Healthcare-Associated Infections Advisory Committee
December 8, 2021

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

Speaker: Recording.

Next Speaker: ****.

Next Speaker: Okay. Recording and everyone is joining.

Next Speaker: Great. Hey, good afternoon everyone. This is Dennis Rapiza, um, from Kaiser Permanente. I'm the chair. So, um, it is now 1:03, and the meeting will now come to order. Um, we're gonna do roll call a little bit differently, um, a little bit differently today. So, um, what we're –

Next Speaker: Sir?

Next Speaker: – gonna ask is that –

Next Speaker: ****.

Next Speaker: ****, and then, um, so we're gonna do roll call a little bit differently. If you check out the chat right now, you can see where Rosa has put in please type your name, organization, professional role and then any pronouns, um, that you might be using, um, into the chat to introduce yourself, so this will definitely save us a lot of time and then we'll all be able to review and see where everybody else is from. Okay, let's kick it off then, um, with our second logistics update coming from Rosa Tanner.

Next Speaker: Hi everyone. Can you hear me okay? Okay, great. Well, welcome to our December HAI advisory committee meeting. Um, in terms of logistics update, I want to first say that, um, we have a new chairperson formally nominated who is Dennis Rapiza. He was, um, sitting in to be our chairperson in an interim basis during our September meeting, so I'm just very, extremely pleased and excited to have Dennis joining us in our chairperson role. Um, he's been a member of our **** for quite a while and, uh, an important collaborator with our program, um, and so welcome, Dennis, and again, just a huge thank you to our outgoing, um, chair, Dr. Genevieve Huser who just was invaluable to our program and served in the chairperson role for an extremely long period of time. Um, we really are grateful and appreciative, so welcome to Dennis. Thank you to Gen. And, um, with that, I will go ahead and

mention our current vacancies. Um, so we have four vacancies, one of which is the consumer or patient advocate role. Um, one is the health insurer representative. One who, is the physician who practices in an ambulatory surgical center with interest in involvement in infection control, and one is the hospital administrator with expertise in infection control in a facility with fewer than 100 beds. I'm gonna actually be pasting this into the chat right now. And then everyone should also have a sheet in their meeting materials, um, called Bring Your Voice to the Table, which also is a one-pager kind of covering the sort of bread and butter of what the **** members do and also lists those vacancies. Do folks have that in their meeting materials? Just to make sure, I'm pretty sure you do.

Next Speaker: I believe it's Page 1 of your meeting material if you guys wanna check that.

Next Speaker: Great. Thank you. So, um, we are making good headway with filling some of our vacancies, but of course, we want to have a fully, um, staffed up advisory committee at all times that we possibly can, so if you are just attending the meeting and not, don't have a formal member role, um, and you feel that you may be qualified for one of these positions, we would love to hear from you, and if you have any thoughts about people who I might be able to follow up with and bring into our fold, um, who might be qualified for one of these roles or interested, I would absolutely love to talk with them. Um, so just thank you so much in advance for helping us to fill our vacancies. Um, obviously we have transitioned to a new platform for meeting which is Zoom. Uh, we had been using Go To Webinar for quite a while. Um, we're hoping that this is gonna be a little bit more user friendly. Um, it's allowing us to see each other's faces already which is such a wonderful and positive thing especially since we don't see a lot of each other in person anymore. Um, so we do have, um, you're welcome to turn your video on at any point so we can see your beautiful face, and we also have a, um, Zoom sort of cheat sheet in your meeting materials as well. If you have any technical issues, you're welcome to paste them into the chat, and the other piece I'll mention here is that, you know, um, if anything kind of comes up that, you know, we don't have covered in our Zoom cheat sheet, we'll definitely be, uh, working on solutions and fixes and adding that, so it will be a living document, and, um, already I think we're seeing that we're not encountering a ton of technical issues, so thank you all for bearing with us with these changes, shifts and changes, um, while we refine our sort of remote meeting approach. Um, let's see. Oh, and the last piece I wanted to mention is that, um, we have changed our registration link slightly. Um, when you register for these meetings, you will need to now indicate your organization and position. Um, that's just because we are having so many new people joining us that we don't know all of you all the time, um, so we just wanna know who we're chatting with, who we're hearing from, so organization and position will be asked for along with, you know, kind of whether you're a lobbyist, a member of the public, all of that good stuff in the future. So does anyone have any questions or thoughts on the logistics update? Great. Well hearing none, I'm going to turn it over back to Dennis for approval of our September 2021 minutes.

Next Speaker: Great. Hey everybody. It's Dennis again. So if you take a look at your packet. I believe it's over on Page 28. It's gonna be our September 2021 minutes. Um, so you should've already received those and hopefully have reviewed them. So do I have a, a motion to approve the minutes?

Next Speaker: I'll move to approve the minutes.

Next Speaker: ****.

Next Speaker: ****. Do I have a second?

Next Speaker: This is Debra Katura.

Next Speaker: Debra.

Next Speaker: Yeah, I'll second it.

Next Speaker: Okay. Great. So the minutes are approved. Um, and our next topic will be Rebekah Pierce, prevent, uh, presenting us with OHA updates. Take it away, Rebekah.

Next Speaker: Thanks, Dennis. Hi everyone. Welcome. Uh, my name is Rebekah Pierce. I manage the healthcare associated infections program. I'm gonna give a very brief, um, Omicron summary 'cause I know that's on the forefront of everyone's mind right now. Um, main takeaway is there's still a lot to learn, so I'll just go through this quickly and then I'm happy to take any questions on this. Um, so I think most have heard this at this point, but on November 24, 2021, South Africa alerted WHO about a sharp increase in cases, um, with an emerging variant that was then dubbed B11529. Uh, the variant was first detected in South Africa on November 9th and has quickly gained dominance. It now accounts for over 75 percent of all circulating variants in South Africa. Um, on November 26th, WHO technical advisory group designated, um, B11529 a variant of concern and assigned it the Greek letter Omicron which has caused a lot of consternation about whether it's Omicron or Omicron. I'll let you choose. Uh, this variant has been detected in quite a few countries at this point. The first case in the U.S. was detected in California, um, in a fully vaccinated returning traveler but has been since identified in 19 states throughout the U.S. Um, what's concerning all of us is that the variant contains approximately 50 mutations across its genome and approximately half of these occur in **** which raises concern for transmissibility and vaccine effectiveness. Um, what we know so far, and it's not all the pieces, but, um, regarding transmissibility Omicron has quickly outcompeted Delta in South Africa, so it appears more transmissible than the Delta variant but we still have more to learn about how much more. Um, disease severity, South Africa has been stating no unusual symptoms have been reported following Omicron infection, but they are monitoring this closely as are other countries. Um, we'll be learning a lot more about this in the coming weeks. Um, it is a little bit difficult to extrapolate from the South African population to others, so more to come on that. Um, regarding vaccine effectiveness, there are mutations present in Omicron that raise concern for reduced vaccine effectiveness. Um, it's unknown whether vaccine effectiveness against severe infection will be affected. For those that are tracking, Pfizer put out some fairly reassuring, um, neutralization data this morning keeping in mind that that's lab data, not vaccine effectiveness. Um, but it does indicate some protection with boosters, so, um, that is good news. Uh, regarding therapeutics, the mutations in Omicron raise concerns for reduced effectiveness. This is actively being investigated at this time. So our message what can people in Oregon do, what can our patients do to protect themselves, what can residents in long-term care facilities do to protect themselves, our message is really the same.

Those who are not vaccinated should get vaccinated. Those due for a booster should get it as soon as possible. Masking, social distancing, hand washing remain incredibly important with an emerging variant. Um, OHA is monitoring this very closely. Um, Oregon has a robust variant surveillance system, and unless it happened in the last few minutes no cases have Omicron have been detected in Oregon at this time, but we do anticipate that will be coming in the next few days. Um, I do wanna put out one note for our partners, um, regarding diagnostics. Um, the variant has an S gene deletion that causes S gene target failure in certain molecular tests, so our laboratory partners have asked us to remind that laboratories using the ****, um, are requested so send any specimens with an S ge, S gene target failure pattern to be sent to our public health lab for testing, um, and this information was sent out via handler, um, earlier this week. That's all for me. Happy to take any Omicron comments or questions.

Next Speaker: So remember to unmute yourselves if you have any comments or questions, and the mute button should be on the bottom left hand side of the screen.

Next Speaker: All right. So I'll hand it back off to Dennis.

