# Healthcare-Associated Infections Advisory Committee
March 23, 2016

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Speaker: Okay, can we start with who's on the phone?

Next Speaker: Yeah hi this is Dee Dee Valle from Hood River representing the consumer.

Next Speaker: Hi Dee Dee.

Next Speaker: Hi Mary, this is Lori **** Mental Health.

Next Speaker: Hi Lori.

Next Speaker: Can we turn it up?

Next Speaker: Yeah.

Next Speaker: This is Pat Preston.

Next Speaker: Hi Pat.

Next Speaker: Hello Mary.

Next Speaker: This is Theresa Shepherd.

Next Speaker: Hello.

Next Speaker: This is Betsy **** representing Health Security Preparedness and Response for ****

Next Speaker: Great. Anybody else on the phone? Okay then let's quickly go around the room. Start over there.

Next Speaker: Uh, Diane Roy with the AGI program and Genevieve **** with ****.

Next Speaker: Hi **** director of the Oregon State Board of nursing and ****

Next Speaker: Yay.

Next Speaker: **** health security, Preparedness and Response Program here at the Oregon Health ****.

Next Speaker: I'm Becky **** the executive director for the Oregon **** and Safety Commission.

Next Speaker: Do you want to say something else?

Next Speaker: Um, and unfortunately this will be my last HAIAC meeting. At the end of April, uh, I have to join my husband in Eastern Michigan. Um, he has accepted an opportunity there for his military career. So I'm gonna miss everybody. Let me just say that and it's, uh, been such a pleasure for the last 5-plus years to be **** so, um, yeah that's what I have to say about that. I'm gonna miss you.

Next Speaker: We're gonna miss you too. That's part of the problem.

Next Speaker: Diane Waldo from the Oregon Institution of Hospitals ****

Next Speaker: **** Oregon ****.

Next Speaker: Debbie ****, I'm infection preventionist **** hygiene.

Next Speaker: Um, I'm Mary Post, I'm direction of infection prevention at the **** Safety Commission.

Next Speaker: I'm Lexi **** um, HAI Program.

Next Speaker: I'm Vince **** the interim, um, mentor for the communicable disease section for the Oregon Health Authority and also the program mentor for the healthcare ****.

Next Speaker: Mary Shine **** infection preventionist at Kaiser Westside and, um, chairing the, um, committee for the moment.

Next Speaker: Okay and my name is Becky Ellison. I'm from the, um, AGI program here at OHA and Mary **** is our chair and she does mention that her term might be up in December. We'll have to check and make sure.

Next Speaker: **** two years, maybe it was only one ****.

Next Speaker: And I'm Tina Meyer. I'm also with AGI, I'm an office specialist.

Next Speaker: Okay well thank you everybody and the next order of business will be the, um, voting on acceptance of the Minutes as written from December. Has everybody had a chance to review them? And does anybody have any corrections? Do we have a move to approve?

Next Speaker: So moved.

Next Speaker: Second.

Next Speaker: Okay.

Next Speaker: We shall approve the Minutes from December.

Next Speaker: Okay, um, so the, the next order of business is to approve some minor language changes in the OARs related to, uh, healthcare associated infection. So those should all be in your packet as well right after the meeting minutes. So those actually start on Page, uh, 9, if you wanna kinda flip through the back. Um, basically it, all we did was switch around **** the order and clarify some language for our required reporting elements and, uh, this new, our new reporting poster which is actually, uh, it's currently being printed and will be, we're gonna be sending, um, 11 by 17 glossy poster to all of our, um, healthcare facilities in Oregon and so we just, um, updated some wording in the OARs, it was a little old like IP instead of ICP, um, and just kind of clarified, um, what was reportable since we now have, as of 15 we've got, um, quite a number of **** infections reportable. So, um, but we, this committee can actually serve as an advisory committee and officially, uh, you know move to approve these edits. So if someone would approve them or move to approve them that would be great. Or if you have objections that's fine too.

Next Speaker: I just have a comment.

Next Speaker: Yeah.

Next Speaker: I read these, I'm sorry. Um, under, uh, when you describe the type of units that have to report, particularly in pediatrics, there are a lot of sub specialty units, they don't call themselves **** units for example, hematology, oncology, bone marrow transplant and in looking at some of these and **** past history, um, that's a, that's a little bit of a sneak out. 'Cause well there's pediatric hematology, oncology which is usually a separate unit all on its own.

Next Speaker: Mm hmm.

Next Speaker: It's not consider a med surg unit.

Next Speaker: Yeah.

Next Speaker: Are they also part of this reporting requirement?

Next Speaker: They are not.

Next Speaker: They are not.

Next Speaker: So they are not. That should be listed here that that would be the exception.

Next Speaker: That those are exceptions?

Next Speaker: Right.

Next Speaker: Okay.

Next Speaker: **** just in general those special care areas?

Next Speaker: Yes.

Next Speaker: That's where the confusion has been.

Next Speaker: Yeah specialty care areas.

Next Speaker: Okay.

Next Speaker: Because, you know for me orthopedics should be med surg but it's not, it's like **** as you said it's under special care area.

Next Speaker: Okay.

Next Speaker: This is, this is Genevieve from Oregon, just as a, a potential way to look at this more broadly, would it be better just to use, you know, language according to the NHSN definitions? 'Cause that's how these are falling out, right? They're not, by NHSN they're not considered med surg.

Next Speaker: Uh, well correct we just actually, actively mention, we said medical, surgical and medical-surgical wards. Um –

Next Speaker: For any, is it per NHSN definitions?

Next Speaker: Yes, yeah ****

Next Speaker: I'm just saying maybe that might cover these things more broadly.

Next Speaker: Yeah.

Next Speaker: And make it clear going forward ****.

Next Speaker: That report, that are reporting **** yeah.

Next Speaker: To how **** NHSN.

Next Speaker: Right.

Next Speaker: Then and that would just a consideration to make it.

Next Speaker: Yeah 'cause there's always that argument of we don't have to report this because we're a special team and it says med surg here. And so people will think that way.

Next Speaker: But if yet it's true, I mean they actually currently don't have to report those.

Next Speaker: Yeah, right.

Next Speaker: Those **** for those.

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: Because NHSN doesn't have them. It's all, any **** standard right?

Next Speaker: Right well actually and these are, this is sort of like the units that CMS has selected for, you know so hospitals are already reporting according to these. Um, I think the issue is that they're not, risk adjustment is not quite as, as good for ****

Next Speaker: Okay yeah.

Next Speaker: Correct.

Next Speaker: Um, so that's one of the reasons that, that CMS does not require it but if we think that these are, I mean that's kind of what we're here to discuss. So if we think that, you know, more attention needs to be paid to these units and we should be reporting **** for the ****.

Next Speaker: You know when you walk, look at bone marrow transplants versus hematology, oncology, that's a little bit of a different, uh, risk.

Next Speaker: Absolutely.

Next Speaker: And I've always felt that we at least need to know what's going on there so that you can see, even if you have, it's like a bad scale, even if it gets 5 pounds off, you're still gonna know when there's a change.

Next Speaker: Right, right.

Next Speaker: So I, I would think that you know we have concerns about those types of specific **** relations that are at high risk of these infections –

Next Speaker: Yeah.

Next Speaker: – is there something in the environment that's causing the risk for these particular individuals in this particular unit, at this particular time to be even higher?

Next Speaker: So I think, I think this is something that we, um, you know I mean we can consider and I think some of the issues that we would wanna discuss are, um, you know we may as a group decide this is an important unit to address and then would need to consider what would be the result of, um, you know kind of including these, these infections would be, you know, some hospitals have these units and others don't and maybe, I mean I think like on, on an in-hospital, um, looking at rates for your specific hospital **** really important that CDC encourages it. So how do we encourage that without kind of introducing some of the unintended con, consequences of hospital comparisons and public reporting? Those are some of the things that we might wanna weigh. So, so I, I'm glad you brought that up. Because I think this is, um, this is something we could, we can get on the agenda to discuss.

Next Speaker: I'm sure, speaking as somebody who, who worked in some of these places that they do already look at this.

Next Speaker: ****

Next Speaker: Mm hmm, mm hmm, you just don't see it yeah.

Next Speaker: Yeah, right. They do look at it and, and there's always a, uh, again if you really wanna know about healthcare associated infections, is it because of this individual's morbidity or ****

Next Speaker: Correct.

Next Speaker: That's why they're having these infections or is it because there's poor **** care in that, in that particular organization? You don't know that information and to assume that it's just because someone has an immunocompromised, um, disease and they're gonna eventually have a Lyme infection is that the right assumption **** make?

Next Speaker: There is a special **** for that.

Next Speaker: Yeah right and that might be the answer. Is that you have, and because even in smaller hospitals who don't have these specialty units, those patients are gonna be intermingled with a med surg population or could be intermingled with a med surg population and then that could throw someone's data really off, um, because these people are in those units. So I, I think that, my, my main point in this was, is there a special discussion about certain types of diseases either in a specialty unit or for certain types of **** patients in a specialty unit or in a, um, mixed in the general population.

Next Speaker: I don't know that we can, um, have public reporting that's not already, um, legislated. Um, so it would be voluntary.

Next Speaker: Mm hmm.

Next Speaker: Is that what you're saying?

Next Speaker: I, I, you're just asking methodology?

Next Speaker: Uh huh.

Next Speaker: **** mixed population **** population **** like ICUs that have more than 8 percent a specific population it would be labeled as specialty ****

Next Speaker: **** mixed acuity, mixed acuity, all age, so there's different mixed acuity units.

Next Speaker: Yeah.

Next Speaker: **** about this and usually because I know we try to align with **** head around this ****

Next Speaker: Yeah.

Next Speaker: I know where their head is, uh, in terms of those, those mixed acuity units. I know, what I, what I do know is that the, um, is that for ICUs, I, it used to be only medical surgical and medical surgical ICUs and now it's all adult, pediatric ICUs. So I, I feel like, um, yeah it, it sort of expanded on that and, um, uh, requiring reporting from non-ICU wards, inpatient wards is, is relatively new and so I think the idea of starting medical surgical and medical surgical ward was sort of to establish the baselines and, and risk adjustments within that population and then figure out, you know how best to incorporate those special populations. That's my guess.

Next Speaker: Yeah.

Next Speaker: I don't know for sure.

Next Speaker: I, I think you're probably right. But if I was a manager of a pediatric med surg unit that was in a smaller facility that was mixed, I would be really concerned about some of my **** what is the definition of the med surg unit? I see the definition for med surg, ICU but I don't see a definition for a med surg ward. What would that, maybe exclusions, not counting –

Next Speaker: Mm hmm.

Next Speaker: – these particular types of patients.

Next Speaker: Yeah I mean there is, there's a huge document that describes exactly what types of wards are included in **** definition so I mean that is something we could potentially, uh, link to. I don't know if there's a precedent for doing that within the –

Next Speaker: Mm hmm.

Next Speaker: – the law. Like within the –

Next Speaker: Yeah.

Next Speaker: You can, you can use Genevieve, yeah you can link to a document that's considered your standard.

Next Speaker: Yeah.

Next Speaker: That is possible so you can match –

Next Speaker: Yeah.

Next Speaker: – your standards to an HSN or to CMS definitions. And then they would change accordingly over time as those CMS or HSN definitions changed.

