Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

September 9, 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)
- 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)
- 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)
- Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon Public Health Division, Oregon Health Authority (phone)
- Jesse Mensik Kennedy, RN, Nurse Practice Consultant, Oregon Nurses Association (phone)
- Kirsten Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante (phone)

MEMBERS EXCUSED:

- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center
- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center
- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University

- Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc.
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control

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)
- Pamela S. Bruhn, RN, BSN, MAN, ANP, Infection Control/Employee Health Coordinator/Pharmacy RN, Blue Mountain Hospital District (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)
- Molly Hale, Manager, Infection Prevention & Control, Oregon Health and Science University (OHSU) (phone)
- Karen Keuneke, RN, MSN, Supervisor of Infection Prevention, Good Samaritan Regional Medical Center (phone)
- Katherine Kroll, Director for Infection Prevention, Quality, PeaceHealth (phone)
- Connie Lowder, Comagine Health (phone)
- Shanna Middaugh, Samaritan North Lincoln Hospital (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)
- Joseph Scarpelli, Stryker Sage (phone)
- Tracy Wart, Infection Prevention/Employee Health, St. Anthony Hospital (phone)

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

OREGON HEALTH AUTHORITY (OHA) STAFF PRESENT:

- Lisa Iguchi, ACDP Epidemiologist (phone)
- Sarah Kooienga, CDC Foundation Infection Preventionist Public Health Nurse (phone)
- Laura LaLonde, MPH, CPH, CHES, HAI Office Specialist
- Valerie Ocampo, RN, MIPH, HAI Public Health Nurse (phone)
- Saman Perera, CDC Foundation Infection Preventionist Public Health Nurse (phone)
- Monika Samper, RN, HAI Reporting Coordinator (phone)
- Nicole West, MPH, Influenza Epidemiologist (phone)
- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist (phone)

ISSUES HEARD:

- Call to order and roll call
- Logistics update
- Approve June 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 Items
Call to order & roll call Roza Tammer, OHA		No action items
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.	Please share "Bring your voice to the table" one-pager with your networks and email Roza if interested

	➢ Remote attendees will remain unmuted for meeting; reminder to unmute yourself to speak. Guidance for using webinar platform is included in meeting minutes.	
Approve June 2020 minutes	Jon Furuno moved to ap prove the minutes as read. The minutes were approved.	No action items
COVID-19: Situational overview Becca Pierce, OHA	As of yesterday, in Oregon, we have had 28,355 confirmed and presumptive cases of COVID-19 and 486 deaths. About 22% of these cases are aged 20-29 and about 18% are aged 30-39. About 8% of cases have been hospitalized during their illness. Our cases are about 40% white, about 48% non-Hispanic, and about 40% Hispanic. About 14% of our cases are associated with congregate settings. We have 190/699 available adult intensive-care unit (ICU) beds and 835/4,400 available non-ICU adult beds. 47/323 of neonatal intensive care unit (NICU) and pediatric intensive care unit (PICU) beds are available, and 91/332 of pediatric non-ICU beds. There are 153 cases hospitalized, 44 in the ICU, and 22 are on ventilators. We have 778 ventilators available in the state. COVID-19-related illness is still making up a very small percentage of emergency department (ED) visits, and overall, our ED visits are lower than they were pre-COVID-19 and are fairly stable. For a situational overview points, the Centers for Medicare and Medicaid Services (CMS) is sending point-of-care antigen testing machines from BD and Quidel to about 126 nursing homes in Oregon. Some have received these already. These will supplement the new CMS testing requirements for nursing homes and the antigen testing algorithm for nursing homes from the Centers for Disease Control and Prevention (CDC). Our program continues to do virtual and in-person infection control assessments for COVID-19 for long-term care facilities and some other facility types (e.g., behavioral health). These visits are being done both in response to outbreaks and proactively. The Oregon Health Authority (OHA) is currently bringing on new team members but we will continue to be here	

