

DRAFT

Healthcare-Associated Infections Advisory Committee

September 23, 2015

MEMBERS PRESENT:

Jordan Ferris, RN, BSN, CMSRN (phone)
Kathy Phipps (phone – in place of Laurie Murray-Snyder)
Pat Preston, MS
Mary Shanks, RN, MSN, CIC
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC
Bethany Walmsley, CPHQ, CPPS

MEMBERS EXCUSED:

Paul Cieslak, MD
Kelli Coelho, RN, CNOR
Jon Furuno, PhD
Jamie Grebosky, MD
Joan Maca, RN
Csaba Mera, MD
Nancy O'Connor, RN, BSN, MBA, CIC
Rachel Plotinsky, MD
Dana Selover, MD, MPH
Dee Dee Vallier

STAFF PRESENT:

Zintars Beldavs, MS, HAI Program Manager
Genevieve Buser, MD, HAI Public Health Physician
Kate Ellingson, PhD, HAI Reporting Epidemiologist
Monika Samper, RN, HAI Reporting Coordinator

ISSUES HEARD:

- Call to Order and Roll Call
- Approval of June 2015 HAIAC Meeting Minutes
- OAR Updates and Reminders
- Review Highlights from 2014 HAI Annual Report with 2014-15 HCW Influenza Vaccination Data
- Discussion: Looking Ahead to More Actionable NHSN Data
- Member Updates: Round Robin
- Update on Federal Grant Funding for HAI Prevention
- Overview of CDC-funded Facility Consultations for Acute, Long-term, Dialysis, Ambulatory Surgical, and Outpatient Settings
- Public Comment / Adjourn

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Call to Order and Roll Call

Chair Mary Shanks

The meeting was called to order at approximately 1:00 pm.

Approval of June 2015 HAIAC Meeting Minutes

All Committee Members

Minutes for June 24, 2015 meeting were unanimously approved as written.

OAR Updates and Reminders

Monika Samper, OHA

- Dialysis facilities must report healthcare worker influenza vaccination data through NHSN beginning in the 2015-2016 flu season.
- Long-term acute care hospitals (LTACH) will be required by CMS to report ventilator-associated events (VAEs) in NHSN starting January 1, 2016. Oregon would like to align reporting mandates with CMS, but LTACHs are classified as hospitals in Oregon statutes.

Discussion/Decisions

Oregon Health Authority will have an internal discussion and consider asking Vibra (the only Oregon LTACH) whether they would consider voluntarily providing OHA with access to VAE data through NHSN; changing statutes to reclassify LTACHs as a separate category from hospitals would be an arduous process.

Review Highlights from 2014 HAI Annual Report with 2014-15 HCW Influenza Vaccination Data

Kate Ellingson, OHA

- The revised release date for the HAI annual report is September 28, 2015. For the first time, the report will contain healthcare worker influenza vaccination data for the most recent flu season, 2014-2015; in previous reports, vaccination data lagged behind by one year.
- Two editions of the annual report will be published to accommodate different audiences. Both editions will include a two-page executive summary.
 - Provider or full report offers detailed, technical facility-level data including SIRs and aggregate data to illustrate Oregon trends over time.
 - Consumer or condensed report presents concise, simple facility-level data using elementary statistics and incorporates tips on what can be done by patient/family members to prevent infections.

- Findings in the annual report reveal Oregon’s success varied by infection type based on federal government benchmarks and national data.
 - Hospitals:
 - Exceeded national 2013 U.S. Department of Health and Human Services (HHS) reduction targets for central line and MRSA bloodstream infections and for surgical site infections (SSIs) following coronary artery bypass graft (CBGB), laminectomy, and knee replacement surgeries.
 - Did not meet HHS reduction targets for *C. difficile* infections (CDIs), catheter-associated urinary tract infections (CAUTIs), and surgical site infections following colon, abdominal hysterectomy, and hip replacement surgeries.
 - Dialysis facilities: Oregon pooled mean for bloodstream infections was lower than national pooled mean across all access types except non-tunneled CVCs.
 - All facilities: healthcare worker influenza vaccination rates have increased for hospitals, ambulatory surgery centers, and skilled nursing facilities; however, only hospitals met the Healthy People 2015 target of 75% vaccination.

Discussion/Decisions

- Committee members discussed possible reasons for hospitals not meeting targets.
 - Some HAIs, such as CDI, are difficult to prevent as evidenced by national data showing steady increases in rates of community- and healthcare-associated rates; development of more effective intervention methods are necessary to diminish these infections.
 - High CAUTI rates may be the result of fewer catheter days following campaigns promoting judicious use of catheters. Patients with longer periods of catheterization are typically sicker and therefore more prone to infections.
 - Variability in cutoff levels used by laboratories to identify urinary tract infections may have biased CAUTI rates. (Cutoff levels are now specified in 2015 NHSN definitions.)
 - The high incidence of reported CDI might be due to increased laboratory testing or possibly a larger colonized population in the Northwest region of the country. (Note: although HHS targets were not met, Oregon’s SIR was statistically lower than the national baseline.)
- Attendees concluded further investigation is essential to better understand how to reduce infections. Ideas included:
 - Examine Oregon dialysis data in more detail to ascertain why non-tunneled CVC infections have increased since 2013 and are higher than the national pooled mean.
 - Research infection prevention activities including bundles that promote best outcomes.
- The Oregon Patient Safety Commission, who receives many calls related to the annual report, asked for an OHA contact who would be able to field questions. OHA responded that calls from news media can be directed to the Public Health Division’s External Relations department and talking points will be sent out to assist members with inquiries.

Discussion: Looking Ahead to More Actionable NHSN Data

Kate Ellingson, OHA

Topic will be covered in future meeting due to time limitations.

Update on Federal Grant Funding for HAI Prevention

Zints Beldavs, OHA

- Development of an effective framework for infection prevention must address:
 - Regional interconnectedness of healthcare systems to reduce transmission of infections resulting from the movement of patients between different medical settings.
 - Integration of infection prevention efforts throughout the healthcare system to achieve maximum effectiveness, such as antimicrobial stewardship programs.
- Oregon Infection prevention methods encompass:
 - Detection:
 - Reporting: healthcare facilities are required to report HAIs through the National Healthcare Safety Network (NHSN) and laboratories must notify their local health department (LHD) of carbapenem-resistant Enterobacteriaceae (CRE).
 - Emerging Infections Program (EIP): focuses on surveillance of emerging infectious diseases such as candidemia, CDI, and carbapenem-resistant *Pseudomonas aeruginosa*. (CRPA). Program periodically employs antimicrobial use prevalence studies to better understand the burden of HAIs and use of antimicrobials.
 - Inter-facility transfer communication: Oregon law requires a referring healthcare facility to notify receiving facility when transferring a patient with an MDRO or pathogen warranting transmission-based precautions.
 - Protection:
 - Programs: Oregon Patient Safety Commission is working on MDROs, dialysis blood stream infections, and antimicrobial stewardship. OHA has a pilot study aimed at preventing inter-facility transmission of CDI.
 - Education: OHA offers webinars, meetings, and materials to meet the needs of stakeholders.
 - Outbreak response: OHA is responsible for identifying and responding to multi-facility HAI clusters and is part of a statewide network established to prevent the spread of carbapenemase-producing CRE.
 - Special studies/projects:
 - EIP studies: seek to understand HAI risk factors for infections such as CDI, determine incidence of HAI-related deaths following hospitalization, and improve surveillance through better NHSN definitions and more efficient HAI tracking methods.
 - Data validation: ensures quality data is available for analysis and development of infection prevention programs.
 - Ebola project: employs consultative visits to evaluate and improve the capacity of Ebola assessment hospitals to care for patients.
- Strategies to reinvigorate the Oregon HAI program include:
 - Establish regional hubs where facilities would collaborate to prevent CDI and MDROs.

- Offer statewide infection control evaluation and support to healthcare facilities, focusing on medical settings with limited resources.
- Provide injection safety outreach.
- Make NHSN data actionable: detect outbreaks, target facilities for infection prevention, and promote increased healthcare worker influenza vaccination rates in LTCFs.
- Expand outbreak response capacity.
- Perform CRE prevalence studies.
- Evaluate compliance of healthcare organizations with Oregon inter-facility transfer communication rule.

Discussion/Decisions

Committee members expressed an interest in creating an HAI support group for IPs to deliberate whether components of complex cases meet NHSN definitions. OHA responded favorably adding that CDC experts might be willing to participate in conference calls.

Overview of CDC-funded Facility Consultations for Acute, Long-Term, Dialysis, Ambulatory Surgical, and Outpatient Settings.

Mary Post, Oregon Patient Safety Commission

- Epidemiology and Lab Capacity (ELC) Domestic Ebola grant awarded to OHA focuses on building statewide infection prevention infrastructure, capacity, and education through a multifaceted approach.
 - Conduct readiness consultations with Oregon Ebola Tier 2 Assessment Hospitals.
 - Develop statewide infection control capacity to prevent healthcare-associated infections.
 - Expand biosafety capacity at the Public Health Laboratory.
- Healthcare Infection Control Assessment and Response (ICAR) program developed by CDC emphasizes cultivating partnerships to bolster infection control practices across the healthcare system.
 - Provides exciting opportunity to work with a variety of partners including: state and county health departments, healthcare facilities, emergency preparedness partners, and professional organizations.
 - Requires development of well-defined goals and alignment of regulations among agencies to achieve optimal results.
- ICAR Activity A
 - Strategy 1: Expand state HAI plan and advisory group.
 - Update state HAI plan to include assessment of gaps in infection control practices and outbreak reporting.
 - Broaden role of HAI Advisory Committee to encompass participation in planning of infection control activities:
 - * Recommend criteria for selecting facilities who would most benefit from infection prevention consultations.
 - * Propose mitigation strategies for addressing infection control gaps identified through analysis of facility assessment data.

