Healthcare-Associated Infections Advisory Committee
December 16, 2015

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Speaker: Okay, well, welcome to, uh, our meeting. We'd like to get things started. So can we go around the room and do introductions so those people on the phone know who's here?

Next Speaker: Uh, Lexie John, HAI program, here at OHA.

Next Speaker: Monika Samper, OHA.

Next Speaker: Paul Cieslak, Communicable Disease Section here at the Oregon Health Authority.

Next Speaker: Kate Ellingson, OHA.

Next Speaker: Mary Shanks, uh, Kaiser Permanente.

Next Speaker: Laurie Murray-Snyder, Acumentra Health.

Next Speaker: Zints Beldavs, OHA.

Next Speaker: JJ Dicker at Oregon State, OHSU.

Next Speaker: Kelli Coelho, **** Ambulatory Surgery Center.

Next Speaker: Rebecca Robbins, Patient Safety Commission.

Next Speaker: Diane Roy, OHA.

Next Speaker: Maureen Cassidy, OHA.

Next Speaker: Jen Detser, OHA.

Next Speaker: Great and we have Mary Post who is with the Patient Safety Commission.

Next Speaker: And on the phone, we have Pat Preston, um, Diane Waldo, and Dr. Rachel Plotinsky. Okay, so has everybody had a chance to review the minutes from our September meeting? Does anybody have any, um, changes that they would like to make to that?

Next Speaker: So this is Kate. I just wanted to, um, you know, I think going forward, we're going to try to just very briefly review some of the, you know, major decisions made at these, uh, meetings, um, and so in September, uh, one of the things we discussed was, um, setting up a committee, um, setting up sort of a support group for IPs dealing with complex NHSN questions. So that was, we're, we haven't actually, uh, set that up yet, but we're interested in pursuing that. So if people have thoughts or ideas about how to make that happen or if anyone is interested in kind of taking charge of that, um, please let us know because we, we'd like to support that as well.

Next Speaker: Right.

Next Speaker: Um, one of the other issues last meeting, we, um, all of us remember having a quorum and voting, but we actually, uh, it doesn't look like we actually had the number. So last meeting, it looks like we had Jordan Ferris, Kathy Fitz in place of Laurie Murray-Snyder, Pat Preston, Mary Shanks, Diane Waldo and Bethany Walmsley, um. We also had a number of members from OHA, but is there anybody on the line or in the room who was here last time that I didn't mention? All right, because for some reason, we just don't have a quorum listed. I think we may, not everybody may have signed it. So if you hadn't, if you didn't sign in on your way in, please make sure you do so on the way out so we can get it recorded here and make all the voting official.

Next Speaker: Okay, if there's no changes to the minutes, do we have a motion to approve? Anybody?

Next Speaker: All right, JJ and Kelli, okay, JJ and Kelli.

Next Speaker: Okay, first up on the agenda, Monika.

Next Speaker: Okay, this is Monika, with the OHA and I'm just going to briefly, 5 minutes or less, discuss what I've been working on and that is revising our current health care acquired infection reporting poster. This is the poster that we provide to the hospitals, labs, etc. that shows, um, what CMS requires reporting, what we require as being reportable for mandatory reporting of diseases and infections, and so I'm revising it currently to look like our new posters. This was last done in, uh, September of 2014 and since then, we've had some changes. So it's going to be updated to look like this to match our other new poster, so the color scheme is kind of similar instead of totally being out there like this one is, and so mainly, the changes are stuff, if you remember the old poster, there were a lot of items on there that said proposed rule change for January of 2015. Since we proposed, we already had that rule changed, we're obviously going to change that language and make it now current rule. Um, the other sorts of changes were there were a couple of little typos I found on the poster obviously that I needed to change, and also, I'm in the process of changing our OARs to match the language that you will see in the poster to match the language so it all sounds the same. So instead of having, uh, different language from the OARs as opposed to the poster as opposed to CMS, it's all going to sound the same so there's no confusion.

Next Speaker: So the changes will be –

Next Speaker: Minimal like –

Next Speaker: – okay.

Next Speaker: – adding the word all –

Next Speaker: Okay.

Next Speaker: – and adding, you know, all adult and pediatric ICUs, wards, **** stuff like that so that it just sounds the same and there should be no confusion at all.

Next Speaker: And, and this is Kate, um. You know, one of the big additions for 2015 was for device associated infections. We've added, um, all pediatric and adult ICUs, so not just medical, surgical, and med-surg wards, um, and also, uh, wards to the mix, and so that actually was sort of listed as proposed on this previous poster and that will be updated. So we hope we're kind of leveling out in terms of the number of different infections that hospitals have to report. So, um, you know, this, we've got a bunch of new infections for '15, but after that, um, we hope to just kind of make the language very clear, and for those of you on the phone, Monika didn't have slides but she's just got a poster here that we keep updating, and we'll be sure that when, when the new one comes out, we'll send it out to everybody on the committee.

Next Speaker: ****.

Next Speaker: Yeah, it's us. Carrie said if anyone, if anyone does have any feedback or what might be useful to add to the poster or other kinds of methods that might be helpful for IPs or anyone doing reporting, uh, please let us know, and, uh, if there's anything right now, let me or let us know and if not, just in, just send an email.

Next Speaker: Right, you know, that poster –

Next Speaker: We –

Next Speaker: – oh, go ahead.

Next Speaker: – um, hi, Diane. What is, what is the timeline to get feedback of, to you about the poster?

Next Speaker: Any time before the end of the year. I can't anticipate getting this done before the holidays, probably after the holidays, so.

Next Speaker: Okay, but you're thinking like to distribute the revised poster sometime early in January, then.

Next Speaker: Right, early to mid-January.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Great, thank you.

Next Speaker: Yes.

Next Speaker: Yeah and, um, definitely we'll get it distributed to APIC as well and post it on our APIC web site.

Next Speaker: Great.

Next Speaker: So, okay, thanks. So Laurie, you're up next on the agenda.

Next Speaker: Okay, Kate invited me to talk about what Acumentra Health is doing and we have so many new projects.

Next Speaker: ****.

Next Speaker: Can you all hear me? Yeah, if you could.

Next Speaker: **** thank you.

Next Speaker: And for those of you on, on the phone, we're on, um, Page 9 of your meeting materials.

Next Speaker: ****.

Next Speaker: Thank you.

Next Speaker: No problem.

Next Speaker: Sorry.

Next Speaker: So, um, so Acumentra Health is, uh, a quality improvement organization working on CMS contracts for Medicare. We have, we're currently, um, CMS regionalized this last contract period, so now there's 17 regions in the United States and we're part of a QIN site, QIN, that's Quality Innovation Network, and we're the QIO for Oregon, the quality organization for Oregon. The other states that we're involved with are Utah, Nevada, New Mexico and we're soon to be Health Inside next year. We'll be Health Inside Oregon. Um, we also work on Medicaid external quality review projects and multiple research projects and I'll tell you about those as we go down the list. Next slide, please. So, that's right.

Next Speaker: That's okay.

Next Speaker: Uh, our first project that we're working on is, and we think this is central to all of our work, is coordination care and currently, we're working with two communities, Jackson and Josephine County and they've, they're working, this past year, they've been working on transfer forms in that group. They work with, um, hospitals, nursing homes, physicians, home health agencies, just anybody in the community that deals with patients. They'll be working on a new project coming into '16 and this is a CM, a continuation of a CMS project to, it's a home care pilot project, and they've received a lump of money from CMS to work on 23 DRGs for the communities. So home care is not home health. It's non-skilled, um, staff seeing three patients, or seeing patients, um, following discharge from a hospital. So they'll have, for a hundred dollars, they'll provide three visits and it's, and the hospitals and the long term care facilities would pay their fee. So it's hoping to save money from readmissions from this pilot, this pot of money they've received, um.

Next Speaker: The visits are made by non-skilled –

Next Speaker: Yes.

Next Speaker: – personnel.

Next Speaker: So they provide, they do shopping. They do house care. They, you know, just help around the house.

Next Speaker: Okay.

Next Speaker: And fill in maybe for some, uh, home health might've filled some of those services, but –

Next Speaker: That's interesting.

Next Speaker: – yeah. They just need help, and we're also working in the Portran, Portland metro area and that's with heart failure, and then they're recruiting now for, uh, the third year of this contract and that's with Coos County. So they'll be working with the three Coos County hospitals, plus Curry and the nursing homes and physician offices, we'll help in that surrounding area. I think they're going to be working on a similar type of project with home care as their focus to reduce readmissions. Next slide, please. And then we have reducing ATIs in hospitals, um. We're working with PBS and Cause. We currently have 16 hospitals in the project and all these projects go through July of 2019, just so you know. It started August of 2014 to, through July of 2019. We're working with 16 hospitals, um. Our goal is to reduce the aggregate served to meet, meet the national benchmark. We're using NS, NHSN data and we're aligned with state overtime, crossover targets. See aggregates that are greater than the national benchmark, no. That's what we're attempting to increase. Oh, the aggregate served is of the 16 hospitals that we're working with.

Next Speaker: It's higher than the national?

Next Speaker: No, not, not in all topics.

Next Speaker: Okay.

Next Speaker: But that's the goal of the project, nationwide.

Next Speaker: And what are PPSs?

Next Speaker: PPS, it's the DRG hospitals.

Next Speaker: Okay, thank you.

Next Speaker: Nursing home project, so currently, we're working with two, two 18-month collaboratives. Uh, the first collaborative started April 2015. It runs through 20, uh, September of 2016, and the second project will be April 2017 through September of 2018, um. The goal, the goal of this project is to engage 102 nursing homes, being ****. We currently have 61 signed up and we're still recruiting, so. It's a big project. We need to, and then there's a second, a second contract that CMS has added to this and that'll be working with C. Difficile. So that'll be, um, we'll be engaging 25 nursing homes and the goal is to get them to report to NHSN, their C. Diff rates to NHSN.

Next Speaker: And when do you anticipate they'll be reporting by?

Next Speaker: Uh, September of 2016, that's the goal. So they'll be starting recruitment in 2016, so, coming up.

Next Speaker: ****.

Next Speaker: **** can I ask a question about it.

Next Speaker: Yeah.

Next Speaker: So do you have incentives for, for ****.

Next Speaker: Nobody **** yeah.

Next Speaker: ****.

Next Speaker: And it's a big facility to acquire for C. Difficile.

Next Speaker: Yeah.

Next Speaker: It was interesting today. We had a, in the HAI, um, call we did. We have to take a call. We've got roundtable calls every other month for CAUTI and CDI, and then the C. Difficile, we were talking with the hospitals and asking them about their nursing homes because you have the community onset infections, right, that come into the hospitals. So, so many of

them are interested in being involved in the extended collaborative to help their nursing homes and avoid further C. Diff exposures.

Next Speaker: Yeah.

Next Speaker: Well, I know a lot of patients discharging from hospitals have resolving or resolved C. Difficiles, you know. They might be ripe for reoccurrence.

Next Speaker: Right.

Next Speaker: So, so like ****. Our next initiative is a, it's new to us. We haven't begun the work yet. We've been recruiting. Behavioral health initiative, uh, this is one of the largest CMS Medicaid investments in behavioral health remission. Only 6 QINs, 6 of the 17, were selected to conduct this work. It addresses the fragmentation or silos that operate without resources, um, that pool resources and identify gaps and learn how the system can work. It helps practitioners address patients with complex needs and understands on how improving these measures can lead to future reimbursement. The first two measures are screening measures. So they're primary, through primary care and through depression and alcohol misuse. The third, Measure 3, oh, this is on hospital, uh, follow up after hospitalization for behavioral health conditions, and they receive follow-up care through the mental health provider in Measure 4.

Next Speaker: Mm hmm.