	and hold this meeting. We are also available to do COVID-19 infection control consultations for other facility types so please reach out to us with those requests.	
Discussion: COVID-19 All members and attendees	• Your organization's role and experience • Successes and challenges • Questions • Resources and support needed and available Roza Tammer: One of our partners asked a question regarding how to handle COVID-19 follow-up and quarantine in healthcare settings. Some facilities are treating any contact within 6 feet or less for more than 15 minutes, even if recommended personal protective equipment (PPE) has been worn, as an exposure. When staff has a positive test but worked in the days prior to when their test result was known, this is resulting in many patient and staff notifications and patient quarantines. There are concerns about resources needed and sustainability of this approach given that these staff are wearing PPE. Recently there was a Tri-City call on this with good representation from hospital epidemiologists but not many infection preventionists (IPs). There is not a lot of guidance around this. We are not always sure how well PPE may contain infection, but we do believe that PPE is fairly protective. Patients may be wearing cloth face coverings, but we don't know how protective those might be. We don't want our healthcare personnel (HCP) to work while they are symptomatic and having asymptomatic positive HCP work is a crisis-level contingency that we don't advise. These are also often quick encounters, so another thing to think about is how we are defining contacts related to which patients we want to quarantine, and how to communicate this. Kirsten Schutte: I think that pretty much all healthcare facilities have policies in terms of universal source control and PPE use, even with patients who aren't suspected of having COVID-19 symptoms. I would imagine this significantly reduces risk aside from aerosol-generating procedures (AGPs) or other specific	

	situations, but it might be helpful to call out. We've started incorporating a template in the notes to encourage documentation about what PPE was used during the encounter, which allows our IP and providers to have some level of comfort saying what PPE was worn by the patient, family member, and providers. What are others doing in terms of patients who are in quarantine in the outpatient setting, or if they're not in quarantine, have other risk factors? In particular, we are struggling to define what travel would be high enough risk that someone might need to be treated differently if they are admitted to the hospital, especially because we are doing universal source control and wearing PPE in almost all of our settings. Susan Diskin: Trying to mitigate as much risk to patients is so important. On the other hand, at Legacy, we're staffed at a very lean level and resources to do internal contact tracing for one staff person is limited. It's all retrospective, so we're counting on them to recollect what patients they saw. We ask patients to mask when someone enters their room, but it's hard to determine how reliably that happens. It would have to be a detailed conversation with a staff person who's out on illness furlough. In-house, we have daily surveillance for patients that develop symptoms. It is burdensome to ask providers to monitor for this as well as any changes in their status. Since March, we've seen thousands of people come through our doors and we haven't yet seen any hospital-onset cases that we're aware of. We are struggling with how to do this and do it purposefully. Nancy O'Connor: I share pretty much everything that Susan just said, particularly the lean staffing. Some staff are impacted by online school and school closures, so which reduces our staff even more. Some of our staff had to be evacuated due to wildfires, so that's impacting our overall staffing. Our IPs are doing PPE auditing as much as possible using an audit tool that we created to get some sense of compliance and do just-in-time education. We discussed potential patient-to-caregiver exposures with Jen Vines, who said if you're confident in your	