Next Speaker: Kate, I'd like to compliment you for your **** on this document. It's very nice. I've frequently asked what's reportable.

Next Speaker: Mm hmm.

Next Speaker: And this will be a great reference to share and, um, I'm just curious how you plan to communicate it when it's done.

Next Speaker: Um, so we, uh, I don't, I think we're gonna email facilities. When we send out kind of, um, 2015 annual data we'll promote, there's a link to this poster on our website. Also, um, every dialysis facility, uh, ASC skilled nursing facility, um, anyone who's, any facility type listed on that poster will receive like a, a hard copy, um, the infection control department. I don't know can other people think of other ways that we could promote this or distribute the poster or the forms?

Next Speaker: Whenever I get a new one I send it out because I just think it reinforces.

Next Speaker: Okay.

Next Speaker: So, um, because it's, as Mary said it's super handy so ****

Next Speaker: Yeah we can send it out through **** again too.

Next Speaker: Oh yeah, okay.

Next Speaker: Multiple exposures.

Next Speaker: And I think generally at the end of the session, I think Steve **** there's some kind of CD summary that he does a summary of.

Next Speaker: Yeah.

Next Speaker: The changes and the rules so.

Next Speaker: Okay.

Next Speaker: We can make sure it's included in that. Again that's a smaller audience but it may be complementary.

Next Speaker: So how 'bout this? How 'bout we not go to into it further right here but we will, um, we'll go back and take a look and we'll link to that NHSN definitions document, make sure we have a link that's, that's dynamic and will update over time. Um, and then there, we actually have another forum in which we could approve changes or rules **** committee that someone in our group is, is organizing.

Next Speaker: Mm hmm.

Next Speaker: So what I can do is, um, after we make the updates I'll send it out to this committee so you guys can lay eyes on it. Let me know if there's anything else you want changed and then we have, we'll have another forum within the next, so we don't have to wait 'til June to approve these.

Next Speaker: ****

Next Speaker: Sound good?

Next Speaker: Yeah.

Next Speaker: Do you want me to jump in right now and just say a couple words?

Next Speaker: Yeah.

Next Speaker: Okay so just to build on what Kate's saying, this is Genevieve **** on the line for Morgan, uh, to build on that. The, uh, Rules Advisory Committee otherwise known as, fondly as the RAC Committee, uh, is where we will be forward the new rules. So in addition to these, uh, there is one that is, uh, addresses the issue that was brought up at the last HAI Advisory Committee around clarifying how outbreaks of disease are reportable as well as diseases of public health significance. Even if those diseases are not specifically itemized on our reportable disease paragraph. Uh, so we've tried to, um, to, to I mean it's there, we're trying to make it appear and sound clearer. Um ****

Next Speaker: You know Jen on that particular one I'm thinking about the outbreak definition or surgical side of, uh, infections greater than two with the same organism. You know most surgical site infections are staph.

Next Speaker: Mm hmm.

Next Speaker: Skin **** so I, I would like more, IP weigh in on that particular thing.

Next Speaker: Mm hmm.

Next Speaker: Because I can tell you, um, we don't consider that to be an outbreak.

Next Speaker: Right and so I think there's wording around that there's an epidemiologic link that's, that you have considered to be that this is more than just your regular sporadic –

Next Speaker: **** more than two.

Next Speaker: Excuse me?

Next Speaker: **** more than two.

Next Speaker: And, and that might be the case. I mean it's just, I mean you could say the same thing of, you know, if you're a physician in a community clinic seeing influenza come in, right you're not gonna necessarily call if you're just seeing two in your normal season but if you've got –

Next Speaker: But that's what the, that's what the document says.

Next Speaker: – right that's the general, that is the definition of an outbreak by CDC in many things but again, right you have to use your discretion on what you're, what you're looking at.

Next Speaker: What the threshold would be for outbreak.

Next Speaker: Yeah ****

Next Speaker: Yeah it's, it's above threshold. But if you look and you look for definition of what an outbreak is; that's the CDC definition and ****

Next Speaker: You've already inundated.

Next Speaker: **** yeah so it's wheth, it's also whether it's above your current baseline. So you know, maybe that can be further clarified. Though that's typically understood to be the, um, the, the understanding based upon surveillance, I'm sorry **** are all diseases that are under surveillance you have an idea of when you're outside of your expected number of cases. So, um, but these are, this is really good input and that's why **** the Rules Advisory Committee so that you'll be able to weigh in on that. Um, so we need to, and, and to keep it a rule that is usable beyond HAI, um, but is also, you know, it provides clear background. So, um, in the, in the actual rule it just says outbreaks and it says diseases of public health significance. Realizing that an outbreak of one case of anthrax, is, uh, needs **** versus, you know, ten cases of flu, you know, not so exciting except they're all in the same facility. Then it's exciting. So the, the rule

actually leaves it just as outbreaks of public health significance so that there can be that adaptation depending on the, on the facility. So stay tuned for that. Steve and I will send his, uh, who organizes our Rules Advisory Committee and so that will be that. Um, that'll be this year. We've already been asked to consider legislative concepts for 2017. And so some of those, um, we're gonna actually have more formal discussion, organized discussion about that but based upon, you know, some of our assessments and reviews that we've done so far, uh, both of our public health law and then also just working with, with facilities and our investigations, um, is realizing there's some gaps in our reportable disease program and who's responsible for reporting. Um, and that there may be some clarification, um, could be used in community-based care which is like your adult foster home and residential care. There's also some gaps in our AGI program because it's really isolated to facilities but we're you know, the consideration is that these can happen in outpatient surgery facilities who are not technically facilities or under provider's license so we wanna have discussions about that. That should be, um, broadened. Um, there's some perceived gaps in training around continued education of professionals. Um, dentists are required to have 2 of their 50 hours I believe for infection control for, uh, safe injection practices among those **** whereas none of the other boards have any requirements around that and that's something you don't leave out in our, um, investigations, particularly for, um, uh, clinicians practicing outside of hospitals that that is not something that they keep up on and that has led to gaps and lapses. Uh, also thinking about as **** infection control guidance for those types of practitioners that are practicing outside of the healthcare facilities, having **** and, um, instead of, you know, coming in afterwards to, to investigate a problem, try to prevent that problem ahead of time. And then also looking at some infection control requirements and oversight for county jails. So those are just some ideas but we'll be, um, discussing them more formally in future Advisory Committees and we look forward to hearing **** thanks.

Next Speaker: **** thanks Jen. Um, so before we move on with, um, with our regularly scheduled program I just wanted to do a couple of quick introductions as we're, you know, expanding our committee, um, so that we can, we can really sort of start to weave in, um, prevention and these legislative activities, preparedness activities with, um, with, with the data that we are receiving because we wanna use this for ****. Patient **** and so we're very excited to welcome, um, Apeco **** who is right here in the room. Um, Apeco has both an MPA and, a bachelors in public health from Portland State University. And she is currently the operations chief for **** which is the Oregon Public Health Division's Health Security Preparedness and Response Program. So in her role she oversees, um, the local, uh, public health, uh, liaisons who are out in many of our states and we have, that's the PO on the line who's one of our liaisons from Southern Oregon, um, and we are very excited to have her join us and we'll, um, as we move along, you know, we'll try to encourage, um, you know when we have meetings that, where we focus more on sort of, um, coordination of care and preparedness our goal assessment hospitals for example and how we, uh, coordinate with emergency transport, et cetera we'll really wanna pull at these numbers and, um, **** expertise weigh in. Next team member is Debbie Hirsch. She's over here in the corner. Um, Debbie, uh, is an infection, long-time infection prevention and control consultant. She was an infection prevention nurse, um, in Indiana, I believe for about 12 years and then, uh, moved up to, um, uh, Asante Road Regional Medical Center where she was the infection program manager. And she now, uh, you know, works as a, as a consultant and she's worked in many areas of infection control but, um, has a well-known expertise environmental services, environmental health, environmental services. So

we are excited because we'll learn from Mary later on we're seeing a lot of those lapses across the spectrum of healthcare facilities so we're excited to have her on board. Um, our next team member who's joining us, uh, on the phone is Theresa Shepherd. Um, Theresa has a master's in science, uh, science and nursing from Loyola and she currently works as an infection prevention and control nurse at the VA Portland. Um, so she wears many hats there and, um, one of the things she's been doing since 2009 is serving as the chief of **** processing services. So we've identified this as a definite, uh, gap in an area where we want to promote, uh, prevention, uh, because we, we will prevent a lot of different types of AGIs. Um, and finally we have Ruby Jason who is, uh, who introduced herself as the, uh, executive director of the Oregon Board of Nursing. So, um, we have a number from the Oregon Nurses Association who felt very strongly knew to involve the, uh, the medical boards and the boards of nursing specifically and so we're very excited to be working with this group. Uh, we hope to coordinate with her, um, on a regular **** partners as well and, and really figure out, um, how we can move the needle potentially **** and, and other policy **** that you know more about than we do so. Uh, thank you so much for joining us. And I also wanted to introduce Tina Meyer who is our, uh, a new member of our team, over at the Healthcare Associated Infections Program. Uh, Tina is like kind of a renaissance woman. She's done a little bit of everything. We're super excited that her most recent position was actually, um, as a, a corporate trainer in hospitals for **** so we have a lot of initiatives involving electronic medical records so she's got some expertise in that. Uh, she is also a high school and elementary school teacher and then also relevant to this group she was, uh, a pharmacy tech and IV tech. So welcome, Tina. Um, all right, um, and we also have Beth **** on the phone and, um, I actually wasn't sure if she would be attending this meeting but Beth, uh, was extremely helpful, uh, during the, the, uh, well at the **** she had so much experience with doing drills and integrating with community emergency services and was a, was a tremendous asset to our **** so we're very excited ****. Thank you everybody for joining. Um, I wanted to give so the, the new kind of structure of this meeting, we're gonna try to spend the first half really giving you guys an update on where we are with data. So the way that data flows into us here at the Oregon Health Authority for Healthcare Associated Infections is through NHSN mandatory reporting program; through outbreak reporting which we just touched upon and now through this new method is and which is, which are these facility, uh, site visits which Mary can talk about a little bit and which Judy Guzman talked about last time **** full assessment hospital. So we really feel like NHSN gives us a picture of what's going on in terms of the outcomes or maybe a slice of the picture and really the onsite facility visits gives us a sense of what's going on terms of the processes. Uh, so, uh, this is the 2015 annual data. I just, uh, pulled it down. It's preliminary because it has, it hasn't all been validated with facilities but we've got a lot of data here. So I'm just gonna kind of go through these quickly and you've got them, I know you've got them in your, in your packets and you can, uh, pour over them and you know, call me if you have questions or thoughts but, um, this year we had 52 hospitals reporting. This is, um, more than we had last year which was around 40 because now we are receiving reports from wards, not just ICUs. So, uh, ***** 169,000 central line **** so 130 infections and, uh, the overall SIR for 15 was .45. And so, uh, this means there were 55 percent fewer infections than we predicted based on the national baseline for Class E established by the CDC. And remember the HHS target is 50 percent, was a 50 percent reduction by 2013 and so I guess we were sort of under this currently. Um, and just so you know the HHS targets have been reestablished for 2020 and they're gonna use this year, 2015 as the new baseline. So, um, but there are little checkmark from 2014 report **** HHS target. Um, I just wanted to give you a