- Strategy 2: Improve coordination between OHA and healthcare settings.
- Strategy 3: Assess readiness of designated Ebola facilities.
- Strategy 4: Evaluate and improve HAI outbreak reporting and response.
- ICAR Activity B
 - Strategy 1: expand infection prevention consultations, both in number of facilities and depth of content.
 - Consultations expanded beyond hospitals to include long-term care facilities (LTCFs), ambulatory surgery centers (ASCs), dialysis facilities, and medical clinics.
 - * Goal for 2015 is to perform consultations at 25 healthcare organizations.
 - * Facility selection criteria based on examination of findings from multiple sources including: outbreak reports, NHSN data, and regulatory surveys.
 - Consultations focus on quality improvement.
 - * CDC assessment tool evaluates: infection control program and infrastructure; infection control training, competency, and implementation of policies and procedures; and systems to detect, prevent, and respond to HAIs and MDROs.
 - * Follow-up visits assess efforts to mitigate infection control gaps.
 - Regional approach instituted to promote collaboration and networking within six designated Healthcare Preparedness Liaison Regions. Infection Preventionists certified through APIC will be contracted and trained to respond to issues within these regions.
 - Funding available for resource and tool development.
 - Strategy 2: increase infection control competency and practice.
 - Investigate modification of state regulations (e.g., OARS) and credentialing/licensing requirements to address identified infection prevention gaps.
 - Offer educational opportunities including regional workshops covering assessments and tools and courses on fundamentals of infection prevention.
 - Strategy 3: enhance surveillance analytic and reporting capacity.

Discussion/Decisions

Committee members suggested development of collaborative networks, comprised of facilities with similar patient populations, to enable successful organizations to mentor facilities struggling to reduce infections.

Public Comment / Adjourn

Chair

No comments from public.

Minutes Reviewed by:

Kate Ellingson
Zintars Beldavs

Exhibit Summary

A – Agenda

B – June 24, 2015 Minutes

C – Executive summary: Health Care-Associated Infections in Oregon Hospitals - 2014

D – Oregon 2014 Annual Report

E – Oregon HAIAC HAI Program Update

F – Healthcare-Associated Infections Advisory Committee: Ebola Grant Overview Part B



Reducing Healthcare-Associated Infections in Hospitals

QIN-QIO Initiatives with Acumentra Health

Laurie Murray-Snyder

December 16, 2015

Acumentra Health

- Medicare Quality Improvement Organization (QIO) Program
 - Oregon affiliate of 4-state HealthInsight Quality Innovation Network-QIO (QIN-QIO)
- Medicaid External Quality Review for Oregon
- Multiple research projects



Coordination of Care

- All provider types recruited as a community unit
- Reduce unnecessary admissions and readmissions to the hospital
- Improve transitions of care
- Improve medication safety, focus on anticoagulant, diabetes, and opioid medications



Reducing HAIs in Hospitals

- Hospitals—PPS and CAHs
- CAUTI, CLABSI, *C. difficile* and VAE reporting
- Reduce aggregate SIR to meet national benchmark
- NHSN data
- Align with stakeholders on crossover topics



Nursing Home Quality Care Collaborative

- Reduce unnecessary antipsychotic medications
- NHSN reporting and reduction of *C. diff*
- Integrate Quality Assurance Performance Improvement (QAPI)
- Align with stakeholders on crossover topics



Behavioral Health Initiative

- Screening and referral for depression and alcohol use disorder
- Improve care transitions after hospitalization and mental health follow-up
- Primary care, mental health agencies, IPFs



Improving Adult Immunizations

- Influenza, pneumonia, and shingles
- Pharmacies, primary care, home health agencies, and hospitals
- Partnering with the state immunization registry (ALERT)



Cardiovascular Health and Million Hearts

- ABCS measures:
 - Aspirin therapy
 - **Blood pressure control**
 - Cholesterol control
 - Smoking/tobacco cessation
- Learning and Action Network webinars, technical assistance, partnering with new stakeholders
- Primary care and home health agencies



Meaningful Use of HIT

- Support in meeting Medicare incentive program requirements
- Virtual community, collaboration with IT stakeholders, technical assistance
- Hospitals and practices



Quality Reporting and Incentive Programs

- Better understand CMS methodology and achieve performance goals
- Technical assistance with reporting and improving measure outcomes
- Physicians, physician groups, inpatient psychiatric facilities, ambulatory surgery centers, PPS and Critical Access Hospitals



Everyone with Diabetes Counts

- Expanding access to Diabetes Self-Management Education (DSME) to reach more patients
- Increasing provider referrals to DSME
- Practices and community health workers



Oregon Health Authority

External Quality Review

- Compliance
- Performance Improvement Project
- Utilization review of residential care;
 \leq age 18 and \geq 65
- Eligibility determination residential services;
foster care
- Mental Health survey: Adults, children and
adults of children



Grant work

- Prescription drug monitoring database (PDMP)
- AHRQ: Opioid reduction toolkit for pharmacists, developed by OSU and Fred Meyer pharmacy
- NIH: Joint grant with State and OHSU, studying how doctors use PDMP database to decrease opioid use



Oregon's Prescription Drug Monitoring Program (PDMP)

- Goal: improve health and public safety
- Oregon-licensed providers, pharmacists, and staff can be authorized to access web-based information to manage patient treatment
- Includes data for all controlled substance prescriptions dispensed to Oregon residents
- Outpatient pharmacies are required to submit prescription data weekly (every 72 hours starting in 2016)



Beneficiary & Family Advisory Council

- Experience as a patient and/or patient's family member
- Commitment to participate for at least 1 year
- Attend an orientation
- Attend regularly scheduled monthly meetings in downtown Portland (parking or transit fare will be covered, refreshments provided)
- Contact Jennifer Wright, jwright@acumentra.org



Contact information

Topic area	Contact	email
Coordination of Care BFAC	Jennifer Wright	jwright@acumentra.org
Reducing HAI in Hospitals	Laurie Murray-Snyder	lmurraysnyder@acumentra.org
Nursing Home Quality	Leah Brandis	lbrandis@acumentra.org
Behavioral Health	Susan Yates Miller	syatesmiller@acumentra.org
Immunizations Cardiovascular Health	Carrie Beck	cbeck@acumentra.org
Meaningful Use Quality Reporting: Clinics & physicians	David Smith	dsmith@acumentra.org
Quality Reporting: Hospitals, ASCs, IPFs	Kathy Phipps	khipps@acumentra.org
Diabetes Self-Management	Tracy Carver	tcarver@acumentra.org
External Quality Review Grants: PDMP, AHRQ, NIH	Jody Carson	jcarson@acumentra.org



Healthcare-Associated Outbreaks Update & Review

Alexia Zhang, MPH

Healthcare-Associated Infections Epidemiologist
Acute and Communicable Disease Prevention Program

