Healthcare-Associated Infections Advisory Committee
June 24, 2015

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Speaker: I don't know if everyone knows this, that, remember those, um, detailed, um, uh, survey protocols that they had for discharge planning for infection control and for **** improvements, um, the QIs program. Um, so they had them in place for about 2 years and we ended up doing several pilots on those. But they've now transitioned **** TMS ****, um, to, um, requiring those for all complaint investigations. So every complaint investigation that has to do with an infectious control, um, you know, allegation basically or a discharge planning allegation or a **** improvement, um, program is called swapping in, in TMS **** but it's quality assessment and performance improvement. Um, so, uh, so they're using those on when they go out to do that, they not only do their regular survey but they use that tool, you know, as part of that. That's **** and, um, you, what started out as **** just 'cause they keep refining it and revising it. ****, yeah, now it's ****, uh, less than 40 so it's ****. Yeah, it's a lot of boxes to fill out. It's a lot of work. So, um, but if anyone, you know, wants to see it or can't find it on the TMS web site, which I think it is **** available, um, that ****.

Next Speaker: Hi, sorry I'm late.

Next Speaker: Um, I'm Judy Guzman. I'm, uh, this is my first time at a Hyatt, um, meeting. I'm the new medical lead for the Ebola grant and, which is on the agenda so I'll get into that when we get to it on each of them.

Next Speaker: I'm Kate Ellingson and, um, I'll definitely be providing updates throughout the, the hour.

Next Speaker: I'm Barbara Wade and I'm the director of performance improvement. I'm working with Diana at the Hospital Association and I'm glad to be here.

Next Speaker: Diane Waldo, Hospital Association. **** executive director for the organization's Safety Commission. Um, we're pleased right now to be partnering with the Oregon Health Authority on work related to the **** grant ****. And, uh, Mary Post who can't be here today, she's also had ****, uh, the client's primary role and her helping support that work ****. Uh, in addition to that we do have some other grant work and we're racking up ****, uh, UTI prevention and ****, uh, ****. Um, we're racking up one **** of those two initiatives and then the HR, HR **** the national effort, Cohort 2 is what it's called, that ****. **** collection and work at those facilities ****. So that's what we have.

Next Speaker: Hi, Paul Cieslak. I'm medical director for communicable diseases here at the State Public Health Division.

Next Speaker: Paul, um, and how about the folks on the line?

Next Speaker: I'm Rachel Plotinsky from infectious disease at Saint Vincent.

Next Speaker: Thanks Rachel.

Next Speaker: I'm Kelli Coelho, I represent the Ambulatory Surgery Center.

Next Speaker: Thanks Kelli, calling us from Salem, I think.

Next Speaker: Eugene.

Next Speaker: Oh, Eugene, okay, um.

Next Speaker: This is ****, I'm a family doc representing Vicente.

Next Speaker: Anybody else on the line? Pat, are you there?

Next Speaker: Yes. I'm Pat Preston representing, uh, Industry at Lark Long-Term Care Facilities.

Next Speaker: Okay.

Next Speaker: I'm Dee Dee Vallier representing the consumer.

Next Speaker: Great. Thank you all for calling in. We actually have, um, quite a good group in attendance. Do you want to introduce yourself?

Next Speaker: Oh, I'm, I'm Vince –

Next Speaker: ****

Next Speaker: – Valdez. I manage the Healthcare Association infectious program here at Oregon Health Authority.

Next Speaker: Great. Okay. Well welcome everybody. The fir, the next, um, issue on the agenda is OAR updates. Um, and so for those of you who are **** committee OARs are our, uh, Oregon Administrative Rules that guide the, um, HAI mandatory reporting program. Um, Monica Sampare who does these updates usually is out sick today. Um, there aren't, uh, very many updates in terms of, uh, new legal mandates, just that, uh, we just wanted to remind everybody that starting in the 15-16, um, flu season we will, uh, or will be asking dialysis facilities to participate so the, for the first in healthcare influenza vaccination. So that will be, this will be the first season that they have been reporting that data. Dialysis facilities are currently reporting, uh, bloodstream infection events to us through NHSI, uh, and that everything's on track for that to happen. Um, so I think we're a little bit ahead of schedule which

is, which is good because I think we've got a lot to talk about today. So I'm gonna actually start, uh, by giving an update on where we are with these annual reports. Okay, so yeah, so for folks on the phone, um, we're just kind of gonna start moving through the presentation called proposed update to Oregon State's HAI plan. Oh, actually no, we're not. This is the wrong presentation, presentation. We're gonna start with the 2014 HAI annual report June update. So this is kind of the, the summertime update. Um, I'm sure you're all feeling very relaxed right now and it's good to go to your happy place before you start to try to wrap your head around all of this data and everything that we have to report. Um, so I think that although there have been, um, there are a lot of infections out there that we're, that we need to report for a lot of facilities, I think we're beginning to sort of get a handle on where we want to go with the report. Um, as recently as June 15 CDC and CSTE which is the Council of State and Territorial Epidemiologists has come up with some recommendations for standardizing these reports. So most states in the U.S. put out some sort of HAI report. And so CDC and CSTE, uh, really are, are looking to provide some guidance for standardizing it 'cause they're in all different types of formats. Um, so I'll share with you some of their key recommendations and, and discuss kind of how those dovetail with what, what we've decided **** and how they don't. Um, we'll review kind of a new report, report, um, format and then hopefully I can get some feedback from you guys on some formats that we're experimenting with. So, uh, this next slide, this is just a review of the different types of infections that are reportable from the different types of facilities. So these are all, um, infections reportable under Oregon Administrative Ru, Rule 353018. Um, this, uh, rule is sort of the first infections that were mandated in 2009, were **** in intensive care units and su, subsequently, um, just in expanding those infections. So hospitals in 2014 are required to report central line-associated bloodstream infections, um, in ICUs, uh, catheter-associated UTIs in ICUs only, uh, MRSA-backed uremia, lab I.D. events and that is new in 2014 as is ****, um, C. Diff. events which, uh, began a couple of years ago and then six different surgical site infections. So that's a total of ten HAIs that our hospitals are required to report in addition to healthcare worker implemented vaccinations. Dialysis facilities are required to report bloodstream infections and then, which is sort of a, a very generic category. And then there's a d, uh, a more specific category for access-related bloodstream infections. Currently Ambulatory Surgical Center reports only influenza vaccinations. This is actually the first year that they're getting up and running on, um, NHSN. So thank you Kelli Coelho for helping kind of, uh, get that community on board, um, ****. Our, our influenza vaccination report is coming out a little bit later this year because their, their deadlines have been extended 'cause they're reporting to NHSN. And our skilled nursing facilities, uh, have been reporting for a couple of years now and they are still using a non-NHSN platform to report. And so all of these infections need to be report **** in aggregate for all of Oregon and then also, uh, at facility-specific level. So just to kind of remind you where we are with this timeline the next flag, um, we, uh, we're still moving along. We're, we're, you don't have to read all of the fine print on this. But we've sort of broken timeline into two timelines. On top is sort of report creation and publication. On the bottom is data. And so as you can see since our last meeting in late March we've really been kind of working on that bottom part of the timeline which involves, um, downloading data that facilities have submitted, going back and forth and then making sure to correct. Um, we have on here, we were very ambitious that we were gonna threaten fines if we didn't have complete data by a certain date which, uh, it didn't end up happening, not because we were stopping but because there were a lot of things that were, you know, sort of out of the control of hospitals that sort of, uh, hindered them from getting it in on time. So anyway, we're, we're moving towards, um, this

final **** of the data set which we have, we dated here for this Friday. Um, so I think we're, we're getting close to that point where we're feeling confident with the quality of the data that's been submitted. So the last few months we've, um, this whole process of confirming the data really involved, um, each facility reviewing the data that, that we can see. So all the facilities report data to NHSN then we at OHA ask them to confer right so that we can view their data. I know Diane Waldo is very familiar with this as well with some of work. Um, and then we need to kind of confirm with the facilities hey, this is what we see, this is what we're gonna publically report and then they need to verify. So base, at the most basic level we make sure that those numbers match. Um, we kind of check their exemption status so some hospitals don't have to report if they have fewer than ****, they do fewer than 20, uh, surgical procedures **** the reportable procedures, etcetera. Uh, we look for missing data so if I see that there's only 9 of 12 months reported we, I tell them, you know, where is March and, um, go back and forth with that. Um, we're, we flag surgical procedures that look a little bit fishy. So, um, NHSN actually won't calculate metrics like a, like an SIR for any procedure that is, uh, they, they say longer than, it meets their IQR five which is basically five times the interportile wage of the, the length of a typical surgical procedure. So NHSN, CDC has sort of compile all the data for the reportable infections, a defining **** point. So basically any procedure that meets that cut point I point out the visibility and then they, most of the time they go back and check it. Maybe there is a long procedure, there have been a few typos, uh, so it didn't get resolved. Um, non-primary closure status was a big one this year. There were a lot of hospitals reporting infections that really, um, should be primary closures but were kind of **** to non-primary closures so that's something we, we address and **** status. Um, so we basically had, uh, for hospitals and dialysis facilities we basically said, you know, we wanted all their data correct by last Friday but we really meant this Friday from our standpoint.

Next Speaker: ****

Next Speaker: Could, could you give any more details on how the primary collection status has ****, with the initial report looking like it wasn't closed primarily but it turned out to be or what, what?

Next Speaker: Yeah, exactly. And actually, um, yeah. So I'll, uh, I'll talk about that a little more. 'Cause that, that was something we discovered this year as a, was, uh, probably a problem with the way that facilities are importing their data from, um, they're basically importing data for a system like Epic into NHSN. Because surgical procedures the hospitals need to give us a alignments of every surgical procedure that fall, that's reportable. That's a lot of information so IPs at big hospitals just import it. And for whatever reason the import function was like defaulting to non-primary closure. So while the, in some cases there were like colon surgeries that weren't primary closures and they were legitimate since, you know, there were a lot of **** and hip replacements, things that you wouldn't think of as being left open. Um, and so that actually happens that we had a lot of those. Um, I think like Legacy Emmanuel had to switch 40 from like non-primary to primary. So that's something I'm, you know, I'm gonna give that feedback back to CDC. I'm sure they've heard it before but I, I assume like a lot of things that'll get kind of ironed out, um, as CDC works with the vendors on, on those imports. Um, so, uh, it kind of, you know, this, I think this whole process of, of validating from any data with hospitals is, is kind of stressful to the IPs. I mean this is, this is data that's gonna be reported publically.

And, um, you know, when I sent out the data there was actually, um, a problem with the NHSN group user function so the data didn't look the same and this was kind of, this was a little bit stressful. Um, but we did, you know, I think we, we got to the bottom of a lot of things. I think it was, um, I built a lot of relationships with the IPs. I think in a way it was really, um, it was good. And we, we discovered things about the, the NHSN issue with the non-primary closure, things that were kind of looking funny. So I think that the process is a little bit painful but it also I think was, was very valuable in terms of validating our data. And if OHA didn't have a self-reporting law then all the data that TMS would get would essentially be, you know, unvalidated or these checks wouldn't be in place. So, um, so that's sort of a bright spot. Um, one, another issue **** and, um, MR **** are new this year so some of the people, uh, you know, some of the hospitals could have experience reporting these and so that was, we had to work through a lot of definitions. Critical access hospitals, um, are sort of an interesting group because if they have fewer than 25 beds they're not subject to the TMS paper-reporting incentives. And so, um, so they're not already submitting data anyway that we're seeing. They are only submitting this for us here at OHA. And so I think a lot of times we run into, you know, the, there's staff turnover, they haven't enrolled in NHSN, um, they need a lot of help with the definitions, um, how do I submit a monthly reporting and a lot of that stuff. Um, and so I'm must, uh, you know, the theme is to not to give you, you know, so many details about what I've been doing the last few months but, but mainly just like as a committee when we add new infections every time this is, it is, uh, it's a burden on facilities particularly at the critical access hospitals who, who aren't reporting anyway for TMS. Um, I haven't even filed my emails in the last couple weeks but I think like I kind of, I looked and I, I think I have, it's about seven email exchanges with each hospital so there's a lot of individualized attention that goes into this. And currently we have about 57 of the new ones, uh, confirmed for hospitals that sent emails and the data ****. On the bright side, dialysis facilities have been extremely easy to deal with except for tracking down the person who we need to get to confirm the data. But Diane Roy has been wonderful with that so thank you Diane. Um, I, you know, I expected us to have a lot of, uh, issues with dialysis facilities or just because, you know, this is relatively new, um, uh, metrics that they're reporting. But many of the large dialysis organizations have one central data person who is, uh, and they are extremely motivated to get this data right because, uh, they are subject to TMS paper reporting incentives and they basically are completely funded by TMS because of the nature of what they do. And so, um, their data was perfect. Um, nobody had, the only, you know, there were some clarifications about where to look and which cell the number was supposed to be in but, um, 61 of 61 dialysis facilities have confirmed that the data they submitted is what we see. So that was kind of a nice refreshing contrast. So just to return a little bit to the, um, we're on the next slide for those on the phone looking at the report format. Um, so, uh, this, we're gonna kind of review what this committee has collectively decided in terms of the direction of the report. But I just wanted to kind of remind people of how we reported out data last year. And so the primary metric we used was the standardized inspection ratio. So the ratio of observed infections to the number expected based on national baselines. And so here you can see this is, uh, for knee pros, prosthesis, uh, surgical site infections, um, this is how we refer the data. Number observed expected. We reported the SIR and then had to, you know, for our legend we would say whether that SIR was, uh, we, you know, represented significantly fewer infections than the national average, whether it represented fewer infections but it wasn't statistically significant, you know, whether it represented more infections but not specifically significant or whether it represented more infections and was specifically **** the ****. Um, and then Diane Applegate, Ben