Next Speaker: Great. Thank you for that update. Now let's move onto the next topic, uh, influence of vaccination and surveillance update. It's gonna be presented by Monika Sam, Samper and Andi Hendrick.

Next Speaker: Hey, this is Andi Hendrick. I can go first if that works for you all. Uh, Laura, were you going to share your ice cream? Oh perfect. Um, all right, so like I said my name is Andi Hendrick, and I am the OHA influenza epidemiologist. Um, so first here we'll take a look at what's been happening in the respiratory pathogen world in the last 2 weeks. So last week the percentage of ED visits with influenza like illness was 1.3 percent, um, which is a little bit higher than we saw the previous week. For the 2021/22 season 1.3 percent, uh, is pretty standard. We report these percentages out on a weekly basis and over the season we've seen ranges from 1.2 to 1.5 percent. Um, for positive influenza tests in the state, last week we reported 0.3 percent of influenza tests being positive. Um, for this 2021/22 season, this number has also been pretty standard. We've seen these ranges fluctuate from 0.1 to 0.5 percent. Um, and last week we saw our first flu cases in the tri county area, so while this table says, um, oh, and while this table said we've had zero hospitalizations, um, I did see our first flu hospitalization in the tri county area yesterday. Oregon has no influenza outbreaks and no influenza associated pediatric mortality to report. Um, and RSV in Oregon has been on the rise, so last week we reported 12.1 percent positivity which is the highest we've seen this season. Um, next slide. Thanks. Um, so this table takes a look at the influenza test results by region for the week of November 21st to 27th. Uh, during the week we saw majority of our cases coming out of southern Oregon, um, and as I mentioned in the previous slide, we're now seeing a few cases in the Portland metro area. Uh, you can always take a look at our flu bites report. It's published every Friday, um, so if you ever wanna kinda see a breakdown of cases by region, um, you can look at the entirety of the season in that report. Next slide. Um, so this one just kinda takes a broader look at positive influenza cases for the 2021/22 season. Um, as I mentioned, the lowest percentage of flu positive tests, uh, is 0.1 percent, and that was seen in Week 44 and the greatest we've seen is 0.5 percent which was seen a couple weeks ago at Week 46. Next slide. Um, for a breakdown, um, for percentages of visits for ILI outpatient clinics and ED by Oregon region, um, we can kinda see here that our, our

lowest rates here have been seen in the Willamette Valley. Our highest have been seen in the central and Gorge area and then right in the middle is gonna be, um, that Portland metro area. Next slide. All right, so looking at Oregon ILI activity level from kind of a broader scope, um, we're doing really well. So our ILI activity status has been low for the entirety of the 2021 to '22 season. Um, this map is updated on a weekly basis, so if you're ever curious to see how Oregon or any other states are doing, you can check out CDC's web site. Um, it's also included and updated on our weekly flu bites report, so a couple of different places you can find it. Uh, next slide. Perfect. Um, and then I'm sure many of you saw the hand, um, update that recently came out about influenza. We are expected to see an increase in influenza activity in young adults in collegiate settings. Um, so we have some conversations in the works about ways we can be proactive around vaccines and education, um, but in the meantime, recommendations for clinicians and public health practitioners include recommending and offering the influenza vaccine, testing, um, influenza patients with antivirals, testing for influenza when it's expected and recommending those non-pharmaceutical options like routine surface cleaning and proper cough etiquette. Um, for members of the public, it's recommended to get vaccinated as soon as possible, to take everyday actions to reduce germs such as staying at home when you're sick, um, and taking those antivirals when they are prescribed by a healthcare provider. Um, so that concludes my presentation on the flu. Uh, I mentioned it a couple times, but Oregon's flu data is published every week on Fridays, um, and then you can also find our RSV report and that goes out every Wednesday if that's something you're interested in, in taking a closer look at. Um, if you're unsure of where to find that material, just put it in the chat and I can get you set up with where to find it and how to get put on the certs to be, um, notified when it comes out every week.

Next Speaker: Okay. Now I think we'll go over to Monika.

Next Speaker: Hi, this is Monika. I'm actually not going to present to you.

Next Speaker: Oh wait ****. I think –

Next Speaker: Becca's gonna present for me.

Next Speaker: I think we have a question for Andi.

Next Speaker: Okay great.

Next Speaker: ****. It looks like, oh the question what's going on in New Mexico. I guess ****.

Next Speaker: Um, I am not sure what's going on in New Mexico. Uh, if you'd like I can try to find some material to like maybe review, um, or send out if that's something that you'd be interested in, but it has been, um, higher than the other states for a little while now, but I'm not quite up to date with what's going on in New Mexico.

Next Speaker: Okay. Are, are there any other questions. I'm sorry, before I move on, uh, to Monika, I wanted to make sure to give people opportunity to ask a question.

Next Speaker: Looks like there's a chat from Jesse Kennedy regarding being adding to the list serve.

Next Speaker: Yeah. I can definitely send that information out. I will connect with you, um, in a separate chat.

Next Speaker: Okay, great. Hearing no further questions, um, let's move on to Monika.

Next Speaker: Hi there. Um, Becca again. Sorry to disappoint. I'm, uh, gonna steal the spotlight from Monika today because we wanna give a very specific, um, influenza vaccination data update today, um, to follow Andi, here. Um, so, what I'd like to share today is a mockup of our healthcare worker influenza dashboard, which we hope to release in the coming months or so. Um, couple of goals to, in getting this together, so I think as, as many will remember, Monika puts together an annual flue vax data report that summarizes healthcare worker, um, influenza vaccination by **** type and by types of healthcare workers. It shows both state level and facility-level data, and it's been hugely helpful. The one thing we wanted to add in releasing a dashboard was having, um, previous years' data available as well so that we can see trends, um, progress for our different facilities, and have a more interactive resource for our partners, consumers, others. Um, so, that is one piece. The other piece is, we were observing, as I think many will not be surprised to hear, some decreases in flue vaccination among healthcare workers over the last 2 years, and think a lot of that is the focus on COVID, COVID vaccination, um, and we felt that this was well-timed to get out there because it is still possible to get your flu vaccine and your booster at the same time. A lot of our clinics are offering those now, so we really wanna encourage people to get vaccinated for flu so we're not, um, having a lot of susceptible people in our population, particularly in our healthcare workers, when flu does reemerge. So, I'm going to try and share my screen again here. Bear with me. Let's see. All right, maybe Dennis or someone else, can you tell me if that's visible?

Next Speaker: Yeah, I can see it.

Next Speaker: Does it look like a dashboard?

Next Speaker: Uh, ****, yeah. You might wanna maximize, yeah.

Next Speaker: All right, let's try that.

Next Speaker: Great. Yeah, that looks good.

Next Speaker: All right. So, this is a mockup. Just note that this is dummy data, uh, for now, but, um, we did wanna share what we anticipate this will look like. So, um, the first tab of this dashboard summarizes key metrics for the current influenza season. Now, remember current for us is 1 year retrospective because we collect annual data from our healthcare facilities, so this shows total vaccination acute care hospitals, long-term acute care hospitals, free-standing ambulatory surgery centers, inpatient psychiatric facilities, outpatient dialysis facilities and field nursing facilities, and it looks very much like the data that we report in our, um, annual report. So, it talks, it gives you denominators, tells you total healthcare workers, the rate of healthcare

workers vaccinated among those that are eligible, so don't have a medical contraindication, and that's at 73 percent, um, notably lower than we've seen in previous years, and then it gives some information about declination, um, unknown status, and the number of healthcare workers we need to meet to reach a 90 percent vaccinated goal. Again, dummy data, so don't infer too much about this, but, um, the, um, dashboard will show trends over time by different facilities. It can be filtered by county, so you can see specifically for your area. Um, –

Next Speaker: Healthcare facilities.

Next Speaker: – so, you'll receive an email soon asking you to verify this information, um, but what we'll be asking you to do is to go onto the detailed pages where you can see all facility-level data. Um, it does show kind of overall trends. However, you have this filtered at the top, so you can look by facility type, any of those that report to us, county, healthcare worker classification, so whether they're contract employees, licensed independent practitioners or students, trainees or volunteers, and then of course you can search or look by a specific facility. Um, you can see trends over the last 5 years or so, um, and then we'll ask healthcare facilities, when they're doing some validation work for us, to actually go to this table, look at their facility, and document the, their vaccination rates over time, make sure that's consistent with what they reported. Um, that is about it. I hope we're achieving the goals of having an interactive tool to help us track this better in our state, and special thanks to Monika Samper, who's led this effort for the last I'm not sure how long but longer than 5 years, um, and she does a great job. So, um, that is it for me. I'm happy to take any questions about the goals or what this will look like once published.

