Healthcare-Associated Infections Advisory Committee
March 25, 2015

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Speaker: Hi everybody, welcome and thank you for coming and thanks for calling in, um, I'd like to get the meeting started so I will start by, um seeing whose on the phone. Did I hear Pat Preston?

Next Speaker: Yeah, Pat's on board.

Next Speaker: Anybody else on the phone?

Next Speaker: This is Jamie Urbaski as well from Sante in Southern Oregon.

Next Speaker: Welcome.

Next Speaker: Joan Maca from McMinnville.

Next Speaker: Hello Joan; anybody else?

Next Speaker: Laurie Green Schneider from Accent on Health.

Next Speaker: Hi Laurie; anybody else? Okay well let's go around the room and introduce ourselves to the group.

Next Speaker: Can we start?

Next Speaker: Yeah, let's start over here.

Next Speaker: Sure, Diane Waldo, Hospital Association.

Next Speaker: Genevieve Buser with Acute Communicable Disease HAIT.

Next Speaker: Mary Jennings from Kaiser representing hospitals.

Next Speaker: Kay Ellington also from Acute Communicable Disease.

Next Speaker: **** the same.

Next Speaker: Monica Sam here, the same.

Next Speaker: Uh, Didi Valle representing the consumer.

Next Speaker: Merelie appearing as a guest representing ONA and NPO.

Next Speaker: Great. I'm Jordan Perris. I'm taking over Carl Brown's position on the committee and I'm representing the Oregon Nurses Association.

Next Speaker: Kara?

Next Speaker: Oh, I'm Kara Middleton; I'm in the public health division in the public health director's office.

Next Speaker: Great. Thank you very much. So has everybody had a chance to look through the minutes, um, from last meeting in December? Does anything have any requests for changes or corrections? Do I have a move to approve?

Next Speaker: So moved.

Next Speaker: Second?

Next Speaker: Second it.

Next Speaker: Second. Minutes approved. Thank you very much. Okay, so moving along with the agenda on Pages 1 through 11, uh, that was the meeting minutes so on Page 12 of your, uh meetings we have findings and recommendations from Oregon's Modernization of Public Health Report. Kara?

Next Speaker: Okay, um, so thank you. I appreciate the time you're allowing us to have this afternoon. So essentially I'm just here to help raise awareness about some work that's happening and will be underway to modernize Oregon's public health system. So, um, I think you should have received a one pager that had a little bit of information on it as well as the presentation for, um, those of you on the phone. Essentially what I'm gonna do is walk through a process that took place over the last year of so, that came out of some legislation in 2013, and review for you the key findings and sort of where we are now be there's sort of some legislation in session, both in the House and the Senate bill that will help to operationalize, uh, the findings from this report. So, um, essentially we just want to raise awareness among our stakeholders that this is happening and, um, because should we have the bill passed it will be kind of a quick timeline to get everything underway. Um, so I'm really informal. Feel free to ask questions or, um, interrupt me as we're going forward. I also realize that the PowerPoint that was sent is quite lengthy, um, it's probably more information that you really need so I'm probably gonna skip around in it and kinda skip over a lot of the intro, introductory slides around the public health system in Oregon and start with the task force and its work. So, um, if we go to I believe it's the sixth slide, uh, back in 2013, House Bill 2348 passed and essentially this bill originated as, um, a proposal to turn Oregon's, uh, local health departments into eight, uh, regional health departments. And, um, I think the legislature quickly recognized that, um, we probably needed a little more time to be thinking about what the impacts might be for the public health system, um, before we went

straight to regionalization. So that regionalization concept got changed quickly into the creation of a task force, um, that would study and then propose recommendations to the legislature that would create a public health system for the future, consider how regionalization might fit in with that model but not have that drive the model. Um, like for opportunities to enhance efficiency and effectiveness. Uh, allow for appropriate partnerships with, um, for example CCOs and other emerging partnerships coming out of health system transformation in Oregon, um, and are supported by Best Practices. Uh, the task force membership was pretty vast. We had, uh, county representation, non-profits, CCO, local public health, uh, other partners as well as elected officials. And they met monthly between December of 2013 and September of 2014 producing a report that you'll see later on that was submitted at the end of September 2014 in preparation for the 2015 legislative session. That's the report cover. For those of you in the room I do have some nice colorful copies if you want an executive summary, I'll leave that on the table. Um, but it's also linked on our web site so you can definitely find more information there. Um, so essentially the task force before starting to look at some of the other components of the public health system wanted to establish sort of what's the what, what is it that the public health system needs to deliver for Oregonians, um, and how do we get there. So they quickly adopted this conceptual framework for governmental public health services. This is based on some recommendations that, um, come out of the World Health Organization and, um, other national entities. Washington State has used the same model to, uh, figure out how they might figure out how they might focus on these core capabilities and programs. And essentially, um, the issue is that public health in Oregon as well as in many other states, um, relies heavily on federal grants that are often highly prescriptive. They are for specific activities, um, and we don't really generally have the funds available to support that core work that public health really should be providing and the leverage money here and there. Um, I know Dr. Sislack who joined us, he's on the phone, he gave a great example of this related to communicable disease work for the task force a few months ago, um, but really we're tryin' to focus on the things that public health must deliver to everybody across the state regardless of whether you live in Multnomah or Morrow County. Um, so the recommendations that came out of the task force were that those foundational capabilities and programs should be adopted, um, that significant and sustained funding be provided to allow for oper, operationalization of the foundational capabilities programs, and that we allow local communities to identify their pathway for implementing those. So based on their local partnership, what made sense for them, that we allow them to have the time be planful and then go ahead and implement when they're ready. Um, and similarly giving them the flexibility to either implement those foundational capabilities and programs as a single county so maybe maintaining their current structure, a county where they might share services, for example and epidemiologist position that might be shared across three counties of, uh, perhaps there is no epidemiologist position that exists in the county. Um, or they might choose to form a health district if that makes more sense, um, for the geographic area for their constituents. And then kind of overall we would have some changes in government for Oregon's' public health system. We would, um, take the existing public health advisory board and essentially task them with overseeing this process of implementing the foundational capabilities programs and that they would be setting outcome measures that the public health system would need to deliver on because currently, um, we aren't held to specific measures, that everybody needs to be you know delivering for the State of Oregon, so it would really be moving us forward into a new generation. Um, so essentially I'll just kind or run through these quickly but, um, foundational capabilities that are um, found in the foundational framework are assessment

and epidemiology, um, emergency preparedness and response, communications, policy and planning, um, leadership and organizational competencies, health equity and cultural responsiveness and community partnership development. So essentially those would be the capabilities but staff that work in state and local health departments would have to possess in order to implement the foundational programs. Um, so those programs are communicable disease control, environmental health, prevention and health promotion and then access to clinical preventive services. Um, and then you know you'll see in the graphic of the model that there's also a call out for additional programs, and just to clarify that those might be things that particular communities might need to have based on, uh, the circumstances where they live. So for example here in the metro area there may be a need for a tuberculosis control program whereas in other parts of the state that may not be necessary. So it's not to say that tuberculosis is not important or we may not be addressing it but it may be somethin' specific to certain parts of the state versus others. Um, or, you know there may be a need for particular efforts around smokeless tobacco in Eastern Oregon and that may be less of an issue here in the metro area, for example.

Next Speaker: So is it based on risk assessment?

Next Speaker: Exactly, so each community, like they have to do now, would have to do a community health improvement plan and then, you know some of those, some of that work would be folded into what these core programs and capabilities are and then others might to beyond, so it would just depend on the circumstances in the individual communities and what other partners they might already have at the table who might be providing some of these services, um, that are of public health benefit. Um, so I'll, I'll just kinda skip through this. I think the take home point here is that there is very little state general fund going to public health. We rate 46th in the nation for state, um, investment in public health per capita. And so part of this is designed to, um, again really make sure that public health is really well positioned to be where it needs to be in the future as a support system for health transformation and, um, for population health generally. Um, so then again I mentioned this earlier but the point here would be that local communities would be able to determine their own pathway for implementing the foundational capabilities and programs. Um, they would be able to do that in waves, so those that are ready and willing to go would be able to go ahead and those that need a little more time to organize themselves would have the flexibility to do that, um, and that they'd be able to do that either through, um, a single county or by sharing either certain aspects of the foundational capabilities and programs with others of forming a health district. Um, so, uh, I think that that's really the gist of what's goin' on. Currently there is a House Bill, House Bill 3100 and Senate Bill 663 are in the legislature. Both had hearings on March 9th and you know assuming that these bills do pass and become law we will be under a quick timeline over the next biennium to really, uh, to figure out how we implement these foundational capabilities and programs so that in 2017 we can be ready to start implementing by wave. So are there questions?

Next Speaker: Yeah, I'm just curious if there is any requirement to, um, have coordination with the local coordinated care organization, just because public health you know as being the HI advisor committee –

Next Speaker: Mm hmm.

Next Speaker: – in close interaction with public health and medical care?

Next Speaker: Yeah, so the task force had a lot of conversation about how relationships between public health, CCOs, education and other partners really vary locally right now. Um, in some cases that is kind of hand in glove and in other cases that work might still be forming. Uh, but in that kind or assessment of how, to what extent are you meeting those foundational capabilities and programs and how will you get there, the CCOs and other partners are very much at the table. And it may be that in certain communities, uh, a particular foundational capability or program may be, aspects of that may fall responsible to a CCO because it may make more sense for that community. Um, I think the task force really had in mind that, uh, what was important is that these are, these foundational capabilities and programs are provided and to be, agnostic about who actually does that work.

Next Speaker: Okay, any other questions?

Next Speaker: What about, what about checks and balances and compliance? I mean how will you know, how will you monitor –

Next Speaker: Mm hmm.

Next Speaker: – how counties are doing and if they're up to the stand you want 'em to be?

Next Speaker: Right, and also I probably didn't make this clear enough but the public health division itself would also be implementing these foundational capabilities and programs and sort of in that process, what's the state role in doing this and what's the local role and making that very clear what those functions are. So one of the things that's new about this model is that the public health advisory board would be recommending metrics by which the public health system would need to perform and there would likely be some kind of process by which great performance or being able to meet certain measure would be rewarded financially or otherwise. Um, those details are yet to be worked out but this would be a brand new way of holding the public health system accountable for outcomes, um, and we'd be needing to report those on an annual basis.

Next Speaker: That would be interesting, like for STDs and that kind of thing as well, you'd set standards and see if you can meet them?

Next Speaker: That is the plan. We're really trying to move our system forward, to move away from individually counting the process that we do to being held accountable for outcomes.

Next Speaker: Through public education and getting out there and doing whatever?

Next Speaker: Yeah, you know I think some of those details will come in the next two years but it's absolutely the intention of the task force to move us to outcomes.

Next Speaker: So I'll take Dee Dee's role here, so what, if I'm a consumer what am I gonna understand about this work and what, what communication has there been to consumers?

Next Speaker: So we're just sorta hitting the ground running with getting, you know getting word out about this opportunity in the future. Part of it is that there's a bill in the legislature right now and it's a matter of you know wanting to inform our stakeholders but not wanting to get ahead of that process so that assuming the bill passes we can hit the ground running but we haven't gone outside of our lane here. Um, I think what's important for consumers to know is that, um, currently in Oregon is that our public health system, and the extent to which we provide public health services really varies based on where you live. It varies a lot with regard to county investment in public health. Um, what's really important and the task force talked about a lot is that everyone in Oregon should expect a minimum public health service, regardless of where they live and this would help us more there. Uh, right now it's really variable and you can't expect the same service from one county to another based on the funding that goes along with that. Yep.

Next Speaker: I was just wondering, I'm sorry, you **** slide in –

Next Speaker: That's okay.

Next Speaker: – and you may have said something about this but either the task force or do you guys have plans to assess some of these other states who clearly getting more funding or maybe they have a structure in place, you know how does that help inform –

Next Speaker: Mm hmm.