Applegate who was in my position last year was really responding to a lot of, um, uh, you know, a lot of feedback about wanting to see, uh, the SIR in different ways and wanting to do trends. So, um, on a separate page for Kapro there sort of we looked at trends over the year and so this is how she **** year. Um, also, she also responded to, um, requests to see the SIRs sorted by, uh, you know, from high to low and so you can see that. This is another page for Kapro only. And then, you know, finally there was sort, there was an appendix, um, that looked at these SIRs with a competent ****. Um, and so, you know, at the end of the day I think the report last year was really, uh, I mean it was really comprehensive in terms of how you looked at this SIR. Um, but I think that the struggle is how do we get this information into a more concise format that's sort of, you know, easier for people to, to read through. Um, so again, so, so with the 2013 annual report, again that's the report that was published last summer so it's about, um, 6 or 7 months away in getting the data together. Um, I think the positive feedback and what I thought of as were positive, uh, it was comprehensive, it was very well organized. Diana added a lot of new graphics in response to, to what, uh, stakeholders had asked for. And some of the critiques were that the, the report was too long, that it was not consumer friendly and that it really didn't offer kind of a bottom line, you know, what's the message, where do we go with HAIs from here. And so that's what, you know, the committee had been sort of trying to sort through in the last couple meetings. And so just to summarize the recommendations that, that you all have given us, um, and that, you know, we, we agree with is that we need to create a tight executive summary, somewhere where you can look at all of the infections together in Oregon and, and be able to sort of, uh, see, you know, the relative burden of one versus the other. Um, uh, a lot of you asked for, you know, presentation of the data in both a very simple way and then also a complex way so having, you know, different ways presented. Um, people were concerned that if we went too simple that we should assure that somewhere, somehow somebody can get to that granular data if they want it. So we've been thinking about ways that we can get some of this data online embedded in our maps, etcetera. Um, some of you requested aggregate data by hospital size for benchmarking. So if you're a medium size hospital you can look at what the SIR is for other medium size hospitals instead of just like overall. Um, some of you wanted to con, to consider publishing rates in addition to SIRs. And then there was a recommend, uh, a great recommendation at the last meeting that we seek consumer feedback from patient hospital boards. Um, and so I think, although I wish we could do that before we get this report out, I think what we're gonna try to do is, is get a consumer report out there and then make sure that we, uh, we get feedback from before, after, after it comes out, incorporate that into next year's report. Um, so I mentioned that as late as, you know, that, that a couple weeks ago the FCE and CDE, CDC put together this, um, report standardization tool kit. Um, and so this, uh, group is called the, uh, HAI data analysis and presentation standardization support group called, uh, **** so ****. And they've actually been great about reaching out to us I think in terms of, they, they've asked about our perspective as a state that has a lot of hospitals, uh, smaller hospitals that don't always reach statistical significance and so, um, we've had some back and forth with them over the last couple years. So I, I just kind of pulled out some key recommendations. This was like a 90-page report. They have a lot of recommended language for consumers versus the technical, um, consumer of this report. Um, so they recommended, uh, creating two reports which a few states have done in the past and has been, uh, well received. So a consumer friendly report **** a technical provider report. Um, they recommended in this report not to publish rates for SSI, C. Diff. for MRSA just because currently those SIRs which rely on that, you know, expected number. Uh, they incorporate a lot of risk adjustment, uh, for example, for CBI, the

type of testing that's sent to the hospitals, CPR. Um, you know, they, they, they risk adjust differently for, um, hospitals that have, you know, large admission ****. So I think they, they're sort of discouraging us for doing that, from doing that. It doesn't mean that we can't but that's the consensus from this group. Um, they said okay to report waste, uh, for CLABSI or CAUTI, uh, but also recommend stratifying by location, um, because that's the primary risk adjuster and that SIR is, is what type of **** unit ****.

Next Speaker: So when –

Next Speaker: ****

Next Speaker: – you say **** location you mean by patient care area within the hospital?

Next Speaker: Exactly, yeah, patient care area within the hospital. So, you know, burn unit, uh, ****.

Next Speaker: That's sort of ****.

Next Speaker: Exactly, yeah, mm hmm, yeah. Um, and they u, they recommend using the better, same or worse language for SIR interpretation in the consumer report. So I'm, when we look at a couple of examples that I built based on some of our recommendations I, I would be interested in what you guys, you guys think about this. Um, and they also recommended highlighting hospitals with zero infections. So this is, this would be a way to recognize some of our small hospitals, um you know, that, that may not reach statistical significance in terms of an SIR. Sometimes an SIR can't even be calculated. If the expected number is less than one we can't even calculate an SIR so the CDC recommends against it. So, um so in those cases you know, we could give them, um, some sort of re, like a symbol of recognition. Like in Hawaii they have like a, a high **** or something they give to the hospitals with zero infections. So I don't know, maybe we want to **** first and then **** something like that. Um, so okay, so based on all of these we, we sort of, we have a plan, we're moving forward. Um, you know, now that we're, our data is nearly finalized, uh, we've been working to come up with this executive summary that, that ****, um, you know, a lot of people have been asking for. So this is kind of giving us an overall picture of Oregon where the successes were and priorities. We, um, got some input from our graphic designers up in publications at OHA and we have a couple of people helping us out. Um, and really the goal of this executive summary is, um, you know, it, it's gonna appear in both consumer and, uh, provider reports. We also wanted to do something policy makers, um, you know, can look at it and understand. Um, and so we'll kind of, maybe I'll show you the two-page summary that we started to mock up for hospital reported HAIs. We'll also do a summary page for dialysis and one for influenza vaccinations so that people who may not have time to read through the whole report can just look at the pages and hopefully, uh, understand what's going on. Um, and then we're gonna move forward with the two-report model so the consumer report will look at some tables that we've mocked up. Um, the, the consumer report is gonna be simple use, simpler language, um, have background information in there about what these HAIs are, some, um, uh, some information about what consumers can do, what patients can do to protect themselves and really, you know, guided interpretation. So instead of providing an SIR we'll say something like better than the national experience. And, uh, and just really kind of leading them

straight to the interpretation instead of just putting the data out there and letting them kind of fend for themselves. The provider report will be, uh, a bit different. It'll be, you know, technical, assumes background in terms of knowing what an SIR is, knowing what these infections are and, um, and we would just put more data out in front of them because, uh, they could, they could use it. Uh, data that might not be relevant to a consumer.

Next Speaker: So **** what's the timeline you have for the report?

Next Speaker: We, our goal is to get this out by, uh, sometime between, well July 31 and August 31 ****. So yeah.

Next Speaker: Somewhere in August.

Next Speaker: Uh, somewhere in August, yeah, yeah. I'm only looking at this 'cause we had initially said July 31 **** but.

Next Speaker: I mean every year we try to actually rush it out and, and, um, meet the, the statutory guidelines for this but I think this year we decided to, to make sure we have what we want and, um, put that out. It might be a little bit later than we had in the past but I think it's gonna be a good report. I don't know if you ****.

Next Speaker: And I, I always like to remind Vince that CDC is, like CDC's report for 2014 won't come out until January '16.

Next Speaker: But yeah, and that's the thing, I mean in the past I've really like been stressed about that and tryin' to make sure we get that out and I just, I think it's, we really need to make sure that the report is good, that it's meeting the real needs and what not. I think that's the most important ****. I don't know, Paul, it looks like you might want to say somethin' ****.

Next Speaker: What I wanted just put from –

Next Speaker: Yeah.

Next Speaker: – so **** by the Public Health Division what's more important to use **** or, uh, you know, the, uh, **** report ****.

Next Speaker: The quality of the report is definitely, you know, a lot of people know, I guess people are kind of expecting it now any time and so I get questioned.

Next Speaker: Yeah.

Next Speaker: And so if I can just give 'em a ballpark and just say, you know, we're gonna, there, there's two reports comin' out, this is why it's gonna be a little bit later in August, don't worry.

Next Speaker: **** I agree. **** is we get a lot of questions about it.

Next Speaker: Okay.

Next Speaker: And, yeah, ****. For some reason **** a lot of interest in this report as well as **** they call me and I'm like I'll let you talk to Vince.

Next Speaker: Yeah.

Next Speaker: ****, you know, so.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: It's just good to know when it's coming out.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Any, um, comments from people on the phone about the, the report timeline and thoughts about prioritizing, you know, timeliness over pretty format, things like that. I feel like I'm ****.

Next Speaker: No comment.

Next Speaker: Dee Dee, from the consumer perspective is this, is this even useful if it's, you know, 8 months after the end of the year? We may have lost Dee Dee. We're so untimely that we lost her.

Next Speaker: Yeah.

Next Speaker: Okay. Um, okay, so this, um, you guys have a copy of this, like a full-page color copy in your packet, um, that we can go over. This is an example of, this is a total draft although the data in it are, um, they are preliminary. I mean this is based on 2014 data but as you saw we, we're not totally complete, we're still missing data from a couple of hospitals. Um, the red markings are sort of intentional 'cause we, we don't want this distributed, um, 'cause it's, 'cause it's not final. Um, and we've been kind of, we're in the process of, of, uh, providing comments on this. So, um, you know, our, we took this kind of issue, the, the patient's shadow approach from, the CDC has kind of a similar, uh, presentation format that they've used in the past and that was sort of vetted by the consumers group just reminding people that this is, is about the patient. Um, and so let me just read through the text at the top and then we'll, maybe we can pick through it as a group. Let me know if this even makes sense. Um, so Healthcare associated infections are painful, costly and potentially deadly infections that patients require, acquire at healthcare facilities. The Oregon Health Authority seeks to eliminate HAIs and mandates hospitals to report ten types of HAIs. This page shows the number of HAIs reported in Oregon in 2014. The arrows and percentages show how this number compares to the national baseline data collected

by the CDC. The green checkbox indicates that in 2014 Oregon met national targets for HAI reductions set by experts at the U.S. Department of Health and Human Services. The red X indicates that Oregon did not meet HHS reduction targets set in, uh, in 2014. And so I guess first of all I'd like to ask people on this committee if, um, you know, are you, are you aware of the HHS reduction targets that were set by the HHS working group, um?

Next Speaker: I think we actually did talk about the HHS targets at –

Next Speaker: Yeah.

Next Speaker: – at our, a previous, uh, HAI meeting a long time ago. 'Cause I think it's in our –

Next Speaker: It's in our plan.

Next Speaker: – yeah. Um, but people may not remember those specifically. And we also have a lot of new people.

