Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

June 10, 2020
1:00 - 2:15 pm

Webinar only, PSOB
800 NE Oregon St.
Portland, OR 97232

Agenda, materials, minutes, recordings, and transcriptions for meetings are available at: http://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Meetings.aspx.

MEMBERS PRESENT:

- Joshua Bardfield, Supply Chain Services Manager, The Oregon Clinic, P.C. (phone)
- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center (phone)
- Deborah Cateora, BSN, RN, Healthcare Education/Training Coordinator and Nurse Consultant, Safety, Oversight and Quality Unit (SOQ Unit), Oregon Department of Human Services (DHS) (phone)
- Paul Cieslak, MD, Acute & Communicable Disease Prevention (ACDP) & Immunizations Medical Director, Oregon Public Health Division, Oregon Health Authority (phone)
- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center (phone)
- Pamela Cortez, MBA, BSN, RN, CNE, BC, Director of Patient Safety and Clinical Support, Salem Health (phone)
- Dennis Drapiza, MPH, BSN, RN, CIC, Regional Director - Northwest Infection Prevention and Control, Kaiser Permanente Northwest (phone)

- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University (phone)
- Jesse Kennedy, RN, Nurse Practice Consultant, Oregon Nurses Association (phone)
- Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc. (phone)
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control (phone)
- Kirsten Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante (phone)

MEMBERS EXCUSED:

- Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon Public Health Division, Oregon Health Authority

OTHER PARTICIPANTS PRESENT:

- Sandra Assasnik, Director, Safety and Quality, Washington State Hospital Association (phone)
- Leah Brandis, Senior Project Manager, Comagine (phone)
- Karen Brooks, Infection Control Practitioner, Legacy Silverton Medical Center (phone)
- Hailey Colangeli, Oregon Health and Science University (phone)
- Melissa Davis, Facility Administrator, DaVita Inc. (phone)
- Susan Diskin, BSN, RN, CIC, Infection Prevention and Control, Legacy Emanuel Medical Center (phone)

- Mesa Greenfield, Infection Prevention/Employee Health Nurse, Lake District Hospital (phone)
- Ryan Grimm, Director of Surgical Services, Ambulatory Surgery Centers, The Portland Clinic (phone)
- Aisha Hedden, Medical Laboratory Scientist (MLS), Strategic Business Executive Infectious Diseases, Abbott (phone)
- Karen Keuneke, RN, MSN, Supervisor of Infection Prevention, Good Samaritan Regional Medical Center (phone)
- Gretchen Koch, MS, RN, Policy Analyst, Nursing Practice and Evaluation, Oregon State Board of Nursing (phone)
- Myles Nelligan, Endoscopy Center Manager, The Oregon Clinic Gastroenterology West (phone)
- Brie Noble, Senior Faculty Research Assistant, Oregon State University College of Pharmacy (phone)
- Nancy O'Connor, Regional Director of Infection Prevention, Providence Health System (phone)
- Jewel Peterman, RN, BSN, CNN, Quality Improvement, Comagine (phone)
- Mary Post, RN, MS, CNS, CIC, Infection Prevention/Employee Health Coordinator, Shriners Hospitals for Children - Portland (phone)
- Thomas Rollins, Chief Clinical Officer, Prestige Care Inc. (phone)
- Yolanda Ryckman, Infection Prevention/Employee Health/Quality Improvement, Harney District Hospital (phone)

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- Zintars Beldavs, MS, Section Manager, Acute and Communicable Disease Prevention (phone)
- Maureen Cassidy, MPH, Multi-Drug Resistant Organisms (MDRO) Epidemiologist (phone)

(OHA) STAFF PRESENT:

- Laura LaLonde, MPH, CPH, CHES, HAI Office Specialist
- Valerie Ocampo, RN, MIPH, HAI Public Health Nurse (phone)
- Ama Owusu-Dommey, MPH, Viral Pathogens Epidemiologist (phone)
- Angela Phan, Executive Support Specialist
- Dana Selover, MD, MPH, Healthcare Regulation & Quality Improvement (phone)
- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist (phone)

ISSUES HEARD:

- Call to order and roll call
- Logistics update
- Approve March 2020 minutes
- COVID-19: Situational overview
- Discussion: COVID-19
- Discussion: Topics for future meetings and reports
- Public comment
- Final roll call and adjourn

Item	Discussion	Action Item
Call to order and roll call	Twelve members (92%) and 18 participants present.	No action items