Next Speaker: – where we're headed, uh, other best practices around the country that maybe you guys are learning from?

Next Speaker: Yeah, so, um, when the task force was meeting we did bring in some national consultants –

Next Speaker: Yeah.

Next Speaker: – that have done some work around cross jurisdictional sharing or basically sharing some of the work across county lines. Uh, we also heard several times from Washington State that had kind of undertaken this process before we did and we adopted you know aspects of their work, uh, they haven't implemented yet, they've kinda gotten to the place of figuring out how much this costs to deliver and then they've kinda stopped there. Um, so we plan to kind of figure out what other states are doing, um, but Oregon is also a little bit ahead of the curve of –

Next Speaker: Yeah.

Next Speaker: – actually thinking about operationalizing this work.

Next Speaker: I see, so there's a bit of a pioneer thing goin' on here as well and I know the CCO think is so unique here –

Next Speaker: Mm hmm.

Next Speaker: Okay.

Next Speaker: Yeah, yeah, so you know our director was recently in a meeting with the Robert Wood Johnson Foundation and some other states that are taking a look at how to make this real so I'll certainly stay plugged and try to be a leader too.

Next Speaker: You have that network though.

Next Speaker: Yeah, thanks.

Next Speaker: One quick question, I was just wondering if healthcare associated infections are at all mentioned in the bill specifically?

Next Speaker: So –

Next Speaker: Or is it just generally more public health?

Next Speaker: I would need to get the bill for you, but essentially the big report, if you're interested, the web site is **** healthoregon.org/task force, um, each of the program areas and capabilities have kind of a, a straw definition to them and essentially what would need to happen after the bill, if the bill passes is to better define what those mean so they're measurable so we would know whether or not a particular health department is meeting that foundational program requirement or not. So I think more work of that is to come, um, and I'm sorry, I should have looked at this for you.

Next Speaker: I'll take a look at the executive summary.

Next Speaker: Yeah, and the report itself will have the fuller definition and that's where the field language really came from almost verbatim.

Next Speaker: Thank you.

Next Speaker: I had a quick comment, one question.

Next Speaker: Yeah.

Next Speaker: The comment is I think this committee has been meeting for a while discussing metrics so when you kind of get to the point of lookin' at outcomes it would be really great if we could you know have some representation or collaborate with you on that.

Next Speaker: Great.

Next Speaker: And **** and, um, also just a, sort of like a question on budget. So if the bill were to pass would this sort of kind or program, the funds to increase the foundational capacity, would that be sort of, would that come from the state general fund or what's the anticipated source?

Next Speaker: So, um, the elected officials that served on that task force sort of agreed that the conversation on funding needed to happen and it needed to happen in the legislature. Because the bills have only had a, each had a public hearing. Um, yet I don't think we've quite gotten into how we provide a glide path to making sure that these are robustly funded. Um, although that's a recommendation that's here and I think it's a recommendation that's heard pretty clearly. Um, one of the things that would have to happen is once we define exactly what we mean by these programs and these capabilities is to figure out what it actually costs. And that's kinda where Washington State has ended up. They, uh, fully defined that we definitely start with their definitions for the foundational capabilities and programs because they kinda got down to real specific things. Um, then they figured out okay that means that many FTE, this means this, kind of a database, this means this and that's gonna cost you this thing so it's a little tough because we would anticipate that that piece of the work would happen in the 2017 session. Those are great questions, thank you.

Next Speaker: Thank you very much. Okay, are we ready to move on to our next presentation? Which will be Diane will be presenting, giving us an update on HAI metrics for hospital transformation performance, starting on Page 39 for those of you on the floor.

Next Speaker: Would you mind if I quickly, I just wanted to ask, I think someone else joined on the phone or some other people. Is that true? Okay, maybe not! I thought I heard –

Next Speaker: I heard it.

Next Speaker: Well, Kate asked me to come share with you a little bit about the hospital transformation program and in short we call it HTP just because that's a mouthful, and the reason why that's important for this group to understand is that in the measure list for this program there are two HAI measures that directly, um, align with what hospital are already reporting to the state and that you would be interested in knowing about. So really what this program is all about, it's really a pay for performance of incentive program for hospital, or specifically the DRG hospitals in the state which there are 28 of, so a lot of the 62 members, 62 hospital members that belong to the Oregon Association of Hospitals and Health Systems, 28 of those are DRG hospitals which means they are, the participate in the, uh, hospital provider tax program. And so basically this program, um, allows the Oregon health authority through a deal with CMS to make payments to hospitals that show performance improvement in a whole list of measures that I'll share with you in just a minute. These measures were not pulled out of thin air. They were greatly discussed for a long time as you can imagine. Anytime measures are a topic of discussion through a metrics advisory committee that was led by the Oregon Health Authority and so really at this point in time we're smack in the middle of this program. This really began, we had approval actually way in the middle of the program, or the baseline year. So it's a two-year program that started October 1st of 2013, um, and the baseline program ran for 12 months

and now we're in the performance period which started October 1st of 2014 and will run through September of this year. So, um, the metrics committee that I referenced, this is, has the authority through, uh, Oregon Hospital 2216 from the 2013 legislative session and, um, you can see there the composition of the metrics advisory committee. Um, it was a well balanced and well rounded committee. There were about half the group from hospitals, that represented hospitals. We had some CCO representatives; we had three other individuals who had, um, metrics expertise. Um, and I mentioned this already about the 28 hospitals that are eligible to participate. And so here's a list of measures which probably is of most interest to you. You can see there on the left hand side two major areas, a hospital focus and a hospital CCO coordination focus. CMS was really interested in having, uh, having this program think more broadly than just within the four walls of a hospital. So they wanted to know how hospitals were engaging with their community partners and community stakeholders. Um, so that was the reason for the split in the focus areas. So what you see here basically on the right hand side is a list of the total, list of 11 measures, and the top eight of those are focused around what happens in hospital operations and the remaining there, um, are around the community pieces. So to be really honest the most difficult ones, uh, to help hospitals with at this point in time have been those bottom three, uh, around the CCO coordination focus, around emergency department, uh, visit information, and around, um, implementing ESPIRT which is, uh, screening, brief intervention, referral to treatment for drug and alcohol, uh, for folks who come through the emergency department. But uh, you know this is a, a great thing for our state because a year ago we had none of this piece, and, and now we have made significant progress in this area. So as far as the HAI measures you see up there, uh, CLABSI and CAUTI and ****, um, this was a carryover. I really, uh, pushed this, these two measures because hospitals that were involved with Partnership for Patients over the last 3 years have been tracking this, and it just seemed natural to continue this work because they were beginning to have momentum and to see some progress here and what was already being required through the state. So we're going for alignment wherever possible, right?

Next Speaker: Excuse me.

Next Speaker: Yes?

Next Speaker: Can I just ask you on that screen –

Next Speaker: Yes.

Next Speaker: – on the two bottom, um, 10 and 11 –

Next Speaker: Uh huh.

Next Speaker: – what is the follow up, um, after hospitalization and then also what is the **** the consumers on those.

Next Speaker: Okay, okay. So a little bit more about that. So, uh, so Dee Dee that question around follow up after hospitalization for mental illness. That is a measure that is tracked by the Oregon Health Authority, so the hospitals aren't, uh, tracking that one, but, um, OHA gets that information through claims, uh, claims data at the state. So they're really interested in knowing,

um, folks that have been recently discharged from a hospital for a mental health diagnoses, are they receiving the follow up that they need to have. So, um, so that's an important one that's being tracked. And then No. 11, the ESPIRT measure, uh, you may have heard that this has been, uh, uh, initiated more so in primary care offices especially in Oregon. Uh, at OHSU Jim Winkle has been really instrumental in this work in helping primary care, uh, offices and clinics up there do this work. Now we're trying to, uh, integrate it and embed it in a hospital emergency department so that the measure is such that any patient who comes to the ED who's age 12 and older will have a brief screen. Uh, ha, uh, and there are three questions that they ask 'em in – and, and I don't have it off the top of my head. But it's just to evaluate them on gee, is drug and alcohol, is that gonna be, uh, impactful for the reason that's bringing them here to the hospital, uh, or is there something else that we can do to, uh, assist them. And so if they screen positive, then the next piece of that is then they're eligible for a full screen which is a longer, uh, screen with an approved tool, uh, so that those folks that, uh, indicate that they have a need or an issue or a problem can be referred to resources that are available. So it, it's really trying to get more of a handle on, um, uh, a more holistic perspective of a patient when they come to a ED. So it very much, very much needed as you can imagine. Did that answer it?

Next Speaker: Yeah.

Next Speaker: Okay.

Next Speaker: Good.

Next Speaker: Okay. So I mentioned to you that, um, this, this money – I should probably explain a little bit how this, how this comes. So hospitals agree to tax themselves through the hospital provider tax program at, at a certain amount, uh, which helps fund the state Medicaid budget. And they agree to increase that amount by 1 percent to have this, have funds available for this incentive program. And so what that ha, what that means is that they've got to demonstrate, uh, performance and improvement in that holistic measures to be able to get those funds back, returned to them. And if they don't do well, their piece of the funds would go to somebody else and, and, and has done, has done so. And so, uh, they're two pieces here for the baseline year that I just talked about that is over with. Uh, if hospitals submitted data on 75 percent of that list of 11 measures, they got a floor allocation of money. And they really weren't looking at, uh, how did they do compared to anybody else or, or what was their improvement. So this next phase, the performance year which we're in right now, it's, they're going to be paid according to how they performed. Um, so this is a little bit more detail in case you're interested, um –

Next Speaker: Mm.

Next Speaker: – how did they do against each measure. The Step 2, uh, what is the measure worth which I'll show you a breakdown on the next slide. And then, um, uh, in addition to what the measure is worth, they get rewarded on, uh, hospital size, so there's an adjustment factor depending on how many Medicaid patients that they have to make it a little more even. Here's the breakdown. Probably more detail than you wanted to know, um, but we just tried to simply as much as possible so that, uh, uh, you see the breakdown there.

Next Speaker: And this is readmission within 30 days?

Next Speaker: Yes, yes. All cause readmissions. So here's that adjustment factor that I spoke about based on Medicaid discharges and Medicaid in-patient days, and then, um, uh, the calculation, uh, based on, uh, discharge data and the timeframe there for when that was, uh, calculated. So this has been a big partnership between the Hospital Association, Apprise is our data subsidiary, and then of course, the Oregon Health Authority. This slide just kind of outlines what our role in this has been, uh. We've been really key in helping with, we set up a reporting platform, uh, for hospitals, um. We are making sure that the data gets submitted to us timely. We're looking at it for validity. We get it to the Oregon Health Authority so that they can, uh, review it and make sure that it is in line before it gets submitted to CMS. Oregon Health Authority, they're the ones that track this hos, after hospitalization for mental illness measure, um. They're looking at the data to see if it meets the thresholds, if things are correct. They're going to perform the payment calculations and they're the ones that distribute the payments. So where we are right now, um, hospitals, as I mentioned, they just, uh, had their baseline data submitted. They had it reviewed by the state. The hospitals got to see their data back to them just to say here we are at Oregon Health Authority. This is what we've seen from you. Is this correct? Uh, and then based on that, uh, Oregon Health Authority will notify them about what their payments are going to be, which they'll be distributed on April 30th. So there's a lot more information on, uh, Oregon Health Authority web site. Here is the link, if you want to see all of the measure specification and all the, the backdrop to this program. So I know I raced through that, but any questions about what it is or how it's being implemented or why?

Next Speaker: Yeah, I was just, I was curious on, um, how, why decide to use CLABSI and CAUTI and what other options you might have had ****?