Next Speaker: Okay. Well so I mean so this, this is good because maybe we need a, a little bit more of an explanation of what that means in this, in this front piece. And the idea is that you know, this, this SIR compares the number of ob, observed infections in 2014. So what would be expected based on a baseline that was collected in 2006 to 2008 or in 2009 for some infections? And so it really is kind of like if we were to just look at our SIRs it would look like Oregon was doing great because we're below one, you know I mean we're, we're doing better than that national baseline experience. But what does that mean in terms of 2014? You know, HHS basically said by 2013 we want to see a 50 percent reduction in CLABSIs, 25 percent reduction in SSIs and CAUTIs. We want to see a 30 percent reduction in C. Diff. infections. And so, um, I think a, you know, some of us in the HAI program thought well this is a little, this is kind of more meaningful. Why don't we actually see if as a state we've reached those targets? So it's, we'll report the SIR and say where we are relative to these national baselines. But, um, it seems that in 2014 we should be, we should be holding ourselves **** the standards of production. Um, so that's what the, that's why we kind of added the did you need it did you not to these infectious.

Next Speaker: So would something like this be in the consumer report? Say so for example, to me this could be confusing. If you look C. Diff. and then you look at colon surgery, you got nice green arrows down meaning better than the national baseline. But then you've got this, you know, red X here so what is **** and as a consumer would I understand that? I mean gee, we're making progress but not enough progress. I mean that would be my takeaway, right?

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: I think that, I mean that is effective the takeaway. Like, you know, we have achieved significant reductions as compared to the national baseline. But as a state we haven't met the 2013 reduction target. We haven't reduced by 30 percent C. Diff. ****.

Next Speaker: So, so I guess those HHS targets would be important to show somewhere.

Next Speaker: Okay.

Next Speaker: So what, what they are.

Next Speaker: Okay.

Next Speaker: Yeah, I complete –

Next Speaker: ****

Next Speaker: – but thanks for mentionin' that 'cause, you know, I agree, when I'm looking at this –

Next Speaker: Yeah, I agree.

Next Speaker: – tryin' to put myself in this consumer frame –

Next Speaker: Right.

Next Speaker: – ****.

Next Speaker: ****

Next Speaker: And if we, if we could some, uh, somehow summarize those two –

Next Speaker: Yeah.

Next Speaker: – and I don't know where ****.

Next Speaker: **** understood but **** so what ****.

Next Speaker: Yeah.

Next Speaker: So are we yellow? So what's that ****?

Next Speaker: Yeah.

Next Speaker: But yeah.

Next Speaker: We can have a yellow thing next to it. If it's, we come up with some kind of –

Next Speaker: Yeah.

Next Speaker: – if you distance this and, you know, ****.

Next Speaker: Well so if you flip over the page this is, I mean and again, this is sort of drafting this out trying to figure out how to kind of, uh, get the information in here without it being overwhelming. Like we're kind of considering the first page we have **** to work on this, how the first page to be kind of just an overall snapshot, um, and the second page has the sort of, uh, so you, you can actually by HAI type, uh, you know, what the national baseline was and then what the HHS reduction target was. So, for example, CLABSI the reduction target was 50 percent. So to meet it we would need an SIR of .5. Our SIR was .3 so we, we did meet it. Um, and so the, this second page is sort of an opportunity to fit a little bit more context in to the numbers reported on this first page. So not all hospitals report every infection. It was even suggested also being adding some kind of timeline.

Next Speaker: One possible suggestion might be **** is to leave it on the table, **** table –

Next Speaker: Okay.

Next Speaker: – that targets for the, yeah reduction targets, but take it off this page.

Next Speaker: Okay.

Next Speaker: So it's like –

Next Speaker: Keep the page ****.

Next Speaker: – look at the Oregon experience but now what does that really mean? Now look at the table and you get all this other, yeah.

Next Speaker: I, I completely agree.

Next Speaker: Yeah.

Next Speaker: I think it's way less confusing here now that I'm ****.

Next Speaker: On the snapshot page I don't know if you need to, I'm assuming like the 35 CLABSI, those are the raw numbers.

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: Yeah, those are the raw numbers.

Next Speaker: Yeah.

Next Speaker: So that was another thing I wanted to ask you guys, what you think about having that. We've never done that before, um, kind of totaled the number of infections from last year.

Next Speaker: I, I don't like the color or –

Next Speaker: I don't either.

Next Speaker: – or how it's, like where it's placed.

Next Speaker: Yeah.

Next Speaker: I think if you had it may be on the right in a different color and like a different font, you know.

Next Speaker: I think it could be the same color, it can be orange and it could say 35 CLABSI. I think that's clear what the 35 means then. 'Cause when I first la, looked at it I thought it was a reference number to something else.

Next Speaker: Yeah, I mean this is only 'cause this is like, these are Adobe Acrobat –

Next Speaker: Yeah.

Next Speaker: – and, uh, so I mean yeah, we, uh, it's definitely not gonna look like that. But I mean yeah, so we, it would be shifted over in the same color. It would, it would flow with the, with the design. It's just we just sort of added this after we kind of we working with publications we decided, you know, what would it look like to have numbers on there. I mainly just wanted to see like conceptually do we like the raw numbers or I think we would not, you know. But yeah, it looks weird. And also the SSIs won't be in red boxes and all that, just, you know.

Next Speaker: I like showing the numbers somewhere.

Next Speaker: Okay.

Next Speaker: Yeah, I think showing the number is great. I ***** I'll just show my hand. We looked at that page, and to be honest with you, for some reason I didn't even notice ****. Does that make sense?

Next Speaker: Yeah.

Next Speaker: For some reason they just feel like they, they ****. **** but they didn't mean anything to me **** somehow with the formatting or whatever, and I feel like they ****.

Next Speaker: Yeah, I think it's all about formatting.

Next Speaker: Yeah, ****, uh, formatting ****.

Next Speaker: So maybe the numbers in the table too?

Next Speaker: Yeah.

Next Speaker: And just, and so keep the front page literally just kind of the SIR.

Next Speaker: ****, yeah.

Next Speaker: Just make it super simple. Okay. Um, ****.

Next Speaker: I think, uh, one other thing, when I first glanced at this, because there's the green like the CLABSI, for example –

Next Speaker: Mm hmm.

Next Speaker: – the, the arrow going down and then 70 percent, um –

Next Speaker: Yeah.

Next Speaker: – I think somebody could easily read that as a 70 percent reduction compared to the 13.

Next Speaker: Right, right.

Next Speaker: Okay.

Next Speaker: ****, yes.

Next Speaker: Um, um, this is, um, yeah, I'm glad to hear it. This is, this is really important because the way that this is kind of initially written was we didn't have the, the HHS stuff. The HHS stuff was added later.

Next Speaker: Mm hmm.

Next Speaker: And we basically said 70 percent and then it said reduction compared to national baseline. But our, our publications people said that's just too much repeated information on every line.

Next Speaker: Mm hmm.

Next Speaker: But I think that if we get rid of some of the other stuff, the numbers and the HHS stuff, we can add that, that back in. So you would read it and it would say 70 percent reduction compared to national baseline.

Next Speaker: Yeah.

Next Speaker: And then that's real clear. So, you know, yeah, 'cause otherwise you're relying on people that toggle back to the –

Next Speaker: Right.

Next Speaker: – to the legend.

Next Speaker: So I mean I guess I just wanted to get back to, so what should it look, should it be yellow? Like if it's one of the, the HHS's is red and the other one is green? Is that, do we call that a yellow? Or like what's, what is that?

Next Speaker: So how would you display that then? What, say again?

Next Speaker: Um, I mean I don't know if I have a fully formed idea. I think I was kind of goin' off what we were talkin' about just now.

Next Speaker: Yeah.

Next Speaker: Just, um –

Next Speaker: Yeah, we have a green, yellow and a red. Green is we're better than national baseline and we've met the HHS reduction ****.

Next Speaker: Yeah.

Next Speaker: Yellow is one or the other.

Next Speaker: One or the other, yeah.

Next Speaker: And red is we haven't, we're below –

Next Speaker: Yeah.

Next Speaker: – we're worse than the average and we haven't met baseline.

Next Speaker: So, yeah –

Next Speaker: **** are you on table ****?

Next Speaker: Yeah.

Next Speaker: Oh.

Next Speaker: Well I was on the front page actually.

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: Yeah, I think there's the, the arrow –

Next Speaker: Yeah.

Next Speaker: – the percentage and the checkmark are X's.

Next Speaker: It's a lot.

Next Speaker: It's a lot of information that's not very quick to comprehend.

Next Speaker: Right.

Next Speaker: And it could be miscomprehended.

Next Speaker: Should it just be a dot that's like a color?

Next Speaker: That could be because the percentages are on the other side.

Next Speaker: So if they're both red ****.

Next Speaker: I mean if a true snapshot is are we doing good, okay.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: It's not ****, yeah.

Next Speaker: Yeah.

Next Speaker: So there shouldn't even be a percentage on that.

Next Speaker: Make it –

Next Speaker: So maybe it should just be –

Next Speaker: – the green dot, red –

Next Speaker: – green, red or, or yellow.

Next Speaker: So it's super simple. Not even like specifically, I mean just, yeah.

Next Speaker: 'Cause that'll be on here.

Next Speaker: Yeah, 'cause it's all on here.

Next Speaker: I don't know.

Next Speaker: Well I mean I think that actually it's sort of in the spirit of the, the way that it was put together is that this front page is like, it's, it's graphic and it's simple.

Next Speaker: Mm hmm.

Next Speaker: Which is not now but, but that's the intention. And then this page is like okay, let's break it down. What does it mean? Why, okay, so if this yellow means HHS, or why, or that's why it's ****.

Next Speaker: So what it, uh, sorry, for what, so what is CAUTI then? 'Cause CAUTI is red and, and gray.

Next Speaker: Well I mean so, uh, you, that's –

Next Speaker: Is that red?

Next Speaker: – it's worse than the national experience but not statistically.

Next Speaker: Is that the red or is it?

Next Speaker: I think it's probably red.

Next Speaker: Mm hmm.

Next Speaker: Okay.

Next Speaker: Red with the gray for all of that ****.

Next Speaker: So we are really in the weeds now, aren't we?

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Sorry, I didn't mean this.

Next Speaker: So just in comment, we recently refreshed out web site, uh, a, around some quality data. And we modeled after two other states that did good work. And, uh, kind of the best practice right now is don't just rely on colors because you've got people –

Next Speaker: Right.

Next Speaker: – who are color blind and they're not gonna –

Next Speaker: ****

Next Speaker: – they're not gonna understand it. But if usin' color you use some verbiage with it too to help them analyze what they're seeing. So if it's green and so some text to say better than the national.

Next Speaker: Gray better.

Next Speaker: Better, you know, uh –

Next Speaker: Yeah, better.

Next Speaker: – um, you know, above average, average or below average or something like that. I mean we, we, we have done that with some, some, uh, data I'm sure. But just to be really careful about relying just on one –

Next Speaker: Okay.

Next Speaker: – **** for this.

Next Speaker: Yeah.

Next Speaker: Yeah, well, no, go ahead.

Next Speaker: ****, I'm thinkin' that it's the two data on here that I most want to see that is a personal preference. So, um, but, but I want to see the number of infections there are and I want to see whether we've got a checker in that. And I guess I'm most interested in where we are in comparison to this, you know, this baseline. It just doesn't speak to me, uh.

Next Speaker: So it could be just a check, an X or, and then it be colored red or green and/or yellow would be, I don't know what that's, what that, what is that, what?

Next Speaker: Well there would be no yellow at that point ****.

Next Speaker: Yeah.

Next Speaker: To be back on the ****.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: No, that's on ****.

Next Speaker: Yeah.

Next Speaker: You're not into it?

Next Speaker: Mm mmm.

Next Speaker: Okay.

Next Speaker: Look at the body.

Next Speaker: I know ****.

Next Speaker: Well, well, welcome to this cage.

Next Speaker: ****

Next Speaker: I'm not **** either but this is sort of like a –

Next Speaker: Uh, that's pretty funny.

Next Speaker: – but it's just **** something like ****.

Next Speaker: They are using it, they are.

Next Speaker: I would like kind of their **** format.

Next Speaker: That's their –

Next Speaker: This is their format.

Next Speaker: – their format.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Just getting ****.

Next Speaker: Yeah.

Next Speaker: I am ****.

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: Thanks for saying what everybody's thinking. Like wow, that's a lot of focus on that part of the body.

Next Speaker: I wish Monica were here because I asked Monica, I said Monica –

Next Speaker: Can you ****?

Next Speaker: – I'm thinking if anyone would give me an honest opinion it would be her.

Next Speaker: I swear.

Next Speaker: She'd ****.

Next Speaker: ****

Next Speaker: Yeah, and she is, **** and then ****.

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: People, come on.

Next Speaker: Anyway.