Wednesday, December 16th, 2015

Oregon
Health
Authority

Outbreaks since 9/1/2015

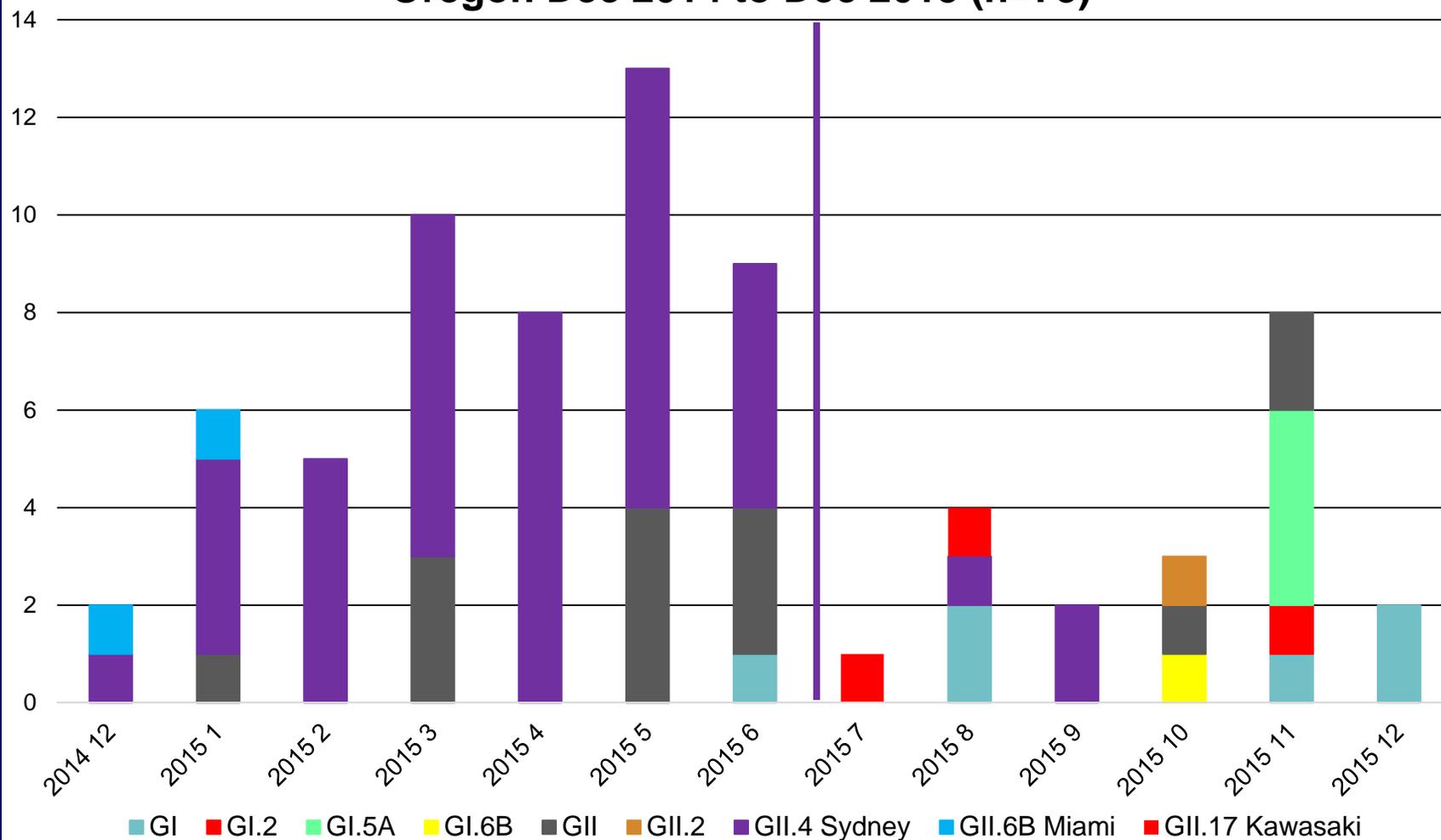
Etiology	Count	Setting
Norovirus	12	LTCF (9) , school (2), caterer (1)
Gastroenteritis		
<i>Salmonella</i>	2	Private home (1), Reception facility (1)
<i>Shigella</i>	1	School
STEC	1	restaurant
<i>Clostridium difficile</i>	1	LTCF
unknown	25	DCC (2), Hospital (1) , LTCF (11) , Restaurant (4), school (8)
Respiratory		
Pertussis	3	school
influenza	2	LTCF (2)
rhinovirus	5	LTCF (5)
unknown	2	LTCF (1) , school (1)
Rash	2	school (1), DCC (1)
Total	56	

Healthcare associated outbreaks, Sept 1- Dec 10th 2015

- Healthcare associated infections account for 53.4% (n=30) of all outbreaks from September to December
- Most common etiology was norovirus and noro-like outbreaks
 - 70.0% of all outbreaks in a healthcare setting (n=21)
- 1 facility had 2 GI outbreaks during this time

Facility type	Norovirus	Rhinovirus	unknown-GI	unknown-respiratory	Influenza	C. diff
Memory Care	5	1	5	1	0	0
Assisted Living Facility	1	2	2	0	0	1
Skilled Nursing Facility	3	0	3	0	1	0
Rehabilitation Facility	0	2	0	0	1	0
Residential Care	0	0	1	0	0	0
Hospital	0	0	1	0	0	0
Total	9	5	12	1	2	1

Laboratory confirmed norovirus genotypes by month, Oregon Dec 2014 to Dec 2015 (n=73)



What makes an HAI outbreak?

- Two or more cases of disease
- Epidemiologically-linked
- Occurring in a healthcare facility
- Reportable by the facility (ORS 442.015)
 - Hospital
 - Long term care facility
 - Ambulatory surgical center
 - Freestanding birthing center
 - Outpatient renal dialysis center

Other reportable disease? Yes!

- Any case of a reportable disease* and, if unsure:
 - Highly transmissible
 - Results in serious or severe health consequences

AND

- “...any known or suspected common-source outbreaks; any uncommon illness of potential public health significance.”
 - Whether or not a mandated reportable disease
- Reportable by each healthcare provider *or any individual knowing of such a case*

Outbreak expectations

- Facilities and providers will work collaboratively with PH
 - Make timely reports to public health*
 - Share information
 - Discuss recommendations
- Public health will work collaboratively with facilities and providers to contain the outbreak and identify a source:
 - Share information
 - Provide recommendations, as indicated, including lab testing
 - Protect personal health information
 - Work with providers to ensure patient safety
 - Educate facilities and providers, as indicated

What information will be requested?

- Provide information to facilitate the assessment:
 - The identity, address, and telephone number of the person reporting and attending health care provider;
 - The name of the person affected or ill, that person's current address, telephone number, and date of birth;
 - The diagnosed or suspected disease, infection, or condition;
 - The date of illness onset;
 - The name or description of the test;
 - The test result.
- Provide information related to care at the health care facility or provider:
 - Admission, discharge, procedures, room, exposures, risks, etc.
 - Epidemiologically-linked ill or exposed patients or staff

Possible actions to stop outbreak

- Conference calls between facility and public health
- Site visit and observations of practice by public health or consultant
- Recommendation letter
- Environmental cleaning recommendations
- Screening of exposed patients or staff
- Testing of ill patients or staff identified during investigation
- Environmental testing if a source suggested by the investigation
- Testing of medical equipment
- Isolation of patients, staff, or medical equipment
- Patient recommendations: e.g., chlorhexidine wipes
- Staff recommendations: e.g., test and treat for positive GAS cultures

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Healthcare-Associated Infections (HAI)

- Learn about HAIs
- For Health Care Facilities
- For Health Professionals
- For the Public
- HAI Reporting**
- HAI Surveillance
- HAI Validation
- HAI Prevention
- HAI Publications and Maps
- Infection Control Resources

[Public Health](#) > [Diseases and Conditions](#) > [Communicable Disease](#) > [Healthcare-Associated Infections \(HAI\)](#) > [HAI Reporting](#) > [Healthcare-Associated Infection Outbreaks](#)

Healthcare-Associated Infection Outbreaks

Guidelines for investigating HAI outbreaks, including multidrug-resistant organisms (MDRO)

On this page:

- [Mandatory Outbreak Reporting](#)
- [Basic Definitions](#)
- [Control Measures](#)
- [Data Collection and Basic Descriptive Epidemiology](#)
- [Data](#)
- [Educational Resources](#)
- [Resource Links](#)

www.healthoregon.org/hai

Mandatory Outbreak Reporting

Acute care hospitals and long-term care facilities (LTCFs) are required to report to the local health authority under OAR 333-018-0000 any healthcare-associated infections (HAI), including by multidrug-resistant organisms (MDRO), that meet the following threshold: "any known or suspected common-source outbreaks; or uncommon illness of potential public health significance" (OAR 333-018-0015; ORS 433.004). Local health authorities are empowered to investigate such outbreaks under OAR 333-019-0000, ORS 433.006.

Carbapenem-resistant *Enterobacteriaceae* is a reportable disease (OAR 333-018-0015; ORS 433.004).

Local health authorities need to report HAI outbreaks, including MDRO outbreaks, to the state communicable disease epidemiology program at 971-673-1111 within 24 hours of receiving an outbreak report.

Related Resources

- [Diseases A-Z](#)
- [Emerging Infections](#)
- [CDC's HAI website](#)
- [National Healthcare Safety Network \(NHSN\)](#)
- [HAI Definitions \(pdf\)](#)

Contact Us

- [HAI Staff Directory](#)
- [Acute & Communicable Disease Prevention Section](#)

Data Collection and Basic Descriptive Epidemiology

- Track cases using the [Healthcare Associated Infection Case Log \(pdf\)](#). The log can be completed by hospital or LTCF infection control staff; establishing a single point of contact is recommended.
- Use tools to get basic descriptive epidemiology, including an epidemic curve (i.e., cases by onset day).
- Review facility's microbiology laboratory for other cases of the same organism or MDRO within the last 12 months. If found, perform a limited chart review and note name, date of birth, source, room number, admission source, healthcare facility exposures.
- Consider performing a [patient prevalence survey](#) to assess burden of the organism or MDRO in healthcare facility. Refer to the [Specimen Collection Protocol \(pdf\)](#).
- Monitor the outbreak for new cases for 6 months.
- If ongoing transmission is identified, discuss performing further investigations (e.g., [environmental prevalence survey](#))

Response

- Review case medical records for risk factors
- Environmental cleaning
 - [High-touch Cleaning Checklist \(pdf\)](#)
 - [CDC Environmental Checklist for Monitoring Terminal Cleaning \(pdf\)](#)
- Interfacility transfer forms: Find forms and resources at [Interfacility Communication](#)
- Patient prevalence survey
 - Tools: [Patient letter \(pdf\)](#), [Staff letter \(pdf\)](#)
- Staff Education: [Person Protective Equipment \(PPE\) Protocol \(pdf\)](#)
- Patient Education:
 - [10 Ways to be a Safe Patient \(pdf\)](#)
 - [MDR Ab Patient Education \(pdf\)](#)
 - [CRE Patient Education: Oregon CRE Toolkit \(pdf\)](#)
 - [Provider CRE Notification Letter \(pdf\)](#)
 - [Prevention: CDC Detect/Protect \(pdf\)](#)