Next Speaker: It focuses on reducing readmissions to the inpatient psychiatric facilities, and we're currently recruiting for those, practices, mental health agencies, and inpatient psych facilities. Next slide, immunizations. So we're focusing on the three, influenza, pneumonia, and shingles and in hospital, home health, pharmacy, and primary care settings. It's a huge recruitment, recruitment target, so 3, they want 300 EPs or eligible, eligible professionals and so far, we're recruited **** pharmacy, which provided a 150 pharmacists. So that was a, that was a big win and then we'll have, we're to recruit 18 hospitals and 18 home health agencies.

Next Speaker: Is that all patients' immunizations or?

Next Speaker: Yeah, health care immunizations. Uh, the next –

Next Speaker: Hmm.

Next Speaker: – the next ta, the next project is cardiovascular, a Million Hearts campaign. This is working with hospital or home health agencies and private practice, primary care practice. Emphasis, CMS emphasis on, is on blood pressure control and the home health agencies are working through HHQI, which is Home Health Quality Initiative and they provide, it's a great web site if you've never been. Just go to hhqi.org and they provide great resources about practitioner education materials, patient education materials, best practices for nursing and other therapies and they provide reports.

Next Speaker: Infection control too, infection control too?

Next Speaker: Yeah.

Next Speaker: Because I know that **** is sort of under them.

Next Speaker: And they were partnering with Q Corp on that to provide the cardiac education to the primary care practitioners, things like this. Next project is meaningful use for health, health information technology and we're still reporting recruiting PPS hospitals and cause and the goal describes to provide technical and learning opportunities to **** enable use ****. Quality reporting –

Next Speaker: **** so what, what are you doing with that? Do you have s, specific details **** when you report these things?

Next Speaker: You know, there's a lot of different –

Next Speaker: ****.

Next Speaker: – yeah.

Next Speaker: I'm wondering if you, well, I'm, we're just kind of thinking about some, some things in the direction of like an **** registry and, and use with, in many ways, and there might be a bit in that direction, so I was just curious ****.

Next Speaker: Antibiotic stimulation.

Next Speaker: There is, there's various possibilities and we're looking in that direction. So I was just curious if you have details on it at this point or if it was like just ****, just started out.

Next Speaker: Each, each **** whatever and just measure things **** process?

Next Speaker: Yeah, I mean I think one of the reasons we like to have a partner update is to look for areas of, you know, synergy so they're, for example, Jan is going to present a little bit later on our antimicrobial use and resistance module. So we're working with CDC, working with vendors, and you know, considering a lot of meaningful use issues. It would be great to connect with your people and you.

Next Speaker: On, yeah, talk, is that through hospitals? Yeah, David or Kathy.

Next Speaker: David, okay, great.

Next Speaker: And their contact information is on the last ****.

Next Speaker: Um, quality reporting, **** value, purchasing for hospitals and QRS reporting for clinics and physicians, and that's the measure outcomes. This is cause inpatient psych facilities and ASCs and they can report any measures you have and they're still ****. Um, diabetes, the

diabetes collaborative, so the goal of this project, this is a huge project, is to educate 980 beneficiaries by 2019 and if you know anything about diabetes education, they have it in little tiny classes, six to eight people at a time. So it's a big, it's a big charge. So some of the private contracts we have, one is through the Oregon Health Authority. We do external quality review, see here what they're working on. Next slide, please. Then next is the grant work. So they're working on the pre, prescription drug monitoring program, PDMD, um, throughout, they're working on the opioid reduction toolkit for pharmacists and that was developed by Oregon State University and Fred Meyers Pharmacy, and through NIH. It's a joint grant with the state and OHSU studying how doctors use the PDMD database, to create, to decrease opioids, and this is more details here about, about the PDMD project. That's, they started it a couple of years, a few years ago, I think 3 years ago, so this in ongoing, and this is a best practice for the nation now. So other people are logging, or copying it as well.

Next Speaker: Yeah, no, there are kind of connections to our work I kind of thought about when I went to the, a CCO summit recently with, um, a lot of these, you know, innovative work going on in Oregon with prescription drug monitoring. It involved communication between facilities, so hospitals, like all facilities being able to kind of, you know, see a flag if there is a patient with, for example, multiple, coming in multiple times. So we're looking to develop the assistance for inter-facility transfer of MDROs, etc.

Next Speaker: Oh.

Next Speaker: Oh, I was going to say another, another one that, and I don't, I don't know if it works for us, but there are some, at least one state actually is able to use this data to communicate antimicrobial use data. So they have all these different drugs that are going in there and the way it worked before, they'd filter out, uh, the, the, um, the narcotics or whatever it is. This, they're now able to actually get the antimicrobial data there and I don't know, I, but we need to check into that.

Next Speaker: We would, yeah, we've –

Next Speaker: Yeah.

Next Speaker: – spoke with Dave Enright and, and that group. This **** and it doesn't look like that the –

Next Speaker: Yeah, that's what like.

Next Speaker: – that people will hear just the way that we are **** adjusted to narcotics, but again, you always have that ongoing complication ****.

Next Speaker: Well, I think I really, yeah, they said we'd have to renegotiate all the agreements with everyone. I mean maybe we could do it, but ****.

Next Speaker: Maybe on a smaller scale or something.

Next Speaker: Um, if you have any more interest in this, you'd want to talk to Nicole O'Kane, she's our clinical director.

Next Speaker: Okay.

Next Speaker: She's a PharmD.

Next Speaker: Nicole.

Next Speaker: Nicole O'Kane.

Next Speaker: Kate and Laurie?

Next Speaker: Yes.

Next Speaker: Yeah, hi, Diane here, just to interject. There's a lot of interest with Oregon Health Leadership Council, OHLC around opioid prescribing and a prescription monitoring program and, um, with that being said, you know, that, that EDIE is in every hospital in the state, that Emergency Department Information Exchange.

Next Speaker: Yeah.

Next Speaker: There is work and a lot of interest being devoted to how can we ling EDIE or their platform with collective medical technologies, the, the vendor to be able to, um, access the, uh, prescription database so that emergency docs would have easy access to see that information. So lots of parallel efforts doing on and so I just offer that as, as an FYI, um. If you want more information or whatever, I can help connect you with folks. I think it would be great to align efforts, right?

Next Speaker: Absolutely.

Next Speaker: Yeah, thank you.

Next Speaker: Thank you very much, Diane.

Next Speaker: ****.

Next Speaker: And then lastly, we're developing a Beneficiary and Family Advisory Council. So if you know of anyone or a family member that you think would be good for this, um, love to hear from them.

Next Speaker: So what is, what is it? What's happening?

Next Speaker: So, um, this to inform our works. We'd like to create this advisory council for beneficiary families or beneficiaries and families to comment on what we're doing and how we're conducting our work so we can get the patient perspective.

Next Speaker: Yeah.

Next Speaker: So it's patient centered.

Next Speaker: I, I'd like to get more of that because I know a lot of these –

Next Speaker: Are these?

Next Speaker: Yes, those are the flyers.

Next Speaker: Okay, did anybody not get one?

Next Speaker: Thank you.

Next Speaker: I'll just pass it out while we're talking about it.

Next Speaker: Yeah, and, and one, I think this is, Diane Waldo, are you also involved with this patient advisory council or is this separate from your collaborative?

Next Speaker: Yes, yes, now so, so we actually through the Hospital Association have a 18-month collaborative, um, ongoing right now with, um, 32 hospitals to help them create and build and strengthen their patient and family advisory function. It's so that they have a productive and sustainable committee or council at the end of this work, which goes through May of 2016.

Next Speaker: Okay.

Next Speaker: Great, thank you, Diane. So and one thing we've sent, um, or we've contacted the leaders of, um, seven of Diane's, uh, collaborators, so they're basically patient advisory boards.

Next Speaker: Mm hmm.

Next Speaker: And, um, so we're sending them, uh, copies of our consumer reports so that we can get the feedback. So we might be interested too in connecting with people in this to get more feedback on what, what the consumer community needs with regard to these NHSN reports, so.

Next Speaker: Great.

Next Speaker: **** because I **** the microphone **** talking to.

Next Speaker: Oh, yeah.

Next Speaker: I just have a question about the coordination of care piece and the readmissions.

Next Speaker: Mm hmm.

Next Speaker: I had, chatted a little bit with Jennifer Wright –

Next Speaker: Mm hmm.

Next Speaker: – but sort of if that was also going to include maybe inter-facility transfer communication about MDROs or CDI, that piece.

Next Speaker: Uh, did you –

Next Speaker: ****.

Next Speaker: – have you talked to her about the worksheets that were done in the Medford area because that's what they were working on.

Next Speaker: That's the one, okay.

Next Speaker: Right.

Next Speaker: So she'd the one to have this all together.

Next Speaker: Yes.

Next Speaker: Okay, thank you.

Next Speaker: Then the last slide is just our, the contact information and the various leads for these projects. Are there any questions?

Next Speaker: ****.

Next Speaker: Okay, thank you.

Next Speaker: Okay, Laurie?

Next Speaker: Should be ask if anyone else is still on the phone? Maybe we should.

Next Speaker: Yeah, did anybody else join on the phone since we did our introductions?

Next Speaker: ****.

Next Speaker: I thought I heard something.

Next Speaker: Yes, I thought I heard a beep too. Okay, so next on the agenda, Lexie to talk about HAI outbreak and MDRO update and doctor user.

Next Speaker: Yeah.

Next Speaker: So for people on the phone, we are currently on Slide 24, uh, and if I haven't met you yet, uh, my names Lexie John. I'm one of the HAI, uh, epidemiologists just here. I started back in like the end of August. I'm slowly meeting everyone, um. So I'm going to give a brief update of, uh, outbreaks that have been reported to the Acute and Communicable Disease Prevention program here at Oregon Health Authority since, um, September. So since September, we have seen a total of 56 outbreaks, or I guess we have, we have had 56 outbreaks reported to us and so here is just the general table showing what we've been, um, and so not surprisingly, given the time of year, we have, um, seen a lot more, uh, outbreaks of norovirus of noro like outbreaks, so, um, gastroenteritis outbreaks that have unknown pathogens so far because it's getting tested or because we didn't have enough stool samples, or because they know nothing, and so we've seen 12 norovirus outbreak reports, reported to us, 9 of which were in long term care facilities, 2 in schools, 1 in caterers. We've had a couple salmonella outbreaks, one shigella outbreak in a school, and one, um, aspect, which is one, um, shift toxin producing e. coli, um, and one C. Diff, uh, C. Diff/maybe some other etiologies in a long term care facility. Of those, um, GI outbreaks where we don't know the etiology, uh, we've seen 2 in daycare centers, 1 in a hospital, 11 in long term care facilities, uh, and then 4 in restaurants and 8 in schools and also, given the time of year, we have seen an increase in respiratory outbreaks, so we've seen 3, uh, we've had 3 outbreaks of pertussis reported to us, all in schools, 2 influenza, uh, outbreaks reported to us in long term care facilities, 5 rhinovirus outbreaks reported to us in long term care facilities and a couple of unknown respiratory outbreaks, 1 in a school and 1 in a long term care facility, along with 2 rashes. So 56 outbreaks in total, um, not too bad, not, not too good.

Next Speaker: How are you defining unknowns again, or not defining them?

Next Speaker: Not lab confirmed.

Next Speaker: Not lab confirmed.

Next Speaker: What was the question, sorry?

Next Speaker: Unknowns.

Next Speaker: How are you defining an unknown?

Next Speaker: Oh, so an unknown, so for example, if it's gastroenteritis, they have some sort of vomiting, nausea, or diarrhea or other sorts of GI illnesses, but, um, they did not find a pathogen in stool samples or vomitus samples.

Next Speaker: Has there been any unknown cases?

Next Speaker: Two, which Jen will talk about what constitutes an outbreak for here in Oregon, but to be a lab-confirmed outbreak, you need at least two positive samples.