sense of, you know, we were really just looking at three locations of Class, well four, we had NICU and then med surg, surg and, uh med surg ICUs last year but this is the, kind of the spectrum of, um, wards that we're looking at or units for **** so you can see, um, most are, most of the infections were still reported for medical surgical critical care but if you look at the next three they're all wards and so we actually had overall more **** were reported from wards than ICUs, 52 percent of our **** came from wards, 9 percent from NICUs. So this is, uh, these are infections we've never had access to before **** uh, this is a real area for prevention focus. Um, and this is just looking at the different SIRs across the different unity types. Um, so urinary catheter associated, uh, infections we, we have reporting from 55 hospitals, again with, we have **** wards this year so about 190,000 catheter **** 186 infections and I'm not gonna really spend too much time on SIR or focus too much on it. It looks great. As you remember from 14 we had an SIR over one, um, the definition for **** changed significantly in 15 and so I don't really, I feel like the, uh, you know, really wen can't make too many comparisons. So I think despite what we see we, we just don't know what to think and we, this is something we can look for in years to come using 15 as the baseline. Um, I just kinda wanted to show where the **** that had been reported were coming from. Most were coming from critical care so unlike **** a greater proportion of **** were actually coming from ICUs, reported from ICUs rather than wards. Um, and here's the FIRs for those so although where we're coming from was the SIR appeared to be lower. Um, surgical site infections so, uh, we had about close to 35,000 procedures performed in the category of, you know, reportable infections. Um, and here I just looked at complex, not superficial SSIs; that's kind of where we're moving since we realize superficials are sort of inconsistently assessed across Oregon. Um, our SIR overall was .59 and the HHS target at 25 percent reduction. So, uh, we're looking pretty good in terms of surgical site infections but, um, just to kind of give you a sense these are absolute numbers so the blue bars are the number of procedures performed, uh, and the red dots are, uh, sort of a secondary **** on the right side represent the number of infections. So you can see that the highest number of infections was colon surgeries and, um, but the highest number of, uh, procedures performed was in knees **** 10,000 knees last year. Um, and this actually sort of, um, you know, I think we have a lot of work to do on **** but it's also, it may not be surprising because these are only, uh, incisional organ space infections. So these surgeries are dirty by nature and most of those infections are **** incisional organ space. Um, and here's the kind of breakdown of SIRs, um, this is kind of a first that we've ever seen every single category have the **** under one, um, for an SIR so I think this is perhaps a reflection of, um, prevention efforts ****. Um, CDI we had, uh, 60 acute care hospitals reporting which is everybody actually didn't look at our **** included here because they actually have a different NHSN reporting mechanism this year but, um, so it's one **** 4,000,000 patient days **** and 898 hospital onset infections. So this has actually increased from last year, um, and we have not met the HHS target for a 30 percent reduction.

Next Speaker: I think that's reflecting a lot of extra case finding.

Next Speaker: Yep.

Next Speaker: People that have said oh we're testing too much.

Next Speaker: Where like **** yeah and also **** presuming, also referring to the PCR testing sensitivity as well, yeah.

Next Speaker: Mm hmm.

Next Speaker: Yeah ****

Next Speaker: Yeah I imagine that, yeah that is a risk, it is a factor for the SIR, um, but it might be **** yeah. Um, and then **** infection **** metric here, um, so there were only 59 reported, um, and again **** more patient dates, we have exclusive patient dates for the **** denominator so **** days here. Um, but the SI, overall SIR for the state was .58. Which actually does meet the HSN target. Um, and so yeah next steps we're actually, uh, sending out spreadsheets to facilities with all of their data. We have, we go through this process of verifying it before we can, before we'll post it. Um, publicly. Um, trying to finalize this by the end of April and get it all tied up before Beth **** her new job. Um, so actually we're gonna try to, something a little different his year having a radiated print report so you can, we'll still do a consumer and a provider one but it's just gonna be the aggregate findings with, with, we'll put links to facilities with specific data so that can all be found online and we think this will kind of make the data easier for people to work with and also, um, kind of expedite the process on this end too.

Next Speaker: Okay when, when do you think it'll be ready for public consumption? Not 'til June or what ****?

Next Speaker: Yeah I would think the soonest, um, I, yeah I would say the soonest would be June. I think we need at least a month after **** on the data, yeah. The thing, the, the thing about putting that online that allows us to potentially get it out earlier is I feel like we spend 90 percent of our follow-up efforts on maybe 5 percent of the facilities so the facility, you know, um, it is possible that we get information up online before that last facility gets it. Whereas when it's a PDF we have to wait for everybody **** so we'll see how that goes.

Next Speaker: Makes sense.

Next Speaker: I, again just wanna comment you did such a great overhaul of last year's reporting and graphics and **** simplifying the summaries.

Next Speaker: Oh I love looking at it. It's great.

Next Speaker: **** it is so much easier to interpret.

Next Speaker: Yeah no it's really great and I just wanna, that's what, this is Genevieve I just wanna follow up and see if there will be printable option because having, especially with the long-term care facilities.

Next Speaker: Yeah.

Next Speaker: **** having something **** and not necessarily –

Next Speaker: Yeah.

Next Speaker: On the computer to be able to show and talk about so.

Next Speaker: Yeah I mean that's a good question so I mean so it will still have, we're gonna print out a sort of aggregate findings for all of Oregon but one kind of fantasy I have is, uh, like a facility **** printable report card, report card for every facility. Um, I would love to do that so I'm just trying to figure out if we can **** the resources. I don't wanna hold up the publication date because of that but I would love that.

Next Speaker: I would just request that you know in the future, similar to what you've done this year, um, that for example I could look at **** and I can look at bubble spectrum and see where people are, number of procedures, number of infections, SIR.

Next Speaker: So you like, you like the detail provided ****

Next Speaker: I do because then it allows you to identify, hmm, I'm not doing well here I'd like to maybe call a colleague who has had no infections in this category. So it's, it's nice to run down and see who, who's a resource.

Next Speaker: So this is **** and when, we'll actually at the June meeting, um, you know we can look at different ways to prove ****. If it's not printed maybe there is an online way to kind of, you know, put up a graph where you can pull up like facilities or, um, **** and, and maybe **** experiment. If it, if it kind of fails **** and everybody wants printed ones ****

Next Speaker: I think we could probably do it right on the computer too. You know hospital compare Oregon.

Next Speaker: Mm hmm, yeah.

Next Speaker: Just make it electronic.

Next Speaker: Mm hmm.

Next Speaker: It doesn't have to be printed. But I found that a valuable tool ****.

Next Speaker: Yeah, yeah. All right ****.

All right so this is **** Jung, um, I believe **** HA **** ACBP and I'm gonna give a brief, a brief, uh, update, um, since the beginning of this year. So these are all, not just healthcare **** updates like title **** like the title says but these are all **** to us from January 1, 2016 up until last Friday, March 18. And so there has been a total of 84 outbreaks and so we are in the middle of norovirus and GI and, uh, respiratory outbreaks. And so not surprisingly we see the most amount of **** norovirus outbreaks, we see 30. Um, further slides will break it down just by

HAIs but this is all. Uh, and we've seen 28, uh, other GI type outbreaks of salmonella, **** viruses, **** and some unknowns which means you know they have facilities and restaurants are reporting, uh, diarrhea or vomiting and we just don't have an etiology yet. Um, for respiratories we've seen a handful of flu, confirmed flu, um, outbreaks as well as RSV, some mixed RSV **** virus and other respiratory viruses and again for unknowns for respiratory, these are usually outbreaks that are **** so influenza like illnesses meaning fever and cough or fever and sore throat or fever, cough and sore throat. And then a handful of rash outbreaks so, um, these are mostly hand, foot and mouth disease and others which, uh, the one other hospital I will get to **** since January 1. Okay moving on to just health care **** outbreaks. So, uh, HAI infections, um, in that category out of the 84 accounted for 54.2 percent, so 45 out of the 84 outbreaks occurred in a healthcare **** a healthcare setting. So most common syndrome for these 45 outbreaks was, um, a, sorry the most common syndrome was gastroenteritis, so 34 out of the 45, 75 percent, uh, were GI related and all but 2 of these gastroenteritis outbreaks occurred in long-term care facility, facility. The other two occurred in hospitals. So, um, not surprisingly the most common etiologies for these GI outbreaks is norovirus, uh, and we are seeing a lot of norovirus in G2. So 15 out of 20 of the norovirus, uh, has been G2. And so right down at the G2, norovirus G2 outbreaks we see 4 **** a couple of G24 ****, uh, G23s and G22s and one G27 **** and a couple of not typed, um, as in they have not differentiated between G2 4, 2, 3, 17 but they are G2s. Um, so this is different from last year because last year we were just seeing G24 **** like almost every single outbreak, okay so it was G24 Sidneys. So this year we are seeing actually quite a big spread of, um, the **** types of norovirus. So and interestingly we had three confirmed **** virus, uh, outbreaks in, uh, **** facility so at the Oregon State Public Health Lab if you send in a sample and it's negative for norovirus we will reflexively, reflexively test for astro virus, **** virus and **** virus and so these all have, uh, three confirmed **** virus. So when I say confirmed I mean there were at least two specimens that were sent from each of these facilities that were positive for the ****. Moving on to respiratory so 22 percent of the healthcare associated outbreaks were respiratory in nature. Um, 80 percent **** ten occurred in a long-term, uh, care facility and 20 percent **** occurred in a hospital wing. Uh, we are seeing Flu A, Flu B. The Flu A strain for this year is H1N1, um, and Flu B, uh, actually I don't know what the Flu B strain is. Um, but we've also seen a handful of RSVs and a mixed RSV, uh, **** virus and also **** virus and so, um you know a good spread of flu going on. And this season seemed to peak later than last season. So last season we had our peak, you know, really early on in the season and for this season, uh, the peak is occurring just about now. Lastly, uh, **** reporting so you guys have heard this many times already but you know, we encourage all facilities, facilities to report outbreaks and you know our outbreaks are defined as two or more **** cases, uh, with syndromes are clustered in time and space. And so again why are we reporting? Because our outbreak surveillance system depends on people that report outbreaks and so to have this surveillance **** we kinda need you guys to report your outbreaks. Um, I wanna reiterate and stress that reporting outbreaks is non regulatory at all whatsoever. We don't tell, you know, regulatory people that you guys are having an outbreak. We're really here, um, to help you guys with your outbreaks. So for example, if you need some additional laboratory testing we're happy to set that up with the Oregon State Health Lab and, you know, **** response **** control measures or if you had anything, uh, a strange outbreak going on, we can help you guys bounce ideas off of that, um, about that outbreak. And lastly, I said I'd come back around to that other hospital, um, outbreak and so we recently had a hospital report **** and so, uh, our role for this, um, outbreak or cluster if you will has really been in consultation

**** you know where bringing in subject matter **** helping them come up with, uh, ideas of how this cluster might have originated, how it's spreading and ways to mitigate it. So, um, so really we're not, we're not regulatory at all. We're just here to help you guys **** outbreaks and to have a great surveillance system.

Next Speaker: That would be great to report out at, uh, ****.

Next Speaker: Mm hmm.

Next Speaker: To, to the IPs. Can you give us a little idea about the procedure and the organism?