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Joe Smith

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Interfacility transfer rule

- **Effective January 1, 2014:** When a referring health care facility transfers or discharges a patient who is infected or colonized with a multidrug-resistant organism (MDRO) or pathogen which warrants Transmission-based Precautions, it must include written notification of the **infection or colonization** to the receiving facility in transfer documents. The referring facility must ensure that the documentation is readily accessible to all parties involved in patient transfer (for example, referring facility, medical transport, emergency department, receiving facility).
- **In Oregon, health care facilities include:** hospitals, ambulatory surgery centers, nursing homes, residential care facilities, assisted living facilities, and adult foster homes.
- **MDROs include, but are not limited to: MRSA, CRE, VRE, C. difficile**
- ***Colonization is assumed to be 1 year following most recent infection***

Inter-facility Infection Control Transfer Form

SENDING FACILITY TO COMPLETE FORM and COMMUNICATE TO ACCEPTING FACILITY

Please attach copies of latest culture reports with susceptibilities, if available

Patient/Resident Last Name	First Name	Date of Birth
<i>Print or place Patient Label</i>		

Sending Facility Name	Sending Facility Unit	Sending Facility Phone #

Is the patient/resident currently on antibiotics? NO YES **DX:** _____

Does the patient/resident have pending cultures? NO YES

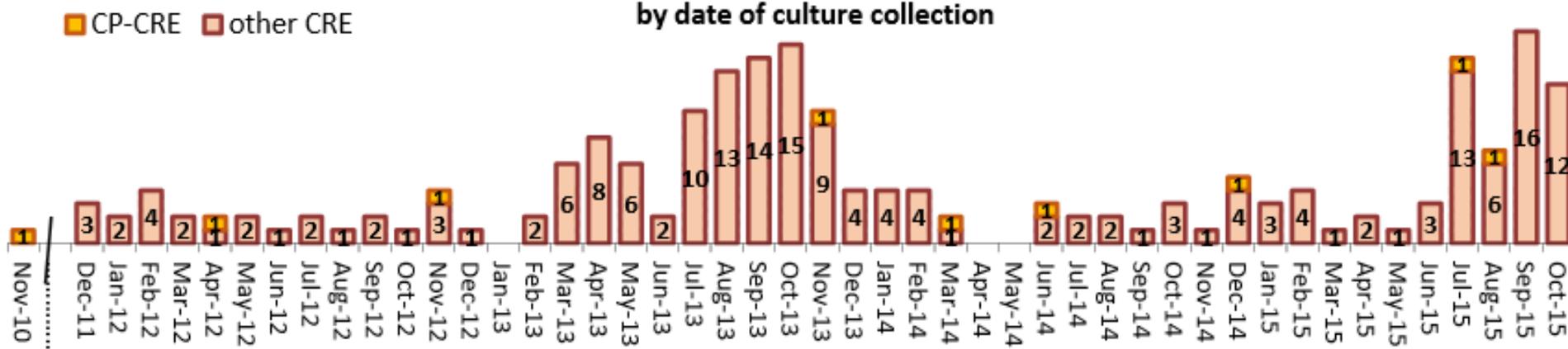
Is the patient/resident currently on precautions? NO YES

Type of Precautions (check all that apply) Contact Droplet Airborne Other: _____

Does patient currently have an infection, colonization OR a history of a multidrug-resistant organism (MDRO)?	Colonization or history <i>Check if YES</i>	Active infection on treatment <i>Check if YES</i>
MRSA (methicillin-resistant <i>Staphylococcus aureus</i>)	<input type="checkbox"/>	<input type="checkbox"/>
VRE (Vancomycin-resistant <i>Enterococcus</i>)	<input type="checkbox"/>	<input type="checkbox"/>
<i>C. diff</i> (<i>Clostridium difficile</i> , CDI)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Acinetobacter spp.</i> , multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
Gram-negative organism resistant to multiple antibiotics* (e.g., <i>E. coli</i> , <i>Klebsiella</i> , <i>Proteus spp.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
CRE (carbapenem-resistant <i>Enterobacteriaceae</i>)	<input type="checkbox"/>	<input type="checkbox"/>

Carbapenem-resistant Enterobacteriaceae Update

CRE reported by Oregon laboratories,
2010 - Oct 2015
by date of culture collection

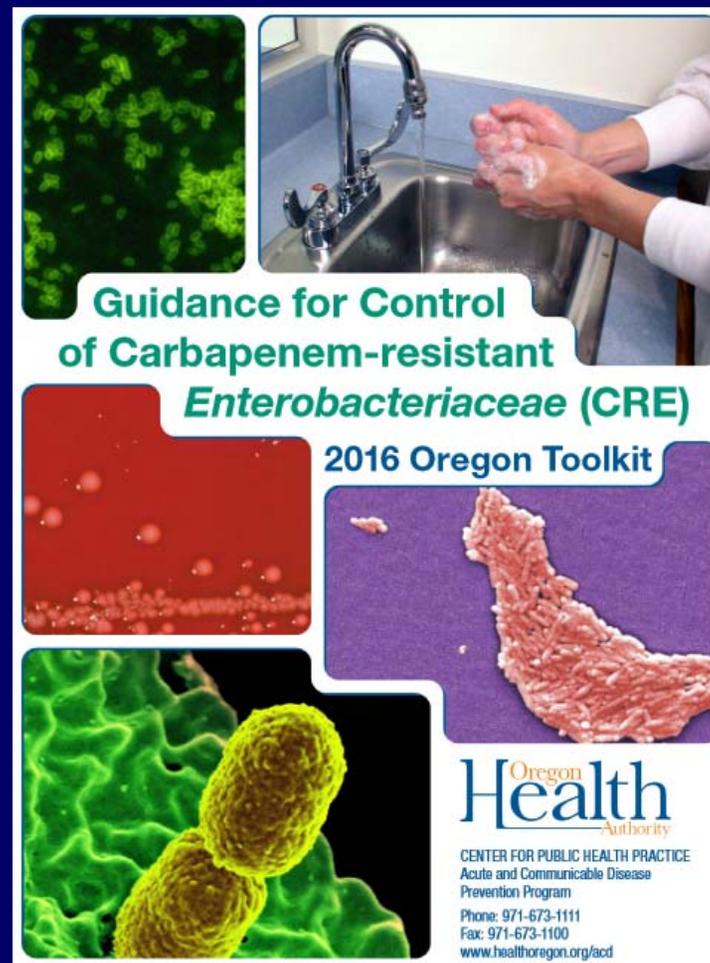


- 208 cases, F > M (because mostly urine samples?)
- 9 carbapenemase-producing CRE; no transmission identified
 - 7 with healthcare outside of Oregon
- 60% collected from a hospital setting

Acute and Communicable Disease Prevention Program
Oregon Public Health Division

2016 CRE Toolkit—Finally here!

- Key updates:
 - CRE definition
 - Separate sections for different healthcare settings
 - Update resources
 - LTCF table (p 23)
- <http://public.health.oregon.gov/DiseasesConditions/DiseasesAZ/Pages/disease.aspx?did=108>
- Paper editions to follow



Summary of recommendations for management of SNF residents with CRE

Measure	CP-CRE infection	CP-CRE colonization	Non-CP-CRE infection	Non-CP-CRE colonization ^{††}
Notify receiving facility*	Yes	Yes	Yes	Yes
Notify county health upon transfer or death	Yes	Yes	No	No
Standard precautions	Yes	Yes	Yes	Yes
Contact precautions [†] Gown/gloves for in-room resident care	Yes	Yes	Yes	For residents at higher risk of CRE transmission
Door signage	Yes	Yes	Yes	For residents at higher risk of CRE transmission
Private room	Yes (strongly encouraged)	Yes (strongly encouraged)	Yes	No
Restricted to room	Yes	No ^{**}	No ^{**}	No ^{**}
Enhanced environmental cleaning	Yes	Yes	Yes	No
Designated or disposable equipment	Yes	Yes	Yes	No
If >1 case, cohort staff if feasible	Yes	Yes	Optional	Optional
If >1 case, cohort residents if feasible	Yes	Yes	Optional	Optional
Consult with OHA regarding screening cultures	Yes	Yes	No	No
Visitor recommendations:				
• Perform hand hygiene often, particularly after leaving the resident's room.	Yes	Yes	Yes	Yes
• Gown/gloves if contact with body fluids is anticipated.	Yes	Yes	Yes	Yes
• Gown/gloves if no contact with body fluids is anticipated.	No	No	No	No

***C. difficile* collaborative**

- Enrolled 3 hospitals
- 7 skilled nursing facilities (1 pending)
- Ongoing enrollment: genevieve.l.buser@state.or.us
- 5 main areas of work:
 - Surveillance: NHSN enrollment
 - Best practices
 - Environmental hygiene
 - Antibiotic stewardship
 - Interfacility transfer

UP AND COMING

Acute and Communicable Disease Prevention Program
Oregon Public Health Division



Antibiotic Resistance and Utilization

- Funding to recruit hospitals to begin submission to NHSN AU/AR module
- Requires close collaboration between hospital, public health, and EMR and LIMS vendors
 - Data transfer (CDA/HL7) as opposed to manual entry
 - Monetary support offered
- Satisfies CMS requirement for meaningful use
- Goal:
 - Provide regional antibiograms
 - Provide regional antibiotic use patterns

Thank You

<http://public.health.oregon.gov>

www.healthoregon.org/hai

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Oregon
Health
Authority

Healthcare-Associated Infection Prevention Plan

Oregon health Authority

Public Health Division

Executive Summary:

Oregon's first State Healthcare-Associated Infection (HAI) plan was created in 2009 to target HAIs in acute care, expanded in 2013 to include MDROs and non-acute care settings, and updated in 2014 to adopt prevention targets set by the US Department of Health and Human Services (HHS). The Oregon State HAI Plan was most recently updated in 2015 to include an Infection Control Assessment and Promotion (ICAP) program. The ICAP program will commence with assessment of infection prevention and control practices at Oregon's six Ebola Assessment Hospitals using a standardized tool adapted by CDC's Rapid Ebola Assessment teams to prepare hospitals during the 2014-15 Ebola outbreak. Next, the ICAP program will prioritize assessment of other inpatient, outpatient, and long-term care facilities, based on the following factors: NHSN-reported burden of infection, inclusion in a region that is the focus of MDRO prevention efforts, outbreaks reported to the Oregon Health Authority (OHA), and infection control citations noted by state surveyors. Through gap analysis, targeted training, evaluation, and targeted resource allocation, the ICAP seeks to enhance adherence to standard and transmission-based precautions, safe laboratory and waste management practices, and communication between healthcare and public health partners.