Next Speaker: I mean so other thoughts, like do we want the body, I mean we, what if we replace the body with like a picture of patient, I mean care or something like that?

Next Speaker: ****

Next Speaker: Or a germ, I mean.

Next Speaker: I mean **** the body, **** the body.

Next Speaker: If that's consistency with it.

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: It's pleasant to see a picture with all of the ****.

Next Speaker: Yeah.

Next Speaker: **** and, and numbers and, you know, uh, yeah.

Next Speaker: And, uh, can you move the other ones to this?

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: Right.

Next Speaker: **** cord level.

Next Speaker: We can totally ****.

Next Speaker: The abdominal ****.

Next Speaker: So okay, well let me push some other folks in on this issue and, you know, I need to, so Paul basically said I want to know the number of infections and if we've met a national benchmark, two pieces of information. Which, although those national benchmarks rely on the SIR, like they're defined by the SIR, I mean you're suggesting we, like completely leaving the SIR off this page, which on one hand simplifies things. We never have to like talk about a national baseline or anything, so it makes it simple. I mean, however, we don't highlight the fact that we are, you know, significantly below national baselines for some of these. I mean, do you guys have thoughts about that? Or is the SIR in your communities, uh, do people think in terms of the SIR and really wanna see that front and center?

Next Speaker: Why don't we talk about the two different reports?

Next Speaker: Reports, yeah.

Next Speaker: ****

Next Speaker: **** gonna fit for the consumer and one's gonna fit for the other ****.

Next Speaker: Yeah. Yeah. I mean, and it, and right, and this executive summary is kind of a hybrid, like one page for the consumer. I guess what I'm asking, let, let's say on the consumer page, to just kind of ask, to get a vote, you know, if we did just add something like that, no SIRs, just the number of infections and the checkmark or the X, would people be okay with that?

Next Speaker: Mm hmm.

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: Wait, so then what does the checkmark mean? What does the X? Is it related to the SIRs or the HHS targets or ****?

Next Speaker: It's HHS target.

Next Speaker: Target met, not men.

Next Speaker: Target met, not men.

Next Speaker: AT test target.

Next Speaker: Yeah, AT test target.

Next Speaker: All right.

Next Speaker: Reduction target.

Next Speaker: Yeah, absolute numbers of infections there, that's also, I mean, I like to see it because, but, um, but what does the absolute number mean, you know? Because it doesn't always mean the same thing. Um.

Next Speaker: Well, I'm, I'm just remembering that back when, when the committee was started, you know, we, we had this, uh, statement that we, we think we should, our goal is zero infections.

Next Speaker: Right.

Next Speaker: And to, to me, that, that gives some inkling about how close we are to that, to that goal. Um.

Next Speaker: Yeah. I mean, I sort of liked when I put all the numbers together. It was kind of, I mean, so then, and if you look at the red rectangle at the bottom of the page, the, these are just things we could play with, they could be in tech somewhere. But, but so the total number of HAIs reported in Oregon, with this preliminary dataset is 1,455. So, if our goal is zero, that means there were almost, there were over 1,400 preventable infections.

Next Speaker: Right.

Next Speaker: I mean, for the, the issue of whether it's preventable is debatable, and I know that, that's, yeah, but, but I mean, that, I think that's a big number. I mean, and if you look at the total expected based on national baselines, is 1,999. So we were under that, we, we're –

Next Speaker: You know, and it's so hard to –

Next Speaker: – definitely moving.

Next Speaker: – **** consumers.

Next Speaker: Exactly. I, I agree.

Next Speaker: That total expected, oh, my gosh.

Next Speaker: Yeah.

Next Speaker: I, **** my mom, she ****.

Next Speaker: Yeah.

Next Speaker: You know?

Next Speaker: No, I think that's ****.

Next Speaker: Yup.

Next Speaker: ****

Next Speaker: That totally **** that's a really ****. And it's delicious, I love it.

Next Speaker: Yeah, I, I like having it somewhere, but probably in the technical report ****.

Next Speaker: In the tech ****.

Next Speaker: Right.

Next Speaker: Yeah.

Next Speaker: Because it speaks to the, to the importance, I mean, **** one of the things that we do is we talk about our different reportable diseases, right? Well, how important are HAIs compared to our 400 cases of salmonella a year?

Next Speaker: Right.

Next Speaker: You know, and the answer is, pretty important.

Next Speaker: Yeah.

Next Speaker: And, and so I think it, it addresses that. And it also addresses, um, you know, the fact that we have had some improvements. Uh, but as a total number, I mean, it's hard for me to add CAUTIs to MRSA.

Next Speaker: Right. Yeah.

Next Speaker: ****

Next Speaker: I think the word ex –

Next Speaker: It's just so **** –

Next Speaker: – expect, it's not really the ideal word. I think predicted is probably –

Next Speaker: ****

Next Speaker: – better. Expected means like, you know, I mean, I don't wanna expect any ****.

Next Speaker: ****

Next Speaker: Right. Right.

Next Speaker: Right.

Next Speaker: I know, and that –

Next Speaker: Statis, statistically predict.

Next Speaker: – **** I mean, it's been that way forever.

Next Speaker: Well, yeah, but I think you can say predicted or some other word choice –

Next Speaker: ****

Next Speaker: – makes it a little bit –

Next Speaker: Yeah, that's a ****.

Next Speaker: **** gonna go, oh, is predicted different than inspected, or expected? You know, they'll say, are they trying to express something else? You might, if you're gonna talk to anybody who's wonky and **** expected, they know what expected means. For the public, you can use predicted, if you really want to, but, eh, 'cause otherwise, then, people are not gonna know. Even though it's imperfect and unsatisfying for you to look at, at least people kinda know what it is.

Next Speaker: I'd say get off this page, though.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: So.

Next Speaker: And, Dean, I'm –

Next Speaker: Uh, this is Jamie. One particular piece of information I believe the consumer would be interested in is, am I better or worse off in the State of Oregon, receiving care for these conditions than in other parts of the nation? So I believe it would be helpful if you, if there was some sort of comparative data, that compared us, uh, to the national. And I think the SIR is too complex a concept to put out there for the public, but, but somehow, um, that we in Oregon, for example, are 30 percent better than the nation. Something like that, that gets that concept across.

Next Speaker: I, I agree with that. And, and the SIR is also problematic, because it's so dated and everybody's gotten better since then. So, um, I think it gives a false impression that we're better than everybody else when we say we're 17 percent less than the national baseline. Uh, when, when we know that everybody else has gotten better, too. So, uh, are there data, uh, **** since, um –

Next Speaker: Well, I mean, the issue is –

Next Speaker: ****

Next Speaker: – with timing, right? I mean, even though this report, we don't consider it timely, it is actually much more timely than CDC. So, the latest data we have from CDC is 2013. So, it is, and we have the ability.

Next Speaker: That's not bad.

Next Speaker: We can –

Next Speaker: ****.

Next Speaker: – we can compare, as a patient, Jamie in Oregon in 2014, are you safer than patients were in 2013 nationwide. We've got that.

Next Speaker: Mm hmm.

Next Speaker: I mean –

Next Speaker: But I think that's a reasonable method to get across because if our, if our intent is to tell patients **** they are doing well or poorly, I think that's a way to get the message across.

Next Speaker: Okay.

Next Speaker: And journalists always like to see our ranking.

Next Speaker: Yes, they love –

Next Speaker: **** –

Next Speaker: – rankings.

Next Speaker: – **** report card.

Next Speaker: Well –

Next Speaker: Yeah and –

Next Speaker: – they want to know our overall ranking and our ranking in Class Cs, you know, where –

Next Speaker: Right.

Next Speaker: – uh, the best or the worst or where is the, the –

Next Speaker: ****.

Next Speaker: – **** middle or –

Next Speaker: Sure.

Next Speaker: – ****.

Next Speaker: They're, they're No. 1 –

Next Speaker: Uh huh.

Next Speaker: – question is how are we doing –

Next Speaker: Yeah.

Next Speaker: – in –

Next Speaker: – how are –

Next Speaker: – Oregon –

Next Speaker: – we doing.

Next Speaker: – compared to the rest of the –

Next Speaker: They –

Next Speaker: – country.

Next Speaker: – love rankings.

Next Speaker: And –

Next Speaker: Yeah.

Next Speaker: – they want to know –

Next Speaker: That, that's –

Next Speaker: – every **** –

Next Speaker: – everybody –

Next Speaker: – ****.

Next Speaker: – **** interested in.

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: Not only how are we globally to the national but how are we –

Next Speaker: ****.

Next Speaker: – **** compared to other states. Are we No. 62?

Next Speaker: I can hear the story now. They'll have **** where we're best and where we're –

Next Speaker: Oh, ****.

Next Speaker: – ****.

Next Speaker: Yeah.

Next Speaker: Oh yeah.

Next Speaker: ****.

Next Speaker: Of course.

Next Speaker: I mean one, one possibility, I mean, is, is this, this information already exists in the CDC report for 2013 data so, I mean, we already have, we already know that we were, I believe, well, it depends on the infection but we know how we in two, as a state in 2013 compared to the nation in 2013, so that could potentially be some, even though it's already out there, we could highlight that in this report and say –

Next Speaker: Mm hmm.

Next Speaker: – um, and I guess, you know, a new piece of data could be well, how, how in 2014, how do we look but, um, but yeah, I mean I think that that's, that comparison has been made and there's sort of a precedent for it, so we can definitely ****.

Next Speaker: **** think that might be confusing with the, you know, relying on 2013 data and we're really trying to focus on the 2014 –

Next Speaker: I know.

Next Speaker: – information getting out there, especially for –

Next Speaker: Yeah.

Next Speaker: – reporters who call me for a interview –

Next Speaker: ****.

Next Speaker: – it's like what does this really mean.

Next Speaker: It's their No. 1 question.

Next Speaker: I mean could your answer just be we don't know how we compare to the nation **** 'cause we don't have that data. We, what we can tell you is the CDC training, what we can tell you is we, we are better or worse than the nation ****. I mean the other thing that's confusing is with the HHS targets, I mean it, to me, it makes a lot of sense like here's a target, do we meet it, yes, no, but the target was actually set for 2013, not 2000, there's no target for '14. In fact, this committee sets 5-year reduction target for 2013 and then they decided that they were gonna set the 2020 target based on a new 2015 baseline, right, 'cause our baselines are getting old, which is why the SIRs are becoming irrelevant, so that's a little bit of a confusing message. That's why I'm kind of trying to get –

Next Speaker: Right.

Next Speaker: – stick to the language of met HHS target and then a footnote say something like –

Next Speaker: Yeah.

Next Speaker: – it's 2013. Um, but okay. This is, this is very helpful. You have guys have given me a lot **** make some changes. I guess the one question for, I guess, Jamie and the group is in terms of that comparison of Oregon to the nation, is that something you'd like to see on this first kind of more consumer oriented simple page or is that something you think belongs on that second page of the summary like in a table, in a column of the table?

Next Speaker: ****.

Next Speaker: **** that.

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: Both places.

Next Speaker: Both places, okay.

Next Speaker: ****.

Next Speaker: I know **** want to do that ****.

Next Speaker: ****.

Next Speaker: That's what they're gonna want to see ****.

Next Speaker: Yep.

Next Speaker: What did you say, a map?

Next Speaker: A map.

Next Speaker: **** we were just talking about a visual map that's –

Next Speaker: Mm hmm.

Next Speaker: – **** people are gonna –

Next Speaker: Yeah.

Next Speaker: – ****.

Next Speaker: Yeah.

Next Speaker: And how we compare for, so for each of the **** time or something, is that –

Next Speaker: Yeah.

Next Speaker: – what you're saying?

Next Speaker: I mean, you know, like what we do, of course, is simplify it as much as you can in how you present it and then in the back you have like a resource that says here's how we look for SSI, here's how we look for blah, blah, blah and it's a map and –

Next Speaker: Uh, overall ****.

Next Speaker: Like would it be a map of –

Next Speaker: ****.

Next Speaker: Like where –

Next Speaker: – ****.

Next Speaker: – the hospital is, you mean or ****?

Next Speaker: No. I just mean generally nationwide because the No. 1, I –

Next Speaker: Oh, I see.

Next Speaker: – **** –

Next Speaker: **** all the states.

Next Speaker: – **** it's a map. It's literally a map of the United States that says here is Oregon and look what color we are and it's –

Next Speaker: Right.