Next Speaker: Yes, so mixed organism, this was, uh, uh, mixed, uh, knee and hip replacements and I think five out of six were actually, uh, deep incisional infection, one was superficial, um, they saw six or so cases, uh, in a month or so **** their cases originated, you know, back in February. They needed **** and really a, a mix of organisms, um, all kind of GI and GU, not staph.

Next Speaker: Interesting.

Next Speaker: Interesting definitely. So yeah we're still working on that, um, trying to help and, uh, see what happens from there. So that was, that was actually really interesting.

Next Speaker: Yeah, GI, yeah you wonder.

Next Speaker: ****

Next Speaker: **** culture or different culture yeah and technically not our first SSI cluster. We, we've done other ones before but first ****

Next Speaker: **** so, so yeah **** really interesting.

Next Speaker: I got, I got a question. So but there's a requirement to report actually too.

Next Speaker: There is a requirement to report, yes.

Next Speaker: I think what she means to say is –

Next Speaker: **** well yeah and the other thing is in terms of the non, yeah we aren't regulatory but might there be a situation where we had to report something to the regulatory body? 'Cause there is a regulatory body within this. So I just wanna make sure people are clear like there might ****

Next Speaker: Well actually any, any state employee, yeah any state employee is a mandatory reporter. If you see, you know, elder abuse –

Next Speaker: If you see ****

Next Speaker: – and other egregious things.

Next Speaker: Right, we're mandatory, right.

Next Speaker: ****

Next Speaker: Most healthcare, most healthcare providers are mandatory reporters in similar things.

Next Speaker: My, my point is we're not gonna like, you know, call **** and be like hey ****

Next Speaker: Yeah, we try to avoid that, yeah.

Next Speaker: **** we're, we have to follow our rules but no we're not going to call you out because you had –

Next Speaker: Call the surveyors.

Next Speaker: – yeah **** because you guys have an outbreak or two or four or something like that **** more outbreaks, um, but, but yeah so ****

Next Speaker: And I'd just like to point out that this facility also with the **** very low rates, we were able to look up their rates **** and actually sort of an **** facility in terms of **** procedure so, um, we were, we **** findings ****

Next Speaker: That would be great.

Next Speaker: But you know I think we, um, we had presented last year on a previous surgical site infection cluster, um, that was associated with, um, non-hospital staff infection control practices so we try to share our, you know what can be learned because anything that we're seeing is not something that's isolated to that facility. It happens, you know, typically throughout the entire **** system processes. So we try to share those learnings so folks can go back and say okay how are we training our non, um, hospital staff to be in the OR and are, are they, you know, held to the same accountability, bility as our surgeons and our OR techs and that kind of thing? So, um, and sort of being able to then take back to the FDA as well like hey there's some gaps here, lower instrumentation **** works and so, um, so we try to use it on an educational purpose. Again, you know, as we do always with quality improvement, so.

Next Speaker: All right one last slide on **** um, so this is our **** page so as of 2016 we have six travel associated cases, um, none that are homegrown cases, let's call them. Um, and so if you have any questions about **** virus, um, there is some **** virus information on the page for Oregon Healthcare Providers and a short link but ****

Next Speaker: We can't see it.

Next Speaker: Oh, uh, it's in your packet. It's really easy it's ****.com/****Oregon and so this has all the information that you could possibly want about **** virus and you know how to report it, how to send samples, um, what, what's the current case definitions **** so, um, if you have any questions about **** virus you guys are always more than welcome to call us, uh, at, on **** at 971-673-1111, I believe it's Option 3. Or you can look at this website, so.

Next Speaker: Yeah it's just, it's just for folks on the phone it's, you wanna spell it out?

Next Speaker: Oh yeah so it, it's bitly.com/zikaoregon, so um, so that's all I had. Do you have any questions?

Next Speaker: Can I just put a little bit of context? One of the reasons why we have a lot of healthcare associated flu and gastro, uh, outbreaks, especially in long-term care facilities is we work very hard with them to get them to report to us because we have all sorts of, um, resources **** to guide them through how to respond and control it so. That's a good, good thing ****.

Next Speaker: Okay.

Next Speaker: I'm, um, passing around a set of assessment tools so, um, it's just for you to review so you know what the four different tools I'll be talking about look like. Those who haven't seen them. Well it has been a busy year to say the least. So, um, we started our, it's hard to believe. We started our new grant cycle almost a year ago. So, uh, we'll be summarizing a **** what is part two and, um, I'm not gonna go through, there's a lotta slides and do I need to be done by 2:00? Yes, so, um, I will try and get us caught up but just know there's a lot of slides and I really had intended just to do a high level review but give you the information **** so, um, just to **** um, this is the grant from the CDC **** but it actually deals with trying to build the infection prevention infrastructure across the continuation of care. And if you look at the second bullet here, it develops statewide infection control capacity to prevent healthcare associated infections so that's really what I'll be focusing on today. Um, the Part B assessments, um, allow us to actually go on site and provide, um, consultative infection prevent assessments. Oregon decided to use a regional approach so that we can go partnerships and communities. Um, we do a baseline consultation and then we come back several months later and do a follow-up visit. We're planning when we come back to actually have some meetings **** the regions, like all the healthcare facilities so it can be an opportunity for people to meet partners not only for healthcare facilities but emergency preparedness providers, et cetera. So we'll be planning, um, those meetings probably to be occurring late spring and summer. Um, the first year we provided a consultation so we targeted, um, or said we did 25 facilities and in the next two years we'll be, um, increasing that volume to 35, um, depending on what our budget looks like we may actually, um, add additional, um, visits to that as well. Um, we are trying to include and invite the local health departments as well as local **** members, um, you know to come onsite or at least be there for part of the tour of the facility so they have an opportunity to come and join and meet their partners as well. We've only had a couple people partake of that. It's mostly due to scheduling issues but hopefully again as we gain more momentum, we'll be able to do more of that. Um, we, last year at the meeting I think in December we spent a lot of time talking about our selection criteria. Basically it was a combination of data **** outbreak data, um, we looked

at regulatory survey radiance, um, um, recommendations, um, that were suggested to us, um, and sometimes we decided to, um, have some, um, assessments be based on a facility that is sort of dusting up after a particular outbreak and they actually were asking for additional support. Um, I think in the future one thing we didn't do was we really didn't take a facility or system or chain approach to selection and I kind of found out that some of the facilities even though they had a different name were affiliated with certain chains for instance. So I think in our selection next year we'll kind of focus on trying to ensure we're putting, um, a little better, um, sample of the different, um, chains and systems that are out there. Um, and also consider, um, you know focusing on trying to, um, maybe work with **** infection preventionists in their roles to again really provide some support for them. Um, this is just again a sample of how we're trying to take a regional approach partnering with our, um, emergency preparedness providers in those different regions throughout the state. So today we've completed 19 assessments. You can see the facility, um, types on this slide **** um, I'm happy to say we will have four more completed by, uh, the end of the month with the remaining two to be completed by the middle of April. So, um, it feels quite good to have them completed. Um, we had some initial problems getting through the door. Um, I think as word has spread about the benefit and other people have shared their experiences, um, I call and sometimes I've even been requested to go ahead and provide additional assessment so I think that's, um, definitely moving better. It should be easier this next year. I passed out the four assessment tools that the CDC, um, uses. There's one for acute care, one for long-term care, one for dialysis and one for ambulatory. Um, acute care includes **** as well as, um, the critical access hospitals if you will. Um, long-term care includes **** settings **** as well as, um, intermediate care, um, and then ambulatory includes ambulatory surgery centers as well as other types of clinic settings. Um, each tool has different domains and requirements. Um, I've created template agendas for each of the facilities, um, based on what I've learned it really works for the flow, um, and I also learned that they're going to a 25-page survey tool that it's really boring and really dry. And the best way to capture the assessment is by being out in the clinical areas, doing audits, observations and interviews with staff and I think that really enhances the educational opportunity because we can really, um, talk about, um, sign and symptoms and assessments and, you know, have people begin to incorporate it in nursing care plans and have them think about identifying high risk patients and having them talk about how they're implementing the bundles and the types of things they're doing and looking at so again I think it really just helps reinforce how much of this project is to focus on early identification and, um, intervention for potential concept of infections. Um, during the visit you can see briefly what we do with the opening conference toward the facility observations. There is a combination of chart audits for inter-facility transferred communication and, um, antibiotic orders. We look at policies and procedures address, um, additional concerns and have an exit conference. It's most of the day, uh, fairly exhausting day. Um, you can look at the type of things we monitor here in the slide. Again I won't go into detail but it's really looking at a lot of different domains, um, that we'll be talking about and again really focusing on actual practices and I have to tell you I've become a big fan of observations because you really can see some system issues, um, and opportunities for improvement when you're really focused on doing them. Um, I do wanna caution, I'll share the data for you. I wanna tell you right now that most of the domains, the CDC tool asks if you are performing observational competencies on higher, annually and, um, when equipment changes or processes change, as well as periodic audits which require you to monitor and document those results and then provide performance feedback to personnel. This is across the domains for everything and I can pretty much tell you it's not

what's in place right now. It's not a regulatory requirement. It has not been an expectation but based on what we learned with Ebola, it's really, I think the state of the art of where the CDC would like us to move to endure again we have solidified infection prevention practices in place. Um, so the majority of facilities are gonna have zeros on most of the domains. So I wanna give you that heads up and that's exactly why. Um, with that being said it is not reflective of the quality of care in that facility. I just wanna really emphasize that. Um, and I think I explained why. So hospital data. Um, again I'll just do high level and all these results, you have copies of what we have, um, in the slides. Um, most of the facilities met infrastructure requirements, about 50 percent of infection, on preventionists were certified, um, and we only found one facility with some outdated policy and procedures. In terms of looking at the hand hygiene domain, only one hospital met all of the domain requirements and again that's mostly the competency based issues they want us to move to. Um, most hospitals had, uh, routine audits with performance feedback, um, supplies were readily available and, uh, they all had policies to promote preferential use of alcohol-based hand rubs. Personal protective equipment, no facility met requirements. And again it's because of those competency requirements. Um, the equipment was available and, uh, you know, hospitals, if they were using a nine five mask did have plan in place for, um, annual **** testing of their nine five mask. In terms of, uh, catheter associated UTI, again no hospital met all of their requirements; 66 percent had champions identified for **** prevention activities. So this is really again I think a pretty big focus of a lot of our hospitals and, um, some of it may be because our partners **** the Hospital Association have actually led improvement projects focusing on **** prevention. Um, I was quite surprised only 33 percent reported a system in place to check the necessity of, uh, on a daily basis, which really surprised me. One of the things I learned is that, um, it is a lesson that all of us should remember when you switch to an electronic medical record system, some of these, uh, hospitals had reports that when they switched to the system they lost their reporting capability. So it's just a reminder, you know, again to really think about what are the reports you need and the processes you need in place when you make the changes. Um, all use **** date to drive improvements and about 83 percent provide feedback to frontline staff. In terms of **** prevention again no hospital met, uh, the criteria for all domains. Only 17 percent identified champions which actually surprised me until I thought about the number who said that they haven't had **** or they haven't had **** for a couple of years and I think that's maybe one of the things that the CDC needs to talk about with their plans. If you've gone a couple years with no **** do you really need to have the big emphasis and time spent and resource allocation for improvement efforts or should your focus simply be on periodic auditing to ensure processes haven't slipped? So that again will be something at the future discussion. Only 50 percent assess, uh, necessity on a daily basis. All use **** to drive improvement access but only 60 percent shared they actually shared the data results with frontline staff. Which actually surprised me as well. In terms of ventilator associated **** domain, again unfortunately no hospital met all the requirements. Um, 50 percent had champions. A lot of times it was somebody from the respiratory department who was leading the efforts. Um, all assessed ventilator necessity on a daily basis. All had spontaneous, uh, daily, uh, breathing trials with lightening of sedation, and oral hygiene programs. All use **** to drive data, only 60 percent provided feedback to frontline staff. Injection safety, again no hospital met all requirements. Um, one of the new things which I know again a lot of hospitals don't have in place but is now recommended in a lot of CDC publications is that they actually have drug diversion programs that involve infection prevention notification and involvement to actually, um, assess the