Next Speaker: Well, that, that's, um, that's a really good question. At the time, um, it, especially, uh, there's a lot of work that's been done around CLABSI in the state. So folks have, have done really well with that in the ICU, but not particularly all tracked units, and then CAUTI is, you know, a horse of another color. That's a tough one, a tough nut, not just for our state but every state across the nation, and so yeah, you know, it was kind of like a, a balance, you know. One, we have a fighting chance of doing well and looking pretty good and the other one, we still have a lot of work to do. So, um, you know, because those were being, being tracked and they seemed to be of, of importance to the state, um. I think, you know, it had been, there could've been a whole list of other ones.

Next Speaker: Oh, yeah, sure, right.

Next Speaker: Yeah.

Next Speaker: Are there validations being planned to, um, review, to make sure that people are reporting appropriately?

Next Speaker: So these, this data is all from NHSN. So, uh, at this point in time, no, we're not planning validations.

Next Speaker: Validations.

Next Speaker: Yeah, on this, so imported data, so yeah.

Next Speaker: It'd be great to do that if we –

Next Speaker: Yeah, we could.

Next Speaker: – **** and we've seen that it's extremely important.

Next Speaker: Yeah, for sure.

Next Speaker: Yeah, so.

Next Speaker: For sure, for sure.

Next Speaker: But I mean I, it, it's obvious that there's now enormous incentive –

Next Speaker: Yes.

Next Speaker: – to low haul your, your accounts, right.

Next Speaker: Yeah, exactly.

Next Speaker: The pressure, you know –

Next Speaker: Yeah.

Next Speaker: – we had three UTIs this month, uh oh.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah and I mean the, the issue of hospitals being penalized that are doing a better job of, of actually –

Next Speaker: Right.

Next Speaker: – reporting and surveillance and whatnot is concerning.

Next Speaker: ****.

Next Speaker: And that's, I don't have a great answer for that, but I think that ideally, you validate all data and that at least would get the accurate initial data.

Next Speaker: Can I ask, uh, what, what do you think, Diane, would be, um, the, the most difficult of these, all these measures to reach? I mean can you kind of predict based on what they are and what you know about hospitals that, um, you know, these particular ones are going to be difficult to, difficulty will go up?

Next Speaker: Well, um, the medication safety measures have been tough, um, but I started my group of hospitals that worked with me on Partnership for Patients on these three measures last year. So, um, I feel like that some of them have a little bit of a head start because believe it or not, some hospitals were tracking these three on a regular basis, and so it's like why not, right, um. So those are probably not as tough, but the ones that seem to be the toughest, uh, like No. 11, the ESPIRT, so there's a lot of confusion on, um, you know, how do I track this. It, it really isn't so much about doing the screening. It's how do I implement this workflow into my existing emergency department. Who's going to do it? Who's responsible? How do we record it? How do we track it? It's, you know, just that, that learning curve, um. So if you know about ESPIRT, um, you know, we're only looking at like the first two components of ESPIRT and there's like, you know, other ones that come behind. So there's the thought that this program will continue. Uh, it's in front of the legislature now. If it continues for the next 2 years, it is reasonable to think that, uh, this measure list will change somewhat, um. ESPIRT probably will be expanded and it may be that the focus around CCO community, um, measures would be 50 percent, and it would be impossible to focus 50 percent, it would be more it would need. So, um, you know, just a natural output from there, but I, I just, I think that, um, anything that's been CCO related or, um, you know, something new like ESPIRT, that's really the biggest learning curve.

Next Speaker: I have one question on Measure 3. What, what would be excessive?

Next Speaker: So there's a, um, there's a benchmark now of, um, 5 percent, so anything over 5 percent. I mean really, really what you want to shoot for is zero. You don't want anybody having excessive anticoagulation or, uh, an adverse drug event, um, but where we're starting them right now is, um, first of all, monitor your data and can you, can you consistently perform below 5 percent, and then if that measure continues, that would be ratcheted down.

Next Speaker: Although there are, you know, different patients sometimes have different –

Next Speaker: Yes.

Next Speaker: – target levels –

Next Speaker: Yes.

Next Speaker: – based on what their history is, um. Is it possible to take all that into account when you're looking at excessive?

Next Speaker: Well, um, the measure is worded such that, um, it's, you know, uh, the first dose of Warfarin that you give in the hospital. So if, a lot of patients come to the ED with elevated

INR already. So you're not going to be dinged for that one, but you know, what happens on your watch here, um. Then there's also been a question about what if they're on, um, Argatroban as well, right? That sometimes causes it to be falsely inflated. So, um, the measure specs kind of take all of it into, into account. So I mean, you know, it's not rocket science. It's not perfect by any means but, um, doing the best we can here with this, with this measure.

Next Speaker: It's not, it's not like they have a bleed or some accident. It's just that the number, the level's too high for adequate reassessment.

Next Speaker: Okay.

Next Speaker: You don't have to have that.

Next Speaker: So within your formal **** yeah.

Next Speaker: And you're only looking at Warfarin, not any of the other anticoagulants that are commonly used in hospice?

Next Speaker: Yes, Warfarin. Yep, starting somewhere.

Next Speaker: Like I feel like **** –

Next Speaker: Yes.

Next Speaker: – but to me, your target at the hospital isn't, isn't a relative measure, so you just have to just decrease from 1 year to the next rather than be absolute, just because I noticed that it's rate. There's no risk investment here.

Next Speaker: Right, right.

Next Speaker: So there is, um, the, based on all of the data for the baseline year, benchmarks were being established, right, and so, um, you have to, you have to either meet the benchmark or have a 10 percent improvement for your, from your own rate, from your baseline.

Next Speaker: Okay, so the benchmark is for all hospitals.

Next Speaker: Yeah.

Next Speaker: So the better you are, the harder it is to maintain.

Next Speaker: Yes, yes, it is.

Next Speaker: Especially if you're at zero, which is –

Next Speaker: Yeah, yeah.

Next Speaker: – a lot of hospitals.

Next Speaker: Right.

Next Speaker: Yeah, yeah, for sure.

Next Speaker: The, the only, um, see, I think you alluded to the possibility that you might potentially re-evaluate our ****. Is that, so what is the process for that?

Next Speaker: So right now, the, there's a call out from Oregon Health Authority for, um, for members for this committee.

Next Speaker: Mm hmm.

Next Speaker: And that you either need to be a hospital rep or have, be a metrics expert, right, or from CCO so that, um, you know, the floor's open for you to participate here. So that group's going to be convened again in the spring –

Next Speaker: Okay.

Next Speaker: – to be looking at well, what does Phase 2 of this program look like.

Next Speaker: And how long is this program going on? It says 2 years or this is a –

Next Speaker: Right, so we're in the middle of the second year right now, and, um, the next phase of this would begin this, this fall if everything clicks along –

Next Speaker: – okay.

Next Speaker: – with timing that.

Next Speaker: And that's it, okay.

Next Speaker: Yeah, for sure. Yes.

Next Speaker: Question, um, I'm intrigued to hear about the funding methods that are used.

Next Speaker: Mm hmm.

Next Speaker: How has that worked? I know the metrics will change, but how do hospitals, uh, you know, function in a healthy efficient way to incentivize essentially their own money coming back to them from an external.

Next Speaker: Well, this is, this is totally brand new. This is totally brand new. They've never had this before and so, um, they, they are –

Next Speaker: What it comes down to is thousands of dollars placed, doesn't it?

Next Speaker: – yeah, it –

Next Speaker: It's state money.

Next Speaker: – it's a chunk of change.

Next Speaker: If you make your, they're taxing themselves into a pool of money –

Next Speaker: Mm hmm.

Next Speaker: – and if they do well, they get a portion back.

Next Speaker: Yep.

Next Speaker: And has that, I mean from a hospital's point of view, has that been a successful model?

Next Speaker: Yeah, the hospital provider tax and then this extra 1 percent, uh, is, you know, out there for, which they may get some back or they may not get any back, depending on how they do. Any other questions?

Next Speaker: Okay, thanks, Diane.

Next Speaker: Mm hmm.

Next Speaker: Okay, coming up next on the agenda, we have Kate Ellingson who will present the HAI annual report for closed-unit formats for consumers and providers and facilities ****.

Next Speaker: That's everybody's favorite topic.

Next Speaker: Yes.

Next Speaker: We've been holding our breath for a year.

Next Speaker: I know.

Next Speaker: Okay, so yeah, this, um, we're basically just going to have a break in about 15, 20 minutes so, um, you know, bear with me through this and this actually is meant to be fairly interactive. I'm trying to get some feedback based on, you know, how we've integrated your feedback from the last session and kind of what our plans are going forward. Um, so we, um, basically, I just want to talk a little bit about the timeline, um. The report format, we received some feedback at the last meeting about the desire to sort of have two ways of viewing this data, from the consumer perspective and from the provider perspective, um, and we discussed some data displays and I wanted, I had some additional follow-up questions for you all about that.

We've also, um, been talking on our team about this concept of facility specific report cards, so these reports are basically going to have data listed by facility and, um, in previous years, there's sort of been an appendix where each facility is listed individually with, you know, all 12 of their metrics and that's something we haven't, we didn't do last year and I think, uh, is something that might be useful for facilities instead of having to go look for themselves on Page 2, 8, 17 of the report, to have everything in one place. So we're also thinking about that. Um, this, I showed this slide last time. This is just to kind of like reorient with where we are for hospitals, um. These are all of the metrics that have been proposed since 2009 and you can kind of see how they've been reported, and so for the 2014 report, we have 12 metrics for hospitals and so I just mention this to you as kind of, um, to plant the seed as we're moving forward, one of, um, you know, last year's report was very comprehensive, I think. Everybody liked the various data displays. The only complaint they had was it was over a hundred pages and kind of unwieldy. So given that we've got to get 12 metrics reported, that's sort of, we're trying to think creatively about how that's displayed, that information in kind of a less overwhelming way. Um, you know, still for non-hospitals mostly, it's influenza, uh, health care worker influenza vaccination, um, is the only required reporting metric for, uh, long-term care facilities and AFCs and our dialysis facilities do some dialysis event reporting, which the events are, um, meant to sort of, to approximate bloodstream infections in dialysis patients. So publication schedule, last year's report came out in summer of 2014, and so our target this year is to get the report out by July 31st, 2015 and this just sort of aligns also with some of our funding, the funding we receive to do this report has this deadline. Um, it might seem like a long time, um, but this actually is faster than the CDC reports out data and most states actually have more of a lag in reporting out their data, and this is mainly because hospitals have some time before they have to get into our NHSN reporting system, um, CMS, Dunlap, etc. So we're trying to align ourselves with when CMS requires hospitals to report data, um, and then try to get it out in a timely fashion. I don't know if everybody, this is actually a pretty bad slide because nobody can see it, but, um, I guess all this is to say is sort of on the top. This is like going January through April, is just that we're trying to actually focus our work on getting the report format right, figuring out what we want it to look like, how long we want it to be, whether we want one or two reports, and we're moving forward on that, and then the other piece on the bottom is really getting the data from all these facilities, which is a pretty, uh, big effort, and just to kind of let you know where we are now, we're, um, we're downloading the data, uh, from NHSN, and sending preliminary reports out to the hospitals so that they will have between early April and mid-May to just check their numbers, because in mid-May, EMS is basically releasing the data and that's what goes up on hospital compare. Uh, so we actually want to work with the da, with the hot facilities with that timeline so we can help them with uploading their data, but also make sure that what we have in our report isn't different from what CMS ends up with, which has happened in years past and it's always a little bit awkward. Um, and so you can see like for the second half, from April through July, I think that we, we're just going to be focusing on, on data and data quality, and following up with the facilities, um. As Monika, Monika actually helped write some, um, a standard operating procedure for following up with our long-term care facilities, and ASCs in terms of getting their, uh, influenza vaccination data in, um. They actually can be fined and we've never invoked this before, but it ended up being quite, quite an effort on Monika's part to follow up. So we're going to try to be, uh, you know, to be very clear about, you know, when it's due and, uh, try the standard operating procedure issue, so.