Next Speaker: – difficult to do that for each infection but –

Next Speaker: Mm hmm.

Next Speaker: – that's what I think people can digest easily –

Next Speaker: Okay.

Next Speaker: – personally and that's a lot of maps.

Next Speaker: ****.

Next Speaker: I know, it's a lot of maps and I don't know if that's practical or not.

Next Speaker: Well, it's not as bad as tables.

Next Speaker: No.

Next Speaker: That's right. That's right.

Next Speaker: You have to look at –

Next Speaker: Yeah.

Next Speaker: Mm hmm.

Next Speaker: I mean if there's –

Next Speaker: You know.

Next Speaker: – any ways to –

Next Speaker: ****.

Next Speaker: – make it a little more visual.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: **** is what, what **** –

Next Speaker: Right.

Next Speaker: – if we've got, um, 10, 11 –

Next Speaker: 10.

Next Speaker: 10.

Next Speaker: ****.

Next Speaker: 10.

Next Speaker: Yeah.

Next Speaker: What's with ****?

Next Speaker: Six circles, oh yeah, that's an overall so we ****.

Next Speaker: Five Xs –

Next Speaker: ****.

Next Speaker: – and five, um –

Next Speaker: Yeah.

Next Speaker: – rechecks and then one ****.

Next Speaker: In, in terms of a, I know we didn't talk about this but in terms of how we present this data to consumers and is, there's a question that you have here on the table up on the right hand corner about replacement percentage change of annual trends, question mark, for example. I think in terms of that report, that would be better –

Next Speaker: Mm hmm.

Next Speaker: – and I think it's a little more visual for people.

Next Speaker: Okay.

Next Speaker: Maybe not necessary for the one that we are looking at all the time but I think for that one –

Next Speaker: Okay.

Next Speaker: – personally, that's ****.

Next Speaker: Okay. Well, this is good. I mean just for the interest of time, I'm gonna move through a couple of other tables and, um, you know, we can, we can come back to this at the end too if we've got extra time 'cause this is a really valuable discussion. Um, so this is sort of, uh, again, this is, in, in each report consumer or the technical provider report, we need to provide a row of facility specific information and so, um, you know, here, like this is an example of, of SSI's **** procedures in Oregon so I kind of, I use this, the same name, hospital names and the same number that the CDC, CSTE recommended report format did just so we could see the difference between, kind of what we mocked up before seeing that and then what, what they said. Okay, so this, we have number procedures because we think it's important for consumers to really be able to kind of compare the number of procedures performed at each hospital. Observed infections, predicted infections, again, I wanted to mention to both Dana and this, that in that, the CDC guidance, they actually said use predicted in the consumer report and expected in the policy report, so –

Next Speaker: Oh.

Next Speaker: – **** that –

Next Speaker: ****.

Next Speaker: – **** too.

Next Speaker: ****.

Next Speaker: Exactly. That's the –

Next Speaker: ****.

Next Speaker: Yeah, the –

Next Speaker: Yeah.

Next Speaker: – same reason 'cause expected is like all the statistical stuff but predicted is just –

Next Speaker: Yeah.

Next Speaker: – more intuitive.

Next Speaker: Like we're hoping for Santa to come.

Next Speaker: Yeah, right.

Next Speaker: Right.

Next Speaker: ****.

Next Speaker: Yeah, exactly.

Next Speaker: ****.

Next Speaker: Um, and then so –

Next Speaker: **** –

Next Speaker: – how does the –

Next Speaker: – ****.

Next Speaker: – facility compare to national baseline. This, this is exactly, this is the same format that we used last year except for last year, we had, we had a like a light green triangle instead of a gray triangle going down or a light red. Um, I personally sort of like the gray because it's like you've got, you have direction but not statistically significant, so, but that's just me. Um, and then the, does the facility meet the HHS production target so this is sort of, this is what we mocked up and I just want to show you quickly, the, the bottom, what's here is this is straight from this kind of draft guidance report. It looks a little bit different so, I mean here, we have the same hospital. They report the number of procedures observed and predicted infectious but then this is sort of their recommendation for like giving a qualitative like summary to

consumers so just like Diane mentioned, it's, there is words with it, it's, um, so they say, for example, that first clean hospital. They say this SIR was no different than the national average, so there's just an equal sign and it says the same. Um, if we were to use this format, um, I can tell you that a lot of hospitals are just gonna say the same because we're, we're a small state with small hospitals and so, um, so that's kind of why we kind of decided to go with the triangle, the up and down triangles, uh, just so that because even that clean hospital, they meth the HHS production target, right, and you wouldn't know that if we had, if, uh, you wouldn't know they had, they were better than the national baseline or that they had met the target, so, um, so these are some differences. I mean I, I, I don't know if we have time to kind of walk through everything but just kind of on a gut level, when you look at these two things, I mean, do you like kind of the symbols recog, uh, recommended in the CDC report, like the star and the X and the equal sign better than the triangles, that ****?

Next Speaker: One, one thing I was thinking, uh, one idea is to take your symbols down low, the stars then or whatever **** in that column **** national baseline, put that there instead, right.

Next Speaker: What the –

Next Speaker: The same question, right?

Next Speaker: Mm hmm.

Next Speaker: If you had a combination where you said, you see where they met the target or not and then you have a very visual same or better or X, whatever, in that column, does that work?

Next Speaker: So I, what I, are you saying to add some words to that, the column, the how do you compare the national baseline?

Next Speaker: Yeah, so –

Next Speaker: So it could be like better –

Next Speaker: – **** a way to, I know there's people on the phone but I'm wondering if there is a way to –

Next Speaker: What –

Next Speaker: – **** say this –

Next Speaker: Mm hmm.

Next Speaker: – somehow have it in that –

Next Speaker: – so, so you're –

Next Speaker: – **** –

Next Speaker: – **** saying, it would say same up there, like say for the gray one and then it would say –

Next Speaker: Right.

Next Speaker: – better for the green one.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: And would you still have it down or up –

Next Speaker: **** could.

Next Speaker: – ****?

Next Speaker: Mm hmm.

Next Speaker: You could.

Next Speaker: Okay.

Next Speaker: But I'm saying having a word next to along with the color or whatever your –

Next Speaker: Yeah.

Next Speaker: – **** is, is more –

Next Speaker: It's appealing.

Next Speaker: – clear.

Next Speaker: You don't have to go –

Next Speaker: Yeah.

Next Speaker: – back to the –

Next Speaker: I agree.

Next Speaker: – legends –

Next Speaker: ****more –

Next Speaker: – it's ****.

Next Speaker: – like –

Next Speaker: Yeah.

Next Speaker: – she said. I mean –

Next Speaker: Right.

Next Speaker: – it's –

Next Speaker: Or just put the word in the color that –

Next Speaker: Right.

Next Speaker: – you want.

Next Speaker: Oh.

Next Speaker: Or you can –

Next Speaker: Yeah.

Next Speaker: – do that too.

Next Speaker: Yeah.

Next Speaker: It's ****.

Next Speaker: You can do that too, but that, yeah.

Next Speaker: Okay.

Next Speaker: It seems like that would simplify it.

Next Speaker: Okay. I like that.

Next Speaker: ****.

Next Speaker: Okay and then for the tech, the consumer report on the other thing that the, the CDC, CSTE document had a bunch of, um, like resources for patients so, um, you know, fast facts about HIIs and so this is adapted from a few other states' reports and so I kind of, I'm working with our, um, publications people on doing this. They, they don't like the patient, the shape of the patient's head now and –

Next Speaker: This, this –

Next Speaker: Yeah.

Next Speaker: – this is ****.

Next Speaker: ****.

Next Speaker: Yeah. Our design guy said it looked like a dogs head but **** –

Next Speaker: **** –

Next Speaker: – ****.

Next Speaker: – where did you get this from?

Next Speaker: This one, well, this one is from the CDC guides document but they took this one, I think, from Kansas.

Next Speaker: 'Cause that –

Next Speaker: Yeah.

Next Speaker: – doesn't look –

Next Speaker: Yeah.

Next Speaker: – I was gonna say it was, it's not –

Next Speaker: Yeah.

Next Speaker: – it doesn't –

Next Speaker: Yeah.

Next Speaker: – look that professional –

Next Speaker: So anyway –

Next Speaker: – to me.

Next Speaker: – we'll change –

Next Speaker: ****.

Next Speaker: – conceptually which –

Next Speaker: ****.

Next Speaker: – ****.

Next Speaker: Yeah.

Next Speaker: **** people there.

Next Speaker: ****.

Next Speaker: The other thing I'd like to in their recommendation is I'd –

Next Speaker: ****.

Next Speaker: – like to –

Next Speaker: Yeah.

Next Speaker: – plop in our report is this, what can patients do to prevent infections.

Next Speaker: That's right.

Next Speaker: I think it's so important –

Next Speaker: That's –

Next Speaker: – because –

Next Speaker: – so right.

Next Speaker: – many times, they can't choose where they get it so –

Next Speaker: Right.

Next Speaker: – we're definitely gonna, um, adapt this for the report. This is the technical report. Again, I think some of the things you guys said before are probably relevant to here. I mean here we, here we put because this is the technical consumer, the actual SIR is in there, the 95 percent confidence interval is in there. I kept the SIR interpretation and production target and then we do compare it to 2013, um, and then **** throw in a trend line. I mean I guess from, I was thinking from a consumer perspective, I wouldn't really care what the trend was over time, I would want to know in for, in the last year, did they meet the target. I mean I don't really care if you've gotten better or worse, like where are you today so that's why I left the stuff out but I mean we also are free to put any of this information back in the consumer report. It's, it exists. It's just, um –

Next Speaker: Yeah, I think it's more the providers. I mean I definitely have had IPs telling me they really like having that information –

Next Speaker: Good, okay.

Next Speaker: – so it's, you know, to see how they change over the year –

Next Speaker: ****.

Next Speaker: – ****.

Next Speaker: And then this is, so yeah, basically, CDC, CSTE, the only, they could, they keep this interpretation in the provider report so I think maybe whatever qualitative interpretation we choose for consumers we **** the providers. Um, they also, I'm just gonna kind of rush a little bit through this stuff 'cause they, they have some recommended, um, resources for providers that they recommend putting in the report, um, and I think we should reference them **** resources so I'm gonna definitely look to Mary in the **** to do that. They also had some recommendations about how to present influenza vaccination data that's a little bit different than the way we've been doing it. Um, they like kind of using is statistically better or worse than this healthy people 20/20 goal of 90 percent vaccination, um, which we can totally do but I just kind of wanted to show that, you know, this is the way that, I sort of like the way Monika had set it up before to **** she listed all of the facilities and their rates and then kind of if there's color codes to see whether they've met health people tag 15 or 20 goals. Um, this is sort of the way, um, okay, so for the, you people on the phone, I'm on Slide 19 now. We're kind of rushing through this but, um, healthcare worker influenza vaccine possible alternative formats. Um, for the provider report, one thing that, uh, I keep talking to Jen Bueser about this kind of like number needed to treat or like that providers like to know, what do I have to do to meet this benchmark, you know, and so I kind of threw in this column, uh, additional vaccinations needed to meet the healthy people 2015 target, um, and so anyway, there's kind of a lot of information in here but, um, and maybe at the next meeting since, um, since the healthcare, the next healthcare influenza vaccination report is not coming out 'til the fall, we can explore what, what we want to do but I just kind of wanted to give you **** here. Um, so I think, um, I'd like to move on because I know that if, we have some people who need to leave. Um, why don't, while we're getting kind of Judy set up, we're gonna kind of skip my presentation on the state plan updates, which is, um, not as important, I think, as getting, um, Judy's presentation about the Ebola grants **** where we're going with this, so maybe if people need to get up and move around or get a drink, we'll do that. So for you guys on the phone, we're actually gonna be moving in your packets to **** last night, kind of we're gonna skip the proposed update to the state plan and that Word document and head right into the Ebola assessment hospitals in Oregon readiness and ****.

Next Speaker: Uh, can you tell us what slide that is?

Next Speaker: Um, let's see, it's –

Next Speaker: Did they get ****?

Next Speaker: They got this but they, not in handout form –

Next Speaker: Oh.

Next Speaker: – so it's, the pages are gonna be a little bit different.

Next Speaker: Okay.

Next Speaker: So when you –

Next Speaker: All right.

Next Speaker: – kind of scroll through your document, do you see that, kind of the Word document that's in between the, the PowerPoint presentation?