potential risk for blood born transmission, um, when drug tampering is suspected. Um, and again that's not a policy of procedure that's in place at most settings. Um, nor could they really describe what that process would like, who would be involved and how they would make the decisions and notifications if needed. Um, most hospitals have eliminated the use of multi-dose vials with guess what? The exception of the anesthesia cart. I know nobody's surprised by that and it's like this magical wall. I don't get it. They've done great everywhere else but you walk into the OR and look what you find. So, um, I observed a lot because I do do, um, routine, um, OR observations and I do interview the anesthesiologist and found a lot of, um, issues again with, um, USP797 guidelines for immediate use as well as labeling, um, and again, um, sharing of multi-dose vials in the, um, immediate patient care area. In terms of prevention of surgical site infection, um, unfortunately again nobody met all competency and audit requirements. Everybody did have surgical care improvement programs in place. All use data to drive improvement efforts, um, 83 percent provided data to frontline staff and surgeons. Um, some of the things in my OR observations, um, are that there's, you know the good news is a lot of people are using CHG products, um, as their surgical skin antiseptics. The bad news is they're not following the drying time or the application procedures. So, um, there's a lotta people doing the old concentric circle so that would be just something we recommend. Um, we have had a lot of discussions as the team and debriefing about, um, their processes for, uh, sterile, uh, technique and there's been a lot of good discussion. Um, I just sort of say I'm not an expert but this is something I haven't seen before, can we talk about it? So again it's great people talking and thinking about what they're doing and why. Um, and then in terms of, um, OR setup and turnover, we also have kind of discussed practices and I know I've been given a list of things to follow up and, um, consult Debbie and others for. In terms of, uh, CDI, it's actually I would say one of the, um, bigger, um, initiatives of most of the facilities. About 33 percent, um, had identified champions for prevention activities. All are using **** data; 66 percent provide feedback to staff; 17 percent had specific antibiotic stewardship strategies in place to reduce CDI; 66 percent had strategies, um, to reduce unnecessary use of antibiotics that are high risk for CDI like **** and 50 percent actually had a process in place to review appropriateness of antibiotics **** for treatment of other types of infections, like, um, in patients who had recent, um, uh, CDI diagnoses. Those are all part of the recommended, um, strategies that the CDC is, um, recommending for antibiotic stewardship. Um, environmental cleaning domain, here, um, the gaps were that, uh, you know again the competencies, um, but 33 percent, only 33 percent had policies that clearly defined the responsibilities for cleaning of, um, the noncritical findings in terms of observations. Um, in hospitals, environmental service staff were able to articulate dwell times for specific disinfections as well as the practices they need to use when, um, cleaning and working in the rooms for transmission-based precautions. ****

Next Speaker: ****

Next Speaker: Yes.

Next Speaker: I'm wondering what a dwell time is.

Next Speaker: Dwell time is contact time.

Next Speaker: **** time.

Next Speaker: So how long the surface is wet once it's been placed. Um, every disinfectant, depending what you're using it for has a labeled dwell time. So one of the things I do when I interview is actually query them ****

Next Speaker: Right.

Next Speaker: Um, you know and reinforce again that that has to be wet for that dwell time. Um, in terms of device reprocessing, um, no hospital has met all elements of the domain. Uh, 100 percent did maintain both documentation; 83 percent so there was a gap there, a lapse, um, had the log for a QC check for high level disinfectants. 17 percent consulted IP when new equipment or products will be purchased so that's a gap there. Um, and no hospital had an actual policy and procedure outlining how they would pull a team together and do a risk assessment in the event that they have a significant reprocessing error and that again is some new documentation and resources that the CDC, um, has made available and is encouraging people to use. And again a lot of that for safe injection practices as well as this is the result of all the patient notifications that have had to occur over the last couple of years. Um, okay multi-drug resistant organisms, um, 83 percent had systems in place for early detection and management at points of entry, um, 66 percent had inter-facility communication for isolation requirement but, again it was not in written form on the front of the sheet. Um, only 17 percent had a system to notify facilities where patients had been transferred of positive cultures. So I think what's happening again is the patient is transferred but nobody's really following up to notify them of that result. Um, no facility reported consistent notification of identified infections that may be related to care at the facility that were present on admission. So again when a patient's coming into them, they're not calling the transferring facility and letting them know of that infection and believe me I know why it's not happening. The busy life of the IPs and others. Um, 50 percent of facilities had antibiotic stewardship programs, um, that met the seven CDC core elements. Okay long-term care data. Go quickly, 80 percent had identified infection preventionists. Usually it was the director of nursing services. They report that on average they're spending 4 hours a month on infection prevention activities. All report an infection prevention training so they usually got this local course but not going to a full **** or **** infection prevention fundamentals course. All use policies and procedures based on CDC guidelines but many don't have facility specific guidelines. They're coming from the corporate office or, um, you know they maybe have purchased, uh, a policy manual. So again we really need to try and individualize it to the facility. Um, one facility **** healthcare personnel resident safety domain actually met all requirements. They did have work exclusion policies. All are conducting, um, employee TB screening, 60 percent however are not really doing facility specific annual TB risk assessments. All are offering Hepatitis B and influenza, um, I asked them about their current vaccination rates and I actually am hearing 50 to 80 percent, which again it's a sample that seems to be improved over previous years. Um, all are screening residents for TB and, um, 60 percent are now screening residents for two pneumococcal vaccinations, so that's good. Um, surveillance and disease reporting, um, all have, or 80 percent have written intake procedures, 60 percent have a system to notify the IP when MDROs or CDI are reported by clinical lab so that's something I think we can improve upon. Only 40 percent have an actual written surveillance plan, 80 percent, um, have processes in place to follow up on information when residents are transferred to acute care hospitals, um, and, um, 100 percent have procedures in

place, um, to report and notify county health departments of potential outbreaks. Their outbreak reporting, believe me in partnerships with the local county health departments is very, very strong. Hand hygiene domain, um, again unfortunately no facility met the requirements; 20 percent had policies for, uh, the preferential use of alcohol-based hand rubs so very low there. Um, some facilities really would benefit from, um, installing more hand sanitizer. Um, 60 percent had supplies that were necessary. Um, when I do the assessments I just audit while I'm out and about on the units and I was finding between 30 to 50 percent hand hygiene compliance. Um, one of the things I observed was, um, hand hygiene was not commonly practiced or if I saw less it was more related to not, um, practicing hand sanitize, sanitizers, using it, hand hygiene. After blood removal. I know that this is consistently with environmental services. I'm looking at Debbie just to be certain that they are in fact trained after dirty procedures to remove gloves and practice hand hygiene.

Next Speaker: ****

Next Speaker: Yeah? Okay 'cause it, it, it's consistent with multiple facilities.

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: Uh, personal protective equipment, um, no facility met all requirements, 80 percent have, um, policies and procedures, um, they do have, uh, transmission based policies and procedures; 80 percent had supplies available but when you ask where the gloves are, the gowns, they're frequently locked with access, key access only with an RN or they're in a totally different building. Um, so again I would really be, and I have been encouraging them to increase their gown use for standard precautions. Uh, respiratory cough etiquette, um, only one facility met all elements. Um, most had signage, supplies available or educating family and staff and all staff does receive education on respiratory precautions. Antibiotic stewardship, um, again nobody met the requirements. As you know, hospitals are trying to put these programs into place. Long-term care is even further behind, um, so they are not reporting leadership, um, you know efforts policy and procedures or routine education for everyone. Um, 80 percent report access to individuals with antibiotic prescribing expertise. They usually work with a contracted pharmacy and have somebody available there. Um, and they do report having, um, access to a report summarizing uses but it's really boring. Patients specifically report talking about dates, dosage, medications and things like that and it's not an aggregated report. Um, 50 percent of orders are not being written with indication or staff dates. Injection safety, um, all have supplies that are necessary. They all had really, I think some pretty good policies in place for drug diversion tracking and documentation. Um, unfortunately when using the glucometer it was not always disinfected appropriately with the appropriate disinfectant that's required for use by the manufacturer, um, and, um, one was using one not approved for multi, uh, resident use. And, um, I can tell you that multi-dose vials other than TB were not being shared which is really good news and also insulin pens were not being shared between residents which is sort of common sense but unfortunately, we've had issues with that not in Oregon but in other states.

Environmental cleaning, um, here, um, there's a lot of train the trainer that's going on, not a lot of competency assessments, um, most have policies and procedures, um, uh, only 20 percent that clearly differentiate responsibility for cleaning. Um, they are using microfiber products which is great and environmental services staff, um, um, was not really able to articulate dwell times and often, um, communicated, um, practices and have inconsistent mixing of the solution, um, reported. Um, staff, um, often not following the clean to dirty work flow as well, um, as appropriate when cleaning and as I mentioned not, um, removing gloves. Okay, ambulatory facilities. These are one-pagers. These are short. We're gonna have to do kind of a Part B because I knew I'd have to, um, um, watch time. So we did three, um, facilities, um, most unfortunately did not have an IP with adequate training. Um, none had competency based training programs. All were offering healthcare worker vaccinations. All had surveillance programs in place, um, but you can see again they're, they're not doing competency based training for the different, um, domains. Um, and I did observe a couple times where multi-dose vials were in immediate clinical areas, um, respiratory hygiene cough etiquette programs were in place, environmental cleaning, training and audits, um, had really not been implemented and then unfortunately we did observe lapses in sterilization of reusable devices as well as high level disinfection processes. So again this is an area of concern where we're going to be trying to provide some additional support. Um, to me processing is like hand hygiene. When I go in there, we're gonna find gaps. It's again just really having to constantly reinforce and monitor and audit practices. Um, dialysis findings I wanted to alert everybody to **** about the Hepatitis C outbreaks that were going on. It was very nice that we have those grants actually to be able to go in and observe practices. It really stresses environmental disinfection of the dialysis station. Um, we've completed three consultations, two of the three actually have a designated IP with specific IP training, um, all facilities had competency based programs with periodic audits. They're ahead of the game with this. All are offering, um, employee vaccinations and TB screening. All have surveillance programs in place. They're required to report into NHSN. Um, none have, um, competency based hand hygiene, PPE, blood glucose monitoring, et cetera in place. Um, there was some sharing of multi-dose vials in immediate patient care area observed. Um, respiratory hygiene, cough etiquette programs were in place. The big thing I really wanna mention is the CDC has a new tool that they've come out with for dialysis station disinfection and audits. There's a lot of pushback coming across the nation to these tools. And the reason is they have traditionally begun disinfection between, before the, um, patient has left the dialysis chair and as you can envision there's a lot of opportunity for potential cross-contamination, um, the resistance is because of the amount of time that it increases, uh, before they can turn that chair over. So just know that our facilities were zero on this across the board, um, in all the audits I did but I just wanna again say this is a discussion that's happening on a national level. The CDC is trying to change standard practice and there's some pushback on it right now. Um, and again some of the CDC catheter exit site care, um, recommendations **** antimicrobial ointment on the site was not being followed. So, um, where are we at? Again I think consistently we have issues with, uh, multi-dose vials being used in, uh, immediate patient care areas and labeling and use of, um, immediate use medications. Um, I am kind of pinpointing anesthesiologists here but again there are practices in other settings as well. Um, my recommendation is they have conversations and partner with pharmacy because some facilities have been very successful at accomplishing this and I think it's come about by partnering with pharmacy to get the drugs they need prepared in the manner they need. Um, implementation of inter-facility transfer, written communication requirements is incomplete. We really can't say