Next Speaker: When, when is it due?

Next Speaker: Um, it's, actually, so May 15th is, so CMS has all these different quality reporting programs, so facilities get reimbursed for just reporting to NHSN, and they have to have their data in for the fourth quarter of 2014, which is the end of our kind of reporting period, it has to be in by May 15th for all of the hospital metrics and also influenza vaccination data for 14-15 from all of these facilities. I literally just checked my email when I got back here at 12:30. There is an email that was blasted out by CMS that long-term care facilities –

Next Speaker: Yes.

Next Speaker: – or no –

Next Speaker: Surgical, yes.

Next Speaker: – Ambulatory surgical centers don't have to have their data, flu vac data now by, until August.

Next Speaker: Oh, okay, well.

Next Speaker: Yeah.

Next Speaker: It's hard to get that so.

Next Speaker: So that's going to be separate for us.

Next Speaker: Hm.

Next Speaker: We haven't even talked about that, and I literally just read it.

Next Speaker: Okay, sorry.

Next Speaker: But I did note in the past, Monika has had to contact facilities like as many as ten time over a period of months to try to get the information that they're require to report.

Next Speaker: Yeah, so now the, the standard operating procedure says that we won't potentially fund facilities 'cause we could. Um, we'd prefer not to do that.

Next Speaker: Will threatening work?

Next Speaker: I tried, to be honest.

Next Speaker: Hopefully, not, but.

Next Speaker: But it didn't work, you know. I just tried it. So we can actually do it and see if that works. While I mean this is, and this may have implications. We were sort of excited that

the May 15th deadline appeared to be consistent because we could get everything into one report, but you know, last year we actually, the flu vaccination report came out, um, in the fall instead of coming out in the summer, and we may have to revert to that this year, but.

Next Speaker: I see.

Next Speaker: Um, so just to kind of, uh, at the December meeting, sort of recap what this committee recommended, um, basically everyone agreed that we needed some kind of clear summary presentation for consumers and that, you know, the hundred page report, um, which was really rich in information and data, maybe wasn't the easiest for consumers to read, and so we talked about, um, you know, having kind of a, you know, very simple level of, of data presentation for consumers and a more detailed and complex level for the providers, and so that's the direction we're moving this year, but keeping in mind that everybody will have access to that kind of more granular data, um. So if the more savvy consumer wants to get into what confidence intervals are, what SIRs are, they can, they can go there. Um, a couple of things also came up in December was that, um, a few of our members wanted us to display rates in addition to SIRs, which actually is not a problem. In our previous reports, we report the observed infections and the denominators. We just don't, um, we focus most on SIRs, but we can, we can put rates in as well, um, and the reason we moved towards the standardized infection ratios is because they're, they're risk adjusted, like nothing precludes anyone reading the report from calculating a rate. So, uh, we can certainly include that, um, and, um, also, there was, some people were asking, I know Mary in particular was talking about how it would be nice to be able to compare your hospital to peer hospitals, and so, um, one of the things that we thought about is just, um, doing a very simple stratification by hospital size. So when, you know, you look at your data, you could also look at, you know, what does a similarly sized hospital, uh, look like in terms of their SIRs and rates for the various metrics, um. And we also talked about some color coding of some confidence intervals. I'll ask you for some feedback on that. Uh, the other thing that came up is sort of this need for like a tight executive summary so that we could just, you know, you have your sort of SOCO or single overriding communication method about how Oregon was doing, where it was weak, where it was, it appears to be strong, and so we're really going to work to get that together too. So based on the recommendations I mentioned, we have two reports, um, and try to do an executive summary that is graphic, um, it, I think in a good way, um, graphic with an overall picture of Oregon. So like I'll show you an example in a minute, but we're going to work with our design and publications groups to, um, to come up with something that would sort of be a two pager front and back where you can see all the infections and all their rates. So, um, but before we get to the executive summary, I, I just wanted to share with you some findings from a CDC subcommittee, um, that is really dedicated to people at the state level who are putting out these reports. The, most of the states in the country are doing annual reports just as we are, and, um, a lot of people are struggling with, you know, the complexity of the information relative to, you know, the audience that's seeking this information, the public, and so, um, there was a subgroup that actually went and did some pilot testing and focus groups with consumers to see how they would want to see the data. So they had, uh, various kind of experimental groups, um, you know, some where people were shown, you know, here's an SAR and a confidence interval and a rate, um. You know, here's no confidence intervals and all these different permutations and what's displayed up here was the most well received on the consumer level, and so we'll just sort of walk, like one thing to first, to notice is,

well, think of the, the table at the top is the legend and then on the bottom, it's sort of how it might look to have sort of facilities listed out, um, and you'll notice that there's no SIR here at all, um, although there's sort of a qualitative assessment based on the SIR in the right hand column. So, so if you look at the first facility, this is, this is like an example for CLABSI reporting, clean hospital, and you know, you can't, we don't actually report out wards yet, but for states that are reporting wards, you can split ICUs and wards. So you can see the number of infections in that calendar year and then the number of predicted infections, and there's a very kind of, um, we've talked about very simple ways of explaining how the predictive infections are generated, and then an assessment of whether this is significantly better than what we would expect based on the national experience. Is it significantly worse or the same or no conclusion. Um, and I think that came from just, uh, what people were hearing from the consumer groups was I don't necessarily want all the data, but tell me which hospital is better, and so, um. So we're sort of, we're looking into this and let me, I'll just show you another, um. One of the issues that has come up is that in Oregon we have a lot of, um, you know, there are some smaller hospitals that don't necessarily have the, enough denominator days to actually achieve statistical sig, significance in either a positive or a negative way. So a lot of our hospitals will have, if we were to use this report, they would have this gray sort of same, um, you know, qualitative assessment, and the question is, is that, is that usable. Do we sort of by kind of making it so simple, do we sort of lose some of the, you know –

Next Speaker: It would be less than one anyway.

Next Speaker: Yeah, I mean and you could, yeah, I guess they can see the SIRs left. You could do that calculation, but, um, one thing that some of the other states that, um, are dealing with this issue as well, um, Hawaii is one that they have so many small hospitals that nobody can reach statistical significance, and so they really, um, they've started sort of emphasizing this zero infections. So for hospitals that have zero infections, they don't get kind of a red or green star or a red X, but they get like a hibiscus flower next to their names. You know, so it's like there's something positive that they take away just because they had zero infections, um. You could make the argument that that's not really fair. If you had a big hospital that had one infection, but they expected 30, that maybe they should get a hibiscus flower, but, um, it's, there's not perfect solution here since there's highs and **** we're thinking about. Uh, and then so this statis, I'm kind of overlaying this. This is kind of how we, we had sort of this kind of color coding system in last year's report for SIRs, so sort of the dark green with SIRs significantly less than one, a light green if it's less than one but not significant, a light pink if it's more than one, but not significant, and then this sort of dark red if it achieves statistical significance. So I guess my question for you, for the group is, um, you know, A, kind of how you feel about this type of, uh, different format for consumers, and whether you think we need to, whether you think we need to do something to provide information on the hospitals that are not statistical difference from the national average. So they would appear like with this skewing to be the same.

Next Speaker: Well, we did struggle with how to identify that, remember.

Next Speaker: Yeah, we've gone, I mean I –

Next Speaker: Yeah.

Next Speaker: – those of us that have been here for a long time, we've gone around various possibilities.

Next Speaker: But I do like the, the CDC workgroup identifying it. It's more clear than what we have ****.

Next Speaker: Now, are you, I guess that, are you concerned about the, so the issue that she's kind of bringing up, you're going to have a lot of hospitals then that just stay the same –

Next Speaker: Yeah.

Next Speaker: – on that, and so I know in the past we've had some people that have been concerned about that, said well, this place, yeah, they might not be statistically significant or worse, but they are, they do have a number that's above the national –

Next Speaker: Mm hmm.

Next Speaker: – average and I'd like to know that. Now, I don't know. Right now, maybe everyone's fine with it like this. I kind of, I'm fine with what everyone else wants to do, you know, so.

Next Speaker: Um, it's a shot in the dark, but I'll ask a question anyway. Is there any chance the Health Authority has any sort of patient advisory group where this could be, if they did a little context, float it by them so that they could, um, respond? I mean it strikes me that we're asking a question and all of us are inside the industry.

Next Speaker: Right.

Next Speaker: And very tainted because of that and I know that at the commission, we start **** as well. It's like what are they really seeing when we put this out, right.

Next Speaker: Yeah.

Next Speaker: So, um, I just wondered if there was any sort of patient advisor of the Health Authority that could just be leveraged to ask, and frankly, I understand that it's probably no, but I figured I'd ask anyway.

Next Speaker: I think it's a great question. I, I don't know, you may.

Next Speaker: You know, I have to say I'm not aware. Now, are Paul or Dana or anyone else, aware of something like that? I am not aware of that. I think it's a great idea.

Next Speaker: I think it should be assigned to you next session.

Next Speaker: Yeah, but they're bringing it up ****, you know, and I realize that there's always a limit too, but I do think that's one of the things that we struggle with is, uh, you know, they're hard to put together, but if there was any chance that there was one in place.

Next Speaker: Well, that's, I think –

Next Speaker: That would be great.

Next Speaker: – it's great. I'd love, I, I've been wanting to have more interaction with patients.

Next Speaker: Because I think **** –

Next Speaker: I'm trying to figure out how to do it. I'm not sure how to do it.

Next Speaker: – this top and we will continue to because we're all, we're all very jaded with what we, what we operate under.

Next Speaker: Right, but if you had it in place for 2 or 3 years and they become **** also and you know.

Next Speaker: They can't, in that way.

Next Speaker: And what you could do is a lot our com, standing committees do have public members. You could take like the public member for drinking water. That would be a good person. They're pretty fresh. They don't, you know, the drinking water.

Next Speaker: So do you.

Next Speaker: Like a couple of the other, that's a great idea.

Next Speaker: So if you took them and have it a couple times each year. You took all your public members and have this extra public, because each one of us, a lot of us have advisory committees where we have a public member.

Next Speaker: Yeah.

Next Speaker: There's one that's there. We have a couple and maybe get those people together, um, and you could leverage, you know, if you need to do like a list of things.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: The CCOs all have to have a member and a board too, which might be ****.

Next Speaker: Oh, ****.

Next Speaker: Yeah, that's what, I do too.

Next Speaker: Yeah, because I mean it just needs a little framing and then you can just say, you know, what strikes you. What's working for you and what's not?

Next Speaker: Yeah.

Next Speaker: And most of the hospitals, uh, have patient advisory committees as well, and you could take representatives from each of those, you know, and put together a super advisory committee, you know.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Usually, **** that think like that, who are pretty happy to give you an hour of their time.

Next Speaker: Mm hmm.

Next Speaker: We'll offer food and a nice ****.

Next Speaker: Yeah, yeah, coordinating it is the hardest part, right.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: Yeah, it's a great suggestion.

Next Speaker: I mean I like that idea and actually it's to question the hospitals and asking if each one could volunteer someone from each advisory committee.

Next Speaker: They already have those committee's in place.

Next Speaker: I mean yeah, we're reaching out to them now to send them their preliminary data.

Next Speaker: Yeah.

Next Speaker: That's a good point.

Next Speaker: So this can be part of it as we send out the email, you know, this is an opportunity to have some input on the new format.

Next Speaker: Yeah.

Next Speaker: Just as another random, um, possibility, um, SurveyMonkey also has the option of, um, you can buy responses, some of your responses, and that really would be like Joe Community or Joe ****.

Next Speaker: And send it.

Next Speaker: And you can send out your thing and ask for it. I don't know, I don't know what the cost of it or anything like that is, but you can just sort of have some people answer.

Next Speaker: Yeah.

Next Speaker: You'd have to have a pretty big **** people to get some kind of response or anything you felt good about, but it's still there, yeah.