Next Speaker: Okay.

Next Speaker: Or norovirus.

Next Speaker: For norovirus. For, uh, varicella, it's five to be an outbreak and look at –

Next Speaker: Give in a school or –

Next Speaker: Yeah, so it's different for each of the different, um, etiologies, but.

Next Speaker: – if, for gastroenteritis, the main reason for unknown is lack of specimens, so.

Next Speaker: Yeah.

Next Speaker: Negative.

Next Speaker: Yeah, so taking a closer look at just the health care associated outbreaks and between September 1st and December 10th, so, um, for those on the phone, we're on page, uh, Slide 26, which is page, Slide 26, okay. So, um, health care associated outbreaks has accounted for just over half of all outbreaks seen between September and December, about 30 out of the 56 were in a health care, uh, setting. The most common etiology in these outbreaks were norovirus or noro like outbreaks, um, and so about 70 percent or exactly 70 percent of those outbreaks were in a health care setting, which was 21 out of the 30. One facility had two separate GI outbreaks during this time, and so we're looking at facility type and etiology, uh. You can see that memory care units have the highest amount of, um, norovirus or unknown GI so noro like outbreaks, um, followed closely by skilled nursing facilities and also assisted living facilities, um, and so this is, this table is really interesting to us because skilled nursing facilities and assisted living facilities aren't really, are not required to report to NHSN outcomes, and so we had to see a little bit what's going on in these facilities with our outbreak data, and so just one more slide about what's going on in norovirus, um, this year.

Next Speaker: Can I just –

Next Speaker: Yep.

Next Speaker: – can I just interrupt and I just want to do a reality check question.

Next Speaker: Mm hmm.

Next Speaker: Um, so for those who work in hospitals, how well and how, do you feel the hospitals are really tracking when they have like two or more employees who call in sick with gastroenteritis in a given 24 or 48-hour period?

Next Speaker: That's always –

Next Speaker: You said that they reported.

Next Speaker: – from a hospital perspective, it's always difficult, especially in a larger hospital where you have a lot of staff because they, uh, should report those instances to employee health. Not always does this happen. A lot of times, they'll call off to the staffing office or whatever and they are not required to give a reason. So –

Next Speaker: See, I think again it's probably –

Next Speaker: – word of mouth, though, um –

Next Speaker: – yeah.

Next Speaker: – does get out in terms of what's happening, you know, whether it's a respiratory illness that has taken out staff or, uh, a GI illness. So that's often when you see holes in staffing in an area, is what will alert you, um, to a problem.

Next Speaker: Yeah, I mean we, we don't have any delusions. I mean it has to be recognized by somebody and –

Next Speaker: Mm hmm.

Next Speaker: Yeah.

Next Speaker: – probably by an infection control person, uh, before it's going to get reported to us.

Next Speaker: Yeah, I just think again, when you look at data, it's like I think the schools are pretty good about reporting, the long term care facilities are really too, they're good about reporting, but I know for acute care facilities we probably don't pay as much attention to it as we should.

Next Speaker: And we don't get that many, um, maybe not as many as we, as really are in hospitals, so, yes. Okay, so I just had a brief update about norovirus, uh. When I last gave a talk at APIC, I was saying how, you know, like you're up for a strain replacement because GT4 Sydney is going to go out the door and we're going to see J27 Kawasaki. Well, have of that statement is so far true, um. If you look at the graph, uh, we've seen a dramatic decrease in DG4 Sydney, which is the purple, um, as of summer. So we really, we've seen like three outbreaks of GT4 Sydney since, uh, June, which is highly unusual given it was the many outbreaks strains that passed nearly 3 years. So far since then, we've seen a lot of G1, um, some G1s, a lot of G15As, but we really haven't seen that many J27 Kawasakis, which is the reported strain that was going to replace GT4 Sydneys because that was a strain that was, um, all over east Asia and, uh, all over east Asia last year, so they thought it was going to come towards us, but so Safety Board is what's going on with norovirus, so, and any questions about outbreaks, uh, seen here or reported to us at ACDP.

Next Speaker: You have any hypotheses as to why this is the current distribution of the?

Next Speaker: Um, so for right now, we've had actually a lot of school reports and not long term care facilities, and so, um, I've been told that the GT2 Sydneys were seen mostly in long term care facilities and as of right now, we've seen an increase in long term care facilities, but when, um, but it's been slowly building and so the past month or so, it's really been a, a lot more schools than usual. So that might be just to bring, to bring, you know, bodies.

Next Speaker: And you know how much lower the success rate of getting samples when they're school outbreaks.

Next Speaker: Mm hmm.

Next Speaker: So we, so there's a family bias there that, yeah.

Next Speaker: Have there been, was there anything from those investigations that suggests that the –

Next Speaker: The etiology.

Next Speaker: – the etiology.

Next Speaker: Well, yeah, ****.

Next Speaker: But like ****.

Next Speaker: Yeah, exactly.

Next Speaker: I know there were a few more. I think there was at least one ****, I mean there's a story of a kid vomiting and then everybody got it after that.

Next Speaker: Yeah.

Next Speaker: But those have been much more confusing problems that we had ****.

Next Speaker: Yeah, we had one county, uh, one public school area where, you know, one school got, got hit really hard and then it just sort of dispersed into like ten other school in the area. It's, this was pretty bad. That one was, that one was D1, um.

Next Speaker: ****.

Next Speaker: I'm interested in the C. Diff outbreak.

Next Speaker: Oh, yes, I figured someone would be.

Next Speaker: Yes.

Next Speaker: Actually, Kate worked on that one, so I figured she would.

Next Speaker: That's an unusual outbreak to have reported, so.

Next Speaker: Mm hmm.

Next Speaker: Yeah, I think what happened was this was reported in, um, there were some residents of an assisted living facility that had C. Diff and then it was reported among staff, um, they were called service assistants. They're not trained clinical staff, but people who helped with, you know, food and, uh, patient transport. So this was, it was reported that two of them had C. Diff and then, um, we did some testing. There was a third with a GI illness and, uh, that third test was negative for C. Diff, um, and then, uh, we had, so we had what looked like a, a parallel norovirus outbreak, and one of the food handlers also was one of our salmonella cases we were following up on. So this was an interesting –

Next Speaker: Mix.

Next Speaker: – outbreak where we had three likely pathogens, and one is assisted living facility and this actual connects with what Mary's going to talk about, so I won't say too much about this, but, um, because we have this new source of funding from CDC to offer on-site non-regulatory, eye infection control consultations, um, we were able to actually connect with this facility, that's also, the **** is connected to a skilled nursing facility and, uh, Mary went out and did site visit with these funds with the county, uh, communicable disease nurse, and so we were able to connect with the health system, the county health department, and then Mary was able to go out there. So that's sort of an example of how we can use, you know, we can see what's going on with outbreaks and that's one of the ways we can target each facility that –

Next Speaker: So that –

Next Speaker: – okay.

Next Speaker: I think also Jen can.

Next Speaker: So this is Jen Detser. So just to give a little bit of context of what we're looking at here, um, what defines an outbreak and more specifically, what makes it a health care associated infec, uh, outbreak, uh. Outbreak, we, in Oregon we typically define two or more cases of the same disease that are epidemiologically linked whether that's through work or school, or eating at the same restaurant, uh, having care in the same health care facility, that kind of thing. Specifically, in regards to health care associated, that's when it occurs in a health care facility and, uh, the list there of hospitals, long term care facilities, ambulatory, free sanding, and even dialysis centers are the main health care facilities that are defined in ORS 442, uh, but in, but in other, you know, it's possible to interpret that also with any facility that is paid to provide health care, so that side should be a slightly larger list and that would include other things like assisted livings, uh, I'm sorry, community based care or residential care, that kind of thing, but these types of outbreaks are by law reportable by the facility and it's their own responsibility to notify Public Health about, about that. So are there other types of reportable diseases, of course, and these are sort of those discrete cases of any reportable disease, of which there is a list that can be

found online, uh, you know, every, including everything from, uh, hepatitis, hepatitis to, um, coxiella to what have you. So any of those are reportable in addition to if the person's not sure if the disease that they're seeing is reportable or not but is highly transmissible or may result in serious health care consequences, that's also a time that, uh, that provider should report. Uh, and then the other piece I want to focus on is not only single cases of reportable diseases, but if there's any known or suspected common source outbreaks, even if that disease is not a reportable disease. It is not on that main list, but you're seeing a cluster like three to five cases of chicken pox. If chicken pox is an individual case, it is not considered mandated reportable, but when you see a cluster of those, um, it's to be reportable. Same for seeing MRSA, that's surgical site infections in a hospital, you know, one surgical site infection with MRSA is not reportable on our mandatory list, uh. However, seeing a cluster of them together is suggesting that there is some kind of common source or common illness because they're all, they've had surgery recently from the same facility, that is in fact reportable to Public Health, and these types of diseases don't have to be associated with health care associated facilities, obvious, and, um, any health care provider or any individual knowing of such a case even if they're not a health care provider is required by law to report these to Public Health, and so that's where, um, you know, beyond like the, you know, doctor and nurse, or anyone working in the office, etc. or in a, in a assisted living or something like that, if there was if there was **** etc. would see this that they.

Next Speaker: I don't know and I would ask anybody on the phone who works in infectious control, is everybody well aware of common source outbreak being, um, reportable? I'm not.

Next Speaker: Yeah, that's what I, that's why I'm bringing it up today. That's why I'm talking about it, because, uh, I think the way that it's written, it kind of gets hidden in the paragraph that lists each of the individually reportable diseases, like I said like coxiella or, um, why am I blanking on all these, usual things, botulism, like the plague, that come through. So at the, like the last two sections says, it says any known or suspected common source outbreak, um, or any uncommon illness of potential public health significance, uh. So you know, that could be someone in the, you know, a physician in the ED noticing that he's seen three patients that have this like really unusual rash, uh, that are coming in and are very sick and have to be admitted, but don't know what it is yet, but he's, you know, seeing that cluster in time and you know, maybe they all have in common. Exposure of having been to some –

Next Speaker: Well, what comes to my mind immediately is surgical site infections with, uh, the same organism with a very similar sensitivities that you may or may not have sent out for PT ****, um, hospital gel electric bruises, so if I was working in a hospital and I'm not saying that this has happened, but you know, it's not, but if I did have a rash of, um, surgical site infections with same organism with very similar sensitivity matters –

Next Speaker: Mm hmm.

Next Speaker: – that is something I should report to Public Health, okay.

Next Speaker: Uh, yes, we would –

Next Speaker: You say like fast too?

Next Speaker: Huh?

Next Speaker: Fast too, like how many times have you had, uh, clusters of ventilator associated pneumonias, you know, with many of the same organisms. I mean again, I **** lot that could happen.

Next Speaker: Certainly, if you had a patient that were linked in time in a unit, time and place –

Next Speaker: Mm hmm.

Next Speaker: – with the same organism. See, this is a whole new, um, concept.

Next Speaker: So yeah.

Next Speaker: And that's a –

Next Speaker: What's, do you have any suggestions for what we should do so to make people aware?

Next Speaker: I think that needs to go out through APIC.

Next Speaker: So that APIC could know.

Next Speaker: Yeah, or present when you do a presentation for APIC.

Next Speaker: Yeah.

Next Speaker: Bring this out because I don't think this is well understood by practitioners.

Next Speaker: Fair enough.

Next Speaker: And also employee health too. She touched upon it a little bit earlier. We've got, you know, when we do see clusters of health care providers **** in the same service line, but if they're respiratory illness or influenza or **** here, I mean. You know, they get worked up if you will. It's a hospital thing, but –

Next Speaker: Mm hmm.

Next Speaker: – and there's so many of those.

Next Speaker: I'm wondering if we actually need to change the wording in the, um, I guess it's OAR wording, um, you know, again to spell it out, um, a little bit more because again, I think people have really felt, felt that this is more associated with communicable diseases and not necessarily health care associated clusters of infections.