that we've got that one, um, met. Um, reports such as **** elements are sometimes lost with the HR implementation, antibiotic stewardships are being implemented in hospitals but other settings, um, are gonna require additional support and resources. Um, instrument sterilization, **** disinfection issue are a problem across the continuum of care and then we need some solid, um, training programs for EBS teams and, um, infrastructure infection prevention programs have **** hospital needs additional dedicated training resources. Um, in terms of take, take aways, um, to me this is really validated why, um, competency based training, performance, um, feedback and routine auditing affect us, this is so important. It hardwires, um, training for new employees and new grads. Um, I noted and I probably should have known this but it's very difficult for rural areas to recruit experienced staff so they actually are having to really establish more robust training programs for this. Um, also practice **** reinforced, so for instance the skip measures that used to be required for antibiotic timing, selection, et cetera, a lot of places no longer do that. They're not doing audits so you wonder with time what's gonna happen there. Um, and again I think there needs to be discussion that what to, what should be expected for facilities to go a long time without infections. At a minimum we hope that they're celebrating and keeping people thinking about prevention efforts. Um, and then again presence and feedback is a very important component of infection prevention because care happens at the bedside. Next steps, we'll finalize our assessments, complete analysis of findings during April, we'll plan our mitigation, um, visits, um, incorporate findings into our IP fundamentals training course that we had and will have and then hold our regional meetings. Um, and then we'll be asking this committee to, um, have some input on our second year facilities who may benefit from a consultation. So with that I went over a little.

Next Speaker: That's okay Mary, excellent.

Next Speaker: Can I just ask a question?

Next Speaker: Mm hmm.

Next Speaker: Very, really helpful information. So it sounds like you are gonna prepare a report and then go back to the hospital and kind of have **** story with you on ****?

Next Speaker: Yes, yes.

Next Speaker: Okay.

Next Speaker: Mm hmm.

Next Speaker: You know I really support the, um, training and the, the, um, **** type of thing, um the competencies but, um, hand hy – and I'm thinking of the resources needed to do that on an ongoing basis and where is it coming from and if this is not a regulation, how are you gonna get administration to support the additional **** required for this?

Next Speaker: She asked the tough question.

Next Speaker: **** for me.

Next Speaker: No so I think it needs to, you know when I first started nursing, um, you know part of my role as a staff nurse was to routinely do some auditing and I think we kinda lost that, you know and I love, I don't know who Mary, I'm gonna worry about Mary but Mary has a program where she's working with a, um, infection prevention liaison program. So she's trying to work with some of the staff nurses on the units and provide them with infection prevention education and to me they'd be perfect to help, um, with these audits because that again reinforces behavior and if you wanna, if you have a barrier to compliance, the best people to involve with resolving it are those who are involved with the work. So, um, again I think you know hopefully we can figure out how to build in some of this time into staffing but, um, you know that to me is really how we can help build our infrastructure.

Next Speaker: Now as the token regulator in the room, I am by no means want to add **** reporting each and every individual practitioner to their licensing board 'cause that's very traumatic to the individual and it's, it's a lot of, of, of, um, heavy handed type of, of ****

Next Speaker: Mm hmm.

Next Speaker: However, um, the, the reason you have a license, a medical license and a nursing license, whatever license is because it's a social contract with the people of Oregon that says I promise to keep you safe. Our job as a board is public safety is not professional, uh, **** so the question I have is especially when I look at the minutia of this, everybody has a CNO and for, for nursing, I, I won't speak for the other **** but there are specific standards for infection prevention written into the nurse practice act to this state that says the nurse will do what needs to be done to have a safe environment for patients, to include keeping up to date in practicing infection prevention. At what point do you say, you know, leadership is the one who's supposed to formulate plans and **** eventually there's a CNO who's responsible for the environmental care. And that is a route that is an option in places that just you have these outcomes that are just horrible for public. Again I wanna go on record saying do not report every, you know, Tom and Nancy nurse who is not washing their hands but the fact is, is what is the organization and the nursing leadership or that, for that matter the medical leadership 'cause they have pretty much the same kind of rules, what are they doing to abide by the practice act that has allowed them to practice in this state, their profession that says you will adhere to infection prevention, uh, procedures in your environment? 'Cause it's written right there, at least in the practice act. So there is some –

Next Speaker: Oh I agree with you but I think people know what they should be doing.

Next Speaker: Mm hmm.

Next Speaker: Um, but **** and they're busy and they're this and they're that and nobody's really watching.

Next Speaker: But if you have a bad ****

Next Speaker: ****

Next Speaker: For example I saw some there.

Next Speaker: Yes.

Next Speaker: And you look at your infection and you go you know this organization doesn't have any leadership or doesn't, there are things that raise, and again **** don't leave this room saying **** report everybody but I think that there are some regulatories just because I know people don't want to do the regulatory part, heavy hand but as 30 years as a hospital nursing director, I'm here to tell you this hasn't changed since the 1980s. It really hasn't. Anesthesiologists haven't changes, nurses at the bedside really haven't changed. It really hasn't changed so what do we do now that's different? That's just the token regulatory person.

Next Speaker: Aren't we glad we have Ruby now?

Next Speaker: One, one of the, I wanna and this is a question, this is Jennifer Morgan but the news or CMS infection control worksheet that was since November 2014 I know they're gonna start using does that start to address it? It seems to me that there, they do start asking now about these competencies and things like that but I mean it's, I looked at it like last week or something.

Next Speaker: Yeah I think I –

Next Speaker: I think they're actually starting to **** those questions.

Next Speaker: – so when you're talking hospitals they do have those through the worksheets but again most hospitals are, um, deemed by other regulatory agencies so unless they have a state survey they don't have the CMS worksheet.

Next Speaker: ****

Next Speaker: In terms of ASCs, ASCs does have that into their CMS worksheet and they are not always using it but they're supposed to look at the same processings. Um, I think right now though, um, if I recall I think they're on like a four-year cycle for surveys right now.

Next Speaker: So a, a deemed, a deemed facility that, um, third party is not required to, to, to judge a facility based on CMS standards?

Next Speaker: If you're deemed basically you are **** permission certified instead of state cert, certified by the state. Um, and the other one is DMV.

Next Speaker: DMD.

Next Speaker: DMD.

Next Speaker: D.

Next Speaker: They don't use ****

Next Speaker: That's the other major accrediting is, um, ****

Next Speaker: I guess I assume ****

Next Speaker: The patient does not say that you have to do this.

Next Speaker: It's the competency.

Next Speaker: Right.

Next Speaker: So I ****

Next Speaker: **** catheter ****

Next Speaker: Right but for instruments processing.

Next Speaker: Oh right.

Next Speaker: That is but you're right for the other practices that it's not a regulatory requirement at this point.

Next Speaker: Okay and then the –

Next Speaker: But, but CDC has contracted with CMS so we'll have tools, um, this year that are looking at education and training and they're starting with long-term care and my understanding is then they'll go to hospitals. I have not seen those tools. But, um, from conversation I think they are nearing much of this.

Next Speaker: And just a question of clarification so Jayco and DMD don't have to use the same standards as CMS for their surveys?

Next Speaker: They don't use the same process but they have to meet the minimum requirement.

Next Speaker: Okay and so right now the infection worksheet may not be a minimum requirement.

Next Speaker: Okay.

Next Speaker: It's many pages long. It's a special survey ****

Next Speaker: It's like 40-some-odd pages.

Next Speaker: ****

Next Speaker: We had one large facility that it was a **** survey.

Next Speaker: Okay thank you for clarifying.

Next Speaker: In California the state and **** together and they do multi horrible, long survey, um –

Next Speaker: Routinely? That's their routine?

Next Speaker: Yeah in California, at least when I worked there it was every three years the state, um, and **** commission came at the very same time and you had five or six surveyors and they would go together and you would have the state CMS type, uh, requirements and then state CMS and **** commission **** in California.

Next Speaker: Hmm.

Next Speaker: So most states it's deemed, **** pass **** commission then you're okay unless there's a specific patient complaint and then CMS can come in and –

Next Speaker: Or the state may come in and do a validation survey which you get to repeat the whole thing.

Next Speaker: Right.

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: Well I'm just, just for the sake of time, um, thank you so much for presenting all this, Mary. I think this is there's a ton to talk about and I think it's kind of the charge of this committee to figure out how we wanna prioritize this. Maybe between now and the next meeting we'll send out sort of a list of, you know, all those **** summary observation and, you know, uh, we might want to discuss as a committee you know which ones we wanna prioritize and as we hear about her findings, think about how might this inform our outbreak investigations and how, which type of patients will **** and are we required reporting from those types of patients? I think we can kind of reevaluate you know our, our NHSN reporting based on kind of what we're seeing here. We're trying to leave all the pieces of data together so thank you for that sort of blast of data and I think what Mary Chase and I will try to do is, is figure out how to kind of **** you know kinda like dive a little bit deeper into each one of these. So I know we had a, we had sort of a break of schedule so I think if people need to get up ****

Next Speaker: All right so, um, I'm gonna kind of kick off the prevention half, um, half an hour here, quarter of our meeting, um, and, uh, just, just wanted to let you know about some activities we've got going on in Oregon related to injection safety. Um, on your way out you can, there's some free materials on the back table, um, that we're, we're trying to promote and, um, I'll tell you a little bit about how you can get some of those yourself. Um, so basically our AGI

program, uh, got a small CDC grant to improve injection safety practices in Oregon and some of this is driven by an out, well an incident in Southern Oregon where you know we, uh, were dealing with a physician who had, was, um, was identified as, as doing unsafe, having unsafe injection practices and, um, then it led to a hepatitis outbreak in California and he was also practicing in Oregon. So what we wanna do is we basically joined as a state the one and only campaign, there are nine other states, um, who have joined this campaign. Our goal is to raise awareness among, um, public health professionals and provide our communities and, um, we, we're doing a small pilot in, um, Jackson County to look at, uh, facilities' injection practices. Um, so I just wanted, you know, for those of you who, um, are not familiar with it, the one and only campaign is, um, it's basically a CDC funded campaign and there's a ton of, um, there's a place you can go and order free material, there's a lot of, uh, videos and training materials but it really was, um, it, the motivation for starting this campaign was that you know over, uh, one, a decade basically or a decade, about 15 years, there were over 50 outbreaks, um, that had been identified as, uh, being caused by unsafe injection practices, so both viral and bacterial, uh, with over 700 patients infected and then these infections usually led to, uh, huge patient notification of potential exposure to blood borne pathogens. Um, so some of the common culprits were syringe reuse, improper use of single and multi-dose vials, um, and improper monitoring of glucose equipment. And so this is kind of a typical, um, this is a little bit hard to see in here but kind of it demonstrates you know how, um, how reusing syringes after changing the needle can potentially infect another patient so this usually occurs with redosing, um, a provider will, you know, re-enter a vial with a, uh, clean needle but the same syringe can contaminate the vial and then that vial gets used on another patient and lead to, um, transmission. And, um, some of these transmissions identified in I think 2007 led **** greater assessment of practices and this **** paper actually was looking at, uh, practices in ambulatory surgical center and found that, you know, over a quarter of the facilities actually said that they were using single dose, uh, vials on multiple patients, um, and you know even if there's not sort of, um you know, even if it's used on the same patient, um, using the single dose medication vial twice, uh, can lead to bacterial contamination because those vials are, uh, they usually don't have a preservative to keep bacteria out. Um, so, uh, there, there are those lapses with vial use but there's also, um, been a lot of Hepatitis B outbreaks associated with long-term care and reuse of, um, assisted glucose monitoring devices for multiple patients. Um, even a couple that have been tied to reuse of lancets, although obviously this is less common. Um, but so we've been trying to message to our long-term care facilities about that **** use.