Background:

In June 2007, the Oregon legislature passed House Bill 2524 to create a mandatory HAI Reporting Program in Oregon. The bill stipulated that the Oregon Office for Health Policy and Research (OHPR) conduct the following activities: implement an HAI surveillance and prevention program; maintain a multi-disciplinary HAI Advisory Committee (HAIAC) to advise the OHPR regarding the mandatory HAI reporting program; require healthcare facilities to report metrics determined by OHPR with guidance from the HAIAC, prepare periodic public reports to summarize aggregate and facility-specific HAI data, and regularly evaluate the quality and accuracy of the data collected for the HAI reporting program. The HAIAC was established in October 2007, and at that time, eight of 57 Oregon hospitals were using a system for collecting HAI data. The committee observed that the CDC's National Health and Safety Network (NHSN) was emerging as the nationally preferred system for tracking HAIs. The committee partnered with Association for Professionals in Infection Control (APIC) and the Oregon Association of Hospitals and Health Systems (OAHHS) to provide training for all Oregon hospitals to use NHSN.

In September 2009, the Oregon Public Health Division (OPHD) was awarded a grant from the American Recovery and Reinvestment Act (ARRA), distributed through HHS, and managed by CDC's Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) program. The funds were to be used to enhance HAI infrastructure, surveillance, and reporting. These goals dovetailed with the activities currently underway as a result of Oregon's House Bill 2524, and the activities overseen by the HAIAC. In 2009, an HAI program manager was hired to build an HAI program within OPHD's Acute and Communicable Disease Prevention (ACDP). As of December 2009, all hospitals required to report HAI data stipulated by

the HAI program were enrolled and reporting through NHSN. The first state plan, submitted to CDC in 2009, followed a standardized structure required of all states receiving ARRA funding for HAI program activities (details below). Since 2009, the HAIAC has expanded the number and types of HAIs that hospitals are required to report. Additionally, dialysis facilities are now required to report bloodstream infections, and hospitals, ambulatory surgical centers (ASC), and skilled nursing facilities (SNFs) are required to report healthcare personnel vaccination rates as part of HAI Reporting. Activities supported with ARRA funds were expanded in subsequent years by Affordable Care Act (ACA) funds; these funds continued to support basic HAI infrastructure (i.e., a coordinator and oversight of the HAIAC), expanded HAI surveillance and validation activities, and supported prevention collaborative activities in conjunction with partners such as the Oregon Patient Safety Commission and Oregon Health and Sciences University. In 2015, the OPHD received an ELC Ebola Supplement Grant to expand the coordination of HAI activities with preparedness, regulatory and laboratory communities. Specifically, funds were allocated for mapping and coordination activities to allow enhanced awareness and coordinated response potential throughout public health, regulatory, and healthcare communities. Additionally, the funds were designated for support of standardized assessments of Ebola Assessment Hospitals as well as other inpatient and outpatient facilities throughout the state. These activities – including the formation of an Infection Control and Assessment and Promotion sub-committee of the HAIAC – are reflected in updates to the Oregon State Plan detailed below.

Summary of Previous State HAI Plans:

- 2009: First official state plan
 - Submitted in standardized format to CDC as stipulation of ARRA funds
 - Publically available here: <http://www.cdc.gov/HAI/pdfs/stateplans/or.pdf>
 - Supported formation of official HAI Program within ACDP to conduct:
 - Infrastructure activities, including formation of state plan, hiring of a state HAI coordinator, and coordination of the HAIAC to build and solidify partnerships
 - Surveillance activities, including validation of NHSN data submitted to OHA per the requirements of the Oregon mandatory HAI reporting program
 - Prevention activities, including development of multi-facility collaboratives to introduce and champion HAI prevention strategies
- 2013: Update to initial plan with the following objectives:
 - Detect and reduce the number of multidrug-resistant organisms (MDRO) and *Clostridium difficile* (CDI) circulating in Oregon healthcare facilities
 - Improve antimicrobial stewardship and environmental cleaning standards
 - Enhance surveillance and prevention of HAIs in non-hospital settings including:
 - SNFs through the state's Drop CRE program and inclusion in of influenza vaccination reporting requirement
 - ASCs through inclusion of influenza vaccination reporting requirement
 - Dialysis centers through addition of dialysis event reporting requirement
 - Promote inter-facility transfer communication regarding patient infection or colonization with MDROs or *C. difficile*

- 2014: Update to include HHS reduction targets as part of HAI Program Goals
 - HHS Federal Steering Committee for the Prevention of Healthcare-Associated Infections developed the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination in 2009 with Target goals including
 - CLABSI: 50% reduction by 2013 from national baseline in 2006-2008
 - CAUTI in ICUs: 25% reduction by 2013 from national baseline in 2009
 - Hospital-onset MRSA BSI (LabID): 25% reduction by 2013 from national baseline in 2010-2011
 - Hospital-onset *Clostridium difficile* (LabID): 30% reduction by 2013 from national baseline in 2010-2011
 - SSI: 25% reduction by 2013 from national baseline in 2006-2008
 - Updated plan proposed using these targets to benchmark progress in Oregon and at specific facilities

2015 Plan Updates:

In 2015, the state HAI plan will incorporate goals set forth by the HAI program to enhance coordination with regulatory and preparedness communities, and to begin standardized HAI assessment at Oregon healthcare facilities with appropriate expertise to guide remediation of problems identified. Expanded state plan goals will include:

- Expansion of the HAIAC to include an Infection Control Assessment and Prevention Committee (ICAP), comprised of the following multidisciplinary members:
 - Onsite Ebola Assessment Hospital consultation team
 - Physician infectious disease specialist lead
 - Infection preventionist with experience across healthcare settings
 - Laboratory sciences expert
 - Industrial hygienist
 - Members of the state and local preparedness community
 - State Health Security Preparedness and Response (HSPR)
 - Local Public Health Emergency Preparedness (PHEP) liaison
 - Members of the regulatory community
 - Health Care Regulation and Quality Improvement (HCQRI)
 - Office of Licensing and Regulatory Oversight (OLRO)
 - Members of provider boards:
 - Medical Board
 - Nursing Board
 - Pharmacy Board
 - Infection Prevention Specialists
 - Sterilization and reprocessing
 - Environmental infection prevention
 - Other specialists as areas of need are identified
 - ICAP Responsibilities
 - Advising facility consultation teams

- Making recommendations for remediation
- Identify synergies with ongoing HAI prevention, regulatory, or preparedness efforts
- Creation of an inventory of all healthcare facilities in the state by combining data from multiple sources; inventory will be updated annually to include accurate contact information and up-to-date information about publically reported infection rates as well as other metrics to be determined in consultation with the ICAP sub-committee of the HAIAC.
- Standardized assessment of and consultation with Oregon's six Ebola Assessment Hospitals on 12 domains defined by CDC's Rapid Ebola Preparedness tools.
- Standardized infection prevention assessment of and consultation with a targeted selection of hospitals, ASCs, and LTCFs throughout the state using CDC tools.

Proposed Update to Oregon State HAI Plan

Kate Ellingson, PhD
Healthcare-Associated Infections Program
Oregon Health Authority
December 16, 2015

Oregon
Health
Authority

Some Background



- HB 2524 Establishes Mandatory HAI Reporting Program in 2007
- OHA received \$725K in 2009 from HHS/CDC as part of the Recovery Act (ARRA)
- State Plan required per ARRA framework
- Official plan submitted September 2009
- Updates to plan in 2013 & 2014 with extensions of state funding through ACA

Why update now?

- Ebola 2014 exposed gaps in infection control infrastructure at US healthcare facilities
- CDC funded states to enhance capacity at facilities through on-site consultations
 - Ebola Assessment Hospitals (Part A: led by Guzman)
 - Other facilities throughout state (Part B: led by Post)
- CDC: multidisciplinary advisory committee should guide grant activities
 - “Infection Control Assessment and Promotion” (ICAP)
 - If building on current HAIAC, need to expand membership

Existing HAIAC

- Healthcare-Associated Infections Advisory Committee (HAIAC) established 2009 to guide mandatory reporting program
- HAIAC composition defined by ORS 442.851

Sec. 4. (1) There is established the Health Care Acquired Infection Advisory Committee to advise the Director of the Oregon Health advisory committee shall consist of 16 members appointed by the director as follows:

(a) Seven of the members shall be health care providers or their designees, including:

(A) A hospital administrator who has expertise in infection control and who represents a hospital that contains fewer than 100 beds;

(B) A hospital administrator who has expertise in infection control and who represents a hospital that contains 100 or more beds;

(C) A long term care administrator;

(D) A hospital quality director;

(E) A physician with expertise in infectious disease;

(F) A registered nurse with interest and involvement in infection control; and

(G) A physician who practices in an ambulatory surgical center and who has interest and involvement in infection control.