Next Speaker: Correct, those are usually handled internally by the infection control team.

Next Speaker: Okay.

Next Speaker: And that may very well, yeah, and that may very well be the case that goes on, but I think it's the calling it having a discussion and, and making sure that the, you know, that, you know, asking the right questions and if there's assistance for specialized laboratory testing, like doing PFGE on a cluster of, of cases that maybe your clinical laboratory doesn't, you know, isn't validated to do that for your team, we could put you in touch with someone, that kind of idea. So it's not necessary that we would, uh, come in or do anything in particular, but I think reviewing the case and if additional resources or assistance is needed, we could provide that, help with that.

Next Speaker: That makes sense.

Next Speaker: Yeah.

Next Speaker: Yeah, I mean would there be other potential reasoning so we could potentially identify if there is any kind multi-facility thing going on.

Next Speaker: Mm hmm.

Next Speaker: But that would, I would think that would be a role that we would play, you know, so the facility –

Next Speaker: I think, I think –

Next Speaker: – isn't going to be able to identify, so.

Next Speaker: – yeah, thinking back to what happened with the fungal meningitis piece, I mean that was, you know, providers saying look, I just have this really unusual, a patient with this very unusual fungal infection that happened to have this injection and that was only maybe on, maybe two patients per facility, but then some facilities had more. It's making that connection between the different facilities across, uh, several states that then eventually pulled it together with the investigation and the commonality of the compounded steroid injection. So especially when it kind of comes to medical equipment, uh, like we've seen in the news or compounded pharmacy medications, things that may have, um, import beyond your hospital, that can be helpful, um. Again, it may be very straightforward, um, but there also may be something there that can lead to, you know, finding out that there's something going on they should like, so that's sort of the, the why I'm bringing this to everyone's attention too, in addition to like I said, the classic, you know, ED physician sees three folks coming in with, you know, you know, psychotic breaks after attending a party and smoking something. Like those are the kinds of things also that should be reported to Public Health. They're not, you know, communicable, but, um, would be investigated in a similar fashion, so, yeah.

Next Speaker: I think, um, you know, there's a, a hesitancy for facilities to report, period.

Next Speaker: Mm hmm.

Next Speaker: And if you look at like the rules for long term care and respiratory infection reporting, GI reporting, it's much more specific, that I think, you know, I can just see how again, unless you, you really spell it out more specifically, there's going to be, you know, facilities are going to say well, that doesn't apply because they just look at common source outbreak. They're going to say that doesn't apply to this situation.

Next Speaker: Right and if, right, and if you're having, you know, people are out because it's flu season, your staff, that's one thing, but if it's you've got, you know, five patients on a unit that all have flu, that's a different, different level.

Next Speaker: Okay, how are they supposed to, with, with the common source outbreak –

Next Speaker: We'll provide them ****. I'm sorry, how do they what?

Next Speaker: – how do they actually go about it. Like if, if someone were to report that, what do they?

Next Speaker: Sure, um, what did I do, oh, here. Okay, well, sorry, I've got this right down here. So this is the, that's why I did up a slide on outbreak expectations. So what you would do, at the bottom of the slide, um, this is Slide No. 30, excuse me, that says Health Oregon.org/disease reporting, that has a listing of all the local health departments, um, but you can also call the main, um, ACDP line here, uh, and I have our email at the end of this too, but that's 971-673-1111, the ACDP line or their local health department. Option 30, sorry, we have a new, we have a phone tree, so when you call ask for the on call epi. That's usually the best way, um, to, to report your thing. So I wanted to set up, give a little bit of background on what to expect, you know, when we work with facilities. So, um, we expect that the facilities and providers will work collaboratively with us and, and make timely reports and share information, and work with, you know, discuss recommendations, what they feel will work and not work, and we, and what their input is, and that you know, our responsibility is to share information back to you, provide any recommendations, and that might be, like I mentioned before, doing, um, being able to provide or facilitate a specialized lab testing that could then lead to finding what the source is or the cause, um. We work always to protect personal health information, and work with our disease registry, etc., so it's a very important part of what we do and that our goal is to, is to help you, um, you know, provide, and providers with to, ensuring patient safety in your health care facilities and that's really what we're here for, for consultation and education, etc. So what sort of information do we usually ask about, and this is, this is very typical to when we investigate any sort of disease that's reportable, um. We ask about who's reporting it and also who the health care provider who diagnosed it, and this helps us to be able to circle back around to ask for more information and details. Um, we ask about the person or people who are affected and their contact information and date of birth, because again, this allows us to track and describe, you know, who is affected and that might provide, um, important clues to what is the source behind the, all these common illnesses, um. Obviously, what the illness or condition is, the onset is very important, uh. When, uh, not only when they had their testing done and when that was positive, but when their disease actually began, uh, and how they were tested, and then, there's usually

follow up information to understand what sort of risk factors, especially in health care setting, they had around **** patients, procedures, uh, as you can imagine, things that would have put them at risk to have this, this common illness, and these are some of the things that we do. We don't do all of them every time, uh, and there's probably things in here that I didn't list that we do, but, um, usually there's, you know, calls between a facility and Public Health to share that information, uh. If it reaches the level where, uh, an outside observation or site visit might be helpful, we can help facilitate that. Uh, we usually either do some sort of recommendation whether informally over the phone during a conversation. Sometimes we do it more formally with a recommendation letter, especially if there's been an on-site visit, so there's very clear communication, uh. Our, you know, oftentimes we, again we focus on the fundamentals of infection control, um, and working through the facility's capabilities around environmental cleaning, uh, around if any patients or staff need to be screened, uh. For example, we had an outbreak a couple years ago with Group A strep in a, in a, in a, um, long term care facility, uh, where there were some patient infections and it was found that, um, 30 percent of the staff were actually colonized with Group A strep in their throat and 20 percent of patients who really got into that facility and spread. So we did testing at work with them, um, to facilitate that, uh, and other things is sometimes we do environmental testing, um, testing of medical equipment if that is what is pointing to during the investigation, so this kind of thing, um, but usually there's always some kind of patient and staff recommendations around, um, isolation, return to work, that kind of thing, and all of this is done, we do this in consultation with the facility. For example, each of our carbapenem-resistant Enterobacteriacceae, CRE folks, Maureen, uh, works really closely with them, with the facility to make sure they understand how to protect their staff, how to protect other patients, um, when and if, uh, transmission based precautions need to be used, when and if other, uh, patients need to be screens for, for having gotten ****, that kind of thing. So I wanted to give you a little bit of the tools, um, that, that are there right now. We're actually in the process of updating this, but it, I have a lot of the basic tools, and our little short link code is www.healthoregon.org.hai is our short URL that can take you to this page that has basic definitions and control measures. Uh, and these are some of the tools that are there. There's a case log, uh, in order just to facilitate, uh, data collection by the facility, uh, and so that helps communication between the facility and Public Health, uh. I just looked at some other things there. There's a specimen collection for when that's necessary, or when that's recommended. There's also some, um, information on the web site around data collection and sending a response in there. Again, I'm going to be working on, on updating these in the months to come. Uh, that brings me to the sort of next piece when we, where we talk about MDRO or any sort of infection that could be transmissible between facilities, as a reminder about the inter-facility rule, and that this is, that any, a patient who has been, uh, recently colonized or infected with an N viral or it's a multi-drug resistant organism or other infectious disease that would require transmission based precautions. So, you know, norovirus, influenza, excuse me, tuberculosis, that kind of thing. It is required to communicate that to the receiving facility, and I've listed some MDROs here as MRSA, CRE, but I do want to emphasize that this extent to, um, norovirus, so if there's an outbreak that's going on in a long term care facility, making sure to communicate that to the ED if that patient needs to be transferred that hey, there's actually an outbreak going on here and that you know, please either do testing or be, be ready for that, and we've arbitrarily, somewhat arbitrarily said that coloni, colonization should be assumed to be about 1 year following the most recent infection, and this is a standard that's used in other places. It is somewhat arbitrary, but we know that things like CRE and MRSA can, can remain, um, as

colonizers for many months, um, despite no obvious clinical infection. This is a sample, uh, form. Again, it's on our, on our web site, right by the HAI web site there, um. We've made some updates to this where we, there's a place to say that the patient's currently on antibiotics and if they have pending cultures, what type of precautions they're on and then with the list of, of, um, diseases below, there's a place where you can say whether is a colonization or history of person active infection, and I really want to emphasize that colonization or history of because that can be equally important, um, in the terms, in terms of any disease that can resurface later during the, the stay, during the duration of their care passed in another health care facility than the one when they were initially diagnosed. So any questions before I move, I was going to do a quick comment, uh, down here. Do you have any questions about outbreaks or anything like that?

Next Speaker: I have one.

Next Speaker: Sure.

Next Speaker: Um, is that update, general update, outbreaks update ****. Is that something you guys would like to see at every HAIAC meeting? Just a quick 5-minute like we'd seen, this many, this many outbreaks reported to us and so many of these are long term care facilities versus ****?

Next Speaker: Sure.

Next Speaker: Yeah.

Next Speaker: **** yeah.

Next Speaker: We'll continue to do that then.

Next Speaker: Great.

Next Speaker: Uh, this is a –

Next Speaker: One question.

Next Speaker: – go ahead.

Next Speaker: Does the common source, does that still have the two, is that completely different than the other thing. So is that still two cases or is that, uh, open to interpretation?

Next Speaker: Uh, so let's see. So the, so the classic definition is two or more cases.

Next Speaker: Right.

Next Speaker: And then but any sort of other suspected common source.

Next Speaker: Okay, so okay, so that's –

Next Speaker: So –

Next Speaker: – there's no miracle, there's nothing tied to that.

Next Speaker: – there's no miracle number with that, but if that's in, in your, you know, in your hunch or whatever, your preliminary investigation that that's expected, then –

Next Speaker: Got it.

Next Speaker: – or any –

Next Speaker: More, more than expected.

Next Speaker: – more than expected.

Next Speaker: More than expected, right.

Next Speaker: Yeah. That would be the other.

Next Speaker: But it's also, you can also call us and ask us if like, you know, someone, you see someone and they just tell you that their other friend got sick. Maybe that's something that we could help you guys investigate. So like you know, they both went swimming and then someone came, they both got sick with this weird infection on their arm, and not only this one person that came to see you, but they said that their friend got sick as well. We could help if that's the case as well, so.

Next Speaker: Yeah, or like with tat, tattoos stuff. We've heard that, you know, with tattoo parlors. Maybe only one person actually gets the care and gets tested, but they know other people have been to that same parlor and have skin rashes and things like that, so. We can, we can facilitate for that case maybe.

Next Speaker: Okay.

Next Speaker: Kate, Kate, I have a question.

Next Speaker: Sure.

Next Speaker: Go ahead.

Next Speaker: Sure, hi, this Diane again, um. Around the outbreak expectations, um, are you through OHA planning to send out some communication kind of as a reminder to reinforce the practices you're looking for or are you asking, um, that, that we do that either through Oregon APIC or through the Hospital Association, or just looking for direction there.

Next Speaker: Uh, Diane, this is Zints. I was actually planning on emailing you after this meeting to see if you wanted to coordinate on, on something in that direction.

Next Speaker: Oh, I think that, that's fabulous. Thank you, Zints. I'll look for that.

Next Speaker: Okay.

Next Speaker: And, and Mary's also, this is Jen, Mary's also requested an update to APIC, so we'll, we'll work on that, and again, this has been in the rules for a long time, but I think it's just been sort of buried under some of these other –

Next Speaker: **** yeah.

Next Speaker: – lists, so –

Next Speaker: Exactly.

Next Speaker: – we want to work just to tease that out so it's, it's clear, so folks can.

Next Speaker: Great, great.