Next Speaker: We have a case right now. A healthcare provider was using the same insulin on multiple patients because the rationale was that the patients didn't have any more insulin, they didn't have any money so use the one that ****

Next Speaker: Yeah think of the, some of those cartridges are designed for multiple use on the same patient.

Next Speaker: Right.

Next Speaker: So there's, so it's sort of like the engineering is like **** so ****.

Next Speaker: Um, so we know this is happening but you know we hear these stories. We, we don't always identify them, it's hard to identify a human hepatitis transmission particularly Hepatitis C so we believe we just know about the tip of the iceberg which is why we're trying to promote these practices. Mary mentioned a little bit about drug diversion, um, so you know we eventually had patients in Oregon notified of abuser patients that received care out of state but, um, um, you know that, that healthcare worker had been caught diverting drugs and that they were potentially at risk. So, um, the CDC and, and specifically one and only campaign has a lot of resources out there, um, this was sort of an interesting, the 2012 multi-state, uh, hepatitis outbreak is sort of a really fascinating, harrowing tale, um, **** read this article about the, um, the healthcare provider actually shares his perspective on it and how, um, you know the, the regulatory credentialing laws in various states really sort of allowed this, this guy to slip through the cracks.

Next Speaker: This is Jenna, I just wanna make a, a quick point, I think to be cognizant of our changes that are happening with the prescription drug monitoring where oral opiates and **** uh, access to that is shrinking and so users are gonna need to look for other sources so they might be going back to heroin leading to more overdoses but also might be going for safe sources like healthcare opiates to use so just be aware that other social changes may impact **** hospital ****.

Next Speaker: Our biggest increase in cases is with our advanced practice nurses who are recognizing all of these issues and are really tapering back on their drug dosage for some of their chronic patients. We had a complaint from a patient who had been on long-term opioids since 1996 and had a new provider and that nurse practitioner said look I'm gonna have to taper you off, I'm gonna have to give you a contract and she filed a complaint with the Board of Nursing saying this individual is cruel and inhuman and not safe to practice. So there's that other side to it but we're seeing, yes we're seeing a lot more of the practitioners really being aware of trying to **** opioid pain interventions in acute injuries but then they go ER shopping ****.

Next Speaker: So **** in Oregon if you wanna be a part of that ****

Next Speaker: Maybe you should **** 'cause it's, we're seeing a lot more.

Next Speaker: Yeah.

Next Speaker: But yeah if it's, I mean it's like **** just you know the rise in opioid use, uh, that's the end treatment for overdoses and, and healthcare workers are not **** rates from certain **** with the general population in terms of substance abuse. Um, so I mean somewhere like, you know, Ruby mentioned some of the mechanisms for diversion, there's you know, false documentation, um, scavenging of wasted medication and **** and most disturbing example of this is when, um, you know a healthcare worker will inject something like Fentanyl and replace it with saline **** which does happen. So, um, you know we're just trying to **** healthcare workers are obviously trying to do the right thing. This is rare but I think, uh, we're trying to get IPs to start kind of looking for those opportunities, doing things like injection safety rounds where you kind of look, if I were trying to, you know, get a hold of a controlled substance what would I do? And so there are a lot of resources on the CDC website. Um, and, uh, a ton of

videos that we try to push off to providers to share with their teams from all different types of settings. Um, and so I'll go ahead and you know, we're gonna share some more data probably at the June meeting about it, you know a survey we had about injection safety practice, injection practices in Jackson County, um, but for now I just wanted to make people aware that we were doing that. Um, I have to discuss this, you know any time but I kinda wanna move on with the program and make sure that other people have a chance to discuss what they've been doing.

Next Speaker: We've been doing a lot of work at Kaiser at our clinics and outpatients have a safe injection practices and certainly the clinics are, you know, I won't say a hot bed of, uh, issues but they, yeah.

Next Speaker: It's true.

Next Speaker: They need a little, uh, tightening up. So I think that's a great campaign.

Next Speaker: So my, uh, update in conjunction with Diane Waldo is we had talked about using the data from the 2014 report where, um, the hospital, uh, infection roads are compared and looking at surgical site infections per the reported procedures done in Oregon, um, I really wanted to have, um, a way to share best practices by identifying the facilities that have excellent surgical site infection rates. Um, so looking at the data, looking at the facilities that had **** uh, well under one so Diane, uh, helped coordinate and publicize the event. We have three scheduled, two have already happened, uh, starting in February. We had, um, hospitals, uh, share their, uh, experiences around, um, total joints so that was back in February and Kaiser, uh, myself and my colleagues at Kaiser, Legacy, Good Sam and Providence St. Vincent and Salem all participated in this webinar. Uh, we reviewed pre-admission, uh, practices, pre-operative preps, inter-operative, uh, procedures and post-operative practices. So we looked at things like bathing, uh, with CAC or **** how many days, how many showers pre-op, uh, decolonization with the **** versus iodine surgical preps were, uh, different. Um, some hospitals did have the best outcomes, had excellent traffic control and, um, looked at, uh, a tire, um, making sure that you know there was no air showing, that kind of thing. Um, so the biggest difference is, between hospitals were in the pre-operative screening. Some screened for MRSA and MSSA. Some, some just screened for MRSA and then the decolonization of those patients who was to colonize. Some hospitals, uh, decolonized both, uh, using **** and some did not. So the dressings are also discussed so there's some good information about, uh, the different types of dressing used by the facilities that have great infection rates, uh, stress the importance of glucose management, **** glucose, involvement of the surgical team as well as leadership in reviewing any, uh, infections for, uh, opportunities. The second, uh, webinar was on colon surgeries and this was on March 17th and Kaiser as well as OHSU and Multi Care from Tacoma, uh, participated. Jeanette, um, Paris, the IP up at Multi Care has done a lot of work improving their colon procedures because they had issues. So she was, she did present an **** so I invited her to present at this one. And we presented our Pathway to Zero which is just a return to the basics and what Mary was talking about, auditing those processes so when your outcomes aren't fabulous, look at your processes. So it was a return to some of the basic practices. OHSU shared a lot of good information regarding the work they're doing, including a standardized bowel prep, um, dedicated closure tray and Multi Care I think had some great information regarding clean **** closing so they actually do a timeout after the **** is closed where the whole surgical team

re, you know, changes their gown and gloves and, uh, uses a clean, um, instrument set to close. So that's, that's good, not everybody does that. Use of a wound protector which is, um, a device that is inserted into the abdomen that keeps the wound edges clean and protected. Again not always used. Um, then let's see, uh, the other thing that, uh, Jeanette mentioned from, uh, Multi Care was the, a particular instrument there, purchasing which is, you know, quite expensive, over $100,000.00 but it's really good at detecting leaks prior to closure and leaks are the number one reason that we get inter-abdominal abscesses post-operative colons because a lot of these patients are very high risk. You know they've got cancer or they've got, um, issues, they've been on steroids for a long time for **** what have you. So being able to detect those leaks before you close the wound is, is really I think a great idea. So these are some things that I'm gonna bring to my surgical team at 4:30 today when we have our regional meeting 'cause I think we got a lot of good ideas. Um, on some surgical practices. So the next one will be on laminectomies, it's scheduled for April so we're working on getting some volunteers to participate in that. Not everybody is willing to, to speak. So, uh, hopefully I'll be able to recruit, uh, because we do have some hospitals that are doing some excellent work in laminectomy and spinal surgery. So that will be coming up. So I think that these have been very helpful. I don't know if you've had feedback.

Next Speaker: I have had feedback, they said what a great idea so we really structured them to be a, a safety **** so the only people **** have been at the hospital. Um, **** so and then of course Kate is our partner **** because the state is public information. And so Beth has really kind of broken down barriers as far as them being willing to, to talk and to share so, um, Mary mentioned in April we have, uh, the one on spinal surgery so that's April 20th and then I've invited Mary to come **** to speak to our **** patient, uh, collaborative and then to talk about well we have these series of three webinars and here the best practices I'd like to share with you so that's **** audience so just kind of be **** the best practices to say, you know, um, if you're not doing these things you may consider looking at your **** data. We're also having Kate there, uh, to speak that day too on maximizing **** data and really helping kind of, uh, **** all of that stuff **** HSN so really looking forward to that, it should be a good day.

Next Speaker: Yeah I mean ideally we would think more of using our NHSN data to really hone in on which prevention practices, um, you know we need to focus on and what I love about this group is that it sort of, I feel like brought to light a lot of **** I'm not an infection preventionist but I just, the amount of detail to me was striking and I don't think, um, I don't know that that information was readily available to people.

Next Speaker: No it's highly technical.

Next Speaker: Yeah.

Next Speaker: A lot of the stuff that goes on in the OR unless you are an OR person you're not gonna really understand. Um, and in terms of the different types of closures whether you're stapling or over sewing or whatever, they're very technical things that only somebody who's really expert in surgery could say. So that's why I'm gonna take it to the surgeons and see what they have to say.

Next Speaker: Thank you guys both for, for **** this is your idea and making it happen through this whole safe table and then publicizing the information ****.

Next Speaker: Well I think it's also good for new IPs or hospitals that may have a, a lack of experience or expertise.

Next Speaker: ****

Next Speaker: Yes, yes where, where do they start? What do they look at? What are the things that they should be looking at if they're not?

Next Speaker: Just if I may Pat, this is Jen from Oregon for those on the phone. Just thinking 'cause we had a lot of, we're talking a lot about the ambulatory surgery centers and we all know how much more surgery is going on outside of hospitals, um, including, I'm thinking down the road but you know maybe something about sharing these best practices that you have outside of the ambulatory **** surgical ****

Next Speaker: You know ambulatory surgery centers don't, uh, report too many surgical procedures so it would be hard to know maybe they would know. I don't know what kind of surveillance they're doing and what kind of reports are coming in in terms of their surgical site infection rates by procedure. I know that –

Next Speaker: Most are doing it, most do some kind of ****

Next Speaker: Some, yes.