(b) Nine of the members shall be individuals who do not represent health care providers, including:

(A) A consumer representative;

(B) A labor representative;

(C) An academic researcher;

(D) A health care purchasing representative;

(E) A representative of the Department of Human Services;

(F) A representative of the business community;

(G) A representative of the Oregon Patient Safety Commission who does not represent a health care provider on the commission;

(H) The state epidemiologist; and

(I) A health insurer representative.

Updated Plan: Expand HAIAC per Evolving Mission of HAI Program

- Regular and standardized on-site facility consultations: new territory for HAI program
- Need to strengthen collaboration with:
 - Licensing and regulatory groups (HCQRI and OLRO)
 - Preparedness communities (HSPR, state & local)
 - Provider boards (medical, pharmacy, nursing)
 - Experts in specific areas requiring most remediation (e.g., instrument reprocessing, environmental, etc.)
- Pending approval of updated plan, expanded HAIAC to meet for first time in March, 2016

HAIAC Membership

- Quarterly Meetings

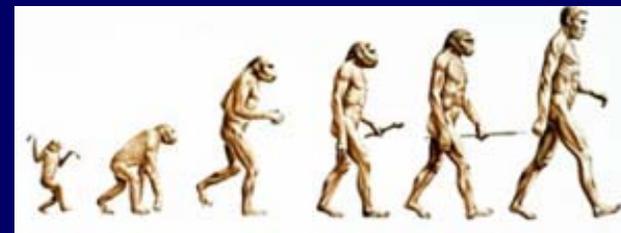
- March 23, 2016
- June 22, 2016
- September 28, 2016
- December 14, 2016

Portland State
Office Building
1-3pm

- Meeting Format (Updated for 2016)

- NHSN reporting updates (summary of HAI outcomes)
- Summary of HAI outbreaks investigated over previous quarter
- Aggregate findings from facility consultations
- Structured feedback from committee on issues identified through reported data, outbreak investigations, and facility consultations

Evolution of Oregon State HAI Plan



- 2009 Plan Organized by ARRA Funding Categories
 - Infrastructure (HAI coordinator, advisory committee maintained)
 - Surveillance (NHSN onboarding & data validation)
 - Prevention (promotion evidence-based practices)
- 2013 Updates
 - Expanded goals to include MDRO & CDI prevention
 - Expanded target population to include dialysis, SNFs, & ASCs
- 2014 Updates: Increasing emphasis on “data for prevention” and HHS targets
- 2015 Update (pending): CDC/Ebola funded facility consults

Proposed 2015 Updates

- Include Goals CDC-Ebola Supplement Funding
- Healthcare facility consultations/assessments
 - Ebola Assessment Hospitals
 - Other facilities throughout state
- Expansion of HAIAC to include Infection Prevention Assessment and Promotion (ICAP) Sub-committee
 - Committee will include current & new members
 - Multidisciplinary: IP, physician lead, industrial hygienist, preparedness & regulatory representatives, other interested parties
- Coordination with preparedness/regulatory
- Mapping & outbreak prep initiatives

Proposed Next Steps



- Today:
 - Hear findings from 2015 facility consultations
 - Vote on whether to incorporate expanded vision and HAIAC membership into updated State Plan
- Early 2016
 - Sent appointment letters to new HAIAC members
 - Submit updated language for ORS 442.851 (HAIAC composition)
 - Publish updated state plan on website
- March 2016
 - First meeting of expanded HAIAC
 - Pilot standardized meeting format

High-Level Findings from Ebola Assessment Hospital Consultations

Judy Guzman-Cottrill, DO

December, 2015

ICAP and HAIAC Committee Update

Objectives

- Review our team's significant findings from the Oregon Ebola Assessment Hospital consultation visits
 - “Baseline visits” of 6 hospitals
- Discuss strategies to mitigate identified gaps
 - Identify additional experts, via ICAP and HAIAC member suggestions

Ebola grant goals

A.3: Assess readiness of designated Ebola facilities

- Conduct on-site readiness consultations of all designated Ebola assessment hospitals
- Determine gaps in readiness
- Address gaps through consultation and training using CDC-based resources
- Develop mitigation and implement plan with hospital
- Follow up to confirm mitigation of gaps

Grant Steering Team

- **Zints Beldavs:** Grant Project Oversight
- **Judy Guzman-Cottrill:** Ebola Consultations
- **Mary Post:** Expansion of General IP Consultations and Education
- **Gen Buser:** Surveillance and Outbreak Systems
- **Kate Ellingson:** HAIAC Committee Liaison

Oregon State Ebola Consultation Team

- Judy Guzman-Cottrill (Physician Lead)
- Mary Post (Infection Preventionist)
- Daniel Cain (Industrial Hygienist)
- Robert Nickla (Microbiologist)
- Gen Buser (State Public Health Physician)

Participating Hospitals

Hospital	Consultation Visit Date
Providence Milwaukie Hospital	July 29, 2015
Legacy Good Samaritan Hospital	July 30, 2015
Kaiser Westside Hospital	August 4, 2015
St. Charles Community Hospital - Redmond	August 6, 2015
Asante Ashland Community Hospital	September 29, 2015
Samaritan Lebanon Community Hospital	October 15, 2015

11 Capability Domains

- Facility Infrastructure:
Patient room(s)
- Patient Transportation
- Laboratory
- Staffing
- Training
- PPE
- Waste Management
- Worker Safety
- Environmental Services
- Clinical Management
- Operations Coordination
- [Special Populations]

Structure of the Day

- Introductions
- Walk-through from PUI entry to patient care area, laboratory, Emergency Dept
- Review 11 domains
- Wrap-up session

CDC Assessment Tool

Hospital Assessment Summary

Who this is for: State or local health department Ebola readiness assessment teams, ELC grantees, or other health department staff who are responsible for reporting about Ebola Assessment Hospital capability to CDC

What this is: Table used to summarize a hospital's overall Ebola readiness across 11 capability domains following an on-site assessment

Instructions: Ebola Assessment Hospitals are hospitals that have minimum capability in place to receive, isolate, and treat a patient under investigation (PUI) for Ebola virus disease (EVD). Mark "Y" for any capability element that is present (i.e., minimum capability is met) in a domain. If all elements in a domain are present, mark "Y" in the Minimum Capability in Place column. Minimum capability can be considered adequate if all elements in a domain are sufficiently met. "N" responses indicate gaps that require mitigation before designation as an Ebola Assessment Hospital. If any element in a domain is marked "N," mark "N" in the Minimum Capability in Place column. Familiarity with CDC guidance documents for [U.S. Healthcare Workers and Settings](#) will be necessary.

Facility Name: _____ State: ____ Zip code: _____

NHSN OrgID: _____ Date of assessment: _____

Role: EAH ETC Adult capability: Y N Pediatric capability: Y N

Ebola Assessment Hospital Capability Domain	Elements Required for Minimum Capability	Minimum Capability in Place? (Y/N)
Facility Infrastructure: Patient room(s)	Hospital has: <ul style="list-style-type: none"> • Private room with in-room dedicated bathroom with covered toilet or covered bedside commode: Y N • Dedicated patient-care equipment: Y N • Separate areas/rooms immediately adjacent to patient room for <ul style="list-style-type: none"> ○ Donning PPE: Y N ○ Doffing PPE: Y N • Sufficient space available to allow a trained observer to safely and effectively supervise donning and doffing of PPE: Y N 	Y N

Ebola Assessment Hospital Capability Domain	Elements Required for Minimum Capability	Minimum Capability in Place? (Y/N)
Patient Transportation	<p><u>Inter-facility</u> Plans are in place that have been jointly determined by the state and local public health agency, emergency medical services, and hospital for inter-facility transfer/transport of:</p> <ul style="list-style-type: none"> • PUIs for EVD to an Ebola Assessment Hospital or Ebola Treatment Center: Y N • Patients with confirmed EVD to a designated Ebola Treatment Center: Y N <p>Plans include:</p> <ul style="list-style-type: none"> • Ground transport: Y N • Air transport*: Y N N/A • Identification of transportation provider(s) with appropriate training to safely transport a patient: Y N • Identification of transportation provider(s) with appropriate PPE to safely transport a patient: Y N <p><u>Intra-facility</u> Intra-facility plans for patient transport (e.g., from ambulance entrance to the designated ward or unit for patients under investigation) are in place: Y N</p> <p><i>*May be required for inter-facility transport in some scenarios; health dept. should determine if air transport to assessment or treatment hospital represents a minimum capability. Indicate 'N/A' (not applicable).</i></p>	Y N

