Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

March 10, 2021
1:00 – 3:00 pm

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

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

MEMBERS PRESENT:

- Joshua Bardfield, Supply Chain Services Manager, The Oregon Clinic, P.C. (phone)
- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center (phone)
- Deborah Cateora, BSN, RN, Healthcare Education/Training Coordinator and Nurse Consultant, Safety, Oversight and Quality Unit (SOQ Unit), Oregon Department of Human Services (DHS) (phone)
- Paul Cieslak, MD, Acute & Communicable Disease Prevention (ACDP) & Immunizations Medical Director, Oregon Public Health Division (PHD), Oregon Health Authority (OHA) (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)
- Jesse Mensik Kennedy, RN, Nurse Practice Consultant, Oregon Nurses Association (phone)
- Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc. (phone)
- Kirsten Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante (phone)
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control (phone)

MEMBERS EXCUSED:

- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center

- Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon PHD, OHA
- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University

OTHER PARTICIPANTS PRESENT:

- Sandra Assasnik, Director, Safety and Quality, Washington State Hospital Association (phone)
- Lisa Barton, Associate Improvement Advisor, Comagine Health (phone)
- Sydney Edlund, MS, Director of Analytics and Research, Oregon Patient Safety Commission (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)
- Carolyn Ham, PTA, Strategic Partners Program Supervisor Healthcare-Associated Infections and Antimicrobial Resistance Section, Washington State Department of Health (phone)
- Aisha Hedden, Ecolab (phone)
- Kristi Ketchum, RN, MBA, HACP, CPHQ, CEO, Oregon Outpatient Surgery Center (phone)
- Karen Keuneke, RN, MSN, Supervisor of Infection Prevention, Good Samaritan Regional Medical Center (phone)
- Jessina McGregor, PhD FSHEA, Associate Professor, Oregon Health and Science University (OHSU) (phone)
- Pamela Michalowski, Quality Director, OHSU Health Hillsboro Medical Center (phone)
- Jamie Miller, RN, CPHQ, Senior Manager, Clinical Services, Surgical Care Affiliates (phone)
- Jewel Peterman, RN, BSN, CNN, Quality Improvement - ESRD Networks 16 & 18, Comagine Health (phone)
- Mary Post, RN, MS, CNS, CIC, Infection Prevention/Employee Health Coordinator, Shriners Hospitals for Children - Portland (phone)
- Tom Rollins, MS, RN, Chief Clinical Officer, Prestige Care Inc. (phone)

- Amber Stevenson, BSN, RN, OCN, System Clinical Educator/Clinical Orientation Specialist, Asante Rogue Regional Medical Center (phone)
- Maisie Taylor, Quality Improvement Specialist, Blue Mountain Hospital District (phone)
- Keenan Williamson, MPH, CIC, Infection Preventionist, OHSU (phone)

OHA STAFF PRESENT:

- Therese Antony, RN, Regional Infection Preventionist Public Health Nurse (phone)
- Jeanne Bristol, Client Care Surveyor, DHS (phone)
- Pamela S. Bruhn, RN, BSN, MAN, ANP, Regional Infection Preventionist Public Health Nurse (phone)
- Erin Coke, RN, BSN, MPH, Regional Infection Preventionist Public Health Nurse (phone)
- Anne Eades, BSMT, MPH, CIC, Infection Preventionist Contractor (phone)
- Gabriela Escutia, MPH, Emerging Infections Surge Epidemiologist (phone)
- Heather Hertzel, MPH, Multi-Drug Resistant Organism (MDRO) Epidemiologist (phone)
- Lisa Iguchi, MPH, Epidemiologist (phone)
- Elizabeth Johnson, RN, BSN, Regional Infection Preventionist Public Health Nurse (phone)
- Meghan Linder, MPH, Council of State and Territorial Epidemiologists (CSTE) Fellow (phone)
- Laura LaLonde, MPH, CPH, CHES, HAI Office Specialist (phone)
- Meghan Millet, BSN, RN, Regional Infection Preventionist Public Health Nurse (phone)
- Valerie Ocampo, RN, MIPH, HAI Public Health Nurse (phone)
- Sarah Odell, RD, Nursing Facility Program Manager (phone)
- Saman Perera, MSN, RN, Centers for Disease Control and Prevention (CDC) Foundation Infection Preventionist Public Health Nurse (phone)
- Monika Samper, RN, HAI Reporting Coordinator (phone)
- Roza Tammer, MPH, CIC, Infection Control Epidemiologist (phone)

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

ISSUES HEARD:

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

Item	Discussion	Action Items
Call to order and roll call Roza Tammer, OHA	Forty-five attendees, ten members	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. ➢ Remote attendees will remain unmuted for meeting; reminder to unmute yourself to speak. Guidance for using webinar platform is included in meeting minutes. ➢ SurveyMonkey survey was sent to members and to attendees to collect information to ensure everyone has an opportunity to serve in a formal role and to fill long-standing vacancies. Request to resubmit with contact information.	Please share "Bring your voice to the table" one-pager with your networks and email Roza if interested. Complete SurveyMonkey with contact information.
Approve September and December 2020 minutes	December and September minutes were approved.	Approve September and December 2020 minutes

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<td>COVID-19 updates
Roza Tammer, OHA</td>
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- OHA COVID-19 Weekly Data Report published March 3rd (February 21-27, 2021):

2,652 new cases (17% increase from prior week’s total). Testing increase from 70,200 to 120,678 with a slight increase in test positivity from 3.5% to 3.7%. Patients newly hospitalized increased from 158 to 164. 57 Oregonians died in association with COVID-19.

155,787 total cases have been reported in Oregon since the start of the pandemic, 2,212 have died for a case-fatality rate of 1.4%, and 1,621 were hospitalized for a hospitalization rate of 5.5%. Epi curve is included in the weekly report.

There are currently 56 active outbreaks that meet the following criteria: Active and resolved outbreaks in care facilities, senior living communities, and congregate living settings with three or more confirmed COVID-19 cases or one or more COVID-19 related deaths. Outbreaks are considered resolved if no new cases identified for 28 days after the last case’s onset. This includes correctional facilities and foster homes.

OHA is aware of 221 unidentified congregate settings that have five or fewer beds with three or more confirmed cases or one or more deaths.

One death of a staff person who worked in a congregate care setting from COVID-19.

There have been 13,362 cases and 1,210 deaths associated with congregate care settings in Oregon.

- Oregon Health Authority's Surveillance Data Flu Bites published March 5th (February 21-27, 2021)

Percentage of emergency department (ED) visits for influenza-like illness (ILI) dropped from 0.5% to 0.4%.

Percentage positive of flu tests increased from 0.2% to .3%.

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	In the current week, one influenza-associated hospitalization was reported in the Tri-County area. 23 COVID-19-associated hospitalizations reported. Zero reported flu outbreaks, zero reported flu-associated pediatric mortality and no respiratory syncytial virus (RSV) activity. Minimal transmission of influenza, or minimal ILI being reported nationally. ➢ Breakthrough COVID-19 infections among fully vaccinated people: OHA tracks and investigates COVID-19 infections among fully vaccinated people to understand patterns and suboptimal immune response to the vaccine, waning immunity, compromises in vaccine storage and shipping, culturing, and viral mutations or variants that impact accessibility to the immunity typically induced or thought to be induced by vaccination. Defined as people who have RNA or antigen-positive respiratory specimens collected more than 14 days after their second dose of vaccine. It may be requested to hold samples from case-patients since some specimens will be shipped to CDC for RNA amplification, sequencing, viral isolation, and immune characterization. Facilities may be asked if there is residual respiratory specimen or if the patient is willing to have an additional nasopharyngeal (NP) swab collected. Reporting these cases as an adverse event into the VAERs reporting system is only recommended if the case died or was hospitalized. ➢ Discussion:	

	Roza Tammer: Does anyone have experience with breakthrough infections? Kirsten Schutte: We have struggled with correlating the information at time of collection and relying on patients' self-report. There are a lot of questions at the time of swab collection and there are operational challenges in connecting that data. Deborah Cateora: Communicating properly with nursing facilities and LTCFs that may start their own testing can be problematic. In theory they should know what vaccines their residents have received. It would be helpful to have standardized language and directions on what to do if a possible break through infection is identified that we could share with the facilities. Tom Rollins: A staff member tested positive and was a breakthrough case at a Prestige facility and we had no idea of the OHA expectations until the local public health authority sent it. Paul Cieslak: Dat and Becca were going to reach out to long-term care facilities (LTCFs) as this is a highly vaccinated population and they are regularly testing and finding cases. Roza Tammer: When you either get a breakthrough case or a re-infection, a positive test more than 90 days after an original positive, are you considering them a case or checking the cycle threshold (CT) value on the polymerase chain reaction (PCR) test? Genevieve Buser: For Providence the infectious disease doctor can contact the lab and find out the CT value and consider if it is a breakthrough or re-infection and refer to the state for sequencing. Roza Tammer: Do you use the CT value to ascertain if the patient is going to be isolated? Genevieve Buser: The cases have been case-by-case, but it is based on the CT value, the clinical history, the patient's current symptoms.	