Next Speaker: I have a quick question, actually. Do you guys also incorporate a graph of Oregon with the counties broken up with rates highlighted, or?

Next Speaker: Yeah. We, the, the dashboard is filterable by location. It also has a separate map on one of the detailed pages where you can actually, you click and interact with the Oregon map itself, but yes, that information is accessible. All right. Well, more to come on this, um, thanks everybody.

Next Speaker: Great. Um, but now, Monika, did you have a slide?

Next Speaker: No. Becca was presenting on Monika's behalf today, but Monika –

Next Speaker: Oh, okay.

Next Speaker: – prepared with the material, I think, –

Next Speaker: Okay.

Next Speaker: – so.

Next Speaker: Okay, looks like we're, we're making really good time. Um, let's, let's move on to the next agenda topic, the NHSN data review with Rosa again. Um, there's –

Next Speaker: Yes.

Next Speaker: – some really interesting ****. So, okay.

Next Speaker: Thank you. And Laurie, will you be able to share my, the slide on my behalf? Thank you so much. Can everyone see this okay?

Next Speaker: Yes.

Next Speaker: Yeah, okay, great. Okay, well, I'm presenting, um, a bit on 2020 HAI data. Um, and I wanna just give some credit to my colleague, Lisa Iguchi, who many of you know. She is, um, our NHSN lead now, and she did prepare these slides, so thank you to Lisa in her absence today. Next slide, please. So, the objectives for this presentation are to discuss HAIs in the context of COVID-19, review national 2020 HAI data, and then preview Oregon's HAI data and visualization. Next slide. So, pre-pandemic, we were seeing pretty encouraging decreases widely in HAI incidents in U.S. hospitals, um, and recently, CDC published a summary of data reported to NHSN for the year 2020 that illustrates the impact of COVID-19 and the pandemic on HAIs. So, while significant progress on reducing HAIs has recently been made, the COVID pandemic placed a burden on hospitals, infection preventionists and surveillance professionals which impacted HAI incidents, mainly for, um, CAUTI, so catheter associated urinary tract infections, VAE, or ventilator associated events, MRSA bacteremia and, um, with CLABSI, or central line associated blood stream infections having the largest increase. Next slide, please. So, just as quick refresher, the standardized infection ratio, or SIR, is the summary measure that we use to track HAIs at the national and state level, and it is our ration of observed infections, uh, over predicted infections, and when we are interpreting our SIRs, we're looking at any SIR greater than one indicating that more infections were observed than were predicted. If it's less than one, fewer infections were observed than predicted, and if it's equal to one, the same number of HAIs were observed as were predicted. If the number of predicted infections is less than one, an SIR will not be calculated, and if there are zero infections, I believe the SIR is also equal to zero. Next slide, please. And I will just also clarify that the number of predicted infections is based on 2015 national baseline data. So, looking at this next side, while CLABSIs saw a significant increase in 2020 nationwide, the impact differed among states. When comparing Quarter 3 of 2020 to Quarter 4, uh, 3 of 2019, acute care hospitals in Oregon saw a 12 percent increase in the CLABSI SIR, but the SIR did remain below 1.0, meaning there were still fewer CLABSIs observed than were predicted. Next slide, please. For CAUTIs, a larger increase was seen in Oregon, so compared to Quarter 3 of 2019, Oregon acute care hospitals saw a 31 percent increase in the CAUTI SIR in Quarter 3 of 2020. Again, however, the SIR remains low, um, below one, meaning fewer CAUTIs were observed than were predicted even considering the increase. Next slide, please. Um, however, for MRSA bacteremia lab I.D. events, while an increase was seen in the U.S. overall, Oregon acute care hospitals actually saw a 33 percent decrease in MRSA bacteremia SIRs when comparing Quarter 3 of 2019 to Quarter 3 of 2020. Again, that SIR was lower than one in both 19, 2019 and 2020, showing that Oregon hospitals saw fewer MRSA bacteremia than **** predicted both years, but again, there was a decrease in MRSA bacteremia. Next slide. So, these tables provide a comparison of 2019 and 2020 quarterly SIRs for the U.S. and Oregon acute care hospitals. None of the differences for

Oregon were ****, statistically significant. It's been a while since I've gotten to say that phrase. Um, so when they do go up and down, you can see that the arrows are represented in a lighter shade of red or green. Most of the changes at the national level are statistically significant, probably driven by the fact that the numbers are just so much larger. Um, something to take away here is that while we're seeing rising SIRs over time for these infections nationally, we're seeing less consistent increases in Oregon, and in some cases, just as I mentioned in ****, for MRSA bacteremia, we're actually seeing decreases as well, and I just wanna point out that these slides have another quarter of data than do the ****, the data on the slides with the maps, so we ended at Quarter 3 of 2020 on the previous slides where that was the comparison, Quarter 3 of 2019 to Quarter 3 of 2020. This, we're looking at all four quarters of 2020 nationally and state. Um, okay, next slide. So, again, we're looking at some tables here. Um, for colon surgery and abdominal hysterectomy surgical site infections, and for Clostridium or Clostridioides, difficile lab I.D. infection events, decreases were seen in the U.S. overall. Note that there were a very small number of colon surgery SSIs, fewer than five in 2019 and 2020, so while we're seeing kind of a large-looking increase during the last two quarters for, um, colon surgeries in Oregon, um, it's really related to a different Sub 1 or 2 infections. Some of the decreases observed, um, in the U.S. and Oregon could potentially be related to the decreases in surgical procedures being carried out and possible decreased antibiotic use, um, although, you know, I think that there are a lot of differing opinions on this and, like, really complex dynamics that way. Um, you can see again that the Oregon changes are not statistically significant at the state level and also that the SSIs and CDI events look pretty different from CLABSI, CAUTI and MRSA, at least at the national level as well. Next slide, please. So, the 2020 HAI data are now available on the CDC antibiotic resistance and patient safety portal. Um, you can look at data overall. You can also look at it by a geographic region, and you can download a report for an Excel file of the data; an uplink is at the bottom of the slide here. Next slide. So, now, we will go through some preliminary data from Oregon in 2020 in comparison – or, sorry – presented alongside previous years. So, as a reminder, the data are preliminary and subject to change. We're looking at trends from 2016 to 2020 in statewide SIRs for Oregon, acute care and critical access hospitals for CLABSI on the left and CAUTI on the right. You can see there was a bit of a jump for critical access hospitals for both types of infections, but we're also not seeing any major upticks in either type of facility or infection right now other than, you know, a jump from SIR 0 in 2019 to 1.2 in 2020 for CLABSIs in critical access hospitals. I just wanna say those data are quite low, and an SIR of zero is, you know, subject to interpretation, I guess, in terms of how it kinda falls in this trend. Next slide, please. So, this is looking at trends from 2016 to 2020 in statewide SIRs for Oregon acute care and critical access hospitals for lab I.D. MRSA bacteremia events on the left, and Clostridioides difficile infection events on the right, again, not seeing any huge jumps here. Like the last slide, the numbers for critical access hospitals are less consistent, um, than for acute care hospitals since the numbers are smaller, but the SIRs are actually declining for acute care hospitals for both of these types of events, um, and for critical access, we're seeing a kind of drop between, um, 2019 and 2020 for MRSA and pretty much right on par, um, 2019 to 2020 for, uh, CDI. Next slide, please. Okay, and finally, looking at the same data, but for adult surgical site infection SIRs, from left to right, we're looking at coronary artery bypass graft, colon procedures, hip arthroplasties and knee arthroplasties, so CBGBs in blue, colon in orange, hip in teal and knee in green. Notably, all of our 2020 SIRs were below 1.0. For, for each of these SIR, SSIs we're seeing fewer infections than predicted, so that's a positive thing. Two of these did have an increase between 2019 and 2020. You can see that for CBGB and ****, but three actually saw