Next Speaker: Diane, I like the idea of, um, maybe getting word to, uh, administrators too that this is required so that nobody gets freaked out if, uh, the Infection Control Department reports something.

Next Speaker: You bet, you bet, sounds good.

Next Speaker: So great, thank you. So I wanted to give, um, a quick update on carbapenem-resistant Enterobacteriacceae as one of our reportable diseases, also is a multi-drug resistant organism, uh, so the first image is sort of the epi curve of the cases that we have seen, uh, since November of 2010. The more recent spike here from July to October 2015 is probably related to our new definitional change, uh, which captures for of the **** that are sent to us because it only requires resistance to one carbapenem and the, the full detail of that is, will be provided in our CRE toolkit that just came out that I will talk about in the next slide, but overall in summary, we've had 208 cases reported to us that meet the definition of, uh, a bacteria, so grand negative is part of the Enterobacteriacceae family being Klebsiella, e. coli, Enterobacteriacceae as the big players, uh, since 2010 meeting that definition. Um, more females than males reported, but we think that's also because more of our samples are urine samples, so there might be some kind of bias there. Also most of our, uh, cases are older than 65, so again, that's a bias towards having more female cases. Thanks to this surveillance, we have identified nine carbapenemates producing CRE and again, these are the carbapenem, the series that we worry about because that type of resistance is transmissible between species on ****. Thanks to our investigations, we haven't identified transmission, so that's great. We've had good infection control at the facilities, uh. Interestingly, uh, I want to note this for the hospital and, and long term, well, more for the hospitals I think is that seven of those had a history of receiving health care outside of Oregon and most, several of those were international, so from Africa, Eastern Europe, um, back east, uh,

Calif, uh, southern California as well, and those are all places that are known to have a higher rate of CP CRE so something to consider, um, when you're receiving patients transferred from those areas high in ****. So that means the next thing we have, a new addition, uh, thanks to Maureen and Chris Fifer and all their hard work, the 2016 CRE toolkit is here. Uh, it is posted online electronically and paper editions are to follow. Some key updates is like I said, the updated CRE definition. We also have some, created very discrete sections for different health care settings to try to facilitate clear, uh, recommendations, uh, for them all, um. We've updated our resources. In addition, there's a new long term care facility table that was created, uh, over a months, 2 years, I don't know, several months and lots of feedback from, from different stakeholders that really tries to assist skilled nursing facility residents, and how to care for residents with CRE since that is a health care setting that's trying to balance rehabilitation along with medical care, uh. So we hope that that will be useful and we look forward to hearing feedback on that. Uh, I, just a quick update. Um, so I'm working on a C. Difficile collaborative and so far, we've enrolled three hospitals and seven skilled nursing facilities and enrollment is ongoing. If, uh, anybody is interested in, in enrolling at the facility, we work on the five areas around C. Diff of surveillance best, best practices, environmental hygiene, antibiotic stewardship and inner facility transfer, um, but I really try to tailor what the goals are for each facility based upon what they want to work on, uh, and NHSN enrollment is a key, key part of the collaborative.

Next Speaker: ****.

Next Speaker: One minute, yeah. And the up and coming, as mentioned before, the antibiotic resistance and utilization, uh, grant so we were able to receive some grant funding to recruit hospitals to start submitting into the National, um, Health Safety Network, antibiotic utilization and resistance module and what this is, is, um, it, this is different because it requires a lot of close collaboration between the vendor and the hospital and public health because it's actually based upon a huge data transfer as opposed to manual entry, but the idea is that you, we would be able to have a better understanding of how antibiotics are used and regional antibiotic, antibiograms which could help with stewardship and prevention of multi-drug resistant organisms. Um, there is gonna be monetary support offered for this and it also satisfies CMS requirement so stay tuned for that. And that's everything I have here. Uh, I just wanted to point out that this is our short URL, it gives you direction to our HAI web page for further information. Thanks very much.

Next Speaker: **** that was good.

Next Speaker: Um, yes, so there's a lot of information there. Actually, we're gonna try to take a break and start again, um, at about, in 5 minutes or just after ****.

Next Speaker: Okay everybody, we're gonna get started again ****. Um, for those of you on the phone, um, we're kind of taking a little break from the slides right now. We're gonna go to the link that I sent you which is to, um, this is not, I repeat, not published yet. This is, uh, we're experimenting with, uh, putting our HAI data into an updated map, so the map from last year was, um, it was a great start. It's, there were a lot of prob, like user issues, it was difficult to load, it was really slow and so we've tried sort of using a, a different template. Um, we're

working with a contractor now but actually, Lexie and I are, um, we're doing some in-house training so that we can maintain this and hopefully, update this more regularly than –

Next Speaker: Mm hmm.

Next Speaker: – you see the report. Having kind of an online form allows us to not wait until we like have to go through publication. So, um, so for those of you on the phone, if you touch the link and you're kind of at the home page, we just started. Um, this is basically a map that walks you through the data in our report vertically so this is or executive summary from the report. Oops, lost my mouse, here we go. Um, and then if you just kind of scroll down, um, I'm scrolling down but the, to the first, uh, this map which is basically aggregate information so this looks, this is actually very dark. We're try, we're trying to lighten this up. But basically, we wanted one location where we could, um, have all information is for a given hospital. So, for example, here is Providence Hood River. You can see they actually were exempt which is the start. They're exempt from reporting a lot of this information so that's not a great example but it's a place where you can see every reportable, um, data. So let's see, this is Asante Three Rivers Medical Center so you can kind of see where they fell on, um, adult CLABSI. They don't have a NICU, CAUTI SIR, um, you know, they, they were below the, they had fewer than expected but not significant. There is the, um, C. Diff SIR and so you're scrolling on and see okay, they did great with C. Diff, not so great with hip surgery so it's just, um, it's, it's, we don't have any place in the report where everything is in one place for each hospital so that's what's this, that's what this helps us with. Um, so yeah, we're gonna look to, we're gonna work on the optics for this a little bit more so, um. Okay, now, I'm scrolling down to some of our infection specific pieces so if you scroll down sort of an overview of CLABSI reporting. You can see the trends over time, um, and then this is actually directly from the consumer report on the left hand side. You can click on it and make that bigger but if you go over to the map, um, you can click on it and see more specific information about CLABSI and ICUs, so you see the number of line dates of their, of their infections, expected infections, um, the SIR interpretation and we also want to work on having a legend up here. So most of the information that's in the chart to the left. We also have, did this facility meet the HHS benchmark for having a reduction of, having an SIR .5 or less. Um, we also allowed facilities to meet the benchmark if they had the oral infections. Um, so scrolling down, we basically do this for all of the, um, specific infections that are in the report. Um, so there's sort of this interactive feature. So if you go to CDI and scroll out, um, you can, you know, zoom in on any one section and kind of, you know, move it around, play with, you know, see what's going on in Portland. Um, and if you get in close enough, the facility names will pop up. Like, um, so here's Tualatin. Um, you can look at their data. Here we go, this red one, OHSU ****. OHSU was ****, um –

Next Speaker: Yeah, nobody –

Next Speaker: Yeah.

Next Speaker: – **** right –

Next Speaker: This is –

Next Speaker: – **** there.

Next Speaker: – um, so the, again, this is just C. Diff they –

Next Speaker: Right.

Next Speaker: – were great on **** things and just to kind of a re, reminder of what's in there that's sort of different, we have the traditional SIR interpretation is that, uh, were there more infections observed than would be expected after risk adjustment. Something new this, this year in the report is, is the, um, where the facilities lies on the national distribution, um, so we got the national facility distribution of SIRs on CDC reports and then we sort of, you know, for each facility marked where they were and then whether or not they met our benchmark.

Next Speaker: It's true that people looking at this don't really knew, know the nuances of this because –

Next Speaker: I, it's true.

Next Speaker: – and, you –

Next Speaker: – yeah.

Next Speaker: – know, some people do more testing, some people do better testing, so.

Next Speaker: We did an argument for a better validation and, and –

Next Speaker: **** money for that.

Next Speaker: – I can, no, I completely agree and –

Next Speaker: Yeah.

Next Speaker: – messaging the SIR is just extremely difficult.

Next Speaker: Mm hmm.

Next Speaker: Um, so –

Next Speaker: Hey Kate, Diane here.

Next Speaker: Mm hmm.

Next Speaker: Did you have any, um, patients or public folks help you or review this or provide input?

Next Speaker: Um, I did not, not for the map, um. I mean I'm hoping we can, we can get into contact with some of those, the patient and family boards and present, you know, not only the report but also the, the map.

Next Speaker: The map as well?

Next Speaker: Yeah.

Next Speaker: **** –

Next Speaker: Okay.

Next Speaker: – report ****.

Next Speaker: Yeah.

Next Speaker: Hmm?

Next Speaker: That was the report I think prevented a different formatting and metrics.

Next Speaker: Oh yeah.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: For the report.

Next Speaker: For the report, yeah.

Next Speaker: Um, but that's what, you know, we're always looking for that because I don't know the best for more feedback on how to message this to the public. Um, so then I'm still scrolling through, for people on the phone, it's sort of a, the same deal for each of the surgical site infection. Again, we have sort of overall and then, you know, you can kind of see for these are the facilities that reported, uh, that had, that actually performed, for example, um, coronary artery bypass grafts, um, and all of them had SIRs below one so I'm actually, in the interest of time and this, this link, again, we, I ask that you don't share it with anybody because it's not updated and we haven't gone through and valid, you know, made sure that all of the information is correct yet, which we will do before we publish it. Um, but I, I made the link available to everybody in an email so that you can go through, play with it a little bit, zoom in, um, and, you know, email me if, if you have thoughts about how we can make it better, um, and, and we'll, we'll incorporate that so and this link should be updated as often as we make updates, so. Um, so I'm scrolling down to the bottom because the last thing we published in our report was healthcare worker influenza vaccination rates, um, and I've had some thoughts about pulling this information out, perhaps making it its own app or making, you know, somehow getting this information out separately because there's been a lot of interest in this lately. Um, so here we've,

we've put all hospitals, ambulatory surgical centers and long term care facilities or skilled nursing facilities that are required to report to NHSN on one map, um, and we don't have it or we don't have our legend here but the way that we set, set up the color coding was, um, in accordance with the healthy people 2015 and 2020 goals so a dark green means that, uh, the facility had, uh, over 90 percent so I'd like to highlight Harn, Harney District Hospital. Um, this is a small hospital and a lot of times, small hospitals 'cause they have really hard to report and, and get all of this together but they had 91 percent influenza vaccination for their healthcare workers so they had, that dark green. The light green means that a facility has met the 2015 goal of at least 75 percent reporting but they haven't reached 90 percent yet so there's Blue Mountain. The light, uh, light red basically means that they're below 75 percent so unfortunately, this nursing facility almost made it but they haven't yet met the, the goals. And then a dark red basically means, uh, that's a bad, that's a mistake **** pull out a dark red, it's actually dark red. Uh, dark red means below 50 percent, so this 24 percent for this, uh, nursing facility.

Next Speaker: Uh, well, I think this is awesome and I love the colors. The one thing is I'm just wondering in terms of like people that are colorblind or something in that direction, if, well, I'm wondering if it –

Next Speaker: Yeah.

Next Speaker: – I think we should, it, it would be great to keep this but what if, would it be possible to have it so you click something if someone is in that situation and then it uses symbols or a gradation or something that the –

Next Speaker: Yeah.

Next Speaker: – **** someone in that situation ****.

Next Speaker: No, I like that. We should, we'll definitely try, we're working with a contractor now to educate our self in how to do this kind of stuff and so, um, so I, yeah, I like it. Well, we'll definitely follow up on that and one thing we are kind of thinking maybe we can adjust the size of the circle so that they can be color coded but maybe have a bigger circle –

Next Speaker: Maybe –

Next Speaker: – if you have higher vaccination rate.