	Kirsten Schutte: These cases are found during asymptomatic screening such as at with a labor and delivery unit with a patient with previous COVID-19 history. Vicki Nordby: We have picked up cases with a routine survey as part of Centers for Medicare & Medicaid Services requirements with CT and PCR values to determine variant testing. These patients are isolated until we have the additional information. Kirsten Schutte: Is there reconciliation being done with the ALERT immunization database at the state level? We have a fair proportion of outpatient testing from a system perspective; unless we ask that question or verify vaccination records within our system we're not going to be picking up every breakthrough case. Paul Cieslak: When a case is reported it comes through an electronic lab report into our database. There is an automatic feature to query the ALERT system for the patient's vaccinations and upload into our records. The issue with breakthrough cases is getting a specimen to test for a variant strain. Often too much time has elapsed. It would be helpful if holding on to specimens and testing for variants was done on the front end. Kirsten Schutte: Thank you, the easiest way to do that is at time of specimen collection. But this is not part of the process yet. Genevieve Buser: Kenan Williamson from OHSU said they're doing a similar process using the CT count and clinical history. ➢ Fit-testing discussion and questions: Who is doing the fit-testing at your facility? Who is getting fit-tested, does this include all individuals with direct patient care duties? How are facilities managing fit-testing in context of supply shortages?	

	Are there concerns about getting consistent supplies of particular respirators? Are staff getting fit-tested for multiple respirator models? What infection control approaches are being taken to re-process fit-testing equipment between uses? Are facilities seeing that employees are failing to fit-test to any N95 respirator and how is that managed? Tom Rollins: All of Prestige skilled nursing facilities (SNFs) and assisted livings have done fit testing. We are re-fit testing now because we had allocated a large amount of N95s through 3M and so we are switching folks to them and using the other ones as backup. Our staff fit testers are infection preventionists on the SNF side or our executive directors or maintenance directors on the assisted living side. They watch a train-the-trainer video with their local healthcare associations. We’ve had a handful of folks that have failed every fit test and we’ve concluded that they need to take time off work if they are going to need to wear an N95. Roza Tammer: Do you consider offering a power air-purifying respirator (PAPR) to those individuals or is that outside of the scope of your respiratory protection program? Tom Rollins: We've thought about that. However, in our setting, PAPRs are really hard to wear. It’s hot, a lot of places don’t have central air, and residents yank them off of provider’s faces. Roza Tammer: Which organization puts out the train-the-trainer video being used? Tom Rollins: It depends on the state where the facility is in, but a lot of the healthcare associations have shared them. There's one on YouTube and Occupational Safety and Health Administration has one. Our biggest challenge was with assisted living because they just have such a different number of staff members.	

	Roza Tammer: Are you doing both qualitative and quantitative fit-testing? Tom Rollins: We're doing qualitative only. We use the Bitrex or banana oil, depending on which kit they use. Roza Tammer: How are you approaching the disinfection of hoods between uses? Tom Rollins: We use List N disinfectants. In Washington, the state pays people to come do your fit-testing, if that is ever an option for Oregon. They come in, get it done, and move on. Erin Coke: I had a situation with an assisted living facility that was fit tested by an occupational health provider in the area with only the quantitative method. All of the staff members failed. They're looking at the qualitative. Roza Tammer: Has anyone seen any patterns in folks that are failing to fit to any make or model or size or style of an N95 and how they're addressing that situation? Mary Post: At Shriners we have a variety of N95 respirators available. we primarily use the 3M 1860 series. We've had to get pleated duckbill respirators or other options for employees. During qualitative fit testing we use both saccharine and Bitrex, because we found some people couldn't pass with just one. We disinfect hoods with a COVID-approved disinfectant and rinse with water. We do have PAPRs available for those who are unable to fit-test and train them how to use the PAPR. We've got a core group of individuals in all departments who have been trained so that we have fit-testing capability 24/7. The nurses are primarily clinical and 3M has a fit-testing video that we use for training and support, and then we had people practice fit-testing on each other, and then we did a series of observations as they fit-tested others. Roza Tammer: One of the group brought up that there could be an issue with people who have a lack of smell or taste due to a recent history of COVID.	