Next Speaker: **** process where a physician reports infections.

Next Speaker: So cataracts **** hernias, there's different procedures that can be tracked and because joints are, are reportable in Oregon **** to CMS, do they report joints, ACS?

Next Speaker: ****

Next Speaker: Much of them, I doubt they're not reporting it to NHSN, they're not required yet. 'Cause our requirement is strictly for inpatients so right.

Next Speaker: There's a lot of hospitals **** was here last year mentioned the fact about the hospital ambulatory surgery centers are not part of the licensed ambulatory surgery centers and so hospitals under their license have, also have a lot of ambulatory procedures being done that currently are not **** reported into NHSN.

Next Speaker: Right.

Next Speaker: Yep and there's new, new entities like Zoom Care that are doing surgeries or ER. **** to be an ER and so things like that.

Next Speaker: So they're doing procedures in Zoom Care?

Next Speaker: ****

Next Speaker: Like what kind of procedures?

Next Speaker: **** I mean again it's like any other office based **** surgery let's do **** similar to some of the other out patient, outpatient ****

Next Speaker: Like **** procedures or something?

Next Speaker: I don't know the full extent but that's **** they, they are advertising ****

Next Speaker: ****

Next Speaker: ****

Next Speaker: **** office based surgical procedures.

Next Speaker: Right.

Next Speaker: *** extremely **** these are the things that are **** procedures and Zoom Care is gonna take **** push ****

Next Speaker: Really, wow, interesting.

Next Speaker: Because there are a lot of botoxes being done there, a lot of **** so we're seeing nurses doing Botox **** procedures; that's a whole other story but the point is that's where they're ****

Next Speaker: Or they were, if they can have someone with credentials as an emergency physician does that make them emergency room and no it's not really **** they're trying to push those barriers so.

Next Speaker: Yeah I was amazed to find out that there are ASCs doing ****

Next Speaker: And there are, you know, full abdominal and breast reconstruction, I mean pretty major surgeries so I feel like this is a big area, I mean it's, it's a little bit of a black box in terms of information we have coming in for a mandatory reporting program so as we kind of go out and assess practices in these, in these, uh, environments **** think about how we can get a better handle on that outcome. And Mary actually was on the agenda to present, um, **** and **** and laundry care. I'm wondering if we might postpone that to another meeting so we have a little bit of time to talk about planning because I think, uh, unless you wanna, I do wanna ****

Next Speaker: You know what I, I'm sitting here in my mind doing, how can I do a really high level fast one so you guys have the slides and I'll do that.

Next Speaker: You could, yeah is that okay?

Next Speaker: Sure we had, I mean we do have one public comment, should I do that now?

Next Speaker: Yes.

Next Speaker: Or do that after.

Next Speaker: Do that ****

Next Speaker: Okay.

Next Speaker: ****

Next Speaker: Um.

Next Speaker: Do what you feel you need to do.

Next Speaker: Well I just –

Next Speaker: I, I guess, let me just say for the record –

Next Speaker: Yeah.

Next Speaker: There's a lot of data here, um, this was a project that we did with long-term care facilities over the last year. We learned a lot. I think our real opportunities here relate to antibiotic stewardship. And not sending, um, unnecessary urine cultures when patients are not symptomatic and not starting antibiotics without sending cultures and, um, not, um, treating unless residents have symptoms. We had great success at reductions and, um, on slide, it's not numbered but on Page 32 you can, uh, see a lot of information about our successes and so I think it's just very ripe for future, um, grand projects and what I'd really love to see, um, it was hard for long-term care facilities to be working on improvement efforts when residents would go to the emergency departments and they'd immediately start cultures or treat and call it a UTI.

Next Speaker: They do all the time.

Next Speaker: And that made them fail badly and I also in my, um, site consultations have met with hospital **** who are saying there's too much antibiotic treatment coming out of the emergency department, it's masking the real source of the infection. So I think again future grant opportunities we should really think of partnership between, um, long-term care, emergency departments and acute care ****

Next Speaker: You see that inpatient all the time too, uh, urine cultures sent for no reason.

Next Speaker: Yeah I think we can have a huge impact on antibiotic stewardship and multi-drug resistant organisms in the community.

Next Speaker: Okay thank you.

Next Speaker: No thank you, thank you for that overview. I mean I, I, um, what I would like to do in, in future meetings is almost sort of have a, a theme **** we can't spend a meeting talking about **** interception of these different types of projects, um, uh, also there's been some interesting talk, in talking specifically about infection prevention and reporting in, uh, long-term care so that's another **** idea. Um, so actually, ****I think, um, you know some of the topics that we thought about for future meetings and I'm interesting in hearing some brainstorming on this, um, you know, um, we have the surveys that Oregon sent just actually sent out earlier this month, um, surveys to all hospital, skilled nursing facilities, **** surgical center and outpatient clinics and a lot of the questions asked on these were kind of driven by, um, some of the **** tools that Mary, uh, discussed and so we have some statewide information where we can look at certain metrics and look at kind of training competencies and I think it would be wonderful to be able to look at that along with some of our, you know, credentialing partners and, uh, you know, trying to figure out, uh, how we might kind of, um, how we might, uh, you know, move the needle on, on some of these gaps because it sounds like, like many of them have **** issues. Um, uh, yeah so long-term care and residential settings is a, a particular, uh, topic. I know there's a lot of interest in here and, um, and also Mary had mentioned some, you know, specific, uh, issues with sterilization, disinfection and environmental reprocessing. So those were some ideas for kind of, you know, just get a theme to focus our, our meetings around. Um, we also wanna, wanna kind of bring, um, Judy Guzman back into the fold with the next **** hospital, **** now centers or excellence for emerging infections. They're talking about what that looks like and how those resources will be **** and, um, other NHSN infection specific.

Next Speaker: ****

Next Speaker: Oh sorry ****

Next Speaker: That, that clock's wrong, I just realized ****

Next Speaker: I know I totally forgot.

Next Speaker: Can I ask one thing? With all of this stuff here it seems to be just meeting quarterly, we're never gonna get to all of this and so not that, slap me if, when I say this but, um, either extend this meeting a little bit or go back to every other month just because ****

Next Speaker: Or **** like some of these topics it might be more, of more value for preparedness partners to be in here when we're talking about like transitions of care and preparing, you know ****.

Next Speaker: Um, yeah I mean I, I think maybe having like some subcommittees, um, that would met more regularly. I, you know, I'm definitely open to those ideas.

Next Speaker: I think it's great that somebody's asking for more meetings.

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: ****

Next Speaker: ****

Next Speaker: I mean you know what I mean, it's a reality.

Next Speaker: I don't mean to dilute this because sometimes subcommittees can be very challenging as well. This is a relatively small group.

Next Speaker: Yeah.

Next Speaker: And it's like, you know even if we start by okay let's add on 30 minutes and see what we can get through and whatever. I mean it just, that it seems like I hate to wait three months to get to talk about this.

Next Speaker: ****

Next Speaker: Ex, extending the time might be easier for us than adding.

Next Speaker: Than adding, yeah I would say that would be.

Next Speaker: Just like here we can **** make it much easier and probably for everyone ****

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: Yeah does anybody on the phone have any, um, comments or feedback? We do have a public comment that was brought to us, I mean I can also I think 'cause people have to leave please feel free and I can summarize this in an email. This was brought to us by, um, a physician who's in independent living. Um, he basically said the Oregon Health Authority currently requires hospitals, ASCs and skilled nursing facilities to report annual healthcare worker **** vaccination rate. Since moving to the continuing care retirement community I've been surprised by the number of residents of independent living with two or more CDC risk factors for influenza, residents are unprepared to protect themselves by having annual influenza vaccinations as well as to practice hand hygiene. Unfortunately immunizations are not always effective. The CDC reports individuals infected with influenza may be contagious the day before someone develops symptoms. Strategies focus on instructing healthcare workers to stay home if they're sick are not enough. Um, because of this potentially life-threatening illness, residents in all long-term care settings including assisted living, independent living and those

receiving home care deserve robust influenza protection. So I think our influenza reporting does not apply outside of skilled nursing facilities. So this person said Oregon should know that California recently passed Senate Bill 792, it's a very well researched comment. Employees and volunteers are required to have influenza, measles and pertussis immunization, child daycare centers and Senate Bill 277, uh, about children who are required to have vaccines. So this person said the Oregon Health Authority should consider requiring healthcare worker vaccination rates across the continuum of care for all residential care settings and a law, a law should be considered that stipulates that anyone considering employment or volunteering at healthcare, in healthcare industry be immunized for influenza or mask as protocols used by Providence or OHSU ****. So I, I, um, think this is an important public comment and it is, it does bring up the issue of, of reporting outside of, um, **** just something we kind of have more direct control over, um, and toward the larger issue of, of mandatory healthcare worker vaccination which I know is sort of an issue being taken on by our immunization program. But if people are interested in, in bringing that to this committee, that's another potential sub topic that we could, we could address and we could ****

Next Speaker: Well I'm totally interested in that because I have gone as part of **** legislative, uh, I have talked to, um one of the representatives about this and it, you need to, uh, get a champion to change the law currently in Oregon to mandate, uh, immunization and getting buy in and, uh, there's a strong contingent in this state which has the lowest immunization rates in the nation pretty much. Um, I, I think it's worth a try but I think it's an uphill battle to get a law passed that would mandate immunizations.

Next Speaker: I think there's strong, obvious **** strong lobbying against that particularly from some of the labor unions mandating because what then if they don't, are they gonna lose their job **** I know at OHSU when we tried that, um, it was a lot of **** a lot of **** a lot of hard work and we still didn't get everything we wanted in terms of protecting the patient. It was more about protecting the healthcare worker and their job. So **** the lobbying I, until I got into this job I had no, um, recollection, I had no idea how strong that lobby really is because even things that are for public safety, unless certain organizations support it, it's not gonna happen.

Next Speaker: Yeah we're one of the few states, if the only, I can't remember that have a requirement **** well you can't do that.

Next Speaker: Right, you can't.

Next Speaker: You can't force them.

Next Speaker: And there, there's, uh, legislation across, in some of the states across the country to get that changed or to go from mandatory to you can't. So there's a lot of states right now with this on their dockets.

Next Speaker: Right.

Next Speaker: But it, in 2017 is the next legislative session.

Next Speaker: Jen, and this Jen, the other piece is, you know, I just, I just keep seeing it's just in hospitals as ASCs and skilled nursing facilities that would get it, where we get the flu vaccination so maybe, extending that, at least surveillance reporting or having a better idea **** as a stepping stone to realizing that.

Next Speaker: ****

Next Speaker: **** reported data.

Next Speaker: ****

Next Speaker: **** maybe in the interim before I, you know I can talk to Deb *** about what is this a reasonable kind of require, if we're gonna be considering this what would be, um, what do we need to do **** and then what **** have on ****

Next Speaker: Yeah it's very complicated.

Next Speaker: It'd be huge, it's very complicated to require that.

Next Speaker: ****

Next Speaker: I know that **** residential are we have about 464. I don't know how many ****

Next Speaker: Yeah I think there's like 705 **** or something.

Next Speaker: So it's, it's a huge **** let's, you know ****

Next Speaker: ****

Next Speaker: Okay thank you everyone, I'm sorry we ran over but I really appreciate ****

Next Speaker: Thanks ****