Next Speaker: – that would be a –

Next Speaker: Um –

Next Speaker: I don't know.

Next Speaker: – and also, I don't know how people feel about it, I, I sort of –

Next Speaker: ****.

Next Speaker: – this might be helpful for accounting. Oops, what's going on? Uh, you know, kind of see what's going on in an area but it, is it weird to lump all the different facility types together, like should we have different symbols for ASC versus long term care.

Next Speaker: I think it would be good if you can sort it by –

Next Speaker: ****.

Next Speaker: Mm hmm.

Next Speaker: – facility type as well.

Next Speaker: Okay.

Next Speaker: I think it's important to –

Next Speaker: ****.

Next Speaker: – have it –

Next Speaker: – both.

Next Speaker: Yeah.

Next Speaker: **** –

Next Speaker: **** I like –

Next Speaker: – like all if the –

Next Speaker: I like the closer.

Next Speaker: There is kind of –

Next Speaker: ****.

Next Speaker: – going –

Next Speaker: Yeah.

Next Speaker: – **** partners.

Next Speaker: Yeah.

Next Speaker: But then the hospitals are ****.

Next Speaker: Or a different symbol than just the circle, maybe a square or rectangle or –

Next Speaker: Yeah.

Next Speaker: – **** for the different facilities –

Next Speaker: Yeah.

Next Speaker: – ****.

Next Speaker: Yeah.

Next Speaker: I like ****.

Next Speaker: Or to see more green on that map.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: I know, we were trying to lighten it up. I don't know why, whether, we just, we keep, yeah –

Next Speaker: ****.

Next Speaker: – no, we keep going back to, to nighttime but I, I wonder if maybe we have to get more green before we can make this lighter with the **** –

Next Speaker: No, more green dots.

Next Speaker: – **** green dots, yes.

Next Speaker: Most hospitals do better than the long term care –

Next Speaker: Yes.

Next Speaker: – facilities.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: And there are –

Next Speaker: Fewer hospitals.

Next Speaker: – twice as, more than twice as many long term care facilities –

Next Speaker: Yes.

Next Speaker: – in the state, so.

Next Speaker: Yeah.

Next Speaker: It might be making it look better than it is.

Next Speaker: This ****. Um, the other thing that we're working on with facilities is making sure that they document, uh, influenza vaccination because we consider, um, you know, if, if you don't know about the vaccination status of 25 percent of your employees then you're automatically, 75 percent is the highest you could ever achieve, so, uh, unknown is we've, is no for us so. Um, so anyway, we, um, I want to move on with our program. I just wanted to show you guys this. You have the link. Um, we'll be kind of, we'll be giving you updates and when it goes live, uh, we'll definitely email everybody but this is kind of our time to play. Um, okay, so let me. Oh, oops, yeah.

Next Speaker: Thank you.

Next Speaker: This is the Reed Canyon, everybody, we, where we live very closely, um.

Next Speaker: ****.

Next Speaker: Okay, um, so I and Mary, thank you for or we're kind of behind in our plan and, and Mary has, has offered to, um, present at the next meeting when she actually, she has more data, um, but, uh, we'll have, if we have time at the end, I'd like her to still give kind of an overview of what she's found. Um, so for this, this next section of the meeting, I wanted to talk about proposed updates to our HAI state plan and, um, you know, in a nutshell, this actually, it involves incorporating into our state plan which directly affects the committee is, um, incorporating a lot of our, uh, CDC Ebola funding, um, which funds a lot of the staff in our program and this funding is basically, um, you know, to enhance infection control capacity across the state. So just, just some background about the state plan. I mean most people, I didn't even know we had a state plan until after I had worked here for like 8 months or something but we do have a state plan and it guides all of our activities. So, um, House Bill 2524 basically established the mandatory reporting program which as part of that program, this committee was established and so, um, in 2009, uh, Oregon Health Authority received a large grant from the Recovery Act Funds, um, basically to build public health infrastructure at the state and that's when this committee was born and, um, this committee was really the, the main goal was and is to advise, um, NHSN reporting, but that plan has sort of been updated over the years. We had, um, you know, Affordable Care Act funding and, uh, we expanded, you know, beyond acute care facilities and also beyond, um, uh, beyond just the, the devices **** associated infections we had

started with. Um, and so, so why update the plan now. It's, basically, it's a, as I mentioned, we have this new source of funding, um, and so CDC has funded, uh, all of the states to do some type of infection control enhancement at facilities through onsite consultations. So the first part of this grant is what, um, Judy Guzman is gonna talk about next, which is, is going out and doing standardized assessments of our Ebola assessment hospitals and the second piece of the grant is, is basically, um, sampling and we have a lot of leeway as to which facilities we select but to go out to other facilities including long term care facilities, ASCs, outpatient clinics, critical access hospitals and also implementing some standardized assessments on these. Um, so CDC has advised that as part of this grant, we build a multidisciplinary advisory committee and that if we had an existing committee, like this one that we're all sitting on, that we actually, uh, you know, build its membership to sort of reflect the type of expertise that would help with these onsite consultations. Um, and so this is just a reminder of the, you know, existing, um, healthcare-associated infections advisory committee is actually, um, defined by Oregon by Statute 442851, um, and so you may see it, so basically, it's, there's a very specific definition of who should be on the committee as you guys may, you know, see yourself. In these, this listing here, there is seven appointees from healthcare facilities and nine from other, uh, other communities, labor, consumer, purchaser, um, academic researcher, etc. and so what we want to do with our updated, updated plan is to expand this sort of list of people that would participate in the community, in the, on the committee, um, because this sort of regular standardized onsite facility consultation is re, is, is a new, new territory for our program in particular and, um, so in order to make these site visits most effective, we feel like we should, uh, work more closely or coordinate with our regulatory and licensing group. That includes, uh, HCRQI which does the acute care settings which we already have Dana Selover on this committee. She couldn't make it today but also expanding it, uh, inviting Deb Catoura from OLRO which licenses long term care facilities, um, and, and having her participate. We also would like to invite members from our **** communities, um, provider boards and then, uh, experts in specific areas. For example we've identified instrument reprocessing as a key area where we'd like some input, also environmental infection control. So if this group you know sort of is, is on board and we're very open to hearing any concerns about this type of expansion, you know we'd like to vote on it today and if, if everybody agrees then we would invite this sort of expanded membership. Some of these people are already here at this meeting but, but there are some additional individuals we'd like to invite to participate in our committee.

Next Speaker: Can I ask –

Next Speaker: Uh huh.

Next Speaker: – a quick question? When you talk about provider boards, what, um, kind of expertise on the provider boards are you looking for?

Next Speaker: That's a good question and I can actually defer to you guys if you have thoughts about the type of expertise, but I know that we, um, I mean we're looking for, um, somebody on the medical board who can sort of speak to you know what happens when an infection control breach occurs at a facility. What role does that board play, and you know we've sort of been learning as things happens by contacting you know these various boards, but we –

Next Speaker: Right.

Next Speaker: But do they have roles?

Next Speaker: – would like to enhance their role.

Next Speaker: Yeah, exactly, yeah.

Next Speaker: **** board and, and so also not only, um, you know at healthcare facilities but other home care provider settings, so outpatient clinics.

Next Speaker: Mm hmm.

Next Speaker: Dental offices, uh, these kinda places where it doesn't, it's not a defined healthcare facility.

Next Speaker: Uh huh.

Next Speaker: So then the regulatory piece goes to the board so how do we work with that. When working with a provider maybe there's a Hepatitis D operator association for injection practices that kinda thing –

Next Speaker: Okay.

Next Speaker: – so it, it's specifically for input into non-healthcare setting, setting situations.

Next Speaker: And just to use an example if, when I'm doing my, um, assessments I find trends, so maybe I'm finding issues with let's say anesthesia carts and –

Next Speaker: Uh huh.

Next Speaker: – the sharing of multi-dose files you know we can say you know we can turn to the Medical Board and we can say what type of education has been done for them or what is required in terms of their licensing or credentialing and likewise if we have you know, kinda go to the Board of Pharmacy and say what have you done you know and, and what can we do and how can we maybe unify our efforts so that again we get information out to all the settings to try and ensure that we are following you know national standards and are creating a, um, safe, um, environment for patients.

Next Speaker: I'm not sure it's the boards then that, that is the involvement that you want. It's, it's why I guess I'm getting that because, um, the boards have to deal with like, um, disciplinary action and licensing right but not necessarily education or continuing education around, um, specific issues. So that's why I was wondering.

Next Speaker: Yeah.

Next Speaker: And I think we did. We, we had, I guess our role was sort of edu, getting that education to the right folks. Um, what we're concerned about is if, if there's an outbreak that's in an outpatient setting like **** clinic that sort of you know need to intervene and –

Next Speaker: Because you don't have the hospital association involved, is that why you're saying that?

Next Speaker: Well because they don't regulate. They don't regulate outpatient clinics 'cause the outpatient clinics.

Next Speaker: The hospital association does not, right?

Next Speaker: Correct. Right. So the clinic that, it's really not a, the license is through the provider who has their outpatient clinic so if we're, if we need to intervene to, to correct that practice then that, the board is the regulatory, uh, arm to do that for an individual –

Next Speaker: Right.

Next Speaker: – individual player.

Next Speaker: Right.

Next Speaker: Versus when you're in the hospital, great.

Next Speaker: Yeah.

Next Speaker: There's gonna be **** if it's a –

Next Speaker: I'm just –

Next Speaker: – statistically –

Next Speaker: – 'cause I'm representing the Oregon Nurse Association which is the most professional organization for nurses in the state, and I'm actually feeling like that organization is where we can really do targeted education more so than the board, of, of the OSBN because the OSBN really is, um, a licensing and, um, uh, ****.

Next Speaker: Yeah.

Next Speaker: Great, no –

Next Speaker: No, I, I **** –

Next Speaker: – those are, those are important.

Next Speaker: Mm hmm.

Next Speaker: I think ****.

Next Speaker: Right.

Next Speaker: So.

Next Speaker: So look at the, uh, the same thing for the medical. Um, people with **** many time, uh, **** the same?

Next Speaker: So it was probably because there's the Medical Board of Examiners and **** you know there's the –

Next Speaker: ****.

Next Speaker: – the OMA and then there's the Board of Examiners but I think that it's a kind of a dual role similar to what, what ours is.

Next Speaker: And I think the problem is also is if we find that there's common, um, laxes in say safe injection pro, practices or knowledge around that, you know can the boards through requirements or the CME for providers like they'd have to do an hour on that –

Next Speaker: So that takes long but yeah, those –

Next Speaker: Yeah, those take longer right?

Next Speaker: – those, those were actually legislated, um, and it takes longer –

Next Speaker: Yeah.

Next Speaker: – to, whereas if you know we can target, um, I think providers want education you know. Providers want to be current and they want to be practicing responsibly and so I think if you can target, um, through professional associations we might be able to reach people faster.

Next Speaker: Mm hmm.

Next Speaker: Yeah, it's probably, yeah, yeah ****.

Next Speaker: Yeah, no that's **** great –

Next Speaker: ****.

Next Speaker: – comment on, on that combined piece and I will, the one, the one, um, interaction that I've had with a medical board was, um, discussing also an injection safety breach and, um, and you know the, the, basically one of the reasons we thought this might be a good idea for the committee was you said you know we do have newsletters that go out and so instead of saying

you know we're gonna nail you if you do this, they ha – you know this, this happened to a member of our group. It was really, um, you know there, there is some, not everybody has been educated you know in the last 5 years –

Next Speaker: And it has a lot of ****.

Next Speaker: – so it was sort of, uh, I, for me it was sort of surprising that there are certain mechanisms maybe for reaching out to board members and, um, so, we –

Next Speaker: **** currently **** lists.

Next Speaker: Yeah.