Roza Tammer, OHA		
Logistics update Roza Tammer, OHA	➢ HAIAC membership updates: • Four vacancies: • Hospital Administrator with Expertise in Infection Control in a Facility with Fewer than 100 Beds. • Consumer and Patient Representative. • Health Insurer Representative. • Oregon Patient Safety Commission Representative. ○ Opportunity for current member to serve as Chairperson. ➢ Remote attendees will remain unmuted for meeting; reminder to unmute yourself to speak. Guidance for using webinar included in meeting minutes.	Please share "Bring your voice to the table" one-pager with your networks and email Roza if interested
Approve March 2020 minutes All Committee Members	March 2020 meeting minutes were approved by 92% of members.	No action items
Covid-19: Situational overview Becca Pierce, OHA	Becca Pierce was unavailable.	No action items

Discussion: COVID-19 All members and attendees	Topic is a group discussion regarding successes, challenges, resources and support needed and available. Jesse Kennedy: Variances in guidelines from document to document and managing the dissemination. Genevieve Buser: Clear guidance for testing in LTCF, PPE levels and crisis contingency, how testing might change PPE, and clear PPE recommendations in non-hospital settings like LTCF. Question: ➢ Genevieve Buser: Any challenges or concerns around testing in long-term care facilities (LTCF)? Deborah Cateora: Memo yesterday stated OHA and DHS will soon release guidance for LTCFs to test staff and residents in larger facilities. Individual facilities have been testing staff and residents already. Tom Rollins: Current recommendation is to test symptomatic staff and residents. Genevieve Buser: Are there particular areas of concern that you would want addressed in the guidance? Tom Rollins: The number of tests, getting testing, and the variation between counties. If guidance is to test all residents and staff on a routine basis, what would testing *en masse* look like? Would this be statewide? Genevieve Buser: Can facilities, in general, collect samples in-house? Tom Rollins: Yes. In Washington they are providing kits to nursing homes and LTCF for all staff and residents. In	Roza will compile shared resources to provide to the group.

	Oregon, who would supply testing kits? Who is paying? How often are you expected to test? Vicki Norby: We have been able to obtain some testing materials but still scrambling. This delayed the ability to test. We need a plan to test *en masse* going forward. Kelli Coelho: Testing 100% of patients in ambulatory surgery centers (ASCs). Polymerase chain reaction (PCR) if time allows and rapid testing for emergent cases. No patients are allowed to enter until testing's done and the results are back. It has been a challenge to get results back for PCR testing, because it is going to Bellingham, Washington. Genevieve Buser: Have patents been okay with doing the testing? Kelli Coelho: Some resistance but okay after discussion. ASCs are doing aerosol-generating procedures (AGP). Patients from Roseburg and the coast have had difficulties organizing where they can be tested. The challenge is coordinating the test if not from the Eugene/Springfield area. The guidance that our surgery center is using to proceed with providing surgical care during the COVID-19 pandemic is the Society for Ambulatory Anesthesia (SAMBA) Statement on COVID-19 Testing Before Ambulatory Anesthesia document): https://sambahq.org/wp-content/uploads/2020/05/SAMBA-Statement-on-COVID-19-Testing-Before-Ambulatory-Anesthesia-4-30-20.pdf	

	DHS' documents regarding ASC practices during COVID-19 are available here: https://www.oregon.gov/oha/PH/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Pages/forms.aspx#ASC Question: ➢ Genevieve Buser: Does it change your personal protective equipment (PPE) at all that you use during surgery? Kelli Coelho: Yes. N95s during intubation and extubation and 20 minutes for air exchanges. Since 100% testing was in place there is a regular 15-minute turnover since all tests have been negative. Staff are more comfortable with N95s even with patients reporting self-isolation up to three to four days. Dennis Drapiza: Kaiser is also doing this. In the ASC we are not proceeding with surgery if the patient is positive as those are mostly elective. Kirsten Schutte: Is there a framework to preserve testing with asymptomatic, presurgical, or admitted patents and PPE conservation? Various guidance takes into account the local situation or worst-case scenarios that don't apply to places with low prevalence such as southern Oregon. We could use help defining intermediate prevalence and making sure we have the state and regional data to inform that and PPE use at different risk levels. Has there been	

	any thought about risk stratifying based on community disease prevalence for testing and PPE guidance? Mary Post: We have the same issues at moderate risk with no clear guidance. Instead of N95 masks for AGP we opted for full face shields and surgical masks with gowns and gloves for patients even with a negative test. Genevieve Buser: OHA does publish case counts and deaths of positive/negative tests and count per 10,000 by county. This is one way to understand the prevalence across the state and how that might affect your pre- and post-test screening. Rapid tests have a false negative rate between 18-46% and in general the laboratory community agrees that the rapid tests have a higher false negative rate than the PCR testing. With all the caveats of a pre-print and small case numbers, interesting that found in patient testing and cell phones and hand rails, supporting hand hygiene and droplet as major modes of transmission. (See Air and environmental sampling for SARS-CoV-2 around hospitalized patients with coronavirus disease 2019 (COVID-19) document). Question: Genevieve Buser: Are other systems using testing to change the level of PPE for AGP? Susan Diskin: Legacy has a document in which we've categorized AGP and testing. We have categorized by	