<p>Laboratory</p>	<p>Diagnostic laboratory procedures and protocols are in place for:</p> <ul style="list-style-type: none"> • Testing of specimens for Ebola by the nearest Laboratory Response Network (LRN) laboratory capable of testing for Ebola: Y N • Space for clinical diagnostic testing: Y N • Minimal level of diagnostic testing capability* prior to availability of Ebola test results: Y N • Equipment and supply selection: Y N • Disinfection: Y N • Staffing: Y N • Specimen handoff and transport for routine clinical diagnostic testing at the facility: Y N <p>Lab personnel have been trained and have demonstrated proficiency in:</p> <ul style="list-style-type: none"> • Donning and doffing of PPE: Y N • Waste management: Y N • Processing specimens while in PPE: Y N • Specimen transport: Y N <p><i>*At a minimum this testing capability should include CBC, glucose, potassium, malaria exam, influenza test, liver function tests</i></p>	<p>Y N</p>
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Ebola Assessment Hospital Capability Domain	Elements Required for Minimum Capability	Minimum Capability in Place? (Y/N)
Staffing	<ul style="list-style-type: none"> • Readiness plans include input from a multidisciplinary team of all potentially affected hospital departments (including clinical and nonclinical staff): Y N • Staffing plans have been developed and scheduled to support 96 consecutive hours of clinical care; sufficient physician and nursing staff are available to handle the patient's care needs: Y N • Hospital has a process for continuous staff input from those who may or may not be directly involved in Ebola patient care and for addressing employee safety questions and concerns: Y N • The overall safe care of Ebola patients in a facility is overseen by an onsite manager at all times: Y N 	Y N
Training	<p>All staff involved in or supporting patient care are appropriately trained for their roles: Y N</p> <p>All staff involved in or supporting patient care and according to their roles have demonstrated proficiency in:</p> <ul style="list-style-type: none"> • Donning and doffing of PPE: Y N • Proper waste management: Y N • Infection control practices: Y N • Specimen transport: Y N <p>Retraining is provided as needed and to address observed gaps: Y N</p>	Y N

PPE	<p>Hospital has selected appropriate PPE for PUIs or confirmed EVD patients who are clinically stable and do not have vomiting, diarrhea, or bleeding, or a clinical condition that warrants invasive or aerosol-generating procedures (intubation, suctioning, active resuscitation). The minimum PPE requirements for this scenario are outlined in Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients under Investigation (PUIs) for Ebola Virus Disease (EVD)</p> <p>Y N N/A</p> <p>Hospital has selected appropriate PPE for confirmed EVD patients or PUIs with vomiting, diarrhea, or bleeding, or for EVD patients requiring invasive or aerosol-generating procedures. The minimum PPE requirements for this scenario are outlined in Guidance on Personal Protective Equipment to be used by Healthcare Workers during Management of Patients with Ebola Virus Disease in U.S. Hospitals, including Procedures for Putting on (Donning) and Removing (Doffing) Y</p> <p>N N/A</p> <p>Each step of every PPE donning/doffing procedure is supervised by a trained observer to ensure proper completion of established PPE protocols: Y N</p> <p>Hospital has at least a 4–5-day supply of PPE in stock: Y N</p> <p>Hospital has a vendor capable of providing PPE re-supply: Y N</p>	Y N
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<p>Waste Management</p>	<p>Hospital has in place the services of a waste-management vendor capable of managing and transporting Category A infectious substances*: Y N</p> <p>OR</p> <p>Hospital will sequester medical waste until the patient's Ebola test result becomes known; if the patient is confirmed to have EVD, arrangements can be made with a vendor capable of managing the waste as a Category A infectious substance*: Y N</p> <p>Hospital has appropriate containers for the safe temporary storage of Category A infectious waste: Y N</p> <p>Staff that handle waste are trained in the correct use of PPE and the proper handling and storage of Category A infectious substances at the facility: Y N</p> <p><i>*Yes to either question meets the first Ebola assessment hospital minimum capability element for waste management.</i></p>	<p>Y N</p>
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Worker Safety	<p>Worker safety programs and policies are in place: Y N</p> <p>Hospital is in compliance with all federal or state occupational safety and health regulations applicable to reducing employee exposure to the Ebola virus: Y N</p> <p>Hospital has a program for assuring direct active monitoring of all healthcare workers involved in direct patient care to assure monitoring for 21 days since the last known exposure: Y N</p> <p>This monitoring will be done in coordination with local and state public health agencies: Y N</p>	Y N
Environmental Services	<p>Hospital has a program in place to clean and disinfect patient care areas and equipment, including use of an Environmental Protection Agency-registered hospital disinfectant with a label claim of potency at least equivalent to that for a non-enveloped virus (norovirus, rotavirus, adenovirus, and poliovirus): Y N</p> <p>Designated staff are:</p> <ul style="list-style-type: none"> • Trained in correct cleaning and disinfection of the patient room and equipment: Y N • Trained in the correct use of PPE: Y N • Directly supervised during all cleaning and disinfection: Y N <p>Workers engaged in environmental cleaning and disinfection of patient care areas and equipment follow safe practices including appropriate PPE: Y N</p>	Y N

Clinical Management	<p>Staff who will be involved in managing the patient know the clinical protocols for management of PUIs: Y N</p> <p><i>See Laboratory domain regarding minimum clinical diagnostic testing capability.</i></p>	Y N
Operations Coordination	<p>To ensure coordination of the response and communication regarding any PUIs for Ebola, the hospital has:</p> <ul style="list-style-type: none"> • An emergency management structure: Y N • Plans and processes for routinely communicating with local and state public health agencies, emergency management authorities, and its healthcare coalition (if appropriate): Y N • Plans and processes for routinely communicating with hospital employees, patients, and community leadership: Y N 	Y N

In addition: Pediatric and Obstetric PUI Plans

HPP Measure Manual (version 7)

Assure Readiness of Assessment Hospitals				
8	A	B	Time, in seconds, from active monitoring/direct active monitoring (AM/DAM) patient's arrival to placement in isolation at assessment hospital (Goal: = <60 seconds).	AH exercise or real event
9	A	B	Time, in minutes, it takes an assessment hospital to identify and isolate a patient with Ebola or other highly infectious disease (e.g., MERS-CoV, measles, etc.) following emergency department triage, as evidenced by a real-world case or no-notice exercise (Goal: Within 5 minutes).	AH exercise or coalition exercise, or real world event
10	A	B	Proportion of health care and emergency medical services (EMS) workers in PPE that an AM/DAM suspected Ebola patient under investigation (PUI) makes contact with after health department notification to the assessment hospital or ETC (Goal: 100%).	AH exercise or real event
11	A	B	Number of health care and EMS workers in PPE that an AM/DAM suspected Ebola patient makes contact with after health department notification until isolation (Goal: =<3).	AH exercise or real event
12	A	B	Proportion of emergency department staff trained at least annually in infection control and safety (Goal: 100%).	AH measure
13	A	B	Proportion of intensive care unit staff trained at least annually in infection control and safety (Goal: 100%).	AH measure
14	A	B	Proportion of assessment hospitals that can access their PPE supply (i.e., know location and have sufficient quantity of unexpired supply) within 10 minutes of a patient with suspected Ebola transfer notification or arrival, if no notification (Goal: 100%).	AH exercise

Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities CFDA # 93.817
VERSION 7.0, Page 8

Findings: General

- Excellent multi-disciplinary teams working together with strong administrative support
- Overall, hospitals have excellent plans in place
- Hospitals are working in “silos”
 - No collaboration or communication between IPC teams.
- Inpatient admission of a PUI would be very disruptive to any of the 6 hospitals

Specific Findings

- Need clarity on patient transports
 - High-risk PUI: Immediate transfer to ETC?
 - Harborview Medical Center; Seattle
 - Seattle Children's Hospital; Seattle
 - Providence Sacred Heart Medical Center; Spokane
 - Who arranges transport?
Hospital/local/state/fed?

Specific Findings

- Need to strengthen pediatric PUI plan/algorithms
 - Likelihood of a pediatric PUI is very low
 - What is threshold for pediatric patient to be admitted to Ebola treatment center (ETC) versus an Ebola assessment hospital (EAH)?

Specific Findings

- No low-risk PUI ambulatory evaluation plan
- Two systems have successfully performed a PUI evaluation without admitting the patient.
 - Consider developing “ambulatory PUI evaluation plan” for all 6 Assessment Hospitals? Or one in each region?

Specific Findings

- EMS partner
 - Decontamination with bleach spray not consistent with US Federal OSHA regulation
 - Assume hospital will be responsible for ambulance decontamination and waste storage/removal
 - Local HDs working with EMS partners to clarify plan

Specific Findings

- Need to clarify plan for SW WA State PUM
(and transport plan if PUM becomes a PUI)

Specific Findings

- Lab capability varied among hospitals
 - Increase lab capacity of OSPHL?
 - Influenza PCR and Ebola PCR testing

Specific Findings: Outside Metro Area

- Large catchment area outside of county
 - Need to improve PUM awareness
- PUI could greatly impact access to general healthcare needs in each region
 - Decrease staff from other hospitals within system
 - Concern of patient apprehension in large catchment area

Findings: HPP metrics

Assure Readiness of Assessment Hospitals					
8	★	A	B	Time, in seconds, from active monitoring/direct active monitoring (AM/DAM) patient's arrival to placement in isolation at assessment hospital (Goal: = <60 seconds).	AH exercise or real event
9	★	A	B	Time, in minutes, it takes an assessment hospital to identify and isolate a patient with Ebola or other highly infectious disease (e.g., MERS-CoV, measles, etc.) following emergency department triage, as evidenced by a real-world case or no-notice exercise (Goal: Within 5 minutes).	AH exercise or coalition exercise, or real world event
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11	?	A	B	Number of health care and EMS workers in PPE that an AM/DAM suspected Ebola patient makes contact with after health department notification until isolation (Goal: =<3).	AH exercise or real event
12	★	A	B	Proportion of emergency department staff trained at least annually in infection control and safety (Goal: 100%).	AH measure
13	?	A	B	Proportion of intensive care unit staff trained at least annually in infection control and safety (Goal: 100%).	AH measure
14	★	A	B	Proportion of assessment hospitals that can access their PPE supply (i.e., know location and have sufficient quantity of unexpired supply) within 10 minutes of a patient with suspected Ebola transfer notification or arrival, if no notification (Goal: 100%).	AH exercise

Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities CFDA # 93.817 VERSION 7.0, Page 8

Additional work

- **10/23/15:** Hosted a networking event in Portland
- **11/10/15:** Team conference call with CDC
- **11/19/15:** Judy met with tri-county local HD to discuss priorities, goals for Portland area
- **11/20/15:** State Consultation Team reviewed all findings and strategized follow-up plans

Future work

- **January 2016**
 - Start quarterly conference calls, working to strengthen collaboration among 6 hospitals
- **February –April 2016**
 - On-site 6 month hospital follow ups
- **March 2016**
 - ICAP/HAIAC meeting update

Thank You!