declines from 2019 to 2020, H pro, um, I'm sorry. I failed to mention hyst, abdominal hysterectomy and knee arthroplasties are ****. So, we have seen some publications over the last year that are talking about the impact of COVID-19 on HAIs. I think there's just a lot of thoughts about this floating around. Um, you know, for example, non-emergent surgeries were delayed, you know, fewer surgeries, in general, were performed. Um, optimization strategies for PPE may have impacted infection, um, rates as well. So, we may be seeing both kind of positive and negative externalities of our COVID, um, COVID mitigation kind of intervention, but also just the reality of dealing with COVID in kind of a healthcare setting in the community. Um, one thing I will say, however, is that Oregon, as per usual, looks good in comparison to national numbers. I just take a lot of, you know, it makes me feel good to see our performance even those these are preliminary data and that the national numbers also give us an inkling of what we need to be, you know, vigilant for and watching out for in the future as well. Next slide, please. So, currently, we're working on developing an interactive tableau dashboard to display HAI data for Oregon hospitals, and we will expect that to, um, display statewide trends from 2016 to 2020. Uh, we hope that it will allow data to be filtered to the facility level and can serve as a master dashboard where subsequent years of data will be added as well, and we'll be communicating further with Oregon hospitals as that dashboard gets developed. Next slide. So, um, that brings us to the end of my presentation, um, and I do see one question in the chat, and then I'll turn it over to Dennis for facilitating some group discussion. Um, the, we are not fully up to date on having, you know, our annual reports published on our website. Um, I believe, uh, I'd have to double-check which is the most recent year, but Jesse, I'm sure you're correct there. So, um, these data are gonna be made publically available, I believe mostly in the dashboard form before we possibly could expect, um, like an aggregate report, but maybe, Becca, you have, uh, updates on that, that you might be able to offer as well here. I think Becca might have had to hop off, so let's, I will put that on hold for now. Um, you know, we, our staff has been, uh, really impacted by the COVID work that we've been doing here in our agency. Um, so, you know, what we have online is probably what is available at the moment publically. Um, certainly, our 2020 data aren't available online yet, um, but, uh, if we have any updates on when those data are expected to come out, I will certainly share them. Thank you for the question, and Dennis, to you for some Q and A and discussion.

Next Speaker: Yeah, great. Thank you so ****. That's really interesting. I'm so glad you guys are going to that, um, tableau report too 'cause it's, it will be great to be able to filter out by facility and, you know, 'cause then we can look at each other and see what might be best practices and stuff. That's why I always find those reports very useful. Um, so, uh, in terms of discussion, though, we really wanted to know about how reporting went, you know, in Oregon. Like, how, how did your reporting go? Was there anything holding you back from reporting, um, you know, anything that impacted you? Was it hard to detect them during COVID? Um, anything that may have affected your implementation, and like, just for an example, I can give you an example of, uh, Kaiser Permanente. Um, we know that we were pulled in so many directions with COVID. Um, for one, we were reviewing all of our chemicals to make sure that they were effective at that time. Um, we were reviewing all the PPE, rewriting PPE protocols so many times, getting it on the website, getting these messages out. Um, so it really pulled the IPs away from a lot of their surveillance activities and a lot of the in the moment on the unit trying to make a difference, you know? Um, our audits went by the wayside for CLABSI and CAUTI. Therefore, I will admit, we did also see an increase in our CLABSI and CAUTI at Kaiser during

this time, and a lot of it, we think, may have been impacted by our, our ability to get on that floor and, you know, talk about **** bundle and see we were, where we were not in compliance. Um, so, there just wasn't enough manpower at the time. So, I'm wondering if those of you on the call have run into things like that, if we, you know, we wanna discuss, um, anything that impacted your ability to do surveillance, detect it or report it, and then I know I see a bunch of you guys on here who report. Um, you know, I, I see Trista, Carolyn, um, Karen Brooks and Yu-jin, so if you guys would like to comment on any of these, uh, the floor is open. Remember, the mute button is in your lower left-hand corner. It's like a little telephone; you can click on that, or you can also get it by the three dots, um, next to the three dots in your picture.

Next Speaker: And just as a reminder, we're talking about NHSN reporting of our kind of bread and butter data that we just went over. Obviously, NHSN has grown tremendously, um, so, we're really talking about the SSIs, CLABSI, CAUTI and the, you know, MRSA and CDI events as well as **** if you report it.

Next Speaker: This is Trista Berry, um, with Saint Alphonsus in Eastern Oregon, and I know for us, um, we've been able to keep up with our surveillance and reporting. Um, what's been hard, though, is, um, when we have incidents, um, is really being able to follow up with action plans from our managers and frontline colleagues. Um, they're so overwhelmed and overworked, um, that really asking them to do more than just take care of patients right now, um, has been really hard, um, and that was really hard in 2020 as well. So, um, you know, while our, our infection prevention was pulled to other areas, we were asked to, uh, join the labor pool and help with screening and all of those other activities, we still tried to prioritize our surveillance to keep up on that.

Next Speaker: Yeah, that was definitely the case. I, I completely forgot about the, the labor pool being called in, so we, we always had emails at Kaiser saying can you, you know, can you be sitter for this afternoon or anything that's, like, trying to **** control staff out of there, um, out there and helping out on the ****. Um, what about, um, OHSU or Salem? Do you have any comments on how you guys handled reporting to NHSN during this time period?

Next Speaker: Hey, Dennis, this is Yu-jin from OHSU. Um, can you, I just got back on because I had, uh, a side conflict. What was the question?

Next Speaker: We, we just went through the NHSN, uh, data for showing, that was over the time period for COVID, and we're wondering, um, how your reporting was going, was anything impacted, you know, by COVID? Um, were you able to detect things the same way and report those things out?

Next Speaker: Um, I, at OHSU, we were very fortunate to have, uh, five experienced IPs with CIC certification, so we didn't have any impact to surveillance, but what we, um, did, uh, notice is LAM is no longer, um, OHA mandated, but we are continuing to perform LAM surveillance, and I was just curious to see how many other hospitals were continuing to do LAM surveillance.

Next Speaker: I know at Kaiser we're continuing because, uh, we've got an increase in our final inspection, so I was like, uh, I didn't wanna drop it at this time period, you know. I don't like

dropping things unless, uh, we maintain a steady zero zone, um, but yeah, we are continuing to, um, track those.

Next Speaker: Dennis, this is Karen from Silverton Hospital here.

Next Speaker: Hi ****.

Next Speaker: Hi. So, I can't say that we had, um, problems with reporting to NHSN, but I can say that there was a change in length of stay for patients, which I –

Next Speaker: Mm hmm.

Next Speaker: – believe everybody experienced to the point that, that increased their risk for possibly getting a CLABSI or a CAUTI because devices remained in longer. Um, and then, you know, I've read the comment here from Willamette Valley Medical Center. You know, I do believe nurses are doing the best they can. I just really value the impact that our EMR is as well, so that is where I think reviewing of a patient's, um, record and then pulling the data points from there to help with our reporting, um, particularly our SSI, um, HAI report that we can build, it's just, it just is, has a wealth of resources there, so.

Next Speaker: Yeah, thanks for those comments. We, we definitely saw some of the same, uh, ****, especially with the, uh, extended length of stay, um, and then you know, several of our COVID patients had to be in that prone position, so we did see an increase in our CAUTI. It's, it's quite hard to perform cath care and, and maintenance some when the patient is prone. We actually came up with, uh, a COVID-CAUTI bundle that, you know, trying to reinforce what to do when the patient, um, does have a COVID diagnosis who has to be in that prone position. Um, and then I, I can see the comment from Kristen, um, about the, how they're seeing the same at WVNC, um, and they're taking all the efforts to get back to the basics, which I think is, uh, extremely important right now. I just did a pitch, I think, last Thursday to Kaiser leaders on, um, you know, during this time when we're, um, you know, we have compassion fatigue and we're overrun with all these new things coming at us, that maybe it is the best time to get back to the basics and remind everybody of some of those basic things in infection prevention, you know, have a whole-house effect across the board in reducing in reducing HAIs. Thank you for those two comments. Any, anybody else from the hospitals who's interested in letting us know about how you were impacted in reporting? I do remember that for a time period, there was, um, there was an ability to let up on your reporting. I don't know how many hospitals took advantage of that, um, and maybe I'm just dreaming, but I thought, I thought for sure that that had happened.

Next Speaker: Dennis, this is Pam from Salem Health. Um, I would certainly, uh, echo the comments from folks about the additional pressures on staff and new impacts on our, um, protocols. We, too, have been focusing on back to basics, particularly our ICU level areas or who've been, um, the, the most impacted where we've seen the change. As far as reporting, um, there was the ability to let, lighten up a bit, and, uh, our team's very talented and dedicated, and they have kept up with that even though reporting all of the cases, they've had to start doing more evening/night or weekend kinds of work that were not necessarily prior to the pandemic, but they

managed to keep up their surveillance in all areas and, uh, and keep the reporting to NHSN whole.