	Genevieve Buser: For individuals who have that particular symptom, the quantitative method would be more appropriate. Mary Post: We did send reminders out prior to fit-testing that they shouldn't smoke, eat, or drink prior to coming. We send out the infographic about facial hair so that people know that they must be clean shaven. Roza Tammer: if anyone on the line is interested in sharing infection control protocols or any additional process documents that incorporate infection control elements, we would love to see those for best practices and strategies on how to get people fit tested to a respirator. Genevieve Buser: Providence uses a nicely detailed lab order that has questions about past infection, and I'm going to bring it to incident command and see if maybe we can request to add the data history of vaccine and see if we can get that included and if that would help us follow up. Roza Tammer: We are working on gathering vaccination data from LTCFs here at OHA. LTCFs are working either with the Federal Pharmacy Partnership Program or other partners to vaccinate residents and staff for COVID-19. However, the data shared about administering vaccine isn't routinely transmitted as a proportion of eligible staff and residents and then additionally, information from these partners doesn't always capture staff or resident turnover, or things like vaccination outside of the LTCF's clinics. OHA has developed COVID-19 vaccine tracking tools, adapted from the National Health Care Safety Network (NHSN) tools, that will automatically calculate summary data. OHA is working with DHS to make this the standard tool that LTCFs will use to track vaccine information. Our agency plans to collect that same summary data from LTCFs. As more information on reporting this to OHA more information will be forthcoming. These tools will allow both individual- and aggregate-level tracking for the facility. Tracking information is important to inform outbreak response	

	and infection control strategies and identify key vaccine outcomes of public health concern like breakthrough infections, vaccination-related adverse events, or large outbreaks post-vaccine. We plan to collect summary data to calculate accurate vaccine uptake percentages, which are needed to track progress, identify gaps to allocate vaccine distribution appropriately, and help our agency to define next steps for reopening and infection control policies. Vicki Nordby: Are you going to closely align with the NHSN form for data collection? My concern is that we do a tremendous amount of reporting on a regular basis, and if you're adding an additional requirement where we can't utilize the same data for two sources that this is an added resource drain. My request would be that it closely mirrors the NHSN data gathering. Roza Tammer: I believe that they are adapted and modified from the NHSN tools, so they are similar formats. They do allow for some additional information collection. Our forms will allow both individual and aggregate level tracking of staff and residents. Tom Rollins: Our building is actually piloting the same thing, and it does take time away. You're talking hours per resident and the staff because it takes resources. Vicki Nordby: I hope we're not going to go backwards to onset of vaccination to gather data. Oregon could utilize the data that's already been entered into NHSN because most facilities have already done their initial round of vaccination the third week in December. It is a big ask to ask for facilities to go gather that information. Roza Tammer: This is still a pilot project with Lisa and Becca. I can share any feedback if you email me. Kirsten Schutte: Our leaders felt that it was too unwieldy to add questions related to breakthrough infections to the other testing questions at present, but I'll bring it up again. Another option is once the clinic or employee speaks to the person with the positive test, they can	

	verify vaccine status as part of that protocol. This would be less work. Keenan Williamson: OHSU has separate Infection Control and Occupational Health programs. Occupational Health typically handles fit-testing. We eliminated annual fit-testing, but staff do need to get fit-tested for our current respirators. We have three models and they have a qualitative machine that does the testing in the department. Early in the pandemic when supply was very low, we approved the process for staff to do just-in-time fit-testing if they required the use of a respirator that they weren't already fitted for. The just-in-time process involved putting the respirator on and checking for leaks by putting their hands up around their face and blowing or breathing deeply. Roza Tammer: Did you find that that machine comes with robust instructions on re-processing? Keenan Williamson: I know the machine gets disinfected, but I'm not sure on what cadence the tubing gets replaced between users. ➢ References: COVID-19 Updates: link Surveillance Data Flu Bites: link	
Discussion: Approaches to COVID-19 All members and attendees	➢ CDC guidance regarding double masking and improving mask fit and filtration Roza Tammer: There is new guidance from CDC regarding layering cloth face coverings over medical-grade masks, and the use of a tucking and tying strategy, which is to tie a knot right at the base of each ear loop on a medical-grade mask and then tuck in the excess material to create a closer fit with fewer gaps. The other options are the use of mask clips behind the head to hold ear loops or straps more tightly around the head, to take off pressure from the back of the ears, and there are mask	