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: I would, it looks like Slide 39 for us –

Next Speaker: Okay.

Next Speaker: – ****.

Next Speaker: Thank you for that.

Next Speaker: ****.

Next Speaker: Thanks guys.

Next Speaker: Okay.

Next Speaker: All right guys, I think we're gonna get started again, so.

Next Speaker: Okay.

Next Speaker: So I'd like to do just a brief introduction of, um, Judy Guzman and as she mentioned, she's our physician lead for this Ebola work that we're doing, so we're really excited to be working with her. Um, she has a lot of experience as head of infection control at OHSU and she's on the Shay Pediatric committee for, I forget exactly –

Next Speaker: The board.

Next Speaker: – the board.

Next Speaker: Mm hmm.

Next Speaker: Um, and just, um, has done some great work, um, and also is a real champion for infection control so we're super excited to have her working with us and since I sort of skipped an overview, I think as, as Judy goes through these slides, she'll sort of explain, um, you know, where we're going with this, this grant, and this activity.

Next Speaker: Thanks. Um, and Kate, you can chime in any time throughout this 'cause –

Next Speaker: Sure.

Next Speaker: – I know this is kind of an intro to a lot the general grant too. So, um, thanks for the introduction. As Kate said, I'm Judy Guzman and, um, so just by way of introduction for those of you who I haven't worked with before, um, so by training I'm a pediatric infectious disease physician and I'm on fac, I've been on faculty at OHSU in the department of pediatrics since 2004 and from 2004 'til just recently as of March 1st of this year, I also served as the pediatric medical director of infection control, um, at OHSU and, um, so and that role, um, I shared with, um, John Townes who many of you may know. He's an adult infectious disease physician at OHSU so even though I'm pediatric, a lot of the work I did, um, there on the hill, um, kind of overlapped with, um, with, uh, adult hospital. And, um, in my time there, I did a lot of, um, uh, preparedness for all sorts of pathogens including, most importantly, I think in 2009, 2010 the H1N1 pandemic with influenza and then in, um, 2014 up until, um, I stepped away from that role with Ebola, um, preparedness for OHSU. Um, and just with, um, really great timing for me and, um, because I've worked with, of course, in that role, I worked with, um, the state health department and local health department and in many, um, many ways, um, in many avenues in my role there. Um, this, um, this Ebola grant was awarded to the Oregon Health Authority and so I was recruited, um, actually, as a, as a consultant so this is separate from my OHSU role, um, to be the, uh, the medical lead for the Ebola part of this grant. So, um, for the next 15, 20 minutes, I'm just gonna describe the Ebola specific readiness, um, specific elements of this new, um, grant that was awarded to the OHA, to the HAI program and as, um, as I think you know from the kind of early introduction of this grant from the last HAIAC meeting, this is a, a great collaboration and a great project with the Oregon Patient Safety Commission as well who I've worked with in the past also with other collaborative projects. So, um, to the next slide, as we all know, back in September 2014, um, Ebola came to the United States, um, via, um, through Dallas, Texas and, um, the, the next month, um, two of the nurses who cared for index case also, um, developed Ebola virus, um, infection and in all of this, um, kind of urgent panic mode that everybody was in across the country, um, a lot of us providers, um, and people who are, have an interest in infection prevention, patient safety, occupational health, um, really started, you know, we all kind of in, in dire straits were figuring out how do we best prepare ourselves for a possible Ebola patient entering the doors of our healthcare facility and what is the best, how is the best way to do that and as the federal recommendations for PPE and, um, occupational health recommendations were changing, it seemed minute by minute, um, everybody kind of felt, um, really, I think every, every healthcare facility, no matter if it was an outpatient clinic or, um, an acute care hospital, um, really started thinking not only just about Ebola but I think globally about how can we be best prepared for any pathogen that comes in and, of course, Ebola was, was everybody's focus. Um, and in that, um, as kind of a, a response

to really hospitals realizing how important it is to be at a state or readiness all the time for these types of pathogens because no other hospital wanted to be, wanted to experience what, what Dallas experienced. Um, this, this grant opportunity came through and, um, this, um, the, this grant was, um, awarded to all 50 states and the Ebola specific part of it focuses on building an infrastructure, um, relate, specific to infection prevention, um, to make sure that hospitals feel that they are ready and prepared to safely and effectively take care of a patient with possible or confirmed Ebola, um, and to have the capacity to be able to do that and to really focus on education of healthcare workers across the continuum of care. Um, and so my role in this, at least for the first year in terms of my initial kind of priority focus for this grant, is to, um, be leading the Ebola readiness consultations of the Tier 2 or assessment hospitals. So there is the treatment hospitals, um, which have been identified by the CDC, um, through CDC site visits. There are no treatment hospitals in the state of Oregon. Um, we do have six hospitals who have self-identified themselves to be the Level 2 or Tier 2 assessment hospitals and I'll, um, I list those in a, in a upcoming slide. Um, the closest treatment hospitals, um, are in the Seattle area both for adult and for pediatric. The other two parts of this, um, this grant, which I'm not gonna speak about too much today but we will kind of, it'll dovetail into our next, um, discussion, will be to develop a statewide infection control capacity to prevent HAIs, not just Ebola but, um, including even the device associated infections and SSIs that we just talked about in the previous discussion. Um, and then to expand bio-safety capacity, um, for the public health lab. So, um, the CDC has, um, developed what they call ICAR, which is the health care infection control assessment and response, and, um, the program's emphasis is on collaboration, partnership and engagement of health care facilities all across the country, but then when we think about Oregon, this is really meant to be a, I think, a really exciting opportunity for us at the state level to work, to work closely with the hospitals to kind of, um, as we keep saying, cross-pollinate and to learn from each other and really kind of develop a better infrastructure for infection prevention. Um, you not all, not every hospital, um, and health care facility in this state has the ability and the, the, um, the resources to have even, you know, one full time infection preventionist, and you know, much less an im, a medical director and I.D. trained physician to help with, you know, priorities with gap analyses and with, um, developing a really sound infection prevention plan, um, and so this is gonna, um, really help us to be able to do that. So, I kind of see it as outreach to a lot of facilities that are really wanting and needing help in terms of developing and good infection prevention plans. So, there's really two, the way I like **** to think about it, is there's two activities through this grant. One is Ebola specific and the other is non-Ebola specific, but general infection prevention. And so Activity A is the readiness consultation of Ebola assessment hospitals, and B is, um, Mary Post, again, can't be here because she's on her way to the APIC conference, but she'll be really focusing, um, on the general infection prevention infrastructure and then also improving training, um, and education for health care providers across the state. So, um, I'm gonna be focusing just for this, um, short kind of introduction on the Ebola, um, related activities that we're gonna be doing. First, um, we're gonna be, um, conducting onsite readiness consultations. Um, I like to consider them as consultations and not assessments, because I think a lot of people have a connotation of assessments being kind of like a regulatory site visit or, um, uh, you know, some sort of a, I don't know, an inspection, and that is not what this is meant to be. It's meant to be really a baseline consultation. Um, to de, to really just establish what is the current state of readiness of the six hospitals that have self-designated themselves as assessment hospitals. Um, we're gonna determine the gaps in their readiness when we, um, go on these, um, one-day, uh, site visits. Um, we'll address the gaps

through consultation and training using CDC base resources, so if you haven't seen this, um, on the CDC web site specific to Ebola preparedness, there is a very detailed, um, checklist, um, that health care facilities can use and many of the domains are kind of general, um, general, uh, pieces of in, infection prevention and, um, readiness specific to Ebola, and we'll be uti, using those, um, resources as we, um, go to visit these hospitals. Um, we'll develop the, uh, with the hospitals, we'll develop mitigation implement, implement plans with the hospitals to try to mitigate those gaps, and again we, you know, we see this has to be a long-term, you know, one to two years in terms of working with the hospitals to try our best to figure out how to, um, make their infection prevention plans as strong as possible, and then we'll do follow ups 6 months. Actually **** right now we're doing, um, monthly follow ups, um, as we're starting to work with the hospitals and schedule these, um, these psyche visits to help them strengthen their plans, and the CDC Ebola readiness assessment team, so these assessment teams, of course, have been a red, very busy, um, visiting hospitals all through the fall and winter. They were going to hospitals all across the country, um, uh, really do site visits of hospitals who were treatment hospitals. And now, at this point, that we're in summer of 2015, the CDC feels that they have a good number of treatment hospitals, and so now this, um, the activities of this grant are now, um, kind of taking a step back to all of the assessment hospitals. So, an assessment hospital is a ha, hospital that is agreeing to take a possible Ebo, Ebola patient, so someone, say, who has been a person under monitoring through the health department who's returned from West Africa, and then becomes ill, either with fever or other symptoms, who is now what we call a PUI or a person under investigation, and so these assessment hospitals is, are willing to and prepared to admit these patients to do rule out testing. Is it Ebola? Is it, um, malaria? Is it typhoid or some other disease, so this is, um, what these hospitals are focused on in terms of what they're able to offer, and then, uh, if the patient did actually indeed was diagnosed with Ebola, then they would be transferred to a treatment hospital, and again the closest treatment hospital is in the, um, Seattle area. So, um, these assessment teams from the CDC are actually now going to each state to help us at the state level, our state level team to, um, develop training to be able to, um, do these, um, consultation visits at our hospitals. So, in terms of, um, who's involved, um, right now are what we're calling ourselves the grant steering team. We've been meeting weekly either in person or by conference call, um, just to make sure that we're meeting the goals of **** goals of the grant to really get this kicked off. Um, so Zints, myself, Mary Post, Jen Bueser, um, and Kate are all really the ones who are kind of driving all the activities and the planning and prioritization of all of the activities in, in the, um, in the, uh, grant itself. Of course there's many, many partnerships involved with this. Of course, the health care facilities who have, you know, self-identified themselves to, um, take the time, effort and resources to be an assessment hospital, the local health departments, everybody else who you see here. Um, of course the HAIAC is listed on there and then last but not least on the list is, um, the Oregon Association of Hospital and Health Systems who was integral in helping in, throughout the fall and winter with, um, state level and, and even, you know, metro level planning for, um, Ebola preparedness. So, um, on the next line are, is the six listed participating hospitals, um, for this grant activity. Um, there are three hospitals in the Portland area, Providence, Milwaukee. Legacy is, um, has designated Good Samaritan Hospital as their site. Kaiser, um, west side, and then three outside of the Portland area, Saint Charles, um, medical center has designated their Redmond site, um, not bend. Um, if they had a person under investigation Samaritan, Lebanon and then Asante Ashland Community Hospital. So I have, um, had, um, either group conference calls where a lots of individual, um, uh, discussions with all six hospitals, um, at this point, and, uh, we have,