Next Speaker: Yeah, thank you for that comment. That reminds me also, you know, we went to weekend, um, weekend coverage for sometimes for the IPs and, you know, we're, most of us are all salaried employees, so it's like, you know, just stretching ourselves as far as we can just to get that reporting in. That's great. Is there any, um, other comments on this? Uh, I, I do like the comment about, um, back to the basics. That's definitely –

Next Speaker: Well, I have just –

Next Speaker: – ****.

Next Speaker: – another question for the group. So, um, our program will be funded to do some additional external validation of NHSN data coming up, so just as a reminder, external validation is the process of making sure that we're getting all the cases that should fall under, you know, the surveillance criteria, that we're not classifying cases under those criteria that don't meet the definition, and that they're being classified in a consistent way according to hose NHSN develops and writes its protocols. So, knowing that our program will be looking ahead to doing some of that work over the next few years, it is a requirement from CDC, um, which, if you have – first of all, let me say, it's amazing to hear how consistent people have been with their reporting. It's so impressive. Um, and I'm wondering, you know, if you had to pick one or two NHSN measure or measures for which you had any concerns about data quality or reporting, which ones would they be, and that is really just to help inform us, as we're looking ahead to writing our work plans. Knowing that it's kind of a requirement for our program, um, we'd like to be able to make sure that it's as useful as possible, even though I'm hearing really positive things about the quality of reporting, completeness in NHSN, um, you know, if you just had to choose one or two measures, which ones would they be?

Next Speaker: I'm thinking about it, but does anybody else have, uh, –

Next Speaker: Yes, and –

Next Speaker: – some, um, –

Next Speaker: – know that I won't be taking this as like, we don't think our data in this area are good. Um, you know, it could just be your, like, gut feeling, anecdotal sense, whatever it might be, you know, this is part of what this advisory committee is here to do is to help advise us about our work. Um, so please, we really need your input during this discussion on this, on these measures.

Next Speaker: Hi, this is Laura. Um, just for the recording, we've been answering the chats, but, um, specifically, it stated, um, is this data publically available to OHA site only approved up to 2017, and then the answer was the most recent year of publically available NHSN data that OHA has published is ****, 2017. Annual reporting for the subsequent years is in progress, but unfortunately, I don't have an ETA, and then the second was from Kristen Messenger. We are

seeing the same at WVMC. All efforts to talk about getting back to basics, secondary agency nurses, high acuity and high census meet with we are doing the best we can, and there's nothing else in the chat right now.

Next Speaker: Okay. Thanks –

Next Speaker: Thanks ****.

Next Speaker: – Laura. Um, so any thoughts on external validation of any NHS measures, I'm just hoping that one of you will speak up, um, one or more of you and just tell us, um, what you think might be most useful or least useful. Least useful is also great. Any, any feedback you have on this is really welcome, and I know it's a little bit painful, but I think I'm just gonna ask that we kinda keep this particular question going for a little while.

Next Speaker: Yeah, what do you guys think some of those, uh, who answered about the other, uh, question that we had on there, like Yu-jin or Trista or Karen or Pamela, or any, uh, anybody else who might have an opinion on this?

Next Speaker: I'm only – this is Jesse. Sorry. Um, I'm only thinking from the perspective of treating COVID and the other potential treatments that, that have happened over the last few years. I wonder if it'd be interesting to, to look at, like, the MRSA that you were talking about, the, uh, opportunistic infections that could be increasing as a result of potential treatments related to COVID. I think that might be an interesting data point.

Next Speaker: Jesse, this is Justina. I can throw just a thought out there is that I know that some places have had to change location mapping and, um it's not directly the case definition, but the changes in location mapping might influence comparability of data over time, so that might be something to look at.

Next Speaker: Yeah.

Next Speaker: Right. So, that would sort of mostly influence, um, our device-associated infections, right?

Next Speaker: Yeah. Yeah, that's a really good point.

Next Speaker: And then reading the chart out loud, after a significant length of time – and this is Kristen Messenger – without CLABSIs and now dealing with COVID increased lengths of stay and secondary bacterial infections, I've had to ask for some assistance from NHSN on CLABSI versus secondary BSIs. So, that's super helpful, Kristen. Thank you.

Next Speaker: ****.

Next Speaker: This is Yu-jin for OHA. I, um, second Kristen's remark about, uh, CLABSIs and, um, the challenges of meeting **** criteria with COVID patients and how well we're meeting

for that, so if other facilities are seeing an uptick in COVID, maybe it's because of secondary BSI related to COVID related, so that would be a great start to validate.

Next Speaker: That's super helpful, Yu-jin. Thank you. All right, just to flip it, are there any measures that you would not want to see us do external validation for where you would feel like that was not a good use of time?

Next Speaker: This is Yu-jin for OHSU again. Um, something that I have always been interested in, um, is how testing for C. diff is counting for hospital onset and how impactful that is because I know there's variability on how different organizations are testing for C. diff. Uh, for example, I think from the public health cause, um, Providence, not to put them on the spot, uh, share that they do, um, C. diff testing, a PCR test first, and then go for the toxin assay, and if you, uh, report it that way, it is not considered a hospital onset CDI case, but OHSU is reverse. It is toxin assay first, and then if it is intermediate, we reflux to a PCR test with, and if, in that case, if it is causative, then it is reported as a hospital onset C. diff case. So, just to look at, um, how organizations, um, hospitals are reporting hospital-onset case and seeing the difference in those numbers will be really interesting for me.

Next Speaker: Thank you so much, Yu-jin. Any other thoughts from the group before we take our break? Are folks seeing, um, I'm just curious to know, as you're looking at your own NHSN numbers, are you seeing what you expect to see? Um, when you see the Oregon, kinda preliminary data, does that look kind of right? Does it look wrong? Again, just kind of your gut instinct to help inform our, kind of, activities.

Next Speaker: I think for Kaiser Permanente, those definitely look along the lines of how we're doing. There were a, a couple that I think we need to focus on a little harder in comparison to the state. Um, we'll admit that, so, um, yeah, it's, it's really interesting seeing those numbers. That's why I always love when the data is published 'cause you can really go to those institutions who are doing really well, um, and **** –

Next Speaker: Yeah.

Next Speaker: – as we may not be doing.

Next Speaker: And Rosa, this is Pam from –

Next Speaker: Hey.

Next Speaker: – Salem, um, and I, –

Next Speaker: ****

Next Speaker: – um, so I have some things, like Dennis mentioned, that I went, you know, we're seeing more of an impact or an upward tick in our SIR, like in CAUTI, particularly, right?

Next Speaker: Mm hmm.

Next Speaker: Right.

Next Speaker: When we're doubling down on right now. Um, uh, some of the others, we've really been holding okay, and the data looks good to me, but, um, yeah, I think there are a couple of places where I'd be interested to, um, dig in a little more, as Dennis mentioned, of who's doing that at a facility, you know, kind of our size and, and, uh, it's always good to learn from others if you can.

Next Speaker: Totally. I wish we had, like, more recently-published data available. I just, you know, the, the, COVID has just absorbed a lot of resources from our HAI program, so a lot of the data that, that our staff have been working to make available are, like, dashboard data, healthcare personnel data, things like that. Um, this is so helpful. I just really wanna encourage anyone – I'll put my email address in the chat. I'm pretty sure you all probably have it, but if you do not, if, or if you have any, um, if you have any thoughts on, on our planned external validation activities for NHSN data, like, things that you think need to be investigated further, things that would not be helpful to delve into, any of the above, we really wanna hear from you. We won't interpret it as, an, you know, any kind of statement about the data quality at your own facility, um, and this can be based on whatever, you know, is kind of informing you, right, whether it's just your anecdotal or sort of gut feeling, or you know, certain definitions, you know, as for the secondary BSI, I'm hearing that kind of COVID presented a really specific kind of quandary there, so any of the above, please, please email to me, um, and we will take it all into account when we're determining what measures to do external validation for in the future.

Next Speaker: Great. Oh, were you gonna say something, ****? Okay.

Next Speaker: No, no, back to you.

Next Speaker: ****.

Next Speaker: I think we can just go ahead and take our break.