Next Speaker: Yeah, it would make it much easier.

Next Speaker: Do you still –

Next Speaker: But I think ****.

Next Speaker: – list that stuff on the web site ****?

Next Speaker: Do we have a place now? That's a great idea also though. We should do that.

Next Speaker: What do you think, you know, that we should have, we should do?

Next Speaker: We do have an email.

Next Speaker: Well, we'll find out, yeah. Yeah, maybe it's one of those things.

Next Speaker: We do have an email to ****.

Next Speaker: Yeah.

Next Speaker: It might be good for us to like write –

Next Speaker: Like right next to the report.

Next Speaker: – yeah, exactly.

Next Speaker: Yeah, it'd **** vehicles like that and we just kind of collate what you get back.

Next Speaker: Yeah.

Next Speaker: Yeah, if no one responds on web site, fine, but maybe they will.

Next Speaker: We know those are the people who are looking.

Next Speaker: Yeah.

Next Speaker: Oh, sure, yeah, sure.

Next Speaker: Um, well, I don't know if you have more slides or anything because I just –

Next Speaker: Yeah, I, just this, this is kind of what it looks like with –

Next Speaker: Yeah.

Next Speaker: – the different kinds of, um, so here is an example I just wanted to show where there's, uh, a hospital that was statistically below the national experience.

Next Speaker: And just one piece I was noticing, um, with this is suggestion that the, because you give the absolute numbers, that does put this even, but also it's saying there is some sort of context that you were using, some concrete numbers that need help with that.

Next Speaker: Well, especially with sur, with surgeries, I think that a number of procedures that a hospital performs is sort of important –

Next Speaker: Yeah.

Next Speaker: – and it could get lost in some of our reports with lots and lots of numbers.

Next Speaker: If it's already calculated, it gets lost, but you're, are you –

Next Speaker: Yeah.

Next Speaker: – is that what you're talking about.

Next Speaker: I'm wondering if –

Next Speaker: **** could show the raw numbers.

Next Speaker: – so I was going to say I was wondering if, how if instead of using the term events, saying observed infections or I'm just thinking of trying to put myself in the mind of someone that is looking at this –

Next Speaker: Yeah, yeah, yeah.

Next Speaker: – that isn't used to thinking about this stuff and I would like to know that that's a potentially bad thing that would.

Next Speaker: Yeah, sure.

Next Speaker: There's definitely a plan language component that's really.

Next Speaker: Yeah.

Next Speaker: Yeah and I will say actually we have a, uh, we have publications group that is, that's gonna help work with us on getting, uh, they're gonna read it over to try to get it so that it's consumer friendly, and they do a lot of these reports, so.

Next Speaker: Mm hmm.

Next Speaker: As long as we can get it done in time, that would be a – um, so just quickly kind of what we're looking at in terms of a technical report for providers that'll be on, um, the consumer report. This would have, basically all of this data here is data that was in last year's report. Um, at the bottom, I think there's percent change from '14 to '13, um, SIR. I think that's the thing people are interested in and, um, last year's report had a lot of trends, but again, for, for CLABSI alone, there were still six pages worth of data because it was kind of a separate page for each different thing, and so I'm experimenting with some formats. This isn't necessarily, this isn't pretty, but, um, trying to figure out how to get as much information as possible on one line, um, it makes things kind of busy, but I think having it all in one place instead of having to flip pages, might, uh, might sort of help us, um. So yeah, right now I'm kind of exporting data trying to figure out the best ways to display, but, um, that's where we are with the technical report.

Next Speaker: So are you saying you'd provide this to all hospital and then they'd, tell them what their key is or something like that or?

Next Speaker: Well, uh, well, no, I mean, no.

Next Speaker: So like current, well, they'd be concerned about that that they might be able to identify who it belongs to.

Next Speaker: No, no, we're, actually, no. We're sending out the preliminary report, that's just going to be numbers for them to check. This is just to get your feedback on what it might look like at the end of the, the final report, yeah. And then in terms of the graphic exec, executive summary, this is something I think I showed you last, at the last meeting actually. This report by the CDC was published in January of this year. Basically, each state was given sort of an overall summary and, um, this, this actually graphic was also pilot tested with a bunch of consumer group, um, and they sort of, this was kind of the result of these pilot tests. So we're trying to work on something Oregon specific that has more, we have a few more SSIs to report, um, and that's maybe less wordy, uh, but having this kind of summary report, both the consumer and the provider report. So working with our design people on that. Um, and then yeah, we talked a little bit, uh, about, in the interest of time, I'm not going to go into detail about this, but we've talked a little bit about facility report cards, and that might be something at the next meeting when, you know, I'm showing you the, we're going to have the report pretty much done and the

facility report cards are, they're the next step I feel like, getting individual facilities their data in a way that's helpful and useful.

Next Speaker: Can I just clarify for, um, the report that's, uh, on there for consumers for anybody to find, would there be rates published by the facility –

Next Speaker: There would, um –

Next Speaker: – or other denominator ****.

Next Speaker: – actually, I mean we could add that but the, kind of the format I showed there actually did not have rates, but the consumer would have access. You know, they still would have access.

Next Speaker: You have, because currently what they're getting and I, not really thinking that publishing the rates is all that good because rates, like you say, are not re-stratified.

Next Speaker: Yeah.

Next Speaker: So there's a lot of things that come off of that –

Next Speaker: Mm hmm.

Next Speaker: – before you see the SIR.

Next Speaker: Yeah.

Next Speaker: So I think rates are, for C. Diff for me, personally as a hospital person, I would really like to know C. Diff rates because those are something that seem to be hard to control.

Next Speaker: Mm hmm.

Next Speaker: You're setting your goals every year and it's going up.

Next Speaker: Mm hmm.

Next Speaker: So for me, I would be very interested in other hospitals' rates, not the SIR.

Next Speaker: Yeah.

Next Speaker: Just to see, so when I'm goal setting, what would be realistic? Am I setting my goals too low –

Next Speaker: Mm hmm.

Next Speaker: – and therefore, I'm not hitting my target. So what is, what's going on in terms of C. Diff rates in hospitals in the State of Oregon? I'd love to know that and I don't need to know the hospital name, but I would love to know the bed size category.

Next Speaker: Okay, yeah, I mean definitely, we can provide it and I mean we should, uh, for each, for each hospital, we should be able to see, I mean we could do a rate per, this actually for 10,000 patient days.

Next Speaker: Right.

Next Speaker: You can actually see the big table right here.

Next Speaker: Right.

Next Speaker: Um, so we would have it by hospital, but then yeah, the additional stratification by hospital size would allow you to kind of look at that.

Next Speaker: So I would say that those rates are pretty good, um.

Next Speaker: This is kind of, yeah.

Next Speaker: Those are low rates.

Next Speaker: Okay.

Next Speaker: This isn't, this isn't real data.

Next Speaker: Okay, that's ****.

Next Speaker: It's actually another state. I just saw that, yeah.

Next Speaker: Yeah, but I don't know if the consumers, and I don't know if the hospitals are ready to have people compare rates, um.

Next Speaker: Right.

Next Speaker: For different procedures, put out, for example, certain, because, um, there's a lot to be taken in. Who's doing high risk procedures and are people, especially, you know, with the heart and things like that, uh, there's a lot of things that go into that that are not reflected in the rates.

Next Speaker: Mm hmm.

Next Speaker: Plus some are superficial and some are deep, and some are organ space, so they're not looking at that. It's just a total allocation of the number, so.

Next Speaker: So I might read that for, maybe for, um, for surgery, for surgical site infections, you would not want a rate published.

Next Speaker: No, ****.

Next Speaker: But it would be okay to give the facility wide surveillance.

Next Speaker: That's what I'm, yes.

Next Speaker: Well, then we need ****.

Next Speaker: Anybody?

Next Speaker: That's a good comment because it's sort of like.

Next Speaker: Diane, do you have any feelings one way or the other?

Next Speaker: Like I've heard from hospitals ****.

Next Speaker: Now, I'm just speaking, I have not talked to all my colleagues at APIC, but that might be something to put out there at the next APIC meeting.

Next Speaker: Okay, yeah.

Next Speaker: To see, you know, what the feeling would be, but I, I don't, I think people would be okay with unlabeled identification of C. Diff rates, um, but I think surgical site infection rates published by facility, that would make people very, um, uncomfortable because of the reasons mentioned.

Next Speaker: I, well, I think, um, **** I should just move, take out.

Next Speaker: Okay, I'd like to get started and coming up next, uh, from Monika is the OAR update.

Next Speaker: Yes, thank you. I will be brief since we're running behind. If you remember from our January meeting, I'm sorry I didn't bring materials. I didn't want to inundate you with more boring Oregon Administrative Rules, but in January, I had brought up the fact that we were going to align our Oregon Administrative Rules with CMS, which included the dropping of skip measure when CMS dropped them and also the addition of inpatient psychiatric facilities and dialysis facilities to the health care workers influenza vaccination survey starting in the fall of 2015. So to be proactive, we thought we were doing, we were going to change these rules in advance for once, and then Dana brought up the fact at the last meeting –

Next Speaker: She's such a, she's such a buzz ****.

Next Speaker: It's not a thing.

Next Speaker: – that we don't necessarily have that designation in Oregon for inpatient psychiatric facilities. So after spending a very patient hour with Dana helped us with Melody to determine that we do have inpatient psychiatric facilities in Oregon, but they fall under our definition of high, acute care ****. So I took that word, inpatient psychiatric facilities out of the new Administrative Rules, left in just the change, the addition of dialysis facilities this coming fall, but then at a public hearing, we had, nobody showed up for comment, but we did receive a letter after the fact from Fresenius, very large dialysis corporation based, not based in Oregon but has several facilities in Oregon, that they, um, and we included in our statement of need and fiscal impact, which you have to do for every Administrative Rule change, that we were going to be in line with CMS. There would be no additional financial burden, forgetting the fact that we have Oregon specific questions regarding, um, how we, how people, uh, promoted their flu vacs or they, how they, how we included, how did we, the strategy, yeah, and several, we had three or four Oregon only questions, and Fresenius said well, wait a minute, that is more than what CMS required. So we went back to the drawing table at an internal HAI meeting, discussed the fact that we've collected this data for the last 3 to 4 years, which Kate is going to talk about next. We've got some great information from it already. Why don't we just go ahead and drop these Oregon questions. So we did that. So now, um, everybody is going to be reporting, reporting through an NHSN except for long-term care facilities whom we encourage to use NHSN, they just don't necessarily use it right now, and, um, those are the only changes we had to make for our rules from our last meeting update in January. Does anybody have any questions about that? No, okay, I told you I'd be quick. Thank you.