um, confirmation in terms of, uh, the day that we're gonna be doing the site visits for five of the six hospitals and our first, um, site visits will be happening the last week of July. And who will be doing the, the site visits? It'll be myself **** lead, Mary Post, um, will be our infection preventist, Dan Cane who is an industrial, senior industrial hygienist, who will be, um, focusing on environmental care, and, um, occupational health, um, and then Rod Nickla who already has had a lot of, um, who already has been doing a lot of hands-on work with many of these hospitals, doing hands-on training for safe and effective, um, uh, management of blood and body fluids that will be coming through laboratory and then being sent out for, um, diagnostic, um, for diagnostics. So, the next line shows the, the 11 capability domains and these are just really in a very general way looking at the 11, um, categories, if you will, that we'll be looking at in terms of preparedness for, um, the 6 hospitals. So, we'll be looking at facility in structure, looking at patient rooms. Are they, um, you know, in terms of airflow, in terms of space for donning and doffing and be able to safely take care of the patients. Patient transportation, and that's not just within the hospital. That includes EMS. Um, looking at how patients will be transported safe from home or another facility to their facility as an assessment, um, hospital. Um, and then also intra, um, inside the facility from say emergency department or the other hospital entry points into the care area. Laboratory, as I mentioned, staffing, do they have enough staff to take care of the patient, assuming the patient may be there for about 3 days while their doing, um, rule in, rule out testing. Training of health care providers, PPE. Do they have enough PPE? Do they have the right PPE, and do they know how to use it? Waste management, worker safety, environmental services, um, including, um, uh, you know, contaminated, um, uh, patient care items. Uh, clinical management and then operations coordination so that's really having a well-established EOC or emergency operation coordination plan, and how that's gonna work over time and how that's gonna be called. So, how are the four of us gonna become trained? So, there's a few different ways. One is, um, the CDC is offering, um, training courses, which are free of charge to attend. Um, I'm actually going to University of Nebraska Medical Center's biocontainment unit on Monday to go to one of the first training courses, Monday and Tuesday. The nice thing is that they also, so they have two, um, sites, either at, um, Nebraska or Emory, um, their biocontainment unit, and they're, they're offering this course also to the hospitals. Um, so actually Lebanon Hospital is already planning on sending, they're sending three people to the course next week, as well. So, um, so that's really exciting to see that the hospitals are taking advantage of these free training courses as well. Um, there was one already in Atlanta this week, and then they've already scheduled, um, two additional courses later in the summer, and so hospitals are, you know, trying to see if they have the funding to send, um, some of their own representatives to these training courses. Um, and then, as I mentioned, our first, um, site consultation visit is going to be, um, the last week of July, and Portland, Providence, um, Milwaukee, um, has agreed to do, uh, to be the first site. So, what we're gonna do is the CDC ICAR team is going to come and they're actually going to be the ones to do that first consultation, um, at, in Milwaukee, and then our team – me, Mary, Rob and Dan are actually gonna observe and be able to ask questions. So it's kind of a train the trainer type of a thing. And so we'll observe them do the first consultation, and then literally the next day we're going to go to, um, Good Samaritan, um, Legacy Good Sam, and the four of us, the Oregon team will lead the consultation. The CDC is gonna stick around and they're gonna observe us, give us some critiques, positive and negative, and help us, um, really, uh, be able to effectively do a site visit as well, and then they're gonna stay around for 1 more day and then we'll do, um, we'll do kind of a debrief. And then, um, once we've had the first two done with the CDC present, then, uh,

the four of us, the Oregon team, will lead the consultations and do the subsequent for, um, Kaiser and then the three outlying hospitals. Our goal is to have all six of them done by the end of September. So, we have currently right now, we have two in July, two in August, oh, actually **** two in July, three in August and one in September, so. So, what will the day look like? Um, we're kind of planning for tentatively the sched, the, the, um, it will be a 1-day visit from about 9:00 a.m. to about 3:00 p.m. The first hour will be introductions. That's where we think we'll see, um, managers, health care managers and, um, administrators come so we can kind of tell them the day of the plan, show them the tools that we'll be using from the CDC, and then the mornings, say from 10:00 to noon, we'll be doing kind of detailed walkthroughs where, where a lot of, most of these hospitals have been doing simulation training specific to Ebola, so we're encouraging them to actually do a simulation on the day that we're going to be there rather than just walk, walking, talking it through around a round table. It makes sense to actually have them do a simulation on that day. We'll be looking at their entry points either through the emergency department of whatever the entry point that they've identified – sometimes it's a loading dock – to get into the hospital. Then, and then, um, observe them as they take the, that person under investigation through the, that, um, through the corridors and then into their identified patient care area, look at how they've set up their donning and doffing areas. If their needs, if we need negative airflow, what does that look like. Um, where are they gonna be doing laboratory care and all those types of things. So that'll be, we'll spend, um, a good part of the morning really focused on the patient care area. Then we would break for lunch, and then, um, in the early afternoon, we would, um, depending on kind of they, how they're physically set up, we may divide up into different groups, one group go to the laboratory, look at lab safety. One, uh, group go to occupational health look at, and, uh, PPE training of donning and doffing, and then another group environmental care looking at, um, their, at EDS, and, um, feeding practices and are those people trained to safety do that? How are they gonna get contaminated garbage in and out of their area? What is their plan for that because there's a lot of garbage, a lot of contaminated items, that, um, that are involved with patients when they have Ebola virus. Um, so we'll review all of those 11 domains throughout the day, and then, uh, we'll have a wrap up session, um, with the hospitals. Um, the, the reports that are gonna be going to the CDC are gonna be very, very general. They basically want to know of those 11 domains that I talked about earlier, those capability domains, are they prepared. Yes, no. That's all they want. They don't want any details. And it's us at the state level that are gonna really know those details because we're gonna be working with the hospital again over the next year or 2 to try to mitigate those gaps and strengthen their plans. Um, and so if there's hospitals that are actually, that have concern about, you know, documentation of, um, of those details, we actually, um, are gonna recommend that the hospitals have their own scribe there at the wrap up meeting, that they can take their own notes and then they own those notes. Um, so, we're trying to be, um, as, uh, um, you know, to work with the hospitals at the hospital level to make sure that they feel comfortable with, um, with everything that we, all of the findings and then how we, how we work forward. So, the opportunities that I think I, are really exciting with this work, um, and that I've shared with the hospitals about my excitement for being involved with this, is number one, it's gonna establish direct consultation, um, with us, the four of us at the state level, and then, of course, all the other subject matter experts here at the state level, and then also at the CDC. And, you know, I was one of those people at the hospital level in the fall, and we'd have a question that was very specific to our facility or the, the, the brand of gloves that we had or the pappers that we use, and we would send a email to some random CDC email address and hope, and cross our fingers for a

response. But once we've done that baseline site visit with these hospitals, then we're gonna have direct consultation with the ICAR teams that we're working with. So, I think there's gonna be a lot more efficiency in trying to get those answered, those questions answered. So I think that's one really exciting thing, and I keep stressing to the hospitals this is not a one-time consultation. This is a baseline visit to see where they need help, and also for them to be able to share their successes and to collaborate. Um, we, you know, I think one thing that I've been trying to really focus on when I'm talking to these hospitals is, you know, this is, we really want the hospitals to collaborate and learn from each other. And, um, hopefully we'll be able to have some events in the future where the six hospitals actually can come together physically or on a conference call or some sort of webinar where we can actually really feel like this is a collaborative effort instead of just six hospitals working in silo, because I think it's a great way that we can just, um, the hospitals can share their success stories and also help mitigate gaps ****. And then the other thing I think that goes without saying is, um, you know there's always a new pathogen that we have to worry about. Now MERS which used to be just in the Middle East is in, um, South Korea, the Middle Eastern respiratory virus, and you know we live in a really small world now, with, with international travel, and, um, so, I think that, um, to get the most bang for our buck and to make this feel really worthwhile, um, I'm urging all the hospitals to not only think about Ebola virus, but just think of it as being the example pathogen when we do this exercise, but we all wanna develop a solid infection prevention plan for any epidemiologic signif, significant pathogen that may come through. Um, one thing that's not really, that's really not a part of this grant work or, um, is surge capacity, because you know, the chances of an Ebola outbreak happening in Oregon is you know, next to nothing, but there's other pathogens. You know, we have a lot of poultry workers who live here and we need to think about even if one's a, or if we have a big measles outbreak or some outbreak, um, so I want surge capacity also to be a part of the planning and discussions over the next year or 2, because I think that's another way that the hospitals can collaborate each other, and we can really move that into the general, non-Ebola infection prevention planning and education and training over the next couple of years, as well. And with that, if anyone has any questions or comments? Sorry I went so fast, but ****.

Next Speaker: No, thank you, and, and this is Kate. I, I just wanted to kind of tie, um, eh, Judy's presentation, which was a wonderful overview, and, I think, uh, hopefully people have a sense of, you know, what this team is gonna do out in hospitals, and, and just think it's an amazing opportunity and, and it, it is, um, it may sound like something external to this committee, which was sort of formed, to, to discuss, you know, which infection should be mandated for reporting et cetera, but actually, um, the CDC's guidance for writing this grant included a specific provision that this activity, um, have a real home on this committee, and that we develop from this committee, um, something called an ICAP subcommittee. So, that's an infection control assessment and promotion committee, and so basically, um, that committee would include the people that are going out in the field and doing assessments at the same hospital that are – these, these hospitals are all reporting to NHSN. We have their data and so it really, um, CDC is, eh, part of this effort is to connect these, the preparedness communities, regulatory communities, infection control communities and us, you know, the, the, commun, the public health community that's, eh, lookin' at data from these hospitals. And so, um, the role of the subcommittee, which will, um, which will be formed, we're, we're gonna invite the people who are, formally invite them to become part of the, the HAI advisory committee, the people who are going out and

doing these as, the assessments. Um, Judy mentioned those people, um, the, the group of four. Um, additionally, we have some people on the committee already, uh, Dana Selover is our regulatory member, so she will be part of that subcommittee. Um, other interested parties, any of you who, uh, find this work interesting or would like to be a part of it, be a part of that committee, um, eh, this is not gonna be a committee that has a tone of extra meetings, but what their role will be will, to meet prior to these meetings and to kind of present in aggregate form what they found when they've gone out to the hospitals. Um, so at the September meeting, um, Judy and her team will have done the six, uh, additional consultations and she will share, um, a report in aggregate form, and then, you know, she mentioned that the, this Ebola is the first piece, and the second piece is expanding to all other facilities, and so where this committee is gonna play a major role is deciding how we select that next suite of facilities to get consultations. So, they're not Ebola assessment hospitals. They may be long-term care facilities, dialysis, ASCs and so the questions that we'll be kind of asking at this committee meeting are, you know, can we use the data that's submitted by these hospitals and other data sources to prioritize who should get the next assessment or consultation. Um, so even, I, I think that there are some really, um, some direct connections between these activities that may not be obvious right away, but I think, um, by the time we start looking at findings from your visit, um, I think we'll be, Mary Post will definitely be seeking everybody's input on how to use our data to, to prioritize the visits. Does that sound right? What else did I leave out?

Next Speaker: No, I mean, it sounds good. I'm just kind of a little curious to see what everyone here is thinking 'cause they've been given all this information.

Next Speaker: Yeah.

Next Speaker: Well, we were fortunate to have a call with Judy already, so we heard, uh, a lot of this, but it's great to hear it again. I think it's super exciting and especially for the hospitals that are these Tier 2 hospitals. I mean, they, I mean everybody needs it, but I'm really glad that, you know, this is a long-term relationship, there's consultation for the, you know, 1 to 2 years. I mean it can only benefit, um, everyone and it just is terrific. Uh, Kate, I guess I have a question for you. How will this subcommittee roll into the state HAI plan where is that gonna be? I mean, it seems obvious that it would be a part of that, as well. Right?

Next Speaker: Yes. So the, the state HAI plan is, we're planning on updating it. Um, so, so yes, we will update, um, and, eh, I think that can be something we, eh, we discuss at the, the next meeting, too.

Next Speaker: ****.

Next Speaker: But yeah, I mean, so, um, the state plan sort of started in 2009 then it was updated to include MDROs and nonacute care settings in '13 and then in '14, the state plan was updated to include the HHS targets.

Next Speaker: Keeps growing.

Next Speaker: And then it keeps, but, but then we're gonna try to formally update the plan to include these activities, too.

Next Speaker: Great.

Next Speaker: So it'll be written in there at some point. Yeah.

Next Speaker: I guess, I mean, I'm wondering about in terms of the partners for this kind of, this committee or who you might recommend, whether or not people here or on the phone might be interested or who, who else might potentially, uh, be solicited for this kind of work.

Next Speaker: Is Paul **** on this, on that subcommittee?

Next Speaker: Uh, he could be on a, a subcommittee. Who, who's on the, who else on the team, the assessment team?

Next Speaker: Um, me, Mary Post, um, Rob Nickla and Dan Cane.

Next Speaker: Okay. If the, if the committee feels **** assessment **** you show the assessment as being one of three parts ****.

Next Speaker: Right.

Next Speaker: Do you wanna put up the slides?

Next Speaker: I mean, ultimately it's kinda going on –

Next Speaker: Sure.

Next Speaker: – **** the infection control, um, preparation throughout the state –

Next Speaker: Right.

Next Speaker: – **** facility ****.

Next Speaker: ****.

Next Speaker: Yeah, yeah.

Next Speaker: Yeah, Kate's gonna pull up some slides I think that may help clarify it.

Next Speaker: Yeah, so in the, let's see –

Next Speaker: Oh yeah, here it is. It's just a couple slides but I think –

Next Speaker: Yeah.