Next Speaker: Yeah. Yeah. Do, um, do we have a motion to recess?

Next Speaker: So moved. This is Pam.

Next Speaker: This is Jesse. I'll second.

Next Speaker: Great. Um, so we have a person second. We'll recess until, what is the time that we have recess until?

Next Speaker: 2:15.

Next Speaker: So remember, I'm gonna put a reminder in the chat room. Remember to post your name, organization, professional, uh, role if you have not already done so.

Next Speaker: Thank you everyone.

Next Speaker: Okay. I think this is, see you back at 2:15. Ordered. It is 2:16 now and we're coming back from our recess.

Next Speaker: Okay.

Next Speaker: Our first presenter, um, after break is going to be Dr. ****

Next Speaker: Hello. This is Linda. May I help you?

Next Speaker: Oh, remember to put yourself on mute –

Next Speaker: Hello.

Next Speaker: – if you're not, uh, presenting.

Next Speaker: Hello.

Next Speaker: Linda, you're not muted.

Next Speaker: To request a call back **** press one **** call back and ****.

Next Speaker: Okay. So our first presenter for Project Firstline is going to be Dr. Judy Guzman. And remember if you have not already posted in the chat your, –

Next Speaker: Hello.

Next Speaker: – your name and, oh, remember if you haven't already posted in the chat post your, um, name and business and I'll post it again here. Okay. And with that let's get to our speaker Dr. Judy Guzman.

Next Speaker: Great. Thank you so much Dennis and Rosa. Um, hi everybody. It's good to at least electronically see you all today. Um, I'm Judy Guzman Cottrell. I'm, um, youth and faculty, PEDS I.D. at OHSU but I'm also a contractor, um, with the HAI program. And, um, I, if, if you were here at the June meeting I did a, um, introductory presentation on Project Firstline, um, which is a new initiative that's, um, headed by the CDC, um, across the country to improve infection prevention education, um, for all frontline health care workers. And so I'm here today to give, um, the December update for this project. So if you haven't seen, um, the website and kind of initial, um, educational material that the CDC has created, um, I urge you to go to the CDC's Project Firstline website. This is kind of what the landing page looks like. And, um, and it's, it's a national training collaborative for health care infection prevention and control. And really the, I think for me the, the exciting thing about this project, it's really trying to reach out to people who have their hands in health care but traditionally have been very difficult, um, you know, kind of looked over in terms of providing the best and most relevant infection prevention education to those frontline health care workers, and also to actually do a needs assessment to

understand what formats would they prefer to learn in. Not everybody wants to sit in front of a webinar and not everybody wants to go to an in-person meeting. And so it's really, um, uh, you know, a multi-staged training collaborative and the first part of the collaborative was really to understand what the needs are at the state level. Um, just some reminders or just to, um, refresh your memory of the key features of Project Firstline. So first there's core training to address, –

Next Speaker: ****.

Next Speaker: – to, um, address immediate workforce infection control training needs, um, delivered by short and ****.

Next Speaker: One of the tracking number is 1, Z, –

Next Speaker: Um, Linda you are not, um,

Next Speaker: – 9, 4, 4, 4, –

Next Speaker: Excuse me.

Next Speaker: – 5, 6, 0, 3, 5 –

Next Speaker: She can't hear us.

Next Speaker: – 2, 3, 1, 8, 4, 4, 4.

Next Speaker: There we go. Um, it's, uh, Project Firstline will provide practical tools to support everyone working in a health care facility as they implement infection control protocols and procedures throughout their workday. Um, it focuses on partner engagement to share information across all health care settings through trusted partners and channels ensuring that training contents and tools are delivered to the health care workers who need. Mentorship to connect infection control experts with their local health care communities so that they become an ongoing source, resource beyond the pandemic and beyond the Project Firstline initiative. Public health technical capacity building to leverage the public health workforce to facilitate knowledge and tools sharing between public health departments and their local clinical communities. And innovation, to deepen knowledge, to better inform infection control recommendations and to develop inform, innovative platforms and content to provide infection training to a diverse range of adult learners. So the initial steps for Oregon as I mentioned back in June was, um, the initial step for Project Firstline was to create a learning needs assessment. Um, many of you may have, um, completed this assessment. It was pushed out, um, over the past several months in many venues, um, both through direct emails, um, through, uh, societies, through the, um, different health care professional board organizations. Um, some of them did just, um, push emails out to everyone that is in their board. Many organizations, uh, including OHSU where I work, um, included a link to it with an invitation for any health care worker to, um, to complete the survey through, um, you know, an employee-wide kind of newsletter. So there were a lot of different avenues that were used to push the, it's a Survey Monkey format, um, to fill this out. The needs assessment survey is closing this Friday and the survey results will help us to determine the

target audiences that want more infection prevention and control education, to determine who are their most trusted educators so we can potentially partner with those educations, um, to determine gaps in knowledge and their desired learning methods, and then to understand what resources these specific health care personnel utilize when they have questions related to infection prevention. Um, we've also been, um, uh, partnering with OHS regional IPs. Um, they have been so busy doing consultations across the state, um, for COVID, primarily COVID, but potentially other outbreaks as well. So whenever the regional IPs have been doing consultations they've already been utilizing the CDC-created Project Front, Firstline materials for training and education for different facilities and public health departments. Um, so they've been sharing all of these materials, um, over the past several months already. So I'm just going to give you a very quick snapshot because again the survey is not yet closed but, um, I'm thrilled to share that we've already had over 4,600 responses and that was of the last time we did a data download which was, uh, a week ago. You can see here that this, um, this data is of course preliminary as of, um, as of yesterday or today and it shows you the breakdown of the types of health care, um, personnel that have completed the survey, and this is for those that have completed it. So you can see, um, we have, uh, large representation of nurses, uh, but we also have CNAs. We have 350 who, um, who identified themselves as other that were not listed here. And I can tell you that that other, um, includes a really diverse group of, um, of people who work in health care including infection preventionists, tattoo artists, um, radiology techs, pharmacy techs, um, opticians, front desk staff for clinics and hospital front desk, phlebotomy. Um, there was one person whose role is to, um, clean, um, vehicles that are used for, um, for courier services within their health care system, dieticians, um, aestheticians, all different types of people in addition to these, um, health care providers that were, um, kind of the dropdown menu. Um, so these are the types of people that, that were surveyed. And then we also asked them what is their primary workplace for working when they are working in person. Um, because of course this education is no COVID focused. It's for really, for general infection prevention knowledge. And you can see here, um, just 31 percent of them work in acute care hospitals and we have a nice mix of other outpatient facilities, other types of facilities, um, is 14 percent, long-term care is, um, um, about 10 percent, 9 ½ percent, pharmacies, home health, critical access hospitals and so on and so forth. You can see here the different types of workplaces, um, that are represented. So I'm just gonna show you an example of the topics that we covered in the learning needs assessment survey. Um, again I think at the next HIA meeting we'll be able to share with you the results. But, um, you know, we really wanted to get really down, um, into some granular questions in terms of not only what do you want to learn, what do you need to learn, but also how do you like to learn? So we asked about preferred languages for learning. Um, preferred learning settings – do you like to learn alone, in small groups, self-paced webinars or, you know, um, pre-registration webinars? How is you, is it for you to be able to interact with an educator? Um, preferred types of training. We even asked if people, you know, if they ever use Facebook or Instagram Live, YouTube, webinars, podcasts, um, to get infection control education or any type of on-the-job training when they have questions that need to be answered. We asked devices. Do people use laptops, desktops, at work, at home, smartphones or tablets, just so that we can make sure that the educational material that we create is going to be used in the ways that our target audience is going to actually utilize them. We asked about preferred materials. Do people still like the old, old school pocket cards or, you know, downloadable or pro, um, printed posters that are in their work areas? Emails, do people like having access to office hours where they can, um, call in or listen in to experts and get specific questions answered or do people like webinars?