Next Speaker: Right, right.

Next Speaker: I have a big list of issue, pay attention.

Next Speaker: Or if there's any –

Next Speaker: And, and maybe it's a dual prong process you know. We **** to do both.

Next Speaker: Exactly, yeah, okay.

Next Speaker: Mm hmm.

Next Speaker: But it's, but thank you for, for clarifying that there's two –

Next Speaker: Yeah.

Next Speaker: – two arms to that.

Next Speaker: So whoever we end up you know inviting maybe this is, um, you know we, we can discuss like how expansive we wanna make it but there will be the quarterly meetings. They're already set for 16 so we don't really need to re, revise this slide, and I won't belabor this slide a little bit but just, um, you know I wanted you to let you guys know where you can find the state plan. It's, it's in your minutes, um, but to kinda summarize, um, you know the information is in there about sort of the goals of this, the Oregon program which was really focused on infrastructure and surveillance and prevention, with the first iteration and then we expanded to MDROs and C. Diff prevention, um, and also expanded to dialysis and skilled nurse. In '14 we sort of updated the plan to include, um, these HHS targets which you've seen manifest in the report, and so we're proposing this new final 2015 update to include this, these facility assessments. So we kinda see it as, um, you know we'd like to sort of structure these meetings a little bit more so that we would sort of honor each piece so you would come to this meeting and know what, you know you would hear an update on NHSN, some outbreak information and then an update on what you know Mary and Judy and team are seeing at the facility so that we're

incorporating information on process, what we're seeing in real time out in the field with kind of this delayed data that we have as well.

Next Speaker: You know I'm wondering this is just a little off topic –

Next Speaker: Mm hmm.

Next Speaker: – but for the Ebola, um, assessments, might be time to look at changing the name but keeping the same intent.

Next Speaker: Mm hmm.

Next Speaker: 'Cause Ebola's kinda been drifting off the path.

Next Speaker: Yeah. That's the name of the grant though.

Next Speaker: And it's not –

Next Speaker: I mean it's **** –

Next Speaker: – but we could call it something else you know.

Next Speaker: Well **** other significant pathogens.

Next Speaker: Yeah.

Next Speaker: Important pathogens.

Next Speaker: Yeah.

Next Speaker: **** –

Next Speaker: Highly –

Next Speaker: Highly infect – yeah.

Next Speaker: **** kind of important.

Next Speaker: Epidemiologically important infections.

Next Speaker: Yes.

Next Speaker: Um –

Next Speaker: It's already ****.

Next Speaker: – so I'm gonna go through this.

Next Speaker: ****.

Next Speaker: So kinda what I would like to do today is hear about, um, you know Mary's gonna kinda, or, or Judy will give us an update because you, Judy presented here in June and talked about this, we have this grant, what she's gonna do at the facilities but she's been out to all six of those facilities so she's gonna present what she found at those facilities, um, and then the plan was to have present even, uh, Mary has started but has, uh, you know is, her part of the grant was sort of to start after Judy's had completed so, um, I think we'll, she'll present her findings at the next meeting, and afterwards we were gonna sort of vote on this HAIAC expansion but, um, I think we should do that now. So do people have, I mean other concerns? I certainly will follow up and you know before we kind of come up with a final list of who's gonna be on HAIAC we'll send it out to the group. Um, but does anybody have any kinda concerns about the direction that this is going forward?

Next Speaker: I, I just wanted to make one comment which is I think it's fine to go in as, and get reports but I'm hoping that this committee with then take the information and make recommendations for actions –

Next Speaker: Mm hmm.

Next Speaker: Kinda next steps to again improve overall care here in Oregon.

Next Speaker: Yeah. That, that makes a lot of sense –

Next Speaker: Uh huh.

Next Speaker: – and we're, we'll try to work on structuring the meetings so we feel like you hear the information that you need to hear to make those recommendations and try to do that documented in a way that, that makes sense so I mean you know we're deciding as a, as a body of people have time to review the considerations so.

Next Speaker: I really, uh, like the idea of adding, um, an expert in sterilization and disinfection, um, because that is such a, uh, burning topic and, uh, burning need, uh, for, for some facilities that have, um, maybe some lack of expertise in that area and it's such a critical, uh, function. So I think that is an excellent addition.

Next Speaker: I would just caution about trying to commit to having too many new members because it can be difficult to keep the positions filled as we've seen –

Next Speaker: Yes.

Next Speaker: – even on our smaller committee.

Next Speaker: Yeah.

Next Speaker: So.

Next Speaker: Yes, it's true.

Next Speaker: Okay.

Next Speaker: Maybe they could be ad hoc?

Next Speaker: They will all have to be –

Next Speaker: They have to be.

Next Speaker: – ad hoc.

Next Speaker: They have to be ad hoc.

Next Speaker: Mm hmm.

Next Speaker: 'Cause we have to change –

Next Speaker: That's, that's the statute.

Next Speaker: – statute to get them.

Next Speaker: So.

Next Speaker: Which we'll, kind of we're doing where we'll go through the motions but I think it will be a very long time before the statute will be changed. Um, okay. So can we have a vote? Will, does anybody, uh –

Next Speaker: Motion approved.

Next Speaker: – yeah, I need a motion from a member.

Next Speaker: ****.

Next Speaker: Anybody like to second for the motion?

Next Speaker: I'll second the motion.

Next Speaker: Thank you Mary.

Next Speaker: Okay. Make motion is so approved. Um, okay –

Next Speaker: You might need a vote.

Next Speaker: Oh, we need a vote?

Next Speaker: Yeah, yeah.

Next Speaker: Okay. All right.

Next Speaker: Yeah, it's a motion to vote.

Next Speaker: **** well okay. Oh, all those in favor –

Next Speaker: Kate?

Next Speaker: You can vote.

Next Speaker: Oh.

Next Speaker: Kate, sorry.

Next Speaker: Yes?

Next Speaker: Kate, can you read the motion please just so that all of us are on the phone understand where you're at?

Next Speaker: It's a motion to vote on this, so there's been, uh, a proposal and a second.

Next Speaker: The, the motion is to create an infection control assessment and prevention committee. Am I right?

Next Speaker: Yes. Yes.

Next Speaker: Okay. Thank you.

Next Speaker: So we've had, it's been seconded. Okay, all those say aye raise your hand or on the phone.

Next Speaker: ****.

Next Speaker: No.

Next Speaker: Aye.

Next Speaker: Aye.

Next Speaker: Okay. Opposed? All right.

Next Speaker: Yay.

Next Speaker: Motion carried.

Next Speaker: Say ****.

Next Speaker: Unanimous.

Next Speaker: Unanimous, excellent. Right. All right so for those of you guys on the phone we're kinda, we're skipping ahead to Line No. 57 in your, your packet for those on the phone. For those in the room it'll be ****.

Next Speaker: I don't think so.

Next Speaker: Uh, so for those of you who I haven't met, um, I Judy Guzman. I'm, um, by training a pediatric infectious disease, uh, position and, um, I'm also a faculty at OHSU in the peds ID department. Um, but since, uh, April of this year, um, I've been working in a consultative role with the HAI program here to be the medical lead for the, um, Ebola assessment hospital consultations through the funding, um, the CDC funding that Kate, uh, described. So I was here at the HAIAC meeting in June, just to give a very brief overview of what we were gonna be doing all summer and fall and I'm here to give the 6-month follow up. So I'll be talking about, um, high-level findings from our assessment hospital consultations. So I'm gonna review our team's, um, findings from the assessment hospital compils, consultations and as I said in June, um, you know these are not considered any s, in, at any way a regulatory site visit. Um, really the goal of, um, of the visits and of this funding in general from the CDC is to, um, provide, um, resources to improve the infection prevention infrastructure in general and for this part of the goal, um, for the grant specific to Ebola preparedness. Um, so these were considered baseline visits of the six, um, self-identified Ebola assessment hospitals. There are no Ebola treatment centers, um, in Oregon, and, um, and then, uh, I'll be discussing some strategies to mitigate and identi, um, mitigate these gaps that we identify during these site visits and, um, and as mentioned as Mary had said, um, it would be great, um, if anyone here in the room or on the phone, if we discuss any gaps that our team identified, if you know of any other, um, experts or, um, resources that we could use to strengthen these gaps that we found for Oregon. Um, I'm not gonna go through the grant goals 'cause I went through those in June but basically, basically again it's just for us to go on site, to find these gaps and then to help the hospitals to strengthen those gaps. Um, the steering committee, um, um, are all here: Zints, myself, Mary Post, uh, Jen Buser and Kate, and then who's been doing the site visits. There was a group of, um, of five of us that, um, did the site visits for all six hospitals. So myself as the physician lead. Mary Post with the infection prevention expertise. Dan Cane is a senior industrial hygienist with, um, the State of Oregon, um, so looking at worker safety and safety in the workplace, same thing. Robert Nicola, uh, Rob is a microbiologist at Oregon State Public Health Lab, and then Jen, uh, was our state representative in terms of, um, medical, um, expertise. So our first site visit as you can see here on the next slide, um, I've all six participating hospitals, um, listed and the dates that we did the consultations. As I said in June, um, we were lucky enough that, um, uh, for our first and second site visits which were back to back, July 29th and July 30th, we actually had a CDC team come here. They led the first site visit at Providence Milwaukee Hospital, um, on July 29th

and then the following day we went to Legacy Good Samaritan in Northwest Portland and, um, our team, the Oregon consultation team, we led the site visit. Of course, um, still in very close collaboration and discussion with the CDC team, and then they moved on to, uh, do some training in Idaho and we moved on to Westside and went to Kaiser and then, uh, Saint Charles Community Hospital in Central Oregon. In September we went to Asante Ashland Community Hospital and then our last site visit in mid-October was then Samaritan Lebanon Community Hospital. So we have, um, completed all six, um, baseline assessments. So, um, what did we look at? The CDC, um, created a nice template, um, basically a checklist of, um, the different domains or categories, um, that we focused on to ensure that the healthcare facility could both safely and effectively provide care for a possible Ebola patient. So these are just the, um, the general, um, uh, domains as they call them or categories and, um, we, uh, structure of the day we started the mornings with introductions both from the public health side, um, and from the hospital side, usually healthcare administrators, uh, nursing and physician leaders, infection prevention, emergency management and laboratory personnel. Um, we also worked really hard to have the EMS partners and local health department partners join for at least part of the day. We tried to get them to come for the full day. Um, really one of the goals that I had since you know prior to this I was, um, the pediatric medical director for infection prevention at OHSU and my experience both with, my experience with Ebola preparedness back in 2014 and also with other epidemiologically significant pathogens when we're doing trai, uh, training and preparedness is, um, there's so many people involved with the common goal but nobody's really working together or even knows, can't even put a face to the name. So that was, um, one of our team's major goals is to kinda bring down those barriers and have emergency preparedness, the healthcare providers, the administrators, um, infection control, um, and public health and EMS all in the same room. So that seemed like a feat in itself but we actually were able to do it and it was very helpful. Um, we reviewed the 11 domains and then we would have a wrap-up session at the end of the day. So this is a snapshot of the, um, assessment tool that we used, um, from the CDC. This is specific for assessment hospitals, not for treatment hospitals. There is one for treatment hospitals available, um, through the CDC. It's much longer. It's 36 pages I think and on Version 18. This one was just about five pages and as you can see, um, uh, down at the bottom, um, of the slide on the, the left-hand column it had the domain listed and then all of kind of the sub categories or, um, the points within that domain that we had to assess, and some of it would be by observing, um, looking at the space where the patient would be or the laboratory or ER or it'd be through conversation with the, um, with the, um, with the team at the hospital. So we did, uh, facility infrastructure. On the next slide, um, a lot of elements for patient transportation both interfacility, so ground transportation, air transportation, EMS plans then intrafacility, from the point of entry of the hospital to their care area. The next element was laboratory so we looked to see what capability they had specific to Ebola PUI meaning what lab tests were they prepared to do safely and effectively, and then also to make sure that their staff was trained to be able to do it safely. Next we looked at staffing. Did they have enough trained staff to be able to provide, um, safe continuous care for at least 96 hours while they're ru, waiting for that rule in rule out Ebola PCR and preparing for transport if the patient was ruled in as having Ebola, and then of course training we looked at a lot in terms of are there staff trained and was there an appropriate number of staff trained for donning and doffing PPE, waste management, infection control practices and specimen transport. We then looked at PPE so we actually looked at the components of PPE or personal protective equipment at each hospital, what types of masks, gowns, gloves, aprons, booties, what have you, all different, and every