	high-risk AGP, low-risk AGP, and not an AGP, then by PPE use, such as fit-tested N95 mask for airborne contact, followed by any person under investigation or lab-confirmed COVID-19, then categorized as asymptomatic or negative with COVID-19 screen. Anyone who is asymptomatic and has a negative test we do standard precautions, including for AGP. Every patient is tested prior to surgery. For unplanned, urgent, or trauma we do rapid testing if possible but do tend to err on the side of high-risk AGP with N95s. Question: ➢ Genevieve Buser: Have you had to entertain a lot of questions for laboring women? Susan Diskin: We follow the OHA document with consideration from professional organizations that have written their own. For the second stage of labor we do opt-in for N95s for the provider. Genevieve Buser: There is a comprehensive list from Ask Mayo Experts that can be shared that has a spectrum extended from high-risk, intermediate risk to low-risk and reference what PPE is used at each level with their current disease prevalence. They have a list of outpatient and inpatient procedures that require testing. References Ask Mayo Expert for risk stratification of AGP, connection to PPE use/precautions and pre-procedural testing:	

	Comment: ➢ Jesse Kennedy: There has been variances between guidelines released by OHA, Centers for Disease Control (CDC), and World Health Organization (WHO). There has been a lot of variance within individual facilities as far as how those guidelines are interpreted. Some facilities are still utilizing facility disaster plans while resuming non-urgent and non-emergent or elective procedures. It would be fantastic to have work groups to sit down and talk about disaster planning and prepare for a second surge or fall surge with influenza. Currently we're still limping along but we're already seeing surges in other states related to reopening. It would be good to get everyone on the same page with a comprehensive plan regarding PPE as we get closer to influenza season. Roza Tammer: This is the right group to have that discussion. There still are PPE shortages and we are going to have to continue with PPE optimization. Jesse Kennedy: I would like to work together towards a framework for the future should this happen again. PPE is still short right now and facilities are following PPE optimization guidelines. I'd like to see something similar to the Ebola response where we designated what was going to happen and what sort of PPE was used between different facilities.	

	Comment: ➢ Deborah Cateora: I would like to discuss staff fatigue with PPE, hand hygiene and removing PPE and cutting corners due to heavy workloads and long hours. Roza Tammer: I would love to know if people are doing ongoing education and training with staff to address this. Jesse Kennedy: Continuing education or certifications for infection prevention would be helpful. Paul Cieslak: Richard Leman (RICHARD.F.LEMAN@dhsoha.state.or.us) previously had a crisis care guidance developed with a medical advisory group. Richard may have insight on PPE guidance. Genevieve Buser: There has been a lot of work with healthcare systems and public health regarding different levels for contingency versus normal functioning and how this relates to use of PPE, visitor restrictions, and similar details. This can vary by individual facility. Josh Bardfield: Individual hospital-level recommendations would be useful. Governor Brown mentioned PPE was in ample supply but that wasn't the case for facilities that didn't have allocations. PPE was available through the county but that wasn't guaranteed, and it wasn't guaranteed you would get PPE staff is fit-tested for. That led to shortages in supplies to fit test staff. Sandra Assasnik: I'm part of a weekly infection prevention (IP) forum. They have been able track by district the space, staffing, and the supplies to easily manage this between different groups. There have been shortages of PPE,	

	medications (e.g., allergy medication used by some emergency responders), testing, and solutions for N95 fit-testing. We can share this information and lessons learned. We learned that rural hospitals, or particularly hard hit were those that service migrant and seasonal farmworkers and Latinx populations. Oregon is welcome to join this IP forum. We've also come across shortages of vendors. Question: ➢ Genevieve Buser: Any other comments around supply chains? How many facilities are moving to universal eye protection for front-line staff, are you using goggles or face masks? Tom Rollins: Our LTCF are using face shields because they are more comfortable, last longer, and don't fog up as much. For reusable face shields we have cubbies with disinfectant outside rooms. We are having to go to contingency and crisis conservation more frequently than hospitals. We are using cloth gowns and facemasks for a whole shift. Sandra Assasnik: The cloth gowns seem to be a great solution in Washington because you can launder them. Tom Rollins: We are getting mixed messages about reuse and don't know how to address differences in the messages and regulations.	

	Sandra Assasnik: We've used different types of cloth gowns like painting coveralls with hoods.	
Discussion: Topics for future meetings and reports All attendees	Future topics: Please email Roza Tammer. Comment: ➢ Dennis Drapiza: ASC-centered meeting to discuss surgical site infections and lessons learned in September.	Email Roza any topics for 2020
Public comment		No action items
Final role call and adjourn		

Next meeting will be September 9, 2020, 1:00 pm - 3:00 pm, location to be determined.

Submitted by: Laura LaLonde
Reviewed by: Roza Tammer