Or even in-person conferences? And then we asked a lot of questions about baseline knowledge and understanding of many infection prevention topics, many of them I'm sure that you could guess what we asked about. Hand hygiene, um, do you understand what source control is and why we use it? Do you, do you feel comfortable quickly identifying and isolating somebody who may be contagious when they come into your, into your facility? Um, do you understand transmission-based precautions and why people are placed into isolation? Do you know why you use gowns and gloves or how to use them properly? And we had people sc, um, kind of score their level of, um, of, um, of understanding or how comfortable they were with specific topics. And then we also asked them about what their specific, what their individual trusted sources were for infection prevention information? Was it their boss? Was it CDC? Was it state health department or was it associations? So the survey will close this Friday and as I mentioned, um, Rosa has been really instrumental in working, um, uh, with me with, um, finalizing the, um, the learning needs assessment survey and helping to push it out, um, multiple times to, uh, health care workers across the, across the state. So thank you Rosa for all of your work and collaboration with that. And the data analysis will begin next week and we'll be able to share that data with you at the next meeting. Once we have a better understanding of who needs infection prevention education and how best to provide education then we'll be able to increase awareness about where to find reliable resources that already exist and then we'll also be able to create and provide education in various formats depending how people want to receive it – short videos, printed materials, social material. Um, I actually would love any input from any of you who've done any type of creating educational material for any type of health care educational material. It doesn't even have to be specific to, um, infection prevention. So experts that are, you know, experts in creating educational material that is, um, interesting and digestible rather than just, you know, the thing that I am trying to prevent us from doing is just, you know, um creating PowerPoint presentations, making PDF versions, versions and putting them on the OHA website. Like that's, that's not gonna do it. We really want to invest the time, um, and the money in really creating really important, usable and digestible information and the information is information that people want in the format that they want. And then we'll be able to share our, um, the feedback that we hear and education gaps with the CDC and, um, we work with other states that are also doing Project Firstline work and strategize ways to mitigate those knowledge gaps. As I mentioned we'll share the results at the next HIA meeting. So in addition to this learning needs assessment that we're wrapping up this week, the other thing that I wanted to mention is, um, uh, the CDC has set forth to all states and jurisdictions what they want our Project Firstline teams to be focused on over the next couple years. So I'm going to share with you what the CDC has provided guidance for our Oregon Project Firstline team and, um, after I share with you those, uh, those, uh, activities then I, I would love to open it up for a few minutes to hear any input or any ideas that anyone on HIA has. So first is to partner with local health departments to engage and train frontline health care workers. Consider prioritizing partnerships with local health departments that have health care workers or health care facilities that serve communities experiencing health disparities. Second activity, identify and build partnerships with local health care organizations such as hospital associations, health systems and local chapters of professional associations to wear awareness of Project Firstline materials and to disseminate information about HIA's and infection control. Consider prioritizing partnerships with organizations that represent health care workers that are historically underserved. For example, professions requiring lower levels of education, health care workers who speak English as a second language and health care workers from racial and ethnic minority groups. Third,

partner with local academic institutions to education and train rising health care workers on infection control tailoring the Project Firstline curriculum to local threats that rising health care workers may be more likely to encounter on the job. Consider partnering with academic institutions like community colleges that offer train, that often train health care workers in non-clinical fields. So I think this is trying to focus on, you know, um, potentially, uh, partnering with educators at community colleges that work, that, that work to train allied health members such as technicians, um, who often don't get, technicians that only work in the outpatient setting for example. Um, for example, like a dental hygienist, um, who doesn't, isn't going to get education that, you know, health care systems require, that people who work in hospital and, and large health care systems will get because of joint commission or other requirements, but those that are working in other parts of health care that are getting missed from really important education. Uh, fourth, analyze and leverage data from the learning needs assessment, so that's the survey that we're completing this week, and an understanding of the health care workers in the jurisdiction to frame, disseminate and adapt the Project Firstline curriculum for local needs, experiences, et cetera, and to consider how the learning needs identified may highlight broader health equity disparities in the health care workforce including linguistic accessibility, cultural appropriation, et cetera, and address these disparities within planned framing and dissemination activities. Um, and then next is to use existing Project Firstline and health department dissemination channels such as trainings, partners, social media, town halls, promotional campaigns, to communicate with frontline health care workers about local HIA threats, explaining where the threats tend to live, like its reservoir, how it spreads, who is most at risk and actions that health care workers can take to assess risk and stop spread keeping in mind that the actions specific, keeping in mind actions specific to certain health care professions and settings. And then lastly, to be able to obtain and maintain capacity to provide continuing education credits relevant to health care workforce such as CME, CNA, CNE, CHES credits, et cetera. So those are, um, kind of moving forward. And you can get, you can tell really the main theme across all of these are to continue educating health care workers at all levels and in all types of facilities and all types of health care delivery and to do as much as we can from, from the public health side to partner with different health care systems, local health departments, societies, et cetera, to make sure that the educational material that we create, um, gets to where it needs to go and really gets to those specific health care workers that are identified in our needs assessment. So your ideas are really welcome. We'd love to see some partner, um, your ideas for partnerships with organizations, associations and health care systems that we may not have thought about. Um, if you have any presentations that you're working on or that you're part of planning committees for conferences or a meeting in 2022 and 23 we would love to come and, and, uh, do a presentation on Project Firstline and also still continue to listen to gaps in educational material and create those. I would love again to hear if any of you know, ever have collaborated in the past with any experts in educational and instructional design because we want to make educational material that is interesting and engaging. And, um, would love some help in determining communities that are experiencing health care disparities. As you can see that's a major priority. And connecting, um, if anyone has connections at any community colleges or allied health colleges that you've worked with, um, I would love to hear from the, um, hear, um, and get connected with those, um, with those individuals or groups, um, because we would really like to focus on them as a way to, um, provide infection prevention education to those allied health students and, um, um, health care workers. Um, other con, continuing education credits. I've already, um, started, um, working on, um, I've already contacted

Providence and OHSU CME, um, departments to see if we could partner with them but any other ideas for any of you who have, who have worked with CME or any type of **** accreditation meetings or conferences, um, uh, that would be great. And of course, any other ideas and comments. And with that, I am gonna end there. There's my email address that I use for my OHSU work. You can also email Rosa as well, um, my partner in crime with all of this work. So I'll stop sharing here and open it up for discussion for the last few minutes.

Next Speaker: Can we, can we go back to that previous slide with the discussions questions on it?

Next Speaker: Sure. Yeah.

Next Speaker: This is our last, uh, structured agenda item **** –

Next Speaker: Oh, okay.

Next Speaker: – so we can do this until we reach our last couple, um, housekeeping.

Next Speaker: Perfect. Thanks Rosa.

Next Speaker: So I'm just gonna, we're gonna open it up and, um, anyone feel free to either, um, uh, you know, raise your hand or just unmute and, um, we'd love to hear some reactions or ideas for what we're, what we're going to be doing moving forward.

Next Speaker: And I'm happy to monitor the chat for folks who'd prefer to offer some thoughts that way.

Next Speaker: Hi, um, this is, this is Nora. Uh, I teach at a community college part-time and I'm wondering, uh, and I teach in chemistry for allied health professionals, that's one of the courses, um, that I do. So I'm wondering what, what exactly were you hoping to gain with the connections at community college?

Next Speaker: Um, what I'm hoping is, oh sorry, my, my screensharing went away for a second. Uh, thanks Nora. I think, you know, we're, we're, we would love to talk to, um, allied health programs and just say, what type of infection prevention education do you teach them and, um, here are some, you know, what are you looking for that you don't have right now. And, um, you know, how can we help? Can we help create or can we, you know, even tap on experts both locally and nationally to meet those gaps? Um, you know, we can, we can provide material. We can provide, um, speakers for specific, you know, even for lectures, et cetera. I think there's a lot of different things that we can offer. Um, I think right now one of the things, you know, the first question is, um, you know, what do you feel that you need? Rosa and I would love to look and see what material they're providing right now, um, and see if the data that, or the information that they're sharing with their students is up-to-date information, um, because even infection prevention recommendations change over time. Um, so I think that's, that's kind of what we're envisioning in terms of, um, uh, with community colleges.

Next Speaker: Awesome. Yeah, um, I, so I work in the science department so I can definitely connect with you the chair of the science department at Clackamas Community College.

Next Speaker: Mm hmm.

Next Speaker: If you're interested in educational dissemination to students in terms of the higher level, like, uh, CCC policies regarding infection prevention for the community college itself, –

Next Speaker: Mm hmm.

Next Speaker: – um, we get emails pretty regularly but I'm not entirely sure if they cite the CDC sources every time we get updates on them so, um, we, yeah, yeah. I would love to help facilitate some of that.

Next Speaker: Great. Thank you so much. Nora, I'll, um, I'll send you an email over, within the next couple days so that we can connect after this meeting.