	fitters which fit over the top of the respiratory protection and help the mask seal more closely to the face. Keenan Williamson: OHSU eventually decided on a well-fitting mask and you can do what you like to make that happen, but we aren't encouraging double masking. Roza Tammer: Are you allowing your staff to wear cloth face coverings over a medical-grade mask, in the building? Keenan Williamson: No. If it's patient-facing, then it should be a hospital-approved mask. Genevieve Buser: Are staff using two hospital-approved masks? For example, using an N95 with a disposable mask over that. Keenan Williamson: Yes, but that isn't part of our official recommendation. Vicki Nordby: We've taken the CDC information for public use and shared it with staff for their use in their personal time. We continue to not have any cloth masks or double masking and stressed that this was for personal use and not for healthcare. Kirsten Schutte: We're currently considering options for groups that are dealing with lots of patients, where our burn rate would be very high, We have had serious concerns about using any kind of cloth mask over a procedural mask to try to get it to fit more tightly to the face. We've taken the same approach saying that's not appropriate for a healthcare setting. Genevieve Buser: Providence has a similar approach to OHSU. We ask that caregivers use a well-fitting mask but not double masking. We are considering returning back to single-use N95 because we have good enough supply right now. Joshua Bardfield: At the Oregon Clinic we are not requiring double masks, but we're strongly recommending it. We're not at the point for single-use	

	N95s yet. Mostly providers are double masking with medical grade masks. Roza Tammer: We should mention that this is in the context of extended use and wherever possible, we do want to see facilities returning to conventional PPE use. Genevieve Buser: Does anybody know if their lab is performing sequencing on COVID tests in-house, or are they referring those all to the Oregon State Public Health Laboratory? Vicki Nordby: Marquis Companies use Kashi Clinical Laboratories, and they're doing select sequencing in certain situations based on vaccination and CT value. Genevieve Buser: Providence is sending anyone identified at risk to the state lab. Genevieve Buser: Are facilities moving to universal testing on admission? Are you using antigen testing or full PCR testing? Keenan Williamson: OHSU is not doing universal testing but is doing routine testing for anyone who might be getting an aerosol-generating procedure or admitted into the ICU. It is routine testing every three days for up to 14 days and it’s a PCR. There have been surprises within the asymptomatic population. Anyone that is tested is put on appropriate precautions so exposures are limited or nil. Vicki Nordby: Marquis Companies are doing testing upon admission and seven days after admission. We’re doing both the antigen and the PCR for initial information and following up with the PCR. It has been helpful as we’ve identified some asymptomatic positives. Genevieve Buser: Have you noted a discrepancy between your antigen and PCR testing? Vicki Nordby: Marquis Companies has done a tremendous amount of antigen testing. I would say we've had less than ten cases where there's been a discrepancy and they have all been a positive antigen and negative PCR.	

	Genevieve Buser: Are there differences in visitor management, and are you changing any of your approaches to visitors based upon current vaccination status? Keenan Williamson: Visitation at OHSU is still the same as it were six months ago. The patient gets one visitor a day. Patients or visitors go through checkpoints where they're asked if they're symptomatic and they're given a mask if they don't have one already. Mary Post: There is a lot of pandemic fatigue and enforcing it can be a challenge. I remind people that the state has not changed its guidance and that most people are not vaccinated out in the community, especially pediatric patients. Kirsten Schutte: What are people doing in regards to leaving operative rooms and surgical areas closed after aerosol-generating procedures? If folks are undergoing a surgical procedure that's expected to generate aerosols or an aerosolizing procedure in a higher COVID prevalence area, are you guys using respiratory protection, N95s or equivalents? Keenan Williamson: At OHSU if they're undergoing an aerosolizing-generating procedure we're following airborne precautions for that patient and they are tested prior. Kirsten Schutte: In outpatient settings are you amending any of your practices if they are negative, like not doing the full expected room turnover? Keenan Williamson: The only amendment we make is some of our rooms are negative air pressure so the time's different. Kirsten Schutte: What would need to be in place, whether that's community prevalence or vaccination or testing, that would allow us to decrease room turnover time or not have to do pre-procedure testing?	

	Keenan Williamson: I think at OHSU we would like to make it less stringent but we are looking towards state and CDC guidance. Genevieve Buser: Any other recent scenarios? Keenan Williamson: OHSU recently had a neutropenic patient who, after 90 days, tested positive again. We put the patient on precautions and treated it as a new infection. Would this be a specimen that would qualify for sequencing or further testing, and would that be just because of immunosuppression? Roza Tammer: Yes, it would be considered a new infection. Are any LTCFs incorporating healthcare worker vaccination status on whether or not they need to be quarantined after an exposure? Please email any comments.	
Discussion: Topics for future meetings and reports All members and attendees	• None	
Public comment		
Final roll call and adjourn		

Next meeting will be June 9, 2021, 1:00pm-3:00 pm via webinar only.

Submitted by Laura LaLonde
Reviewed by Roza Tammer