Next Speaker: Okay, I will be **** get onto the discussion of supplement funding. Um, so this, uh, for you guys on the phone, you had a handout on Page 69 of your, um, of your meeting materials, um, and this is basically, um, I summarized that up in this, the first part of this here, just what Monika said, um, so that basically we have been collecting information from, um, long-term care facilities, ASUs and hospitals about what, how they, what promotion strategies they use, etc., which is above and beyond what CMS asks these facilities to report, uh, for reimbursement like we talked about before, and so if you kind of, I'm just going to scroll down in this document here. So what are the NHSN elements that everyone is currently reporting? Um, any, it's right here, it's basically the number of, you know, employees, licensed and practitioners, um, students, volunteers and other personnel, the number vaccinated, the number with a medical contraindication, the number who declined vaccine and number with unknown vaccination status. So it's very, they are going to give us the information we need to calculate a vaccination rate for your facility, and so that's, um, that's what, you know, facilities across the nation are reporting and what CMS is reimbursing for at this point. So if you scroll down to the bottom of the page, you'll see actually the Oregon specific elements, which are, you know, arguably, more interesting, but also not part of this national reporting program, not part of NHSN, so facilities who report these have to, uh, go into NHSN, uh, record their data, and then fill out a separate SurveyMonkey survey. Uh, that's what they've been doing and so, and, and you kind of realize, we haven't actually, we've been reporting out these numbers every year, but we haven't necessarily done a lot of analyses with them. So we just kind of wanted to draw your attention to these elements and let you know that they are not going to be asked as part of our Oregon reporting program from here on out. It doesn't mean that they can't be asked as part of other surveys, and so, um, that's kind of one of the things we just wanted to draw your attention, to

these questions, um, you know, have you think about them a little bit and maybe, you know, get some of your thoughts about whether we should be asking these through different forms. For example, there's a mandatory survey that all long-term care facilities have to fill out every year. We could ask some of these questions on that survey. Um, so the Oregon specific element, you know, which of the following methods did you use to deliver vaccine, uh. So these are, they're listed here. Promotional strategies, um, kind of incentives for, for individuals to get vaccinated, and then we also, um, asked the question you, questions about they're reasons for declination. Um, and so one of the things we, when we were talking about getting rid of these questions, we thought well, what do we actually do with these questions, and we realized we hadn't actually, um, looked at whether or not vaccination rates differ depending on whether facilities use these different strategies. So we just, we did sort of a, a quick and dirty analysis and we'd like to kind of, we'd like to do a more involved analysis, but, uh, I just wanted to provide this data to you guys, the committee, because it actually was requested by one of our members at the last meeting, um, and so I'll just kind of take you through this Table 1 on the second page of the handout. So basically, in the left hand column, you have all of the vaccine delivery methods or strategies, and so if we move across kind of the first row, no cost vaccine, um, the first kind of big column is hospitals. We had 61 hospitals reporting on this and out of those hospitals, 90 percent use this strategy, provide no cost vaccine. So out of those, you know, the 90 percent that use this strategy, they had a 76 percent vaccination rate and, um, for the 10 percent that didn't use it, they had a 79 percent vaccination rate. So it's kind of like it did really appear to change, um. Not sure what's going on, but if you look up in the next column at ASCs, um, we see that, you know, 85 percent provide no cost vaccine and actually, for the ASCs that provide no cost vaccine, they have significantly higher, uh, vaccination rates that ASCs that do not provide no cost vaccine. Um, and so this is kind of how this analysis went. We just sort of went through each of the different, um, strategies and just kind of wanted to point out for hospitals, most of the hospitals are adopting most of these, uh, strategies. The one that they're not sort of, you know, uh, one, they're not really doing much with **** but also only a third of them, um, say this, vaccinate or wear a mask. Basically, it means if you don't get a vaccination, you have to wear a mask when treating patients during the influenza season. So only 31 percent of hospitals are doing this, but it appears to be a significant predictor of, um, getting your vaccination rates nudged above the average, so, you know.

Next Speaker: And what do they do for incentives? What are some examples of incentives?

Next Speaker: That's a really good question. That's, all it says is incentives.

Next Speaker: Only a few identified, a $5.00 dollar use at any one of the beverage carts from the hospital, just little tiny things like that is I think what they do.

Next Speaker: You get like a comp card or a –

Next Speaker: Yeah.

Next Speaker: – Jamba Juice, that kind of thing.

Next Speaker: Yeah.

Next Speaker: So yeah, I mean like the bottom line would be like the, that you know, the different strategies appear to be, you know, effective, um, kind of variably effective depending on what kind of setting you're in and so, um, you know, we're trying to, we were going to try to summarize some of this information and if we do a facility specific report card, we'll put their vaccination rate and then but if it is an ASU, we can say these are the factors that appear to be associated with improving vaccination rates.

Next Speaker: They were definitely looking at, uh, wearing masks, and I know several hospitals, for hospitals that's risky, I think it's significant.

Next Speaker: Yeah.

Next Speaker: – in improving our rates, but there is a pushback.

Next Speaker: I've heard from unions and other places.

Next Speaker: Well, 'cause it's something about, uh, protected health care information. I mean you're wearing a badge that says I didn't get my flu vaccine by wearing a mask.

Next Speaker: Yeah, that's true.

Next Speaker: **** health care information.

Next Speaker: Sure, but it's your, it's your decision on whether or not to vaccine. That shouldn't be something that's public knowledge.

Next Speaker: I think herein is the, yeah, the debate.

Next Speaker: **** see the mask right there, I mean.

Next Speaker: Yeah, yeah.

Next Speaker: Okay, well, this, um, really, you know, if you guys have any other questions or comments, we can talk afterwards or you can email me. I just wanted you to have this information and let you know we're using this data and that we might, um, one option is to potentially, you know, not collect this information every year, but we could have a survey that goes out every few years and we could kind of recollect it and see where we are at another point in time, so.

Next Speaker: Okay, thank you. Okay, so next on the agenda, we have Zints who will present new Ebola funding from CDC that would expand to HAI.

Next Speaker: I think Gen volunteered.

Next Speaker: Oh, okay.

Next Speaker: Yeah, I started putting together slides yesterday, walked over and Gen was already doing it, so ****.

Next Speaker: Is this your ****.

Next Speaker: Thank you, so again for those on the phone, uh, my name is Genevieve Heuser and I work at ACDP with HAIT and, uh, wanted to tell you about, uh, hopefully an exciting funding opportunity. We're still waiting to hear about, about this, but since the deadline is soon, we wanted to share a little bit about our whole **** along with all states across the U.S. So just to put this into context, so because of the huge response that we needed across the nation to being the health care system, uh, up to speed to be able to handle something like Ebola, just an enormous amount of resources and time and learning occurs, as I'm sure you're familiar with and so in response to that, uh, CDC and its partners put out several grants in order to assist states with continuing to build these resources, and so there are several grants, uh, named here, the different blue boxes on the screen, and they go to different partners or with the, the HPD, uh, is part of the preparedness as well as the PHEP preparedness, and so could you remind me and since we're not familiar with those acronyms –

Next Speaker: Sure, uh –

Next Speaker: – HPD.

Next Speaker: – back **** preparedness, that goes to all our local public health authorities that do preparedness work as well as to our **** and then the **** hospitals for health care preparedness program and **** our coalition, our health care coalition in each of the regions and they're made up of hospitals, um, they do care facilities, um, EMS folks, and also the, the Health Authority.

Next Speaker: So it's, uh, so I should have mentioned that both Akiko and Mike are with us today, uh, from Preparedness and Emergency Response because this grant, grants have been given to both our, our departments, uh, and that comes out of just the experience or working on the Ebola response. It really was, you know, an independent agency with many different parts, not just the hospitals, but emergency transport, waste management, so. The pa, part that I will focus on today is what's in the red star, which is the grant, it's the Epidemiology and Laboratory Capacity grant of ELC grant, but it, it's part of a larger group of grants, uh, that we hope to receive funding for, to work, not only Ebola, but you'll see in other things. So the funding for the Epidemiology and Laboratory Capacity is separate from preparedness, uh, parts of the Ebola funding and our part has a two-part focus, and it's as other of the LT grants, our focus on building statewide capacity and education, uh, in not only state, but in the local regions, and the main part of this that we talk to, a lot about is these consultative and non-regulatory verifications or assessments of those hospitals who were so great to stand up and volunteer their services to the assessment hospitals, and assessment hospitals are the hospitals that will, if we have a person who is at risk of, uh, developing Ebola disease, becoming symptomatic with fever or other symptoms, these hospitals said we are ready to receive them and take care of them until we can confirm or rule out the diagnosis. So we have seven of those with, um, in different regions

across Oregon. So the first part of the grant would be, uh, to go in and have these, uh, consultative verifications to see are they meeting the domains that CDC has put forward as being necessary and I'll talk a little bit more about those later, and that would mostly be done in Year 1. The part that's really interesting for all hospitals across Oregon are this, the other part, which has to do with developing a statewide infection control capacity to prevent health care associated infection and other emerging, emerging pathogens in the future, and, uh, so this is the part that I think we should all be jazzed about because we're not just focusing on Ebola, but general capacity building, uh, around our favorite topic. Thirdly, there's also a piece to improve biosafety capacity at the public health laboratory. So many partnerships are involved with this or will be involved in this, including health care facilities across the state ****, uh, the state laboratory. This HAI advisory committee, which I will talk a little bit more about, will actually have a particular, particular role in it, um, because we hope to house what's called the Infection Control and Assessment Program and it's basically, um, the subcommittee that will help organize the ELC activities as part of this grant we, if we get that. Of course, the Patient Safety Commission, who we've, um, partnered with a lot, uh, over the years, APIC, CDC, and also our preparedness and EMS folks, um, which are key, a key component. So a little bit about how this committee here, uh, would be involved with the grant, so as I mentioned, there's, the grants asks that each state develop what's called an Infection Control and Assessment Program group and they are usually going to be housed within the HAI existing advisory committees, not necessarily, but that's usually what is recommended be placed since these are, um, group that have a history of working with health care, and that, that this would take this committee, which has historically been surveillance only and start thinking about ways we can use the EPI and the data that we have for action, specifically around infection prevention activities, and so there's be work around developing what that plan would mean for Oregon, uh, based upon guidance from CDC and other states, and based upon our own lessons learned from some several months of Ebola preparation, and we would, uh, be inviting new partners to join the subcommittee. So our preparedness and response folks, as mentioned, the liaisons who are out in the regions already and, uh, coordinate a lot of communication between EMS and hospitals and preparedness resources, whether it's for an infection or for a natural disaster. Our, uh, Office of Licensing and Regulatory Oversight, which, OLRO, which works with nursing homes and non-hospital based, um, facilities in Oregon, and emergency medical, uh, services, and others as well. So a little bit more about this, uh, the assessment hospital verification, so, uh, this would be a project that we would start with you on this April if we receive funding and we would be using, uh, a verification or assessment tool that is based upon the CDC drafts that they were actually using for their treatment hospitals and other assessment hospitals already, and the model that they had there was that, uh, you know, they were having to bring online all these hospitals to make sure they had the capacities to take care of these folks and so they came up with some major domains that they felt were necessary in order to safely care for the patient and protect workers, uh, and so these visits became a, you know, a sharing and learning opportunity while following certain domain, um, uh, components and I'll talk a little bit more about that. So what this group would do is they would finalize the, the tool for Oregon use, would share the tool with the hospitals here, the seven assessment hospitals, and there would be an EPI team that would go out to and meet with the folks at each hospital and go through these verification visits, uh, see what capacity they had, what resources they had, and which ones they needed, and there would be follow up at 6 months and a year, and most likely this, there would be a summary report of what was found and lessons learned, mostly for sharing and understanding what barriers were there to

know how to, um, respond and improve in the future, and again, this isn't, uh, I just want to emphasize this is not a regulatory visit. Regulatory people would not be on the actual teams going to the hospital. It's really, um, supposed to be, uh, to, um, meet, to learn and to find out what's, what needs to be done to improve. So some of the capabilities, and these are already, can be found on the CDC web site, and more details will be forthcoming with, when the tools finalize, are finalized, but it goes around, it works mostly around so patient transport, how's the patient safely get to the hospital, how are they received, what rooms would they be in, what kind of waste, waste management would work, uh, the laboratory capacity, all the way down to communications and operations coordination, so very, um, talked about and as you can see, it's not just, um, it's not just a commun, communicable disease that's on here. We've got occupational health, environmental services. So that's where this, the multifaceted comes in. So that's, that's how the, that's the Ebola assessment hospital, mostly your one activity, and then the other second case, which I mentioned before would be this increasing infection control capacity education around the state, and this is, I think, really exciting, um, because hopefully, this would be an opportunity to really, uh, assess our public health system and bring it up, um, just as the first presenter talked about, sort of meeting some, um, some capacities. So a lot of the, in the grant, they talk about working to, uh, improve identification and response to health care associated with outbreaks, uh. So moving again beyond surveillance to actually identifying outbreaks and being able to intervene and working around building tools and educating, also aligning our statutes. So we work, you know, a health care system as a whole in Oregon falls under different or regulators and different agencies, and so how do we align our rules so that we're working together, uh, in the most efficient way possible, uh, and then, the other piece that we talk about a lot in the grant is, uh, it's around capacity building for emerging infections, and so that's where there would be sort of smaller, uh, assessments and verifications, again non-regulatory, but then out in the different regions and different health care systems to help them coordinate, uh, what resources they have, what capacity they need to build in order to be, uh, to better identify emerging infections, how to work with outpatient clinics, how to work with their EMS transport, how to work with their, their local regional hospital to, um, better respond, identify high risk patients, get them to the right care without, um, infecting others, uh, and part of that is improving communication. So, uh, that was that part that I, kind of the overall gestalt I wanted to give about the Ebola grant, um, that we're still waiting to hear verification, um, but happy to answer questions about that.