Next Speaker: – the discussions might **** –

Next Speaker: **** the very last slide in everybody's packets, um, we just, just had three slides. So, um, you know, I kinda just gave a brief overview of the role of this, this ICAP subcommittee and again as Vince mentioned if people, you know, after absorbing this information have some thoughts or some interest in being on this committee please email us and we can loop you in early on in the planning phase. Um, but so Mary Post is, is the, is gonna be in charge of the second wave of consultations and assessments and so again this is, we have three years of funding and so in Year 1, um, Mary plans to select 25 facilities from 6 to 7 regions, um, so that will include 7 hospitals, 3 dialysis facilities, 5 ASCs and 10 skilled nursing facilities and so one of her questions for this committee is, you know, how should we be using data we have to select, um, hospitals. Should, for hospitals we could, or hospitals and other facilities and so she kind of, this very last slide in your packet has some, a list of selection criteria that she had emailed me, um, and so, you know, she, obviously we don't have any to send data for, um, skilled nursing facilities, so, you know, should we be looking at outbreak data and so something she suggested aside from NHSN was, um, you know, CMS hospital prior conditions or, um, um, we have survey results that we could use to start looking at infection control practices. We have, you know, we, we monitor, uh, CRE and other MDROs so should we prioritize facilities that have, um, have seen these kinds of MDROs. Uh, we could look at our outbreak databases. Should we focus on facilities and regions that have, have the most, um, persons under monitoring or that are EA, uh, partners of **** assessment hospitals, um, and then, you know, are there any other criteria that you guys ****.

Next Speaker: So these 7 hospitals they'd be separate and, and above the 6 **** –

Next Speaker: Correct.

Next Speaker: Right.

Next Speaker: Correct.

Next Speaker: So we'll have, you know, 13, that's a good number ****.

Next Speaker: It, it seems to me I like this criteria. I don't know how you, um, you know, with 7 it's gonna be hard, but maybe some geographic, um, component, too. I, I, I just think that's important.

Next Speaker: Yeah.

Next Speaker: You know, with the 6 that you have you, you've got 'em around the state and I think that's important, too, to kinda make sure that we're –

Next Speaker: Yeah.

Next Speaker: – you know, spreading the, the gems.

Next Speaker: Yeah.

Next Speaker: And we love the idea of kinda targeting like health, like centers, like the hospitals and associated long-term care facilities or other kind of **** –

Next Speaker: Kinda clusters of **** –

Next Speaker: – clusters of where you might, it seems like you might be able to kinda get more bang for the buck and on some level facilitate some of these connections which I don't think are ideally developed at this point.

Next Speaker: Sure. That's a great point.

Next Speaker: Which are important.

Next Speaker: When do you have to bring 'em?

Next Speaker: Soon, right? Uh, we start pickin' 'em –

Next Speaker: ****.

Next Speaker: She's gotta do the first ones by December I think, have –

Next Speaker: Yeah.

Next Speaker: – 25 completed theoretically. I –

Next Speaker: Yeah.

Next Speaker: I don't know if that's gonna actually happen.

Next Speaker: I, I think her goal is to have them identified, the facilities i, identified by the end of July.

Next Speaker: Yeah.

Next Speaker: Um, which is, you know, be here before we know it and, um, and then have August, September, October, you know, for the rest of the year to actually go to these places and, you know, start doing baseline analysis determining what their needs are. Um, I agree with this insight thing being strategic in terms of choosing a hospital, a skilled nursing facility, an ASC in different regions and, and then, because then, um, you know, for efficiency sake if we went there to do hands-on training with the healthcare providers, you know, do it all at once and kinda do the whole continuum of care –

Next Speaker: Right, right.

Next Speaker: – because the patients are, are at all of those types of facilities in that region and, you know, her, and she really wants to also do, model the train the trainer where, you know, she, um, kinda gets really interested IPs and nurses and physicians or whoever to come and really, um, train them so that they can continue to train other healthcare providers in that area and within their healthcare systems, too.

Next Speaker: Yeah, I mean, that's one thing also that, that we mentioned at the **** talk, we're working with APIC and, and such so that we'd have training, uh, for different IPs and also in hospital **** so tonight this **** every single place that's not sustainable ****.

Next Speaker: It may be interesting to see once you collect some of this data for some of this criteria it may kinda wash itself out to where you have commonalities. You may see the same facility showing up in multiple areas so that it's, it would, it would kinda rise to the top to say opportunity here.

Next Speaker: **** I, I, I feel like I still need some context in terms of, uh, you know, what, what these consults are trying to achieve, um, you know, are you lookin' for people who might be leaders in their communities to go out and train other people, are you looking for the facilities that seem to be doing the worst and are most in need of consultation, advice, **** –

Next Speaker: Yeah, I mean, I think that's, I mean, I think it's multiple things. I think that one of the things is, uh, doing assessments, so we're tryin' to assess and do a kind of a gap analysis to determine what we have to do, so, um, I mean, we do know that, you know, long-term care facilities in general are under resourced for **** intervention, for example, and we also know that there are a lot of situations where there may be isn't adequate communication between different facilities, but I, I think, I mean, some of this is just, that's the initial part of what she's gonna be doing is an assessment and then after that providing a consultation. **** think that's too general for you, but –

Next Speaker: You, you may find yourself considerably constrained by who, who's willing to, to do ****.

Next Speaker: You think? I don't know.

Next Speaker: You mean by who would be willing to let, let this group in the door?

Next Speaker: Yeah, yeah.

Next Speaker: This is a voluntary thing, so **** does a lot of ****, uh, nursing home facility, not necessarily **** control, but, um, but sort of being identified as a special needs case, you know, and then, um –

Next Speaker: Maybe you don't message it that way.

Next Speaker: Yeah.

Next Speaker: ****, but, but, but, but any smart adult is gonna read through the tea leaves, know that the **** have been identified as we're trying to fix something, so obviously it's really critical how you communicate that, but, um, once they get past that **** –

Next Speaker: They may say we're working on ****.

Next Speaker: – **** thank you very much but no thank you, you know, and that kinda thing, so, um, and some of the small ones might be kind of thrilled to have a little free consulting, so, you know, that, but it's hard to say.

Next Speaker: Is that another argument for maybe doing a clusters approach? We're looking at all facilities in this region or, I mean, 'cause if, 'cause if we're not actually saying it's because you're –

Next Speaker: We're helping 'em, so –

Next Speaker: – ****.

Next Speaker: – ****.

Next Speaker: Yeah ****.

Next Speaker: It's gonna take some resources on your part just to –

Next Speaker: Yep.

Next Speaker: – show up and work ****, so.

Next Speaker: That's true.

Next Speaker: Yeah.

Next Speaker: You know, so some of 'em may be more or less willing to make that kind of investment.

Next Speaker: I mean, I think that's what, that's all the more reason to make sure that we have, um, thinking things out as, as well as possible how we can actually help these people, so we're still working out ideally how to message that.

Next Speaker: Yeah. I think one way to be able to do that is to look at, um, you know, like healthcare faci, hospitals that are joint commission accredited, you know, you have to document that your healthcare providers get annual training on CLABSI, CAUTI prevention and all those types of things, so this could count for that, so I think that'd be one way to kind of –

Next Speaker: Yeah.

Next Speaker: – propose it for some hospitals –

Next Speaker: ****.

Next Speaker: – is that we'll, we'll be, we're, we're for free for, for them –

Next Speaker: Free consultation.

Next Speaker: – ful, yeah –

Next Speaker: You know, I –

Next Speaker: – fulfilling, uh, a lot of regulatory-related education for their healthcare providers.

Next Speaker: I, I think hos, I, I know a group of hospitals that would welcome this, like big time because they don't have the resources –

Next Speaker: Right.

Next Speaker: – ****.

Next Speaker: Right.

Next Speaker: If you work with the system, you know, you've got your **** and you've got your Providence all over the place, you've got your **** in Oregon, you know, you've got your Asante friends in the south, so if you look at it from that perspective that might be a more palatable way to work with a group of facilities not usually ****, you can have it semi-regional, there's Providences everywhere, but, um, you know, you could, you know, say we're doing it for the system, we like to work with the system **** people 'cause oftentimes those systems, you know, **** East Portland but they probably know each other and they probably, you know, are sharing some level of resources and expertise and stuff especially when it comes to infection control, so that might be a way to –

Next Speaker: Well, that would be a good way to spread the **** for sure.

Next Speaker: Right.

Next Speaker: In the system.

Next Speaker: Right and then they could be looking at what the sort of, um, you know, special, uh, uh, needs, not special needs but special needs or special, uh, um, kind of situations they could say **** looks different for this reason or, or it's a bran, we have one brand new hospital, they're gonna have, Prineville's gonna be grand new and Madras is gonna be an old hospital and they may have infection control. I know that a physical environment makes a huge difference. Yes,

the Kaiser west side, the Kaiser east side really wanna do their surgery. If you're a surgeon it's gonna be someplace where it's clean and new.

Next Speaker: Mm hmm.

Next Speaker: Not ugly.

Next Speaker: I mean, I have to say I'm not, I really am not too concerned about having facilities not wanna participate based on just talkin' to people in general. I was called today actually by someone saying hey, would you be able to provide some infection control training, someone not aware of this grant or anything like that at all, um, and saying that we've heard some other states are doin' this kind of work, so I, I think that it's gonna be welcomed as long as we aren't, you know, someone doesn't think we're gonna single them out and publicize in the paper oh this guy's, this facility's terrible. So we're gonna go try to help 'em out, so.

Next Speaker: Yeah. We've identified you as –

Next Speaker: Yeah.

Next Speaker: – as one of our ****.

Next Speaker: Yeah.

Next Speaker: I mean, one element that we didn't talk about much is that the, part of this grant, too, is like to, to merge all these data sources together, so for like any one facility we would know their **** and **** what, how many outbreaks they had reported in one year, etc., etc., so this data maybe instead of being selection criteria could also be a starting point for discussion –

Next Speaker: ****.

Next Speaker: – you know, not, not like, you know, coming to them –

Next Speaker: ****.

Next Speaker: – and saying, you know, you know, we're not here to publicize this, we're not here to –

Next Speaker: ****.

Next Speaker: – penalize you for this, but here's the data, you know, we have on, on your facilities and it might be, it might highlight where that assessment needs to start, but –

Next Speaker: Why not just put it out for them to volunteer? Say we want one from north, south, east, west or however you wanna, I don't know. I think –

Next Speaker: Have 'em compete for it.

Next Speaker: Huh?

Next Speaker: They can compete for it.

Next Speaker: Well ****.

Next Speaker: **** SSA.

Next Speaker: ****.

Next Speaker: If you're lucky **** 25 ****.

Next Speaker: ****.

Next Speaker: Yeah.

Next Speaker: If we have people wanting to do it –

Next Speaker: Yeah.

Next Speaker: – they might, you know, get a lot more out of it –

Next Speaker: No, I agree **** –

Next Speaker: – rather than simply saying –

Next Speaker: That's a good point.

Next Speaker: – you've been chosen and –

Next Speaker: Right.

Next Speaker: I don't know. If it were me I'd rather –

Next Speaker: Yeah.

Next Speaker: – volunteer.

Next Speaker: Offer it as an opportunity ****.

Next Speaker: Yeah.

Next Speaker: A limited opportunity.

Next Speaker: ****.

Next Speaker: Well, yeah, you say there's only so many slots and –

Next Speaker: Mm hmm.

Next Speaker: Yeah that's right.

Next Speaker: – first come first serve.

Next Speaker: I don't, and what about, um, adding home health to the training?

Next Speaker: Hmm.

Next Speaker: Didn't we talk about that in the **** interview in the grant? I think we may, we probably vaguely touched on it. It's gonna –

Next Speaker: ****.

Next Speaker: **** made at the agency level, yeah.

Next Speaker: Yes.

Next Speaker: And I think we had such a geographic kind of mapping of facilities in our head, but, but that's a great plan, you know, if can get, get the agency's ****.

Next Speaker: That's a great idea.

Next Speaker: Oh, we're over time.

Next Speaker: ****.

Next Speaker: I think.

Next Speaker: It's very, um, different, I mean, even within one home health agency the level of infection **** training that they get **** central lines –

Next Speaker: Mm hmm.

Next Speaker: – and things like that. It's a good point.

Next Speaker: Well, I was thinking about the patients that **** and home health ****.

Next Speaker: Should we wrap up the meeting just 'cause it's –

Next Speaker: I think so.

Next Speaker: ****.

Next Speaker: – 3:00.

Next Speaker: Yes.

Next Speaker: ****.

Next Speaker: We could be here all day.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: ****.

Next Speaker: Okay, thank you all on the phone for participating, um –

Next Speaker: Thank you.

Next Speaker: Follow up with you soon.