	policies and compliance with them, then you'll be meeting the spirit of what the state is requiring for the patient-to-caregiver exposures. We felt better being able to ensure overall good compliance on a particular unit when the nursing unit leader could speak to consistent knowledge and compliance. However, when we started having potential caregiver-to-patient exposures, which we call reverse exposures here, that presented a different problem. Providence decided to not require all acute-care inpatients to be masked if a caregiver is in the room, though it is strongly encouraged unless it's a safety issue. For outpatient appointments, it is different; we require patients to be masked and universal masking and face shields for our employees. Dennis Drapiza: Have we looked at potentially going back to low- and high-risk exposure type scenarios? Regardless of PPE, couldn't there be something to differentiate between the two because do they both really require furlough, quarantine, and massive notifications? I'm just wondering if there's a middle ground with the intent of being protective but balanced. How do people feel about making decisions between lower- and higher-risk exposures that take place within 6 feet and for at least 15 minutes? Aside from PPE, distance, and length of time, what would be some of the decision points to decide whether we have low- or high-risk exposures? Mary Post: Based on experience, the amount of coworker-to-coworker exposure is next to nil, especially when you have universal masking and eye protection in place. I relied heavily on the CDC's Risk Assessment for Healthcare Workers Exposed to Persons with COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/downloads/appendix-1-hcw-risk-assessment-tool.pdf). They have broken down the risks as well; were you masked, was the patient masked, if the patient wasn't masked, was the employee wearing a face shield and a mask? If an AGP occurred, was everyone in full PPE? I find using that risk assessment very helpful in trying to define if exposures happened.	

	Pam Bruhn: Sometimes the challenge is going back and trying to determine that, with the number of potential contacts involved in all of these different scenarios, whether it was the patient who we think was contagious potentially exposing healthcare workers (HCWs) based on the type of treatment they were receiving, or what PPE they were wearing. However, I'm just as concerned about our HCW and their contacts with each other. People are getting tired and may get lax because they feel very comfortable around the people they work closely with day in and day out. Mary Post: Our first employee with COVID-19 was way back in March and that's the only one with an unknown source of infection. All our other employee cases have been close contacts of cases, usually household contacts, and they've been placed on work restrictions. They can work remotely, but they do not work at the hospital. At this point, we have been able to accommodate staffing and coverage for people who have been on work restrictions. Katherine Kroll: One of our Washington hospitals is in a county requiring us to notify patients if a caregiver works at all during their infectious period, and we have found since going to universal masking that we've had no transmission from any HCWs to patients in any of these situations. We've done both testing and monitoring of symptoms in those patients. We do place the patient into isolation precautions after a known exposure because we're testing them and want to make sure that they don't end up in a shared room. As a community, I'm wondering how much data we feel is needed before we can show universal masking effectively prevents transmission and what a burden this is on our infection prevention teams. Paul Cieslak: We endorse CDC recommendations unless we have data to suggest that things are different. We posed this question directly to CDC and their response was unequivocal: even if both people are masked and all recommended PPE was worn, if they're meeting the time and space criteria, of 15 minutes spent together within 6	

	feet, we would still consider them exposed and quarantine accordingly. We reviewed one paper that looked at a couple of hundred patients in the hospital who were exposed and after testing about 40% of them, the only positive they found was somebody whose spouse was also positive. So, that was presumably a community-acquired case, not hospital-acquired. There is not a lot of data and it would be awesome if you all would summarize your experience with HCWs who prove to be positive and you described how you followed up with them so that we could collectively say that this doesn't appear to be a risk. The other topic I have for our discussion is how people are approaching PPE purchasing. As the number of manufacturers rise, new info comes out about what types of PPE is and is not the most effective or appropriate, and, of course supply chains continue to be interrupted. We know that we need to be using medical-grade PPE, but what type of medical-grade PPE can be a bit difficult to assess and there are different ways that PPE are categorized such as different levels that the Food and Drug Administration (FDA) assigns to masks. Assessing whether your masks are that level or not can be challenging. How are you evaluating and making purchasing decisions about PPE? Mary Post: This is a real headache and a struggle if I am interpreting some of the guidance correctly. You fall into Tier 3 if you're using any PPE that has FDA emergency use approval that has international standards. If I look at the language in the documents, it appears to apply to N95 respirators but also other types of PPE, such as masks. We got some donations of face shields that came from an auto repair company, but my interpretation is that puts you into Tier 4 because they are basically homemade and from various companies like Ford. We know where they were manufactured, but I can't tell you if they have medical grade claims, so we're having to spend a lot of time backtracking and reassessing our inventory to be certain that we are staying in Tier 1 and Tier 2 of PPE contingency standards, and then, I think,	