Next Speaker: Well, coming from a hospital **** as one of the designated hospitals and being the one that’s doing the drills and the simulations, it’s complex, it’s complicated and if you’re not doing it routinely, you forget bits and pieces. So I think this is gonna be a great little partnership. I hope it works out. I think it would be wonderful to get other input and I know that there’s other hospitals in the cities that’ve done a lot of work as well. It’s be great to share **** to see who’s got the best practices. So I think that’s be great.

Next Speaker: Yep. And that, that’s why we’re hoping to do it because we realize this is, you guys have done an amazing amount of work over the last several months and learned a lot and so I think sharing would be, you know, the best use of what you guys have done and so that would be the hope and that there would be folks coming in learning, maybe, you know, cross-pollination –

Next Speaker: Right.

Next Speaker: – ****, uh –

Next Speaker: Even have them one, rule out patient who is admitted to another hospital in the city. It'd be great to hear –

Next Speaker: Mm hmm.

Next Speaker: – about their experience. Exactly.

Next Speaker: So again, we're tryin' **** the kind of, uh, idea that we're trying to foster with this.

Next Speaker: And then I wanna, uh, also mention that, um, **** the first **** we talked about the dif, we have two other **** one, um, of which is going to the **** hospitals. So we just made it fit in this last week and went out for, um, primary input and, uh, everybody, um, kinda chose to, uh, give most of the money to **** hospitals and ****. So right now we're having webinars to kinda talk about the details on that. Well, we're getting 74,000 which doesn't sound like a lotta money and all of the, the whole **** all the hospitals that we're getting 74,000 per hospital, um, ****.

Next Speaker: The biggest challenge from a hospital setting, I'll tell you this, across the board, is maintaining state of readiness. Because you, you go back to your regular operations and it's very difficult to strip away the resources that you need to produce one of these practice sessions because it's labor intensive and resource intense to go through and simulate. 'Cause we've done intubations and central line placements and, and Metro **** delivering the patients ****. So it's very intense. So it's very difficult, especially with low-level activity in the community, it was very different last fall than it is now. So the sense of urgency is not as strong as it was at that time.

Next Speaker: We were hoping this fall that if they need more help, um, and any region wound up pulling all the coalition funds **** hospital then one of the **** is the **** and we have to be **** and doing that sort of, you know, your tabletop exercises, some kind of exercise regionally for the next 5 years, make sure that we are prepared and we're doing that. So that's part of our **** that we have, um, on the HPD kind of the health as well. So we'll be excited to be able to work with them and **** talked about having **** healthcare coalition meeting, which happen to be doing usually on quarterly basis and **** players are **** table at the regional level ****, um, not just to pull up 'cause we obviously **** seen it here yet. Um, uh, but, you know, on other types of infections and other types of things that might have ****. So this is a really kind of exciting, I think, springboard for what we're already doing **** coalition healthcare ****.

Next Speaker: Yes.

Next Speaker: Yes. Yeah, exactly. And I think that's what, what we learned a lot at ACDP is that there is already great regional work through trauma, uh –

Next Speaker: Advisory board.

Next Speaker: – advisory boards and so there's like how do you move a patient for, uh, you know, trauma or the **** preparedness around non-infectious disease work that's been done and infrastructure that's already there. And so how do we build a, a medical or infectious disease on to what's already **** and already has some great roots. So that's what we're working on to do here and work on these regions that are, that are **** so.

Next Speaker: I, I have a question. I know you said this was a competitive grant. When will you know if, uh, if you, if you get it or not?

Next Speaker: ****.

Next Speaker: Right, we're getting –

Next Speaker: I, I, I was told that we would know the final, um, like the 30, around the 31st, so very soon.

Next Speaker: March. Yeah. Like how many grants are they awarding? I mean is there a good chance?

Next Speaker: So the prob, I think there is a good chance that every state will get some funding –

Next Speaker: Something.

Next Speaker: – to do the hospital assessment verification, and it's more that second piece of building capacity –

Next Speaker: Got it.

Next Speaker: – that is the more competitive piece, if you will.

Next Speaker: Though –

Next Speaker: I hope –

Next Speaker: – I mean I, I, I'm very optimistic and I think it's reasonably likely. There were still a fair amount of states that are gonna get the, the higher funding and I, I know that CDC looks very highly on Oregon in terms of their HAI work, RHAI work, so I'm optimistic.

Next Speaker: Good.

Next Speaker: And I think also a piece with the, with hospital assessments, a question that's come up is that, you know, we want the, the tool has been recommended by CDC, but we definitely wanna get, you know, stakeholder input as far as the hospitals that will participate with that, so that would be part of the subcommittee the, uh, ICAP as they call it, uh, who will, you know, help take that input and then, uh, finalize the tool and get them to the hospitals, and so there's no like, this isn't like a secret test. This is really gonna be something collaborative, uh, so **** so we'll have more pushout, a formal pushout of information once we know about the grant, and I should say also that the three main EMS agencies that are, have stepped up to help transport patients who are being evaluated, they will also have an assessment as well, uh, or verification capacity if you will, um, as well. Again, we're tryin' to bridge that, those historically kinda different, uh, pieces but kinda bring them together around ****.

Next Speaker: Fresenius too, because of the dialysis piece.

Next Speaker: **** lotta blood **** so okay. So the next, my last piece here, um, just move on here, um, thank you, Spike and Kiko, for joining us, you guys.

Next Speaker: **** sounds good.

Next Speaker: Uh, the, the next piece I wanna, on the agenda was to talk about **** PCL initiative, uh, that we are working on here at the state, uh, and, and, uh, I chose this picture. This is a picture of the Nat, the Natu, Natural History Museum in Paris, France, and just got the idea of looking at CDI from the inside out **** right now.

Next Speaker: What, where are we gonna –

Next Speaker: This is a, uh, I think it's a sperm whale jaw, a mandible of a sperm whale jaw, but it's a neat place. It's not often visited by tourists, but I had **** so, um, part of, so **** contacts before I get to what's on the slide. Uh, we received a grant for, to work on Clostridium difficile, uh, and to really try to better understand transmission, inner-facility communication, and how to decrease rates, not only in hospitals, but in, across healthcare systems, who really, uh, see, uh, nursing homes as, as partners in that, and so as part of the preparation work that we did over the fall – and thank you all those who participated – we sent out, uh, HAI program surveys that, uh, not only asked you questions about pos, uh, carbapenem-resistant Enterobacteriacceae, as we had done in 2012, but also some new questions around C. Diff to try to get, um, a broader idea of the capacities and current practices around Clostridium difficile, and so, uh, wanted to just tell you a little bit about these surveys and, um, we just closed, or, you know, finalizing getting the last folks together, but we'll be, uh, reviewing that data and working on that data in the months to come, but to give you some more context about what we're asking about, it's not just hospitals but skilled nursing facilities and laboratories, uh, answered questions, uh, about their infection control support time and staff around practices for screening for multi-drug resistant organisms and what precautions they typically used, whether it was an active infection or colonization, uh, and I, we're hoping that this will give us a better idea, 'cause there's always, when we talk to the nursing homes, they're like well, we do differently than the hospitals. The hospitals are like well, we do different than nursing homes, so we get a better, uh, understanding of the lay of the land so that we can, uh, you know, use, use the right language and, and, uh, um, make, you know,

make sure that we are cognizant of the different ways that they practice. Uh, we ask questions around inter and intra-facility communication 'bout whether flags were used to notify providers of out, presence of an MDRO. Uh, we also asked around Clostridium difficiles, some more questions. Uh, we asked questions around policies and how they, uh, monitor adherence, so do they do, um, observations? Do they use like ATP or Glo Germ or things like this to verify that their environmental, that their housekeeping, their environmental staff is, um, is cleaning well. Uh, we also ask some questions around antibiotics stewardship, which is a big piece of all of our work here at the HAI, especially around Clostridium difficile, and also, uh, some subjective questions about adequacy of response and, uh, facility support, uh, and for the lab, we ask the more technical questions to see what they were testing with, which will help us understand some of the sensitivity and specificity of our surveillance. So, again, we're hoping that, uh, this will give us a broader idea of what's going on around work and, so just, uh, just a few of the questions and examples of what were used, or what were asked of, um, hospitals and nursing homes mostly, not, not so much for the laboratories, but, uh, uh, monitor, correcting, uh, etc., uh, so right now we've, uh, received responses from about, uh, almost, I guess, well, **** all the hospitals have responded I think, uh, and then the labs were getting really close, and the same for skilled nursing, so we've been, uh, really happy with the responses and, and thank everybody for their time in doing this, and we hope to, to use this information from the surveys to then help the next part of the grant, which is we're, we're gonna be working hopefully in three different hospital, uh, skilled nursing partnerships in different, couple a different regions in Oregon, and really then take that deep dive. Like I said, like going down to the insides about how do they identify CDI? How do they respond to it and test for it? What is their response? And work around, uh, developing and verifying best practices around, uh, infection control and also communication, and this comes out of, um, a real need to better understand both transmission and prevention, uh, because as we're learning from our epi herein Oregon, at least 50 percent of cases originate in the community without any known, uh, contact with healthcare, so, and we know that just in general, there's lots of Clostridium reservoir in the dirt and in the environment, uh, but then somehow that comes into a, a healthcare facility and it's amplified and it may, uh, lead to transmission. So based upon those different pathways, how would we intervene through infection control, through antibiotic stewardship of the hospital and community? So we're hoping to use these three different sites to look at slightly different pieces of that. I'm going down to Klamath County next week to work with their hospital skilled nursing, and they've had **** to work a lot on their outpatient antibiotic stewardship, so we're gonna try to partner with our sister program here, another program here, um, called the Aware Program, which focuses on outpatient antibiotic stewardship that has a lotta great materials for clinicians, uh, practice guidelines, um, tools and education, communication for patients that's in a patient-friendly manner to set out expectations around antibiotic use, so try to bring that down there and see if we can, uh, expand that in the community there. So I guess just stay tuned and, um, hopefully we'll know more about that later, and I don't know if any people have any questions about that.

Next Speaker: So in terms of, um, C. Diff, emerging C. Diff, is it, do we still see an increasing, um, uh, evidence of increasing rate of C. Diff across the country and across Oregon? Or is it too early to say for this year?

Next Speaker: Oh, gosh, for this year, um, well –

Next Speaker: There's a, there's a slight increase –

Next Speaker: – it's hard to **** community and then there's ****.

Next Speaker: Yeah, just like, you know, from, from hospitals, because people I'm talking to, hospitals, it's, it's definitely a problem. People are increasingly aware because, uh, C. Diff's always been around, but it's becoming, obviously, more and more something we're measuring and looking at and going after, detecting as early as we can, so we're looking harder, we're finding more, so I'm wondering if rates are going up across the board.

Next Speaker: I would think that in, on a national level, we're, we're just now really getting good national estimates. Um, there was a recent paper that we participated in, uh, the publication for as an EIP site and, um, but that's, that's kind of initial information on some level on a really good estimate for the burden, um, so it's clearly a problem but I don't know –

Next Speaker: How many years of NHSN data have we had –

Next Speaker: Well, we have, uh –

Next Speaker: Two?