- Questions, comments, or suggestions?



HEALTHCARE-ASSOCIATED INFECTIONS (HAI) ADVISORY COMMITTEE UPDATE

Mary T. Post, RN, MS, CNS, CIC
Director, Infection Prevention
December 16, 2015

Part B: Targeted Infection Prevention Assessments

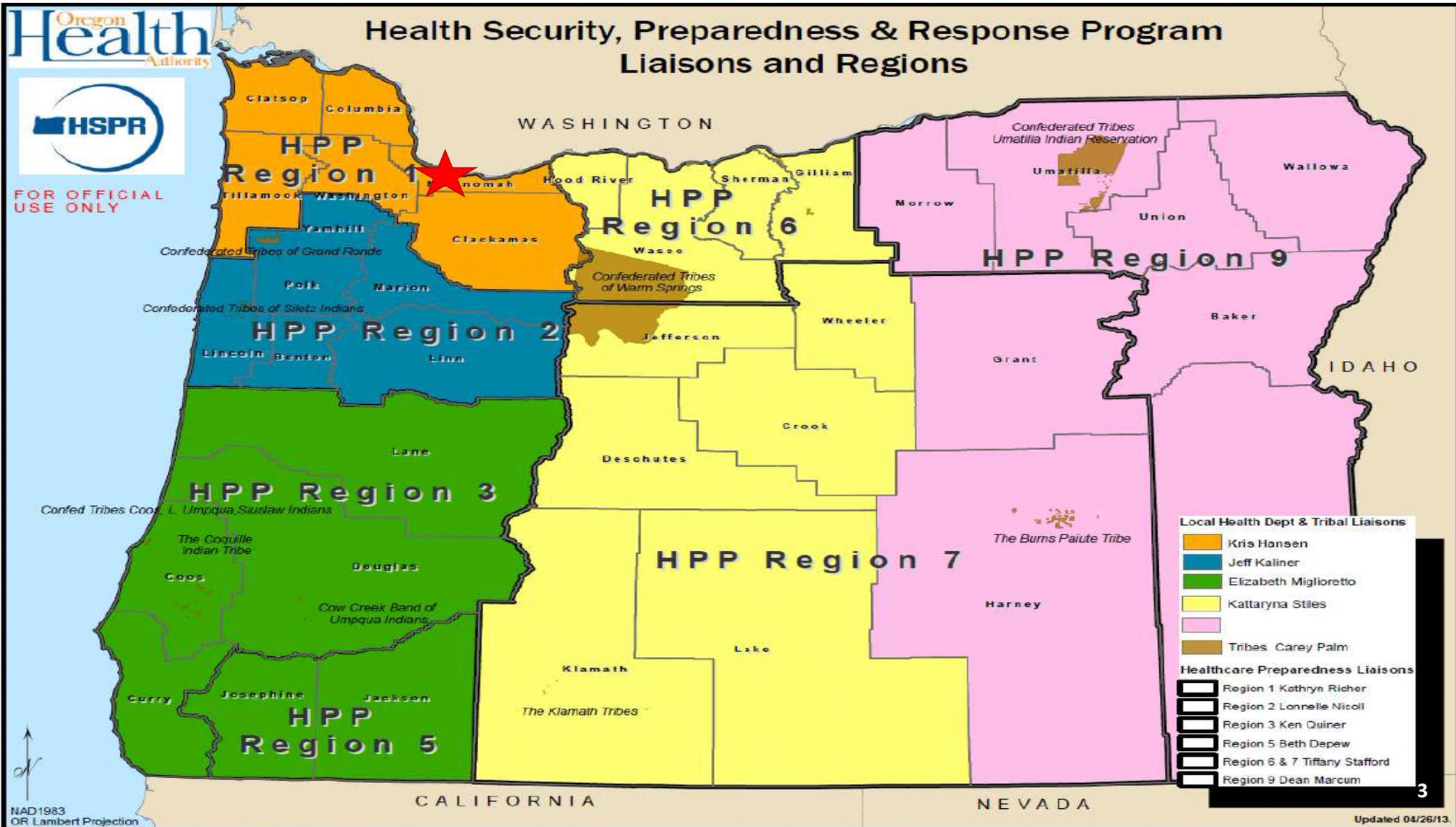
- The Centers for Disease Control (CDC) is funding on-site infection prevention assessments for facilities across the continuum of care
- Oregon is using a regional approach in facility selection with a goal to build partnerships between facilities in the same vicinity
- 25 targeted facilities will be offered the opportunity for consultations during the first year; numbers will increase in subsequent years
 - 10 long-term care facilities
 - 7 hospitals
 - 5 ambulatory settings, may include ambulatory surgery centers and clinics
 - 3 dialysis centers
- Local health departments and local APIC members will be included on visits
 - Cross-pollination, practice ICAR tools



Health Security, Preparedness & Response Program Liaisons and Regions



FOR OFFICIAL USE ONLY



Local Health Dept & Tribal Liaisons	
	Kris Hansen
	Jeff Kaliner
	Elizabeth Miglioretto
	Kattaryna Stiles
	Tribes Carey Palm
Healthcare Preparedness Liaisons	
	Region 1 Kathryn Richer
	Region 2 Lonnelle Nicoll
	Region 3 Ken Quiner
	Region 5 Beth Depew
	Region 6 & 7 Tiffany Stafford
	Region 9 Dean Marcum

NAD 1983
OR Lambert Projection

Selection Criteria

- Team reviewed the following data elements
 - Point system using HAI NHSN Data (two years), HAI CADs
 - Outbreak and unusual pathogen data (e.g., Noro, Flu, CRE, NTM)
 - CMS Nursing Home Compare (star rating)
 - Healthcare worker influenza immunization rates
 - Regulatory Surveyors recommendation
 - Regional Dialysis Network recommendation
- Some facilities have requested consults due to infection clusters

During the Visit

- Opening conference - encourage Medical Director attendance
- Brief tour of facility
- Meet with individuals responsible for the infection prevention (IP) program
- Use assessment tool to assess IP program infrastructure, competency-based training and routine auditing of IP practices
- Perform recommended observations
- Exit conference
- Initial visits take a full day

Assessment Domains

- Infection control program and infrastructure
- Healthcare personnel and resident safety
- Surveillance and disease reporting
- Hand hygiene
- Personal protective equipment
- Respiratory/cough etiquette
- Antibiotic stewardship
- Injection safety and point of care testing
- Environmental cleaning
- Additional domains specific for facility type settings

Recommended Observations

- Blood glucose monitoring
- Hand hygiene and contact precautions
- Urinary or vascular catheter insertion and/or maintenance checklist
- Environmental cleaning
- Wound care
- Catheter access techniques

General Infection Prevention Assessments

- Eight assessments complete
 - 2 ASC, 1 Clinic, 1 hospital, 2 dialysis center, 1 assisted living facility, 1 nursing home/skilled nursing facility
- CDC Assessments Tools updated on a regular basis
- CDC is working with states who have not yet instituted assessments
 - Difficulty “getting through the door “ is common nationally
 - Acute care facilities are interested, but scheduling is challenging
 - Most facilities require regional and/or national corporate approval

Assessment Realities

- Tools focus on educational training process, observation and validation of staff competency, and compliance audits and feedback
- Tools are based on best practices and not necessarily regulatory requirements so many facilities will not have them in place

But it is a great opportunity for CDC and others to identify needs so resources can be strategically positioned

Common Findings

Gaps were identified in the following areas

- Instrument sterilization and equipment high-level disinfection processes
 - Quality monitoring
 - Instrument packaging
 - Documentation
- Multi-dose vials sharing in immediate patient care areas
 - Anesthesia carts
 - Medication carts in patient care hallways, stations
- Labeling and administration of immediate use medications
 - One hour administration or hang time requirement? Clarify standard.

Common Findings (cont'd)

- Interfacility transfer communication
 - Not aware of requirement
- Ill provider policy
 - Work restrictions due to illness
- Adherence to hand hygiene
- Blood glucose monitoring devices
 - Shared devices not labeled for multi-patient use
 - Need policies for disinfection
- Use of Environmental Protection Agency (EPA) registered disinfectants
 - Use of general disinfectants versus those with EPA registration
 - Contact time not followed

Next Steps

- Update resource tools for use by assessed facilities
- Continue to support facilities with training courses and webinars
- On-site consultations are still underway

Infection Prevention Education

- Infection Prevention Fundamentals training course
 - February 23-25, 2016
 - Brochure and registration available on the OPSC website
- Training courses
 - Hands-on training for instrument reprocessing being scheduled for early winter
- Webinars
 - Procedures for instrument sterilization and monitoring for health clinic sites will be offered