	when you apply some of the guidance for extended use versus limited reuse, it becomes very complex. Pam Bruhn: We're having the same discussion in our PPE Committee meetings. The goggles are required to be marked as medical grade. Early on, we were sourcing anything that met criteria for being good protection, and we got face shields from several locations. So, we're trying to do the same thing that Mary mentioned, either repurposing or trying to figure out how we meet the criteria for the tiers. Kirsten Schutte: It's a challenge and we've had our materials management folks trying to source anything that meets medical-grade criteria. There was an emergency use agreement (EUA) for face shields, and essentially because it's just a physical barrier that must be cleanable, for fire resistance companies had to say what they are made of. It allowed us to use some locally manufactured equipment. When that EUA was removed, it was not helpful, and I haven't heard a recent update. The last word that I got, after we had been working on this for months, is there's really nothing out there that's easy to find. We had staff members complaining about what we can source in terms of their ability to do their job and wanting to bring in their own equipment. While I understand we need to have standards, it's challenging when you have a provider who has sourced their own eyewear that meets the physical criteria from a protective standpoint in terms of protecting the eyes, but we don't have the bandwidth to research and say if it meets medical-grade criteria. We're also having difficulty trying to make sure facemasks meet all of the filtration standards as well as the fluid-resistance standards; what happens if we can't enforce that and how far do we need to go to make compromises in terms of what we're purchasing now. We have a fallback plan if we can't source something we feel is better-quality and more clearly meets standards that normally we would expect. Roza Tammer: I'm going to switch gears to another discussion point. We really want to hear from the group on what you want to discuss in December. We had a lot	

	of questions about if we will be rescheduling our Infection Prevention Fundamentals offerings - this was a multi-day training program that we had planned for the beginning of April. We did have to cancel due to COVID-19, because we felt that it would pull a lot of people and resources away from the COVID-19 response, which was beginning to ramp up at that point. At this point we do not have the capacity to begin planning that course again. I know that there is a lot of interest in basic training around infection prevention, because so many of our facilities are bringing on new staff. I wish I could say I knew when it would be happening or when we will have the bandwidth for it but at this point, I don't. However, we are continuing to be available to work with you and offer answers and support around all types of healthcare-associated infections topics, including COVID-19 infection control, flu outbreaks, and multidrug resistant organisms. We just do not have a lot of resources for general training. The Association for Professionals in Infection Control and Epidemiology (APIC) has offered trainings in the past, and for long-term care, there are web-based trainings online from CMS and CDC, so I will ask the group how have you been approaching training for new staff doing infection prevention work and what resources would you suggest to colleagues? Pam Bruhn: I did get a save the date from the University of California at San Francisco (UCSF) and they are having a live stream conference Friday, November 5th with a COVID-19 update for advanced healthcare practitioners. It's about $250.00 and they will go over vaccination, long-term consequences, optimizing diagnosis, and cases across the spectrum in special populations. But it's very specific to COVID-19, not necessarily addressing your question of fundamentals. Roza Tammer: That's great, Pam. I think there may be many training needs at this moment but I'm not as familiar with what they all might be, so if anyone wants to share other opportunities, we can send them out to the group. In terms of what to discuss in December, I	

	think one topic influenza season. Any thoughts from the group on what you would like to hear about in December, or any public comment? Pam Bruhn: I am thrilled to talk about flu, because that was on my mind as well and I'm wondering if there could be something sooner than the December meeting, perhaps in November, to share best practices or how people are doing with their COVID-19 patients and increasing vaccination rates.	
Discussion: Topics for future meetings & reports All members and attendees	• Influenza season • Long-term effects of COVID-19 diagnosis • Cohesive pandemic preparedness system within Oregon	
Public comment		
Final roll call & adjourn		

Next meeting will be December 9, 2020, 1:00pm-2:15pm via webinar only.

Submitted by Brittany Williams
Reviewed by Laura LaLonde and Roza Tammer