Next Speaker: What other questions or comments does everybody have? Oh, my video stopped. Whoops. What other questions or comments does everybody have? Remember, you can unmute yourself in the bottom, left-hand corner.

Next Speaker: This is Jesse Kennedy and I would just say that at, uh, Oregon Nurses Association we are one of the few CNE providers that are accredited through ANCC in the state so, um, you know, I can't speak specifically for, you know, my, my director and everything but I'm sure we'd be happy to collaborate and come up with, with something to help, help provide this education. I think most of our stuff tends to focus more on the professional, uh, development aspect but we are, uh, working on getting, getting more presenters who are specific to the individual specialties and trying to help them, encourage them to become leaders themselves and educators themselves, especially the nurses who are looking towards getting in that path. So, yeah, I, I'd definitely love to see what we can do to help move that forward.

Next Speaker: Great. Thank you so much Jesse. Um, I'll be sure to reach out to you as we work on, to see how we can make all, you know, as many of the materials as we can, um, uh, you know, um, activities, um, that are providing, um, accreditation, or I guess credit, education credit. Thank you.

Next Speaker: Yeah, they keep changing the lingo. Now it's –

Next Speaker: I know. I can't keep up.

Next Speaker: – continuing nursing education contact hours, so.

Next Speaker: Oh, contact hours.

Next Speaker: Yeah.

Next Speaker: I gotta add that to my, to my lexicon. Thank you. All right. Um, so if, if anyone has any other comments, ideas, um, please feel free to contact us any time. This is a project that will be going on for the next couple years. Um, and as I said, we'll, you know, um, we'll share the, um, we will share the results of the, uh, learning needs assessment at the next HIA meeting. So I will stop sharing there and turn it back over to you Dennis. Thank you so much. Or Rosa, whoever is –

Next Speaker: Yes, yes. Uh, yeah, thank you so, so much, um, for that presentation. And I think we'll move on to our next discussion topic. So this is discussion topic for, topics for future meetings and reports. Um, so all members and attendees are welcome to speak up during this part. Um, so we're, we're just asking if you guys have any future topics for future meetings or reports that you would like to see. I definitely want to see that tableau report once that comes out. So I'm really excited about that, um, knowing that, um, which will show all the hospitals and how we're doing as HIA. Then definitely an update to the survey that we were just talking about with Project Firstline. What about anybody else? Any other topics out there?

Next Speaker: Is there anything you've been just like contending with in your professional life that we haven't been touching on? Or that, you know, the other piece of this is that, um, we do want this kind of to be a bit of a forum for all of our members and attendees to come together. So are there things not only that you'd like to hear from OHA on but are there things that you'd like to either share with your colleagues or hear from your colleagues? We can certainly provide a forum for that kind of discussion or even a panel.

Next Speaker: I, so I do know with NHSN reporting I'm, I'm very interested in ASC reporting into NHSN, um, because we have what is 97, 79 ASCs in the state? Um, yes, no mandatory reporting. And again as an avenue to see who's doing best practice and where we might improve, that's definitely a topic that I've been interested as Kaiser has three ASCs.

Next Speaker: Excuse me. Thank you Dennis for bringing that up. So I'll just touch on that quickly because this is something that has been **** discussed during these HIAC meetings in the past. So I think we would all like to kind of explore, um, as part of the same discussions that caused us to remove LAM from the reporting requirements, um, we have conversations about potentially, I'll, I'll just ask folks to go ahead and meet with themselves. Thanks. So, um, we've had, um, some conversations about adding some reporting requirements potentially, some reporting requirements in for outpatient surgeries, um, some for, uh, I'm sorry the noise is just getting me and then it just started hailing right outside my window. Apologies folks. Um, outpatient surgeries performed both in acute care hospitals and in ambulatory surgery centers. Um, we started to kind of explore that, um, that possibility and, um, we did run into some kind of conflict with other existing legislation. Um, so I think that is just a, that's, these are pieces that will take some heavy lifting I think to be able to kind of coordinate internally within OHA and make sure that, you know, we are kind of talking to our partners outside of our own section or even potentially our agency, so within the same system. Um, so, you know, it's still kind of on our radar for sure. I just don't know that's the kind of the, Daniel can you go ahead and mute yourself? Um, thank you so much. Um, so anyway, it's still very much on our radar but I think the capacity to do that work is a little bit low at the moment. So it is something I just actually brought up with Becca recently and we'll just see, we'll see when things loosen up enough for us

to really pursue that. Um, but it's good to know that you folks are thinking about it as well. I wish I had a better update on that.

Next Speaker: Rosa, this is Pam Burt in Salem.

Next Speaker: There you go Pam.

Next Speaker: One thing that –

Next Speaker: Okay.

Next Speaker: – we're working on is, is we are trying to, um, understand how to come back out of the pandemic into infection prevention on a go-forward basis, right. And it's how to try to predict what our current performance is doing conn, compared to, uh, external. And, um, so just anything you all hear or can get from NHSN 'cause just prior to the pandemic we were all kind of expecting them to reset the 2015 baseline for SIRs, for the expecteds. And then now, who knows what that is. So if you guys, um, have any connections and kind of start to even hear what the buzz is so we can start to anticipate what the next year or two might bring.

Next Speaker: Thanks Pam. I think that's actually, you know, it's very funny but, I mean, we're all, it just goes to show that we are all kind of thinking along the same lines. I had a conversation with Becca about these, you know, potential additions to reporting requirements. We all said, so she asked me the same question. So, um, I think we just don't have any word from NHSN regarding a potential new baseline that I'm aware of. However I can certainly reach out and see if they have any, you know, my kind of gut feeling was that just like you Pam they were trying to kind of work towards another re-baseline, um, before the pandemic started. Um, so I have a feeling that it got sidelined, um, due to COVID. So we're right there with you wanting to know. And it looks like Becca is chiming in here. Yeah.

Next Speaker: Okay. Great. So I think our, our next topic is public comment. And this is again open if anybody has any public comments. Okay. So I'm hearing none. Should I go ahead and, should we have **** or should I wait 5 minutes.

Next Speaker: I think it's fine. If anyone has a comment or any other point of discussion you'd like to discuss you'd like to discuss with the group really now is the time. I mean, it's absolutely open if anyone has anything to say. We'll give a couple seconds and then I think we can entertain a motion to adjourn.

Next Speaker: Can I just add, this is Becca. Can I add one thing not really **** –

Next Speaker: Yeah.

Next Speaker: – but I just wanted to flag it for everyone. Um, for those that haven't seen IDSA and CDC, excuse me, teamed up to release a real-time learning network platform that has some really nice curated and summarized COVID updates. It's really geared towards infection

preventionists, health care epidemiologists and health care workers. So I will put that in the chat box in case it is useful. It has been very helpful for me.

Next Speaker: That's great. I would love to see that. Always trying to save ****. Okay. So with no other public comments, um, should we have a motion to adjourn?

Next Speaker: I'm so sorry Dennis. I'm going to interrupt you.

Next Speaker: Oh no, keep going, keep going.

Next Speaker: I just wanted to say thanks everyone for bearing with us and that is to all of our members, attendees and of course our internal staff who work really hard to make sure these meetings go as smoothly as possible. I just wanted to say thank you to everyone especially Lauren, Adriana, Mora and Alonge who, um, do everything on the back end to make these meetings run. Um, thanks to all of you for, you know, bearing with us in a transition from Go To Meeting from Zoom. Um, we're aware of a couple of tiny things to work out after today's meeting but I think overall it's been super positive and smooth. So I just want to encourage anyone to please reach out to me directly if anything didn't work for you today. Um, and then also just to really thank you, give a big thank you to Laura and Lauren for all their work.

Next Speaker: ****.

Next Speaker: Definitely ****.

Next Speaker: Yeah, I would echo that. Thanks.

Next Speaker: Well then I also as a public comment would like to thank all of our public health colleagues at OHA and at the local level for continuing to persevere through this very, very challenging time. Thank you all so much.

Next Speaker: That's really great. Okay. So if you haven't put in your name that you're attending here we want to make sure that that final roll call is taken into account. Remember to put your name and position in the, um, and organization in the chat. Okay. So with that –

Next Speaker: This is Jesse. I'd like to move for adjournment.

Next Speaker: So I have a motion. Do I have second?

Next Speaker: I'll second. This is Pam.

Next Speaker: Okay. Great. Well, everybody have a great day. Um, we'll adjourn the meeting now.

Next Speaker: Thanks everyone.

Next Speaker: Thank you.