get a sense –

Next Speaker: Well, yeah, the thinking, the thinking part is ordering. Um, there's a prompting to order your vaccines. And of course, that's the thinking part, one part of the thinking. The trivalent, quadrivalent, high dose. So there are some thoughts, uh, during that period. And then, formally, when you receive the vaccine, and that generally is in September, um, and I can tell you as a national consultant I get loads of calls about right now, when should we start vaccinating. So my answer is the thinking two stage, ordering the vaccines, which ones, and then when do we start. And that's right now. And so assisted living facilities –

Next Speaker: September.

Next Speaker: – maybe September, that's skilled primarily, thinking now for campaign starts October.

Next Speaker: Okay. Anyone else? Thank you, Pat.

Next Speaker: Welcome.

Next Speaker: Do you want just long-term care, or –

Next Speaker: Sure, you can –

Next Speaker: Well –

Next Speaker: – you can also give us, we may, if you want our input.

Next Speaker: Okay.

Next Speaker: No, I was just gonna say, our, um, we actually have policy around this. So the campaign starts, as he, as Pat mentioned, we actually order vaccine in, like, February.

Next Speaker: Yeah.

Next Speaker: Wow.

Next Speaker: March. Um, and, um, we pull out our policy about August, make sure everybody knows what their role is, and we usually start vaccinating last week in September. Generally.

Next Speaker: Right.

Next Speaker: Yeah, so I guess what I'm, I'm not, like, I understand the timeline. I'm talking about, you know, cam, like, how, in, in developing your campaigns, right. Say what are we gonna do this year to improve vaccination. That's what I'm talking about. Those kind of, you

know, whether it's incentive. Whether it's other things, like promotion. Like, this is what we're talking about. When do you start thinking about it where we can reach out and say hey, these are some tools that's been demonstrated to be effective. Are you considering this? Would you be interested in implementing this? This is what I'm talking about. At that stage where we can have an impact and influence in, in your campaign, if that makes any sense.

Next Speaker: Gotcha. The campaign.

Next Speaker: Hi, this is Mary, from ****. Um, it's a year-round thing for us quite honestly. It's on our, uh, quarterly infection-control agenda in some form or fashion. Um, we report, um, going into January, uh, what our vaccination rates are looking like. We finalize it at the next quarter. We debrief. And at that second-quarter meeting, you know, what went well, what should we do differently next year. That's really when we start making changes. We, too, have to order our vaccine, I think it's usually by March that we have to get our order in. Um, but we really start, come August, we start picking everything off, and we update all of our consents, our declination forms, um, we start, um, updating, ordering posters. We set up a little, uh, vaccination workstation outside our cafeteria that's up, um, for the entire immunization season. Um, it's got a medication refrigerator and everything there. Um, so we, we, we roll it out, and, you know, we are one of those hospitals ****. It was nice to get a certificate for the last couple years for, um, you know, having over 90 percent and reaching that vaccination, uh, threshold, so, um, ****. Thank you.

Next Speaker: Great.

Next Speaker: ****

Next Speaker: Thank you for those comments, and so it sounds like everyone starts in the summer.

Next Speaker: Yeah, I was gonna say, summertime sounds like –

Next Speaker: And that's pretty typical **** Providence as well ****

Next Speaker: Thank you, everybody.

Next Speaker: So thank you. Well, great. Well, um, this has been, uh, a really full meeting, so thank you everyone who participated and shared your stories. Uh, we appreciate that. Uh, do, anybody have any discussion recommendations? Or are there any public comments? I'm gonna combine those two together for right now. Either in the room or on the phone? So as always, if you, uh, come across something in your daily work and that you would like to see a part of this agenda, please reach out to Roza. And then finally, if there was anyone who joined later in the call that missed the first roll call, if you could please announce yourself or email, uh, Roza Tammer immediately following. Actually, you have to announce yourself, excuse me. If you could announce yourself, that would be greatly appreciated so we can, uh, include your attendance. Okay, great. Any final parting comments? Excellent. Well, we will see you in December. Thanks again.

Next Speaker: Thank you.

Next Speaker: Bye.