Next Speaker: – about two **** this'll be our third of, and that's hospital, and plus we have Klamath County.

Next Speaker: Oh, we have Klamath. Right.

Next Speaker: Which is both, which is both hospital and community.

Next Speaker: I don't think it's been going up in Klamath where we – we have a countywide surveillance in Klamath.

Next Speaker: Yeah, that's the small –

Next Speaker: It's hard to know because they've also changed from the antigen to the PCR testing, so that, you know, created a little bit **** but I think we're still somewhat figuring out what everybody's –

Next Speaker: It did actually increase, but I think that that exactly what you were just saying, that it could well be due to the PCR, the change in testing policies. That's –

Next Speaker: **** that stuff doesn't work.

Next Speaker: We know like as, uh, we know like from like, like England, you know, they did a very long study from, I think it's 2007 to 2011, and they definitely saw decreases in rates as, you know, general infection control practices came in into hospital **** stuff, but we also noticed that even the, the community, although it gradually decreased, the **** there was definitely a

larger proportion if you looked at those that were related, but in the community, that did not change, so there's probably, in their hypothesis, that there's a large permanent reservoir in the community, and, but you can make changes in your hospital to, if it's brought in, to prevent transmission and amplification, but there's always gonna be some in the community, and that community piece might need to be changed by something widespread, like changing, um, antibiotic prescription practices in the outpatient clinic and serve the antibiotic burden in the community, that kinda thing, so –

Next Speaker: How is –

Next Speaker: Different levers for different settings.

Next Speaker: How is the, um, long-term care setting? Um, I know that obviously there's a potential reservoir –

Next Speaker: Right.

Next Speaker: – an, anytime you have, um, that kind of situation. Is there a way to even get a measurement there?

Next Speaker: Mm hmm. That, that's part of the, the program, so we're gonna be working with those skilled nursing facilities that are piloting this program to get them enrolled in NHSN and start doing the surveillance, start doing the **** team and understanding their burden, but yes. There, there –

Next Speaker: **** lab testing, you know, having worked on it. Pat, are you still on the phone?

Next Speaker: Yes. Yes.

Next Speaker: Yeah, get, having, uh –

Next Speaker: We, I've seen the literature that 20 to 30 percent of our residents come in colonized. That's all I've seen so far.

Next Speaker: Right, and so –

Next Speaker: **** reservoir.

Next Speaker: Right. Exactly, and is, is it probably some of that's host factors? 'Cause they're –

Next Speaker: They're at risk 'cause they're –

Next Speaker: – ill. Um, it's more common around, uh, elderly people and there's all sorts of that, plus they've probably just come from a place where they've had antibiotics, been very sick, you know, poor gut motility, all those things that, uh –

Next Speaker: Finding it in the food?

Next Speaker: Right. Food, dirt, you know –

Next Speaker: Mm hmm.

Next Speaker: – it's just there in the environment, so, um, so one of the pieces that we wanna discuss with, you know, is that can we do, uh, kind of a, see what the rate of colonization is on that **** for example, so these are questions we'd like to be able to ask and kinda dive into it a little bit in Oregon.

Next Speaker: I think getting the measurement is probably the hardest part.

Next Speaker: It's a bit hard. It is. It is. I mean, and it, it's just, uh, I mean NHSN, in, in a sense it's not difficult in and of itself, but it is a new piece and it can be clunky and, you know, getting that into your daily routine when you've got everything else going on. It's challenging, so those are the kinda things we wanna talk about.

Next Speaker: What's the timeline of this work?

Next Speaker: Uh, this grant is through –

Next Speaker: It's, well, it's, it's, I, I think it's –

Next Speaker: I think it's –

Next Speaker: – a 5 –

Next Speaker: It's a –

Next Speaker: – it's a 5-year –

Next Speaker: It's a 5- year.

Next Speaker: – 5-year most likely, so this is the first year and we're kinda in the setup pilot stage at this point, and then we'll continue likely, assuming we continue to get funding, then that's the general structure of it. I think it was 5. It's either 3 or 5.

Next Speaker: So 3 or 5 years. Yeah. We in, yeah, we're in a sort of understanding the lay of the land. Hence the survey and lookin' at it kinda based on ****.

Next Speaker: Thank you. Any other questions? So if we have anything anybody would like to add or share to the discussions before we adjourn.

Next Speaker: I have one quick question.

Next Speaker: Yes.

Next Speaker: How do we screen for this C. Diff?

Next Speaker: You, for the SNF? Uh –

Next Speaker: C. Diff.

Next Speaker: C. Diff.

Next Speaker: Clostridium difficile.

Next Speaker: You need to have multiple episodes of liquid stools generally. The lab rejects anything that is not conforming to the shape of the container, so somebody coming in with abdominal pain, bloating, with recent, um, antibiotic exposure perhaps, mostly that's, uh, the leading trigger for it, elderly recent stay in a SNF or other healthcare facility, recent colonoscopy or other procedure, so those are all risk factors, and generally they're screened for it in the emergency room and, um –

Next Speaker: And, and usually, uh, yeah. Usually there's a test 'cause there's symptoms. Usually there's symptoms of diarrhea and that's where the testing comes from. The question of colonization is, is a different one so that's when you're testing people who don't have any symptoms, uh, and that's a different question. That would sorta be like who's just carrying it and –

Next Speaker: But how do you screen for that?

Next Speaker: It's, it's –

Next Speaker: I mean –

Next Speaker: – you have to do a spe, you have to do a culture.

Next Speaker: Okay.

Next Speaker: It's a similar test.

Next Speaker: Is it random, though?

Next Speaker: Uh, the testing? It's not usually done. We don't –

Next Speaker: ****.

Next Speaker: We don't, we don't rec, we don't recommend screen asymptomatic people, unless it's in a study form. Most of the, the Clostridium testing that we're talking about here that gets reported to the National Health Safety though should be done on symptomatic people. Uh –

Next Speaker: Because if they were asymptomatic, they probably wouldn't have runny stools. Right?

Next Speaker: Right. Exactly. Right. Exactly, and there, there is like research being done about, you know, could those people be carriers and shedders, but that's, um, that's the **** research phase and not –

Next Speaker: Yeah, so you wanna identify 'em as early as possible so you can prevent contamination of the environment because, you know, the more people going in and outa the patient room, if it's contaminated, the higher the risk of transporting it unknowingly, uh, around the –

Next Speaker: And if –

Next Speaker: It'll –

Next Speaker: – if they are colonized, is there any treatment?

Next Speaker: Usually we don't treat people who are colonized, but maybe they don't have symptoms, so colonized meaning as if they don't have symptoms.

Next Speaker: Right. Right.

Next Speaker: Um, because there's, you know, side effects, **** et cetera, but if they have symptoms of diarrhea, we absolutely treat them because they can progress to have, uh, very significant side effects that you can, very severe infection to perforate your bowel. You know, there's lots of other reasons, so if they're symptomatic, they're treated.

Next Speaker: And usually treated with –

Next Speaker: But we don't usually – um, it's different types of oral antibiotics usually. Sometimes –

Next Speaker: **** work. Usually –

Next Speaker: **** usually it's Flagyl.

Next Speaker: Yeah.

Next Speaker: It doesn't work.

Next Speaker: Flagyl, Legros. Sometimes you can use some –

Next Speaker: I thought they decided not to 'cause they couldn't get the stools from someone or –

Next Speaker: I think it was the FDA approval. Is that what you're talkin' about?

Next Speaker: Yeah.

Next Speaker: Maybe that they were sent – I don't know what ex, I –

Next Speaker: This, they're doing it –

Next Speaker: But I know people that –

Next Speaker: **** usually they won't.

Next Speaker: It's investi, I think it's still considered investigative and –

Next Speaker: Okay.

Next Speaker: – so you screen a donor. Usually they prefer they're related.

Next Speaker: And I think the research is, uh, very promising.

Next Speaker: Right.

Next Speaker: There are –

Next Speaker: If I had C. Diff, that's –

Next Speaker: And as they're doing more, they're also coming up with **** reports of side effects as well, unintended consequences, so that's why they're so **** but it does exist.

Next Speaker: Yes.

Next Speaker: And it's, but it's usually used when somebody has failed courses of antibiotics.

Next Speaker: Okay.

Next Speaker: Yes.

Next Speaker: Yeah, but not ****.

Next Speaker: You, you know, that, um, you tend to get C. Diff after a course of antibiotics wipes out all your normal ****.

Next Speaker: Right.

Next Speaker: The very antibiotics used to treat C. Diff have been associated with giving C. Diff –

Next Speaker: Right, that's why –

Next Speaker: So you wouldn't –

Next Speaker: – I was wondering what are they treating it with.

Next Speaker: – you wouldn't treat a, asymptomatic people because you might give 'em a disease.

Next Speaker: Yeah, but even if you are, even if you have the symptoms and then you get treated with it, doesn't that put you at higher risk?

Next Speaker: Well, the treatment usually works, at least temporarily, but the organism sporulates and the spores aren't susceptible to the antibiotics and so it's easy to get another episode next time you get a course of antibiotics or even if you don't –

Next Speaker: Yeah, I think it's like 10, 10 to 15 percent recurrence **** studies –

Next Speaker: Yeah.

Next Speaker: – that people who will be treated but then it comes back, and, and the more it comes back, the more difficult it is to treat, you know, so the whole, 'cause that's where the whole, uh, push for better antibiotics stewardship, not just in hospitals but really in the outpatient clinic, um, decreasing the times that, um, a person will come in contact with antibiotics should de, decrease their risks, so that's where ****.

Next Speaker: Okay, so I have a question since I have a room of experts. I had a infection in my mouth, and, um, when I went to the endodontist, he used bleach to clean it out, and then I got a prescription for antibiotics, so I haven't started the antibiotics 'cause I'm gonna wait until I'm sure I really have to use it.

Next Speaker: Mm hmm.

Next Speaker: Is that an effective treatment to use bleach in your mouth to, instead of doing antibiotics?

Next Speaker: I've never heard of it. Uh –

Next Speaker: ****.

Next Speaker: Really?

Next Speaker: It wasn't hydrogen peroxide?

Next Speaker: No. It was bleach.

Next Speaker: I would, I'd be afraid to give someone bleach to put in their mouth.

Next Speaker: Yeah, and I asked, I asked another, I asked another dentist and he said well, he said it's kinda nasty, you know, 1 to 20 percent delusion, diluted –

Next Speaker: Yeah.

Next Speaker: – it's like I've never heard of this, and I'm thinkin wow, if that's an effective way of treating an infection in your mouth, why are we all taking antibiotics?

Next Speaker: So the periodontists are also treating gum infections with diluted bleach now as well, so –

Next Speaker: Yeah, bleach kills everything.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: You know? But –

Next Speaker: But it's a, it, it would, it'll be a surface – yeah, it's a surface.

Next Speaker: But right, but would it get into the crevices between your teeth? And I, I don't know.

Next Speaker: **** tissue.

Next Speaker: It would depend on –

Next Speaker: ****.

Next Speaker: It might be – I don't know. I mean if it, it's something that's effective, it might be something to let people know that that is a way to do instead of going through the course of antibiotics.

Next Speaker: Yeah, and they're, they're tryin' to get, like there's a lot of teaching around say cellulitis, you know, like the MRSA and little boils, you know, that if you can, if you can just drain those boils and just provide good wound care, you might not need systemic antibiotics, but again, it all depends upon the type and severity of the infection.

Next Speaker: So, so if was, it, it's past 3 o'clock, so we can keep Amy **** because ****.

Next Speaker: Yeah, that, that's part of the education that we hope to do for patients and providers is to –

Next Speaker: Yeah, and thank you, everybody.

Next Speaker: ****.

Next Speaker: That's gonna be interesting ****.