hospital had a different variation, um, of, um, of the PPE they had chosen based on preference of the healthcare providers or what they, you know what they could actually, um, get stock of. We also made sure that they had enough PPE to last for 4 to 5 days. Waste management, um, as with most hospitals across the country with Ebola preparedness the bed, bedside nurses were, um, the plans at most hospitals were that the nurses were gonna be tasked with doing more than what's their usual standard work, so not only patient care but waste management, cleaning up the environment, sometimes even doing the X-rays. More bedside laboratory work than usual so we would look at their waste management plan. If they had a vendor that was capable of managing and transporting, um, infectious substances and, um, or if they were gonna, um, sequester that, um, that, uh, contaminated waste what their plan was to make sure that they had, had trained on it. Worker safety was basically making sure that there was, uh, a safety program in place and that the healthcare providers actually had a voice to be able to say you know I'm worried about this part of the plan or this component of the PPE and that, um, that they, that they could, um, safely and openly share that. We also made sure that the hospitals had close collaboration with their local CD nurses and health departments because of course if the pashe, if the healthcare provider was exposed and the patient, or provided care to a pa, a person under investigation who ended up being confirmed with Ebola, then those healthcare providers would now need to be determined, um, as persons under monitoring. So we had to make sure that they had those types of plans in place, and then EVS again. Making sure people were trained in collect, correct cleaning and disinfection of the room and equipment, and lastly, um, clinical management. Make sure those who were taking care of the patient knew exactly what was gonna be expected in terms of clinical protocols and procedures. Um, operations coordination to make sure each hospital had a good emergency operation coordination plan both within their hospital, within their healthcare system and with the health, with the health departments, and then one thing that wasn't listed as an element, um, or a domain specifically but we made sure to talk about it all six hospitals is if they had a pediatric PUI plan or person under investigation plan and an obstret, obstetric plan. I'm also adding in here, um, some measures which may not be known to all six hospitals which, um, really we're just, uh, um, finalized by H, by HPP which is hospital preparedness programs, um, Ebola preparedness, um, so HPP got their own separate grants, uh, separate to this ELC grant for Ebola preparedness so this is more emergency management, EMS etc., and they actually have their own metrics also which are specific to infection prevention in the healthcare setting, um, and these measures they are going to have to report on also. Um, so, um, I, we didn't actually have these measures at the time that we did the six hospital assessment so this will be something that we'll following up on with the six hospitals. So in terms of, um, what we found in general I can say and I think everyone on my team would agree that there was really great rich excellent strong multi-disciplinary teams working together. We were really impressed by the administrative support we saw at all six hospitals. Um, we can tell it wasn't just you know the hospital administrator showing up for 1 day for our site visit and that was the first time they were hearing about, um, the, the plans. Um, they were really involved, um, in a lot of, you know the planning from the beginning. Um, overall the hospitals had excellent plans in place but the hospitals are you know kind of working in silos. We weren't seeing one hospital you know collaborating with another hospital in Oregon about what their plans were you know between one assessment hospital to the other, um, and that's one thing that we'd like to improve, um, in 2016, and, um, of course as expected it was really clear, um, to our team that any admish, in, inpatient admission of a person under investigation for Ebola would be extremely disruptive to any of the six hospitals and really affect, um, the ability to provide just general medical care to

their community. Um, specific findings that we found, um, we need to develop some more clarity on patient transports so if it was a high risk person under investigation or, uh, would that patient just immediately be transferred to Ebola treatment center, um, I've listed the three of them in, in Washington State, um, or if it was somebody who was positive, um, for Ebola and they needed to be transferred, who would arrange the transport, who's responsible for that at the hospital local, state and federal level. Um, so this was one of the things that we really needed to work on. Fortunately I just found out yesterday, um, from, uh, Melissa Powell here that in late January there is a, um, a meeting that will be set up to, um, to start that discussion at the regional level with Oregon, Washington and Idaho, so, um, and, um, and I'm going to be sending out an invitation or a communication to the six hospitals including yours, Sue, um, to identify, um, who from each hospital should be, um, you know who should, uh, either attend that meeting in person. It'll be here in Portland, um, or, um, by teleconference, um, to start understanding and making, um, plans for patient transport. Um, we really need to, to strengthen our pediatric PUI plan. Um, there are no, there is no written plan or written algorithms for a pediatric PUI. Of course the likelihood of a pediatric, um, person under investigation is extremely low, um, but we need to, um, you know I think, uh, Randall Children Hospital and Emmanuel has, um, said that they're, they've done some training with their pediatric staff or pediatric PUI but, um, you know they've said that they really feel like that needs to be strengthened and we need to identify, to determine what the threshold is for a pediatric patient to be, um, admitted to just go straight to a treatment center for their and for their rule out, um, or if they would stay here, um, while we wait for that test, and you know maybe that's determined on their risk of exposure. Um, another specific finding is, um, we really don't have a written or clear, um, ambulatory evaluation pan, plan for what we call a low risk PUI. So someone who's returning from West Africa who didn't have direct contact with someone with known Ebola, um, and develops a fever. Well usually those patients are gonna end, or those, those, um, those, uh, residents will end up having, uh, malaria. Um, two healthcare systems have successfully performed a PUI evaluation without admitting the patient in the Portland area. So because we, there's been some experience and it was successful, um, should we consider developing an ambulatory PUI evaluation plan for all six assessment hospitals or should we re, do a regionalized plan? Um, these are you know things that we kind of are, are considering after our assessments.

Next Speaker: Yes.

Next Speaker: Yeah.

Next Speaker: We did another one I can tell you about.

Next Speaker: Oh okay. So there's been three. Um, another finding we found and I think this was a perfect example of why it was so great to get all of the partners in the continuum of healthcare for these patients in one room or at least in one location for 1 day. Um, we found that, um, that some of our EMS partners had assumptions of what the hospital would do and the hospital had its assumptions of what EMS would do, so one example was, um, one of our EMS partners is planning on decontam, uh, their decontamination plan for their staff was, um, to use a bleach spray but that's actually not consistent with the current US federal OSHA regulations specific to Ebola. Um, uh, an EMS partner assumed the hospital would be responsible for the ambulance decontamination and the waste storage removal of all of their contaminated PPE once

they dropped the patient off at the hospital. That was news to the hospital. Very wide eyed, um, hospital staff when the, when we asked that question so you know who cleans up your rig and they said oh well that, that's the hospital's, um, responsibility. So there was one of those ah ha moments. Um, so, uh, we already have local health departments working with their local EMS partners to clarify these plans and review the OSHA regulation with them. Um, another specific finding we had was, um, uh, when we were at one of the hospitals they had mentioned oh we actually may get you know persons under monitoring who become ill from southwest Washington and, um, this was news to some people, um, here in Oregon State so we need to clarify the plan for southwest Washington State people under monitoring if they become sick. Um, who would be in charge of the transport etc. and then, um, what would be the transport plan if they become, um, if they become sick and need to go to a, um, a treatment center but they're her in Oregon. Um, we found that the lab capability varied among the hospitals in terms of what labs they're able to do and what labs that they are willing to do. Um, so, um, I am working with the Oregon State Public Health Lab to review kind of that, that, um, the variation of the hospitals and seeing if just asking the question if, um, OSPHL could provide influenza PCR and Ebola PCR testing, um, here for our assessment hospitals 'cause currently we do not do Ebola PCR testing here in Oregon at the state lab and, um, we do have influenza PCR testing but not specific to PUI.

Next Speaker: Yeah, and it would contaminate all the lab equipment so that's why hospital labs just won't do it.

Next Speaker: Exactly. Yeah, that's not something we can do point of care in the, in the, like a point of care quick test in the patient's room. It would have to be sent to Lab Central. Some other important specific findings for the non, uh, Portland area hospitals. Um, you know we know it would be disruptive for a PUI to be admitted to these hospitals but, um, we also realized that these, these hospitals outside of Portland have a large catchment area outside of their county, so for example, um, Saint Charles Redmond, they always, they were always aware of who was being monitored in their county in Deschutes County I think. Yeah. But there are other counties, I think several other counties that they get patients from but they didn't have a close or clear, um, line of communication with those county health departments to know if there were any people under monitoring who had just returned from Africa there. So that's actually one, um, one gap that we've already fixed. Um, for, um, for three, for actually for the three, um, um, non-Portland hospitals. Um, and then you know again it was very clear that it would greatly impact access to general healthcare. Um, for example, um, Redmond, um, Saint Charles, they, um, provide neurosurgical care to a huge catchment area all the way down to southern Oregon and they are really concerned that if they have a person admitted with even possible Ebola to their hospital, um, you know as the, as was the experience in Dallas and even in Emery and in New York, um, patients won't come to the hospital for any other healthcare. They're just too, too nervous and too scared and would that affect, um, the, uh, access to healthcare for that entire region? So in terms of those HPP metrics again I'm still kinda hashing out, um, where we are with those metrics. Three of them we're already, uh, meeting and so some of the other ones, um, I'll be following up with the hospitals, um, directly, um, A to let them know that these metrics exist and then B to see where we are with those but we have until next year or yeah, middle of 2016 I think on reporting those. Additional work, um, one thing that I, I was really happy and excited that we were able to do was after the APIC meeting, um, in October we invited all six

hospitals to have a networking event, um, afterwards so, um, we had, um, representatives for actually five of the six hospitals come together. It was a chance for the health department, um, both local and state to thank them for all of their week, um, because we know it's a lot of, a lot of work, um, and then people got to you know meet each other and talk about their experiences so far. We had everybody bring a set of their PPEs so everybody knew what everyone else was doing. Um, our Oregon consultation team, um, had a call with the CDC in, um, November to give them an update. Um, I've met actually twice now with the Tri County local health department to discuss priorities and goals for the Portland area. Um, and then our consultation team met, um, right before Thanksgiving to kind of relook at all of the reports that we generated for all six hospitals and kind of make assignments, um, for who's gonna be assigned to what in terms of these gaps that we've identified. Future work, we're planning, um, in January to start quarterly conference calls with all six assessment hospitals, um, A to report any updates and any federal guidelines, any changes from the last time we were all together, and then also we're gonna choose one, um, topic of interest, um, with hopefully a subject matter expert to discuss and then open discussion, so things like, um, the ethics of limiting healthcare for, um, an Ebola PUI and how you make those, you know how you have that discussion for your healthcare system is one example. The pediatric plan once we actually have a pediatric plan, we'll share that on the conference calls as well. Um, I'm already scheduling our on-site 6-month in-person hospital follows ups. Those will just be half day really looking at the report with each hospital and kinda seeing you know where, where, what has changed since we were here, um, in summer or fall of 2015, and then, um, I'll be giving quarterly updates, um, as Kate mentioned, um, both to the IKEP subcommittee and then also to this group. Any questions, comments or suggestions? Sorry I went over. Thanks.

Next Speaker: Interesting.

Next Speaker: Mm hmm. Thank you.

Next Speaker: Well thanks everybody. I know we're a little bit over but can we officially adjourn?

Next Speaker: Yes, um, if nobody has any questions or issues or comments we will adjourn. Thank you.